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

Council Outlines Health Care Priorities in Letter to 118th Congress

With the 118th Congress in full swing and key committee chairs in place, The American Benefits Council is urging lawmakers to focus on health care policies that will support employers' ability to offer affordable, high-quality coverage to employees and their families.

In a **February 27 letter** to the U.S. Senate and House of Representatives leadership, the Council explained how Congress can unleash the power of employer engagement by lowering costs and removing barriers to innovation:

- Preserve and strengthen employer-provided health coverage: More Americans rely on employers for health coverage than any other source. This coverage represents a tremendous bargain for beneficiaries and the federal government and is a foundation upon which efforts to improve value and access should be built.

- Lower cost and improve value: Congress can and should take bold steps to address the root causes of rising costs and improve transparency for payers in the system. Any proposal that merely shifts costs to employers should be soundly rejected.

- Leverage telehealth to improve access and value: Barriers remain to realize the full potential of telehealth to improve access to affordable, high-quality care, especially mental health care.

- Combat the mental health crisis: Employer efforts to combat the nation's mental and behavioral health crisis must be supported by policies that strengthen the mental health provider workforce; leverage telehealth; increase integration, coordination and access to care; and promote the use of evidence-based behavioral health care.

The letter and its detailed appendix take a deep dive into 20 specific areas of focus for lawmakers under these four principles, supported by extensive research and polling data.

"Pursuing health care policy reform in a divided Congress is a challenge, but with every challenge comes opportunity," the Council's Senior Vice President, Health Policy, Ilyse Schuman said in a media statement supporting the letter's release." One clear direction Congress can follow is to strengthen the employer-provided health coverage system that is favored by Americans across the political spectrum."


Preserve and Strengthen Employer-Provided Health Coverage
Preserve the tax exclusion for employer-sponsored health insurance
Preserve nationwide uniformity for multi-state ERISA plans
Lower Health Care Costs and Improve Value
Expand site neutral payment reforms
Restrict hospital billing practices that fuel consolidation and mask appropriate payment amounts
Restrict anti-competitive contracting provisions
Ensure federal antitrust laws are fully applied to horizontal hospital integration
Support implementation of the *No Surprises Act*
Reject legislation that would exacerbate market failures
Support greater price transparency
Support quality transparency and meaningful, harmonized metrics
Support drug pricing transparency, competition and value, and increased PBM accountability
Remove barriers that impede employer initiatives to prevent or manage chronic conditions
Leverage Telehealth to Improve Access and Value
Make permanent the ability of plans and employers to allow HSA-eligible high-deductible health plans to cover telehealth services on a pre-deductible basis
Remove state barriers to telehealth
Safeguard robust employer plans with telehealth services so they do not violate ACA market reforms
Combat the Mental and Behavioral Health Crisis
Provide funding to expand and retain a diverse mental health workforce
Promote greater network participation by behavioral health providers and facilities
Enact policies that leverage telehealth to improve access to affordable, quality mental health care
Reject proposals to create new and unwarranted civil monetary penalties
Support the development of processes and programs to integrate behavioral health with primary care
Pass the Chronic Disease Management Act
Promote the use of evidence-based care

RECENT REGULATORY ACTIVITY

Agencies Issue Guidance on Group Health Plan Attestations Related to Gag Clause Prohibition

On February 23, the U.S. Departments of Health and Human Services (HHS), Labor and Treasury (the "tri-agencies") issued several pieces of guidance to implement the requirement under the Consolidated Appropriations Act, 2021 (CAA) that group health plans and insurers attest annually they are in compliance with the gag clause prohibition under the CAA.

In general, the gag clause prohibition under the CAA refers to the rule that a plan or insurer may not enter into an agreement with a health care provider, network or association of providers, third party administrator (TPA), or other service provider offering access to a network of providers that would directly or indirectly restrict a plan from: (1) providing provider-specific cost or quality of care information or data through a consumer tool or any other means, to referring providers, the plan sponsor, participants, or individuals eligible to become participants and (2) electronically accessing de-identified claims and encounter information or data. The gag clause prohibition was effective December 27, 2020, the date of enactment of the CAA.

This provision also required plans and insurers to annually submit to the tri-agencies an attestation that the plan/insurer is in compliance with the gag clause prohibition. In prior sub-regulatory guidance, the tri-agencies stated that the gag clause prohibition itself is self-implementing and thus noted they did not expect to issue regulations generally with regard to the prohibition provision and unless and until any further guidance is issued, plans and insurers are expected to implement the requirement using a good faith, reasonable interpretation of the statute. The tri-agencies did state, however, that they intended to issue guidance to implement the provision's attestation requirement.

On February 23, the tri-agencies issued several pieces of guidance to implement the gag clause prohibition compliance attestation including:

- A set of Frequently Asked Questions (FAQs) providing guidance on the gag clause prohibition and attestation requirement;
- A website for plans and insurers to use for submitting attestations, which is a module within the Health Insurance Oversight System and a related user manual;
- Instructions on how to submit the attestation; and
- A template for entities to use when submitting an attestation on behalf of multiple plans.

Of note, the FAQs provide helpful guidance regarding what types of provisions constitute a gag clause and provide some helpful examples (including cases in which a TPA asserts rate information is proprietary). The FAQs also confirm which entities are required to submit an attestation, including grandfathered plans and church plans, and which entities are not required

to submit an attestation, including plans offering only excepted benefits or account-based plans (such as health reimbursement arrangements).

The FAQs also provide important guidance on the attestation requirement including that:

- The first attestation is due no later than December 31, 2023, covering the period beginning December 27, 2020, or the effective date of the applicable plan (if later), through the date of the attestation.

- Subsequent attestations, covering the period since the last preceding attestation, are due by December 31 of each year thereafter.

- A service provider, like a PBM or TPA, may attest on behalf of a self-insured plan, assuming the plan enters into an agreement with the service provider to make the attestation (however the legal requirement remains with the plan).

- An insurer/TPA may submit a single attestation on behalf of itself, its fully-insured policy holders and its self-insured plan clients.

- A plan or insurer may authorize any appropriate individual within the organization to make the attestation and that a service provider that has been provided the authority to make the attestation on behalf of a plan or insurer may authorize any appropriate personnel within the organization to make the attestation.

- There can be different attestation submissions for different provider agreements (e.g., medical, pharmacy, behavioral health) (this is addressed in the instructions).

The agencies also include in the instructions contact information for a help desk.

Some of the guidance provided is consistent with requests made by the Council in prior communications, including providing a flexible definition as to which individuals may make the attestation and to allow TPAs and other service providers to make the attestation on behalf of plans. The Council welcomes feedback on areas where more guidance or clarity is needed.

More generally, the Council has long supported a gag clause prohibition along the lines of the CAA provision to help facilitate plan design decisions and network decisions as employers engage in efforts to provide high quality care as efficiently as possible. However, we understand that further work is needed on this front because even when employers and plans have access to their own plan data, anti-competitive contract terms at the network provider level often stand as obstacles to employer flexibility in implementing value-based plan designs. We continue to work to address those issues as well.

DOL Issues Final Revisions to 2023 Form 5500 Reporting Requirements

As suggested by the American Benefits Council, small retirement plans in defined contribution groups (DCGs) will be relieved from additional costs related to trust-level audits, according to finalized rules from the U.S. Department of Labor (DOL).

On February 24, the DOL, Internal Revenue Service and Pension Benefit Guaranty Corporation jointly published a Notice of Final Forms Revisions (NFFR) for the Form 5500 Annual Return/Report of Employee Benefit Plan for plan years beginning on or after January 1, 2023. The DOL separately released a final rule that conforms its reporting regulations to the Form 5500 revisions.

In the final NFFR, DOL decided not to adopt a proposed trust-level audit for a DCG, relieving small plans from being unnecessarily burdened by the associated costs. The Council had raised concerns with the proposed approach in communications with executive branch officials.

The final rule, however, does require separate audits of all large DCG plans.

In September 2021, DOL issued proposed rules and revisions to Form 5500 that would require a trust-level audit of a DCG, requiring participating plans in a DCG to use a "single trust" in addition to having the same trustee. The final revisions permit, but do not require, the DCG reporting arrangement to use a single trust.

Other key takeaways from the NFFR include:

- Large DCG plans can expect additional costs due to the requirement for separate audits of such plans.
- Information will be more easily accessible regarding participating employers in multiple employer plans and pooled employer plans.
- The NFFR adopts the proposal to change the method by which DC plans must count participants for purposes of determining whether they are subject to the large plan audit requirement.
- More Form 5500 proposals are likely on the way.

Agencies Clarify Air Ambulance Reporting Deadline for Group Health Plans

The U.S. Department of Health and Human Services (HHS), Labor and Treasury (the "tri-agencies") recently confirmed that the requirement that group health plans and insurers report information regarding air ambulance services, under the Consolidated Appropriations Act, 2021 (CAA), will not be due until after final regulations are issued (and no final regulations have yet been issued). This is a helpful confirmation as the tri-agencies had previously indicated reporting would first be due in March 2023, based on an assumption that final rules would be issued by now.

Under the CAA, air ambulance providers are required to report to HHS and the U.S. Department of Transportation (DOT) an array of information regarding the services they provide and, separately, group health plans and health insurers are required to report to the tri-agencies claims data for air ambulance services, disaggregated by several factors including emergency versus non-emergency services and network status. For both the provider and plan/insurer reporting requirements, the annual reporting is to take place over two years and

after that, HHS and DOT will provide a comprehensive public report synthesizing the reported information.

Per the CAA statutory provision, initial reporting is not due until more than a year following the issuance of final regulations (*i.e.*, "not later than the date that is 90 days after the last day of the first calendar year beginning on or after the date on which a final rule is promulgated").

In 2021, when the tri-agencies proposed regulations on these requirements, they stated they anticipated reporting would first be due March 31, 2023, because they anticipated releasing final regulations by the end of 2021, as required by the CAA. However, the tri-agencies have not yet finalized these regulations and this has caused some confusion.

Based on questions from plan sponsors, the Council raised this issue with HHS staff who confirmed informally that reporting would not be due until after regulations were finalized. Council staff indicated it would be helpful for the tri-agencies to confirm this in writing.

Last week, HHS updated its website to include on the webpage related to air ambulance reporting a statement that "[t]he final rules will specify the final reporting requirements, including the data elements and the deadlines for the data collection. The data collection will not begin until after the final rules are published." Based on the language in the CAA and the fact that final regulations have not been issued, this means that reporting will not be due in March 2023, as originally anticipated.

'Hard 4 p.m. Close' Proposal Would Harm Retirement Savers, Council Writes to SEC in Opposition

The American Benefits Council **submitted written comments** to the Securities and Exchange Commission (SEC) on February 14 in opposition to a revived proposal that would impose a "hard 4 p.m. close" on mutual fund orders and negatively impact participants in 401(k), 403(b), and 457(b) plans.

The SEC's proposed rule, which was advanced by the commission on November 2, would require a mutual fund, its designated transfer agent, or a registered securities clearing agency to receive any orders before the fund's pricing time (typically 4 p.m. ET) in order to obtain the current day's price. Consequently, this "hard 4 p.m. close" would prevent current day pricing, as permitted under the SEC's existing rules, when a direction to purchase or redeem mutual fund shares is received by an intermediary – such as a retirement plan recordkeeper or third-party administrator (TPA) – before the 4 p.m. deadline, and subsequently transmitted to the fund after such deadline.

The Council's comment letter emphasizes the harmful effects the proposal would have for retirement plan participants who rely on intermediaries to process and transmit their investment orders to mutual funds. That is, the proposal would disadvantage retirement plan participants by unfairly forcing them to accept significant delays between the time that they provide investment directions and the time that their investments are valued – a delay that would not be encountered by other investors. In addition, the Council expressed concerns with the ways in which a hard close would eliminate beneficial features that are currently available

to retirement savers and distort the investment selection preferences of plan sponsors and fiduciaries.

As discussed in the Council's letter, a hard close would also add significant costs to retirement plan administration. Because existing recordkeeping systems are largely designed and operated to only begin processing mutual fund orders after the funds have announced their daily net asset values, to comply with a hard close, all these systems would have to be reengineered to perform order processing without such information. Significant expenditures would be required to redesign recordkeeping systems, investment transaction processing systems, agreements and arrangements with fund families, participant-interactive systems, participant education and communication materials, as well as the contractual agreements with plan sponsors.

"While the Council appreciates the SEC's desire to implement its swing pricing proposal in an effort to combat the fund dilution that can occur during high-volume trading periods, the Council is concerned that the ongoing costs that would be incurred to operationalize swing pricing will be more harmful to fund investors than the dilution problems it is seeking to address. Moreover, the harms that would result from a hard close far outweigh any benefits that plan investors would experience through mandatory swing pricing," the Council said in its letter.

This concept was previously proposed by the SEC in 2003, but was never adopted, in large part due to concerns voiced by the Council about the negative impact on retirement and other individual savers.

RECENT JUDICIAL ACTIVITY

District Court Agrees with Council's Amicus Brief in Dismissing 401(k) Lawsuit

On February 7, the U.S. District Court for the Western District of Washington dismissed a class-action lawsuit brought against a plan sponsor for selecting certain target-date funds (TDFs) in its retirement plan. This is one of many similar lawsuits filed over the past year in which the American Benefits Council has provided *amicus* ("friend of the court") briefs in defense of the plan sponsor.

In the case of *Beldock v. Microsoft*, the plaintiffs alleged that the plan sponsor breached its fiduciary duties under ERISA by selecting a suite of BlackRock TDFs that underperformed available alternatives in its 401(k) plan. The Council filed an *amicus* brief in this case in November 2022.

This current string of lawsuits is notable because, unlike other fiduciary claims brought against plan sponsors in recent years (which have largely focused on fees), the plaintiffs in this string of lawsuits based their claims exclusively on the fact that some of the vintages in BlackRock's TDF series underperformed four of its largest peers over a specified prior period of time.

In granting Microsoft's motion to dismiss the suit, the court wisely adopted the rationale embodied in our *amicus* briefs and advanced by the Council for many years. The Council has

long maintained that any fiduciary claim must allege specific facts showing, or at least allowing a court to infer, a flawed fiduciary process, rather than merely alleging that other funds are less expensive or have performed better. It is not a fiduciary breach to include funds that are not the least expensive or that do not have the best past performance. It is only a violation of ERISA if the plan fiduciary used a flawed fiduciary process to choose the funds. If this standard were applied, as it was in the *Microsoft* decision, virtually all the underperformance and fee suits would be dismissed at the pleadings stage.

As part of its dismissal, the court provided the plaintiffs until February 17 to file an amended complaint addressing the deficiencies identified in the order. However, based on the rationale adopted by the court, it might be difficult for the plaintiffs to cure their complaint in a way that would survive a motion to dismiss.

The dismissal of the Microsoft case is an encouraging development in our ongoing effort to rebuff the frivolous lawsuits that have been brought against plan sponsors in recent years because the court's rationale applies equally to the fee and underperformance cases. While other cases in this string of lawsuits involving the BlackRock TDFs have similarly been dismissed in recent months, this dismissal is particularly noteworthy because the order accompanying the court's dismissal included a well-reasoned explanation of why plaintiffs need to make specific allegations demonstrating an imprudent process — exactly what the Council has been arguing for many years.

While the Council is hopeful other courts will adopt the rationale used to dismiss the case against Microsoft, we recognize courts reviewing similar claims in the past have been reluctant to dismiss those claims on similar grounds. Accordingly, the Council will continue to monitor these cases and explore ways to weigh in against frivolous fees and underperformance litigation.

District Court Ruling Casts New Doubts on DOL's Forthcoming Fiduciary Rule

The U.S. Department of Labor (DOL) reportedly continues to work on new proposed rules revising fiduciary standards for retirement plan investment advice, but a recent district court decision may make it more difficult for any forthcoming rule to address rollover advice – a likely key component of the proposal.

While the sweeping fiduciary rules finalized during the Obama administration were invalidated by a federal court in 2018, the DOL has issued subregulatory guidance in the form of the preamble to prohibited transaction exemption (PTE) 2020-02 and a set of FAQs that impose greater fiduciary responsibility on those that provide investment advice, including in the context of workplace retirement.

The subregulatory guidance sets forth DOL's new interpretations of the five-part test, especially as the test applies to advice to roll over assets from one retirement arrangement to another, and DOL's intended next steps. In unveiling these FAQs, DOL said it "anticipates taking further regulatory and sub-regulatory actions, as appropriate, including amending the investment advice fiduciary regulation, amending PTE 2020-02, and amending or revoking some of the other existing class exemptions available to investment advice fiduciaries."

Following the issuance of this guidance, American Securities Association (ASA) sued in federal court to invalidate the FAQs. On February 13, the U.S. District Court for the Middle District of Florida issued a decision that invalidates DOL's interpretation of a fiduciary in the context of rollover advice. The court upheld other aspects of DOL's guidance, specifically the rollover documentation requirements set forth in FAQ-15 for those using PTE 2020-02.

Very generally, the district court held that the regular basis component of the fiduciary definition is applied separately to "a plan," so advice to the same participant in the context of an IRA cannot be taken into account in determining whether advice is being given on a regular basis *to the plan*. This will make it extremely hard for DOL to treat rollover advice to plan participants as fiduciary advice, as the rollover advice to the plan participant is generally one-time advice if the IRA advice is disregarded.

While DOL is expected to appeal this aspect of the decision to the 11th Circuit Court of Appeals, this is the second court to come to reach the same conclusion (after *Carfora et al v. Teachers Insurance Annuity Association of America* in the U.S. District Court for the Southern District of New York) and a similar decision might arrive soon in a Fifth Circuit case brought by the Federation of Americans for Consumer Choice, though we do not know how that case will be decided.

Pending appeal, it remains unclear whether DOL will slow its work on its fiduciary proposal until this rollover issue is resolved (which could be years), move forward with a fiduciary proposal without the rollover aspect, or include its rollover position in its fiduciary proposal, assuming that it will win on appeal.