DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration

29 CFR Part 2520

RIN 1210 AA55

Interim Rules Amending ERISA Disclosure Requirements for Group Health Plans

AGENCY: Pension and Welfare Benefits Administration, Department of Labor.

ACTION: Interim rules with request for comments.

SUMMARY: This document contains interim rules governing the content of the summary plan description (SPD) for group health plans, the furnishing of summaries of material reductions in covered services or benefits by group health plans, and the disclosure of SPD and related information through electronic media. The rules contained in this document implement amendments to the disclosure provisions of the Employee Retirement Income Security Act of 1974 (ERISA) enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA).

Interested persons are invited to submit comments on the interim rules for consideration by the Department in developing final rules. The rules contained in this document are being adopted on an interim basis to accommodate statutorily established time frames intended to ensure that sponsors and administrators of group health plans, as well as participants and beneficiaries covered by such plans, have timely guidance concerning compliance with the recently enacted amendments to ERISA.

DATES: *Comments.* Written comments on these interim rules must be received by the Department of Labor on or before May 31, 1997.

Effective date. This regulation is effective on June 1, 1997. However, affected parties do not have to comply with the information collection requirements in the amendments to 29 CFR 2520.102–3, 2520.104b–1, and 2520.104b–3 made by these interim rules until the Department publishes in the **Federal Register** the control numbers assigned by the Office of Management and Budget (OMB) to these information collection requirements. Publication of the control numbers notifies the public that OMB has approved these information collection requirements under the Paperwork Reduction Act of 1995. The Department has asked for OMB clearance as soon as possible, and OMB approval is anticipated by or before June 1, 1997.

Applicability dates. The regulatory amendments implementing provisions enacted as part of HIPAA generally apply as of the first day of the first plan year beginning after June 30, 1997. The regulatory amendments implementing provisions enacted as part of NMHPA generally apply as of the first day of the first plan year beginning on or after January 1, 1998.

ADDRESSES: Interested persons are invited to submit written comments (preferably three copies) on these interim rules to: Pension and Welfare Benefits Administration, Room N–5669, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210. Attention: Interim Disclosure Rules. All submissions will be open to public inspection at the Public Documents Room; Pension and Welfare Benefits Administration; U.S. Department of Labor; Room N–5638; 200 Constitution Avenue N.W.; Washington, D.C. 20210.

FOR FURTHER INFORMATION CONTACT: Eric A. Raps, Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, (202) 219–8515 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

A. Background

The rules contained in this document implement amendments to the disclosure provisions of ERISA enacted as part of HIPAA [1] and NMHPA. [2] The amendments affect group health plans as defined in section 733 of ERISA. [3] ERISA section 733(a) defines a ''group health plan'' as an ''employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.'' [4]

As discussed herein, these rules affect the content of SPDs, the furnishing of summaries of material reductions in covered services or benefits to participants, and the disclosure of SPD and related information through electronic media. As also discussed herein, these rules are being adopted on an interim basis in order to accommodate statutorily established time frames for provision of regulatory guidance. The Department, however, is inviting public comment on the interim rules to assist in the formulation of final rules in this area.

B. Content of SPDs

Pursuant to ERISA section 101(a)(1), the administrator of an employee benefit plan is required to furnish an SPD to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan. Section 102(b) and the Department's regulations issued thereunder, 29 CFR 2520.102–3, describe the information required to be contained in the SPD.

Section 101(c)(2) of HIPAA amended ERISA section 102(b) to require SPDs of group health plans to include information indicating whether a health insurance issuer (as defined in section 733(b)(2)) [5] is responsible for the financing or administration of the plan. This amendment, in the view of the Department, is intended to ensure that SPDs clearly inform participants and beneficiaries about the role of insurance issuers with respect to their group health plan, particularly in those cases when the plan is self-funded and an insurance issuer is serving as a contract administrator or claims payor, rather than an insurer. In such instances, it is important that participants and beneficiaries understand that the insurance issuer is not acting as insurer of their health benefits under the plan. In this regard, the Department is amending paragraph (q) of § 2520.102–3, relating to the identification of funding media through which benefits are provided, to add at the end thereof a requirement that, where a health insurance issuer is responsible, in whole or in part, for the financing or administration of a group health plan, the SPD of such plan include the name and address of the issuer, whether and to what extent benefits under the plan

[1] Pub. L. 104–191, enacted on August 21, 1996.

[2] Pub. L. 104–204, enacted on September 26, 1996.

[3] Section 733 was enacted as section 706 of ERISA by section 101(a) of HIPAA and subsequently redesignated as section 733 of ERISA pursuant to section 603(a)(3) of NMHPA.

[4] ''Medical care'' is defined in paragraph (a)(2) of section 733 to mean ''amounts paid for—(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, (B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and (C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).''

[5] ''Health insurance issuer'' is defined in section 733(b)(2) to mean ''an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2)). Such term does not include a group health plan.''

are guaranteed under a contract or policy of insurance issued by the issuer, and the nature of any administrative services (e.g., payment of claims) provided by the issuer.

Section 101(c)(2) of HIPAA also amended ERISA section 102(b) to require SPDs of group health plans to include the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under ERISA and HIPAA with respect to health benefits. Currently, individualized participant assistance on all aspects of ERISA is offered through the Pension and Welfare Benefits Administration's field offices and, in the national office, the Division of Technical Assistance and Inquiries. To ensure that participants and beneficiaries are provided assistance information consistent with HIPAA section 101(c)(2), the Department is amending the model statement of ERISA rights, at § 2520.102–3(t)(2), to replace for group health plans the last sentence of that statement with an updated sentence that reads as follows: ''If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.'' Administrators may include in the statement the address and telephone number of the nearest office or offices of the Pension and Welfare Benefits Administration (PWBA). A directory of current PWBA regional and district offices is printed below.

PWBA Offices

Atlanta Regional Office, 61 Forsyth St., S.W., Suite 7B54, Atlanta, Georgia 30303, Phone: 404/562–2156
Boston Regional Office, One Bowdoin Square, 7th Floor, Boston, MA 02114, Phone: 617/424–4950
Chicago Regional Office, 200 West Adams Street, Suite 1600, Chicago, IL 60606, Phone: 312/353–0900
Cincinnati Regional Office, 1885 Dixie Highway, Suite 210, Ft. Wright, KY 41011–2664, Phone: 606/578–4680
Dallas Regional Office, 525 Griffin Street, Rm. 707, Dallas, Texas 75202–5025, Phone: 214/767–6831
Detroit District Office, 211 West Fort Street, Suite 1310, Detroit, MI 48226–3211, Phone: 313/226–7450
Kansas City Regional Office, City Center Square, 1100 Main, Suite 1200, Kansas City, MO 64105–2112, Phone: 816/426–5131
Los Angeles Regional Office, 790 E. Colorado Boulevard, Suite 514, Pasadena, CA 91101, Phone: 818/583–7862
Miami District Office, 111 NW 183rd St., Suite 504, Miami, Florida 33169, Phone: 305/651–6464
New York Regional Office, 1633 Broadway, Rm. 226, New York, N.Y. 10019, Phone: 212/399–5191
Philadelphia Regional Office, Gateway Bldg., 3535 Market Street, Room M300, Philadelphia, PA 19104, Phone: 215/596–1134
St. Louis District Office, 815 Olive Street, Rm. 338, St. Louis, MO 63101–1559, Phone: 314/539–2691
San Francisco Regional Office, 71 Stevenson St., Suite 915, P.O. Box 190250, San Francisco, CA 94119–0250, Phone: 415/975–4600
Seattle District Office, 1111 Third Avenue, Suite 860, MIDCOM Tower, Seattle, Washington 98101–3212, Phone: 206/553–4244
Washington D.C. District Office, 1730 K Street, N.W., Suite 556, Washington, D.C. 20006, Phone: 202/254–7013

The Department notes that, in the case of group health plans not utilizing the model statement in § 2520.102–3(t)(2), the foregoing information is required to be included in a statement of ERISA rights intended to satisfy the requirements of paragraph (t)(1) of that section.

Pursuant to HIPAA section 101(g), the foregoing amendments to the SPD content requirements apply with respect to group health plans for plan years beginning after June 30, 1997. The Department is amending § 2520.102–3 to add a new paragraph (v), ''applicability dates'', that treats the HIPAA content changes as changes in the information required to be contained in the SPD and applies the requirements of 29 CFR 2520.104b–3[6] to the disclosure of such changes, except that the changes have to be disclosed to participants and beneficiaries not later than 60 days after the first day of the first plan year for which the changes are applicable to the plan.

While the interim rule amendment of the model statement of ERISA rights corrects outdated name and address information for contacting the U.S. Department of Labor, and therefore has obvious applicability beyond group health plans, the Department is limiting the interim rule to group health plans in view of directive under HIPAA section 101(c)(2). The Department, however, specifically invites public comment on the extent to which application of the rule should be extended to other plans.

Section 603(a) of the NMHPA also amended ERISA by adding a new section 711 establishing restrictions on the extent to which group health plans and health insurance issuers may limit hospital lengths of stay for mothers and newborn children following delivery. In an effort to ensure that participants and beneficiaries are apprised of the limitations established under NMHPA, paragraph (d) of section 711 provides that ''[t]he imposition of the requirements of this section [section 711] shall be treated as a material modification in the terms of the plan * * * except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.''[7] Pursuant to NMHPA section 603(c), the provisions of section 603 apply to group health plans for plan years beginning on or after January 1, 1998. In this regard, the Department is amending § 2520.102–3, the SPD content regulations, by adding a new paragraph (u) requiring that the SPDs of group health plans offering maternity benefits include a statement indicating that ''group health plans and health insurance issuers offering group health insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.'' To facilitate compliance, the Department views the statement included in this new paragraph (u) of the regulation as sample language that may be used by administrators to satisfy this content requirement for group health plan SPDs.

Consistent with NMHPA section 603(c), new paragraph (v) of § 2520.102–3, relating to applicability dates, provides that the information described in paragraph (u) of § 2520.102–3 shall be furnished to each participant covered

[6] Section 2520.104b–3 prescribes the requirements applicable to the furnishing of summaries of material modifications to the plan and changes in the information required to be included in the summary plan description.

[7] Section 104(b)(1) generally requires summary descriptions of material modifications to the plan to be furnished to participants and beneficiaries not later than 210 days after the end of the plan year in which the change is adopted.

under the plan and each beneficiary receiving benefits under the plan not later than 60 days after the first day of the first plan year beginning on or after January 1, 1998.

C. Material Reductions In Covered Services or Benefits

Section 104(b)(1) of ERISA requires, among other things, that participants and beneficiaries be furnished summary descriptions of material modifications in the terms of their plans and changes in the information required to be included in the SPD not later than 210 days after the end of the plan year in which the change is adopted. Section 101(c)(1) of HIPAA amended ERISA section 104(b)(1) to provide that in the case of any modification or change that is a ''material reduction in covered services or benefits provided under a group health plan'', participants and beneficiaries must be furnished the summary of such modification or change not later than 60 days after the adoption of the modification or change, unless plan sponsors provide summaries of modifications or changes at regular intervals of not more than 90 days.

The interim rules contained herein amend the regulations governing the furnishing of summaries of material modifications, at 29 CFR 2520.104b–3, to establish a special rule for the furnishing of summaries of material modifications and changes by group health plans when such modifications or changes constitute a material reduction in covered services or benefits under the plan. The rules governing the furnishing of such summaries are contained in a new paragraph (d) of § 2520.104b–3.

Section 2520.104b–3(d)(1) provides, consistent with HIPAA section 101(c)(1), that the administrator of a group health plan must furnish to each participant covered under the plan and each beneficiary receiving benefits under the plan, a summary of any modification to the plan or change in the information required to be included in the SPD that is a material reduction in covered services or benefits not later than 60 days after the date of adoption of the modification or change.

Section 2520.104b–3(d)(2) provides that the 60-day period for furnishing summaries of modifications or changes, described in paragraph (d)(1), does not apply to any participant covered by the plan or any beneficiary receiving benefits who would reasonably be expected to be furnished such summary in connection with a system of communication maintained by the plan sponsor or administrator, with respect to which plan participants and beneficiaries are provided information concerning their plan, including modifications and changes thereto, at regular intervals of not more than 90 days. For example, a summary of material reduction in services or benefits would not have to be furnished to participants within the prescribed 60-day period if such summary is included as an insert in a union newspaper or a company publication regularly furnished to participants at intervals of not more than 90 days. It should be noted that the use of such periodicals must otherwise meet the requirements of 29 CFR 2520.104b–1.[8] It should also be noted that if a plan has participants or beneficiaries (e.g., separated participants, qualified beneficiaries with continuation coverage, etc.) that do not receive the newspaper, company publication or periodic disclosure, such participants and beneficiaries must be furnished the summaries of material reductions in services or benefits under the group health plan not later than 60 days after the date of adoption.

Section 2520.104b–3(d)(3) defines the term ''material reduction in covered services or benefits'' provided under a group health plan. For purposes of furnishing summaries of material modifications or changes, paragraph (d)(3)(i) defines a ''material reduction in covered services or benefits'' to mean any modification to the plan or change in the information required to be included in the SPD that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average plan participant to be an important reduction in covered services or benefits.

While it is the view of the Department that determinations as to whether a particular plan modification or SPD change constitutes a ''material reduction in covered services or benefits'' generally will depend on the facts of each case, the Department believes that in making such determinations it is appropriate, given the nature of the required disclosure, to assess in each case whether the average participant in the plan would view the modification or change as an important reduction in covered services or benefits under the plan. Also, recognizing that the significance of plan modifications or changes may be affected by other contemporaneous modifications or changes, it is the view of the Department that plan modifications and SPD changes must be viewed in the aggregate for purposes of determining whether such modifications or changes, individually or together, result in a ''material reduction in covered services or benefits.''

To facilitate compliance, paragraph (d)(3)(ii) sets forth a listing of modifications or changes that generally would constitute a ''reduction in covered services or benefits.'' In this regard, paragraph (d)(3)(ii) provides that a ''reduction in covered services or benefits'' generally would include any modification or change that: eliminates benefits payable under the plan; reduces benefits payable under the plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases deductibles, co-payments, or other amounts to be paid by a participant or beneficiary; reduces the service area covered by a health maintenance organization; establishes new conditions or requirements (e.g., preauthorization requirements) to obtaining services or benefits under the plan.

The interim rules add a new paragraph (e) to § 2520.104b–3 setting forth the dates on which the requirements of § 2520.104b–3(d) take effect. Under § 2520.104b–3(e), the requirements of paragraph (d) apply to material reductions in covered services or benefits under a group health plan adopted on or after the first day of the first plan year beginning after June 30, 1997.

D. Alternative Delivery Mechanisms—Disclosure Through Electronic Media

In addition to amending ERISA section 104(b)(1) to provide for the furnishing of summaries of material reductions in covered services or benefits, section 101(c) of HIPAA amended section 104(b)(1) to provide that ''[t]he Secretary shall issue regulations within 180 days after the date of enactment of the Health Insurance Portability and Accountability Act of 1996, providing alternative mechanisms to delivery by mail through which group health plans (as so defined) may notify participants and beneficiaries of material reductions in covered services or benefits.''

The Department has issued a regulation, at 29 CFR 2520.104b–1, governing the delivery of information required to be furnished to participants

[8] Section 2520.104b–1 permits the disclosure of plan information through periodicals, such as union newspapers and company publications, if the distribution list for the periodical is comprehensive and up-to-date and a prominent notice on the front page of the periodical advises the reader that the issue contains an insert with important information about the plan which should be read and retained for future reference.

and beneficiaries under ERISA. The Department notes that the regulation does not require delivery by mail where other methods of delivery are reasonably calculated to ensure actual receipt of materials by participants and beneficiaries and likely to result in full distribution of the information. *See* § 2520.104b–1(b). In this regard, paragraph (b) of § 2520.104b–1 cites, as an example, in-hand delivery of materials to employees at their worksite locations. The regulation also references the use of union newsletters and company publications as a means by which an administrator may satisfy its disclosure obligation. An alternative to mail delivery not specifically referenced in the current regulation is delivery of disclosure materials through electronic media. Accordingly, the Department is amending § 2520.104b–1 to clarify the circumstances under which a group health plan administrator will be deemed to satisfy its disclosure obligation under § 2520.104b–1 with respect to the delivery of SPDs, summaries of material reductions in covered services or benefits and other summaries of plan modifications and SPD changes through electronic media.[9] This amendment is intended to establish, on an interim basis, a ''safe harbor'' on which administrators of group health plans may rely in delivering plan disclosures through electronic media. The amendment is not intended to represent the exclusive means by which the requirements of § 2520.104b–1 may be satisfied in using electronic media as a method of delivering plan disclosures.

Under the interim rule, § 2520.104b–1 is amended by adding a new paragraph (c) setting forth the conditions under which the use by a group health plan of electronic media for furnishing documents described in ERISA section 104(b)(1), i.e., SPDs and summaries of material modifications and changes, will be deemed to be a method of delivery that is calculated to ensure actual receipt and result in full distribution, within the meaning of paragraph of § 2520.104b–1. New paragraph (c)(1) of § 2520.104b–1 sets forth criteria that are generally intended to ensure that the system of electronic communication utilized by a plan administrator for distribution of disclosure information results in the actual delivery of such information to participants and that the information delivered is equivalent in both substance and form to the disclosure information the participants would have received had they been furnished the information in paper form. In general, paragraph (c)(1) (i)–(ii) provides for the utilization of an electronic delivery system that: (i) the administrator takes appropriate and necessary steps to ensure results in actual receipt by participants of transmitted information, such as through the use of a return-receipt electronic mail feature or periodic reviews or surveys by the plan administrator to confirm the integrity of the delivery system; and (ii) results in the furnishing of disclosure information that is consistent with the style, format and content requirements applicable to the disclosure (*See* 29 CFR 2520.102–2 *et seq.*). New paragraph (c)(1)(iii) requires notification to each participant, through electronic or other means, apprising the participant of the disclosure documents furnished electronically (e.g., SPDs, summaries of material changes to the plan and changes to information included in the SPD), the significance of the documents (e.g., the document contains summary descriptions of changes in the benefits described in your SPD), and the participant's right to request and receive, free of charge, a paper copy of each such document from the plan administrator. The Department believes such notification is necessary so that participants who, for example, receive a disclosure document as an attachment to an electronically transmitted message will be put on notice that the attachment contains important plan information.

It is the view of the Department that participants have a general right to receive required plan disclosures in paper form from the plan administrator. Accordingly, the Department believes that where a plan administrator elects to utilize electronic media as the method for delivering required plan disclosures, participants must be afforded the opportunity to obtain the disclosures from the plan administrator in paper form, free of charge. The obligation to furnish paper copies of documents furnished through electronic media is set forth in paragraph (c)(1)(iv). The Department specifically invites public comment on the relative costs and benefits of this requirement to furnish paper copies to participants on request of documents furnished through electronic media.

New paragraph (c)(2) describes the participants with respect to whom the electronic delivery of plan disclosures will be deemed to be an acceptable method of delivery for fulfilling the disclosure obligation described in § 2520.104b–1(b)(1). Such participants, in the view of the Department, must have: the ability to effectively access at their worksite documents furnished in electronic form; and the opportunity at their worksite to readily convert furnished documents from electronic form to paper form, free of charge. In this regard, the Department believes that, however effective an electronic system may be for delivering plan disclosures, the critical determination in assessing the adequacy of the system, as a means for communicating to plan participants, will be the extent to which participants can readily access and retain the delivered information.

While the Department believes the criteria set forth in the interim rule have applicability beyond group health plans, the Department is limiting the interim rule ''safe harbor'' to group health plans in view of directive under HIPAA section 101(c)(1) and the absence of a public record on the matter. The Department, however, specifically invites public comment on the criteria established by the interim rule, the extent to which application of the rule should be extended to other plans, the extent to which application of the rule should be expanded to other plan disclosures (e.g., summary annual reports, individual benefit statements) and, if expanded, whether additional criteria may be necessary to ensure private, confidential communications of individual account or benefit-related information.

Administrators of group health plans may rely on this interim amendment on or after June 1, 1997.

E. Interim Rules and Request for Comments

The rules contained herein are being adopted on an interim basis in order to ensure that plan sponsors and administrators of group health plans, as well as participants and beneficiaries, are provided timely guidance concerning compliance with recently enacted amendments to ERISA. Specifically, HIPAA section 101(a) adds a new ERISA part 7, and within this new part, section 707 (redesignated as section 734 by section 603(a)(3) of the NMHPA) provides that the Secretary of Labor may promulgate any interim final rules as the Secretary determines are appropriate to carry out this part. The rules herein complement changes made in the new part 7 of ERISA and are being adopted on an interim basis because the Department finds that issuance of such regulations in interim

[9] In the Department's view, a method of delivery, and conditions applicable thereto, appropriate for furnishing summaries of material reductions in covered services or benefits is necessarily appropriate to the furnishing by group health plans of other types of material modifications, SPDs and updated SPDs, given the similar, if not identical, nature of the information being provided.

final form with a request for comments is appropriate to carry out the new regulatory structure imposed by HIPAA on group health plans and health insurance issuers, and is necessary to ensure that plan sponsors and administrators of group health plans, as well as participants and beneficiaries, are provided timely guidance concerning compliance with new and important disclosure obligations imposed by HIPAA. The Department also finds for the above reasons that the publication of a proposed regulation would be impracticable, unnecessary, and contrary to the public interest.

The statutory provisions of HIPAA and NMHPA implemented by the pertinent regulatory amendments in this document are generally applicable for group health plans for plan years beginning on or after July 1, 1997, and January 1, 1998, respectively. Plan administrators and sponsors, and participants and beneficiaries, will need guidance on how to comply with the new statutory provisions before these effective dates. Pursuant to section 101(g) of HIPAA, the Secretary must first issue regulations necessary to carry out the amendments made by section 101 by April 1, 1997. Issuance of a notice of proposed rulemaking with a period for comments prior to issuing a final rule could delay the issuance of essential guidance and prevent the Department from complying with its deadline. Furthermore, although the rules herein are being adopted on an interim basis, the Department is inviting interested persons to submit written comments on the rules for consideration in the development of final rules in this area. Such final rules may be issued in advance of the above July 1, 1997, and January 1, 1998, dates.

Executive Order 12866 Statement

Under Executive Order 12866 (58 FR 51735, Oct. 4, 1993), it must be determined whether a departmental action is ''significant'' and therefore subject to review by the Office of Management and Budget (OMB) and the requirements of the Executive Order. Under section 3(f), the order defines a ''significant regulatory action'' as an action that is likely to result in a rule (1) having an annual effect on the economy of $100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Pursuant to the terms of the Executive Order, it has been determined that the action that is the subject of the interim rules is ''significant'' under category (4), *supra*, and subject to OMB review on that basis. The estimated cost of compliance with HIPAA and the interim rules are set forth in the Paperwork Reduction Act Analysis, below. The benefits of the interim rules, as yet unquantified, will arise as participants and beneficiaries become better informed about their health care coverage because of additional disclosures and more timely distribution of plan information.

Paperwork Reduction Act Analysis

The Department of Labor has submitted this emergency processing public information collection request (ICR) to the Office of Management and Budget for review and clearance under the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. Chapter 35). The Department has asked for OMB clearance as soon as possible, and OMB approval is anticipated by or before June 1, 1997. As part of its continuing effort to reduce paperwork and respondent burden, the Department conducts a pre-clearance consultation program to provide the general public and Federal agencies with an opportunity to comment on ICRs in accordance with the Paperwork Reduction Act of 1995 (PRA 95)(Pub. L. 104–13, 44 U.S.C. Chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the revised collection of Summary Plan Description Requirements under ERISA.

DATES: Written comments must be submitted to the offices listed in the addressee section below on or before May 31, 1997. In light of the request for OMB clearance by June 1, 1997, submission of comments within the first 30 days is encouraged to ensure their consideration.

The Department and the Office of Management and Budget are particularly interested in comments which:

- evaluate whether the proposed collection is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- enhance the quality, utility, and clarify the information to be collected; and
- minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

ADDRESSES: Comments and questions about the ICR should be forwarded to: Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N–5647, Washington, D.C. 20210, Telephone: (202) 219–4782 (this is not a toll-free number), Fax: (202) 219–4745; and the Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for the Pension and Welfare Benefits Administration, Office of Management and Budget, Room 10235, Washington, D.C. 20503, Telephone: (202) 395–7316. Additional PRA 95 Information:

I. *Background:* The administrator of an employee benefit plan is required to furnish an SPD to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan. The SPD must be written in a manner calculated to be understood by the average plan participant and must be sufficiently comprehensive to apprise the plan's participants and beneficiaries of their rights and obligations under the plan. To the extent that there is a material modification in the terms of the plan or a change in the information required to be contained in the SPD, ERISA requires that the administrator furnish participants covered under the plan and beneficiaries receiving benefits with a summary of such changes.

II. *Current Actions: HIPAA and NMHPA amend certain reporting and disclosure provisions of ERISA*

Type of Review: Revision of currently approved collection.

Agency: Pension and Welfare Benefits Administration.

Title: The title of the interim rule is Amendment of Summary Plan Description and Related ERISA Regulations To Implement Statutory Changes In the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OMB Number: 1210–0039.

Affected Public: Business or other for-profit, not-for-profit.

Total Responses (annual): 43,952,715 (1997), 62,728,915 (1998), 31,896,715 (1999).

Total Respondents (annual): 176,315 (1997), 194,235 (1998), 163,515 (1999).

Frequency: On occasion.

Average Time per Response:

Average SPD/SMM—We estimate it takes an average of 6 hours for preparation of SPDs/SMMs, including the time to copy, assemble, and mail the document to the Department of Labor.

SMM Compliance—We estimate that preparation of an SMM sufficient to satisfy the requirements of this regulation will take an average of 1 hour.

Distribution—We estimate that 2 minutes per participant is the time needed to distribute an SMM/SPD, including time spent reproducing the document and mailing the document.

Estimated Total Burden Hours: 1,007,425 (1997), 1,130,282 (1998), 942,980 (1999).

There is estimated to be no capital/start-up cost. Total Burden Cost for operating/maintenance is estimated to be $72,310,858 in 1997, $82,338,958 in 1998 and $65,002,858 in 1999.

Note: The Average Time Per Response, Estimated Total Burden Hours, and Total Burden Cost have been estimated without accounting for those respondents that will implement the ''alternative mechanisms to delivery by mail'' provision contained in the interim rule. It is expected that some respondents will use these alternatives, and that these alternatives will reduce burden hours and costs.

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of the information collection request; they will also become a matter of public record.

Congressional Review

This interim rule has been transmitted to Congress and the Comptroller General for review under section 801(a)(1)(A) of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*).

Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), as well as Executive Order 12875, this interim rule does not include any Federal mandate that may result in expenditures by State, local or tribal governments, and does not impose an annual burden exceeding $100 million on the private sector.

Statutory Authority

This interim regulation is adopted pursuant to authority contained in section 505 of ERISA (Pub. L. 93–406, 88 Stat. 894, 29 U.S.C. 1135) and sections 104(b) and 734 of ERISA, as amended, (Pub. L. 104–191, 110 Stat. 1936, 1951 and Pub. L. 104–204, 110 Stat. 2935, 29 U.S.C. 1024 and 1191c) and under Secretary of Labor's Order No. 1–87, 52 FR 13139, April 21, 1987.

List of Subjects in 29 CFR Part 2520

Employee benefit plans, Employee Retirement Income Security Act, Group health plans, Pension plans, Welfare benefit plans.

For the reasons set forth above, Part 2520 of Title 29 of the Code of Federal Regulations is amended as follows:

PART 2520—[AMENDED]

1. The authority for Part 2520 is revised to read as follows:

Authority: Secs. 101, 102, 103, 104, 105, 109, 110, 111(b)(2), 111(c), and 505, Pub. L. 93–406, 88 Stat. 840–52 and 894 (29 U.S.C. 1021–1025, 1029–31, and 1135); Secretary of Labor's Order No. 27–74, 13–76, 1–87, and Labor Management Services Administration Order 2–6.

Sections 2520.102–3, 2520.104b–1 and 2520.104b–3 also are issued under sec. 101 (a), (c) and (g)(4) of Pub. L. 104–191, 110 Stat. 1936, 1939, 1951 and 1955 and, sec. 603 of Pub. L. 104–204, 110 Stat. 2935 (29 U.S.C. 1185 and 1191c).

2. Section 2520.102–3 is amended by adding a sentence at the end of paragraph (q) to read as follows:

§ 2520.102–3 Contents of summary plan description.

* * * * *

(q) * * * If a health insurance issuer, within the meaning of section 733(b)(2) of the Act, is responsible, in whole or in part, for the financing or administration of a group health plan, the summary plan description shall indicate the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer, and the nature of any administrative services (e.g., payment of claims) provided by the issuer.

* * * * *

3. Section 2520.102–3 is further amended by revising the last sentence of the undesignated paragraph following paragraph (t)(2) to read as follows:

§ 2520.102–3 Contents of summary plan description.

* * * * *

(t) * * *

(2) * * *

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

4. Section 2520.102–3 is further amended by adding paragraphs (u) and (v) to read as follows:

§ 2520.102–3 Contents of summary plan description.

* * * * *

(u) In the case of a group health plan, as defined in section 733(a)(1) of the Act, that provides maternity or newborn infant coverage, a statement indicating that group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

(v) *Applicability dates.* (1) The information described in the last sentence of paragraph (q) and in the last two sentences of paragraph (t)(2) shall be treated as a change in the information required to be included in the summary plan description for a group health plan for purposes of 29 CFR 2520.104b–3, except that such information shall be furnished to each participant covered under the plan and each beneficiary receiving benefits under the plan not later than 60 days after the first day of the first plan year beginning after June 30, 1997.

(2) The information described in paragraph (u) of this section shall be furnished to each participant covered under a group health plan and each beneficiary receiving benefits under a group health plan not later than 60 days after the first day of the first plan year beginning on or after January 1, 1998.

5. Section 2520.104b–3 is amended by revising the second sentence of paragraph (a), redesignating paragraphs (d) and (e) as paragraphs (f) and (g), respectively, and adding new paragraphs (d) and (e) to read as follows:

§ 2520.104b–3 Summary of material modifications to the plan and changes in the information required to be included in the summary plan description.

(a) * * * Except as provided in paragraph (d) of this section, the plan administrator shall furnish this summary, written in a manner calculated to be understood by the average plan participant, not later than 210 days after the close of the plan year in which the modification or change was adopted. * * *

* * * * *

(d) *Special rule for group health plans.* (1) *General.* Except as provided in paragraph (d)(2) of this section, the administrator of a group health plan, as defined in section 733(a)(1) of the Act, shall furnish to each participant covered under the plan and each beneficiary receiving benefits under the plan a summary, written in a manner calculated to be understood by the average plan participant, of any modification to the plan or change in the information required to be included in the summary plan description, within the meaning of paragraph (a) of this section, that is a material reduction in covered services or benefits not later than 60 days after the date of adoption of the modification or change.

(2) *90-day alternative rule.* The administrator of a group health plan shall not be required to furnish a summary of any material reduction in covered services or benefits within the 60-day period described in paragraph (d)(1) of this section to any participant covered under the plan or any beneficiary receiving benefits who would reasonably be expected to be furnished such summary in connection with a system of communication maintained by the plan sponsor or administrator, with respect to which plan participants and beneficiaries are provided information concerning their plan, including modifications and changes thereto, at regular intervals of not more than 90 days and such communication otherwise meets the disclosure requirements of 29 CFR 2520.104b–1.

(3) *''Material reduction''.* (i) For purposes of this paragraph (d), a ''material reduction in covered services or benefits'' means any modification to the plan or change in the information required to be included in the summary plan description that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average plan participant to be an important reduction in covered services or benefits under the plan.

(ii) A ''reduction in covered services or benefits'' generally would include any plan modification or change that: eliminates benefits payable under the plan; reduces benefits payable under the plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases deductibles, co-payments, or other amounts to be paid by a participant or beneficiary; reduces the service area covered by a health maintenance organization; establishes new conditions or requirements (e.g., preauthorization requirements) to obtaining services or benefits under the plan.

(e) *Applicability date.* Paragraph (d) of this section is applicable as of the first day of the first plan year beginning after June 30, 1997.

* * * * *

6. Section 2520.104b–1 is amended by redesignating paragraph (c) as paragraph (d) and adding a new paragraph (c) to read as follows:

§ 2520.104b–1 Disclosure.

* * * * *

(c) *Disclosure through electronic media.* (1) The administrator of a group health plan furnishing documents described in section 104(b)(1) of the Act through electronic media will be deemed to satisfy the requirements of paragraph (b)(1) of this section with respect to participants described in paragraph (c)(2) of this section if:

(i) The administrator takes appropriate and necessary measures to ensure that the system for furnishing documents results in actual receipt by participants of transmitted information and documents (e.g., uses return-receipt electronic mail feature or conducts periodic reviews or surveys to confirm receipt of transmitted information);

(ii) Electronically delivered documents are prepared and furnished in a manner consistent with the applicable style, format and content requirements (See 29 CFR 2520.102–2 through 2520.102–5);

(iii) Each participant is provided notice, through electronic means or in writing, apprising the participant of the document(s) to be furnished electronically, the significance of the document (e.g., the document describes changes in the benefits provided by your plan) and the participant's right to request and receive, free of charge, a paper copy of each such document; and

(iv) Upon request of any participant, the administrator furnishes, free of charge, a paper copy of any document delivered to the participant through electronic media.

(2) For purposes of paragraph (c)(1) of this section, the furnishing of documents through electronic media satisfies the requirements of paragraph (b)(1) of this section only with respect to participants:

(i) Who have the ability to effectively access at their worksite documents furnished in electronic form; and

(ii) Who have the opportunity at their worksite location to readily convert furnished documents from electronic form to paper form free of charge.

(3) This paragraph (c) applies on or after June 1, 1997.

* * * * *

Signed at Washington, D.C., this 27th day of March, 1997.

Olena Berg,

Assistant Secretary, Pension and Welfare Benefits Administration, U.S. Department of Labor.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 148

[BPD–882–IFC]

RIN 0938–AH75

Individual Market Health Insurance Reform: Portability From Group to Individual Coverage; Federal Rules for Access in the Individual Market; State Alternative Mechanisms to Federal Rules

AGENCY: Department of Health and Human Services.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements section 111 of the Health Insurance Portability and Accountability Act of 1996, which sets forth Federal requirements designed to improve access to the individual health insurance market. Certain ''eligible individuals'' who lose group health insurance coverage are assured availability of coverage in the individual market, on a guaranteed issue basis, without preexisting condition exclusions. In addition, all individual health insurance coverage must be guaranteed renewable. This rule also sets forth procedures that apply to States that choose to implement a