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 composed 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 at 45 CFR 147.200(a)(1) on June 16, 2015 ("2015 Final Rule").

Section 45 CFR 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 a

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 2015 final rule established the addition of a third coverage example, simple foot fracture (79 FR 78578).

The Departments intend to make a few updates after the 60 day comment period. These include an update to the underlying data (i.e., the Narratives and Guides) used to calculate cost-estimates for the three coverage examples, as well as the SBC Calculator for use in the plan year 2021. For the 2020 plan year, plans and issuers are required to continue to use current versions of the underlying data and the SBC Calculator, for plans and issuers who use the tool. More details will be provided about the SBC Calculator for use in the plan year 2021 after the 60 day comment period. The other forthcoming update is to the SBC template and instructions after the 60 day comment period to reflect that starting with the 2019 plan year, the Shared Responsibility Payment no longer applies. The Departments intend to make the updated template required starting with plan or policy years beginning on or after January 1, 2021, along with the 2021 Calculator. Neither the updated Calculator nor the modification to the SBC templates are anticipated to increase the burden hours for plans and issuers.

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 on 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.

2. Purpose and Use of Information Collection

This information collection will ensure that approximately 90 million consumers shopping for or enrolled in private, individually purchased, or non-federal governmental group health plan coverage receive the consumer protections of the Affordable Care Act. Employers, employees, and individuals will use this information to compare coverage options prior to selecting coverage and to understand the terms of, and extent of medical benefits offered by, their coverage (or exceptions to such coverage or benefits) once they have coverage.

3. Use of Information Technology

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

With respect to coverage examples, HHS will make available in an Excel worksheet the clinical benefits scenario(s), including specific services, dates of service, billing codes, and allowed charges associated with each scenario.[1] Plans and issuers will simulate claims processing under each scenario to illustrate how a consumer could expect to share costs with

1 These forms and guidance can be found on CCIIO's website, available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other- Resources/index.html#Summary%20of%20Benefits%20and%20Coverage%20and%20Uniform%20Glossary.

the plan or coverage. Plans and issuers 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.

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 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 are 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. 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 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

A 30-day notice published in the Federal Register on May 13, 2019 (84 FR 20890).

No comments were received. The 30-day Federal Register notice published August 20, 2019 (84 FR 43134).

CMS recently received OMB approval for a non-substantive change to the SBC calculator. Specifically, CMS requested that issuers actively begin using an updated 2020 SBC calculator starting on or after January 1, 2020. However, at this time, CMS is alerting issuers to immediately discontinue use of the 2020. Until further notice from CMS, issuers should revert back to using the 2017 SBC Calculator and all associated materials (including the 2017 SBC Calculator Excel file, the Guides and Narratives for the coverage examples, and the calculator instructions) to calculate coverage example costs for the SBC.

No additional outside consultation has been sought.

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 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 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 511 issuers and 901 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 the burden for issuers in the individual market and 15 percent of the burden for TPAs to account for those TPAs serving self-insured non-Federal governmental plans. The Departments of Labor and the Treasury assume the other 50 percent of the burden related to issuers to account for burden servicing fully insured ERISA plans, and 85 percent of the burden related to TPAs to account for the burden related to ERISA self-insured plans.

To account for variation in costs due to firm size and the number of plans and individuals they service, the Departments divide issuers in to small, medium, and large categories. [3] Accordingly, the Departments estimate that there are approximately 179 small, 256 medium, and 77 large issuers. Because the Departments lack sufficient information to create a similar split for TPAs, they assume a similar distribution resulting in an estimate of approximately 315 small, 450 medium, and 135 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 150 hours in the first year, medium firms would spend 115 hours, and small firms would spend 75 hours 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 $84.16, $64.58, and $136.44 respectively. Clerical labor rates are $35.50 per hour.

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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 2016 Statistics of U.S. Businesses that reports there are 2,702 TPA's. Previous discussions with industry experts suggest that approximately one-third of all TPA's (901) could be providing services to self-insured plans.

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.

HHS used data from the Bureau of Labor Statistics to derive average labor costs (doubled to include fringe benefits and other associated costs) for estimating the burden associated with the ICRs.[4] Wage rates below present the mean hourly wage, the cost of fringe benefits and overhead, and the adjusted hourly wage.

Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Mean Hourly Wage ($/hour)	Fringe Benefits and Overhead ($/hour)	Adjusted Hourly Wage ($/hour)
Secretaries and Administrative Assistants	43-6014	$17.75	$17.75	$35.50
Lawyer	23-1011	$68.22	$68.22	$136.44
Computer Programmer	15-1131	$42.08	$42.08	$84.16
Compensation, Benefits and Job Analysis Specialists	13-1141	$32.29	$32.29	$64.58

Table 1 shows the calculations used to obtain the burden of 41,551 hours and the equivalent cost of $3.3 million for issuers and TPAs to prepare the SBCs and coverage examples.

Based on the foregoing, the total hour burden for this information collection would be 215,432 hours (41,551 from Table 1, 213 for deemed compliance, and 173,240 from Table 4) with an equivalent cost of $9.5 million.

[4] May 2017 Occupational Employment Statistics found at https://www.bls.gov/oes/current/oes_nat.htm). To account for fringe and overhead, HHS is using 100% of the mean hourly wage.

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	41.25	$84.16	3,176	$267,313
	Benefits	77	30.00	$64.58	2,310	$149,180
	Legal	77	3.75	$136.44	289	$39,397
	Sub-Total				5,782	$455,890
Medium	IT	256	31.63	$84.16	8,096	$681,359
	Benefits	256	23.00	$64.58	5,888	$380,247
	Legal	256	2.88	$136.44	736	$100,420
	Sub-Total				14,720	$1,162,026
Small	IT	179	20.63	$84.16	3,692	$310,708
	Benefits	179	15.00	$64.58	2,685	$173,397
	Legal	179	1.88	$136.44	336	$45,793
	Sub-Total				6,713	$529,898
TPAs						
Large	IT	135	12.38	$84.16	1,671	$140,600
	Benefits	135	9.00	$64.58	1,215	$78,465
	Legal	135	1.13	$136.44	152	$20,722
	Sub-Total				3,038	$239,786
Medium	IT	450	9.49	$84.16	4,269	$359,311
	Benefits	450	6.90	$64.58	3,105	$200,521
	Legal	450	0.86	$136.44	388	$52,956
	Sub-Total				7,763	$612,787
Small	IT	315	6.19	$84.16	1,949	$164,033
	Benefits	315	4.50	$64.58	1,418	$91,542
	Legal	315	0.56	$136.44	177	$24,175
	Sub-Total				3,544	$279,751
Total					41,551	$3,280,139

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 427 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 213 hours, at a total estimated cost of about $7,579.25, for each coverage example.

In deriving these figures, we used the following hourly labor rates and estimated the time to complete each task: $35.50/hr. and 0.5 hours per issuer for clerical staff to enter data into an Excel spreadsheet, or $11.83 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.

TABLE 2. -- *Summary of Burden*

Number of respondents (issuers and Plans)	128,938
Number of responses (Notices)	24,433,233
Total hour burden	215,004
Equivalent costs of total hour burden	$9,452,879
Total cost burden	$4,454,347

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 23.3 million SBCs delivered with 128,000 going to non-federal governmental plans, 13 million to policy holders in non-

federal governmental plans, and 10.2 million going to participants and beneficiaries in the individual market annually.[5]

The Department assumes 50 percent of the SBCs going to plans would be sent electronically while 56.4 percent of SBCs would be sent electronically to policy holders.[6] Accordingly, the Department estimates that about 13.2 million SBCs would be electronically distributed, and about 10.1 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 $0.55 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 $4.5 million.

Uniform Glossary – The Department assumes that 5 percent of those who receive paper SBCs, will request glossaries in paper form (that is, 485,000 glossary requests).

The total cost burden to prepare and distribute the Uniform Glossaries would be $364,109.

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,464,406 notices). As with the SBC, 50 percent of plans and plan participants and 56.4 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 $0.55.

[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.

[6] According to data from the National Telecommunications and Information Agency (NTIA), 37.7 percent of individuals age 25 and over have access to the Internet at work. According to a Greenwald & Associates survey, 84 percent of plan participants find it acceptable to make electronic delivery the default option, which is used as the proxy for the number of participants who will not opt-out of electronic disclosure that are automatically enrolled (for a total of 31.7 percent receiving electronic disclosure at work). Additionally, the NTIA reports that 40.5 percent of individuals age 25 and over have access to the internet outside of work. According to a Pew Research Center survey, 61 percent of internet users use online banking, which is used as the proxy for the number of internet users who will affirmatively consent to receiving electronic disclosures (for a total of 24.7 percent receiving electronic disclosure outside of work). Combining the 31.7 percent who receive electronic disclosure at work with the 24.7 percent who receive electronic disclosure outside of work produces a total of 56.4 percent who will receive electronic disclosure overall.

The total cost burden to prepare and distribute the Notice of Modification would be $181,764.

The total annual cost burden is estimated to be $4.5 million.

TABLE 3.-- Preparation and Distribution Costs

	Number of Disclosures	Number of Disclosures Sent on Paper	Material and Printing Costs	Postage Costs	Total Cost Burden
SBC with Coverage Examples to Group Health Plan					
Renewal or Application	16,000	8,000	$3,200		$3,200
Sub-Total	16,000	8,000	$3,200		$3,200
SBC with Coverage Examples to Participants and Beneficiaries					
Upon Application or Eligibility	208,036	104,018	$41,607		$41,607
Upon Renewal	13,002,247	6,501,124	$2,600,449		$2,600,449
Beneficiaries Living Apart	39,000	39,000	$15,600	$21,450	$37,050
Sub-Total	13,249,283	6,644,141	$2,657,657	$21,450	$2,679,107
Uniform Glossary	332,207	332,207	$66,441	$182,714	$249,155
Notice of Modification	260,045	130,022	$52,209	$71,512	$123,521
SBC with Coverage Examples in Individual Market					
Upon Application	10,218,066	3,065,420	$1,226,168		$1,226,168
Upon Renewal			$0		$0
Sub-Total	10,218,066	3,065,420	$1,226,168		$1,226,168
Uniform Glossary	153,271	153,271	$30,654	$84,299	$114,953
Notice of Modification	204,361	61,308	$24,523	$33,720	$58,243
Total	24,433,233	10,394,370	$4,060,652	$393,695	$4,454,347

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	16,000	8,000	133	$4,733	133	$4,733
Upon Request			—	$0	—	$0
Sub-Total	16,000	8,000	133	$4,733	133	$4,733
SBC with Coverage Examples To Participants and Beneficiaries						
Upon Application or Eligibility	208,036	104,018	1,734	$61,544	1,734	$61,544
Upon Renewal	13,002,247	6,501,124	108,352	$3,846,498	108,352	$3,846,498
Upon Request			–	$0	–	$0
Beneficiaries Living Apart	39,000	39,000	650	$23,075	650	$23,075
Sub-Total	13,249,283	6,644,141	110,736	$3,931,117	110,736	$3,931,117
Uniform Glossary	332,207	332,207	5,537	$196,556	5,537	$196,556
Notice of Modification	260,045	130,022	2,167	$76,930	2,167	$76,930
SBC with Coverage Examples in Individual Market						
Upon	10,218,066	3,065,420	51,090	$1,813,707	51,090	$1,813,707
Upon Renewal				$0		$0
Sub-Total	10,218,066	3,065,420	51,090	$1,813,707	51,090	1,813,707
Uniform Glossary	153,271	153,271	2,555	$90,685	2,555	$90,685
Notice of Modification	204,361	61,308	1,022	$36,274	1,022	$36,274
Total	24,433,233	10,394,370	173,240	$6,150,002	173,240	$6,150,002

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 $55.09 at 5 hours a week: Annual cost:

$14,323 GS-9: hourly rate $27.04 at

5 hours a week: Annual cost: $7,030

Total: $21,353

15. Explanation for Program Changes or Adjustments

Burden estimates have been adjusted to account for new estimates of the number of issuers, plans, participants and beneficiaries affected by the information collection, as well as updated data on labor rates and an updated assumption on the usage of electronic distribution. As a result of these updated data inputs, the overall burden has decreased from 325,333 hours to 215,004 hours, resulting in a total burden decrease of 110,329 hours.

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 expiration date and OMB control number will display on the first page (top right corner) of each instrument.