Supporting Statement for the Information Collection Requirements Contained in Summary of Benefits and Coverage and Uniform Glossary Final Rule (CMS-9982-F)

A. Justification

1. Circumstances Making the Collection of Information Necessary

The Patient Protection and Affordable Care Act, Pub. L. 111-148, was signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, was signed into law on March 30, 2010 (collectively known as the "Affordable Care Act"). The Affordable Care Act amends the Public Health Service Act (PHS Act) by adding section 2715 "Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions." This section directs the Secretary, 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 (SBC) explanation that accurately describes the benefits and coverage under the applicable plan or coverage. Section 2715 also requires 60-days advance notice of any material modification in any of the terms of the plan or coverage that is not reflected in the most recently provided summary and the development of standards for the definitions of terms used in health insurance 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. A final rule was published on 02/14/2012.

Section 147.200(a)(1) requires a group health plan and a health insurance issuer to provide a written summary of benefits and coverage for each benefit package to entities and individuals at specified points in the enrollment process.

As specified in §147.200(a)(2), a plan or issuer will populate the SBC 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; (9) an Internet address (or similar contact information) where a consumer may review and obtain the uniform glossary; and (10) with respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage as defined under section 5000A(f) of the Internal Revenue Code and whether the plan's or coverage's share of the total allowed costs of coverage meets applicable requirements.

In order to produce coverage examples, a plan or issuer 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 as defined by the National Guideline Clearinghouse. Allowed amounts for each service will be based on national averages. Plans and issuers will follow instructions for estimating and displaying costs in a standardized format authorized by HHS. The purpose of the coverage examples tool 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. In the first year of implementation, two coverage examples (having a baby and managing type 2 diabetes) will be required 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 double-sided pages in length. Plans and issuers must include an Internet address in the SBC for consumers to access the glossary and provide a paper copy of the glossary within seven 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 shall 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 60-days advance notice of any material modification in any of the terms of the plan or coverage that (1) affects the information required to be included the SBC; (2) occurs 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. A plan or issuer may satisfy this requirement by providing either an updated SBC or a separate notice describing the modification.

HHS is requesting three-year approval by the Office of Management and Budget so that plans and issuers may begin using the forms for making the disclosures under PHS Act section 2715 and the final regulations.

2. Purpose and Use of Information Collection

This information collection will ensure that approximately 90 million consumers shopping for or enrolled in private, individually purchased or non-federal governmental group health plan coverage receive the consumer protections of the Affordable Care Act. Employers, employees, and individuals will use this information to compare coverage options prior to selecting coverage and to understand the terms of, and extent of medical benefits offered by, their coverage (or exceptions to such coverage or benefits) once they have coverage.

3. Use of Information Technology

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

With respect to coverage examples, HHS will make available in an Excel worksheet the clinical benefits scenario(s), including specific services, dates of service, billing codes, and allowed charges associated with each scenario. Plans and issuers will simulate claims processing under each scenario to illustrate how a consumer could expect to share costs with the plan or coverage. Plans and issues may either generate these outputs using automated systems or perform the calculations manually, such as using Excel.

An issuer is permitted to provide the SBC electronically, such as via e-mail or posting on the Internet, if certain safeguards are met to ensure the manner of disclosure results in actual receipt. Flexibility for electronic disclosure will help reduce cost and administrative burden and increase timeliness and accuracy. The Department anticipates approximately 70 percent electronic distribution in the individual market and approximately 44 percent electronic distribution in the group market.[1]

4. Efforts to Identify Duplication and Use of Similar Information

Under the federal health care reform insurance Web portal requirements, 45 CFR 159.200, HHS collects summary information about health insurance products that are available in the individual market. To reduce duplication for purposes of the SBC collection, we will permit individual market issuers compliant with the Web portal collection to voluntarily report to the Web portal for display the five additional data elements (not currently collected through the Web portal collection) for each coverage example. Issuers providing the additional data elements to Web portal collection will be deemed to satisfy the requirement to provide an SBC to individuals in the individual market requesting summary information, prior to submitting an application for coverage.

Under the Employee Retirement Income Security Act (ERISA) disclosure requirements, 29 CFR 2520.104b-2, the plan administrator of an employee benefit plan subject to of Part 1 of

1 The Departments' estimate is based on statistics published by the National Telecommunications and Information Administration, which indicate 30 percent of Americans do not use the Internet. U.S. Department of Commerce, National Telecommunications and Information Administration, *Digital Nation* (February 2010), available at http://www.ntia.doc.gov/reports/2010/NTIA_internet_use_report_Feb2010.pdf.

Title I of ERISA is required to disclose to participants and beneficiaries similar plan information in a summary plan description (SPD). Plan administrators will modify the SPD information for purposes of this collection to generate a standardized summary of plan benefits and costs. Non-federal governmental plans are not subject to the SPD requirements, however, some non-federal governmental plans voluntarily comply with the SPD regulations, reducing the burden of reporting.

5. Impact on Small Businesses or Other Small Entities

Small businesses are not significantly affected by this collection. The information used to populate the form is readily available and disclosed by plans and issuers as part of their current operations. No capital costs are required for this effort. The electronic distribution of information should also ease burden among some plans and issuers. Limiting distribution of the SBC for covered individuals who reside at the same address, as well as other provisions designed to reduce unnecessary duplication, will also reduce the frequency of reporting. Finally, the vast majority of health insurance issuers and third-party administrators are not small businesses.[2] Small businesses are not significantly affected by this collection.

6. Consequences of Less Frequent Collection

This collection is required to fulfill the statutory requirements under PHS Act section 2715 and the final regulations. This collection will ensure that, at multiple points in the enrollment process, consumers have consistent and clear 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.

2 As discussed in the Web Portal interim final rule (75 FR 24481), HHS examined the health insurance industry in depth in the Regulatory Impact Analysis prepared for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis, HHS determined that there were few if any insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for ''small'' business established by the Small Business Association (SBA). Currently, the SBA size threshold is $7 million in annual receipts for both health insurers (North American Industry Classification System, or NAICS, Code 524114) and TPAs (NAICS Code 524292). Additionally, as discussed in the Medical Loss Ratio interim final rule (75 FR 74918), HHS used a data set created from 2009 National Association of Insurance Commissioners (NAIC) Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, HHS used total Accident and Health (A&H) earned premiums as a proxy for annual receipts. HHS estimated that there were 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 6.4 percent of the approximately 440 health insurers that are accounted for in this Economic Impact Analysis of the NPRM. Based on this calculation, the Departments assume that there are an equal percentage of TPAs that are small entities. That is, 48 small entities represent about 6.4 percent of the approximately 750 TPAs that are accounted for in this RIA.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

In some instances, respondents are required to compile and provide a written SBC in fewer than 30 days. Issuers will provide the SBC to individuals in the individual market and to group health plans in the fully-insured group market as soon as practicable but not later than 7 business days after receiving an application for health coverage. If there is any change in the information required to be in the SBC before the first day of coverage, issuers will updated and provide a current SBC not later than the first day of coverage. Additionally, plans and issuers will provide the SBC to any individual as soon as practicable but not later than 7 business days after receiving a request for an SBC or for summary information about health coverage, and they will provide the uniform glossary within 7 days of a request. Plans and issuers may have to provide multiple copies of the SBC or glossary depending on the number of requests.

8. Comments in Response to the Federal Register Notice/Outside Consultation

The 60-day *Federal Register* notice published on August 22, 2011 (76 FR 52460).

As required by PHS Act section 2715, the Departments consulted on this collection with the National Association of Insurance Commissioners (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. Both industry and consumer groups sponsored consumer testing to determine the usability of the forms, and the NAIC additionally invited expert comment on the readability of the forms.

The Departments also consulted with industry experts, including health insurance issuers and groups representing employers with self-funded health plans, to gain insight into the hour and burden associated with this collection, the tasks and level of effort required, and the availability of data.

9. Explanation of any Payments/Gifts to Respondents

Respondents will not receive any payments or gifts as a condition of complying with this information collection request.

10. Confidentiality

This collection does not require the disclosure of trade secrets or other confidential information. No individually identifiable personal health information will be collected.

11. Justification for Sensitive Questions

No sensitive information will be collected.

12. Burden Estimate (Hours & Wages)

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 Department calculates 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 Department estimates 333 respondents each year from 2012-2013. This estimate reflects the approximately 220 issuers offering comprehensive major medical coverage in the individual market and to fully-insured non-Federal governmental plans, and 113 third-party administrators (TPAs) acting as service providers for self-insured non-Federal governmental plans.[3]

To account for variation in firm size, the Department estimates a weighted burden on the basis of issuers' 2009 total earned premiums for comprehensive major medical coverage.[4] The Department defines 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 Department estimates approximately 70 small, 115 medium, and 35 large issuers. Similarly, the Department estimates approximately 36 small, 59 medium, and 18 large TPAs.

2012 Burden Estimate

3 With respect to the individual market, issuers are responsible for generating, reviewing, updating, and distributing SBCs. With respect to non-Federal governmental plans, the Department assumes fully-insured plans will rely on health insurance issuers and self-insured plans will rely on TPAs to perform these functions. While plans may prepare SBCs internally, the Department makes 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 Department uses 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 Department of Health and Human Services shares the hour and cost burden for fully-insured plans with the Departments of Labor and the Treasury, these hour and cost burden estimates for individual issuers and TPAs serving self-insured non-Federal governmental plans are calculated using approximately half the number of issuers (220) and 15% of the number of TPAs (113).

4 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

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

In 2012, the Department estimates a one-time administrative burden of about 230,000 hours with an equivalent cost of about $13,000,000 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 in relation to the new requirements and (2) make appropriate changes to IT systems and processes.

With respect to task (1), the Department estimates about 34,000 burden hours with an equivalent cost of about $1,800,000. The Department calculates these estimates as follows:

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	$600
Total per issuer/TPA		72	$3,700	108	$6,000	144	$7,000
Total for all issuers/TPAs		7,600	$390,000	19,000	$1,000,000	7,600	$370,000

With respect to task (2), the Department estimates about 200,000 burden hours with an equivalent cost of about $11,000,000. The Department calculates 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	$50,000
Total per issuer/TPA		432	$24,000	648	$35,000	864	$50,000
Total for all issuers/TPAs		46,000	$2,500,000	110,000	$6,100,000	46,000	$2,700,000

In addition to the one-time administrative costs mentioned above, the Department assumes that plans and issuers will incur additional administrative burden. With regard to this administrative burden, the estimated burden for the collections of information in 2012 is as follows:

- The Department estimates that there will be about 13,000,000 SBCs.

- The Department assumes 50 percent of the total number of SBCs would be sent electronically prior to enrollment, and 38 percent would be sent electronically after enrollment, in the small and large group markets. The Department further assumes 70 percent of SBCs would be sent electronically in the individual market. Accordingly, the Department estimates that about 7,100,000 SBCs would be electronically distributed, and about 6,200,000 SBCs would be distributed in paper form. The Department assumes there are costs only for paper disclosures, but no costs for electronic disclosures.

Task 3: SBCs – The estimated hour burden is about 130,000 hours with an equivalent cost of about $4,200,000. The Department calculates these estimates as follows:

Task 3: Equivalent Costs for Producing SBCs (Except Coverage Examples)

	Hourly Wage Rate	Small Issuer		Medium Issuer		Large Issuer	
		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		4	$230	4	$230	4	$230
Total for all issuers		420	$24,000	700	$40,000	210	$12,000

Task 3: Equivalent Costs for Distributing SBCs (Including Coverage Examples)

	Hourly Wage Rate	Hours per SBC	Total Number of SBCs	Total Hours	Total Equivalent Cost
Clerical Staff, Individual Market	$30.78	0.033	1,700,000	56,000	$1,700,000
Clerical Staff, Group Market	$30.78	0.017	4,500,000	77,000	$2,400,000
Total			6,200,000	130,000	$4,100,000

Task 4: Two Coverage Examples – Coverage examples for maternity care and managing type 2 diabetes are 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 Department estimates an hour burden of about 27,000 hours with an equivalent cost of about $1,500,000. The Department calculates 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		8,500	$490,000	14,000	$800,000	4,200	$240,000

Task 5: Uniform Glossary – The Department assumes that, in 2012, issuers and TPAs will begin responding to glossary requests from covered individuals, and that 2.5% of covered individuals, who receive paper SBCs, will request glossaries in paper form (that is, about 160,000 glossary requests). The Departments estimate that the burden of providing the glossary to be 2.5% of the burden of distributing the SBC in paper form. Accordingly, in 2012, the Department estimates an hour burden of about 2,700 hours with an equivalent cost of about $83,000.

The total 2012 burden estimate is 390,000 hours with an equivalent cost of about $19,000,000.

2013 Burden Estimate

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

Task 1: SBCs – The number of SBC responses in 2013 is assumed to remain constant at 2012 levels (that is, 13,000,000 responses). Thus, in 2013, the Department again estimates an hour burden of about 130,000 hours with an equivalent cost of about $4,200,000.

Task 2: Two Coverage Examples – The Department again estimates an hour burden of about 27,000 hours with an equivalent cost of about $1,500,000 to produce coverage examples in 2013.

Task 3: Notice of Modifications – The Department assumes that, in 2013, issuers will begin sending notices of modifications to covered individuals, and that 2% of covered individuals will receive such notice (that is, 260,000 responses). The Department estimates the burden of providing the notices to be 2% of the burden of providing SBCs with two coverage examples. Accordingly, in 2013, the Department estimates an hour burden of

about 3,100 hours with an equivalent cost of about $118,000 associated with approximately 260,000 notices of modifications.

Task 4: Uniform Glossary – The Department assumes that, in 2013, issuers and TPAs will continue to respond to glossary requests, and that 5% of covered individuals, who receive paper SBCs, will request glossaries in paper form (that is, about 310,000 glossary requests). The Department estimates the burden of providing the glossary to be 5% of the burden of distributing the SBC in paper form. Accordingly, in 2013, the Department estimates an hour burden of 5,300 hours with an equivalent cost of about $160,000.

Task 5: Maintenance Administrative Costs – In 2013, the Department assumes 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 36,000 hours with an equivalent cost of about $1,800,000. The Department calculates 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		8,100	$420,000	20,000	$1,000,000	8,000	$410,000

The total 2013 burden estimate is about 200,000 hours with an equivalent cost of about $7,800,000.

Deemed Compliance Reporting (45 CFR 147.200(a)(4)(iii)(C))

Under §147.200(a)(4)(iii)(C), if individual health insurance issuers provide information required by these final regulations to the HHS Secretary's Web portal (HealthCare.gov), as established by 45 CFR 159.120, then they will be deemed to have satisfied the requirement to provide an SBC to individuals who request information about coverage prior to submitting an application for coverage. Individual health insurance issuers already provide most SBC content elements to HealthCare.gov, except for five data elements related to patient responsibility for each coverage example: deductibles, co-payments, co-insurance, limits or exclusions, and the total of all four cost-sharing amounts.

Accordingly, the additional burden associated with the requirements under §147.200(a)(4)(iii)(C) is the time and effort it would take each of the 220 issuers in the individual market to enter the five additional data elements into an Excel spreadsheet. We estimate that it will take these issuers about 110 hours, at a total estimated cost of $3,300, for each coverage example. For two coverage examples, the burden and cost would be about 220 hours at a cost of about $6,600.

In deriving these figures, we used the following hourly labor rates and estimated the time to complete each task: $ 30.78/hr and 0.5 hr/issuer for clerical staff to enter data into an Excel spreadsheet, or about $15 per respondent per coverage example.

This information collection requirement reflects the clarification in the final regulations that issuers must provide all content required in the SBC, including the information necessary for coverage examples, to Healthcare.gov to be deemed compliant. The aforementioned burden estimates will be submitted for OMB review and approval as a revision to the information collection request currently approved under OMB control number 0938-1086.

13. Estimates of other Total Annual Cost Burden to Respondents or Record Keepers/Capital Costs

2012 Cost Burden Estimate

- The Department estimates there will be about 13,000,000 SBCs.
- The Department assumes 50 percent of the total number of SBCs would be sent electronically prior to enrollment, and 38 percent would be sent electronically after enrollment, in the small and large group markets. The Department further assumes 70 percent of SBCs would be sent electronically in the individual market. Accordingly, the Department estimates that about 7,100,000 SBCs would be electronically distributed, and about 6,200,000 SBCs would be distributed in paper form. The Department assumes there are costs only for paper disclosures, but no costs for electronic disclosures.
- The Department estimates grayscale printing costs at $0.03 per single side of a page.
- The Department assumes 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% of covered individuals who receive paper SBCs will request glossaries in paper form (that is, about 160,000 glossary requests). The Department estimates the cost burden of providing the glossary in paper form to be 2.5% of the cost burden of providing paper copies of the SBC, plus an additional cost of $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 SBCs (Except Coverage Examples)

	Cost per SBC	Total SBCs	Cost Burden
Printing Costs	$0.12	6,200,000	$740,000

Cost Burden for Printing Coverage Examples

	Printing Cost Per Coverage Example Set	Total Number of Coverage Example Sets Printed	Total Cost Burden
Printing Costs	$0.06	6,200,000	$370,000

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	160,000	$99,000

2013 Cost Burden Estimate

- The Department makes the same assumptions regarding the number of SBCs, electronic distribution, and printing costs in 2013 as in 2012.
- The Department assumes that, in 2013, issuers and TPAs would begin sending notices of modifications to covered individuals and that 2% of covered individuals would receive such notice (that is, about 260,000 notices). The Department estimates the cost burden of providing the notices to be 2% of the cost burden of providing the SBCs (including coverage examples). Notices are assumed to be equal in length to the SBC (that is, six (6) sides of a page).
- The Department assumes 5% of covered individuals who receive the SBC in paper form will request paper copies of the uniform glossary (that is, about 310,000 glossary requests). The Department estimates the cost burden of providing the glossary to be 5% of the cost burden of distributing paper copies of the SBC and makes 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	6,200,000	$740,000

Cost Burden for Printing Coverage Examples

	Printing Cost Per Coverage Example Set	Total Number of Coverage Example Sets Printed	Total Cost Burden
Printing Costs	$0.06	6,200,000	$370,000

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	120,000	$82,000

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	310,000	$190,000

14. Annualized Cost to Federal Government

Government program staffing costs include one GS-14 and one GS-9 with a break down as follows to provide technical assistance to respondents.

GS-14: hourly rate $50.41 at 5 hours a week	Annual cost: $13,107
GS-9: hourly rate $24.74 at 5 hours a week:	Annual cost: $6,432

Government contract costs associated with adding 5 new data fields for coverage examples to the existing Web portal collection is estimated at $25,000 at 120 hours.

Total: $44,539

15. Explanation for Program Changes or Adjustments

This is a new information collection.

16. Plans for Tabulation and Publication and Project Time Schedule

Health insurance issuers will disclose information required by this collection to plans, and to individuals in the individual market, beginning on September 23, 2012. Group health insurance issuers and non-federal governmental plans will disclose information required by this collection (1) to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period beginning the first day of the first open enrollment period that begins on or after September 23, 2012; and (2) to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period beginning on the first day of the first plan year that begins on or after September 23, 2012.

17. Reason(s) Display of OMB Expiration Date is Inappropriate

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

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

B. Collection of Information Employing Statistical Methods

Not applicable. The information collection does not employ statistical methods.