SUPPORTING STATEMENT FOR PAPERWORK REDUCTION ACT OF 1995 SUBMISSIONS

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.

Section 503 ("the Claims Procedure") of ERISA states, in its entirety:

In accordance with regulations of the Secretary, every employee benefit plan shall --

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for the denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claims.

In November 2000, the Department issued a final regulation establishing minimum claims procedure requirements that all employee benefit plans under ERISA must meet in order to satisfy the requirements of section 503.[1] The claims procedure regulation is codified at 29 CFR 2560.503-1. Section 505 of ERISA authorizes the Secretary to prescribe regulations as appropriate or necessary to carry out the provisions of Title I of ERISA. The regulation requires plans to provide every claimant who is denied a claim with a written or electronic notice that contains the specific reasons for denial, a reference to the relevant plan provisions on which the denial is based, a description of any additional information necessary to perfect the claim, and a description of steps to be taken if the participant or beneficiary wishes to appeal the denial. The regulation also requires that any adverse decision upon review be in writing (including electronic means) and include specific reasons for the decision, as well as references to relevant plan provisions.

The claims procedure regulation imposes information collection requirements as part of the reasonable procedures that an employee benefit plan must establish regarding the handling of a benefit claim. These requirements include third-party notice and disclosure

1 The claims procedure regulation replaced an earlier regulation that had been issued in 1977.

requirements that the plan must satisfy by providing information to participants and beneficiaries of the plan.

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.*

   The information collection requirements included in the claims procedure regulation ensure that participants and beneficiaries (claimants) receive adequate information regarding the plan's claims procedures and the plan's handling of specific benefit claims. Participants and beneficiaries need to understand plan procedures and plan decisions in order to appropriately request benefits and/or appeal benefit denials.

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 claims regulation does not restrict plans' use of electronic technology to process and pay claims, to maintain information as to the basis for claim determination, and to generate correspondence related to claims processing decisions. This regulation incorporates by reference the pertinent provisions of the Department's separate regulation, 29 CFR 2520.104b-1, which facilitates and encourages the use of electronic information technology. This burden estimate incorporates the Department's assumptions, described in the response to item 12, below, concerning the rate of use by plans of electronic means of communication.

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.*

   No duplication with other Federal statutes exists. In some circumstances, states may require substantially similar information to be provided to insured persons. However, no duplication occurs because the same information disclosure may be used to satisfy duplicative or overlapping requirements.

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 (small business, small plans) that provide benefits. The Department took into

account the potential burden on small entities in structuring the regulation by permitting plan sponsors the maximum possible flexibility in designing their plans, including the possibility of hiring third-party service providers to carry out these administration responsibilities in order to make use of the lowest cost method of compliance available. A large majority of small plans purchase claims administration services from insurers, HMOs, and other service providers, and the Department has taken this fact into account in deriving its burden estimates. These service providers typically develop a single claims processing system to service a large number of customers, including small entities. Thus, the cost of revising and implementing the procedures 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 improved accuracy and timeliness in claims and appeals determinations.

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.*

The information collection requirements arise in connection with the occurrence of individual claims for benefits and consist of third-party notices and disclosures. No information is reported to the Federal government. Every claim event is normally of importance to the specific participant who relies on an employee benefit plan to provide the promised benefit. The information collection provisions of the regulation ensure that sufficient information is provided to: a) participants and beneficiaries so that they may fully exercise their rights under their employee benefit plans, and b) to fiduciaries responsible for operating plans in accordance with their terms.

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.*

The regulation imposes special timing requirements for the handling of claims under group health plans. Depending on circumstances indicating the urgency of the need for a claims decision, group health plans may be required to notify claimants about health benefit claim determinations in fewer than 30 days.

First, for claims involving "urgent care," the regulation requires, in general, that claimants be notified of health benefit determinations "as soon as possible, but not later than 72 hours after receipt of the claim by the plan. . . ." 29 CFR 2560.503-1(f)(2)(ii). In cases involving urgent care where the health claim is a request to extend the time period or number of treatments of ongoing medical care, this period is 24 hours. 29 CFR 2560.503-1(f)(2)(ii)(B).

Second, for "pre-service" claims, the regulation requires that claimants be notified of health benefit determinations "within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan." 29 CFR 2560.503-1(f)(2)(iii)(A). Pre-service claims involve plan requirements that a claimant obtain approval from the plan prior to receiving health care services or products in order to maintain eligibility for benefits.

Third, for "post-service" health benefit claims, the regulation requires notification of an adverse benefit determination "within a reasonable period of time, but not later than 30 days after receipt of the claim." Even though 30 days is the maximum response time for these claims, a plan must provide a determination sooner if it is reasonable to do so. Disability benefit claims are subject to a similar construct, except that the maximum response time is 45 days.

Appeals of denied claims must be decided within similar, short time limits.

These timing requirements are reasonably related to important policy objectives in an area of important public concern. For example, the shortest time frame for "urgent care" claims applies only under circumstances in which delay could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or where delay would subject the claimant to severe pain. The next shortest time frame applies under circumstances in which medical care, while not urgent, has not been provided to a claimant who needs treatment for a medical problem and where the plan itself requires pre-approval of the medical care before providing coverage. Post-service

health claims and disability claims also involve important concerns relating to the sick and disabled, but under these circumstances plans may take at least 30 days to respond if it is reasonably necessary to do so.

Another reason why these time frames are important is that these notices relate to the payment of money by a plan to claimants to whom fiduciary responsibilities are owed. Without enforcement of reasonable deadlines, payors could be given a financial incentive to delay the payments, and this would likely be inconsistent with appropriate fiduciary standards. Finally, these time frames for health and disability claims are generally consistent with industry standards and with the requirements of other regulators such as state insurance departments.

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.

   The Department published the notice required by 5 CFR 1320.8(d) in the Federal Register on November 23, 2015 (80 FR 72990). No comments were received.

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

   Not applicable.

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

This information collection request (ICR) involves disclosures of information by plan administrators to plan participants. Issues of confidentiality between third parties do not fall within the scope of this information collection request.

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.*

None.

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 and aggregate the hour burdens in Item 13.*
    - *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 information collection provisions of the regulation are found in 29 CFR 2560.503-1 (g), (h), (i), and (j), and in ERISA at section 503. The Department estimates that this information collection affects 5,790,000 respondents. The frequency of response will be on occasion, mirroring the frequency of benefit claims that require responses, totaling about 311,153,000 per year. The hour burden is estimated to be 492,500 hours annually.

The Department's final regulation governing ERISA plans' claims procedures, of which this information collection is part, generally became applicable on or after January 1, 2003. The estimates include only ongoing costs of compliance with the statute and the regulations.

Ongoing burdens are a function of claims volume, as well as the denial and appeal rates of various plans. As shown in the table below, health benefit claims comprise the majority of all claims filed annually.

TABLE 1.--*Claims (in thousands)*

	Health	Disability		Pension	Other	Total
		Short-Term	Long-Term			
Claims	1,328,040	2,850	322	2,078	305	1,333,594
Pre-Service						
Claim Approved	33,865.0	--	--	--	--	33,865
Claim Denied	5,976.2	--	--	--	--	5,976
Post-Service						
Claim Denied	193,229.8	85.5	70.7	18.1	9.1	193,413
Claim Extended	77,291.9	28.5	64.3	0.0	0.0	77,385
Denial Appeal						
Total	455.7	8.6	46.7	1.8	0.9	514
Appeal Approved	182.3	4.3	23.3	0.9	0.5	211
Appeal Denied	273.4	4.3	23.3	0.9	0.5	302
Medical*	131.7	--	--	--	--	132
Claim Approved	52.7	--	--	--	--	53
Claim Denied	79.0	--	--	--	--	79
Administrative	324.0	--	--	--	--	324
Claim Approved	129.6	--	--	--	--	130
Claim Denied	194.4	--	--	--	--	194
Total Responses	310,819	123	182	20	10	311,153

The transaction burden will vary widely with the type and complexity of claim in question, but the mix of claims and associated burdens generally are expected to be similar across plans of the same type. The average time required for the information collection associated with any particular type of health benefit claim transaction will range from one minute for certain routine automatic notices to six hours for certain disclosures on request following adverse claim determinations.

The Department estimates that approximately 93 percent of large benefit and all small benefit plans administer claims using a third-party provider. Approximately 4,520 health, 2,819 disability, 6,035 pension and 4,095 other plans administer claims in-house. In-house administration burdens are accounted for as hours, while purchased services are accounted for as dollar costs and are discussed question 13. The hourly burden as well as

labor costs associated with mailing document for plans processing claims in-house is described below:

TABLE 2.--*In-House Burden Hours (in thousands)*

	Health	Disability		Pension	Other	Mailing Cost	Total Hours
		Short-Term	Long-Term				
Pre-Service							
Claim Approved	27.5	--	--	--	--	$235	27.5
Claim Denied	9.7	--	--	--	--	$42	9.7
Post-Service							
Claim Denied	314.3	2.1	3.5	0.1	0.0	$5,379	319.9
Claim Extended	62.9	0.3	1.6	0.0	0.0	$2,152	64.8
Denial Appeal							
Total	68.0	0.2	2.3	0.0	0.0	$14	70.6
Appeal Approved	15.6	0.0	0.0	0.0	0.0	$6	15.7
Appeal Denied	52.4	0.2	2.3	0.0	0.0	$8	54.9
Medical	48.8	--	--	--	--	$4	48.8
Claim Approved	15.4	--	--	--	--	$1	15.4
Claim Denied	33.4	--	--	--	--	$2	33.4
Administrative	19.2	--	--	--	--	$9	19.2
Claim Approved	0.2	--	--	--	--	$4	0.2
Claim Denied	19.0	--	--	--	--	$5	19.0
Total	**482**	**3**	**7**	**0**	**0**	**$7,823**	**492.5**

Note: Assumed that 7 percent of large plan process these claims in-house. Large plans account for 69.7 percent of policy-holders and therefore 4.9 percent of claims are processed in-house

Total burden hours are estimated at 492,500 hours. Using the hourly cost of clerical workers ($55.21), doctors ($156.10) or lawyers (133.61),[2] as appropriate, the equivalent costs are estimated to be $52,559,000.

13. *Provide an estimate of the total annual cost burden to respondents or recordkeepers resulting from the collection of information. (Do not include the cost of any hour burden shown in Items 12 or 14).*

As indicated in question 12, the bulk of these claims will be processed by third-party service providers. Total costs are estimated by multiplying the number of responses by the amount of time required to prepare the documents and then multiplying this by the

2 For a description of the Department's methodology for calculating wage rates, see http://www.dol.gov/ebsa/pdf/labor-cost-inputs-used-in-ebsa-opr-ria-and-pra-burden-calculations-march-2016.pdf

appropriate hourly cost from question 12, and then adding the cost of copying and mailing responses ($0.57 each for those not sent electronically). These costs are described below:

Table 3.--*Service Provider and Materials Burden Cost (in thousands)*

	Health	Disability		Pension	Other	Mailing Cost	Total Costs
		Short-Term	Long-Term				
Pre-Service							
Claim Approved	$29,641	--	--	--	--	$4,590	$34,231
Claim Denied	$10,462	--	--	--	--	$810	$11,272
Post-Service							
Claim Denied	$338,255	$6,348	$10,504	$79	$40	$27,640	$382,867
Claim Extended	$67,651	$1,058	$4,775	$0	$0	$11,067	$84,551
Denial Appeal							
Total	$198,579	$642	$6,974	$20	$10	$293	$206,518
Appeal							
Approved	$47,481	$7	$41	$1	$0	$120	$47,651
Appeal Denied	$151,098	$635	$6,933	$19	$10	$172	$158,867
Medical	$148,617	--	--	--	--	--	$148,617
Claim Approved	$46,932	--	--	--	--	--	$46,932
Claim Denied	$101,685	--	--	--	--	--	$101,685
Administrative	$49,962	--	--	--	--	--	$49,962
Claim Approved	$549	--	--	--	--	--	$549
Claim Denied	$49,413	--	--	--	--	--	$49,413
Total Costs	**$644,588**	**$8,049**	**$22,253**	**$99**	**$50**	**$44,400**	**$719,438**

Note: Assumed that 93 percent of large plans and all small plans process these claims externally. This results in 95.1 percent of claims being processed externally

The total estimated cost burden for those plans that use service providers, including the cost of mailing all responses (including materials and postage costs for those prepared in-house listed in Table 2), is $719,438,000 annually.

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.*

There are no costs to the Federal government associated with this information collection.

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

No program changes have been made since the previous submission. The changes in burden estimation are due to the use of updated information concerning the number of respondents and claims, as well as updated labor costs.

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.*

Not applicable.

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.*

The collection of information will display a currently valid OMB control number.

18. *Explain each exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submission."*

Not applicable; no exceptions to the certification statement.

B. Collection of Information Employing Statistical Methods

Not applicable. The use of statistical methods is not relevant to this collection of information.