Questions for the Record for Lisa M. Gomez
Subcommittee on Health, Employment, Labor, and Pensions Hearing
"Examining the Policies and Priorities of the Employee Benefits Security Administration"
June 27, 2024
10:15 a.m.

<u>Chairwoman Virginia Foxx (R-NC)</u>

Retirement Security

Fiduciary Rule

1. According to a Deloitte study, more than 10 million lower- and middle-income individuals lost access to investment assistance during the short time that the 2016 fiduciary rule was in effect. Fortunately, the Fifth Circuit rescued the American people from that terrible rule and invalidated it as inconsistent with the *Employee Retirement Income Security Act of 1974* (ERISA). With the new fiduciary rule, the Biden administration again appears to approve of millions of lower- and middle-income individuals losing access to investment assistance.

    a. How many individuals does the Department of Labor (DOL) expect to lose access to investment advice because of the new fiduciary rule?

    Response: The Department's 2024 rule requires trusted investment professionals who make individualized recommendations to make sure their advice is prudent, loyal to the retirement investors, and free from overcharges and misstatements. The Department is confident that financial institutions and other investment professionals will continue to offer and recommend the full range of investment products and advisory models as a part of this rulemaking. The Department anticipates that, under the final rule, the retirement investment advice markets will work more efficiently and that the financial services industry will provide innovative and cost-efficient delivery models to retirement investors. Whether recommending annuities, securities, real estate, or other investments, investment professionals can both market their services and adhere to basic standards of fair dealing. There is no legitimate market that depends for its proper functioning on the ability to give advice that is imprudent, disloyal, or subject to misrepresentations and overcharges. While individual firms may adjust their offerings to better comport with a best interest standard, and some investors may choose to switch firms, there is every reason to believe that the long run impact of the rulemaking will be hugely beneficial to investors who will continue to have access to the wide range of products and services available across the market.

    In this regard, the 2024 rule is narrower in scope than the 2016 fiduciary rule and is aligned with the SEC's Regulation Best Interest, which has not been associated with a decline in access to advice. In its comment on the Department's proposed rule, Morningstar estimated that the 2024 rule would benefit small plan participants by saving

them $47.3 billion in the first 10 years in plan fees.

Regarding the Deloitte study on the 2016 fiduciary rule, which theorized that "in order for investors to retain access to advice on retirement accounts from the study participants, who eliminated or limited advised brokerage access, 10.2 million accounts would have to move to a fee-based option," it is important to note the following: the study was commissioned by a trade association that sued to block the Department's 2016 fiduciary rule; participants in the study were self-selected; responses were not verified; and the Department is not aware of any follow-up study having been conducted to determine how many of those accounts actually lost access to advice as the survey did not account for customers' ability to move to different firms or the availability of a full range of investment choices and advisory arrangements in the market as a whole. Further, the same survey cited by commenters stated that, while firms may eliminate or limit advised brokerage platforms, they generally also acknowledged they would still give retirement investors other options such as a fee-based program, a self-directed brokerage account, robo-advice, or a call-center.

b. What steps, if any, did you take to ensure that fewer individuals would be harmed by the new fiduciary rule than by the 2016 rule?

Response: As noted in the previous response, the Department does not believe that individuals will be harmed by the 2024 rule. Savers with smaller account balances are especially vulnerable to the detrimental effects of conflicted advice addressed by the 2024 rule and the protections of the 2024 rule are essential for them. They cannot afford to lose any of their retirement savings, whether that is through excessive fees or lower performing investments.

In developing the 2024 rule, the Department crafted a more focused definition that responds to the issues identified by the Fifth Circuit's opinion while still protecting retirement investors. The Department was also cognizant of stakeholders' concerns that compliance costs associated with the broader 2016 rule would lead to adverse consequences such as increases in the cost of investment advice and potential loss of access to advice by retirement investors with small account balances.

The 2024 rule accommodates different types of business models and preserves the ability of advice providers to be paid on commission. In addition, unlike the 2016 rule, the 2024 rule included an exemption for pure robo-advice arrangements. Technology-enhanced models—whether pure robo-adviser or hybrid models—will help contain the overall costs associated with providing investment advice and strategies and will help low-balance account holders obtain investment advice at an affordable cost. Overall, the Department expects that industry's response to the 2024 rule will be to offer alternative, less conflicted, products and services to small investors.

Investment Duties Regulation

2. Under your watch, the Employee Benefits Security Administration (EBSA) mischaracterized and misled the public about the Trump administration's final environmental, social, and governance (ESG) investing rule. Under the Trump rule, if a

fiduciary finds that an ESG factor is a pecuniary or financial factor, then the factor can be considered when investing and exercising shareholder rights. The Trump rule was therefore neutral as to the prudent decisions of fiduciaries. What does the Biden ESG rule allow that the Trump rule did not?

***Response*:** The 2022 final rule on Prudence and Loyalty in Selecting Plan Investments and Exercising Shareholder Rights empowers plan fiduciaries to safeguard the savings of America's workers by clarifying how fiduciaries may consider the economic effects of climate change and other environmental, social, and governance (ESG) factors when they make investment decisions and when they exercise shareholder rights, including voting on shareholder resolutions and board nominations. The Department heard from stakeholders that the 2020 rule and investor confusion about that rule were having a chilling effect on appropriate integration of ESG factors in investment decisions. An important change adopted in the 2022 final rule is the addition of regulatory text clarifying that a fiduciary's determination with respect to an investment or investment course of action must be based on factors that the fiduciary reasonably determines are relevant to a risk and return analysis. That text explains that such factors may include the economic effects of climate change and other ESG considerations on the particular investment or investment course of action, but that any factor's relevance to risk and return depends upon the facts and circumstances particular to the investment decision at hand. The 2022 final rule retains and reiterates the core principle that the duties of prudence and loyalty require ERISA plan fiduciaries not to subordinate the interests of participants and beneficiaries (such as by sacrificing investment returns or taking on additional investment risk) to objectives unrelated to the provision of benefits under the plan.

3. ERISA requires that a fiduciary, including an investment manager, perform his or her duties "solely in the interests of the participants and beneficiaries" and "for the exclusive purpose of providing benefits" under the plan.

    a. Do you think this standard is essential to protecting participants and beneficiaries?

    b. Do you think this standard applies to public pension plans? If not, do you think this standard should apply to public pension plans?

***Response*:** The duties of prudence and loyalty are essential to protecting participants and beneficiaries. ERISA's duty of loyalty forbids fiduciaries from subordinating the financial interests of plan participants and beneficiaries to objectives unrelated to those financial benefits. ERISA fiduciaries cannot sacrifice investment return or take on additional investment risk to advance any other objectives. This is an essential part of ERISA's framework for protecting the interests of plan participants and beneficiaries. Public pension plans are typically "governmental plans" and therefore not covered by ERISA. Accordingly, ERISA's protections (such as ERISA's duty of loyalty) would not apply, but there might be state law or other oversight mechanisms that would be relevant.

Improper Payments to Union Plans

4. On January 16, 2024, the Committee on Education and the Workforce (Committee) began its oversight of the Pension Benefits Guaranty Corporation's (PBGC) improper payments to multiemployer pension plans for deceased persons on the rolls.

    a. At any time before this date, did you or any other DOL representative advise PBGC that it should get this money back? If not, why not?

    b. Are you involved in any way, either formally or informally, in the management or decisions of PBGC?

    c. Did you by email on April 14, 2023, or at any time in any way, communicate to PBGC staff or other staff representing PBGC Board of Director members that they would be unable (i) to recover payments of special financial assistance to multiemployer pension plans for deceased persons or (ii) to get information necessary to quantify the amounts to recover?

    d. Were any of the pensions plans that received payments for dead persons your former clients? If so, which pension plans?

    e. Were any of the plans to which PBGC paid special financial assistance former clients of yours?

    f. During the time when PBGC refused to recover improper payments that were made for deceased participants, did you recuse yourself from PBGC's decision-making, or did you only recuse yourself when PBGC decided to recover some of these improper payments?

***Response*:** In my official capacity as Assistant Secretary of the Employee Benefits Security Administration, I am the designated Board Representative to the Secretary of Labor, who is the Chair of the Board of Directors of the PBGC. In my role as Board Representative, I assist in the day-to-day oversight of PBGC and may act on behalf of the Chair of the Board for all matters except those enumerated in the PBGC's bylaws, which include approval of the Investment Policy Statement and approval of certain reports. Section 4262 of ERISA required PBGC to prescribe in regulations or other guidance the requirements for special financial assistance (SFA) applications. PBGC's rulemakings generally involve coordination and consultation with other agencies that have jurisdiction over pension plans, including the Departments of Labor, Commerce, and Treasury. Once the PBGC became aware of potential issues with the calculation of SFA payments, PBGC consulted with DOL and Treasury regarding options for recovering SFA overpayments consistent with statutory obligations while complying with all applicable law.

As the Assistant Secretary of EBSA and the PBGC Board Representative, I hold myself to a high ethical standard. Out of an abundance of caution, I recused myself from matters regarding the recovery of SFA payments made on the basis of inaccurate data

once PBGC began to consider actions, potentially in coordination with the Department of Justice, that could be regarded as recovery actions related to specific plans, and it came to my attention that certain of the potentially affected plans were former clients of mine or of my former firm. In addition, I have recused myself from all matters regarding SFA payments to clients of my former firm that I am aware of to avoid any appearances of a conflict of interest.

EBSA Enforcement

5. Trade groups are reporting that EBSA's investigations have become endless and aimless. For example, a May 2021 Government Accountability Office report highlighted that 16 percent of the cases opened by EBSA in Fiscal Year (FY) 2017 were still open four years later.

    a. What steps have you taken to ensure there is accountability for the scope of documents that EBSA requests and the timely progress in EBSA investigations?

***Response*:** EBSA takes a balanced approach to enforcement that focuses not only on speed, but also on effectiveness in detecting and correcting violations. While we agree it is important to move cases as swiftly as possible within existing resource constraints, it is also important to avoid closing cases before documents have been received, violations have been properly investigated, and any issues uncovered have been resolved. EBSA works to strike the right balance. Our investigations, especially large and complex cases, can take time to complete, particularly in the context of EBSA's resource constraints. The length of investigations varies with the case's size and complexity, the number of witnesses, the volume of documentary evidence, the discovery of new or unexpected evidence, changes in the law, parties' levels of cooperation, and a wide variety of other factors. EBSA strives to only request documents related to targeted issues and does not engage in fishing expeditions.

Timeliness requirements based on case characteristics are incorporated into agency and personnel performance measurements and standards to ensure that appropriate progress is made on assigned investigations while permitting reasonable extensions of deadlines in cases where circumstances beyond the control of the investigator or Regional Office arise. The measures are incorporated in the performance standards of office directors, supervisors and investigators. In addition, the Benefits Advisor program imposes timeliness metrics on EBSA staff who handle direct inquiries from the public.

    b. As of June 27, 2024, what percentage of cases are still open after four years?

Response: As of July 18, 2024, EBSA had 1,714 open civil investigations, of which 242 (or 14 percent) were labelled "open" after four years. However, only 50 (3 percent) civil investigations labelled as "open" after four years were actually still being actively investigated. The rest of the 242 cases were simply awaiting initial or further proof of correction, being resolved through voluntary compliance activities, or had been referred to the Office of the Solicitor for litigation. Additionally, about half of the 50 cases that were still being actively investigated were Mental Health Parity and Addiction Equity Act (MHPAEA) cases, reflecting the fact that EBSA had opened new MHPAEA lines of inquiry in pre-existing health cases that

otherwise might have been closed, based on the new investigative mandate and creation of the comparative analysis process as part of the Consolidated Appropriations Act, 2021. The following table breaks down the 242 cases by status:

Stage of the Investigation:	Number of Cases Labeled "Open" After Four Years	% of Total Number of Cases Labeled "Open" After Four Years
Monetary or other investigative result achieved; awaiting further proof of correction	41	17%
Monitoring corrections being made by fiduciaries; awaiting initial proof of correction	17	8%
Referred to SOL for litigation or a lawsuit has been filed	76	30%
Resolving civil investigation through the voluntary compliance process	58	24%
On-going investigations	50	21%
Total	**242**	**100%**

c. How many cases are still open from FY 2017?

Response: As of July 18, 2024, there were 54 cases that were labelled "open" that were first opened on or before October 1, 2016 (FY 2017). Only 3 of these cases, however, are still being actively investigated. These cases are in the following stages of the investigation:

Stage of the Investigation:	Number of Cases Labeled "Open" and First Opened on or before 10/1/2016	% of Number of Total Cases Labeled "Open" and First Opened on or before 10/1/2016
Monetary or other investigative result achieved; awaiting further proof of correction	22	41%
Referred to SOL for litigation or a lawsuit has been filed.	18	34%
Resolving civil investigation through the Voluntary Compliance Process.	11	20%
On-going investigations.	3	5%
Total	**54**	**100%**

d. What steps have you taken to ensure that investigations are carried out in a timely

manner?

Response: EBSA's Office of Enforcement (OE) and its Office of Field Administration (OFA) conduct a program of aged case reviews that focus both on cases that have missed timeliness goals and on cases that are at risk of missing those goals. OE and OFA identify and monitor cases in the following categories:

1) 18-month Benefits Advisor referral cases or cases referred by other EBSA offices (e.g., the Office of the Chief Accountant), outside government entities (Congress, state agencies, IRS), or other outside entities (e.g., individual complaints to EBSA, referrals from stakeholders) without a voluntary compliance (VC) event or referral to SOL after 12 months;
2) 30-month cases without a VC event or referral to SOL after 24 months;
3) Cases referred for litigation without a complaint filed or litigation referral accepted by SOL within nine months of referral;
4) Major Cases that are more than 48 months old, and Major TVPP (missing participant) cases that are more than 30 months old;
5) Non-Major non-TVPP cases that are more than 48 months old without a VC event.

OE and OFA have communicated with the regional offices throughout Fiscal Year 2024 to assist with processing both cases that are aged and those that are at risk of becoming aged cases, based on the above criteria. In addition, OE reviews cases on a quarterly basis and reports to EBSA leadership.

Uncashed Checks

6. Uncashed retirement distribution checks are accumulating at a rate of $100 million annually. These checks represent retirement savings that individuals have earned and are entitled to receive. Recently, DOL requested additional comments on the merits of a proposed state unclaimed property solution to this billion-plus dollar issue.

    a. Given that that this solution involving state unclaimed property programs will increase owner reunification in addition to the voluntary nature of program participation, as well as the low cost of implementation, what do you hope to achieve from these additional comments?

    b. Why is this solution not being prioritized alongside your other retirement initiatives?

Response: The Department recently sought comments on the merits of various distribution options for accounts of missing and non-responsive participants in its interim final rule updating the Abandoned Plan Program. *See* 89 FR 43636 (May 17, 2024). Several distribution options were identified, including IRAs, state unclaimed property funds, and the Pension Benefit Guaranty Corporation's Missing Participants Program for Defined Contribution Plans. The request for comment was intended to generate public input on which options give participants a better chance at being reunited with their retirement savings. The

discussion touched on a number of considerations in that regard, including the fact that funds transferred to state unclaimed property funds are subject to income tax. The Department received 22 comments on its interim final rule that it will consider as it determines next steps on the Abandoned Plan Program.

Health Care

ERISA Preemption

7. In January 2024, the Committee issued a request for information (RFI) in recognition of ERISA's 50th anniversary. During the June 27, 2024, hearing, I asked you why, in its amicus brief in *Pharmaceutical Care Management Association v. Mulready*, DOL took the position that ERISA does not preempt state regulation of health plan administration. You answered that ERISA preemption was "complicated" and case specific.

    a. Please provide specific examples of any other time DOL took such a position with respect to ERISA, including regarding any court case in which ERISA preemption was questioned.

Response: DOL's position on ERISA preemption is guided by the Supreme Court's opinions on the interaction of ERISA and state laws. The Court has long held that a state law impermissibly "relates to" an ERISA plan in two circumstances: if it either has a "connection with" or "reference to" such a plan. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*., 514 U.S. 645, 656 (1995) (*citing Shaw v. Delta Air Lines, Inc*., 463 U.S. 85, 96-97 (1983)). A state law may be preempted under either or both of these prongs. As the Supreme Court has also explained, ERISA's preemption provision, though expansive, cannot extend "to the furthest stretch of its indeterminacy" because such an interpretation would preempt practically all state laws, as any law could "relate to" ERISA plans in some manner or another. *Travelers Ins. Co*., 514 U.S. at 656.

In evaluating whether a particular state law is preempted, DOL works in close consultation with the Department of Justice (DOJ) in developing a position. DOL, along with DOJ, applies the tests developed by the Supreme Court to the specific contours of the state law in question. Because this is a fact specific inquiry that depends on the particulars of each state law, DOL does not uniformly advocate for or against preemption. Historically, DOL has filed briefs (or consulted on briefs filed by DOJ) both supporting or opposing ERISA preemption theories in different circumstances. Examples of briefs opposing ERISA preemption theories include, but are not limited to: Brief for the United States as Amicus Curiae, *ERISA Industry Committee v. City of Seattle*, 143 S.Ct. 443 (2022) (*cert. denied*); Brief for the United States as Amicus Curiae Supporting Petitioner, *Rutledge v. Pharmaceutical Care Management Association*, 592 U.S. 80 (2020); Brief for the United States as Amicus Curiae Supporting Petitioner, *Gobeille v. Liberty Mutual Insurance Company*, 577 U.S. 312 (2016); and Brief for the United States as Amicus Curiae Supporting Petitioners, *California Division of Labor Standards Enforcement, et al. v. Dillingham*, 519 U.S. 316 (1997).

Examples of briefs supporting ERISA preemption theories include, but are not limited to: Brief for the Secretary of Labor as Amicus Curiae Supporting Plaintiff-Appellee and Requesting Affirmance, *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180 (4th Cir. 2007); Brief

for the United States as Amicus Curiae Supporting Petitioner, *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); Brief for the United States as Amicus Curiae Supporting Respondent, *The District of Columbia v. The Greater Washington Board of Trade*, 506 U.S. 125 (1992); and Brief for the United States as Amicus Curiae Supporting Petitioner, *Ingersoll-Rand Company v. McClendon*, 498 U.S. 133 (1990).

b. Please provide a framework by which DOL evaluates state regulations of health plan administration regarding applicability of ERISA preemption.

Response: Please see the response to (a). DOL, in consultation with DOJ, applies the doctrine developed by the Supreme Court in its body of ERISA caselaw to the specifics of the particular challenged state law to determine whether or not the state law bears an impermissible relation to ERISA plans under ERISA section 514(a).

c. Does DOL's *Mulready* amicus brief represent a change in DOL's position on ERISA preemption?

Response: Please see the responses to (a) and (b). The amicus brief filed by DOJ on behalf of the United States, drafted in consultation with DOL, does not represent a change in DOL's historical position because DOL has never uniformly advocated for or against preemption. Consistent with prior briefs, the *Mulready* amicus brief represents the considered application of the body of ERISA case law to the specifics of the state law in question.

d. Please summarize DOL's position on the breadth of ERISA preemption.

Response: Please see the response to (a).

e. Is it DOL's position that the scope of ERISA preemption is ambiguous?

Response: Please see the response to (a).

f. Please provide an analysis of the impacts on employer and patient costs if ERISA preemption is undermined?

Response: The impact of any particular state law on employer and patient costs as a consequence of the state law not being preempted inherently depends on the particulars of the state law in question and cannot be answered in the abstract.

g. Would DOL support legislation to clarify ERISA preemption? If so, please suggest statutory language that would clarify ERISA preemption.

Response: Please see the response to (a).

h. Will you commit to defending fully strong ERISA preemption moving forward?

Response: Please see the response to (a).

Pharmacy Benefit Managers (PBMs)

8. This Committee has worked to increase transparency with respect to pharmacy benefit managers (PBMs), including advancing legislation to codify the Transparency in Coverage rule. This rule requires health plan transparency of negotiated rates and patient out-of-pocket costs for health services. It also requires PBM transparency of prescription drug costs. Unfortunately, the Biden administration has indefinitely delayed enforcement of the rule's prescription drug reporting requirements.

    a. Why has DOL delayed implementing this rule?

***Response*:** DOL, along with the Department of Health and Human Services and the Department of the Treasury (the Tri-Departments), promulgated the Transparency in Coverage Final Rules (the TiC Final Rules) on November 12, 2020. The TiC Final Rules require non-grandfathered group health plans and health insurance issuers offering non-grandfathered group and individual health insurance coverage, among other things, to publish three separate machine-readable files containing in-network rates for covered items and services; out-of-network allowed amounts and billed charges for covered items and services; and negotiated rates and historical net prices for covered prescription drugs. These requirements are generally applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Shortly after the Tri-Departments issued the TiC Final Rules, Congress passed the Consolidated Appropriations Act, 2021 (the CAA) on December 27, 2020. Section 204 of division BB of the CAA requires plans and issuers to submit certain information to the Tri-Departments, primarily relating to prescription drug expenditures. Following the enactment of the CAA, the Tri-Departments received significant feedback from stakeholders expressing concern that the TiC Final Rules and the CAA imposed potentially duplicative and overlapping reporting requirements for prescription drugs and highlighting significant challenges in complying with the reporting requirements. In response to this stakeholder feedback, and to allow more time to issue regulations to address the pharmacy benefit and drug cost reporting requirements, the Tri-Departments issued guidance temporarily deferring enforcement of certain prescription drug reporting requirements. However, in announcing this temporary deferral of enforcement, the Tri-Departments also "strongly encourage[d]" plans and issuers to ensure that they could begin reporting the required information by December 27, 2022.

Having implemented the reporting requirements in section 204 of division BB of the CAA, and having collected the required information from plans and issuers for the 2020, 2021, and 2022 reference years, it became clear that there is no meaningful conflict between the reporting requirements in the CAA and the TiC Final Rules. The CAA requires disclosure of different and additional information than required in the TiC Final Rules. Accordingly, the Tri-Departments determined that a general or categorical exercise of enforcement discretion was no longer warranted. On September 27, 2023, the Tri-Departments therefore rescinded prior guidance expressing the general policy of deferring enforcement of the TiC Final Rules' prescription drug machine-readable file requirement pending further consideration. The Departments stated their intention to develop technical requirements and an implementation timeline for the prescription drug machine readable file requirements in future guidance.

b. What oversight is EBSA doing on PBMs?

Response: EBSA conducts oversight of PBMs in several ways. First, EBSA monitors their activities indirectly through plan reporting and transparency provisions. For example, the Consolidated Appropriations Act, 2021, imposes a requirement on plans and issuers related to services provided by PBMs. These include prescription drug reporting requirements and the prohibition on gag clauses. In addition, ERISA section 408(b)(2) requires certain brokerage or consulting service providers to health plans to disclose their direct and indirect compensation.

EBSA deploys a comprehensive, integrated approach to continuously evaluate PBM compliance with these rules and with ERISA's fiduciary and other standards. This approach includes programs for enforcement, compliance assistance, interpretive guidance, regulations and research.

Mental Health Parity

9. In 2013, DOL, the Department of Health and Human Services (HHS), and the Department of the Treasury (Tri-Departments) published final rules to implement the *Mental Health Parity and Addiction Equity Act* (MHPAEA). These rules stated that the Tri-Departments "did not intend to impose a benefit mandate through the parity requirement that could require greater benefits for mental health conditions and substance use disorders." However, this is what the Tri-Departments' proposed new requirements will effectively do. The 2013 final rules also stated:

> The Departments recognized that plans and issuers impose a variety of Non-Quantitative Treatment Limitations (NQTLs) affecting the scope or duration of benefits that are not expressed numerically. Some commenters recommended that the Departments adopt the same quantitative parity analysis for NQTLs. While NQTLs are subject to parity requirements, the Departments understood that such limitations cannot be evaluated mathematically. These final regulations continue to provide different parity standards concerning quantitative treatment limitations and NQTLs because although both kinds of limitations operate to limit the scope or duration of mental health and substance use disorder benefits, they apply to such benefits differently.

Could you explain why the recent proposed rule reverses a precedent of more than 10 years by applying the Quantitative Treatment Limitations-test to NQTLs, even though the Tri-Departments rejected this approach previously?

***Response*:** Since the promulgation of the 2013 final regulations on November 13, 2013, plans and issuers have continued to fall short of MHPAEA's central mandate to ensure that participants and beneficiaries do not face financial requirements or treatment limitations with respect to benefits for mental health conditions or substance use disorders that they do not face when accessing benefits for a medical condition or surgical procedure. In the Consolidated Appropriations Act, 2021, Congress required that plans and issuers perform and document their compliance with MHPAEA within 45 days. As highlighted in the Tri-Departments' 2022

MHPAEA Report to Congress and 2023 MHPAEA Comparative Analysis Report to Congress, none of the comparative analyses the Tri-Departments have reviewed contained sufficient information upon initial receipt. Moreover, despite plans' longstanding obligations under MHPAEA, our enforcement experience shows many plans and issuers have not carefully designed and implemented their NQTLs to be compliant with MHPAEA.

Therefore, in August of 2023, the Tri-Departments proposed rules to reinforce MHPAEA's fundamental purpose and ensure that limitations on mental health and substance use disorder benefits are no more restrictive than the limitations applicable to medical/surgical benefits. As part of this rulemaking, the Tri-Departments proposed in 2023 to give meaning to the terms "restrictive," "substantially all," and "predominant" for NQTLs to more closely mirror the statutory language. Additionally, the proposed rules state that a plan or issuer would not be considered to provide coverage in all classifications of benefits unless the plan or issuer provides meaningful benefits for treatment for a mental health condition or substance use disorder in each classification, as determined in comparison to the benefits provided for medical/surgical conditions in such classification. This requirement would not mandate coverage for any particular benefits, but instead would ensure that, when plans and issuers cover benefits for a range of services or treatments for medical/surgical conditions in a classification, plans and issuers cannot provide, for example, only one limited benefit for a mental health condition or substance use disorder in that classification. Overall, the goal of these proposed rules is to ensure that individuals with mental health conditions and substance use disorders can benefit from the full protections afforded to them under MHPAEA, while offering clear guidance to plans and issuers on how to comply with MHPAEA's requirements. The Departments continue to work to issue final rules to advance mental health parity.

10. The Tri-Departments' proposed rule on implementing MHPAEA appears to run counter to congressional intent. Specifically, the 2007 Senate Committee Report that accompanied MHPAEA indicates that the law was not meant to limit benefit management, and the law does not prohibit group health plans from negotiating separate reimbursement or provider payment rates and service delivery systems or managing the provision of mental benefits to provide medically necessary treatments under the health plan. Can you explain why the Tri-Departments are now proposing effectively to disallow medical necessity reviews under the newly proposed NQTL Predominant and Substantially All Test?

***Response*:** Nothing under MHPAEA or the proposed rules prohibits managing the provision of mental health or substance use disorder benefits to ensure that they are medically necessary or negotiating separate reimbursement or provider payment rates and service delivery systems. The statute requires that a plan or issuer ensure that the treatment limitations (including nonquantitative treatment limitations) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits. This includes medical management techniques related to medical necessity and standards for provider admission to participate in a network, including reimbursement rates.

As highlighted in the Tri-Departments' recent Reports to Congress, our enforcement experience over the last several years shows that many plans and issuers have not carefully designed and implemented their NQTLs to be compliant with MHPAEA. Therefore, the Departments

proposed new rules to better ensure that individuals with mental health conditions and substance use disorders can benefit from the full protections afforded to them under MHPAEA, while offering clear guidance to plans and issuers on how to comply with MHPAEA's requirements. Therefore, MHPAEA proposed rules would give meaning to the terms "restrictive," "substantially all," and "predominant" for all nonquantitative treatment limitations, which generally limit the scope or duration of benefits, including medical management techniques related to medical necessity, as well as step therapy protocols, and standards for provider admission to participate in a network. The proposed rules would not prohibit the use of medical management techniques related to medical necessity, but instead would ensure that those applied to mental health and substance use disorder benefits are not more restrictive than the predominant limitations applied on substantially all medical/surgical benefits. Additionally, the proposed rules stated that the Tri-Departments do not intend to interfere with a plan's or issuer's attempts to ensure that coverage for benefits for the treatment of mental health conditions and substance use disorders is consistent with generally accepted independent professional medical or clinical standards, so the proposed rules would include an exception for nonquantitative treatment limitations that impartially apply independent professional medical or clinical standards or applies standards related to fraud, waste, and abuse, that meet specific requirements. The Departments continue to work to issue final rules to advance mental health parity.

No Surprises Act

11. There is a lot of frustration from providers, employers, and insurers regarding the administration's implementation of the *No Surprises Act*'s (NSA) Independent Dispute Resolution (IDR) process.

    a. Why has implementation been such a challenge?

    b. Why did DOL so severely underestimate how many disputes would enter the IDR process?

    c. Do the November 2023 NSA proposed rules address these implementation challenges, and can you provide an update on the administration's work to improve IDR operations?

    d. Provide a description of how the Biden administration is ensuring that its implementation of the NSA aligns with congressional intent.

***Response*:** Since 2021, DOL, the Department of Health and Human Services, and the Department of the Treasury (Departments) have continued to issue regulations in phases that implement provisions of the NSA, including rules to establish the Federal IDR process to determine payment amounts when there is a dispute between plans or issuers and providers, facilities, or providers of air ambulance services about the out-of-network rate for these services.

As with many pieces of sweeping legislation and big changes, implementation can lead to growing pains and unforeseen challenges. The implementation of the Federal IDR process is

no different. After opening the Federal IDR process to accept disputes, the Departments observed that the volume of disputes was substantially larger than the Departments or certified IDR entities initially estimated. Disputing parties initiated 679,156 disputes in 2023; however, the majority of disputes were initiated by a small number of initiating parties or their representatives. For example, the top ten initiating parties represented approximately 76 percent of all disputes in the last six months of 2023, and three initiating parties accounted for approximately 58 percent of all disputes initiated during the same timeframe. In addition, determining the eligibility of disputes for the Federal IDR process requires significantly more review and processing by certified IDR entities than initially anticipated due to complexities in determining whether a particular item or service is subject to the Federal or State surprise billing requirements. During 2023, 22 percent of all closed disputes were determined ineligible for the Federal IDR process. That means that nearly one quarter of the disputes should never have been submitted in the first place, but nonetheless needed to be reviewed through the IDR process.

Moreover, as a result of opinions and orders issued in several lawsuits that vacated portions of the regulations and guidance on the Federal IDR process, the Departments had to suspend initiation of new disputes multiple times to make changes to the process to align with court orders. While the goal was to keep these suspensions as short as possible, the repeated need to suspend IDR operations due to court orders has been highly disruptive to the process and has contributed to a backlog of IDR cases, negatively impacting both disputing parties and certified IDR entities, and has slowed down the ability to make improvements to the portal.

However, as noted in the public use files, we are seeing improvements and bright spots. Certified IDR entities have scaled up their operations to address the high volume of disputes. Certified IDR entities rendered 125,478 payment determinations in the last six months of 2023, a 50 percent increase from the first six months of 2023 (83,868 determinations, which was more than five times the number of payment determinations made in all of 2022).

To address the high volume of disputes, the Departments worked to improve and automate how the Federal IDR portal operates, as well as provide technical assistance and guidance to certified IDR entities and disputing parties to make the process run more smoothly.

We continue to work with the Departments to ensure that the IDR process is an efficient process that works as intended by the statute. We also continue to improve our existing regulations. On November 3, 2023, the Departments published the "Federal Independent Dispute Resolution Operations" proposed rules, which proposed a number of regulatory changes to the IDR process. If finalized, these proposed rules would improve communications among payers, providers, and certified IDR entities to reduce the number of disputes initiated that are ineligible for the Federal IDR process; adjust specific timelines and steps of the Federal IDR process to improve efficiency; and improve the open negotiation process, giving disputing parties a better opportunity to avoid use of the Federal IDR process.

12. The NSA's IDR program was intended to be funded through administrative fees from disputing parties. Why does the President's budget request include an additional $500 million for NSA's implementation when the program is supposed to be self-funded?

***Response*:** Section 103 of the NSA directed the Departments to establish a Federal IDR

process that would be funded by administrative fees, equal to estimated expenditures for carrying out the Federal IDR process. Currently, administrative fees are collected and used by HHS to fund their Federal IDR activities, including Federal IDR portal and related certified IDR entity support. Further, the Federal IDR process is only one part of the NSA, which contains a number of other provisions that protect consumers from surprise medical bills and promote transparency in health coverage. NSA section 118 provides implementation funds for preparing regulations, issuing guidance and public information, preparing and holding public meetings, preparing and publishing reports, enforcing the NSA provisions, collecting, reporting, and analyzing data, initially establishing the Federal IDR process and patient-provider dispute resolution process, conducting audits, and other administrative duties necessary for implementation of the NSA provisions.

Additional funding is critical to continue our efforts to implement and enforce the NSA, and more specifically the amendments made to MHPAEA, to ensure that it provides the protections as intended. For example, the Department currently relies on supplemental appropriations passed as part of CAA, 2021, to fund the MHPAEA enforcement efforts. The supplemental appropriations are currently scheduled to expire at the end of calendar year 2024 with the consequence that the Department would lose funds for between a quarter and a third of its total enforcement program (including non-MHPAEA cases) and EBSA would have to commensurately reduce its staff size by approximately 117 full-time employees – the equivalence of 14 percent of its total staff, or the total employees in two of its regional offices. As a result, its MHPAEA enforcement efforts would necessarily decline.

Facility Fees

13. The President's FY 2025 budget proposes a ban on telehealth facility fees.

    a. Why is such a ban needed?

    b. How would banning facility fees help reduce costs for employers?

    c. Please provide a rationale for anticipated federal savings due to such a policy.

***Response*:** This Biden-Harris Administration has repeatedly stressed that a top economic priority is to lower costs for American families and consumers. To that end, this Administration has cracked down on surprise medical bills, preventing more than one million surprise medical bills every month. The President's proposed budget includes a ban on facility fees for telehealth and certain other outpatient services in order to further the Administration's commitment to lower health care costs and eliminate surprise junk fees.

In general, facility fees for health care provided outside of hospital settings increase health care costs and are often a surprise for consumers—and they are even more surprising when they are charged in connection with care a patient receives without even leaving home. When facility fees are not covered by an individual's plan or coverage, the individual is exposed to financial risk. And when a plan or coverage does cover them, these fees increase the plan or coverage's expenditures, which can result in increased costs for employers and other group health plan sponsors, and can contribute to higher premiums. The Department supports efforts to lower health care costs and expand access to quality, affordable health care.

14. According to the Kaiser Family Foundation, premiums for employer-sponsored health plans increased by 7 percent over the past year. The RAND Corporation, the Congressional Budget Office (CBO), and other economists have identified provider consolidation as a main driver of health care cost increases. Perverse economic incentives have driven hospital to acquire provider offices and incorrectly bill for services.

    a. Would you agree that provider consolidation is raising premiums for employers and workers?

    b. Would you agree that hospitals should not be allowed to charge facility fees to commercial payers for outpatient services?

    c. Do you endorse congressional efforts to ensure that health services are charged on a site-neutral basis?

***Response*:** Consolidation in health care markets has accelerated in recent decades, while the number of independent physician practices has declined and private-equity ownership in the health care industry has increased. Simultaneously, costs have increased for both plan sponsors and participants and beneficiaries, who are often unaware of costs prior to seeking care.

As part of the Administration's efforts to ensure cost transparency, plans and issuers are required to make price comparison information for covered facility fees available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request. In addition, providers and facilities are required to provide good faith estimates to uninsured (or self-pay) individuals in connection with facility fees. The Tri-Departments are monitoring the issue of facility fees and encourage plans and issuers, and providers and facilities, to minimize the burden to participants, beneficiaries, and enrollees that result from imposing facility fees.

Gag Clauses

15. The Committee issued an RFI in recognition of ERISA's 50th anniversary. Respondents to the RFI highlighted problems with implementation of the statutory ban on health plans agreeing to gag clauses. Many respondents do not believe the law banning gag clauses is working.

    a. Provide an update on EBSA's enforcement of ERISA's gag clause prohibition.

***Response*:** Group health plans and health insurance issuers offering group or individual health insurance coverage generally are prohibited under the gag clause provisions of the No Surprises Act from entering into an agreement that would directly or indirectly restrict the plan or issuer from making provider-specific cost or quality of care information or data available to active or eligible participants, beneficiaries, and enrollees of the plan or coverage, plan sponsors, or referring providers, electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan or coverage, or sharing such information with a HIPAA business associate, consistent with applicable privacy regulations.

Plans and issuers must annually submit an attestation of compliance with the gag clause provisions. The Tri-Departments established the Gag Clause Prohibition Compliance Attestation (GCPCA) system for plans and issuers to electronically submit their attestations. The Tri-Departments have provided detailed instructions, a user manual, a reporting template, and a webform for this purpose. The first attestations were due through the GCPCA by December 31, 2023, generally covering the period beginning on the effective date of the gag clause provisions, i.e., December 27, 2020. Subsequent attestations, covering the period since the preceding attestation, are due by December 31 of each year thereafter.

Following the results of the first round of attestations, the Departments are considering what additional steps are needed to promote compliance with the gag clause prohibition.

b. Do you support efforts to strengthen the gag clause prohibition in the bipartisan *Lower Costs, More Transparency Act*?

***Response*:** The Biden-Harris Administration supports bringing more transparency to the American health care system, and the Department looks forward to working with Congress to address this important issue.

Employer-Sponsored Health Insurance

16. I am concerned about HHS' regulatory overreach with respect to self-insured health plans. The 2025 Notice of Benefit and Payment Parameters final rule and the Section 1557 Nondiscrimination in Health Programs and Activities final rule saddle self-insured health plans with new *Affordable Care Act* (ACA) regulations. Under current law, self-funded plans are not subject to Section 1557 and are regulated by DOL.

    a. Will you confirm that it is EBSA's policy that self-insured health plans are not subject to HHS regulation?

    b. Will you commit to opposing any unlawful HHS efforts to regulate self-insured health plans?

***Response*:** The Department of Labor, through EBSA, administers ERISA. Under ERISA, the Department has authority over group health plans, including self-insured group health plans. However, many other laws may regulate plans and issuers in their provision of benefits to participants and beneficiaries. These laws include the ADA, HIPAA, Title VII, the Family and Medical Leave Act, and State law, as well as portions of the ACA. HHS has jurisdiction over HIPAA's Administrative Simplification provisions, Section 1557 of the ACA and provisions of the ACA governing the individual and small group markets, and we refer questions on the interpretations of those provisions to HHS.

17. Small businesses rely on stop-loss insurance to provide more affordable, higher quality health care coverage to their employees by self-insuring. Please comment on whether stop-loss coverage is a necessary tool for many businesses to self-insure.

***Response*:** EBSA supports efforts to increase access to affordable, high-quality, comprehensive health care coverage. Employers and other sponsors of self-insured group health plans, especially small employers, may face large fluctuations in claims, and they frequently seek to reduce this risk by purchasing stop-loss insurance. Stop-loss insurance contracts reduce the risk associated with claims that are catastrophic or unpredictable in nature by covering claims costs that exceed a set amount called an attachment point. Some interested parties have raised concerns that stop-loss coverage is not required to comply with the Federal or State consumer protections and requirements applicable to group health plans or health insurance issuers. When stop-loss coverage has a low attachment point, the majority of the benefits covered under such an arrangement are provided via the stop-loss coverage, which may deny or limit the individual's claim in a way that would be prohibited under the group market Federal consumer protections and requirements, which could leave a small employer liable for the claim for coverage but unprepared to absorb such costs.

Increasingly, small businesses are utilizing a type of self-funded arrangement in which the plan sponsor makes set monthly payments to a service provider to cover estimated claims costs, administrative costs, and premiums for stop-loss insurance for claims that surpass the attachment point. This arrangement is commonly known as "level funding." Given the growing number of level-funded group health plans, many of which rely on stop-loss coverage with low attachment points, the Tri-Departments last year solicited comments to better understand the prevalence of such plans, their designs, and whether additional guidance or rulemaking is needed to clarify a plan sponsor's obligation with respect to coverage provided through a level-funded plan arrangement. The Tri-Departments appreciate the comments received on this topic and are taking them into consideration as they determine whether additional guidance is warranted in the future.

18. According to CBO estimates, ACA plans' cost per enrollee is three times higher for taxpayers than employer-sponsored health insurance. Do you believe that shifting enrollment from ACA plans to the employer-sponsored market would reduce the federal budget deficit? If so, what steps will EBSA take to encourage migration to employer-sponsored health plans?

    ***Response*:** EBSA encourages enrollment in high-quality, comprehensive coverage and supports the Administration's efforts to ensure Americans have access to such coverage. Employers and employee organizations that sponsor affordable, comprehensive coverage play a critical role in protecting the health and wellbeing of workers and their families. EBSA is committed to working with plans and plan sponsors to ensure that participants and beneficiaries have access to such high-quality, comprehensive coverage.

Cybersecurity

19. On February 21, 2024, UnitedHealth Group's Change Healthcare experienced a serious cybersecurity attack. Not only did this attack put beneficiaries' personal health information at risk, but it also caused delays in payments to physicians and disruptions filling prescription drugs and verifying patients' enrollment in plans.

    a. What is DOL doing to respond to cybersecurity threats to personal health

information?

b. Are DOL's current recommendations on cybersecurity sufficient, or do employer-sponsored health plans need more tools to protect employee health data and to prevent breaches?

c. Does DOL plan to update or amend its cybersecurity recommendations? If so, when will DOL post revised recommendations?

d. Does DOL believe that current federal law is sufficient to ensure robust protections for employers and workers? If not, what recommendations do you have for Congress to strengthen the law?

***Response*:** EBSA is very concerned about cybersecurity for employee benefit plans. We continue to investigate potential ERISA violations related to the issue and respond to concerns from the public.

DOL and HHS published an open letter on cyberattacks on Change Healthcare, which is owned by UnitedHealth Group (UHG). The letter explains the actions taken by the Biden-Harris Administration to address the cyberattack head on and calls on UHG, other insurance companies, clearinghouses, and other health care entities to take additional actions to mitigate the harms this attack placed on patients, providers, and others.

We also have issued guidance for employee benefit plans, their service providers, and plan participants and beneficiaries in an attempt to improve plan policies and procedures to prevent and mitigate harmful breaches to plan data and information. The agency's 2021 guidance gives plans and service providers critical information on how to protect employee benefit plan participants and beneficiaries from harmful data breaches. The guidance includes tips for hiring a service provider with strong cybersecurity practices, best practices for managing cybersecurity risks, and online security tips for plan participants and beneficiaries. In response to an ERISA Advisory Council report on a topic that was studied at EBSA's request, the agency plans to update its guidance to clarify that it applies to all ERISA plans, including health and welfare plans and employee pension benefit plans.

EBSA conducts civil investigations of service providers and plans where there is a known cybersecurity breach and criminal investigations on suspected cybercriminals. EBSA collaborates with the SEC, Commodity Futures Trading Commission, and Treasury to address criminal activities, particularly schemes targeting retirement accounts of the elderly population.

EBSA has also hired cybersecurity specialists and developed specialized investigative techniques through its internal investigative Cybersecurity Working Group.

Rep. Tim Walberg (R-MI)

1. The DOL fiduciary rule requires financial institutions provide written acknowledgement that the financial institution and its investment professionals are providing fiduciary investment advice to the retirement investor by September 23, 2024. However, this is mid-quarter, whereas financial institutions more typically provide key disclosures and annual statements at the end of the year. When key disclosures are forced out of the regular annual mailing cycle this increases the likelihood that some retirement investors will miss important disclosures. Has the Department consulted with financial institutions to discuss the timing of these disclosures, and would the Department be willing to have these written acknowledgements of fiduciary be included in year-end annual statements?

   Response: EBSA has been asked to consider extending the compliance date for the fiduciary acknowledgment. In response, we have asked for more information about the amount of additional time firms and investment professionals would need to comply with the requirement. However, EBSA has also repeatedly said that this condition is very important, and that it wants Financial Institutions to acknowledge their fiduciary status as soon as possible.

   Even if EBSA does not extend the compliance date for providing the fiduciary acknowledgment, it must be noted that many Financial Institutions already are complying with current PTE 2020-02, which also requires the fiduciary acknowledgment as a condition for satisfying the exemption. Moreover, the amended PTE 2020-02 provided model language that Financial Institutions can use to comply with the fiduciary acknowledgment requirement. Together, this significantly reduces any compliance burden associated with the subject requirement.

2. Missing participants in retirement plans are a significant issue and I was pleased that my legislation, the Retirement Plan Modernization Act, which increased the cash-out level for the first time in 25 years was included in the final SECURE 2.0 Act. The change I helped advance will support employers who are seeking help to address small balance accounts of former employees. But the solutions to missing participant issues need to be multifaceted, so I was pleased that Section 303 of SECURE 2.0 also established the Retirement Savings Lost and Found as a national registry of missing participant accounts. However, I have been disappointed by the Department's efforts to implement and stand up the Lost and Found database. As you know, in April the Department released a voluntary proposal to have employers provide data on missing participants in its novel Information Collection Request (ICR). The nature and scope of the Department's proposal exceeds SECURE 2.0's narrow structure and has raised a host of questions and concerns from employers and retirement service providers.

   For example, The SPARK Institute wrote to the Department "not to rush the project and to take the time that is needed to thoroughly consider alternatives…" Further, the American Benefits Council wrote to the Department raising a host of concerns about the proposal ranging from cybersecurity to the potential for a data breach and noted that "the scope of the requested reporting in the proposed ICR far exceeds the reporting contemplated by the statute." Assistant Secretary Gomez, can you commit that you will listen to the stakeholders' input, pause implantation of a flawed voluntary approach that

exceeds SECURE 2.0 and take the time needed to make sure the Retirement Savings Lost and Found can be the success Congress intended it to be?

Response: The Department is aware of the concerns expressed by commenters urging consideration of alternative methods to achieve Congress's intent in SECURE 2.0 section 303, as well as the concerns that the proposed ICR included overly broad data collection provisions and for the risk of a potential data breach. The Department commits that it is considering how to best address these concerns, and others, as it proceeds with the development of the Retirement Savings Lost and Found, keeping in mind the deadline set by Congress in the statute.

Rep. Robert C. "Bobby" Scott (D-VA)

1. Under ERISA and DOL's claims procedure regulations, all plan participants are entitled to a "reasonable opportunity… for a full and fair review" of a denied claim through their plan's internal appeal process. Once this process is exhausted, the participant has the right to bring an action in Federal court to challenge denial. This is consistent with the fundamental purpose of ERISA of providing workers with "appropriate remedies, sanctions, and ready access to the Federal courts." Unfortunately, this Committee has repeatedly heard testimony that the promise of a full review of their benefits and fair day in court under ERISA has not been realized.

   a. Ms. Gomez, when a plan fiduciary violates the Department's claims procedure regulations, what are the consequences? Does the Department have authority to impose civil monetary penalties?

Response: The Department's claims procedure regulations (2560.503-1(l)) provide that if a fiduciary fails to establish and follow reasonable claims procedures consistent with the regulation the claimant is deemed to have exhausted administrative remedies available under the plan and is entitled to pursue in court any available remedies under ERISA section 502(a) on the basis that the plan has failed to provide reasonable claims procedure that would yield a decision on the merits of the claim. Similar remedies are available for a disability plan, and for a non-grandfathered group health plan or health insurance issuer (under internal claims and appeals rules added under the Affordable Care Act at 29 CFR 2590.715-2719(b)(2)(ii)(F)). However, there is no penalty authority that specifically applies to violations of the claim procedure regulation or Section 503, which commands that the claims process be "full and fair." Moreover, only participants and beneficiaries are authorized to bring individual benefit claims under ERISA Section 502(a)(1)(B). In cases where plan fiduciaries violate the claims regulation, especially if they do so on a systematic basis, it may be possible for the Department to get a court order compelling compliance with the regulation or requiring fiduciaries to re-adjudicate claims.

   b. When a participant brings an action in federal court in a benefit denial case, what is the standard of review? Isn't it correct that consumers do not generally have *de novo* review?

Response: Following the Supreme Court's decision in *Firestone Tire and Rubber Co. v. Bruch*, 489 US 101 (1989), a denial of benefits challenged under ERISA section 501(c)(1)(B)

must be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits to construe the terms of the plan. Plans have widely adopted provisions providing such discretionary authority to plan fiduciaries, and as a result courts generally do not apply *de novo* review. If the plan has a provision that provides this discretionary authority, the court will apply an arbitrary and capricious standard of review in benefit denial cases rather than a *de novo* standard of review. Even if a plan has such a provision, however, to the extent the plan or issuer fails to strictly adhere to the requirements of the claims procedure regulations for a disability plan (under 29 CFR 2560.503-1(l)(2)(i)) or a non-grandfathered health plan or health insurance issuer (under 29 CFR 2590.715-2719(b)(2)(ii)(F)), the claims regulation provides that the claim is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

2. The Department finalized the Retirement Security Rule earlier this year. I applaud this rule, which would ensure that investment advisors put the best interests of their clients first, free from conflicts of interest. This is a long overdue change that reflects how the retirement system has evolved over the last 50 years.

    a. Could you summarize how saving for retirement has changed since 1975 when the Department created its current rules governing investment advice? Did 401(k) plans exist then?

Response: In 1975, individual retirement accounts had only recently been created (by ERISA itself), and 401(k) plans did not yet exist. Since that time, the retirement landscape has changed significantly, with a shift from defined benefit plans (in which decisions regarding investment of plan assets are primarily made by professional asset managers) to defined contribution/individual account plans, such as 401(k) plans (in which decisions regarding investment of plan assets are often made by plan participants who lack professional investment expertise). Individuals, regardless of their financial literacy, have thus become increasingly responsible for their own retirement savings and have increasingly become direct recipients of investment advice with respect to those savings.

Rollovers of plan assets to IRAs also have become commonplace and the amount of assets rolled over to IRAs is large and expected to increase substantially. Cerulli Associates estimates that aggregate rollover contributions to IRAs from 2022 to 2027 will surpass $4.5 trillion. The treatment of rollover recommendations has been a central concern in the Department's regulation of fiduciary investment advice. Decisions to take a benefit distribution or engage in rollover transactions are among the most, if not the most, consequential financial decisions that plan participants and beneficiaries and IRA owners and beneficiaries are called upon to make.

The shift toward individual control over retirement investing (and the associated shift of risk to individuals) has been accompanied by a dramatic increase in the variety and complexity of financial products and services, which has widened the information gap between investment advice providers and their clients. Plan participants and other retirement investors may be unable to assess the quality of the advice they receive and may not be in a position to learn of and guard against the investment advice provider's conflicts of interest.

In this context, the 2024 rule is designed to ensure that retirement investors' reasonable

expectations are honored when they receive advice from financial professionals who hold themselves out as trusted advice providers. The rule fills an important gap in those advice relationships where advice is not currently treated as fiduciary advice under the 1975 regulation's approach to ERISA's functional fiduciary definition. This may be the case even when financial professionals hold themselves out as providing recommendations that are based on review of the retirement investor's individual needs or circumstances, that involve the application of their professional or expert judgment to the retirement investor's needs or circumstances, and that can be relied upon to advance the retirement investor's best interest.

As compared to the 1975 rule, the 2024 rule better reflects the text and the purposes of ERISA and better protects the interests of retirement investors, consistent with the Department's mission to ensure the security of the retirement, health, and other workplace-related benefits of America's workers and their families.

b. Would you like to respond to criticisms raised by some that requiring advisors to act in the consumers' best interest would somehow limit access to advice, particularly for low-income savers?

Response: Throughout this rulemaking, the Department considered the impact on low-income savers. These savers are especially vulnerable to the detrimental effects of conflicted advice addressed by the rule and the protections of the rule are essential for them. So called "small savers" cannot afford to lose any of their retirement savings, whether that is through excessive fees or lower performing investments. Less sophisticated investors frequently do not know how much they are paying for advice and are not equipped to effectively monitor the quality of the advice they receive. The Department believes that having a common, high standard of conduct associated with retirement investment advice will increase trust in financial advice providers and make it more likely that small savers will seek advice.

The Department's rule also requires advice given to plan fiduciaries to meet a fiduciary standard, resulting in improvements in plan design and selection of investments on the menu that will also benefit small savers, as the vast majority of small savers choose investments from their plan's platform. Moreover, research shows that lower-income participants tend to be more influenced by default options than high income participants, so small savers will benefit from plan fiduciaries choosing default options that are well selected and well monitored.

The Department does not believe that requiring trusted advisers to act with care and loyalty or avoid misleading statements or overcharges – the core obligations of the fiduciary rulemaking – will result in the loss of access to the wide range of investment products and advisory services available today. The rule simply requires advisers to adhere to standards consistent with the way they hold themselves out to customers. The Department anticipates that by requiring advisers to accurately represent the nature of their relationship and advice, retirement investment advice markets will work more efficiently and result in innovations and cost-efficient delivery models to provide prudent and loyal advice to small investors.

Rep. Mark DeSaulnier (D-CA)

1. Ms. Gomez, as you note in your testimony, EBSA has a vast mandate from Congress.

Your agency is charged with protecting more than 153 million Americans' health and retirement benefits – including more than **$13 trillion** in assets in job-based retirement plans alone. Yet your agency only received $191 million in its base appropriation last year, plus a small supplemental funding boost of $25 million under the bipartisan *No Surprises Act*. House Republicans have now put forward a Labor-HHS bill that would actually **cut** EBSA's budget by $10 million while failing to extend the *No Surprises Act* funding. This would effectively slash the agency's funding by a total of $35 million.

How would these cuts impact the ability of your agency to protect the benefits of workers, retirees, and their families?

Response: The expiration of the No Surprises Act (NSA) supplemental funding at the end of the 2024 calendar year, coupled with the proposed reduction of EBSA's budget by $10 million, would be catastrophic to the agency. This would have a devastating impact on EBSA's overall ability to protect the retirement, health, and other employee benefits of more than 153 million workers, retirees, and their families. Specifically, the loss of this funding would severely limit the agency's ability to discharge numerous critical obligations involved with providing help to the public, including providing assistance with the NSA and IDR payments, pursuing investigations of serious misconduct, and providing appropriate guidance to employers, other plan sponsors, plan fiduciaries, plan service providers, and the public on ERISA's requirements.

Even without a proposed $10 million cut to EBSA's base appropriations, if the supplemental funding is not restored or extended, the agency will have to reduce its staffing from 839 current FTE to 724. The number of FTEs that would be lost is equivalent to the total number of people employed by two of the agency's 13 field offices. This reduction will have a disastrous effect on the agency's implementation, enforcement, and other efforts related to the Mental Health Parity and Addiction Equity Act (MHPAEA), surprise medical billing, IDR, and transparency.

EBSA could be forced to limit its assistance to exigent circumstances, such as where people need our help with access to life-saving medical treatment or access to retirement savings to support the most basic level of living. A lack of additional funding will also significantly reduce our outreach, which will limit EBSA's ability to assist employers (particularly small employers), plan sponsors, and their service providers in understanding and complying with their obligations under ERISA, NSA, and other related regulations and procedures. In addition, EBSA will struggle to work its existing investigations and will be unable to open more to ensure proper compliance with ERISA and NSA rules.

2. As I mentioned in my opening statement, DOL has recovered **$6.7 billion** for missing participants and beneficiaries since 2017. But there is still much more to do. That's why it was so important that we created the Lost and Found database in the bipartisan SECURE 2.0 Act.

    a. Could you discuss why EBSA's Proposed Information Collection is so important for Americans and consistent with the statute?

***Response*:** The fundamental purpose of any retirement plan under ERISA is to pay promised benefits, and the Retirement Savings Lost and Found database will be another tool to help plans do so. The Department's goal, which we believe plan sponsors and administrators share, is to make sure that workers and their beneficiaries receive the retirement benefits they earned and were promised.

EBSA's recent proposed information collection request is important because it describes the specific data elements the agency is seeking and how information may be submitted for purposes of populating the Retirement Savings Lost and Found database. The proposal seeks comments and ideas on how to improve the information request so that the database can successfully connect individuals who have lost track of their retirement plan with the benefits they are owed.

EBSA currently conducts extensive investigations into circumstances surrounding missing participants. Since 2017, enforcement efforts have recovered more than $6.7 billion for missing participants and beneficiaries. EBSA is hopeful that this new search tool will help participants and beneficiaries locate their money more quickly and more efficiently, helping plans reduce their missing participant counts.

3. Ms. Gomez, I am deeply disturbed by recent media reports that have unveiled practices by health plans and insurance companies to deny workers and their families' coverage for vital medical services and treatments.[1] These reports reveal how plans and their service providers are conducting arbitrary, improper, and mass denials of health claims. For example, a recent ProPublica investigation found that Cigna constructed a claims review system that allowed "its doctors to instantly reject a claim on medical grounds without opening the patient file," spending, on average, just over a *single second* reviewing each claim.[2]

    a. What is at stake when a patient's health claim is wrongly denied?

Response: Health plan coverage is only truly beneficial to workers and their families when the health plan pays covered claims. When a health claim is wrongly denied, it is imperative that the claimant has the necessary information to timely appeal the claim denial; otherwise, they will not secure the benefits they are entitled to under the health plan. When health claims are wrongly denied as a result of a systemic problem in how the health plan processes claims, thousands of claims may go unpaid. Wrongful denials deprive workers of the benefits they have earned and are entitled to. When the denied claim is a pre-service claim or a request for prior authorization, the individual may go without medically necessary, even lifesaving care because the out-of-pocket costs are too high. Delayed and denied care results in worse medical outcomes and loss of life. For post-service claims that are wrongly denied, the result can be that the individual is forced to exhaust their savings, if any, to pay for medical care or they may end up in collections if they cannot pay their medical bills, ruining their credit, or even forced into bankruptcy.

    b. How does EBSA, through its Benefits Advisors program, help ensure that workers receive the benefits they are owed?

Response: EBSA maintains an assistance and education program that assists participants and beneficiaries who have been denied benefits and helps individuals locate "lost" retirement

benefits from their former employers. EBSA's Benefits Advisors can be reached via a toll-free telephone line, electronic inquiry through our website, traditional mail, and in person in our 13 field offices. Many of our Benefits Advisors are multi-lingual, so they can assist individuals with limited English proficiency. In addition, the agency contracts with a translation service that can both provide interpretive services during telephone calls and translate written material into approximately 300 languages. The Benefits Advisors are highly trained professionals who can explain complicated employee benefits laws to workers, so they understand how to access their benefits and why their benefits were denied. When benefits are improperly denied, the Benefits Advisors educate those who oversee employee benefit plans about their legal obligations and ask them to come into compliance with the law and the terms of the benefit plan. This process involves educating both the participant or beneficiary and the plan fiduciary about the applicable law. If the Benefits Advisor discovers that other individuals have been similarly denied plan benefits, the Benefits Advisor will ask for correction of the denial for all impacted individuals. Since FY 2021, EBSA Benefits Advisors ensured the payment of $95.9 million in wrongfully denied benefits from welfare plans for more than 82,200 plan participants and beneficiaries. In cases of systemic plan problems impacting multiple participants, if the Benefits Advisors cannot get the plan to come into compliance, they can refer the matter to EBSA's enforcement arm as an investigative lead. Approximately 30 percent of investigations opened each year are derived from these leads from EBSA Benefits Advisors.

The outreach and education program also informs participants and beneficiaries about their benefit rights. Benefits Advisors regularly go out into their communities to provide educational presentations about retirement and health benefits so that workers and their families know about the benefits they have earned and how to access those benefits. Additionally, the Benefits Advisors provide compliance assistance to plan sponsors, other plan fiduciaries, and plan service providers about their obligations under employee benefit laws.

In FY 2023, EBSA's Benefits Advisors closed more than 197,000 inquiries and recovered $444.1 million in benefits on behalf of workers and their families through informal resolution of individual complaints. Many of the inquiries came through via EBSA's toll-free number, 1-866-444-EBSA (3272), and www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

EBSA's Benefit Advisors provided tremendous help to participants throughout the year. One person who called EBSA was told he only had 6 months to live without a heart transplant, but his employer-sponsored health plan denied pre-certification for the transplant as not medically necessary and experimental. His doctors tried to help him appeal, but the transplant was still denied. Without the approval, he could not be placed on the organ donor waiting list. EBSA reviewed his plan documents and determined he was seeking benefits for a covered service to treat a condition that met the plan's definition of life-threatening. EBSA reached out to the employer to help determine the reason the third-party claims administrator denied the transplant, despite it being a covered service. As a result of EBSA's intervention and within 1 week of the initial call, the employer reviewed the inquiry and consulted with the health plan. The health plan agreed to approve the heart transplant and the participant received his life saving transplant.

EBSA also conducts education and outreach events for workers, retirees, employers, plan officials, and members of Congress. These nationwide activities include helping dislocated

workers who are facing job loss, educating employers about their ERISA obligations, using a train-the-trainer format to inform congressional staff of EBSA programs for their use in constituent services, and providing workers with information on their rights under the law. In FY 2023, EBSA held 2,159 outreach events, including 904 outreach events for underserved communities, 12 of which were national office webcasts. EBSA conducted 240 of these events in Spanish and conducted events in Chinese, Haitian Creole, Polish, Tagalog, and Vietnamese. Additionally, EBSA delivered 4 media (newspaper, radio, and television) interviews in Spanish and Vietnamese which reached an audience of 360,500 people.

Rep. Jahana Hayes (D-CT)

1. I was proud to be among those who fought to include the Retirement Savings Lost and Found in SECURE 2.0 – and specifically fought to see that it was housed at the Department of Labor where it belongs. This database will make a big difference to those folks who change jobs and understandably lose track of their retirement accounts. By law, the database must be up and running by the end of this year.

    a. Can you please talk about the progress EBSA is making on this important initiative? And specifically, I'm interested in EBSA's proposed information collection asking retirement plan administrators to voluntarily provide specified information to support the establishment of the Lost and Found database.

***Response*:** The Department of Labor published a notice of proposed information collection request (ICR) in the Federal Register on April 16, 2024, with a 60-day comment period that closed June 17, 2024. We received 13 comments responsive to the proposed ICR. Commenters expressed a range of concerns related to the proposed ICR, including the scope of data collected, the impact of state privacy laws, administrative burdens, and cybersecurity matters. The Department is currently considering options to address these concerns as it proceeds with the development of the Retirement Savings Lost and Found. Additionally, the Department has engaged with other Federal agencies to determine if participant data already collected and stored by the Federal government can be used to populate the Retirement Savings Lost and Found.

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[1] https://www.propublica.org/article/your-right-to-know-why-health-insurer-denied-claim
[2] https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims