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 Urges Bipartisan Action on Health Cost Transparency as House Committee Holds Hearing

On March 28, the U.S. House of Representatives Energy & Commerce Committee Subcommittee on Health held a hearing on Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care, during which lawmakers heard from witnesses on how price transparency and competition can lower health care costs.

In a **statement for the hearing**, the American Benefits Council outlined key policy priorities that would support employers' efforts to lower health care costs for workers and their families through greater transparency and competition.

Drawing from our February 27 health care priorities letter to Congress, the Council is calling on lawmakers to:

- 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 and vertical integration.
- Support implementation of the No Surprises Act.
- Reject legislation that would exacerbate consolidation and market failures.
- Support greater price transparency.
- Support quality transparency and meaningful, harmonized metrics.
- Support drug pricing transparency, competition and value and increased pharmacy benefit manager (PBM) accountability.

The Council's written statement echoed much of the witnesses' testimony, with particular emphasis on the simplification and standardization of hospital pricing transparency and expanding the transparency of PBMs.

The following witnesses provided oral testimony to the committee:

- Benedic Ippolito, senior fellow in economic policy studies, American Enterprise Institute
- Chris Severn, co-founder & chief executive officer, Turquoise Health
- Marilyn Bartlett, senior policy fellow, National Association of State Health Policy

- Matthew Forge, chief executive officer, Pullman Regional Hospital

- Sophia Tripoli, director of health care innovation, Families USA (A member of the Alliance to Fight for Health Care, the diverse stakeholder coalition established by the Council to promote employer-sponsored coverage)

Congress can help improve hospital price transparency by creating more standards and prohibiting hospitals from posting anything beyond a dollar-and-cent price with the names of services in layman's terminology, Tripoli said.

Severn and Bartlett agreed that standardization would improve access to pricing data.

"Having a standard, a template, would be the first big step to get those prices out," Bartlett said. "And standard descriptions for everything."

Increased access to pricing data will enable market forces to work more effectively and efficiently, ultimately leading to better cost and quality outcomes, the Council wrote in its statement.

"When we get to full transparency, it would give policymakers the tools to intervene where prices have become completely irrational so we can actually bring down the cost of care," Tripoli said.

Council Weighs in with Senate Committee on Health Care Workforce Shortage

In a **March 20 letter** to the Senate Health, Education, Labor and Pensions (HELP) Committee, the American Benefits Council explained how key elements of our priority health policy agenda will help address the nation's health care workforce shortage.

The HELP Committee issued a request for information (RFI) earlier this month seeking solutions to this crisis following a Feb. 16 hearing exploring potential legislative solutions. The committee "intend[s] to identify bipartisan solutions to remedy our nation's health care workforce shortages and develop these ideas into legislation" this year.

In its letter to Committee Chairman Bernie Sanders (I-Vt.) and ranking Republican member Bill Cassidy (R-La.), the American Benefits Council offered several recommendations – including:

Strengthen and restructure federal graduate medical education (GME) programs to meet workforce needs by building the pipeline of primary care physicians and physicians practicing in underserved and rural communities.

- Diversify the health care workforce.

- Build the behavioral health workforce.

- Support the integration of primary care and behavioral health.

- Leverage telehealth.

- Address hospital and provider consolidation.
- Incentivize the use of the most effective and efficient providers.
- Build the nursing workforce.

According to a 2021 report from Mercer, by 2026, close to 23,000 primary care physicians will permanently leave the profession, leaving a vacuum of demand for primary care providers.

"We need a national health care workforce strategy to better meet the needs of patients in communities throughout the country without increasing costs for all consumers," the Council wrote.

The Council also contributed to similar letters from two other stakeholder coalitions.

The Alliance to Fight for Health Care (AFHC), a coalition of diverse stakeholders supporting employer-provided health care coverage organized by the Council, and the Consumers First Coalition (CFC), a diverse coalition of health policy stakeholders, each submitted to the committee.

AFHC's comments echo the Council's calls to expand and diversify the health care workforce and extend telehealth flexibilities for employers with high-deductible health plans.

Meanwhile, the CFC recommends establishing a "national health workforce committee" that would:

- Make recommendations to Congress about key policy changes needed to operationalize a national health workforce that meets the needs of our nation's families in the 21st century and beyond.
- Collaborate with the secretary of HHS to publish, implement, and update, on an annual basis, a systematic workforce development plan.

The CFC also recommends extending federal grant funding to improve working conditions and training to better retain staff in community health centers, health care organizations and some hospitals.

Council Testimony to Oregon Legislature Urges Changes to Bill Adding New Requirement for Retirement Plan Sponsors

As part of the American Benefits Council's ongoing scrutiny of state-level requirements that would impose new burdens on plan sponsors, on March 29 we submitted **testimony with the Oregon state Senate Committee on Labor and Business**, urging passage of an amendment to a bill that would alter the requirements of employers that either offer a retirement plan or participate in the state's OregonSaves retirement initiative.

Under Oregon Senate Bill (S.B.) 571, currently under consideration in the state senate, any employer that offers or provides contributions to an account under a 401(a), 401(k), 403(a),

403(b), SEP, SIMPLE, or 457(b) plan would be required to offer its employees the option to receive equal contributions to ABLE accounts in lieu of contributions to the employees' retirement accounts. A similar requirement would be imposed on those employers that participate in OregonSaves.

The Council's testimony opposes the bill, explaining that "S.B. 571 could potentially create a risk of litigation to Oregon under ERISA's preemption provision because the bill would interfere with the design and operation of ERISA-governed retirement plans by requiring such plans to provide that contributions that would otherwise be made to a retirement account may be directed outside of the plan to an entirely unrelated account."

However, the Council supports a proposed amendment to S.B. 571 that would amend Oregon's existing ABLE statute to add that "[t]he board shall provide information to designated beneficiaries regarding the potential impact to their benefits and services if contributions are made to a workplace retirement account."

RECENT REGULATORY ACTIVITY

Administration Issues Guidance for Employers on End of COVID-19 Emergency Period, Council to Follow Up with Analysis

The Biden administration **issued guidance** on March 29 in the form of Frequently Asked Questions (FAQs) regarding the impact of the anticipated end of the COVID-19 Public Health Emergency (PHE) and the COVID-19 National Emergency (NE) on participants, beneficiaries, and enrollees of group health plans and group and individual health insurance coverage. The FAQs cover:

- Coverage and cost-sharing requirements for COVID-19 treatments, vaccines and tests.
- Extension of certain timeframes for employee benefit plans, participants, and beneficiaries affected by the COVID-19 pandemic.
- Special enrollment periods for individuals who lose Medicaid and/or Children's Health Insurance Program (CHIP) coverage.
- HSA-compatible high deductible health plan coverage of COVID-19 tests and treatments.

The American Benefits Council wrote to the U.S. departments of Health and Human Services, Labor and Treasury on March 15 requesting guidance to address outstanding questions and issues regarding the impact of the end of the PHE and NE on employer-sponsored health plans. The Council is now reviewing this guidance to assess whether our concerns have been addressed.

Agencies Issue New Instructions for Prescription Drug, Health Care Cost Reporting

On March 27, the U.S. departments of Treasury, Labor and Health and Human Services (the "tri-agencies") issued updated instructions for the prescription drug and health care cost reporting requirements under the Consolidated Appropriations Act, 2021 (CAA 21), for the round of reporting due June 1, 2023, which will be based on 2022.

Under CAA 21, health plans and insurers are required to annually report to the tri-agencies certain information on prescription drug costs and health care spending. The tri-agencies are directed to use this information to provide a biannual public report on drug price and health care spending trends. The first round of reporting (for 2020 and 2021) was due December 27, 2022, with reporting due by June 1 for each year thereafter.

The tri-agencies have released an array of guidance implementing this provision and the Council has provided comments and spoken with tri-agency staff many times over the last several years, including successfully obtaining good faith reporting relief for the December 2022 reporting.

The Council, along with several other groups, recently submitted several guidance recommendations for the reporting due in June 2023. In the subsequently released updated instructions, the tri-agencies responded to some of our requests. Most importantly, the instructions provide that more than one reporting entity may submit the same data file on behalf of the same plan or issuer. This is an extension of prior guidance and is very important as it accounts for the fact that many plans, based on their design, are in a position where multiple reporting entities will need to submit data on their behalf, including the same data file type. (The updated instructions contain several other changes as well, which are summarized in the first few pages of the instructions.)

However, in other respects, the instructions do not reflect our recommendations. Most notably, we requested good faith reporting relief for the reporting due June 2023, both generally and, as a narrower ask, with respect to the reporting of average monthly employer and employee premiums (due to the complexity of this reporting and the fact that June 2023 is the first time this element is required). However, the instructions did not contain good faith relief in either form.

The agencies are accepting comments on the updated instructions through May 26, 2023. Because the reporting for the 2022 reference year is due June 1, 2023 (i.e., six days after the comment deadline) we do not anticipate changes to the instructions in response to those comments. However, those comments may be considered in the instruction or guidance that applies to future years.

Council Supports IRS Proposal for Permanent Remote Notarization for Spousal Consent

On March 29, the American Benefits Council submitted a **comment letter** in favor of the Internal Revenue Service's (IRS) proposal to make permanent its temporary relief from the "physical presence" requirement for spousal consent relating to certain qualified plan distributions.

Additionally, the Council has requested to testify on the proposed regulation at a hearing scheduled for April 11 to highlight some of the key reasons in supporting this proposal, including the Council's belief that remote witnessing can make the witnessing process for spousal consents more convenient, efficient and secure.

The temporary relief was originally included in IRS Notice 2020-42 and subsequently extended three times through Notice 2021-3, Notice 2021-40 and Notice 2022-27. It allows 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 has urged regulators to make the relief permanent because the advantages of remote witnessing.

While generally supportive of the proposal, there is concern with how the proposal would revise Example No. 3, which describes how the rules regarding electronic media apply to a pen-and-paper spousal consent and notarization that are subsequently transmitted electronically to the plan.

While the consent and notarization forms are transmitted electronically, the pen-and-paper consent and notarization are not made through use of electronic media and should not be subject to the "special rules for participant elections and spousal consents." The Council has requested revision of the proposed Example No. 3 for better clarity.

There is also concern about the timing rule that is implied by Example No. 3. The existing and proposed regulations do not specify whether the opportunity to review must occur before or after the plan receives the participant election or spousal consent, rather they merely specify that the opportunity to review must occur "before the election or consent becomes effective."

The proposal envisions a circumstance in which a participant election and spousal consent are transmitted to the plan, and after receipt by the plan, the participant and spouse are given an opportunity to review and confirm their election and consent. This is concerning because it implies that the opportunity to review must occur after the plan receives the election and consent, and the Council has also requested a revision to make clear the opportunity to review may be provided before the plan receives an election or consent.

Council Receives Answer from DOL on Reopening of QPAM Comment Period

In a **March 23 letter** to the U.S. Department of Labor (DOL), the American Benefits Council asked the agency to provide more information now regarding the reopened comment period on the proposal to amend Prohibited Transaction Exemption (PTE) 84-14 (the qualified professional asset manager (QPAM) exemption). According to DOL, "at least one interested party may have additional information to provide the Department that was not submitted by the comment deadline of January 6, 2023. Therefore, the Department is reopening the comment period to provide an opportunity for all interested parties to submit additional information."

The Council asked DOL for more background on why it is reopening the comment period. DOL answered the Council **by a letter** dated the next day. The letter explained that back in January, one coalition had contacted DOL explaining it wanted to "submit responses to questions raised at the November 17, 2022, public hearing, but the comment period expired before [the coalition] could obtain the necessary group membership approvals to submit the comment. [The coalition]

asked whether it would be possible for it to submit a comment late or otherwise informally respond."

QPAMs are investment advisers and other institutions that can process routine transactions between retirement plans and "parties in interest" that would normally be banned without an exemption under ERISA. 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.

Regarding the proposed amendment, 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.

The Council previously submitted two comment letters regarding the proposal on October 11, 2022, and January 6, 2023 – and also testified at the November 17, 2022, public hearing.

The Council welcomes the possibility of, in certain circumstances, reopening future comment periods when new facts or issues come to light that were not raised during the initial comment period.

Additional White House Budget Materials Illustrate Tax Policy Challenges, Implications for Employee Benefits

The White House Office of Management and Budget (OMB) released President Biden's fiscal year (FY) 2023 budget proposal on March 10, outlining the administration's policy priorities for the next year. Following the release of the budget document itself – which included numerous proposals related to health, retirement and paid leave policy – the White House issued its annual **Analytical Perspectives document**, which provides additional context for the policy proposals.

Most notably, the Analytical Perspectives includes the ten-year cost of federal tax expenditures – the revenue lost or forgone as a result of current tax policy.

Health Tax Expenditures

The report identifies the "exclusion of employer contributions for medical insurance premiums and medical care" as the largest income tax expenditure in the federal budget (approximately $3.4 trillion over ten years – up from $3 trillion in last year's budget). While there is no active, serious proposal in Congress that would eliminate or curtail this tax exclusion, such measures have been floated as a potential, substantial source of federal revenue – or precursor to large-scale health reform – by lawmakers in both parties.

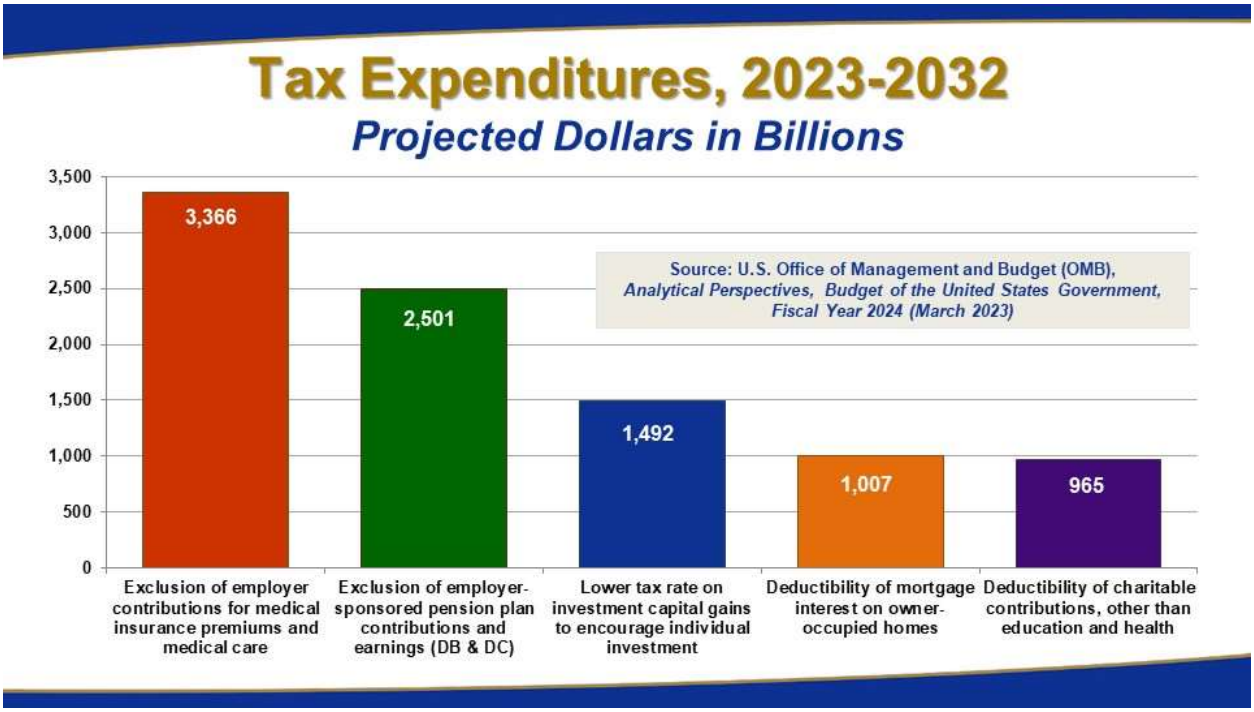
The Council will continue to defend this tax exclusion as an essential and powerful component of America's employer-based health coverage system, as it encourages employers to provide coverage much more efficiently than the federal government would otherwise. A rough calculation performed earlier this year (based on Joint Committee on Taxation and Bureau of Economic Analysis data) found that employer plans provide $4.64 of health benefits for every $1 of tax revenue lost attributable to the exclusion in 2021.

Retirement Tax Expenditures

Additionally, if the tax deferrals for 401(k) plans and the tax exclusion for employer-provided pension contributions and earnings are combined, the total forgone tax (just over $2.5 trillion over ten years – up from $2.2 trillion in last year's budget), would be No. 2 on the list.

In discussions with policymakers and the media, the Council always emphasizes that the characterization of retirement plan tax incentives as a tax "expenditure" is misleading since these incentives involve a deferral of tax, rather than tax loss. Because retirement plan assets are taxed when the participant takes a distribution from the plan, the tax revenue is eventually collected. Furthermore, the tax collected from retirement plan distributions results in a revenue gain for the federal government since the amount taxed includes matching and/or non-elective contributions and the earnings on the savings over time, along with the original deferral.

As with the health tax exclusion, there are no pending proposals to change the tax treatment of retirement plan contributions, but the significant revenue effects of these tax incentives for employer-sponsored benefits is a lucrative target for lawmakers seeking to pay for other policy priorities.



RECENT JUDICIAL ACTIVITY

Texas Court Vacates Part of ACA Preventive Service Requirements

On March 30, 2023, Judge Reed O'Connor, of the U.S. District Court for the Northern District of Texas, issued his long-awaited **opinion and order in Braidwood Mgmt. Inc. v. Becerra**, on the

appropriate remedy for his September 7, 2022, finding that the U.S. Preventive Services Task Force (USPSTF) experts' appointments violated the Constitution's Appointments Clause.

In the March 30, 2023, opinion and order, the court vacated all actions of the U.S. departments of Health and Human Services, Labor, and Treasury (the "tri-agencies") implementing and enforcing the Affordable Care Act's (ACA) requirement to cover without cost-sharing USPSTF preventive services with "A" or "B" ratings. The order also enjoined enforcement of those requirements in the future. The court also found that the PrEP (a medication taken to prevent HIV contraction) mandate violates the plaintiffs' rights under the Religious Freedom Restoration Act (RFRA) and enjoined the tri-agencies from enforcing the PrEP mandate against the plaintiffs.

The Council has asked Treasury and the IRS to provide further guidance on this issue pursuant to IRS Notice 2013-57, which sets forth how qualified preventive services can be provided pre-deductible. On March 30, the Council and its fellow members of the Smarter Health Care Coalition – a diverse group of health care stakeholders dedicated to removing barriers to high-value, evidence-based health care services and medications – sent **a letter urging Treasury and the IRS** "to continue to allow these high-value services to be provided pre-deductible in HSA-eligible plans, including issuing clear guidance that clarifies how this will be supported."

Both parties in the lawsuit can appeal the decision to the 5th Circuit within 60 days. It is also possible that the plaintiffs will appeal the court's decision with respect to the ACIP and HRSA claims. We expect that the tri-agencies will ask for a stay of the decision pending appeal. The district court is not required to grant such a stay, and if it does not, the tri-agencies could request a stay from the 5th Circuit.

In the short term, the court's ruling appears unlikely to have an immediate impact on most plans and issuers. However, if the decision remains intact, plans and issuers could have significantly more flexibility in the manner in which they cover certain preventive services, absent congressional action to the contrary.

Council Files Another Amicus Brief in Support of Surprise Billing Regulations

The American Benefits Council filed an **amicus ("friend of the court") brief on March 17** in support of regulations issued by the U.S. departments of Treasury, Labor and Health and Human Services (the "tri-agencies") implementing certain important aspects of the No Surprises Act (NSA) of 2020 (which was enacted as part of the Consolidated Appropriations Act, 2021). The Council's brief is part of our ongoing efforts to defend the NSA and its twin goals of protecting consumers from "surprise" medical bills and lowering health care costs system wide.

The case at issue is the third round of litigation filed by the Texas Medical Association (TMA) in the U.S. district court for the Eastern District of Texas challenging various tri-agency regulations implementing the NSA. In the prior two cases, TMA challenged regulations establishing the independent dispute resolution (IDR) process between plans and providers. In those cases, referred to as "TMA I" and "TMA II", TMA essentially argued that, in deciding which parties' offer should be chosen as the final out-of-network payment amount, IDR entities should not be

instructed to give the median in-network rate ("qualifying payment amount" or QPA) any more weight than the other factors under consideration.

In the current case ("TMA III"), the provider plaintiffs have shifted their focus to the tri-agency regulations establishing how the QPA is to be calculated, asserting that the regulations deflate the QPA and therefore reduce the amounts they could receive through IDR. The Council has previously supported these regulations as reasonable and fully consistent with the NSA and its goals. In the recently filed amicus brief, which was coordinated by the Council and joined by several other national and Texas-based employer groups, we explain that employers have an immense interest in the implementation of the NSA and that the QPA calculation is particularly important because it is the basis for participant cost-sharing and is a factor that must be considered in IDR. As the brief said:

"Unfortunately, Plaintiffs now seek to undermine the methodology used to determine the QPA in an effort to upset the considered judgment of Congress and the NSA as a whole. Furthermore, rather than acknowledge that a principal goal of the NSA is to bring down healthcare costs, Plaintiffs seek to increase the administrative complexities and associated costs with calculating the QPA. This series of assaults, taken together, would untether the operation of the NSA from its text as well as Congress' intent. In short, having disagreed with the carefully crafted Congressional bargain struck in the form of the NSA, Plaintiffs now seek to prevent its implementation through an obvious litigation strategy of dismantling the NSA, piece by piece."

The brief also explains that, not only do the regulations properly implement the NSA, they also align with the NSA's goal to drive down health care costs. A hearing in this case will take place on April 19 and an opinion from the judge is expected sometime after that.

In a separate but related update, on March 17, the tri-agencies updated the subregulatory guidance for IDR entities to reflect the court's ruling in TMA II. It is not yet known if the tri-agencies will appeal the ruling in TMA II but they will need to make that decision by April 7 (60 days from the TMA II ruling).

The tri-agencies have indicated they are working on additional proposed regulations related to IDR, which could come as soon as this month.