Supporting Statement for the Information Collection Requirements Contained in Summary of Benefits and Coverage and Uniform Glossary (CMS-10407/OMB Control Number 0938-1146)

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.

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[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.

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 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

[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.

conducted less frequently, consumers will not receive the protections to which they are entitled under the Affordable Care Act.

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

A Federal Register notice was published on Nov. 24, 2014 at 79 FR 69854, providing the public with a 60-day period to submit written comments on the ICR.

One comment was received during the 60-day comment period. The comment raised a concern that the ICR does not reflect amendments to the Civil Rights Act of 1964, which include people with disabilities as protected from discrimination. Because this ICR is a renewal without amendments to the underlying rules or requirements, we are not revising the ICR to include new references to the Civil Right Act of 1964, or any amendments to it. We note that other requirements may apply to group health plans, and health insurance issuers in the group and individual markets, related to nondiscrimination and ensuring access for people with disabilities. Such requirements are not a part of this ICR, and are not addressed by it.

The Departments have continued to consult 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.

This analysis includes the coverage examples are part of the SBC disclosure, therefore the Department calculates a single 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.

While regulations require issuers in the group market to provide the required documents for those plans that are self-insured a simplify assumption is made. It is believed that many self-insured plans hire third-party administrators (TPAs) to administer the plan, therefore the burden to prepare the documents will be calculated at the TPA level even while acknowledging the plans and the plan participants in actually bear these costs.

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 500 issuers and 1,050 TPAs affected by this information collection.[3] 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

3 The estimate for the number of issuers is based on the number of issuers for the group and individual market filing with the Department for the Medical Loss Ratio regulations. 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.

Treasury HHS assumes 50 percent of the hour and cost burden estimates for individual issuers and 15 percent of the burden for TPAs to account for those TPAs serving self-insured non-Federal governmental plans.

To account for variation in costs due to firm size and the number of plans and individuals they service, the Department divides issuers into small, medium, and large.[4] Accordingly, the Department estimates approximately 175 small, 250 medium, and 75 large issuers. The Department lacks information to create a similar split for TPAs, so assumes a similar distribution there for the Department estimates 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 Department estimates 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. It is estimated that large firms will incur 150 hours, medium firms 115 hours and small firms 75 hours to perform these tasks. The burden will be split between IT professionals (55 percent), benefits professionals (40 percent), and legal professions (5 percent) with hourly labor rates of $81.03, $61.44, and $126.56 respectively.[5] Clerical labor rates are $29.60 per hour.

Table 1 shows the calculations used to obtain the hour burden (43,300 hours) and its equivalent cost burden ($3.3 million) for issuers and TPAs to prepare the SBCs and coverage examples.

In addition clerical hours used to prepare and distribute the disclosures (see question 13 below for more details) would have a hour burden of 279,000 hours with an equivalent cost of $8.3 million.

The total hour burden for this information collection would be 322,400 hours with an equivalent cost of $11.5 million.

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[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 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.

5 The estimated 2014 hourly labor rates include wages, other benefits, and overhead based on data from the National Occupational Employment Survey (March 2013, Bureau of Labor Statistics) and the Employment Cost Index (September 2013, Bureau of Labor Statistics); the 2012 estimated labor rates are then inflated to 2014 labor rates.

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

	Type of Labor	Number of Firms	Hours Per Firm	Cost per Hour	Total Hour Burden	Equivalent Costs
Issuers						
Large	IT	75	41.3	$81	3,094	$250,687
	Benefits	75	30.0	$61	2,250	$138,240
	Legal	75	3.8	$127	281	$35,595
	Sub-Total				5,625	$424,522
Medium	IT	250	31.6	$81	7,906	$640,643
	Benefits	250	23.0	$61	5,750	$353,280
	Legal	250	2.9	$127	719	$90,965
	Sub-Total				14,375	$1,084,888
Small	IT	175	20.6	$81	3,609	$292,468
	Benefits	175	15.0	$61	2,625	$161,280
	Legal	175	1.9	$127	328	$41,528
	Sub-Total				6,563	$495,275
TPAs						
Large	IT	158	12.4	$81	1,955	$158,434
	Benefits	158	9.0	$61	1,422	$87,368
	Legal	158	1.1	$127	178	$22,496
	Sub-Total				3,555	$268,298
Medium	IT	526	9.5	$81	4,990	$404,374
	Benefits	526	6.9	$61	3,629	$222,990

	Legal	526	0.9	$127	454	$57,417
	Sub-Total				9,074	$684,782
Small	IT	368	6.2	$81	2,277	$184,505
	Benefits	368	4.5	$61	1,656	$101,745
	Legal	368	0.6	$127	207	$26,198
	Sub-Total				4,140	$312,448
Total					43,331	$3,270,212

TABLE 2.-- *Preparation and Distribution Costs*

	Number of Disclosures	Number of Disclosures Sent on Paper	Clerical Hour Burden	Total Equivalent Cost
Group Health Plan				
SBC with Coverage Examples	15,750	7,875	131.25	$3,885
SBC with Coverage Examples- Participants and Beneficiaries				
Upon Application or Eligibility	222,680	111,340	1,855.67	$54,928
Upon Renewal	17,129,262	8,564,631	142,743.85	$4,225,218
Beneficiaries Living Apart	33,000	33,000	550.00	$16,280
Sub-Total	17,384,942	8,708,971	145,150	$4,296,426
Uniform Glossary	428,232	428,232	7,137	$211,261
Notice of Modification	342,585	171,293	2,855	$84,504

Individual Market				
SBC with Coverage Examples	21,784,217	6,535,265	108,921	$3,224,064
Uniform Glossary	762,448	762,448	12,707	$376,141
Notice of Modification	435,684.34	130,705	2,178	$64,481
Total	41,153,858	16,744,788	279,080	$8,260,762

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, currently approved under OMB Control Number 0938-1086), 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 320 issuers in the individual market submitting data to HealthCare.gov to enter the five additional data elements into an Excel spreadsheet. We estimate that it will take these issuers about 160 hours, at a total estimated cost of $4,800, for each coverage example. For two coverage examples, the burden and cost would be about 320 hours at a cost of about $9,600.

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.

[6] For the collection instrument associated with this provision, s*ee* the Plan and Benefits Template included in the Information Collection Request package for OMB Control Number 0938-1086 available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10433.html?DLPage=1&DLFilter=10433&DLSort=1&DLSortDir=descending

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

SBC

The Department estimates that there will be about 39.2 million SBCs delivered with 15,800 going to non-federal governmental plans, 17.4 million to policy holders in non-federal governmental plans, and 21.8 million going to participants and beneficiaries in the individual market annually.[7]

The Department assumes 50 percent of the SBCs going to plans and plan participants would be sent electronically while 70 percent of SBCs would be sent electronically in the individual market. Accordingly, the Department estimates that about 23.9 million SBCs would be electronically distributed, and about 15.3 million SBCs would be distributed in paper form. The Department assumes there are costs only for paper disclosures, with de minimis costs for electronic disclosures. The SBC, with coverage examples, would be eight pages in length. Paper SBCs sent to participants would have no postage costs as they could be included in mails with other plan materials, however all notices sent to beneficiaries living apart 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. This clerical hour burden is discussed in question 12 above.

The total cost burden to prepare and distribute the SBC would be $6.1 million.

Uniform Glossary – The Department assumes that 2.5 percent of those who receive paper SBCs, will request glossaries in paper form (that is, about 1.2 million glossary requests).

The total cost burden to prepare and distribute the Uniform Glossaries would be $822,000.

Notice of Modifications – The Department assumes that issuers and plans will send notices of modifications to covered individuals, and that 2 percent of covered individuals will receive such notice (that is,788,000 notices). As with the SBC, 50 percent of plans and plan participants and 70 percent of policy holders in the individual market will receive electronic notices. Paper notices are assumed to be of the same length as an SBC, eight pages and will incur a postage cost of 49 cents.

The total cost burden to prepare and distribute the Uniform Glossaries would be $269,000.

The total annual cost burden is estimated to be $7.2 million.

TABLE 3.-- *Preparation and Distribution Costs*

7 Based on the 2012 Current Population Survey the Department estimates there are 21.7 million policy holders in the individual market and 17.1 million policy holders in non-federal governmental plans.

	Number of Disclosures	Number of Disclosures Sent on Paper	Material and Printing Costs	Postage Costs	Total Cost Burden
Group Health Plan					
SBC with Coverage Examples	15,750	7,875	$3,150		$3,150
SBC with Coverage Examples- Participants and Beneficiaries					
Upon Application or Eligibility	222,680	111,340	$44,536		$44,536
Upon Renewal	17,129,262	8,564,631	$3,425,852		$3,425,852
Beneficiaries Living Apart	33,000	33,000	$13,200	$16,170	$29,370
Sub-Total	17,384,942	8,708,971	$3,483,588	$16,170	$3,499,758
Uniform Glossary	428,232	428,232	$85,646	$209,833	$295,480
Notice of Modification	342,585	171,293	$68,517	$83,933	$152,450
Individual Market					
SBC with Coverage Examples	21,784,217	6,535,265	$2,614,106		$2,614,106
Uniform Glossary	762,448	762,448	$152,490	$373,599	$526,089
Notice of Modification	435,684.34	130,705	$52,282	$64,046	$116,328
Total	41,153,858	16,744,788	$6,459,780	$747,582	$7,207,361

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 $54.31 at 5 hours a week	Annual cost: $14,121
GS-9: hourly rate $26.65 at 5 hours a week:	Annual cost: $6,929
	Total: $21,050

15. Explanation for Program Changes or Adjustments

The total hour burden estimate associated with this collection has increased 22,180 hours. 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.

16. Plans for Tabulation and Publication and Project Time Schedule

There are tabulation or publication dates associated with this information collection request.

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.