Questions for the Record

Committee on Education and Workforce
Subcommittee on Health, Employment, Labor, and Pensions hearing titled: "Examining the Policies and Priorities of the Employee Benefits Security Administration"

Thursday, April 16, 2026
10:15 A.M.

Questions for Assistant Secretary Daniel Aronowitz

Representative Bob Onder (R-MO)

1. What existing authority does EBSA have to compel payers to pay providers within the statutory 30-day timeline following an IDR decision, under the *No Surprises Act*?

   Response: Under Employee Retirement Income Security Act (ERISA) section 504, the Employee Benefits Security Administration (EBSA) has investigative authority to determine whether a violation of title I of ERISA has occurred or is about to occur, and EBSA will use this authority to address compliance issues related to the payment requirements. Furthermore, under ERISA section 502(a)(5), EBSA has broad injunctive and equitable relief authority to enforce any provisions of ERISA.[1] Under the No Surprises Act (NSA) and the implementing regulations, a determination made by a certified Independent Dispute Resolution (IDR) entity is binding upon all parties involved, in the absence of fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the claim. Payment owed based on the determination must be paid directly to the other disputing party no later than 30 calendar days after the determination by the certified IDR entity.

   EBSA receives thousands of NSA inquiries through its Benefits Advisor program and has recovered millions on behalf of participants and beneficiaries as well as providers. In FY 2025, for example, EBSA closed 27,638 inquiries and recovered $67 million.[2]

2. Does EBSA have existing enforcement authority to levy fines for non-compliance with the statutory 30-day payment timeline?

   Response: Under the No Surprises Act (NSA), the Department of Labor (DOL) does not have express authority to levy fines to compel plans and issuers to pay within the 30-day timeline requirement for payments after an IDR determination. However, EBSA has authority to investigate and compel providers or payers to comply with ERISA and NSA requirements and has broad injunctive and equitable relief authority. *See* ERISA Sec. 502, 504, and Enforcement Manual - Investigative Authority | U.S. Department of Labor.

[1] This outline highlights EBSA's civil authority. EBSA also has criminal investigative authority under ERISA section 506, as amended by the Comprehensive Crime Control Act of 1984, to investigative criminal violations of Title 18 of the United States Code.
[2] https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/ebsa-monetary-results-2025.

3. Some states have held that they have no enforcement authority for *No Surprises Act* violations under ERISA plans. Does EBSA take primary responsibility for enforcement? If not, what enforcement authority is delegated to states?

   Response: Enforcement of the No Surprises Act is split as follows:

   - DOL and the Treasury Department generally have primary enforcement authority over private sector employment-based group health plans. The IRS has jurisdiction over certain church plans. HHS also has primary enforcement authority over non-federal governmental plans, such as those sponsored by state and local government employers.

   - The enforcement responsibilities of HHS and the states with respect to oversight of health insurance issuer compliance with the federal insurance market reforms are set forth in the Public Health Service (PHS) Act. Pursuant to section 2723(a)(1) of the PHS Act, as amended by the No Surprises Act, states have primary enforcement authority over health insurance issuers regarding the provisions of Parts A and D of title XXVII of the PHS Act. Under this framework, HHS has enforcement authority over issuers in a state if the state indicates it cannot or will not enforce a provision or the Secretary of HHS determines that the state is failing to substantially enforce a provision (or provisions) of Part A or D of title XXVII of the PHS Act.

4. According to data from AHIP and Blue Cross Blue Shield, of the 0.7% of claims eligible for IDR, only 6.6% go to arbitration. That means roughly 93% of eligible claims are resolved without IDR. Does that align with EBSA's data, and based on that data, would you say that the goal of using IDR as a last resort, as Congress intended, has been achieved?

   Response: EBSA does not maintain data on the percentage of claims that are eligible for the Federal IDR process. In November 2023, the Departments of Health and Human Services, Labor, and the Treasury released a proposed IDR Operations (IDR Ops) rule to reduce administrative burden and streamline payment arbitrations between health insurers and out-of-network providers. Among other things, the proposed IDR Ops rule would formalize the open negotiation period and require certain disclosures with regard to the qualified payment amount (QPA) and eligibility determinations. The Departments are exploring more ways to continue to improve the NSA and to collaborate with Congress to address continuing operational challenges.

5. A recent GAO report found that the *No Surprises Act* has successfully encouraged more in network contracting between clinicians and insurers, and that inflation adjusted in network costs are decreasing. Despite these findings from a nonpartisan government source, some have argued, based on the fact that IDR awards are often higher than the QPA, that IDR determinations are significantly above historical in network and out of network rates. However, research from ndp Analytics contradicts that narrative. Their analysis compared Q4 2024 QPAs in CMS's Public Use Files to median in network rates disclosed under the Transparency in Coverage data. They found that 60% of QPAs were

below the corresponding median in network rate. On average, the median in network rate was nearly 300% higher than the reported QPA. Allowing policy decisions to rely on inaccurate or misleading QPAs risks serious unintended consequences for both patients and clinicians. That is why the *No Surprises Act* required the tri-agencies to conduct QPA audits. The Biden Administration failed to complete these statutorily required audits. Can you provide an update on the tri agencies' work on QPA audits, and a timeline for when those audits will occur?

Response: As of November 2025, the Centers for Medicare and Medicaid Services (CMS), in coordination with the Department, has initiated 26 QPA audits.

In addition to the QPA audits, EBSA's Enforcement Program is currently reviewing plan and service provider compliance with requirements under the NSA to ensure compliance with all the NSA requirements that apply to payers. EBSA's work in this area centers on enforcing the protections under the NSA, which prevents participants and beneficiaries from receiving unexpected medical bills in certain situations, such as emergency and air ambulance services or non-emergency services performed by out-of-network providers at in-network facilities.

EBSA is reviewing whether plans and issuers:

- Follow the prudent layperson standard, which requires plans to treat a situation as an emergency if a reasonable person would believe they need immediate medical care.
- Apply in-network cost-sharing charges to services protected under the NSA.
- Provide proper notices and disclosures.
- Comply with other NSA protections, such as prohibitions on certain prior authorizations and more restrictive administrative requirements.
- Comply with payment timelines during open negotiation and the independent dispute resolution process.
- Are imposing improper plan exclusions that wrongfully deny emergency services coverage.

Representative Virginia Foxx (R-NC)

1. Health care costs continue to rise, and provider consolidation is one of the main drivers of these increases. Perverse economic incentives have driven hospitals to acquire provider offices and incorrectly bill for services. What should be done to ensure that hospitals are not allowed to tack on hidden facility fees and upcharges billed to commercial payers for outpatient services?

   Response: The Departments of Labor, Treasury, and HHS are aware that individuals are increasingly being charged facility fees for health care received outside of hospital settings, which increases health care costs. When facility fees are covered by the individual's plan or coverage in connection with essential health benefits provided in-network, cost sharing for those fees is subject to the maximum out of pocket limitation requirements under the Affordable Care Act (ACA). Plans and issuers are also 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.[3] However, when not covered by the individual's plan or coverage in connection with the provision of essential health benefits, those fees expose patients to financial risk. Several states have taken or are considering taking action to prohibit, limit, or increase transparency around facility fees.[4] The Departments are monitoring this issue.

   Last year, the Departments proposed updates to the Transparency in Coverage rule that would dramatically improve the quality and usability of data reported by health insurers. As a result, we expect employers will have greater ability to use price transparency data to make more clear judgment about which insurer provides the highest value plan offerings, increase the use of innovative direct contracting arrangements, and ensure their health plan is not being overcharged by a third party administrator. President Trump has called for Maximum Price Transparency in his Great Healthcare Plan and we look forward to working with Congress to make that a reality.

2. This Committee has championed legislation to increase transparency in the health care market.
   a) Why is it important for an employer to have access to the health data of its own plan in order to design a plan that provides quality health care for lower costs?

      Response: This administration understands that access to information is essential to lowering the cost of health care. As Executive Order 14221 highlights, making America healthy again requires empowering individuals with the best information possible to inform their life and healthcare choices. Ensuring employers have access to the health data of their own plans allows them to make informed decisions that can improve the quality of care for participants and beneficiaries,

[3] 26 CFR 54.9815-2715A2(b), 29 CFR 2590.715-2715A2(b), and 45 CFR 147.211(b).
[4] See, e.g., Conn. Gen. Stat. § 19a-508c; Minn. Stat Ann. § 62J.824; Tex. Health & Safety Code Ann. § 254.156; and Wash. Rev. Code § 70.01.040. See also, Goodland, Marianne, Hospitals Decry Bill Banning 'Facility Fees,' Supporters Call it More 'Surprise Billing,' Colorado Politics, (Feb. 24, 2023), available at https://www.coloradopolitics.com/legislature/hospitals-decry-bill-banning-facility-fees-supporters-call-it-more-surprise-billing/article_37169ae0-b466-11ed-8c61-3bab9b968163.html.

promote efficiency in the administration of benefits, and reduce costs for employers, participants, and beneficiaries.

Plan specific health data can shed light on usage and cost drivers for individual plans. In particular, it can facilitate early interventions for people with conditions that can be managed proactively to avoid cost surges. More generally, by analyzing use by participants, plans can be designed to nudge participants towards more cost-effective care. For instance, plans have increasingly utilized a tiered approach with different cost-sharing for providers or sites of service to encourage participants to use those with lower negotiated rates or more cost-efficient services, and evidence suggests that this approach has the potential to reduce aggregate health care spending.[5].

In January 2026, the Department released its PBM Fee Disclosure NPRM which, if finalized, will require disclosure of all direct and indirect compensation charged by a covered service provider providing pharmacy benefit manager services to a self-insured group health plan. In the Department's Regulatory Impact Analysis, the Department estimates that increased transparency around pharmacy benefits alone will save approximately $18 billion over 10 years in better adherence and lower drug costs.

DOL is committed to using all available regulatory and enforcement tools to drive down costs and increase value in employer-sponsored health care.

b) What are the limits on health care data transparency under current law, and how can Congress give employers the tools they need to lower costs?

Response: In the Great Healthcare Plan, President Trump called for legislation to impose maximum healthcare price transparency, and the Department stands ready to work with Congress to accomplish this goal.

The Department has been laser-focused on using existing statutory authority to improve employers' access to pricing information. Lowering costs requires plans and issuers to obtain data from their service providers. For example, group health plans and health insurance issuers offering group or individual health insurance coverage generally are prohibited under the gag clause provisions of the NSA[6] from entering into an agreement that would directly or indirectly restrict them from: (1) making provider-specific cost or quality of care information or data available to active or eligible participants, beneficiaries, and enrollees; (2) allowing plan sponsors or referring providers to access this information; electronically accessing de-identified claims[7] and encounter information or data

[5] *See, e.g.,* Anna D. Sinaiko, Mary Beth Landrum, and Michael E. Chernew. Enrollment In A Health Plan With A Tiered Provider Network Decreased Medical Spending By 5 Percent. 36 Health Affairs 870 (2017).
[6] Internal Revenue Code section 9824, Employee Retirement Income Security Act section 724, and Public Health Service Act section 2799A-9(a), as added by section 201 of title II (Transparency) of division BB of the Consolidated Appropriations Act, 2021.
[7] The prohibition on restricting plans and issuers from electronically accessing de-identified claims and encounter information or data does not apply to issuers offering individual health insurance coverage. *See* PHS Act section

for each participant or beneficiary; or (3) sharing such information with a business associate, consistent with applicable privacy regulations. Plans and issuers must annually submit an attestation of compliance with the gag clause provisions.

These provisions are imposed on the plans and issuers, rather than service providers directly, and do not require the affirmative disclosure of this information. The Departments are aware that some service agreements used by service providers contain non-compliant provisions and have indicated in guidance that plans and issuers must identify, in their attestations of compliance, any non-compliant provisions in their agreements.[8]

In January 2026, the Department released its PBM Fee Disclosure NPRM which, if finalized, will require disclosure of all direct and indirect compensation charged by a covered service provider providing pharmacy benefit manager services to a self-insured group health plan. The Department recognizes that employers do not have access to all the information they need to analyze whether the compensation charged by their covered service provider for managing their healthcare benefits is reasonable. DOL is committed to using all available regulatory and enforcement tools to drive down costs and increase value in employer-sponsored health care.

3. Many of us have heard feedback from health plan sponsors that certain service providers are placing limitations on who the plan can share its data with, including business associates such as brokers.
    a) How do these limitations hinder a plan sponsor's ability to use its own data?

    Response: As stated above, under the gag clause provisions of the NSA, group health plans and health insurance issuers offering group or individual health insurance coverage generally are prohibited from entering into an agreement that would directly or indirectly restrict the plan or issuer from: (1) 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; (2) electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan or coverage, or (3) sharing such information with a business associate, consistent with applicable privacy regulations.

    Examples of these limitations may include:

    - Limiting access to a statistically significant or the "minimum necessary" number of de-identified claims;
    - Limiting the scope of access to the data to specific, narrow purposes (such as limiting access to the context of an audit);

2799A-9(a)(2). In this response, any discussion of restrictions on a plan or issuer from electronically accessing deidentified claims and encounter information or data applies only to group health plans and health insurance issuers offering group health insurance coverage.

[8] FAQs About Consolidated Appropriations Act, 2021 Implementation Part 69 (Jan. 14, 2025), https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-69.

- Unreasonably limiting the frequency of claims reviews;
- Limiting the number and types of de-identified claims that a plan or issuer may access;
- Restricting the data elements of a de-identified claim that a plan or issuer may access; and
- Providing access to de-identified claims data only on the service provider's physical premises.

Such limitations may hinder the ability of plan sponsors to evaluate the performance of their service providers, potentially leaving plan sponsors at a disadvantage when deciding whether to hire or retain service providers, which may raise expenses for plans sponsors and, ultimately, participants and beneficiaries.

In January 2026, the Department released its PBM Fee Disclosure NPRM which, if finalized, will require all disclosure of direct and indirect compensation charged by a covered service provider providing pharmacy benefit manager services to a self-insured group health plan. This will include brokers and consultants to self-insured group health plans who provide pharmacy benefit management services.

DOL is committed to using all available regulatory and enforcement tools to drive down costs and increase value in employer-sponsored health care.

b) How is access to a health plan's data crucial to the role that brokers play in lowering health care costs?

Response: Ensuring access to health data can allow brokers to assist an employer in selecting or designing a plan that is tailored to the unique needs of that particular employer, which can promote greater efficiency, better quality of care, and reduced costs for employers, employees, and their families. It is common for employers to seek assistance from brokers and consultants with requests for proposals and negotiations with issuers and other service providers. In January 2026, the Department released its PBM Fee Disclosure NPRM which, if finalized, will require disclosure of all direct and indirect compensation charged by a covered service provider providing pharmacy benefit manager services to a self-insured group health plan. Group health plans, especially those without sophisticated human resource departments, can share this information with their consultants and brokers to analyze whether or not the fees charged by the covered service provider to the group health plan are reasonable. It may also allow the group health plan to better negotiate plan costs with the covered service provider or shop around for less expensive services.

Representative Ryan Mackenzie (R-PA)

I've heard concerns that the Biden Administration's overreaching amendments to the qualified professional asset manager (QPAM) exemption, under which asset managers are disqualified if any affiliate enters a DPA or NPA or receives foreign convictions, have negative impacts on the efficient administration of retirement plan assets, thereby harming participants and beneficiaries in those plans. This approach significantly increases the number of well-respected managers who face potential disqualification for DPAs, NPAs, or convictions committed by affiliates far removed from acting as an ERISA fiduciary. It is also a position repudiated in the first Trump Administration.

1. Do you plan to re-examine the Biden DOL's 2024 amendments to the exemption, which failed to address cost implications and other potential unintended consequences and that act as an extraterritorial influence on the US retirement industry, as well as QPAM disqualification more broadly?
2. Do you plan to engage with stakeholders to restore a reasonable and efficient framework for operating under the QPAM exemption?
3. Is this urgent matter a near term priority for the Department?

Response: Yes, this is a priority for the Department and EBSA is reviewing regulatory actions from the previous administration, including the QPAM exemption.

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

1. The Advisory Council on Employee Welfare and Pension Benefit Plans (Council) is established by section 512 of ERISA and must meet at least four times per year. The Department is also required by law to support the Council's operations, including by providing "an executive secretary and such secretarial, clerical, and other services as are deemed necessary to conduct its business." However, this statutorily mandated body has reportedly been frozen and has not been convened since 2024.
    a. What is the current status of the Council?
    b. Has the Department provided all statutorily mandated resources and staff to the Council since you took office?
    c. When will the Department appoint new members to fill existing vacancies?
    d. When will the Council's four statutorily mandated meetings be held in 2026?
    e. Is the Council currently under review by the Administration? If so, who is conducting such review? What is the statutory authority that would permit such a review of a statutorily mandated body?

    Response: EBSA appointed the Designated Federal Officer on April 8, 2026. EBSA is conducting its annual review of the purpose and functions of the advisory committee, consistent with FACA regulations. In addition, the agency is reviewing all ERISA Advisory Council activities to ensure alignment with current Administration priorities. With respect to appointments to fill existing vacancies and the scheduling of the mandated meetings for 2026, those matters remain under review as part of EBSA's ongoing evaluation of the Council (41 CFR 102-3.105(f)).

2. In June 2024, then-Assistant Secretary Lisa Gomez testified that EBSA has "less than 1 investigator" for every 13,900 ERISA-covered health, retirement and other benefit plans. Media reports indicate that EBSA has lost approximately 40% of its investigators since then, though your Budget request does not provide any details regarding this matter.
    a. How many investigative staff did EBSA have (including those hired with supplemental appropriations) at the time Assistant Secretary Gomez spoke with the Committee in June 2024? How many does EBSA currently have? How many would EBSA have if the cuts proposed in your budget were enacted?
    b. Do you believe that the ratio of investigators to plans described by the former Assistant Secretary is sufficient to protect the benefits of 155 million Americans and to fully enforce the requirements of ERISA? Similarly, do you believe the ratio that would result under your proposed budget would be sufficient?
    c. Does EBSA plan to hire more investigative staff and, if so, how many? How many investigators per plan will the agency have after you have completed hiring? Please explain how you believe this number will be sufficient?

    Response: EBSA is responsible for protecting more than 156 million workers, retirees, and their families who are covered by approximately 2.6 million health plans, 801,000 private retirement plans, and 514,000 additional welfare benefit plans. Together, these plans hold about $13.8 trillion in assets. Under my leadership, EBSA will use an even-handed, responsive approach to investigations and produce the best results for American workers, retirees, and their families.

EBSA investigators are currently prioritizing high-impact work through the agency's National Projects, which will focus on: (1) systemic healthcare issues, including access to mental health treatment and surprise billing; (2) cybersecurity risks affecting plans, service providers, and participants; (3) protection of benefit distributions to ensure participants receive promised retirement benefits; and (4) loyalty and prudence in retirement asset management at both the plan and service-provider levels. Focusing resources on these areas will increase broad-based employee benefit plan compliance, address abusive practices and bad actors, and deliver results that increase security for participants and beneficiaries.

EBSA intends to hire, promote, and strategically align staff within its enforcement program to strengthen investigative capacity and support high-impact casework. EBSA is analyzing its resource allocation to ensure its investigators concentrate on high-impact targets, while also utilizing technological solutions and artificial intelligence where appropriate. The agency also intends to hire additional staff and recently issued a nationwide vacancy announcement to hire investigators for critical staffing positions. Those critical staffing positions also focus on Benefits Advisor hiring to ensure timely assistance for workers, retirees, families, and other stakeholders.

3. As you are aware, ERISA requires fiduciaries to act "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." 29 U.S.C. § 1104(a)(1)(B). In 2014, the Supreme Court unanimously held in *Fifth Third Bancorp v. Dudenhoeffer* that there is no "special presumption of prudence" afforded to fiduciaries in ESOP cases and that "the same standard of prudence applies to all ERISA fiduciaries." 573 U.S. 409, 417 (2014).

   With that background, it would be helpful for the Committee to understand the justification for EBSA's new approach with respect to the duty of prudence under ERISA. EBSA recently released Field Assistance Bulletin No. 2026-01, which stated, among other things, that the agency will "prioritize" enforcement of breaches of the duty of loyalty, rather than the duty of prudence, and will "avoid second-guess[ing] process-based fiduciary judgments." Additionally, EBSA's proposed rule on *Fiduciary Duties in Selecting Designated Investment Alternatives* would create a process-based safe harbor that would provide that the fiduciary "is presumed to have met the duties under section 404(a)(1)(B) of ERISA of such fiduciary and is entitled to significant deference." 91 Fed. Reg. 16,088,16,136 (to be codified at 29 C.F.R. § 2550.404a-6(f)).

   a. What is EBSA's statutory authority for creating this process-based safe harbor?
   b. Does the regulation require any assessment of whether the fiduciary's decisions are, in fact, those that a "prudent man acting in a like capacity and familiar with such matters" would make, consistent with the clear text of section 404 of ERISA? Or will simply following the process described effectively exempt fiduciaries from this requirement?
   c. How do you reconcile the presumption of prudence described in the proposed rule with the Supreme Court's unanimous holding in *Dudenhoeffer*, which directly contradicts EBSA's proposed regulation?

Response: EBSA is a key steward of ERISA and the United States' voluntary employee benefits system. ERISA was created because employee benefit plans, such as retirement, health, disability and other plans, are of national interest. The continued well-being of these plans is crucial to both employers who sponsor those plans and to American workers and their families who rely upon those plans to provide promised retirement, health and other benefits. During my confirmation hearing, I pledged to restore balance to the employee benefit system, including clearer regulations that follow ERISA fiduciary law and fair and balanced enforcement.

Under President Trump's leadership, the Department of Labor issued a historic proposed regulation increasing potential retirement investment options for more than 90 million Americans. The proposed regulation explains the steps that managers of 401(k) plans should take when considering alternative assets as a component in their investment lineups and establishes a set of process-based safe harbors for plan fiduciaries to use when selecting designated investment alternatives.

Presently, EBSA is reviewing the over 47,000 comments submitted to the investment selection notice of proposed rulemaking (NPRM), including your June 1, 2026 letter. EBSA is thoughtfully and carefully considering all comments received.

Finally, on April 14, 2026, I issued Field Assistance Bulletin (FAB) 2026-01, which is a statement of guiding principles for EBSA's enforcement activities following evaluation of the responsiveness and effectiveness of the agency's enforcement efforts. The first Guiding Principle contains the commonsense goal of focusing EBSA's enforcement on the most egregious conduct or significant harm. The FAB instructs EBSA's investigators to concentrate resources on cases involving the most serious misconduct or the greatest harm to plan participants and beneficiaries. On the criminal side, this means prioritizing cases causing the most significant harm to the employee benefits system. On the civil side, the highest priority is targeting breaches of the duty of loyalty — conduct not taken for the exclusive purpose of providing benefits, such as fiduciary self-dealing, misappropriation of plan assets in bad faith, or pursuing unrelated goals like ESG objectives. The FAB clearly states that "EBSA will continue to enforce both the duties of loyalty and prudence under ERISA." The FAB explains that while breaches of the duty of prudence can threaten workers' promised benefits, "the costliest breaches of the duty of prudence tend to be accompanied by concomitant loyalty breaches." For that reason, EBSA states that "a significant percentage" of our enforcement resources will be focused on enforcement of loyalty breaches or direct evidence of non-exempt prohibited transactions that involve impermissible conflicts of interest.