

**Supporting Statement for the Information Collection Requirements Contained in
Summary of Benefits and Coverage and Uniform Glossary Notice of Proposed Rulemaking
(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 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 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) 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; (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. Additionally, qualified health plans are required to disclose whether abortion services are covered or excluded and whether coverage is limited to services for which federal funding is allowed (excepted abortion services).

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. The 2014 NPRM proposed and the 2015 final rule finalized the addition of 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 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 revised forms for making the disclosures under PHS Act section 2715 and the amended regulations once finalized.

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.

Changes are being made to the forms in this revision of the ICR. Plans with an open enrollment period beginning on or after September 23, 2012 have been required to use the previously approved forms since this date. All other plans have been required to use the previously approved SBC beginning with the first plan year starting on or after September 23, 2012. The new forms are applicable for plans with open enrollment periods beginning on or after April 1, 2017 and all other plans must use the new SBC for plan years beginning on or after April 1, 2017.

Changes are being made to the SBC Template, the Uniform Glossary, the Instructions for Completing the SBC, and the Coverage Example Calculator and Related Information. These changes will also be portrayed in the Sample Completed SBC and Sample “Why this matters” language for “Yes” and “No” Answers, which are posted on the DOL and HHS websites for demonstrative purposes.

3. Use of Information Technology

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

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

An issuer is permitted to provide the SBC electronically, such as via e-mail or posting on the Internet, if certain safeguards are met to ensure the manner of disclosure results in actual receipt. Flexibility for electronic disclosure will help reduce cost and administrative burden

and increase timeliness and accuracy. The Department anticipates approximately 70 percent electronic distribution in the individual market and approximately 44 percent electronic distribution in the group market.¹

4. Efforts to Identify Duplication and Use of Similar Information

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

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

6. Consequences of Less Frequent Collection

This collection is required to fulfill the statutory requirements under PHS Act section 2715 and the final regulations. This collection will ensure that, at multiple points in the enrollment process, consumers have consistent and clear information with which to understand and compare plan and coverage options. If this collection is not conducted, or is conducted less

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.

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 update and provide a current SBC not later than the first day of coverage. Additionally, plans and issuers will provide the SBC to any individual as soon as practicable but not later than 7 business days after receiving a request for an SBC or for summary information about health coverage, and they will provide the uniform glossary within 7 days of a request. Plans and issuers may have to provide multiple copies of the SBC or glossary depending on the number of requests.

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

The 2014 NPRM that was published in December 30, 2014 (79 FR 78577), provided the public with a 60-day period to submit written comments on the ICR. The Departments received two comments in response to this ICR. These comments have been addressed in Appendix A.

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. Furthermore, as required by Section 2715, the Departments consulted the NAIC to provide further input before finalizing revisions to the SBC template and associated documents. The NAIC convened the Consumer Information (B) Subgroup (Subgroup) comprised of regulators and an advisory working group of consumer representatives, industry representatives and provider groups. The Subgroup held conference calls open to the public. Additionally, the work product underwent consumer testing. On October 14, 2015 the NAIC formally submitted their recommendations to the Departments regarding the revised SBC template and instructions. On December 9, 2015, the NAIC formally submitted their recommendations to the Departments on the SBC uniform glossary. The formal NAIC recommendations can be found in Appendix B.

Responses to comments made pertaining to the December 30, 2014 NPRM and comments in response to the 30-Day notice published on February 26, 2016 are contained in the Supplementary Documents section.

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

The Departments assume fully-insured ERISA plans will rely on health insurance issuers and self-insured plans will rely on TPAs to perform these functions. While self-insured plans may prepare SBCs internally, the Departments make this simplifying assumption because most plans appear to rely on issuers and TPAs for the purpose of administrative duties, such as enrollment and claims processing. Thus, the Departments use health insurance issuers and TPAs as the unit of analysis for the purposes of estimating administrative costs.

The Departments estimate there are approximately 544 issuers and 1,052 TPAs affected by this information collection.² Because HHS shares the hour and cost burden for fully-insured plans with the Departments of Labor and the Treasury, HHS assumes 50 percent of the hour and cost burden estimates to account for burden for issuers in the individual market and 15 percent of the burden for TPAs to account for those TPAs serving self-insured non-Federal governmental plans. The Departments of Labor and the Treasury assume the other 50 percent of the burden related to issuers to account for burden servicing fully insured ERISA plans, and 85 percent of the burden related to TPAs to account for the burden related to ERISA self-insured plans.

To account for variation in costs due to firm size and the number of plans and individuals they

² The estimate for the number of issuers is based on the number of issuers for the group and individual market filing with HHS for the Medical Loss Ratio regulations. See 45 CFR Part 158. The number of TPAs is based on the U.S. Census's 2011 Statistics of U.S. Businesses that reports there are 3,157 TPA's. Previous discussions with industry experts led to assuming about one-third of the TPA's (1,052) could be providing services to self-insured plans.

service, the Departments divide issuers in to small, medium, and large categories.³ Accordingly, the Departments estimate that there are approximately 175 small, 250 medium, and 75 large issuers. The Departments lack information to create a similar split for TPAs, so they assume a similar distribution resulting in an estimate of approximately 368 small, 526 medium, and 158 large TPAs.

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

The Departments estimate an administrative burden on issuers and TPAs to make appropriate changes to IT systems and processes and make updates to the SBCs and coverage examples. The Departments estimate that large firms would spend 190 hours (40 hours of which would be new due to the new regulation) in the first year, medium firms would spend 75 percent of large firm hour burden, and small firms would spend 50 percent of the large firm hour burden to perform these tasks. The total burden would be split among IT professionals (55 percent), benefits professionals (40 percent), and legal professionals (5 percent), with hourly labor rates of \$84.50, \$61.90, and \$128.34 respectively.⁴ Clerical labor rates are \$33.90 per hour. The burden is expected to be lower in subsequent years once the initial systems and process changes have been incorporated.

Tables 1 show the calculations used to obtain the burden of 45,684 hours and the equivalent cost of \$4.2 million for issuers and TPAs to prepare the SBCs and coverage examples. In addition, clerical employees would spend 254,000 hours with an equivalent cost of \$6.1 million to prepare and distribute an estimated 15.2 million SBCs by mail.

Based on the foregoing, the total hour burden for this information collection would be 309,275 hours for the first year (304,921 hours for subsequent years) with an equivalent cost of \$12.8 million for the first year (\$12.5 million for subsequent years).

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					

³ The Departments define small issuers as those with total earned premiums less than \$50 million; medium issuers as those with total earned premiums between \$50 million and \$999 million; and large issuers as those with total earned premiums of \$1 billion or more. The premium revenue data come from the 2009 NAIC financial statements, also known as “Blanks,” where insurers report information about their various lines of business.

⁴ The Departments’ estimated hourly labor rates include wages and other benefits were calculated based on the mean wage from the 2014 National Occupational Employment and Wage Estimates.

							\$285,821
Large	IT	82	41.3	\$85	3,383		
	Benefits	82	30.0	\$62	2,460		\$152,274
	Legal	82	3.8	\$128	308		\$39,465
	Sub-Total				6,150		\$477,560
Medium	IT	272	31.6	\$85	8,602		\$726,869
	Benefits	272	23.0	\$62	6,256		\$387,246
	Legal	272	2.9	\$128	782		\$100,362
	Sub-Total				15,640		\$1,214,477
Small	IT	190	20.62	\$85	3,919		\$331,134
	Benefits	190	15.0	\$62	2,850		\$176,415
	Legal	190	1.9	\$128	356		\$45,721
	Sub-Total				7,125		\$553,271
TPAs							
Large	IT	158	12.4	\$85	1,955		\$165,219
	Benefits	158	9.0	\$62	1,422		\$88,022
	Legal	158	1.1	\$128	178		\$22,812
	Sub-Total				3,555		\$276,053
Medium	IT	526	9.5	\$85	4,990		\$421,691
	Benefits	526	6.9	\$62	3,629		\$224,660
	Legal	526	0.9	\$128	454		\$58,225
	Sub-Total				9,074		\$704,575
Small	IT	368	6.2	\$85	2,888.8		\$244,103.60
	Benefits	368	4.5	\$62	2,097.6		\$129,841.44
					257.6		\$33,060.38

Legal	368	0.6	\$128	
				\$407,005.42
Sub-Total			5,244	
			54,275.3	\$4,214,781.39
Total				

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

Under 45 CFR 147.200(a)(4)(iii)(C), if individual health insurance issuers provide the content required for the SBC to the federal health reform Web portal described in 45 CFR 159.120 (HealthCare.gov), 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, coverage limits or exclusions, and the total out-of-pocket cost to the enrollee in view of these cost-sharing amounts and coverage limits or exclusions.

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 submitting this data in the individual market 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 about \$5,242, for each coverage example. For three coverage examples, the burden and cost would be about 480 hours at a cost of about \$16,272.

In deriving these figures, we used the following hourly labor rates and estimated the time to complete each task: \$ 33.90/hr. and 0.5 hours per issuer for clerical staff to enter data into an Excel spreadsheet, or \$16.95 per respondent per coverage example.

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

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS’ Web site at <http://www.cms.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage> or email your request, including your address, phone number, OMB control number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office at 410-786–1326.

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

The Department also estimates the cost burden associated with the SBC, Uniform Glossary and

Notice of Modification. These costs are discussed below.

SBC

The Department estimates that there will be about 39.2 million SBCs delivered with 126,000 going to non-federal governmental plans, 17.1 million to policy holders in non-federal governmental plans, and 21.8 million going to participants and beneficiaries in the individual market annually.⁵

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 24 million SBCs would be electronically distributed, and about 15.2 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 \$0.49 postage cost. Printing costs would be \$0.05 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 \$0.49.

The total cost burden to prepare and distribute the Notice of Modification would be \$269,000.

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

⁵ Based on the 2012 Current Population Survey the Department estimates there are 21.8 million policy holders in the individual market and 17.1 million policy holders in non-federal governmental plans.

TABLE 3.-- Preparation and Distribution Costs

	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	15,750	7,875	\$3,150		\$3,150
Sub-Total	15,750	7,875	\$3,150		\$3,150
<i>SBC with Coverage Examples to Participants and Beneficiaries</i>					
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
<i>SBC with Coverage Examples in Individual Market</i>					
Upon Application	21,800,000	6,540,000	\$2,616,000		\$2,616,000
Upon Renewal			\$0		\$0
Sub-Total	21,800,000	6,540,000	\$2,616,000		\$2,616,000
Uniform Glossary	763,000	763,000	\$152,600	\$373,870	\$526,470
Notice of Modification	436,000.00	130,800	\$52,320	\$64,092	\$116,412
Total	41,170,509	16,750,170	\$6,461,822	\$747,899	\$7,209,721

14. Annualized Cost to Federal Government

Government program staffing costs, to provide technical assistance to respondents, are based on one 14 Grade/Step 1 and one 9 Grade/Step 1 in the Washington D.C. area.

GS-14: hourly rate \$52.17 at 5 hours a week
 GS-9: hourly rate \$26.60 at 5 hours a week:

Annual cost: \$13,564.20
 Annual cost: \$6,916.00

Total: \$20,480.20

15. Explanation for Program Changes or Adjustments

The total hour burden estimate associated with this collection has increased by 2,602 hours (from 322,731 to 325,333). Estimates have been adjusted to account for changes in previously calculated values.

16. Plans for Tabulation and Publication and Project Time Schedule

There are no 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.