BENEFITS INSIDER

Volume 316, February 15, 2023
(covering news from February1-14, 2023)

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 REGULATORY ACTIVITY

Council Outlines Priority Regulatory Guidance, Technical Corrections for SECURE 2.0

The SECURE 2.0 Act, enacted in late 2022 as part of the Consolidated Appropriations Act 2023, has now entered the regulatory phase, with the U.S. Department of Labor (DOL) and U.S. Treasury Department generally responsible for implementing the law. Just as the American Benefits Council was closely involved with lawmakers in developing the legislation, we continue to work with executive branch officials to communicate plan sponsors' immediate guidance needs while also urging Congress to take up urgent technical corrections to the bill. This letter focuses on issues that are more immediate and it is expected that the Council will be doing additional communication regarding issues taking effect later.

Priority DOL Guidance

The Council's **February 7 letter to DOL** asks the agency to issue guidance on various time-sensitive issues identified in provisions of the SECURE 2.0 Act, including two provisions in the law with urgent implications to plan sponsors and retirees:

- **Group of plans reporting:** The original Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019 provided that a group of structurally similar plans (a "group of plans") may file a single, consolidated Form 5500 for plan years beginning after December 31, 2021. SECURE 2.0 provides that any audits with respect to the group may relate only to each individual plan that would otherwise be subject to an audit, were it not participating in the group (i.e., generally plans with 100 or more participants). Although DOL issued proposed regulations and reporting requirements with respect to groups of plans in 2021, those requirements have not been finalized. Final revisions to Form 5500 are needed for groups of plans to utilize the option to file a single, consolidated Form 5500. This provision was effective for 2022, needing further guidance.

- **Recovery of retirement plan overpayments:** In addition, SECURE 2.0 generally allows plan fiduciaries to decide not to recoup overpayments that were mistakenly made to participants. If plan fiduciaries choose to recoup overpayments, then limitations and protections on the amount and manner of the recoupment apply to protect participants. This provision is effective as of the date of enactment. However, the provision raises a number of questions with respect to the new limitations and protections for participants, requiring further guidance such as confirming that a plan fiduciary that previously sought (or is seeking) to recoup a prior overpayment that occurred before the date of enactment but who, following SECURE 2.0, would prefer to no longer seek recoupment, may revise the plan's treatment of the overpayment in accordance with the new provision.

Priority Treasury Guidance

The Council's **February 7 letter to Treasury and the Internal Revenue Service (IRS)** requests additional guidance on more than a dozen provisions in SECURE 2.0 with important, time-

sensitive issues with effective dates in 2023 that have implications for plan sponsors and retirees.

Most significantly, the Council is urging Treasury and IRS to issue guidance on the law's expansion of automatic enrollment. SECURE 2.0 requires 401(k) and 403(b) plans that are "established" on or after December 29, 2022, to include automatic enrollment and automatic escalation, effective for the 2025 plan year.

Guidance is needed regarding what it means for a plan to have been "established" on or after December 29, 2022. This guidance is critical so employers can be fully informed with respect to whether taking certain plan-related actions (such as merging their grandfathered plan into a MEP or PEP), or the timing of such actions, will affect whether the new requirement applies to their plan beginning in 2025.

Some other provisions needing time-sensitive guidance include:

- **Increase in RMD Age:** Due to the late date upon which SECURE 2.0 was enacted in 2022, plan sponsors and financial institutions may not have had time to make the necessary programming changes to stop notices or statements from being sent to individuals turning age 72 in 2023 stating that they must take an RMD for 2023. Guidance is necessary to ensure these individuals are not penalized as a result of the change in the law.

- **Roth employer matching or nonelective contributions**: Employers choosing to allow employees to designate employer contributions as Roth contributions need immediate guidance on the taxation, withholding and reporting requirements that apply to such contributions.

- **Catch-up contributions required to be Roth**: The legislation can be read to eliminate all catch-up contributions over the regular 402(g) limit, whether as pre-tax contributions or a Roth contribution which was not intended.

- **Recovery of retirement plan overpayments**: It is unclear how the effective date applies with respect to prior overpayments.

Legislative Technical Corrections

While the Biden administration may be able to provide limited relief, some outstanding issues were the result of errors in drafting the statutory language and must be fixed through technical corrections legislation.

The Council has provided to Congress and key committee staff **a list of important technical corrections**. We plan to update that list as new technical corrections are brought to our attention.

Some of the more significant technical corrections include:

- Repeal the glitch under which all SIMPLE and SEP contributions reduce the Roth IRA limit, effective this year.

- Repeal the glitch under which no catch-up contributions at all would be permitted, effective for 2024.

- Clarify whether governmental 457(b) plans can include pension-linked emergency savings accounts, effective for 2024.

The prospects for technical corrections legislation is uncertain, which is why the Council is urging Treasury and DOL to provide temporary non-enforcement relief until technical corrections can be enacted.

Biden Administration Issues Contraceptive Coverage Proposed Rule Related to Religious and Moral Objections

On January 30, the U.S. departments of Labor, Health and Human Services (HHS) and Treasury (collectively, the "tri-agencies") issued a proposed rule addressing coverage of certain preventive services under the Affordable Care Act (ACA) related to the law's contraceptive coverage requirement. The rules affect employers and other entities that have moral or religious objections to offering contraceptive coverage. These rules do not affect employers that do not have a religious or moral objection to covering contraceptives.

Under the ACA, in general, non-grandfathered group health plans are required to cover, without cost-sharing, certain preventive services, including items and services recommended by the Health Resources and Services Administration (HRSA) for women, including the full range of female-controlled Food and Drug Administration (FDA)-approved contraceptive methods, effective family planning practices, and sterilization procedures. These recommendations are periodically updated, most recently at the beginning of 2022.

The tri-agencies previously issued multiple rules and guidance implementing the contraceptive coverage requirement, including rules providing exemptions from the contraceptive coverage requirement for entities with moral or religious objections to contraceptive coverage. These rules provided accommodations for objecting entities so they would not have to provide contraceptive coverage, while at the same time providing a pathway for participants and beneficiaries enrolled in coverage sponsored by an objecting entity to separately obtain contraceptive services at no cost. During the period in which the tri-agencies issued these rules and guidance, organizations and individuals filed lawsuits challenging the contraceptive coverage requirement and regulations as being inconsistent with various legal protections, including the Religious Freedom Restoration Act (RFRA).

The proposed rule makes changes to provide enhanced access to contraceptive services, with the broader context being that the tri-agencies note that in their view, in light of the Supreme Court decision in *Dobbs v. Jackson Women's Health*, it is important for individuals to be able access contraceptive coverage without cost-sharing. Among other things, the proposed rule, if finalized, would:

- Eliminate the exemption from the contraceptive coverage requirement for entities that object to contraceptive coverage based on non-religious moral beliefs. The tri-agencies explain there have not been a large number of entities that have expressed a desire for an exemption based on a non-religious moral objection, the tri-agencies are under no

legal obligation to provide such an exemption, and that the RFRA would never apply to require such an exemption.

- Maintain the existing religious exemption for entities with sincerely held religious objections to providing coverage for contraceptive services.

- Allow entities that sponsor insured or self-insured group health plans, among others, that are exempt based on their religious objections to continue to be able to choose to invoke the "optional accommodation" under the current rules, under which the plan notifies HHS or its issuer or TPA of its objection and the issuer or TPA provides contraceptive coverage at no cost to participants and no cost to the plan.

- Provide a new pathway, independent from the employer or group health plan, through which individuals enrolled in plans or coverage sponsored by religious objecting entities can access contraceptive services at no cost from a provider, to address situations in which the objecting entity does not invoke the current optional accommodation, as described above. Through this new "individual contraceptive arrangement," an eligible provider of contraceptive services, who provides these services at no cost to the individuals receiving them, would be able to seek reimbursement from an issuer with whom it has a signed agreement for the cost of providing contraceptive services to individuals covered under these plans and, generally, the issuer can seek reimbursement from HHS.

We note that there continue to be legal challenges to the contraceptive coverage requirement, both as part of broad litigation challenging preventive services generally and specific litigation challenging the current contraceptive coverage regulations that were issued by the Trump administration. It is also possible that these new proposed regulations, once final, will be subject to litigation.

RECENT JUDICIAL ACTIVITY

Judge Rules in Favor of Providers, Again, in Surprise Billing Litigation

On February 6, a federal district court judge struck down pieces of final regulations issued by the U.S. departments of Labor, Health and Human Services and Treasury (collectively, the "tri-agencies") implementing the independent dispute resolution (IDR) provisions in the No Surprises Act (NSA). The ruling is a disappointment to the Council, as we had supported the tri-agencies' reasonable, common-sense rules and opposed provider groups' continued attempts to use the arbitration provision in the NSA to seek inflated payment amounts from health plans.

This case, *Texas Medical Association (TMA) et al., v HHS et al.* ("TMA II"), filed in the U.S. district court for the Eastern District of Texas relates to final regulations issued by the tri-agencies in 2022 establishing rules for the IDR process between plans and providers under the NSA (the "2022 final rules"). The regulations challenged by the providers set out some basic parameters for IDR entities (*i.e.*, no double-counting evidence, consider only credible information, etc.). Despite the modest nature of the 2022 final rules, provider groups took the position that the tri-

agencies exceeded their authority in issuing the rules and that the rules impermissibly prioritized the role of median in-network rates (or the "qualifying payment amount" or "QPA") in the IDR process.

The context here is that the same provider groups also previously sued the tri-agencies, in the same court, with the same judge, in a prior case ("TMA I") based on interim final regulations (IFR) issued in 2021, which included a rule that IDR entities were generally to choose the payment amount closest to the QPA (the QPA presumption). We strongly supported this aspect of the IFR, because by making the QPA central the rules were expected to lower health care costs. However, the TMA was successful in its challenge of the QPA presumption, with the judge ruling for the providers in TMA I.

Although the 2022 final regulations removed the QPA presumption, in TMA II, TMA argued the new, watered-down rules had the same effect as the QPA presumption. In TMA II, as in TMA I, the Council coordinated an effort, along with several other national and Texas-based employer groups, to file an *amicus* brief in support of the 2022 final rules. As stated in the Council's brief: "Although we would have strongly preferred the IFR, Amici now express support for the Final Rule because it is preferable to what plaintiffs suggest, which is an IDR system without clear guidelines, open to abuse and overuse, and leading to increased health care costs for plans and participants." The Council's brief explained that the tri-agencies had clear authority to issue the final rule, that the final rule is completely consistent with the NSA and that the final rule furthers Congress' intended public policy outcomes.

However, on February 6, the judge in TMA II ruled in favor of provider plaintiffs finding that the challenged portions of the 2022 final rule conflict with the NSA in that they improperly restrict arbitrators' discretion and unlawfully tilt the arbitration process in favor of the QPA. As such, the judge vacated (or struck down) the challenged portions of the rule. The provisions that were struck down provided that:

- The IDR entity should first consider the QPA and then consider other additional information,

- The IDR entity should evaluate whether information presented is credible and relates to the payment offer and should not give weight to information that is not credible, does not relate to the offer, or is already accounted for in the QPA or other information submitted, and

- The IDR entity must explain in its written decision, if it considers information already accounted for in the QPA, why it did so.

It remains to be seen whether the tri-agencies will appeal the ruling.

Meanwhile, TMA has filed two additional lawsuits – one filed last December, challenging some of the methodology used to calculate the QPA, arguing it is deflationary, and one filed in late January, challenging a recent increase in the fees associated with IDR. These two new cases are getting underway and we will report on significant developments.