BENEFITS INSIDER

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The ***Benefits Insider*** is a bimonthly member exclusive publication prepared for WEB members by the American Benefits Council ("the Council"), a premiere benefits advocacy organization based in Washington, DC. This newsletter provides the latest news and analysis on the most important benefits-related policy matters in Congress, executive branch agencies and the federal judiciary.

Please note: any views or opinions expressed in these stories represent the advocacy positions of the American Benefits Council and its membership. They do not necessarily reflect the views of WEB or its membership. To inquire about membership with the American Benefits Council, contact Deanna Johnson at (202) 289-6700 or djohnson@abcstaff.org.

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RECENT LEGISLATIVE ACTIVITY

2022 Omnibus Bill Included High Priority Health Measures, Avoided Numerous Provisions Opposed by Council

The Consolidated Appropriations Act, 2023 (CAA 2023), formally signed into law by President Biden on December 29, included a number of important benefits provisions strongly supported by the American Benefits Council. Just as important, however, are the several health policy measures strongly opposed by the Council that were not included in the final measure, several of which were opposed by the Council in the months leading up to the bill's passage. Also of note are provisions that were omitted from the final package that the Council will continue to advocate in support of in the 118th Congress.

Extension of Telehealth Flexibility Included in CAA 2023

The CAA 2023 includes a two-year extension of a temporary provision allowing first-dollar coverage of virtual care under health savings account (HSA)-eligible high-deductible health plans (HDHPs), giving employers flexibility to enable individuals to access telehealth services without needing to first meet a deductible.

This flexibility, which was originally provided under the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020, was previously extended to apply from April 1, 2022, through December 31, 2022. The CAA 2023 extends this flexibility for "plan years" beginning after December 31, 2022, and before January 1, 2025. Accordingly, calendar year plans have the ability to cover pre-deductible telehealth for all of 2023 and 2024 (i.e., the 2023 and 2024 plan years).

Non-calendar year plans, however, may not cover telehealth pre-deductible until the start of the first plan year after December 31, 2022. This creates a potential gap in the application of the extension for non-calendar year plans between January 1, 2023, and the first day of the 2023 plan year. For example, for a plan year that runs June 1st to May 31st, the plan would apparently not be able to cover pre-deductible telehealth in 2023 until June 1, 2023. Such plan would be able to cover pre-deductible telehealth from June 1, 2023, through May 31,2025.

The Council will continue to advocate for making this flexibility permanent.

Provisions not Included in CAA 2023

The following is a summary of measures and provisions not included in CAA 2023, and whether they could take shape in the new Congress. (With the start of the 118th congressional session, all legislation must be reintroduced, with or without modifications.)

The Restore Protections for Dialysis Patients Act

In the run-up to the development of year-end legislation, the Council was concerned that lawmakers would seek to attach the Restore Protections for Dialysis Patients Act (RPDPA, S. 4750/H.R. 8594 in the prior Congress), proposed legislation that would effectively allow

dialysis providers to collect higher reimbursements from employer plan sponsors through a vague and unnecessary benefit mandate and parity requirement.

The measure was a response to the U.S. Supreme Court decision in *Marietta Memorial v. DaVita Inc.*, in which the high court ruled that a group health plan that provides limited benefits for outpatient dialysis — but does so uniformly for all plan participants — does not violate the Medicare Secondary Payer Act The Act prohibits a private health plan from differentiating in the benefits it provides between individuals having end-stage renal disease (ESRD) and other individuals covered by such plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. The Act also prohibits a plan from "tak[ing] into account that an individual is entitled to or eligible for" Medicare due to ESRD.

In letters to the U.S. Senate and House of Representatives on September 15, the American Benefits Council expressed strong concerns with the bill, explaining that "While the legislation may increase profits for dialysis providers … it will ultimately harm employees through higher premiums and hamper employer efforts to make health care more affordable for working families." We also note that the legislation is "unworkable" since the parity requirements are unclear on how to determine a sufficient level of reimbursement or coverage.

During CAA 2023 negotiations, Council staff met with numerous congressional office to voice strong concerns with the RPDPA. Council staff also met with officials from the Congressional Budget Office (CBO) to discuss the likely revenue effect of the measure if enacted, noting that the legislation was likely to raise costs for employer-provided health coverage and for the federal government. CBO reportedly reached a similar conclusion. This estimate that the legislation would not generate savings for the federal government but, rather, had a significant cost likely contributed to the decision not to include it in the final measure.

The RPDPA continues to enjoy bipartisan support, as well as the support of numerous disease advocacy groups, and may be reintroduced in the new Congress. The negative revenue estimate is likely to hurt its chances for further consideration. However, Congress is likely to remain interested in this issue and supporters of the legislation may look to other proposals to achieve a similar objective.

The Mental Health Matters Act

As we have reported, CAA 2023 included a scaled-down version of the bipartisan Restoring Hope for Mental Health and Well-Being Act, which includes provisions to expand access to mental health services, such as through the integration of behavioral and primary health care. (The Council had supported enactment of this measure.)

The final bill did not, however, include a separate House of Representatives-passed mental health bill opposed by the Council, the Mental Health Matters Act. This measure, developed by the House Education and Labor Committee and approved by the full House on a largely party-line basis addresses a variety of mental health challenges (as detailed in the committee's official section-by-section summary).

In a September 23 letter, the Council identified two measures incorporated in the bill that adversely affect employer-sponsored benefits:

- The Employee and Retiree Access to Justice Act, which would deem arbitration clauses, class action waivers, and discretionary clauses in employer benefit plans "unenforceable" under ERISA. In recent years the Council has warned of the hidden and exorbitant costs of excessive ERISA litigation, which often results in enormous costs for plan sponsors and little recovery for participants. Considering the weak enforcement of pleading standards that has fueled this flood of litigation, we are concerned that the provision ignores the value of arbitration clauses for participants and plans and elimination of such clauses would further exacerbate the problem of excessive litigation.

- The Strengthening Behavioral Health Benefits Act, which would expand the ability of the Department of Labor (DOL), as well as a plan participant, beneficiary, or fiduciary to file civil litigation with respect to mental health parity violations "against a plan, health insurance issuer, fiduciary, or other administrative service provider." The measure would also provide $275 million dollars of mandatory funding over ten years to DOL for increased enforcement of mental health parity requirements (under the Mental Health Parity and Addiction Equity Act (MHPAEA)) against health insurance issuers offering coverage in connection with a group health plan.

The House-passed version of the Mental Health Matters Act included new civil monetary penalties for mental health parity violations.

During CAA 2023 negotiations, Council staff met with numerous congressional offices to voice strong concerns with the Mental Health Matters Act and urged lawmakers to reject its inclusion in a year-end legislative package. Because passage of CAA 2023 was a delicately balanced bipartisan and bicameral exercise, the Mental Health Matters Act was ultimately rejected for inclusion. While it remains possible that the bill's sponsors will attempt to revive it in the new Congress, the Republicans' new control of the House makes enactment less likely. However, mental health parity is expected to remain a focus of both Congress and the regulators.

PBM Transparency Legislation

One provision that was not included in CAA 2023 but was supported by the Council is likely to be revisited in the new Congress. While (as noted above) the Restoring Hope for Mental Health and Well-Being Act was adopted as part of the measure, the final bill excluded a key measure related to transparency of pharmacy benefit manager cost information.

As approved by the full House, the bill would have required pharmacy benefit managers to provide group health plan sponsors with reports on the costs, fees and rebate information associated with their contracts. This section, estimated by CBO to raise $2.2 billion over 10 years, remains an attractive offset to pay for different legislation down the line. The Council will continue to support its passage.

RECENT REGULATORY ACTIVITY

Surprise Billing Roundup: New Guidance, New Litigation, Expected Regulatory Activity

Now just over a year into the implementation of the surprise billing provisions enacted in the No Surprises Act (NSA), frequent activity continues, both on the regulatory and judicial fronts. The American Benefits Council continues to be actively involved to support the goals of protecting consumers and lowering health care costs, and to enable smooth implementation.

Status of the IDR Process

In late December, the U.S. departments of Health and Human Services (HHS), Labor, and Treasury (the "tri-agencies") issued a report on the status of the Independent Dispute Resolution (IDR) process, which is the process providers may use to seek additional amounts from plans for certain out-of-network items and services, in addition to the initial payment amount. The report, which is just over 30 pages, covers April 15, 2022 (when IDR first began) through September 30, 2022, and in it the tri-agencies note that the volume of IDR disputes filed so far has significantly exceeded their expectations. The tri-agencies also note that determining whether a dispute is eligible for federal IDR is taking significantly more time than anticipated.

The report provides figures on the dispute volume (90,078 disputes in the reporting period), a breakdown by provider type of dispute filers and a list of the providers who have filed the most disputes. The report also provides information on how many disputes have been closed (23,107) during the reporting period and notes that a large number (41,814) of disputes have been challenged as ineligible for federal IDR. The report also addresses several issues, including incorrect batching of disputes, and includes a state-by-state breakdown of where disputes have been initiated as well as charts showing the types of services subject to dispute, among other detailed information on the IDR process thus far. The tri-agencies are expected to continue to provide status updates periodically.

Increase in Certain IDR Fees for 2023

The NSA sets out certain fees related to the IDR process. Each party to IDR (both the initiating party and the non-initiating party) pay a non-refundable administrative fee, ultimately to the government, to cover the cost of the government running the IDR process (the fee amount is updated annually). In addition, each party to IDR must pay the IDR entity a fee but the fee paid by the prevailing party is returned to the prevailing party, in general, and the agencies have published guidance establishing a permissible range for this fee.

In late December, the tri-agencies issued guidance increasing the administrative fee for disputes filed in 2023 to $350 for each party to a dispute – this is an increase from $50 previously announced by the agencies – to cover the costs to the government associated with the high volume of disputes and the significant backlog. The guidance does not change, but only reiterates, the previously issued guidance providing the IDR entity fee ranges for 2023 (*i.e.*, $200-$700 for single determinations and $268-$938 for batched determinations).

Litigation Activity

As we have previously reported, provider groups have challenged key aspects of the surprise billing regulations in court, with a focus on the IDR process. Providers successfully challenged certain aspects of the regulations that focused on the IDR process and the median in-network rate (i.e., the "qualifying payment amount" (QPA)). Providers then challenged the new regulations on IDR again claiming the tri-agency regulations express a preference the QPA. The Council coordinated *amicus* (or "friend of the court") briefs in both cases in support of the tri-agency regulations, and we are still awaiting a ruling in the second case.

Then in early December, the same provider groups filed yet another lawsuit, this time challenging the way in which the QPA is calculated, claiming that the tri-agency regulations deflate the QPA. This third set of cases is just getting underway and we will continue to report on judicial activity.

Future Regulatory Activity

As we have previously reported, the tri-agencies have issued extensive regulations to implement the surprise billing provisions, but more regulatory activity is expected. The tri-agencies have indicated that in the future they will finalize the parts of the surprise billing interim final regulations that have not yet been finalized and in addition, the federal regulatory agenda notes that the agencies plan to release a proposed regulation on IDR operations by March of this year. We also expect continued sub-regulatory guidance to address issues and questions as they arise.

We continue to closely engage with the agencies on issues related to surprise billing, both to support orderly implementation and to ensure that these provisions are implemented in a way that leads to lower health care costs, as was intended. We have had several formal and informal conversations and meetings with agency staff over the last several months, including as part of the Coalition Against Surprise Medical Billing, and we signed onto December 12 group letter asking the agencies to continue to implement the surprise billing provisions in a way that both protects consumers and lowers health care costs. Implementation of the surprise billing regulations could come under greater scrutiny in the new Congress as well. Notably, the incoming Republican Ranking Member of the Senate Health, Education, Labor and Pensions Committee, Senator Bill Cassidy (R-LA) has signaled that oversight of the agencies' implementation will be a priority.

Council Comments to EBSA: QPAM Exemption Proposal Could Pose Serious Disruption to Plan Sponsors

In a January 6 letter to the U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA), the American Benefits Council offered supplemental information to address concerns in the agency's proposal to amend the qualified professional asset manager exemption.

PTE 84-14 is commonly known as the "qualified professional asset manager" (QPAM) exemption. QPAMs are investment advisers and other institutions that can process routine

transactions between retirement plans and "parties in interest" that would normally be banned. Because the application of "parties in interest" is so broad, plan sponsors rely on an exemption for QPAMs to transact with those parties where appropriate for the plan.

However, to qualify as a QPAM, asset managers (or any related entity) must not have been convicted of certain crimes in the past 10 years.

The DOL's proposal would expand the violations that could lead the agency to disqualify a QPAM to include foreign convictions for crimes that are "substantially equivalent" to U.S. offenses that would result in disqualification, as well as non-prosecution and deferred prosecution agreements for the same.

However, these proposals could pose a serious disruption to plan sponsors and participants. Many investment strategies can be complex and depend on an investment manager to fully understand the short- and long-term needs and objectives of the plan – an understanding that is often built up over years.

While supportive of the general premise of the QPAM exemption's integrity provision – Section I(g) of the current and proposed exemption – the Council believes the proposed changes to the QPAM exemption, and even some of the existing QPAM conditions, could automatically and inappropriately disqualify investment managers in far less severe and far more remote circumstances.

There is particular concern when automatic disqualification stems from conduct conducted by the QPAM affiliate or owner, as opposed to the QPAM itself. To avoid unnecessary disruptions, the Council suggests requiring QPAMs to simply disclose information about these events to their clients.

Further disruption can be seen in the proposal's amendment to disqualify a QPAM through the issuance of a Written Ineligibility Notice in response to Prohibited Misconduct. This approach creates further uncertainty for plan sponsors about whether an individual qualifies as a QPAM, since a unilateral decision by DOL could find that an investment manager is retroactively disqualified from QPAM status.

Instead, the Council suggests DOL continue using existing enforcement authority to address these issues.

Industry Groups Call for Extension to Proposed "Hard Stop" Rulemaking Comment Period

The American Benefits Council, alongside several other industry groups, sent a letter to Securities and Exchange Commission (SEC) Secretary Vanessa A. Countryman on January 9 urging an extension to the comment period on the agency's "hard 4 p.m. close" rule affecting retirement plans. The comment period is set to close February 14 and the Council intends to submit written comments.

The SEC approved the proposal in November by a 3-2 vote, which would impose a "hard stop" on trading after 4 p.m., negatively and disproportionately affecting participants in 401(k), 403(b) and 457(b) plans. While the proposal is complex, the effective result would be that – unless the entire defined contribution recordkeeping industry made substantial changes to its systems to reduce processing time by many hours – retirement plan participants would be significantly disadvantaged. While institutional investors would be able to wait until the very last minute to place a mutual fund purchase or redemption order and take advantage of any market developments during the day, plan participants would either need to receive the next day's price or trade well in advance of the deadline.

Extending the comment period will give the Council the opportunity to gather data on the impact the rule would have on retirement plans which, the SEC acknowledged in its proposal, "may face particular challenges with adhering to the proposed hard close requirement."

Dovetailing with the proposed rule change was also the recent passage of comprehensive retirement legislation at the end of 2022, which plan sponsors will need to absorb and begin to implement, providing additional challenges to gather meaningful comments.

IRS Proposes Permanent Extension of Remote Notarization; Companies Can Rely on Proposal Until Finalized

In a positive development long supported by American Benefits Council advocacy, the Internal Revenue Service (IRS) issued **proposed regulations** on December 30, 2022, permanently establishing remote witnessing rules similar to those provided during the COVID-19 pandemic. This flexibility was set to expire at the end of 2022. However, while technical questions have been raised, the intent is clearly to permit plans to rely on either the proposed regulations or the old regulations until the proposed regulations are finalized and effective.

Certain plan distributions require consent of a married participant's spouse, including lump sum distributions from defined benefit plans, distributions from money purchase plans, and payment of single life annuities from defined contribution plans. The Internal Revenue Code requires that the spouse's consent be witnessed by a notary or by a plan representative. Existing regulations on electronic administration allow for the use of electronic technology but require that the consent be witnessed in the "physical presence" of the notary or plan representative.

For several years, the IRS has provided temporary relief from the "physical presence" requirement for spousal consent relating to certain qualified plan distributions (initially in IRS Notice 2020-42 and subsequently extended three times through Notice 2021-3, Notice 2021-40 and Notice 2022-27). This flexibility allowed spousal consent to be obtained either through remote notarization consistent with state law or through similar audio-visual technology in the case of a plan representative witness.

The Council first advocated for this relief at the outset of the COVID-19 pandemic and urged regulators to make the relief permanent because the advantages of remote witnessing extend far

beyond the context of the pandemic, including reduced burdens on participants and spouses and increased security.

Although the proposed regulations do not technically extend the temporary relief described in Notice 2020-42, the proposal should allow many plans and providers to continue relying on their remote witnessing procedures without interruption, as the proposal's conditions are very similar to the conditions described in the IRS's temporary relief. The regulations are proposed to apply beginning on the date that is six months after the publication of final rule. However, as noted above, prior to the applicability date of the final rules, the preamble to the proposal indicates that taxpayers may rely on the rules set forth in the proposal.

The proposal differs from the temporary relief in two respects:

- Remote Notarization: Under the proposal, if a plan accepts remote notarization, it *must* also accept consents witnessed in the physical presence of a notary public. IRS guidance extending the relief announced in Notice 2020-42 contained similar, yet slightly different language addressing the availability of physical witnessing. Specifically, Notice 2021-03 stated: "During this temporary relief period, a participant is still able to have a participant election witnessed in the physical presence of a notary public and have that participant election be accepted by a plan in accordance with § 1.401(a)-21(d)(6)(i)."

- Remote Witnessing by a Plan Representative: Under the proposal, if a plan permits remote witnessing through a plan representative, the plan representative must record and retain the audio-video conference in accordance with standards specified in the proposal. This condition was not included in the IRS's temporary relief.

The IRS is soliciting comments on the proposed regulations through March 30, with a telephonic public hearing scheduled for April 11.

PBGC Participant and Plan Sponsor Advocate Issues 2022 Annual Report, Calls on Agency to Continue Finding Missing Plan Participants

The Pension Benefit Guaranty Corporation's (PBGC) Participant and Plan Sponsor Advocate, Constance Donovan, issued her **annual report** on December 30, 2022, echoing many familiar challenges plan participants and sponsors faced in 2022 alongside several policy recommendations.

The advocate position was established by the Moving Ahead for Progress in the 21st Century (MAP-21) Act of 2012 to assist participants and sponsors in resolving issues related to the agency. Since the beginning of her tenure in 2013, Donovan has worked extensively with the American Benefits Council as part of her commitment to reaching out to both the plan sponsor and participant community.

The latest report offers a critique of the agency for not doing more to "encourage the continuation and maintenance" of the private pension system – a part of its statutory mission –

arguing that "PBGC is in a unique position to preserve the defined benefit structure." For example, the report suggests that PBGC should consider whether premiums are too high to support continued plan sponsorship and how defined benefit plans can be modernized to incorporate popular defined contribution plan features.

The 2022 report identifies several specific issues affecting plan sponsors and participants:

- **Missing participants:** Regarding plan participants, although the report commends PBGC's initiatives to reconnect participants with unclaimed benefits, more still needs to be done to increase awareness of the resources and assistance available for missing participants. PBGC currently holds benefits for more than 80,000 missing participants. The report states: "Rather than waiting for these participants to contact the agency, PBGC should routinely conduct searches of its unclaimed pension database and take advantage of all available locator resources." This seems to indicate that searches for the 80,000 are not generally being done. The matter of missing retirement plan participants and the ongoing audits of plans on this issue continue to pose challenges for many plan sponsors in the absence of a safe harbor for what needs to be done to try to find missing participants. It is interesting to note that the audits helped approximately 7,000 participants in FY 2022, which is much less than the 80,000 missing participants at PBGC.

- **Pension risk transfer data inconsistencies:** The report states "risk transfer has far-reaching implications, especially for participants whose benefits lose PBGC's guarantee and protection as a result." This suggests that risk transfers create higher risks for plan participants, but hard data makes it clear that the opposite is true. A 2022 white paper from the Council found that "the authors of the paper are aware of no instances in which promised pension benefits from an annuity buy-out contract ultimately failed to be provided." On the contrary, "in a study of 500 plans trusteed by the PBGC between 1988 and 2012, the PBGC found that its three primary guarantee limitations — the maximum insurance limitation, the phase-in limitation and the accrued-at-normal limitation — reduced the benefits of 16% of all vested participants in those plans, totaling 187,000 individuals, reducing benefits by almost $8.5 billion, an average of over $45,000 per affected participant."

- **Success of pension funding stabilization:** The report affirms that defined benefit plan funding stabilization, first developed by the Council and enacted as part of the American Rescue Plan Act of 2021 (and extended via the Infrastructure Investment and Jobs Act of 2021), has improved the environment for pension plans. "While plan sponsors still face uncertainty in the post-pandemic economy, legislative relief for single-employer plans has helped make funding and maintaining these plans more predictable and affordable, resulting in fewer plan sponsors seeking to end their plans through a distress termination," the report noted.

The Council will continue to actively pursue reforms at the legislative level to improve various agency processes and address employer concerns about missing plan participants.