Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
December 2014

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 published a final rule on February 14, 2012 (77 FR 8668).

To implement the 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 are 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) were 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.

The Proposed Regulation

In addition to the two existing coverage examples, these proposed regulations would require a third coverage example – a simple fracture (with emergency room visit). In documents published in connection with these proposed rules, the Departments have published updated claims and pricing data underlying the two existing coverage examples as well as a narrative description and claims and pricing data associated with the third coverage example. These materials, when finalized, will provide plans and issuers with the specific information necessary to simulate benefits covered under the plan or policy for the coverage example portion of the SBC (including relevant medical items and services, dates of service, billing codes, and allowed charges).

In May 2012, the Departments announced the development of a calculator that plans and issuers could use as a safe harbor for the first year of applicability to complete the coverage examples in a streamlined fashion. The calculator allows plans and issuers to input a discrete number of elements about the benefit package, taken from data fields used to populate the front portion of the SBC template. The output of the calculator is a coverage example that can be added to the corresponding SBC. HHS provided instructions, the coverage examples calculator, the algorithm that was used to create the calculator, and a checklist providing information on the inputs needed to use the coverage calculator on its website.

The original guidance regarding the coverage example calculator stated that because using a limited number of inputs in the calculator will be less accurate than the results that a plan or issuer could obtain by processing the full list of claims associated with each coverage example through its system, the calculator would be allowed as a transitional tool for the first year of applicability of the SBC requirements. Use of the coverage example calculator was subsequently extended for the second year of applicability, and later extended again until further guidance is issued.[1] Given the complexity of the existing coverage examples and the

1 The guidance with respect to the coverage example calculator was originally issued for SBCs provided with respect to SBCs provided for coverage beginning before January 1, 2014 (referred to as the "first year of applicability). See Affordable Care Act Implementation FAQs Part IX, question 9, available at at

addition of a new, third coverage example to the SBC requirements, the Departments are proposing that the coverage example calculator be permitted for continued use.

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.*

This information collection will help to ensure that approximately 130.5 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.

These regulations allow issuers and plans to use the "Coverage Example Calculator developed by HHS to satisfy the requirement.[2]" This calculator benefits issuers and plan sponsors by reducing the required time to produce the coverage examples. The calculator allows plans to either manually populate less than 20 data point on the plan's design for one plan at a time, or to enter import the data points for multiple plans at once.

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www.dol.gov/ebsa/faqs/faq-aca9.html

2 http://www.cms.gov/cciio/Resources/forms-reports-and-other-resources/index.html#sbcug

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, the final rule deemed 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.[3]

3 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.

In addition the ability to use the "Coverage Example Calculator" to produce the coverage examples will help reduce burden on small plans.

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 Department published in the *Federal Register* on December 30, 2014 (79 FR 78577) providing the public with a 60-day period to submit written comments on the rule and the ICR.

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 insurance coverage must provide a summary of benefits and coverage (SBC) to plans and participants 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 available upon request, and provide 60-days advance notice of any material modifications in the plan or coverage.

This analysis includes the coverage examples that are part of the SBC disclosure, therefore, the Departments calculate a single burden estimate for purposes of this section, assuming the information collection request for the SBC (including coverage examples) totals eight (8) sides of a page in length.

The Departments assume fully-insured ERISA plans will rely on health insurance issuers and self-insured plans will rely on TPAs to perform these functions. While self-insured plans may prepare SBCs 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 500 issuers and 1,050 TPAs affected by this information collection.[4] Because HHS shares the hour and cost burden for fully-insured plans with the Departments of Labor and the Treasury, HHS assumes 50 percent of the hour and cost burden estimates to account for burden for issuers in the individual market and 15 percent of the burden for TPAs to account for those TPAs serving self-insured non-Federal governmental plans. The Departments of Labor and the Treasury assume the other 50 percent of the burden related to issuers to account for burden servicing fully insured ERISA plans, and 85 percent of the burden related to TPAs to account for the burden related to ERISA self-insured plans.

To account for variation in costs due to firm size and the number of plans and individuals they service, the Departments divide issuers in to small, medium, and large categories.[5] Accordingly, the Departments estimate that there are approximately 175 small, 250 medium, and 75 large issuers. The Departments lack information to create a similar split for TPAs, so they assume a similar distribution resulting in an estimate of approximately 368 small, 526 medium, and 158 large TPAs.

The estimated hour burden and equivalent cost for the collections of information are as follows: The Departments estimate an administrative burden on issuers and TPAs to make appropriate changes to IT systems and processes and make updates to the SBCs and coverage examples. The Departments estimate that large firms would spend 190 hours (40 hours of which would be new due to the proposed regulation) in the first year, medium firms would spend 75 percent of large firm hour burden, and small firms would spend 50 percent of the large firm hour burden to perform these tasks. The total burden would be split among IT professionals (55 percent), benefits professionals (40 percent), and legal professionals (5 percent), with hourly labor rates of $83.99, $62.33, and $129.94 respectively.[6] Clerical labor rates are $30.42 per hour.

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4 The estimate for the number of issuers is based on the number of issuers for the group and individual market filing with HHS for the Medical Loss Ratio regulations. See 45 CFR Part 158, The number of TPAs is based on the U.S. Census's 2011 Statistics of U.S. Businesses that reports there are 3,157 TPA's. Previous discussions with industry experts led to assuming about one-third of the TPA's (1,052) could be providing services to self-insured plans.

5 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. 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.

6 The Departments' estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics http://www.bls.gov/news.release/pdf/ocwage.pdf); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics http://www.bls.gov/news.release/ecec.t02.htm); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be 2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 http://www.bls.gov/news.release/eci.nr0.htm). Computer Systems Analysts (15-1121): $41.02(2013 BLS Wage

Tables 3 (first year) and 4 (subsequent years) show the calculations used to obtain the hours burden of 153,600 hours (first year) and 141,600 hours (subsequent years) and the equivalent cost burden of $11.9 million (first year) and $11.0 million (subsequent years) for issuers and TPAs to prepare the SBCs and coverage examples. In addition, clerical employees would spend 653,000 hours with an equivalent cost of $19.8 million in each year preparing and distributing the SBCs.

Based on the foregoing , the total hours burden for this information collection would be 806,000 hours for the first year (794,000 hours for subsequent years) with an equivalent cost of $31.7 million for the first year ($30.8 million for subsequent years). This burden is split evenly between the Departments of Labor and the Treasury.

TABLE 1.--*Update SBC including Coverage Examples, Year 1*

	Type of Labor	Number of Firms	Hours Per Firm	Cost per Hour	Total Hour Burden	Total Cost Burden
Issuers						
Large	IT	75	52.3	$84	3,919	$329,136
	Benefits	75	38.0	$62	2,850	$177,641
	Legal	75	4.8	$130	356	$46,291
	Sub-Total				7,125	$553,067
Medium	IT	250	39.9	$84	9,969	$837,275
	Benefits	250	29.0	$62	7,250	$451,893
	Legal	250	3.6	$130	906	$117,758
	Sub-Total				18,125	$1,406,926
Small	IT	175	26.1	$84		$383,992

rate) /0.69(ECEC ratio) *1.35(Overhead Load Factor) *1.023(Inflation rate) ^2(Inflated 2 years from base year) = $83.99; Compensation, benefits, and job analysis specialists (13-1141): $30.44(2013 BLS Wage rate) /0.69(ECEC ratio) *1.35(Overhead Load Factor) *1.023(Inflation rate) ^2(Inflated 2 years from base year) = $62.33; Legal Professional (23-1011): $63.46(2013 BLS Wage rate) /0.69(ECEC ratio) *1.35(Overhead Load Factor) *1.023(Inflation rate) ^2(Inflated 2 years from base year) = $129.94; Secretaries, Except Legal, Medical, and Executive (43-6014): $16.35(2013 BLS Wage rate)/0.675(ECEC ratio) *1.2(Overhead Load Factor) *1.023(Inflation rate) ^2(Inflated 2 years from base year) = $30.42.

					4,572	
	Benefits	175	19.0	$62	3,325	$207,247
	Legal	175	2.4	$130	416	$54,006
	Sub-Total				8,313	$645,245
TPAs						
Large	IT	158	88.8	$84	14,034	$1,178,745
	Benefits	158	64.6	$62	10,207	$636,190
	Legal	158	8.1	$130	1,276	$165,784
	Sub-Total				25,517	$1,980,719
Medium	IT	526	67.8	$84	35,656	$2,994,766
	Benefits	526	49.3	$62	25,932	$1,616,329
	Legal	526	6.2	$130	3,241	$421,197
	Sub-Total				64,830	$5,032,293
Small	IT	368	44.4	$84	16,344	$1,372,716
	Benefits	368	32.3	$62	11,886	$740,879
	Legal	368	4.0	$130	1,486	$193,065
	Sub-Total				29,716	$2,306,660
Total					153,625	$11,924,910

TABLE 1.-- *Update SBC including Coverage Examples, Subsequent Years*

	Type of Labor	Number of Firms	Hours Per Firm	Cost per Hour	Total Hour Burden	Total Cost Burden
Issuers						

Large	IT	75	48.1	$84	3,609	$303,151
	Benefits	75	35.0	$62	2,625	$163,616
	Legal	75	4.4	$130	328	$42,637
	Sub-Total				6,563	$509,404
Medium	IT	250	36.8	$84	9,195	$772,314
	Benefits	250	26.8	$62	6,688	$416,832
	Legal	250	3.3	$130	836	$108,622
	Sub-Total				16,719	$1,297,768
Small	IT	175	24.1	$84	4,211	$353,677
	Benefits	175	17.5	$62	3,063	$190,886
	Legal	175	2.2	$130	383	$49,743
	Sub-Total				7,656	$594,305
TPAs						
Large	IT	158	81.8	$84	12,926	$1,085,686
	Benefits	158	59.5	$62	9,401	$585,964
	Legal	158	7.4	$130	1,175	$152,696
	Sub-Total				23,503	$1,824,346
Medium	IT	526	62.5	$84	32,890	$2,762,414
	Benefits	526	45.5	$62	23,920	$1,490,924
	Legal	526	5.7	$130	2,990	$388,518
	Sub-Total				59,800	$4,641,856
Small	IT	368	40.9	$84	15,054	$1,264,343
	Benefits	368	29.8	$62	10,948	$682,389
	Legal	368	3.7	$130	1,369	$177,823
	Sub-Total				27,370	$2,124,555
Total					141,610	$10,992,235

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).

The Departments also estimate the cost burden associated with the SBC, Uniform Glossary and Notice of Modification. These costs are discussed below.

- **SBC-**The Departments estimate that approximately 60.6 million SBCs will be delivered

with 527,000 going to ERISA plans and 60.1 million going to participants and beneficiaries annually.[7] The Departments assume 50 percent of the SBCs going to plans would be sent electronically while 38 percent of SBCs would be sent electronically to plan participants. Accordingly, the Departments estimate that about 23.4 million SBCs would be distributed electronically and about 37.2 million SBCs would be distributed on paper. The Departments assume there are costs only for paper disclosures, with de minimis costs for electronic disclosures. The SBC, with coverage examples, is assumed to be four double-sided pages (eight page sides) in length. Paper SBCs sent to participants would have no postage costs as they could be included in mailings with other plan materials, however all notices sent to beneficiaries living apart from the participant would be mailed and have a 49 cent postage costs. Printing costs would be five cents per page. Each document sent by mail would have a one minute preparation burden, with the task performed by a clerical worker. Based on the foregoing, the total cost burden to prepare and distribute the SBC would be $16.4 million.

- **Uniform Glossary** – The Departments assume that 2.5 percent of those who receive paper SBCs will request glossaries in paper form (that is, about 1.1 million glossary requests). The total cost burden to prepare and distribute paper copies of the Uniform Glossaries would be $760,000.
- **Notice of Modifications** – The Departments assume that issuers and plans will send notices of modification to covered participants and beneficiaries, and that 2 percent of covered participants and beneficiaries will receive such notices (1.2 million notices). As

7 Based on the 2012 Current Population Survey the Department estimates there are 58.0 million policy holders in ERISA plans http://www.dol.gov/ebsa/pdf/coveragebulletin2013.pdf table 2.

with the SBC, 50 percent of plans and 38 percent of policy holders will receive electronic notices. Paper notices are assumed to be of the same length as an SBC, and will incur a postage cost of 49 cents. The total cost burden to prepare and distribute the notices of modification would be $640,000.

Based on the foregoing, the total annual cost burden is estimated to be $16.4 million. This burden is split evenly between the Departments of Labor and the Treasury.

TABLE.-- *Preparation and Distribution Costs: Cost Burden*

	Number of Disclosures	Number of Disclosures Sent on Paper	Material and Printing Costs	Postage Costs	Total Cost Burden
SBC with Coverage Examples to Group Health Plan					
Renewal or Application	527,328	263,664	$105,466	$0	$105,466
Sub-Total	527,328	263,664	$105,466	$0	$105,466
SBC with Coverage Examples To Participants and Beneficiaries					
Upon Application or Eligibility	2,030,000	1,015,000	$406,000	$0	$406,000
Upon Renewal	58,000,000	35,960,000	$14,384,000	$0	$14,384,000
Beneficiaries Living Apart	90,000	90,000	$36,000	$44,100	$80,100
Sub-Total	60,120,000	36,975,000	$14,826,000	$44,100	$14,870,100
Uniform Glossary	1,102,000	1,102,000	$220,400	$539,980	$760,380
Notice of Modification	1,160,000	719,200	$287,680	$352,408	$640,088
Total	62,909,328	39,059,864	$15,439,546	$936,488	$16,376,034

TABLE.-- *Preparation and Distribution Costs: Hour Burden*

	Number of Disclosures	Number of Disclosures Sent on Paper	Clerical Hours	Clerical Costs	Total Hour Burden	Total Equivalent Cost
SBC with Coverage Examples to Group Health Plan						
Renewal or Application	527,328	263,664	4,394	$130,074	4,394	$130,074
Sub-Total	527,328	263,664	4,394	$130,074	4,394	$130,074
SBC with Coverage Examples To Participants and Beneficiaries						
Upon Application or Eligibility	2,030,000	1,015,000	16,917	$500,733	16,917	$500,733
Upon Renewal	58,000,000	35,960,000	599,333	$17,740,267	599,333	$17,740,267
Beneficiaries Living Apart	90,000	90,000	1,500	$44,400	1,500	$44,400
Sub-Total	60,120,000	36,975,000	617,750	$18,285,400	617,750	$18,285,400
Uniform Glossary	1,102,000	1,102,000	18,367	$543,653	18,367	$543,653
Notice of Modification	1,160,000	719,200	11,987	$354,805	11,987	$354,805
Total	62,909,328	39,059,864	652,498	$19,313,933	652,498	$19,313,933

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 Department 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. HHS developed and maintains the coverage example calculator

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

Estimates have been adjusted to account for new estimates of the number of issuers, plans, participants and beneficiaries affected by the information collection. Also labor rates have

been adjusted. The requirement to create a third coverage example is the largest source of new costs.

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.