

**SUPPORTING STATEMENT FOR PAPERWORK REDUCTION ACT OF 1995: ERISA
CLAIMS PROCEDURE REGULATION**

This information collection request (ICR) seeks approval for an extension without change 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.

Section 503 (“the Claims Procedure”) of the Employee Retirement Income Security Act (ERISA) states, in its entirety:

In accordance with regulations of the Secretary of Labor, 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 of ERISA.¹ The claims procedure regulation is codified at 29 CFR 2560.503-1 of ERISA. 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.

¹ The claims procedure regulation replaced an earlier regulation that had been finalized and published in 1977.

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 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.**

ERISA and regulations thereunder provide general standards for the delivery of all information 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. The Department 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.

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 July 11, 2025 (90 FR 30984). No comments were received.

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.

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.

This information collection does not ask 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 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 4,336,356 respondents. The frequency of response will depend on the individual participant, mirroring the frequency of benefit claims that require responses, totaling about 1,436,422,678 per year.

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	1,804,655	3,404	411	2,857	353	1,811,680
Pre-Service						
Claim Approved	46,019	--	--	--	--	46,019
Claim Denied	8,121	--	--	--	--	8,121

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Post-Service						
Claims Approved	1,487,938	--	--	--	--	1,487,938
Claim Denied	262,577	102	90	25	11	262,805
Claim Extended	105,031	34	82	0	0	105,147
Denial Appeal						
Total	474	10	60	2	1	548
Appeal Approved	190	5	30	1	1	226
Appeal Denied	285	5	30	1	1	321
Medical*	137	--	--	--	--	137
Claim Approved	55	--	--	--	--	55
Claim Denied	82	--	--	--	--	82
Administrative	337	--	--	--	--	337
Claim Approved	135	--	--	--	--	135
Claim Denied	202	--	--	--	--	202
Total Responses	1,910,160	146	232	27	12	1,910,577

Approximately 2,765,373 health², 214,124 disability³, 836,843 pension⁴, and 520,016 other welfare benefit plans⁵ administer claims using in-house resources or third-party service providers. Services provided by third-party service providers and in-house administration are accounted for as hour burden and are discussed here in question 12.

The Department assumes that the notices will be reviewed and prepared by lawyers (\$187.58), and doctors (\$222.68). clerical workers (\$72.82).⁶ 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. Please see table 2 for burden and calculations. Materials and mailing costs are accounted for as cost burden and are discussed in question 13.

2 Source: U.S. Department of Labor, EBSA calculations using the 2024 Medical Expenditure Panel Survey, Insurance Component (MEPS-IC), and the Form 5500.

3 Health plans may also include disability covered so the disability plan count is a count not of total disability plans but plans offering disability and possibly other welfare coverages except health.

4 Source: U.S. Department of Labor, EBSA, *Private Pension Plan Bulletin: Abstract of 2023 Form 5500 Annual Reports*.

5 Source: U.S. Department of Labor, EBSA calculations using non-health welfare plan Form 5500 filings and projecting non-filers using estimates based on the non-filing health universe

6 Internal DOL calculation based on 2026 labor cost data. For a description of the Department's methodology for calculating wage rates, see <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/technical-appendices/labor-cost-inputs-used-in-ebbsa-opr-ria-and-pra-burden-calculations-june-2019.pdf>

Table 2. Burden Hours (in thousands)

	Health	Disability		Pension	Other	Total Hours	Equivalent Costs
		Short-Term	Long-Term				
Pre-Service							
Claim Approved	\$55,851	--	--	--	--	767	\$55,851
Claim Denied	\$19,712	--	--	--	--	271	\$19,712
Post-Service							
Claims Approved	\$1,805,860					24,799	\$1,805,860
Claim Denied	\$1,641,808	\$11,370	\$20,118	\$151	\$64	8,897	\$1,673,512
Claim Extended	\$389,805	\$1,895	\$9,144	\$0	\$0	1,800	\$400,844
Denial Appeal							
Total	\$283,681	\$1,149	\$13,350	\$40	\$17	1,517	\$298,238
Appeal Approved	\$74,092	\$12	\$72	\$2	\$1	335	\$74,179
Appeal Denied	\$209,589	\$1,137	\$13,278	\$39	\$17	1,182	\$224,060
Medical							
Claim Approved	\$73,248	--	--	--	--	329	\$73,248
Claim Denied	\$133,689	--	--	--	--	713	\$133,689
Administrative							
Claim Approved	\$843	--	--	--	--	4	\$843
Claim Denied	\$75,901	--	--	--	--	405	\$75,901
Total	\$4,196,718	\$14,415	\$42,612	\$192	\$81	38,051	\$4,254,018

Note: Assumed that 75 percent of health claims and 30 percent of disability claims are processed electronically.

Table 3. Estimated Annualized Respondent Hour Burden and Hour Equivalent Cost

Activities	Number of Respondents	Number of Responses per Respondent	Total Responses	Average Burden (Hours)	Total Burden	Wage Rates	Equivalent Cost
Pre-service							
Health							
Claimed approved	2,765,373	16.64	46,018,694	0.017	766,978	\$72.82	\$55,851,356
Claim denied	2,765,373	2.94	8,120,946	0.033	270,698	\$72.82	\$19,712,243
Post-service							
Health							
Claims	2,765,373	538.06	1,487,937,787	0.02	24,798,963	\$72.82	\$1,805,860,495

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approved							
Claims denied	2,765,373	94.95	262,577,257	0.03	8,752,575	\$187.58	\$1,641,808,060
Claims extended	2,765,373	37.98	105,030,903	0.02	1,750,515	\$222.68	\$389,804,690
Short-term disability							
Claims approved	214,124	0.48	102,123	0.5	51,061	\$222.68	\$11,370,347
Claims denied	214,124	0.16	34,041	0.25	8,510	\$222.68	\$1,895,058
Long-term disability							
Claims approved	214,124	0.42	90,344	1	90,344	\$222.68	\$20,117,693
Claims denied	214,124	0.38	82,130	0.5	41,065	\$222.68	\$9,144,406
Pension							
Claims approved	836,843	0.03	24,926	0.08	2,077	\$72.82	\$151,262
Claims denied	836,843	0.00	0	0.02	0	\$72.82	-
Other							
Claims approved	520,016	0.02	10,584	0.08	882	\$72.82	64,225
Claims denied	520,016	0.00	0	0.02	0	\$72.82	-
Denial Appeal							
Health: Medical							
Claims approved	2,765,373	0.02	54,823	6	328,940	\$222.68	\$73,248,315
Claims denied	2,765,373	0.03	82,235	8.67	712,703	\$187.58	\$133,688,810
Health: Administrative					0		
Claims approved	2,765,373	0.05	134,877	0.03	4,496	\$187.58	\$843,339
Claims denied	2,765,373	0.07	202,315	2	404,630	\$187.58	\$75,900,514
Short-term Disability							
Claims approved	214,124	0.02	5,106	0.03	170	\$72.82	\$12,394
Claims denied	214,124	0.02	5,106	1	5,106	\$222.68	\$1,137,035
Long-term Disability							
Claims approved	214,124	0.14	29,813	0.03	994	\$72.82	\$72,367
Claims denied	214,124	0.14	29,813	2	59,627	\$222.68	\$13,277,677
Pension							
Claims	836,843	0.001	1,246	0.02	21	\$72.82	\$1,513

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approved							
Claims denied	836,843	0.001	1,246	0.17	208	\$187.58	\$38,964
Other							
Claims approved	520,016	0.001	529	0.02	9	\$72.82	\$642
Claims denied	520,016	0.001	529	0.17	88	\$187.58	\$16,544
Total	4,336,356	440.60	1,910,577,375		38,050,660		\$4,254,017,948

The available breakdown of respondents across health, disability, pension, and other plans are assigned in the respective rows categories. Therefore, the number of respondents does not sum up to total. The number of respondents is calculated in the following manner: 2,765,373 (health plans) + 214,124 (disability plans) + 836,843 (pension plans) + 520,016 (other plans) = 4,336,356. As discussed in Question 12, the Department estimates there are 1,910,577,375 responses.

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 and 14).

- **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.**

The Department estimates that it will cost \$1 to mail documents using mass mailing services. The Department also estimates that the material costs are \$0.05 per page. The total estimated mailing and material costs for plans to send responses is \$501,736,152 annually. Please see Table 4 for mailing and material costs.

Table 4.-- Cost Burden (in thousands)

		Mailing and Materials Cost	
14. Provide estimates Federal a description of the cost, which should hours, operational equipment, support staff), and would not have collection of may aggregate cost 13, and 14 in a	Pre-Service		
	Claim Approved	\$12,080	
	Claim Denied	\$2,132	
	Post-Service		
	Claims Approved	4	
	Claim Denied	\$69,105	
	Claim Extended	\$27,656	
	Denial Appeal		
	Total	\$180	
	Appeal Approved	\$77	
	Appeal Denied	\$102	
	Medical		
Claim Approved	\$14		
Claim Denied	\$22		
Administrative			
Claim Approved	\$89		
Claim Denied	\$35		
Claim Denied	\$53		
	\$501,73		
Total	6		

of annualized cost to the government. Also, provide method used to estimate include quantification of expenses (such as overhead, printing, and any other expense that been incurred without this information. Agencies also estimates from Items 12, single table.

the Federal government information collection.

for any program changes reporting in Items 13 or

No program changes have been made since the previous submission. This information collection uses updated wages, mailing costs, and updated data inputs. The Department's estimates for the number of claims per participants was also updated. The number of responses has increased by 474,154,697. The number of respondents has increased by 448,383. These changes have increased the hour burden and cost burden. The hour burden has increased by 9,069,298 hours and the cost burden has increased by \$239,445,498.

- 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 topics of the certification statement identified in “Certification for Paperwork Reduction Act Submissions.”**

There are no exceptions to the certification statement.

B. COLLECTION OF INFORMATION EMPLOYING STATISTICAL METHODS

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