Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2012

SUPPORTING STATEMENT FOR PAPERWORK REDUCTION ACT SUBMISSIONS

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.

Section 2715 of the PHS Act directs the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (collectively, the Departments), in consultation with the National Association of Insurance Commissioners (NAIC) and a working group comprised of stakeholders, to "develop standards for use by a group health plan and a health insurance issuer in compiling and providing to applicants, enrollees, and policyholders and certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage

A notice of proposed rulemaking (NPRM) was published on August 22, 2011 (76 FR 52442) with an accompanying document (76 FR 52475) containing the templates, instructions, and related materials for implementing the disclosure provisions under PHS Act 2715. The NPRM proposed to add section 200 to Part 147 of Title 45 of the Code of Federal Regulations. The Department is now publishing a final rule that takes into account comments received on the proposal.

To implement these disclosure requirements, collection of information requests relate to the provision of the following:

- Summary of benefits and coverage, which includes coverage examples.
- A uniform glossary of health coverage and medical terms.
- Notice of modifications.

Group health plans and health insurance issuers will be required to use the SBC template and instructions for completing the template, as authorized by the Departments, to satisfy the section 2715 disclosure requirements.

For each benefits package offered, requested, or provided, as applicable, a plan or issuer will populate the SBC template with the applicable plan or coverage information, including the following: (1) a description of the coverage, including cost sharing, for each category of benefits identified in guidance by the Secretary; (2) exceptions, reductions, and limitations of the coverage; (3) the cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations; (4) the renewability and continuation of coverage provisions; (5) coverage examples that illustrate common benefits scenarios (including

pregnancy and serious or chronic medical conditions) and related cost sharing; (6) identifying information for the plan or coverage and contact information for questions and for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance); (7) for plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers; (8) for plans and issuers that provide prescription drug coverage through a formulary, an Internet address (or similar contact information) for obtaining information on prescription drug coverage; and (9) an Internet address (or similar contact information) where a consumer may review and obtain the uniform glossary

In order to produce coverage examples (CEs) for various benefits scenarios, plans and issuers will simulate claims processing for clinical care provided under each scenario using the services, dates of service, billing codes, and allowed amounts provided by HHS. Benefits scenarios will be based on recognized treatment guidelines available through the National Guideline Clearinghouse. Allowed amounts for each service will be based on national averages. Plans and issuers will follow the instructions for estimating and displaying costs in a standardized format authorized by HHS. The purpose of the coverage examples is to help consumers synthesize the impact of multiple coverage provisions in order to compare the level of protection offered by a plan or coverage for common benefit scenarios. Initially, two coverage examples (uncomplicated pregnancy and routine maintenance of well-controlled Type II diabetes) will be included in the SBC.

Because the statute additionally requires the Secretary to "provide for the development of standards for the definitions of terms used in health insurance coverage," including specified insurance-related and medical terms, the Departments have interpreted this provision as requiring plans and issuers to make available a uniform glossary of health coverage and medical terms that is two (2) double-sided pages in length. Plans and issuers must include an Internet address (to either the plan's or issuer's website, or the website of HHS or DOL) in the SBC for consumers to access the glossary and provide a paper copy of the glossary within 7 days upon request. Plans and issuers may not modify the glossary provided in guidance by the Departments.

Finally, "if a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the ERISA) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer must provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective." Thus, the Departments will require plans and issuers to provide 60-days advance notice of any material modification in any of the terms of the plan or coverage that (1) affect the information required to be included the SBC; (2) occur during the plan or policy year, other than in

connection with renewal or reissuance of the coverage; and (3) is not otherwise reflected in the most recently provided SBC.

In developing the requirements for these collections of information, the Departments have based the disclosures on the documents recommended by the NAIC, including the SBC template (with instructions, samples, and a guide for Coverage examples calculations to be used in completing the SBC template) and the uniform glossary. However, the Department has made modifications in response to comments on the proposal. These collection instruments were developed and agreed to by the entire NAIC working group and recommended to the Departments by the full NAIC membership.

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.*

Beginning in 2013 this information collection will help to ensure that approximately 138 million participants and beneficiaries enrolled in ERISA covered group health plans receive the consumer protections of the Affordable Care Act. Employers, employees, and individuals will use this valuable information to compare plan or coverage options prior to selecting coverage and to understand the terms of, and extent of medical benefits offered by, their plan or coverage (or exceptions to such coverage or benefits) once they have coverage.

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.*

The SBC template will be made available to plans and issuers in MS Word, a widely available word processing application. Plans and issuers may choose to populate the template manually or to develop systems to capture and report the relevant data in the required standardized format.

With respect to the coverage examples, HHS will make available in an Excel spreadsheet the clinical benefits scenarios, including specific services, dates of service, billing codes, and allowed charges associated with each scenario. Plans and issuers will simulate processing of claims under each benefits scenario to generate an illustration of costs a consumer could expect to share with the plan or coverage. Plans and issues should eventually be able to generate these outputs using automated systems for each benefits package they offer. At the outset, however, calculations for the Coverage example may need to be performed manually, such as using Excel.

Once completed, the SBC may be provided either in paper form or, if certain safeguards are met, in electronic form. Electronic disclosure in the group markets, where appropriate, will help reduce the cost and burden of distributing this information.

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.*

Under the health care reform insurance web portal requirements at 45 CFR 159, HHS collects summary information about health insurance products that are available in the individual and small group markets. The web portal collection is similar to a subset of this information collection (i.e., information about health insurance coverage options offered to individuals or small employer groups prior to medical underwriting). To reduce duplication, this NPRM would deem individual and small group market issuers that comply with the Web portal collection compliant with part of this collection. The Departments nonetheless expect some duplication, as issuers will be required to provide such information in paper form upon request.

In addition, under the disclosure requirements at 29 CFR 2520, Employee Retirement Income Security Act (ERISA)-covered group health plans are already required to disclose to participants and beneficiaries similar plan information in a summary plan description (SPD). This collection will require plans to summarize such SPD information so consumers may better understand the terms of the plan and meaningfully compare plan options. While this collection will thus duplicate some information collected under ERISA, the burden of compiling and providing it in the required standardized format is reduced, because it is readily available to plan sponsors and administrators and disclosed as part of their current operations.

5. *If the collection of information impacts small businesses or other small entities (Item 5 of OMB Form 83-I), describe any methods used to minimize burden.*

The regulation applies to all employee benefit plans and therefore is likely to affect small entities (small business, small plans) that provide benefits. A large majority of small plans purchase administration services from insurers, HMOs, and other service providers, and the Department has taken this fact into account in deriving its burden estimates. These service providers typically develop a single processing system to service a large number of customers, including small entities. Thus, the cost of preparing and distributing the disclosures 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 the disclosures. Finally, the vast majority of health insurance issuers are not small businesses.[1]

1 The Small Business Administration threshold for a small business is $7 million in annual receipts for both health insurers (North American Industry Classification System, or NAICS, Code 524114). Using total Accident and Health (A&H) earned premiums from the 2009 National Association of Insurance Commissioners (NAIC) Health and Life Blank as a proxy for annual receipts, we estimate 28 small entities with less than $7 million in A&H earned premiums offering individual or group comprehensive major medical coverage; however, this estimate may overstate the actual number of small health insurance issuers offering such coverage, since it does not include receipts from these companies' other lines of business. These 28 small entities represent about 6.3% of 442 total health insurers.

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.*

This collection is required to fulfill the statutory requirements under PHS Act section 2715. This collection will ensure that at multiple points in the enrollment process consumers have accurate information with which to understand and compare plan and coverage options. If this collection is not conducted, or is conducted less frequently, consumers will not receive the protections to which they are entitled under the Affordable Care Act. If, however, information collected in the first instance does not change in subsequent collections, duplicate collections are typically not required during the plan or policy year. Furthermore, multiple collections are not required in the case of family coverage, if covered family members reside at the same address. These provisions will limit the collection burden on the industry while providing meaningful and consistent information to consumers.

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.*

Plans and issuers are required to provide the SBC to an applicant upon request of an application for, or health coverage information about, a policy, certificate, or contract of insurance and upon request for enrollment pursuant to a special enrollment right. In such

instances, disclosure must occur as soon as practicable, but not later than 7 days after receipt of the request. Similarly, upon general request, plans and issuers are required to provide the SBC as soon as practicable, but not later than 7 days after the receipt of the request. Depending on the number of such requests, plans and issuers may have to provide several copies of the SBC.

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 proposed rule published in the *Federal Register* on August 22, 2011 (76 FR 52460) provided the public with a 60-day period to submit written comments on the rule and the ICR.

As required by PHS Act section 2715, the Departments consulted on this information collection with the NAIC, which convened a multi-stakeholder working group composed of representatives of consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals. The NAIC process, conducted over many months, was open to the public and permitted oral and written comments from interested parties (NAIC records indicate that approximately 100 people participated in each working group session). America's Health Insurance Plans, Blue Cross Blue Shield Association, Consumers' Union, and others funded consumer focus-group and cognitive interview testing to determine the usability of the forms. Additionally, the NAIC invited expert comment on the readability of the forms. These forms were recommended to the Departments by unanimous consent of the working group and the NAIC.

In addition to the NAIC process, the Department consulted with industry experts, including health insurance issuers and groups representing employers with self-funded health plans, to gain insight into the hour and cost burden associated with this collection, the tasks and level of effort required, and the availability of data.

The Department received comments on several provisions of the proposal suggesting ways to reduce the burden of the information collection. Commenters expressed concern that

time requirements to provide SBCs under the proposal were administratively difficult and costs could be reduced if additional time was allowed to provide SBCs. The Department modified the time requirements in response. The Department solicited comments in the proposal about four content items recommended by the NAIC that were not part of the statute. In response to the comments received, these final regulations generally retained two of the proposed additional content elements without change, modified the third, and deleted the fourth (a requirement to include premiums in the SBC). The proposed rule required three coverage fact labels, but in response to comments current guidance only includes two coverage fact labels, with more possible in the future. The Department also modified the rule in response to comments to allow plans to include the SBC as part of other plan materials provided certain conditions are met. Commenters emphasized that meeting a March 23, 2012 applicability date would be costly. In response, the Departments moved the applicability date to beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. With respect to enrollment other than through open enrollment, these final regulations apply on the first date of the first plan year that begins on or after September 23, 2012.

9. *Explain any decision to provide any payment or gift to respondents, other than remuneration of contractors or grantees.*

Not applicable.

10. *Describe any assurance of confidentiality provided to respondents and the basis for the assurance in statute, regulation, or agency policy.*

This information collection request (ICR) requires the disclosure of information regarding, among other things cost-sharing, covered benefits, and exceptions, reductions and limitations on coverage by plans and issuers directly to consumers. The purpose of this collection is to summarize information about the terms of the applicable plan or coverage that is described in fuller detail in the policy, certificate, or contract of insurance or other plan document. Therefore, the Departments believe this collection does not require the disclosure of trade secrets or other confidential information.

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.*

None.

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 and aggregate the hour burdens in Item 13 of OMB Form 83-I.*

- *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.*

Each group health plan and health insurance issuer offering group or individual health insurance coverage must provide a summary of benefits and coverage (SBC) to entities and individuals at specified points in the enrollment process. This disclosure must include, among other things, coverage examples that illustrate common benefits scenarios and related cost sharing. Additionally, plans and issuers must make the uniform glossary available in electronic form, with paper upon request, and provide 60-days advance notice of any material modifications in the plan or coverage.

Although coverage examples are part of the SBC disclosure, the Departments calculate separate burden estimates for purposes of this section, assuming the information collection request for the SBC (not including coverage examples) totals six (6) sides of a page in length and assuming the information collection request for coverage examples totals two (2) sides of a page in length.

The Departments estimate 858 respondents each year from 2012-2013. This estimate reflects approximately 220 issuers offering comprehensive major medical coverage in the small and large group markets and approximately 638 third-party administrators (TPAs).[2]

2 With respect to employer-sponsored coverage, the Departments assume fully-insured plans will rely on health insurance issuers and self-insured plans will rely on TPAs to generate, review, update, and distribute SBCs. While plans may prepare the SBC disclosures internally, the Departments make this simplifying assumption because most plans appear to rely on issuers and TPAs for the purpose of administrative duties, such as enrollment and claims processing. Thus, the Departments use health insurance issuers and TPAs as the unit of analysis for the purposes of estimating administrative costs. The Departments estimate there are a total of 440 issuers and 750 TPAs. Because the Departments of Labor and the Treasury share the hour and cost burden for fully-insured plans with the Department of Health and Human Services, these hour and cost burden estimates for group health plans are calculated using approximately half the number of issuers (220) and 85% of the number of TPAs (638).

To account for variation in firm size, the Departments estimate a weighted burden on the basis of issuers' 2009 total earned premiums for comprehensive major medical coverage.[3] The Departments define small issuers as those with total earned premiums less than $50 million; medium issuers as those with total earned premiums between $50 million and $999 million; and large issuers as those with total earned premiums of $1 billion or more. Accordingly, the Departments estimate approximately 70 small, 115 medium, and 35 large issuers. Similarly, the Departments estimate approximately 204 small, 332 medium, and 102 large TPAs.

The Department of Labor and the Department of the Treasury have shared jurisdiction over ERISA covered health plans. The burden for the information collection is therefore shared by both Departments. The analysis below includes the total burden. The total burden is then evenly split between the two Departments

2012 Burden Estimate

Burden Estimate for One-Time Implementation Costs

The estimated hour burden and equivalent cost for the collections of information are as follows:

The Departments estimate a one-time administrative burden of 620,000 hours with an equivalent cost of about $34,000,000 across the industry to prepare for the provisions of these final regulations. This calculation is made assuming issuers and TPAs will need to implement two principal tasks: (1) develop teams to analyze current workflow processes against the new rules and (2) make appropriate changes to IT systems and processes.

With respect to task (1), the Departments estimate about 88,000 burden hours and an equivalent cost of about $4,500,000. The Departments calculate these estimates as follows:

3 The premium revenue data come from the 2009 NAIC financial statements, also known as "Blanks," where insurers report information about their various lines of business.

Task 1: Analyze Current Workflow and New Rules

	Hourly Wage Rate	Small Issuer / TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$54.52	32	$1,800	49	$2,600	65	$3,500
Benefits/Sales Professionals	$43.76	36	$1,600	54	$2,400	72	$3,200
Attorneys	$86.86	4	$310	5	$500	7	$630
Total per issuer/ TPA		72	$3,700	108	$5,500	144	$7,300
Total for all issuers/TPAs		20,000	$1,000,000	48,000	$2,500,000	20,000	$1,000,000

With respect to task (2), the Departments estimate about 530,000 burden hours and an equivalent cost of about $29,000,000. The Departments calculate these estimates as follows:

Task 2: IT Changes

	Hourly Wage Rate	Small Issuer/TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$54.52	432	$24,000	648	$35,000	864	$47,000
Total per issuer/TPA		432	$24,000	648	$35,000	864	$47,000
Total for all issuers/TPAs		120,000	$6,600,000	290,000	$16,000,000	120,000	$6,400,000

The estimated hour burden and equivalent cost for the collections of information are as follows:

- The Departments estimate there will be about 77,000,000 disclosures with SBC content elements.
- The Departments assume that 50 percent of the total number of disclosures would be sent electronically prior to enrollment, and 38 percent would be sent electronically after enrollment, in the small and large group markets. Accordingly, the Departments estimate that about 31,000,000 disclosures would be electronically distributed, and about 46,000,000 disclosures would be distributed in paper form. The Departments

assume there are costs only with regard to paper disclosure but no costs for electronic disclosure.

Disclosures with SBC Content Elements – In 2012, issuers and TPAs in the group market will only be responsible for generating SBC content elements, but not SBC format elements, for the 2013 open enrollment season. Based on this assumption, the estimated hour burden to generate the SBC content elements is about 780,000 hours, and the estimated total equivalent cost is about $24,000,000. The Departments calculate these estimates as follows:

Equivalent Costs for Producing Disclosures with SBC Content Elements (Except Coverage Examples)

	Hourly Wage Rate	Small Issuer/TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$54.52	1.5	$82	1.5	$82	1.5	$82
Benefits/Sales Professionals	$43.76	1.5	$66	1.5	$66	1.5	$66
Financial Managers	$78.50	0.5	$39	0.5	$39	0.5	$39
Attorneys	$86.86	0.5	$43	0.5	$43	0.5	$43
Total per issuer/TPA		4	$230	4	$230	4	$230
Total for all issuers/ TPAs		1,100	$63,000	1,800	$100,000	500	$32,000

Equivalent Costs for Distributing Disclosures with SBC Content Elements (Including Coverage Examples)

	Hourly Wage Rate	Hours per SBC	Total Number of SBCs	Total Hours	Total Equivalent Cost
Clerical Staff	$30.78	0.017	46,000,000	780,000	$24,000,000

Coverage examples – A coverage example for maternity care is included in each SBC and will require issuers and TPAs to simulate claims processing for services, and apply the plan's or coverage's cost-sharing rules and benefit limitations and exclusions as appropriate. The Departments estimate an hour burden of about 69,000 hours and an equivalent cost of about $4,000,000. The Departments calculate these estimates as follows:

Equivalent Costs for Producing Coverage Examples

	Hourly Wage Rate	Small Issuer/TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$54.52	30	$1,640	30	$1,640	30	$1,640
Benefits/Sales Professionals	$43.76	30	$1,310	30	$1,310	30	$1,310
Financial Managers	$78.50	10	$780	10	$780	10	$780
Attorneys	$86.86	10	$870	10	$870	10	$870
Total per issuer/TPA		80	$4,600	80	$4,600	80	$4,600
Total for all issuers/TPAs		21,900	$1,260,000	36,000	$2,100,000	11,000	$630,000

Uniform glossary – The Departments assume that in 2012, issuers and TPAs will begin responding to glossary requests from covered individuals, and that 2.5 percent of covered individuals, who receive the SBC in paper form will request glossaries in paper form (that is, about 1,200,000 glossary requests). The Departments estimate the burden and equivalent cost of providing the glossary to be 2.5 percent of the burden and cost of distributing the SBC in paper form. Accordingly, in 2012, the Departments estimate an hour burden of about 24,000 hours and an equivalent cost of about $740,000 associated with about 1,200,000 glossary requests.

The total 2012 burden estimate is about 1,500,000 hours with an equivalent cost of about $63,000,000.

2013 Burden Estimate

The estimated hour burden and equivalent cost for the collections of information are as follows:

SBCs – The number of SBC responses in 2013 is assumed to remain constant at 2012 levels (that is, 77,000,000 responses). Thus, in 2013, the Departments again estimate an hour burden of about 780,000 hours and an equivalent cost of about $24,000,000 to prepare the SBCs.

Coverage examples – The Departments again estimate an hour burden of about 69,000 hours and an equivalent cost of about $4,000,000 to produce coverage examples in 2013.

Notice of modifications – The Departments assume that in 2013, issuers and TPAs will begin sending notices of modifications to covered individuals, and that 2 percent of covered individuals would receive such notice (that is, about 1,500,000 notices). The Departments estimate the burden and cost of providing the notices to be 2 percent of the combined burden and cost of the SBCs (including the coverage examples). Accordingly, in 2013, the Departments estimate an hour burden of about 17,000 hours and an equivalent cost of about $570,000.

Uniform glossary – The Departments assume that in 2013, issuers and TPAs will again respond to requests of covered individuals for paper copies of the uniform glossary, and that 5 percent of covered individuals, who receive the SBC in paper form, will request glossaries in paper form (that is, about 2,300,000 glossary requests). The Departments estimate the burden and equivalent cost of providing the glossary to be 5 percent of the burden and cost of distributing the SBC in paper form. Accordingly, in 2013, the Departments estimate an hour burden of about 39,000 hours and an equivalent cost of about $1,200,000.

Maintenance Administrative Costs – In 2013, the Departments assume that issuers and TPAs will need to make updates to address changes in standards, and, thus, incur 15 percent of the one-time administrative burden. Accordingly, the estimated hour burden is about 93,000 hours, with an equivalent cost of about $4,800,000. The Departments calculate these estimates as follows:

	Hourly Wage Rate	Small Issuer/TPA		Medium Issuer/TPA		Large Issuer/TPA	
		Hours	Equivalent Cost	Hours	Equivalent Cost	Hours	Equivalent Cost
IT Professionals	$54.52	42	$2,300	62	$3,400	83	$4,500
Benefits / Sales Professionals	$43.76	30	$1,300	45	$2,000	60	$2,600
Attorneys	$86.86	4	$350	6	$520	8	$690
Total per issuer/TPA		76	$4,000	113	$5,900	151	$7,800
Total for all issuers/TPAs		21,000	$1,100,000	51,000	$2,600,000	21,000	$1,100,000

The total 2013 burden estimate is about 1,000,000 hours with an equivalent cost of nearly $35,000,000.

The Department of Labor's share of the total burden is therefore in 2012 about 747,000 hours with an equivalent cost of $31.4 million and in 2013 about 500,000 hours with an equivalent cost of $17.3 million.

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).*

2012 Cost Burden Estimate

- The Departments estimate that there will be about 77,000,000 disclosures with SBC content elements in 2012.
- The Departments assume that 50 percent of the total number of disclosures would be sent electronically prior to enrollment, and 38 percent would be sent electronically after enrollment, in the small and large group markets. Accordingly, the Departments estimate that about 31,000,000 disclosures would be electronically distributed, and about 46,000,000 disclosures would be distributed in paper form. The Departments assume there are costs only with regard to paper disclosures, but no costs for electronic disclosures.
- The Departments estimate grayscale printing costs at $0.03 per single side of a page. The Departments make the assumption that the cost of printing a SBC 12 cents.
- The Departments assume that in 2012, issuers and TPAs will begin responding to requests of covered individuals for paper copies of the uniform glossary, and that 2.5 percent of covered individuals who receive the paper SBC will request glossaries in paper form (that is, about 1,200,000 glossary requests). The Departments estimate the cost of providing the glossary in paper form to be 2.5 percent of the cost of distributing the paper copies of the SBC, plus an additional cost burden for $0.50 for each glossary (including $0.45 for first-class postage and $0.05 for supply costs).

The estimated cost burdens for the collections of information are as follows:

Cost Burden for Printing SBC (Except Coverage Examples)

	Cost per Disclosure	Total Disclosures	Total Cost Burden
Printing Costs	$0.12	46,000,000	$5,500,0000

Cost Burden for Printing Coverage Examples

	Printing Cost Per Coverage Example	Total Number of Coverage Examples Printed	Total Cost Burden
Printing Costs	$0.06	46,000,000	$2,800,000

Cost Burden for Printing and Mailing Uniform Glossaries

	Printing Cost Per Glossary	Mailing Costs Per Glossary	Total Glossaries Requested/Printed	Total Cost Burden
Printing Costs	$0.12	$0.50	1,200,000	$740,000

2013 Cost Burden Estimate

- The Departments make the same assumptions regarding the number of SBCs and electronic distribution.
- The Departments assume that in 2013, issuers and TPAs would begin sending notices of modifications to covered individuals and that 2 percent of covered individuals would receive such notice (that is, about 1,500,000 notices). The Departments estimate the cost of providing the notices to be 2 percent of the cost of providing SBCs (including coverage examples). Notices are assumed to be equal in length to the SBC (that is, six (6) sides of a page).
- The Departments assume 5 percent of covered individuals who receive the SBC in paper form will request paper copies of the uniform glossary (that is, about 2,300,000 glossary requests). The Departments estimate the cost of providing the notices to be 5 percent of the cost of distributing paper copies of the SBC and make the same assumptions about postage and supply costs in 2013 as in 2012.

The estimated cost burdens for the collections of information are as follows:

Cost Burden for Printing SBCs

	Cost per SBC	Total SBCs	Total Cost Burden
Printing Costs	$0.12	46,000,000	$5,500,000

Cost Burden for Printing Coverage examples

	Printing Cost Per Coverage Example	Total Number of Coverage Examples Printed	Total Cost Burden
Printing Costs	$0.06	46,000,000	$2,800,000

Cost Burden for Printing and Mailing Notices of Modifications

	Printing Cost Per Notice	Mailing Costs Per Notice	Total Notices Printed	Total Cost Burden
Printing Costs	$0.18	$0.50	920,000	$630,000

Cost Burden for Printing and Mailing Uniform Glossaries

	Printing Cost Per Glossary	Mailing Costs Per Glossary	Total Glossaries Requested/Printed	Total Cost Burden
Printing Costs	$0.12	$0.50	2,300,000	$1,400,000

The total 2012 cost burden estimate is about $9.0 million and the 2013 cost burden estimate is about $10.3 million.

The Department of Labor's share of the total burden is therefore in 2012 about $4.5 million and in 2013 about $ 5.2 million.

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.*

These information collection tools were developed by the Federal government for use by the industry. The Departments will periodically update these forms, as necessary. But because there are no program costs associated with this collection, the annualized cost to the Federal government is minimal.

15. *Explain the reasons for any program changes or adjustments reporting in Items 13 or 14 of the OMB 83-I.*

This is a new collection of information.

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.*

Not applicable.

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.*

The Departments request an exemption from displaying the expiration date, as these forms will be used on a continuous basis. To include an expiration date would result in having to discard a potentially large number of forms.

18. *Explain each exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submission," of OMB 83-I.*

Not applicable; no exceptions to the certification statement.