DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration

29 CFR Part 2560

Claims Procedures for Employee Benefit Plans

AGENCY: Pension and Welfare Benefits Administration, Labor.

ACTION: Request for information.

SUMMARY: This document requests information from the public concerning the advisability of amending the existing regulation under the Employee Retirement Income Security Act of 1974 (ERISA) that establishes minimum requirements for employee benefit plan claims procedures. The term ''claims procedure'' refers to the process that employee benefit plans must provide for participants and beneficiaries who seek to obtain pension or welfare plan benefits, including requests for medical treatment or services, consideration of claims, and review of denials of claims by plans. The primary purpose of this notice is to obtain information to assist the Department of Labor (the Department) in evaluating (1) The extent to which the current claims procedure regulation assures that group health plan participants and beneficiaries are provided with effective and timely means to file and resolve claims for health care benefits, and (2) whether and in what way the existing minimum requirements should be amended with respect to group health plans covered by ERISA. The furnished information also will assist the Department in determining whether the regulation should be amended with respect to pension plans covered by ERISA and in developing legislative proposals to address any identified deficiencies relating to the claims procedures that cannot be addressed by amending the current regulation.

DATES: Written comments must be submitted to the Department of Labor on or before November 7, 1997.

ADDRESSES: Comments (preferably, at least six copies) should be addressed to the Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, Room N–5669, U.S. Department of Labor, Washington, D.C. 20210. Attention: Claims Procedure RFI. All comments received will be available for public inspection at the Public Disclosure Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N–5638, 200 Constitution Ave., N.W., Washington, D.C. 20210.

FOR FURTHER INFORMATION CONTACT: Jeffrey J. Turner or Susan G. Lahne, Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, U.S. Department of Labor, Washington, D.C. 20210, telephone (202) 219–7461, or Cynthia Caldwell Weglicki, Plan Benefits Security Division, Office of the Solicitor, U.S. Department of Labor, Washington, D.C., telephone (202) 219–4600, ext. 106. These are not toll-free numbers.

SUPPLEMENTARY INFORMATION:

A. Background

The Department's regulation, published in 1977, was drafted in response to concerns about plan practices prior to the enactment of ERISA, particularly with respect to participants' lack of information about claims procedures generally. This regulation makes no distinction between pension and health care plans. In the intervening years, dramatic changes in health care delivery have raised many issues concerning access, coverage, and quality of care and have resulted in various legislative responses. In addition to numerous initiatives at the State government level, a number of Federal laws have been enacted to address these issues. The Health Insurance Portability and Accountability Act of 1996, the Newborns and Mothers Health Protection Act of 1996, and the Mental Health Parity Act of 1996 are recent examples. In addition, on September 5, 1996, President Clinton signed Executive Order 13017 establishing the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. More recently, the Balanced Budget Act of 1997 (P.L. 105–33) contains a number of provisions relating to managed care in connection with the Medicare and Medicaid programs.

One of the most important changes to occur has been the growth of managed health care delivery systems.[1] These arrangements adopt various measures to control costs and increase efficiency. For example, they may impose limits or conditions on an individual's choice of physicians and often require prior approval before an individual can obtain, or obtain reimbursement for, hospital care or medical services provided by a specialist. Both fee-for-service and health maintenance organizations (HMOs), as well as preferred provider and other types of delivery systems, may rely on managed care measures. As a result of the prevalence of managed care measures, fair and expeditious resolution of benefits disputes has become an increasingly important issue. Managed care measures magnify the significance of the procedures that surround the decision whether medical services will be made available to a participant or beneficiary, and suggest that the Department should consider whether its current regulatory minimum standards for such procedures are sufficient to ensure that decisions on the availability of medical care are made in a manner that adequately protects the interests of the individual seeking benefits.

At the same time, technological advances in business communications in the last twenty years facilitate more rapid communications and decision-making by plans and participants. The Department's regulation may no longer reflect current plan practices with respect to these aspects of filing and reviewing benefit claims. The Department seeks information about current practices in this area. Along the same lines, market practices such as accreditation by various professional and consumer groups have become important private regulatory forces in the managed care arena. Publication of model acts, such as the Utilization Review Model Act and the Health Carrier Grievance Procedure Model Act developed by the National Association of Insurance Commissioners (NAIC), reflect the importance of time-sensitive review procedures. The NAIC model acts have served as the basis for State legislation to provide procedural protections, including expedited review of claims, to individuals who receive medical benefits through health insurance contracts that incorporate managed care arrangements.

The Department is not alone in its concern for timely resolution of requests for medical treatment from group health plans. The Health Care Financing Administration (HCFA) has recently published a final regulation establishing an expedited process in certain circumstances for Medicare beneficiaries enrolled in managed care entities such as health maintenance organizations.[2] The HCFA regulation requires that managed care entities establish an expedited review process in situations where the time required for

[1] As used in this document, the term ''managed care delivery systems'' includes any measures taken by medical practitioners, insurers, or group health plans to control costs by limiting access to medical services.

[2] This regulation was published as a final rule with a request for comments, 62 FR 23368 (April 30, 1997). The regulation amends a prior regulation codified at 42 CFR § 417.600–620.

the standard review process could seriously jeopardize the life or health of the Medicare beneficiary or the beneficiary's ability to regain maximum function. The rule also provides that a decision to discontinue services that are currently being provided may also be subject to the expedited review process. In the preamble to the regulation, HCFA indicates that it has drawn on the NAIC model grievance act in developing the provisions of the review procedure. As discussed below in section C., Issues Under Consideration, the Department believes that the HCFA regulation and the NAIC model acts may serve as the basis for considering whether, and in what respects, the minimum standards set forth in the ERISA benefit claims procedure regulation should be amended.

B. Current ERISA Regulation

Section 503 of ERISA, 29 U.S.C. § 1133, provides that, in accordance with regulations promulgated by the Secretary of Labor (the Secretary), each employee benefit plan must provide ''adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied.'' The notice must set forth the specific reasons for the denial and must be written in a manner calculated to be understood by the claimant. Each plan must also afford ''a reasonable opportunity'' for any participant or beneficiary whose claim has been denied to obtain ''a full and fair review'' of the denial by the appropriate named fiduciary of the plan.

The Department has issued a regulation pursuant to the above authority that establishes ''certain minimum requirements for employee benefit plan procedures pertaining to claims.'' 29 CFR § 2560.503–1(a). Generally speaking, the following requirements apply. The claims procedure of an employee benefit plan covered by ERISA (hereinafter referred to as an ERISA plan) must be described in the plan's summary plan description. The procedure must not contain any provision or be administered in any way that would unduly inhibit the initiation or processing of claims. Participants must be informed in writing and in a timely fashion of applicable time limits for appeals and responses.

More specifically, the regulation provides that claimants must be informed in writing ''within a reasonable period of time'' if a claim is partially or wholly denied. 29 CFR § 2560.503–1(e)(1). For this purpose, the regulation defines a period of time in excess of 90 days after receipt of the claim as unreasonable, unless ''special circumstances'' require an extension of time for processing. In that case, an extension of an additional 90-day period is available provided that the claimant receives notice of the extension describing the special circumstances prior to the end of the original 90-day period. The notice of a denial of a claim for benefits must be written in a manner calculated to be understood by the claimant and must contain (1) specific reason(s) for the denial, (2) reference to plan provisions on which the denial is based, (3) a description of any additional material necessary to perfect the claim and why it is necessary, and (4) information about how to submit the claim for review. If the notice is not provided in this manner, the claim for benefits is deemed to be denied.

The regulation also requires that every plan establish a review procedure providing a ''reasonable opportunity'' to appeal denied claims to an appropriate named fiduciary or designee. The appeal must afford ''a full and fair review of the claim and its denial.'' 29 CFR § 2560.503–1(g)(1). Minimum requirements for the review procedure include the right to request a review by a written application from the claimant, the right to review pertinent documents, and the right to submit issues and comments in writing. A claimant must have at least 60 days after receipt of the denial in which to request a review. A decision on the review must ordinarily be made within 60 days after the request for a review, unless special circumstances (such as the need to hold a hearing if the plan provides for a hearing) require an extension of time. However, the decision may not be delayed more than 120 days after receipt of the request for review. Special rules provide longer periods of time for plans whose named fiduciary is a group, such as a board of trustees, that holds regularly scheduled meetings at least quarterly. In that case, the review decision must be made by the scheduled time of the next meeting, unless the request for review is received within 30 days prior to that scheduled meeting, in which case the decision is due no later than the date of the group's second successive meeting, with a possible extension to the date of the third meeting if there are special circumstances. 29 CFR § 2560.503–1(h)(1)(ii). As with the initial denial, the decision on review must be in writing, include specific reasons for the decision and references to plan provisions on which the decision is based, and be written in a manner calculated to be understood by the claimant. If no review decision is provided within the time frames specified, the claim is deemed denied.

Under the regulations, plans established pursuant to collective bargaining agreements are not treated differently from other plans, except that they are deemed to comply with the regulatory standards for reviewing denied claims if the collective bargaining agreement pursuant to which the plan is established either contains or incorporates by reference provisions concerning the filing and disposition of benefit claims and a grievance and arbitration procedure for handling denied claims. Participants in plans under which benefits are provided or administered by State-regulated insurance organizations may file claims for benefits, obtain decisions and obtain review of denials through those organizations, but the minimum standards otherwise remain the same. The regulation excludes from its scope employee benefit plans providing only apprenticeship training benefits.

Claims procedures with respect to benefits provided through a qualified HMO, as defined in the Public Health Service Act, 42 U.S.C. § 300e–9(d), are deemed to satisfy the minimum ERISA regulatory requirements if they satisfy section 1301 of the Public Health Service Act (42 U.S.C. § 300e) and the regulations thereunder. 29 CFR § 2560.503–1(j). The regulation addressing claims procedures for federally qualified HMOs is codified in 42 CFR § 417.124.[3] The pertinent provisions of the Public Health Service Act regulations require that each qualified HMO prepare a written description of, among other things, the procedures to be followed in obtaining benefits, a description of circumstances under which benefits may be denied, and grievance procedures. 42 CFR § 417.124(b). Grievance procedures must be ''meaningful'' and must ensure that complaints are transmitted in a timely manner to appropriate decision makers who have authority to take corrective action. Appropriate action in response to grievances is to be taken promptly, with notice to concerned parties of the

[3] 42 CFR § 417.124 does not relate to the requirements HMOs must meet in order to maintain a contract with the Health Care Financing Administration through which health care benefits are provided to Medicare beneficiaries. Section 1876 of title XVIII of the Social Security Act (42 U.S.C. 1395mm) lists those requirements. Regulations implementing the benefit request and benefit review rights of Medicare beneficiaries who participate in managed care delivery systems are found at 42 CFR § 417.600 through § 417.638. This RFI does not involve benefit review procedures for Medicare beneficiaries.

results of the HMO's investigation. 42 CFR § 417.124(g).

C. Issues Under Consideration

Questions have been raised with respect to whether the minimum standards provided in the Department's regulation adequately assure timely and appropriate recourse for employee benefit plan participants and beneficiaries making requests for benefits, or seeking review of benefit claims that have been denied in whole or in part. Although issues that have arisen in the context of group health plans have provided the primary impetus to these questions, section 503 of ERISA and the Department's regulation at 29 CFR § 2560.503–1 apply to both employee welfare benefit plans (the category that includes group health plans) and employee pension benefit plans. The Department is seeking comments concerning the nature of existing benefit determination and review practices of plans and whether the Department's current regulation is adequate to protect the interests of both pension and welfare benefit plan participants and beneficiaries.

The Department is aware that, under current practices, entities that are involved in providing health care employ a variety of terms to describe the process by which an individual eligible for health care services seeks benefits or seeks review of a decision to limit or deny health care treatment or services. Even where the procedural steps are similar, entities may use different terminology for the same procedural step.[4] As part of this RFI, the Department is seeking information as to whether and how it should address the diversity in terminology that is used to describe the procedural protections afforded individuals.

In order to assist interested parties in responding, this document contains a list of specific questions designed to elicit information that the Department believes would be especially helpful in determining whether and how to develop a notice of proposed rulemaking. The Department requests that, in addressing the specific questions in this document, responses refer to the question number as listed in the RFI. The questions listed by the Department may not address all issues relevant to claims procedures. The Department further invites interested parties to submit comments on other aspects of the claims process that they believe are pertinent to the Department's consideration of claims procedures in employee benefit plans covered by title I of ERISA.

In the individual questions below, the following terms have specific meanings. A ''claim'' is a request for a plan benefit by a participant or beneficiary. A ''claimant'' is a participant or beneficiary who has or intends to file a claim. A ''claims procedure'' is the set of rules or requirements by which a claim is filed and resolved under the plan. A ''review'' or ''appeal'' is the next level or levels of claims resolution under the plan after the initial decision occurs or is deemed to have occurred.

Request for Information

Current Practices

1. What information is provided to claimants when requests for services are denied? What are plan practices generally where the plan or a service provider must give prior approval before a participant or beneficiary can obtain certain types of medical treatment?

2. What time frames are typical in ERISA plan claims processes for initial determination and for review of a denied claim? Do plans have different time frames for health care benefits that require prior approval? Do plans maintain special procedures for processing such claims if they involve ''urgent'' or emergency care?

3. When and under what circumstances do plans hire physicians who are not affiliated with the plan to provide independent opinions in connection with a benefit claim? What weight do plans give to the outside opinion?

4. Do plans provide claims reviewers financial incentives based on the percentage of claims denied? Are there compensation arrangements that might influence the reviewers' conclusions? If yes, what are they?

5. The Department's ERISA claims procedure regulation provides that a claimant seeking review of a denial ''may review pertinent documents.'' 29 CFR § 2560.503–1(g)(ii). The preamble to the regulation explains that ''[a]s part of the review the participant must be allowed to see all plan documents and other papers which affect the claim.'' 42 FR 27426 (May 27, 1977). What do plans consider to be examples of pertinent documents or other papers that might affect a claim for benefits? Is there some utility to permitting participants to review pertinent documents prior to filing a claim? Would it reduce claims if a potential claimant could examine documents before filing a claim? What additional costs, if any, would such a requirement impose on plans?

6. When and under what circumstances do plans utilize alternative dispute resolution, arbitration, or similar processes with an outside, independent decision-maker for review of claims denials? Are there any conditions or requirements for electing such processes?

7. Are claimants being asked to pay anything to the plan in order to pursue or perfect their claims review rights? If so, under what circumstances does this occur? Note: The preamble to 29 CFR § 2560.503–1, Part II—Technical Explanation of the Regulation, provides that an otherwise reasonable claims procedure may be deemed to be ''not reasonable if it contains other provisions which unduly inhibit or hamper the initiation or processing of plan claims. For example, a claims procedure may be deemed unreasonable if it requires the payment of a fee as a condition for filing a claim or obtaining review of a denied claim.'' 42 FR 27426 (May 27, 1977).

8. Are there problems making claims processing procedures accessible to plan participants who do not speak English? Should the Department address these problems in a regulation? If so, how?

9. What limits do plans impose on the time within which a participant or beneficiary may file a claim for benefits or may request review? Should the Department adopt minimum standards for filing claims and new minimum standards for requesting review?

10. To what extent are electronic media used to receive or communicate benefit claims information or to process claims? What if any changes to the regulation are necessary to accommodate this?

[4] The Public Health Service Act regulations applicable to federally qualified HMOs require written descriptions of circumstances under which benefits may be denied and written grievance procedures. 42 CFR § 417.124. Regulations promulgated by the Office of Personnel Management relating to both fee-for-service and managed care providers participating in the Federal Employees Health Benefits Plan (FEHBP) use terms such as filing claims for payment or services, reconsideration of claims that have been denied, and review of decisions to deny claims. 5 CFR § 890.105. HCFA's Medicare regulations provide an appeals procedure for Medicare beneficiaries contesting an ''organization determination,'' which, generally speaking, is a decision by a health care provider to deny, terminate, or not pay for medical services that the beneficiary believes are covered under the plan. A ''reconsidered determination'' is the result of a review of the organization determination. The NAIC Health Carrier Grievance Model Act (October 1966) uses the term ''adverse determination'' for a carrier's decision that medical services will be denied, reduced or terminated. The Model Act provides for an appeals procedure to review an adverse determination. The term grievance is defined as a written complaint about the availability or quality of health care services, including, but not limited to adverse determinations. State insurance laws and regulations dealing with health care insurance carriers display a similar variety of terms.

Expedited Claims Procedures

Recently HCFA published a final rule requiring that managed care organizations such as HMOs establish an expedited procedure for Medicare beneficiaries in situations where the longer time frames in the standard review process ''could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.'' 42 CFR § 471.617(b). Expedited review must be completed as quickly as the beneficiary's medical condition requires, i.e., within 24 or 48 hours as appropriate, but in no case longer than 72 hours, absent special circumstances. The Medicare beneficiary, a representative of the beneficiary, or a physician may request expedited review both for the initial request for benefits and for review of decisions to deny or terminate benefits. Any physician, including one who is not affiliated with the plan, may request expedited review on behalf of a Medicare beneficiary, and the plan must accept the physician's decision that expedited review is necessary.

It is the responsibility of the managed care organization to ensure that all Medicare beneficiaries have a complete written explanation of their benefit review rights, of the availability of expedited reviews, of the steps to follow, and of the time limits for each step of the procedures. When a request for benefits is being reviewed after an initial denial, HCFA's regulation requires that managed care organizations provide Medicare beneficiaries with a reasonable opportunity to present evidence and allegations of fact or law related to the issues in dispute, in person as well as in writing. Where the review is expedited, involving a shorter time for decision, the plan must inform Medicare beneficiaries of the conditions for submitting evidence. Medicare regulations provide several levels of review by entities outside the managed care organization. An outside peer review organization provides immediate review of contested decisions to discharge a Medicare beneficiary from the hospital, and if, after the benefit review process is completed, the initial decision to deny the benefit is upheld, an appeal is automatically sent to an independent reviewer under contract with HCFA. In the preamble to the regulation, HCFA also asks for comments concerning (1) guidelines for notice and benefit review rights when the level of services currently being provided to Medicare beneficiaries is being reduced, and (2) when review of a reduction in the level of services should be expedited.

11. Should the Department's regulation require ERISA plans to provide expedited review? If yes, under what circumstances should an expedited review procedure be available?

12. Would the HCFA regulation's expedited review procedure provide an appropriate maximum time frame if ERISA plans were required to adopt expedited review procedures?

13. If ERISA plans were required to adopt an expedited review procedure, how should terms such as ''medical urgency'' be defined? Should the definition of medical urgency for purposes of an expedited procedure be limited to situations where delay could jeopardize life or health or the ability to regain maximum function, as in the HCFA regulation, or should there be some lesser standard, such as intractable pain or temporary inability to perform major life functions such as employment?

14. What additional costs, if any, would be imposed on plans if an expedited claims procedure along the lines of the HCFA regulation or the NAIC model acts were required?

15. The HCFA expedited review procedure permits a Medicare beneficiary, a representative of the Medicare beneficiary, or a physician to request expedited review both for initial benefit requests and for reconsideration of requests that have been denied. The managed care organization decides if the request meets the criteria for expedited treatment. However, any physician, such as a non-plan physician, may request expedited review on behalf of a Medicare beneficiary, and the managed care organization must accept the physician's decision that expedited review is necessary. If ERISA plans were required to adopt some form of expedited review, whose request should initiate the process? Should this authority be restricted to a physician affiliated with the plan, or any physician?

16. Should some claims, such as emergency hospital admissions or hospital discharges, always have expedited review as a matter of course?

17. If some form of expedited review is adopted for ERISA plans, and under the terms of the regulation a claimant is entitled to an expedited review, should the plan administrator be subject to penalties for noncompliance with the procedure?

18. Would an expedited process be subject to overuse or abuse by claimants or physicians? If so, how can this be avoided?

Other Aspects of Reviewing Claims

19. Would the HCFA regulation's system of permitting Medicare beneficiaries or their representatives to present new evidence throughout the benefit review process work for ERISA plans? Should ERISA claimants be allowed to appear and present evidence in person at some levels of the claims review process? What additional costs, if any, would such requirements impose on plans?

20. In what, if any, situations should an ERISA plan service provider be required to continue services at the previous level pending reconsideration of a decision to reduce or terminate services? Should any such requirement affect the maximum time frames for resolution of claims involving such decisions?

21. In contrast to HCFA's Medicare regulation that provides several levels of review by entities outside the managed care organization, ERISA § 503 provides that every plan shall provide ''a full and fair review by an appropriate named fiduciary'' of a decision denying a claim. Do the Department's minimum regulatory standards that implement this requirement provide sufficient assurance of a disinterested hearing? If not, what changes to the existing regulation would assure adequate impartiality in the review process?

22. The Department's regulations at 29 CFR § 2560.503–1(f) require that upon denial, the plan shall provide ''[a]ppropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.'' The plan's decision on review must include specific written reasons for the decision as well as references to the pertinent plan provisions on which the decision is based. Should plans be required to provide claimants with more information concerning the claims review process than is currently required by the regulation? Should a plan be required to inform participants about the need to exhaust the plan's review process, as suggested by *Kinkead* v. *Southwestern Bell Corporation Sickness & Accident Disability Benefit Plan,* No. 96–2282, 1997 U.S. App. LEXIS 6532 at *5 (8th Cir. April 9, 1997), or about judicial recourse? If so, what information should be provided to participants?

23. Would it be helpful in reducing claims and claims review requests to require plans to provide definitions of terms about which there may be controversy or that may generate a

number of appeals, such as ''emergency services'' or ''urgently needed services,'' as some States have done?

24. Health care plans subject to ERISA's claim procedure regulation use certain terms to describe the process by which participants and beneficiaries seek benefits or seek review of decisions to deny, reduce, or limit benefits under the plan. Other regulators, such as HCFA, and FEHBP, as well as the NAIC model Grievance Act and State insurance laws, utilize different terms to describe similar procedures. Should the Department attempt to conform or cross-reference its claims procedure terminology to that of other regulatory schemes? If so, which one?

Differences Among ERISA Plans

25. Is there a need to establish uniform minimum standards for all ERISA plan claims procedures, including plans providing benefits through federally qualified HMOs? Note: Under the current regulation, federally qualified HMOs are now subject to a different set of regulations under the Public Health Service Act. 29 CFR § 2560.503–1(j); 42 CFR § 417.1 through 417.169. What would be the impact and additional costs, if any, of requiring a uniform standard?

26. Under the Department's current regulation, certain plans established or maintained pursuant to collective bargaining agreements are deemed to comply with the existing regulation provided that provisions concerning filing claims, the initial disposition of claims, and a grievance and arbitration procedure to which denied claims are subject are referenced in the collective bargaining agreement. 29 CFR § 2560.503–1(b)(2). Should claimants in such plans be subject to differing claims procedures depending on the terms of the collective bargaining agreement, or should there be a uniform claims procedure for all ERISA plans? What costs, if any, would a uniform requirement impose?

State Laws

28. Should any new regulation take into consideration State regulatory requirements? If so, which requirements?

Data

29. Do ERISA plans and insurers maintain statistics on pre-authorization requests, patient requests for referrals, claims approvals, denials, appeals and court challenges? What information is collected, how is it used, and to whom is it disclosed?

30. What proportion of pre-authorization requests, patient requests for referrals, and requests for benefits are denied? What proportion of denials are appealed? What proportion of appeals are successful? What proportion of denied appeals are challenged in court by those seeking benefits, and what proportion of court challenges are successful?

31. What proportion of pre-authorization requests, patient requests for referrals and benefits, and what proportion of denials, appeals, and court challenges are associated with questions of medical necessity, benefit coverage, out-of-network care, or the participants' insured status?

32. What dollar amounts are associated with pre-authorization requests, patient requests for referrals, claims, denials, appeals, and court challenges?

33. What is the usual timing associated with pre-authorization requests, patient requests for referrals, claims, denials, appeals, and court challenges?

34. Under Medicare, HCFA has broad authority to require reporting of information. Information concerning appeals and grievances from enrollees in Medicare managed care arrangements are collected by the reconsideration contractor that performs reviews for HCFA, and are reported to HCFA by provider and by type of complaint (i.e., non-plan practitioner, mental health, emergency room, inpatient hospital, etc.). Should ERISA plans be required to maintain a written log of benefit denials and benefit reviews for examination by prospective enrollees? In the alternative, should ERISA plans be required to record and make available to claimants and the Secretary the number of requests for review or appeals by claimants and whether the resolution was favorable or unfavorable to the claimant? What costs, if any, would either requirement impose on plans? Would it be useful and less burdensome to have uniform reporting requirements for Medicare, ERISA and State purposes?

Impact on Small Entities

In responding to the questions above, please address the anticipated annual impact of any proposals on small businesses and small plans (plans with fewer than 100 participants).

All submitted comments will be made a part of the record of proceeding referred to herein and will be available for public inspection.

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

Olena Berg,

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

[FR Doc. 97–23483 Filed 9–5–97; 8:45 am]

BILLING CODE 4510–29–P