Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control No. 1545-2229

1. CIRCUMSTANCES NECESSITATING COLLECTION OF INFORMATION

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, P. 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 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 (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 54.9815-2715 to Title 26 of the Code of Federal Regulations. A final rule was published on February 14, 2012. A second notice of proposed rulemaking ("2014 NPRM") was published on December 30, 2014 (79 FR 78577) to propose revisions to the regulation as well as the templates, instructions, and related materials. On March 30, 2015, the Departments released an FAQ stating that the Departments intend to finalize changes to the regulations in the near future but intend to utilize consumer testing and offer an opportunity for the public, including the NAIC, to provide further input before finalizing revisions to the SBC template and associated documents. A final rule, without final revisions to the SBC template and associated documents, was published on June 16, 2015 ("2015 Final Rule").

Section 54.9815-2715(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 § 54.9815-2715(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) contact information for questions; (7) for issuers, an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained; (8) 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; (9) 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 (10) an Internet address (or similar contact information) where a consumer may review and obtain the uniform glossary; and (11) 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) were required in the SBC. In the 2014 proposed rule, the Departments proposed to add a third coverage example, simple foot fracture. 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 three (3) 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 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) 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.

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

2. USE OF DATA

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. USE OF IMPROVED 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 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 processing of claims under each benefits scenario(s) 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 calculations manually, such as using Excel.

An issuer is permitted to provide 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. The Departments anticipate approximately 70 percent electronic distribution in the individual market and approximately 38 percent electronic distribution in the group market.[1]

4. EFFORTS TO IDENTIFY DUPLICATION

Under the federal health care reform insurance Web portal requirements, 45 CFR 159.200, HHS

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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.

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.

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. METHODS TO MINIMIZE BURDEN ON SMALL BUSINESSES OR OTHER SMALL ENTITIES

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.[2]

6. CONSEQUENCES OF LESS FREQUENT COLLECTION ON FEDERAL PROGRAMS OR POLICY ACTIVITIES

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

2 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.

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. SPECIAL CIRCUMSTANCES REQUIRING DATA COLLECTION TO BE INCONSISTENT WITH GUIDELINES IN 5 CFR 1320.5(d)(2)

- *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. CONSULTATION WITH INDIVIDUALS OUTSIDE OF THE AGENCY ON AVAILABILITY OF DATA, FREQUENCY OF COLLECTION, CLARITY OF INSTRUCTIONS AND FORMS, AND DATA ELEMENTS

The 2014 NPRM was 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. The Departments received two comments in response to this ICR. These comments have been addressed in below.

The Departments received one comment during the comment period in response to the Federal Register notice (83 FR 62402), dated December 3, 2018. The comments have been addressed below.

"In response to the Federal Register notice dated December 3, 2018 (83 FR 62402), we received one comment letter during the comment period, from the Church Alliance, regarding disclosure of the summary of benefits and coverage and the uniform glossary for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act. This comment had the following suggestions to help lower burden on the public;

1. Significant burden could be eliminated if Church plans were permitted to electronically distribute SBCs without regard to ERISA Requirements. [Note, ERISA provides certain consumer safeguards to ensure that intended individuals in fact have access to information electronically distributed.]

2. Significant burden could be eliminated if Church Plans were permitted to make assistance available instead of providing translations of SBCs upon request. [The Department of Health and Human Services provides required statements regarding the availability of translations and available assistance and translated SBCs in any language that would be required regarding availability of translations, so plans are not required to produce those on their own . The letter did not provide any data regarding the number of requested translations their group had received under the provision.]

3. Providing an SBC to an applicant at the time of application is overly burdensome for a Church Plan. [The purpose of the SBC is to allow individuals to compare different types of coverages that are available to them; only providing the information after the coverage has been selected is inconsistent with this.]

4. The calculator required for the coverage examples is particularly challenging.

After review and consideration of these comments, the IRS response to these suggestions are, "The foregoing issues are not necessarily unique to Church plans. These concerns, along with other feedback received from stakeholders, were considered by the Departments in issuing these regulations. That being said, we will take these concerns into account to the extent the Departments consider future guidance."

9. EXPLANATION OF DECISION TO PROVIDE ANY PAYMENT OR GIFT TO

RESPONDENTS

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No payment or gift has been provided to any respondents.

10. ASSURANCE OF CONFIDENTIALITY OF RESPONSES

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. JUSTIFICATION OF SENSITIVE QUESTIONS

No personally identifiable information (PII) is collected.

12. ESTIMATED BURDEN OF INFORMATION COLLECTION

Summary

Disclosure Notices	Labor	Treasury	Total
Number of respondents (issuers and Plans)			2,327,850
Number of responses (Notices)			72,826,994
Total hour burden	328,265	328,265	656,530
Equivalent costs of total hour burden	$ 19,553,852	$ 19,553,852	$ 39,107,704
Total cost burden	$ 7,040,366	$ 7,040,366	$ 14,080,732
Number of responses per respondent	31.29	31.29	31.29
Time per response (in hours)	0.00451	0.00451	0.00451
Cost per response	0.09667	0.09667	0.09667

Number of Respondents issuers and Plans

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 leads to 2,327,850 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 as part of the SBC disclosure and therefore,

the Department calculates a single burden estimate 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 511 issuers and 901 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 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.[4] Accordingly, the Department estimates approximately 179 small, 256 medium, and 77 large issuers. The Department lacks information to create a similar split for TPAs, so assumes a similar distribution there for the Department estimates approximately 315 small, 450 medium, and 135 large TPAs.

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 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.

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.

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 202.5 hours, medium firms 155.3 hours and small firms 101.3 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 $103.00, $85.00, and $133.00 respectively.[5] Clerical labor rates are $52.09 per hour.

Table 1 shows the calculations used to obtain the hour burden (108,489 hours) and its equivalent cost burden ($10.56 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 548,041 hours with an equivalent cost of $28.5 million.

The total hour burden for this information collection would be 656,530 hours (108,489 from Table 1 + 548,041 from Table 4) with an equivalent cost of $39.1 million.

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

5 The Department's estimated hourly labor rates obtained from mean wage from the 2045 National Occupational Employment Survey (Bureau of Labor Statistics http://www.bls.gov/news.release/pdf/ocwage.pdf). Wages are then doubled to provide an estimate of other benefits, and overhead.

DOL/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
Issuers						
Large	IT	77	41.3	$103	3,176	$326,328
	Benefits	77	30.0	$85	2,310	$197,320
	Legal	77	3.8	$133	289	$38,487
	Sub-Total				5,775	$562,136
Medium	IT	256	31.6	$103	8,096	$831,783
	Benefits	256	23.0	$85	5,888	$502,953
	Legal	256	2.9	$133	736	$98,101
	Sub-Total				14,720	$1,432,837
Small	IT	179	20.6	$103	3,692	$379,303
	Benefits	179	15.0	$85	2,685	$229,353
	Legal	179	1.9	$133	336	$44,735
	Sub-Total				6,713	$653,391
TPAs						
Large	IT	135	70.1	$103	9,467	$972,627
	Benefits	135	51.0	$85	6,885	$588,117
	Legal	135	6.4	$133	861	$114,713
	Sub-Total				17,213	$1,675,456
Medium	IT	450	53.8	$103	24,193	$2,485,602
	Benefits	450	39.1	$85	17,595	$1,502,965
	Legal	450	4.9	$133	2,199	$293,155
	Sub-Total				43,988	$4,281,721
Small	IT	315	35.1	$103	11,045	$1,134,731
	Benefits	315	25.5	$85	8,033	$686,136
	Legal	315	3.2	$133	1,004	$133,831
	Sub-Total				20,081	$1,954,699
Total					108,489	$10,560,241

TABLE 4.-- 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	493,244	246,622	4,110	$214,109	4,110	$214,109
Upon Request			-	$0	-	$0
Sub-Total	493,244	246,622	4,110	$214,109	4,110	$214,109
SBC with Coverage Examples To Participants and Beneficiaries						
Upon Application or Eligibility	2,538,400	1,269,200	21,153	$1,101,877	21,153	$1,101,877
Upon Renewal	66,800,000	29,124,800	485,413	$25,285,181	485,413	$25,285,181
Upon Request			-	$0	-	$0
Beneficiaries Living Apart	133,000	133,000	2,217	$115,466	2,217	$115,466
Sub-Total	69,471,400	30,527,000	508,783	$26,502,524	508,783	$26,502,524
Uniform Glossary	1,526,350	1,526,350	25,439	$1,325,126	25,439	$1,325,126
Notice of Modification	1,336,000	582,496	9,708	$505,704	9,708	$505,704
Total	72,826,994	32,882,468	548,041	28,547,463	548,041	$28,547,463

13. ESTIMATED TOTAL ANNUAL COST BURDEN TO RESPONDENTS

SBC

The Department estimates that there will be about 73.1 million SBCs delivered with 493,000 going to ERISA plans and 69.4 million going to participants annually.[6]

The Department assumes 66 percent of the SBCs going to plans would be sent electronically while 69 percent of SBCs would be sent electronically to plan participants. 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

6 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.

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 $19.6 million.

Disclosure Notices	Labor	Treasury	Total
Number of respondents (issuers and Plans)	1,163,925	1,163,925	2,327,850
Number of responses (Notices)	36,413,497	36,413,497	72,826,994
Total hour burden	164,132.50	164,132.50	328,265
Equivalent costs of total hour burden	9,776,926	9,776,926	$ 19,553,852
Total cost burden	3,520,183	3,520,183	$ 7,040,366
Number of responses per respondent	31.29	31.29	31.29
Time per response (in hours)	0.00451	0.00451	0.00451
Cost per response	0.09667	0.09667	0.09667

14. ESTIMATED ANNUALIZED COST TO THE FEDERAL GOVERNMENT

.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. REASONS FOR CHANGE IN BURDEN

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, STATISTICAL ANALYSIS AND PUBLICATION

There are no plans for tabulation, statistical analysis and publication.

17. REASONS WHY DISPLAYING THE OMB EXPIRATION DATE IS 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. EXCEPTION TO THE CERTIFICATION STATEMENT

There are no exceptions to the certification statement.