

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

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 Public Health Service Act (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, 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 these disclosure requirements, collection of information requests relate to the provision of the following:

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

Group health plans and health insurance issuers will be required to use the Summary of Benefits and Coverage (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 complete 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)

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

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

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

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

Finally, “if a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act (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;

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

and (3) is not otherwise reflected in the most recently provided SBC.

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

2. *Indicate how, by whom, and for what purpose the information is to be used. Except for a new collection, indicate the actual use the agency has made of the information received from the current collection.*

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 complete 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.

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

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, 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 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 DOL has taken this fact into account in deriving its burden estimates. These service providers typically develop a single processing system to service a large number of customers, including small entities. Thus, the cost of preparing and distributing the disclosures is spread thinly over a large number of small plans. Moreover, small plans and their respective enrollees benefit equally from the service provider's expertise and ability to provide the disclosures. Finally, the vast majority of health insurance issuers are not small businesses.¹

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

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

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

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

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 October 15, 2014 (79 FR 61903) providing the public with a 60-day period to submit written comments on the rule and the ICR. There were no comments received.

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*

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

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 (2,388,423) and health insurance issuer (500) 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 leads to 2,388,923 respondents for this information collection. 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

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

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.

The Department assumes 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 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.² 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, 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. The Departments of Labor and Treasury assume the other 50 percent of the burden related to insurers 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 Department divides issuer in to small, medium, and large.³ 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.

² 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.

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

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

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 \$83.99, \$62.33, and \$129.94 respectively.⁴ Clerical labor rates are \$30.42 per hour.

Table 1 shows the calculations used to obtain the hour burden (121,600 hours) and its equivalent cost burden (\$9.4 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 an hour burden of 653,000,000 hours with an equivalent cost of \$19.8 million.

The total hour burden for this information collection would be 774,080 hours (121,584 from Table 1 + 652,498 from Table 3) with an equivalent cost of \$29.3 million.

This burden is split evenly between the Department of Labor and the Treasury.

TABLE 1.-- Update SBC including Coverage Examples

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

⁴ The Department's 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>). 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. Computer Systems Analysts (15-1121): \$41.02(2013 BLS Wage 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. 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

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

Issuers

Large	IT	75	41.3	\$84	3,094	\$259,844
	Benefits	75	30.0	\$62	2,250	\$140,243
	Legal	75	3.8	\$130	281	\$36,546
Sub-Total					5,625	\$436,632
Medium	IT	250	31.6	\$84	7,906	\$664,046
	Benefits	250	23.0	\$62	5,750	\$358,398
	Legal	250	2.9	\$130	719	\$93,394
Sub-Total					14,375	\$1,115,838
Small	IT	175	20.6	\$84	3,609	\$303,151
	Benefits	175	15.0	\$62	2,625	\$163,616
	Legal	175	1.9	\$130	328	\$42,637
Sub-Total					6,563	\$509,404
TPAs						
Large	IT	158	70.1	\$84	11,080	\$930,588
	Benefits	158	51.0	\$62	8,058	\$502,255
	Legal	158	6.4	\$130	1,007	\$130,882
Sub-Total					20,145	\$1,563,725
Medium	IT	526	53.8	\$84	28,279	\$2,375,160
	Benefits	526	39.1	\$62	20,567	\$1,281,916
	Legal	526	4.9	\$130	2,571	\$334,053
Sub-Total					51,417	\$3,991,129
Small	IT	368	35.1	\$84	12,903	\$1,083,723
	Benefits	368	25.5	\$62	9,384	\$584,905
	Legal	368	3.2	\$130	1,173	\$152,420
Sub-Total					23,460	\$1,821,047
Total					121,584	\$9,437,776

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

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).*

SBC

The Department estimates that there will be about 60.6 million SBCs delivered with 527,000 going to ERISA plans and 60.1 million going to participants and annually.⁵

The Department assumes 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 Department estimates that about 23.4 million SBCs would be electronically distributed and about 37.2 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 \$15.0 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 1.1 million glossary requests).

The total cost burden to prepare and distribute the Uniform Glossaries would be \$760,000.

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 (1.2 million notices). As 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, eight pages and will incur a postage cost of 49 cents.

The total cost burden to prepare and distribute the Notice of Modification would be \$640,000.

The total annual cost burden is estimated to be \$16.4 million. This burden is split evenly between the Department of Labor and the Treasury.

⁵ 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.

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

TABLE 2.-- Preparation and Distribution Costs: Cost Burden

	Number of Disclosures	Number of Disclosures Sent on Paper	Material and Printing Costs	Postage Costs	Total Cost Burden
<i>SBC with Coverage Examples to Group Health Plan</i>					
Renewal or Application	527,328	263,664	\$105,466	\$0	\$105,466
Sub-Total	527,328	263,664	\$105,466	\$0	\$105,466
<i>SBC with Coverage Examples To Participants and Beneficiaries</i>					
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
<i>Uniform Glossary</i>	1,102,000	1,102,000	\$220,400	\$539,980	\$760,380
<i>Notice of Modification</i>	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 3.-- Preparation and Distribution Costs: Hour Burden

	Number of Disclosures	Number of Disclosures Sent on Paper	Clerical Hours	Clerical Costs
--	-----------------------	-------------------------------------	----------------	----------------

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

SBC with Coverage Examples to Group Health Plan

Renewal or Application	527,328	263,664	4,394	\$133,678
Sub-Total	527,328	263,664	4,394	\$133,678

SBC with Coverage Examples To Participants and Beneficiaries

Upon Application or Eligibility	2,030,000	1,015,000	16,917	\$514,605
Upon Renewal	58,000,000	35,960,000	599,333	\$18,231,720
Beneficiaries Living Apart	90,000	90,000	1,500	\$45,630
Sub-Total	60,120,000	36,975,000	617,750	\$18,791,955

<i>Uniform Glossary</i>	1,102,000	1,102,000	18,367	\$558,714
<i>Notice of Modification</i>	1,160,000	719,200	11,987	\$364,634

Total	62,909,328	39,059,864	652,498	\$19,848,981
--------------	-------------------	-------------------	----------------	---------------------

14. *Provide estimates of annualized cost to the Federal government. Also, provide a description of the method used to estimate cost, which should include quantification of hours, operational expenses (such as equipment, overhead, printing, and support staff), and any other expense that would not have been incurred without this collection of information. Agencies also may aggregate cost estimates from Items 12, 13, and 14 in a single table.*

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

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

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. Also only have on-going costs, not start-up 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.

Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1210-0147
February 2015

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.

B. Collections of Information Employing Statistical Methods

Not applicable. The use of statistical methods is not relevant to this collection of information.