SUPPORTING STATEMENT FOR PAPERWORK REDUCTION ACT OF 1995: SUMMARY OF BENEFITS AND COVERAGE AND THE UNIFORM GLOSSARY REQUIRED UNDER THE AFFORDABLE CARE ACT

This information collection request (ICR) seeks approval for an extension of an existing control number.

A. JUSTIFICATION

1. Explain the circumstances that make the collection of information necessary. Identify any legal or administrative requirements that necessitate the collection. Attach a copy of the appropriate section of each statute and regulation mandating or authorizing the collection of information.

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 directed 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 section 2715. The NPRM proposed § 2590.715-2715 to Title 29 of the Code of Federal Regulations. A final rule was published on February 14, 2012 (77 FR 8668). 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 (80 FR 34292). On November 7, 2019, the DOL updated the calculator, template, narratives, and instructions in response to changes related to the Tax Cut and Jobs Act of 2017. An FAQ regarding these changes was released on February 3, 2020.

Section 2590.715-2715(a)(1) requires a group health plan and a health insurance issuer to provide a written SBC for each benefit package to entities and individuals at specified points in the enrollment process.

As specified in § 2590.715-2715(a)(2), a plan or issuer will populate the SBC with the applicable plan or coverage information, including the following: (1) uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage, in accordance with guidance as specified by the Secretary; (2) a description of the coverage, including cost sharing, for each category of benefits identified by the Secretary in guidance; (3) the exceptions, reductions, and limitations of the coverage; (4) the cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations; (5) the renewability and continuation of coverage provisions; (6) coverage examples that illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost sharing; (7) 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; and (8) a statement that the SBC is only a summary and that the plan, document, policy, certificate, or contract of insurance should be consulted to determine the governing contractual provisions of the coverage; (9) contact information for questions; (10) 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; (11) 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; (12) for plans and issuers that use a formulary in providing prescription drug coverage through a formulary, an Internet address (or similar contact information) for obtaining information on prescription drug coverage; and (13) an Internet address for obtaining the uniform glossary, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

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 NPRM, the Departments proposed to add a third coverage example, simple foot fracture. The final SBC documents with the simple foot fracture example were released on April 6, 2016.

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 SBC, 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 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 (summary of material modification).

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

This information collection will help to ensure that 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. This information collection has been approved for use by both DOL and HHS.

3. Describe whether, and to what extent, the collection of information involves the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses, and the basis for the decision for adopting this means of collection. Also describe any consideration for using information technology to reduce burden.

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

With respect to the coverage examples, HHS makes 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 issuers may either generate these outputs using automated systems or perform calculations manually, such as using Excel.

An issuer is permitted to provide the SBC 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.

ERISA and regulations thereunder provide general standards for the delivery of all information an employee benefit plan must furnish to participants, beneficiaries, and other individuals under Title I of ERISA (29 C.F.R. § 2520.104b-1(b)). Plan administrators must use delivery methods reasonably calculated to ensure actual receipt of information by participants, beneficiaries, and other individuals (29 C.F.R. § 2520.104b-1(b)(1)). For example, in-hand delivery to an employee at his or her workplace is acceptable, as is material sent by first class mail. DOL amended ERISA's delivery standards in 2002 by establishing a safe harbor for the use of electronic media to furnish disclosures (the 2002 safe harbor; 29 C.F.R. § 2520.104b-1(c)). The 2002 safe harbor was not and is not the exclusive means by which a plan administrator may use electronic media to satisfy the general standard. However, plan administrators who satisfy the conditions of the safe harbor are assured that the general delivery requirements

have been satisfied. As discussed below in Question 13, the Departments assume that 58.3 percent of SBCs would be sent electronically to plan participants.

4. Describe efforts to identify duplication. Show specifically why any similar information already available cannot be used or modified for use for the purposes described in Item 2 above.

Under the 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 (OMB Control Number 1545-2229). To reduce duplication for purposes of the SBC collection, CMS requires issuers to submit URL data for the plans they intend to offer on the Exchange. URL submissions, including updates, are collected in the Supplemental Submission Module (SSM) in the Health Insurance Oversight System (HIOS). The following URLs should be submitted to the SSM: Summary of Benefits and Coverage (SBC), Plan Brochure, Payment, Formulary, Network, Transparency in Coverage, and Machine-Readable & Technical POC. These URLs should lead to live, active webpages that contain accurate issuer marketing information for consumers by the deadlines communicated by CMS. The URL information is posted on the QHP Certification Website.[1]
In addition, under the disclosure requirements at 29 CFR Part 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.

Issuers are also subject to the SBC requirements, if they provide an SBC for coverage offered in connection with an insured group health plan, the plan does not also need to send out an SBC.

5. If the collection of information impacts small businesses or other small entities describe any methods used to minimize burden.

The regulation applies to all employee benefit plans and therefore is likely to affect small entities (such as small businesses and small plans) that provide health 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

1 https://www.qhpcertification.cms.gov/s/URLs

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.

6. Describe the consequence to Federal program or policy activities if the collection is not conducted or is conducted less frequently, as well as any technical or legal obstacles to reducing burden.

This collection is required to fulfill the statutory requirements under PHS Act section 2715. This collection will ensure that at multiple points in the enrollment process consumers have accurate information with which to understand and compare plan and coverage options. If this collection is not conducted, or is conducted less frequently, consumers will not receive the protections to which they are entitled under the Affordable Care Act. If, however, information collected in the first instance does not change in subsequent collections, duplicate collections are typically not required during the plan or policy year. Furthermore, multiple collections are not required in the case of family coverage, if covered family members reside at the same address. These provisions will limit the collection burden on the industry while providing meaningful and consistent information to consumers.

7. Explain any special circumstances that would cause an information collection to be conducted in a manner:

- **requiring respondents to report information to the agency more often than quarterly;**
- **requiring respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;**
- **requiring respondents to submit more than an original and two copies of any document;**
- **requiring respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;**
- **in connection with a statistical survey, that is not designed to produce valid and reliable results that can be generalized to the universe of study;**
- **requiring the use of a statistical data classification that has not been reviewed and approved by OMB;**
- **that includes a pledge of confidentiality that is not supported by authority established in statute or regulation, that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or**

- **requiring respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.**

Plans and issuers are required to provide the SBC to an applicant upon request of an application for, or health coverage information about, a policy, certificate, or contract of insurance and upon request for enrollment pursuant to a special enrollment right. In such instances, disclosure must occur as soon as practicable, but not later than 7 business 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 business days after the receipt of the request. Depending on the number of such requests, plans and issuers may have to provide several copies of the SBC.

8. If applicable, provide a copy and identify the date and page number of publication in the Federal Register of the agency's notice, required by 5 CFR 1320.8(d), soliciting comments on the information collection prior to submission to OMB. Summarize public comments received in response to that notice and describe actions taken by the agency in response to these comments. Specifically address comments received on cost and hour burden.

Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions and recordkeeping, disclosure, or reporting format (if any), and on the data elements to be recorded, disclosed, or reported.

Consultation with representatives of those from whom information is to be obtained or those who must compile records should occur at least once every 3 years -- even if the collection of information activity is the same as in prior periods. There may be circumstances that may preclude consultation in a specific situation. These circumstances should be explained.

DOL’s notice soliciting public comment and providing 60 days for that purpose as required by 5 CFR 1320.8(d) was published in the Federal Register on July 9, 2024 (89 FR 56416). No comments were received during that comment period.

9. Explain any decision to provide any payment or gift to respondents, other than remuneration of contractors or grantees.

No payments or gifts are provided to respondents.

10. Describe any assurance of confidentiality provided to respondents and the basis for the assurance in statute, regulation, or agency policy.

No assurance of confidentiality is provided. This 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 are described in fuller detail in the policy, certificate, contract of insurance, or other plan document. Therefore, the Departments believe this ICR does not require the disclosure of trade secrets or other confidential information.

11. Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private. This justification should include the reasons why the agency considers the questions necessary, the specific uses to be made of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.

There are no questions of a sensitive nature.

12. Provide estimates of the hour burden of the collection of information. The statement should:

- **Indicate the number of respondents, frequency of response, annual hour burden, and an explanation of how the burden was estimated. Unless directed to do so, agencies should not conduct special surveys to obtain information on which to base hour burden estimates. Consultation with a sample (fewer than 10) of potential respondents is desirable. If the hour burden on respondents is expected to vary widely because of differences in activity, size, or complexity, show the range of estimated hour burden, and explain the reasons for the variance. Generally, estimates should not include burden hours for customary and usual business practices.**
- **If this request for approval covers more than one form, provide separate hour burden estimates for each form.**
- **Provide estimates of annualized cost to respondents for the hour burdens for collections of information, identifying and using appropriate wage rate categories. The cost of contracting out or paying outside parties for information collection activities should not be included here. Instead, this cost should be included in Item 14.**
- **The cost of contracting out or paying outside parties for information collection activities should not be included here. Instead, this cost should be included in Item 14.**

Each group health plan and health insurance issuer offering group insurance coverage must provide an SBC to plans and participants 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. The data and assumptions used in the Department's estimates for the burden of this information collection can be found below in Table 1.

Table 1.-- *General Assumptions*

Assumption	Description	Source
479	Number of Issuers	Medical Loss Ratio Filings[1]
205	Number of TPAs	Medical Loss Ratio Filings
754,862	Number of defined contribution (DB) plans	2022 Form 5500 Data
2,588,299	Total ERISA Health Plans	Departmental Calculation[2]
2,505,976	Small ERISA Health Plans	Departmental Calculation
468,592	Self-Insured ERISA Plans	Departmental Calculation
71,300,000	Number of ERISA Plan Policy Holders	https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2022.pdf
406,256	Number of Beneficiaries Living Away From ERISA Policy Holder	Departmental Calculation[3]
$177.97	Hourly cost for a legal professional	Departmental Calculation[4]
$69.41	Hourly cost for a clerical professional	Departmental Calculation
$65.99	Hourly cost for a clerical professional	Departmental Calculation
58.3%	Electronic disclosure rate	Departmental Calculation[5]
$0.73	First Class Mail Cost	https://www.usps.com/business/prices.htm
479	Insurers in Group and Individual Market	2022 MLR Data
3.6%	New Hire Rate	https://www.bls.gov/news.release/pdf/jolts.pdf, Table 2, Total Private
15%	Share of Issuers/TPAs that are Large	Departmental Assumption
50%	Share of Issuers/TPAs that are Medium	Departmental Assumption
35%	Share of Issuers/TPAs that are Small	Departmental Assumption
$0.05	Printing Cost Per Page	Departmental Assumption

[1] 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. These estimates were provided to the Department by HHS.
[2] Calculation based on 2023 Medical Expenditure Survey - Insurance Component
[3] Calculation based on 2023 Current Population Survey Data
[4] For information on how the Department estimates labor cost see: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/technical-appendices/labor-cost-inputs-used-in-ebsa-opr-ria-and-pra-burden-calculations-june-2019.pdf
[5] Assumptions regarding the use of electronic transmission have been updated to be in accordance to 29 C.F.R. § 2520.104b-31 which provides a new additional safe harbor for plan administrators to use electronic media, as a default, to furnish disclosures to

participants and beneficiaries of pension benefit plans subject to ERISA. This estimate is used as a proxy for the percent of

This analysis includes the coverage examples as 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 (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 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.

Because HHS shares the hour and cost burden for fully-insured plans with DOL and 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. DOL 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 Departments divide issuers into small, medium, and large.[2] The Departments lack information to create a similar split for TPAs, so DOL assumes a similar distribution amongst TPAs. The Departments' assumptions regarding firm size for issuers and TPAs are displayed above in Table 1. How these assumptions are used to calculate entity and hours per entity calculations is detailed below in Tables 2 and 3.

Table 2. —Entities By Size

Entity	Total Entities	15% Large	50% Medium	35% Small
Issuers	479	72	240	168
TPAs	205	31	103	72

Table 3. —Hours By Entity Size and Profession

2 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 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.

Entity	Total Hours	55% performed by IT Professional	40% performed by Benefit Professional	5% performed by Legal Professional
Large Issuer/TPA	150	82.5	60.0	7.5
Medium Issuer/TPA	115	63.3	46.0	5.8
Small Issuer/TPA	75	41.3	30.0	3.8

The numbers displayed in Tables 2 and 3 above are used to calculate the burden associated with issuers and TPAs updating their SBC and coverage examples. This burden is displayed below in Tables 4 and 5 below, while the burden associated with preparation and distribution is displayed in Table 6. The summaries of the burdens are displayed in Tables 7 and 8.

Table 4. —Labor Burden for Issuers Update SBC including Coverage Examples

Entity Description	Entities	Hours per Entity	EBSA & Treasury Burden	Wage	Hour Burden	Cost Equivalent of Hour Burden
	(A)	(B)	(C)	(D)	(AxBxC)	(AxBxCxD)
IT: Large	72	82.5	50%	$135.50	2,970	$402,435
Benefits: Large	72	60.0	50%	$125.88	2,160	$271,901
Legal: Large	72	7.5	50%	$177.97	270	$48,052
Sub-total: Large Issuers					**5,400**	**$722,388**
IT: Medium	240	63.3	50%	$135.50	7,590	$1,028,445
Benefits: Medium	240	46.0	50%	$125.88	5,520	$694,858
Legal: Medium	240	5.8	50%	$177.97	690	$122,799
Sub-total: Medium Issuers					**13,800**	**$1,846,102**
IT: Small	168	41.3	50%	$135.50	3,465	$469,508
Benefits: Small	168	30.0	50%	$125.88	2,520	$317,218
Legal: Small	168	3.8	50%	$177.97	315	$56,061
Sub-total: Small Issuers					**6,300**	**$842,786**
Total					**25,500**	**$3,411,275**

Table 5. —Labor Burden for TPAs Update SBC including Coverage Examples

Entity Description	Entities	Hours per Entity	EBSA & Treasury Burden	Wage	Hour Burden	Cost Equivalent of Hour Burden
	(A)	(B)	(C)	(D)	(AxBxC)	(AxBxCxD)
IT: Large	31	82.5	85%	$135.50	2,174	$294,560
Benefits: Large	31	60.0	85%	$125.88	1,581	$199,016

Legal: Large	31	7.5	85%	$177.97	198	$35,171
Sub-total: Large TPAs					**3,953**	**$528,748**
IT: Medium	103	63.3	85%	$135.50	5,538	$750,336
Benefits: Medium	103	46.0	85%	$125.88	4,027	$506,957
Legal: Medium	103	5.8	85%	$177.97	503	$89,592
Sub-total: Medium TPAs					**10,068**	**$1,346,885**
IT: Small	72	41.3	85%	$135.50	2,525	$342,070
Benefits: Small	72	30.0	85%	$125.88	1,836	$231,116
Legal: Small	72	3.8	85%	$177.97	230	$40,844
Sub-total: Small TPAs					**4,590**	**$614,030**
Total					**18,611**	**$2,489,662**

Under 45 CFR147.200(a)(4)(iii)(C), if individual health insurance issuers provide information required by these final regulations to the HHS Secretary's Web portal (HealthCare.gov), as established by 45 CFR 159.120, then they will be deemed to have satisfied the requirement to provide an SBC to individuals who request information about coverage prior to submitting an application for coverage. Individual health insurance issuers already provide most SBC content elements to HealthCare.gov, except for five data elements related to patient responsibility for each coverage example: deductibles, co-payments, co-insurance, limits or exclusions, and the total of all four cost-sharing amounts. As a result, this requirement is satisfied with regular business practices and the hour and cost burdens for these requirements in Tables 4 and 7 are assumed to be de minimis.

Table 6. —Issuers and TPAs Prepare and Distribute Notices

Entity Description	Entities (A)	Hours per Entity (B)	Wage (D)	Hour Burden (AxBxC)	Cost Equivalent of Hour Burden (AxBxCxD)
SBC Notices to Health Plans					

Renewal/Application	(2,588,299 ERISA Health Plans - 340,270 Self-Insured Plans) x 25% plans renewing per year x 50% sent by mail = 281,004	1/60	$69.41	4,683	$325,074
Requests	0	1/60	$69.41	0	$0
Sub-Total: All SBC Notices to Health Plans	**281,004**	**1/60**	**$69.41**	**4,683**	**$325,074**
SBC to Participants and Beneficiaries					
Application or Eligibility	71,300,000 ERISA Health Plans Policy Holders x 3.6% new hire rate x 50% sent by mail = 1,283,400	1/60	$69.41	21,390	$1,484,680
Renewal	71,300,000 ERISA Health Plans Policy Holders x 42% sent by mail = 29,732,100	1/60	$69.41	495,535	$34,395,084
Requests	0	1/60	$69.41	0	$0
Beneficiaries Living Apart	369,338 Beneficiaries Living Away from Policy Holder x 100% sent by mail = 369,338	1/60	$69.41	6,156	$427,263
Sub-Total: All SBC Notices to Participants and Beneficiaries	**31,384,838**	**1/60**	**$69.41**	**523,081**	**$36,307,027**
Paper Glossary	31,384,838 SBC notices to participants x 5% requesting paper glossary x 100% sent by mail = 1,569,242	1/60	$69.41	26,154	$1,815,351
Notice of Modification	71,300,000 ERISA Plan Policy Holders x 2% receiving notice of modification x 42% sent by mail = 594,642	1/60	$69.41	9,911	$687,902
Total	**33,829,726**			**563,829**	**$39,135,354**

Table 7. —Burden Summary

Entity Description	Total Hour Burden	EBSA Hour Burden	Treasury Hour Burden	Total Cost Equivalent	EBSA Cost Equivalent	Treasury Cost Equivalent
Issuers Updating SBC	25,500	12,750	12,750	$3,411,275	$1,705,638	$1,705,638
TPAs Updating SBC	18,611	9,305	9,305	$2,489,662	$1,244,831	$1,244,831
Preparing and Distributing SBCs	563,829	281,914	281,914	$39,135,354	$19,567,677	$19,567,677
Total	607,940	303,970	303,970	$45,036,292	$22,518,146	$22,518,146

Table 8. -- Estimated Annualized Respondent Cost and Hour Burden

Activity	**Respondents**	**Responses per Respondent**	**Total Responses**	**Average Burden (Hours)**	**Total Burden (Hours)**	**Hourly Wage Rate**	**Equivalent Cost of Hour Burden**
Part A: Update SBC including Coverage Examples							
Large Issuers- IT staff	72	1	72	41.25	2,970	$135.50	$402,435

Large Issuers- Benefit Professional	72	1	72	30.00	2,160	$125.88	$271,901
Large Issuers- Legal staff	72	1	72	3.75	270	$177.97	$48,052
Medium Issuers- IT staff	240	1	240	31.63	7,590	$135.50	$1,028,445
Medium Issuers- Benefit Professional	240	1	240	23.00	5,520	$125.88	$694,858
Medium Issuers- Legal staff	240	1	240	2.88	690	$177.97	$122,799
Small Issuers- IT staff	168	1	168	20.63	3,465	$135.50	$469,508
Small Issuers- Benefit Professional	168	1	168	15.00	2,520	$125.88	$317,218
Small Issuers- Legal staff	168	1	168	1.88	315	$177.97	$56,061
Large TPAs- IT staff	31	1	31	70.13	2,174	$135.50	$294,560
Large TPAS - Benefit Professional	31	1	31	51.00	1,581	$125.88	$199,016
Large TPAs- Legal staff	31	1	31	6.38	198	$177.97	$35,171
Medium TPAs- IT staff	103	1	103	53.76	5,538	$135.50	$750,336
Medium TPAs- Benefit Professional	103	1	103	39.10	4,027	$125.88	$506,957
Medium TPAs- Legal staff	103	1	103	4.89	503	$177.97	$89,592
Small TPAs- IT staff	72	1	72	35.06	2,525	$135.50	$342,070
Small TPAs- Benefit Professional	72	1	72	25.50	1,836	$125.88	$231,116
Small TPAs- Legal staff	72	1	72	3.19	230	$177.97	$40,844
Part B: Preparation and Distribution Costs: Hour Burden							
SBC: Renewal or Application (to Group Health Plans)	562,007	1	562,007	1/60	4,683	$69.41	$325,074
SBC: Application or Eligibility (to Participants & Beneficiarties)	2,566,800	1	2,566,800	1/60	21,390	$69.41	$1,484,680
SBC: Renewal (to Participants & Beneficiarties)	71,300,000	1	71,300,000	1/60	495,535	$69.41	$34,395,084
SBC: Beneficiaries Living Apart (to Participants & Beneficiarties)	369,338	1	369,338	1/60	6,156	$69.41	$427,263
Uniform Glossary	1,569,242	1	1,569,242	1/60	26,154	$69.41	$1,815,351
Notice of Modification	1,426,000	1	1,426,000	1/60	9,911	$69.41	$687,902
Total	2,588,983		77,793,387	-	607,940		$45,036,292
DOL Total*	2,588,983**		77,793,387***	-	303,970		$22,518,146

* In this row, DOL shares the burden calculated with the Department of the Treasury, so the number of respondents, the number of responses, the hour burden, and the cost equivalent will be split evenly.
** This is calculated as the total number of ERISA plans, issuers, and TPAs.
*** This is the sum of the "Total Responses" column in Part B of this table.

13. Provide an estimate of the total annual cost burden to respondents or record-keepers resulting from the collection of information. (Do not include the cost of any hour burden shown in Items 12.)

- **The cost estimate should be split into two components: (a) a total capital and start up cost component (annualized over its expected useful life); and (b) a total operation and maintenance and purchase of service component. The estimates should take into account costs associated with generating,**

maintaining, and disclosing or providing the information. Include descriptions of methods used to estimate major cost factors including system and technology acquisition, expected useful life of capital equipment, the discount rate(s), and the time period over which costs will be incurred. Capital and start-up costs include, among other items, preparations for collecting information such as purchasing computers and software; monitoring, sampling, drilling and testing equipment; and record storage facilities.

- **If cost estimates are expected to vary widely, agencies should present ranges of cost burdens and explain the reasons for the variance. The cost of purchasing or contracting out information collection services should be a part of this cost burden estimate. In developing cost burden estimates, agencies may consult with a sample of respondents (fewer than 10), utilize the 60-day pre-OMB submission public comment process and use existing economic or regulatory impact analysis associated with the rulemaking containing the information collection, as appropriate.**
- **Generally, estimates should not include purchases of equipment or services, or portions thereof, made: (1) prior to October 1, 1995, (2) to achieve regulatory compliance with requirements not associated with the information collection, (3) for reasons other than to provide information or keep records for the government, or (4) as part of customary and usual business or private practices.**

SBC

The Departments assume 50 percent of the SBCs going to plans would be sent electronically while 58.3 percent of SBCs would be sent electronically to plan participants.[3] The Departments assume 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 mailings with other plan materials, however all notices sent to beneficiaries living apart would be mailed.

3 According to data from the National Telecommunications and Information Agency (NTIA), 37.4 % of individuals age 25 and over have access to the Internet at work. According to a Greenwald & Associates survey, 84% 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 31.4% receiving electronic disclosure at work). Additionally, the NTIA reports that 44.1% of individuals age 25 and over have access to the internet outside of work. According to a Pew Research Center survey, 61.0% 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 26.9% receiving electronic disclosure outside of work). Combining the 31.4% who receive electronic disclosure at work with the 26.9% who receive electronic disclosure outside of work produces a total of 58.3% who will receive electronic disclosure overall.

The annual cost burden for the SBC is displayed in Table 7 below:

Table 9. —SBC Cost Burden

Entity Description	Notice (A)	Pages per disclosure (B)	Per Page Cost (C)	Mailing Costs (D)	Cost Burden (AxBxCxD)
Group Health Plan: Renewal or Application	(2,588,299 ERISA Health Plans - 340,270 Self-Insured Plans) x 25% plans renewing per year x 50% sent by mail = 281,004	8	$0.05	$0.00	$112,401
Group Health Plan: Request	0	8	$0.05	$0.00	$0
Beneficiaries and Participants: Application or Eligibility	71,300,000 ERISA Health Plans Policy Holders x 3.6% new hire rate x 50% sent by mail = 1,283,400	8	$0.05	$0.00	$513,360
Beneficiaries and Participants: Renewal	71,300,000 ERISA Health Plans Policy Holders x 42% sent by mail = 29,732,100	8	$0.05	$0.00	$11,892,840
Beneficiaries and Participants: Request	0	8	$0.05	$0.00	$0
Beneficiaries and Participants: Beneficiaries Living Apart	369,338 Beneficiaries Living Away from Policy Holder x 100% sent by mail = 369,338	8	$0.05	$0.73	$417,352
Total	**31,665,842**	**-**	**-**	**-**	**$12,935,953**

Uniform Glossary and Notice of Modifications

The Departments assume that 5 percent of those who receive paper SBCs would request glossaries in paper form. The Departments assume that the length of these glossaries will be six pages.

The Departments assume that issuers and plans would send notices of modifications to covered individuals, and that 2 percent of covered individuals would receive such notices. Paper notices are assumed to be of the same length as an SBC, eight pages.

The annual cost burden for the Uniform Glossary and Notice of Modification are displayed in Table 8 below.

Table 10 —Uniform Glossary and Notice of Modifications Cost Burden

Entity Description	Notice	Pages per disclosure	Per Page Cost	Mailing Costs	Cost Burden

	(A)	(B)	(C)	(D)	(AxBxCxD)
Participants: Paper Glossary	31,384,838 SBC notices to participants x 5% requesting paper glossary x 100% sent by mail = 1,569,242	6	$0.05	$0.73	$1,616,319
Participants: Notice of Modification	71,300,000 ERISA Plan Policy Holders x 2% receiving notice of modification x 42% sent by mail = 594,642	8	$0.05	$0.73	$671,945
Total	**2,163,884**				**$2,288,265**

The total annual cost burden is displayed in Table 11 below. This burden is split evenly between DOL and Treasury.

Table 11. —Cost Summary

Entity Description	Total Annual Cost Burden	EBSA Annual Cost Burden	Treasury Annual Cost Burden
SBC	$12,935,953	$6,467,977	$6,467,977
Uniform Glossary and Notice of Modifications Cost Burden	$2,288,265	$1,144,132	$1,144,132
Total	**$15,224,218**	**$7,612,109**	**$7,612,109**

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

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

15. Explain the reasons for any program changes or adjustments reporting in Items 13 or 14.

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. These updated data inputs decrease the hour burden by 9,520 hours and increase the cost burden by $6,122 compared with the prior submission.

16. For collections of information whose results will be published, outline plans for tabulation, and publication. Address any complex analytical techniques that will be used. Provide the time schedule for the entire project, including beginning and ending dates of the collection of information, completion of report, publication dates, and other actions.

There are no plans to publish the results of this collection of information.

17. If seeking approval to not display the expiration date for OMB approval of the information collection, explain the reasons that display would be inappropriate.

Not applicable.

18. Explain each exception to the certification statement.

There are no exceptions to the certification statement.

B. COLLECTIONS OF INFORMATION EMPLOYING STATISTICAL METHODS

The use of statistical methods is not relevant to the collections of information.