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 Testifies for Two House of Representatives Hearings on Lowering Health Care Costs, Increasing Competition

In two separate congressional hearings on Capitol Hill on April 26, witnesses for the American Benefits Council expressed support for legislation to lower health care costs by increasing fairness, competition and transparency.

The hearings represent the launch of House Republicans' health policy agenda, which includes 20 separate legislative proposals and discussion drafts. The Council was the only employer organization invited to testify and urged lawmakers to address the reasons for high health care costs and provided specific recommendations on how to do so. Earlier this year, the Council issued its priority legislative health care objectives for the 118th Congress, which featured prominently in the **Council's testimony**.

Education and the Workforce Committee Health, Employment, Labor and Pensions (HELP) Subcommittee

The Education and the Workforce Committee's HELP Subcommittee held a hearing, "Reducing Health Care Costs for Working Americans and Their Families." Tracy Watts, senior partner and US health policy leader at Mercer, and immediate past chair of the Council's Policy Board of Directors, testified before the subcommittee jointly on behalf of Mercer and the Council. Citing the need to lower costs and improve choice and flexibility for employers and employees, she expressed support for the following three matters that were the subject of the hearing:

- Dishonest billing practices, such as additional provider fees that are typically driven by consolidation and lack of competition in the health care market.
- Medical stop-loss insurance: the Self-Insurance Protection Act (H.R. 2813) would exclude from the definition of "health insurance coverage" certain medical stop-loss insurance obtained by employer-sponsored plans.
- Telehealth: the Telehealth Benefit Expansion for Workers Act (H.R.824) would allow employers and health insurers to provide stand-alone telehealth coverage as an excepted benefit.

Watts' testimony cited extensive Mercer research underscoring the health care affordability challenge for both employers and employees. **According to survey data**, 68% of employees say they have challenges getting health care for themselves and their family, while two-thirds of large employers said that "improving healthcare affordability" is an important or very important health program priority for the next few years.

"Employers and employees are focused on the need to reduce costs while maximizing access," Watts told the panel. "As a country, we cannot fix this problem if we cannot see the problem. If we are serious about managing costs and making health care more affordable, we need to address the core issues."

Asked by Subcommittee Chair Bob Good (R-VA) why competition is a good thing in a health care marketplace, Watts responded, "Competition is good everywhere, but with the lack of competition, we see… unfair billing practices, where providers can charge what they want to

for services. The [consumer] savings … from site-neutral payment reform, from focusing on more transparency with billing, are enormous: hundreds of millions of dollars."

Watts and other witnesses also took the opportunity to assess the long-term success of the Affordable Care Act. Representative Virginia Foxx (R-NC), chair of the full committee, asked how employer-provided coverage compared to individual market coverage. Watts replied that employer coverage is "superior," with lower premiums, deductibles and out-of-pocket costs, as well as more options through broader networks. She also emphasized that the employer-sponsored system drives employers to innovate and embrace more efficient models of coverage.

In a discussion about the rise in popularity of telehealth during the pandemic, Watts noted that the pandemic not only compelled individuals to try telehealth but also helped keep people healthy by diverting them from hospital settings. The increased use of telehealth has also helped address a health equity issue with regard to behavioral health, she said.

The Alliance to Fight for Health Care (AFHC), a coalition of diverse stakeholders supporting employer-provided health care coverage organized by the Council, also submitted a statement for the record for this hearing.

Descriptions of the testimony of other witnesses and a discussion of some of the other topics addressed during the hearing can be found here.

Energy and Commerce Committee Health Subcommittee

In a memorandum announcing the hearing, Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care, the Energy and Commerce Committee's Health Subcommittee acknowledged a lack of transparency and market consolidation as drivers of high costs.

Ilyse Schuman, the Council's senior vice president, health policy, **testified before the panel**, saying "The only way to truly make health care more affordable for working families is to understand and address the root causes of rising health care spending," and urged lawmakers to advance legislation that would:

- Expand site-neutral payment reforms.
- Restrict hospital billing practices that fuel consolidation and mask what should be the appropriate payment amounts.
- Support greater price transparency in the health care system.
- Require greater transparency and oversight of pharmacy benefit managers.

Schuman's testimony highlighted the need to enshrine transparency into law, like the PBM Accountability Act, so employers can access information needed to help manage costs. During the question-and-answer period, she answered numerous questions regarding transparency.

Responding to a question from Rep. Tony Cárdenas (D-CA), she noted that employers need to understand the true costs of drugs and affirm that savings are flowing back to plan sponsors to be shared with employees. Echoing her response to similar questioning from Subcommittee Chair Brett Guthrie (R-KY), she noted that "[employers] don't know what they don't know. Having transparency is foundational to restoring competition with respect to pharmacy and enabling employers to have the tools to better manage costs."

With the annual growth in national health spending expected to reach nearly $6.8 trillion by 2030, Rep. Bob Latta (R-OH) asked what Congress can do to get more employers involved so the burden of health care coverage does not fall on the federal government. Schuman replied that "proposals that take aim at anti-competitive contracting clauses that tie the hands of employers from pursuing value-based designs is critical," as market competition shrinks due to health system consolidation.

These consolidated markets can also make it harder for employers to design health plans that might incentivize employees to go to a different hospital or practice that may be less expensive and provide higher quality care, Schuman added.

As Schuman did in her formal statement to the subcommittee, another witness, Loren Adler of the USC-Brookings Institution Initiative for Health Policy, concurred noting that "not having site-neutral payments creates a very large financial incentive for doctors to go work for a hospital or for hospitals to buy up physician practices. That has effects on commercial markets as well. We have more and more evidence that this vertical consolidation, when the hospital goes and buys up a bunch of physical practices, tends to increase costs."

The Alliance to Fight for Health Care also submitted a statement for the subcommittee hearing record.

Additional information on measures under consideration by the subcommittee, that the Council supported and a brief description of the testimony of other witnesses can be found here.

Momentum Grows for State-Run Auto-IRA Programs

The American Benefits Council continues to pay close attention to efforts at the state level to expand retirement coverage in ways that could burden existing employer-sponsored plans or impose alternative rules on retirement plans. Generally speaking, these laws require employers without a retirement plan to enroll its employees in an automatic payroll-deduction IRA or similar vehicle.

We are seeing increased momentum in the development and launch of such programs. The first three state programs were implemented at the pace of roughly one per year, whereas the next three programs were implemented over the span of less than a year. A seventh program, in Virginia, is expected to launch by July 1, 2023.

In particular, there has been consistent movement toward using a hybrid fee approach (instead of a solely asset-based fee approach), among both the more established programs and the newer programs. For instance, in California in December 2022, the CalSaversboard approved a resolution to move to a hybrid fee structure, as OregonSaves has already done. This movement is motivated at least in part by the fact that actual program asset growth has generally fallen short of early projections.

As in recent years, we continue to see steady interest by states that have not yet enacted a mandatory retirement program in considering legislation for an auto-IRA program. Concerning language continues to appear in bills and program guidance that could affect plan sponsors and raise ERISA preemption concerns. Thus far in 2023, for example:

- A mandatory auto-IRA bill introduced in **Massachusetts** would require certain employers to participate in the program except to the extent that they offer "each" eligible employee the opportunity to participate in a qualified retirement plan or payroll deduction IRA.
- A mandatory auto-IRA bill introduced in **Minnesota**, although unclear, appears to limit its exemption for plan sponsors to those employers who sponsor or contribute to a retirement savings plan, where such plan must be offered to "all" employees except for those who do not meet the "participation eligibility requirements" permitted under federal law. The bill also fails to limit the employees who would be subject to automatic enrollment in the proposed program to only those employees in Minnesota, which could be problematic for multistate employers.
- In **Connecticut**, a proposed regulation for the MyCTSavings program would require an employer that is exempt from the program mandate to certify that it is exempt. The proposal further appears aimed at subjecting an exempt plan sponsor to civil action if the exempt plan sponsor fails to certify its exemption by a specified deadline.

And updates in other states include:

Implemented Programs

- The **Colorado** Secure Savings Program launched on January 18, 2023. The registration deadline for employers with 15 to 49 employers is May 15, 2023.
- The MyCTSavings registration deadline for employers with five to 25 employees was originally set for March 30, 2023, but was recently extended to August 31, 2023.
- The OregonSaves registration deadline for employers with one or two employees and employers that are clients of professional employer organizations (PEOs) is July 31, 2023.

Programs Under Development

- The **Delaware** EARNS Program interviewed executive director candidates in March 2023.
- As recommended by the Council in 2022, a bill was introduced in January 2023 that would amend the definition of "covered employer" in the **Hawaii** Retirement Savings Act to provide an exemption for employers that "offered or maintained *for some or all* employees at any time" [emphasis added] during the preceding two years a tax-qualified retirement plan. This is helpful legislation that would modify the current definition of "covered employer," which exempts only plan sponsors whose plan is maintained "for all employees."
- The **Maine** Retirement Savings Program has reportedly indicated that a pilot launch is being targeted for fall 2023. The program has also hired an executive director.
- The **New Jersey** Secure Choice Savings Program approved the hiring of an executive director in December 2022.
- RetirePath **Virginia** launched a pilot program in early 2023. The full program is expected to launch on or before July 1, 2023.

Pending Legislation

- In addition to **Massachusetts** and **Minnesota**, as noted earlier, mandatory auto-IRA (or similar) bills have been introduced in 2023 and remain pending in **Nevada**, **Pennsylvania**, **Rhode Island**, **Tennessee** and **Vermont**.
- It should be noted that Vermont enacted a state-run multiple employer plan (MEP) in 2017, which, despite efforts to implement the plan, does not yet appear to have launched. It is unclear whether the Vermont bill to establish an auto-IRA program is intended to replace or supplement the enacted state-run MEP. There has been a trend in states moving toward the consideration of programs that include an employer mandate (such as New York (enacted) and New Mexico (proposed)) as concerns have grown about the feasibility of programs in which employer participation is merely voluntary.

RECENT REGULATORY ACTIVITY

COVID-19 National Emergency Ends Early, Does Not Impact Health Plan Guidance

On April 10, President Biden signed into law joint resolution (H.J. Res. 7) to end the COVID-19 National Emergency (NE), effective that day, about a month earlier than the May 11 end date the administration had previously announced. The administration has informally indicated, however, that this change will not affect the end of the "outbreak period" for purposes of related health plan timeframes.

The expiration of the NE raised a potential issue for plan sponsors because of COVID-19-related guidance tied to the duration of the NE. Specifically, the U.S. Department of Labor and Treasury Department had previously extended certain important health plan timeframes (*e.g.*, deadlines for COBRA elections, COBRA premium payments, special enrollment periods and claims) during the pandemic. These timeframes were extended until the earlier of one year from the date the participant was first eligible for relief or 60 days after the announced end of the NE.

The agencies had announced the outbreak period would end July 10, 2023, 60 days after the announced end of the NE on May 11, 2023. When the end of the NE was pushed to April 10 per the joint resolution, questions arose as to whether that would mean the outbreak period would end earlier than previously announced.

Council staff raised this question to DOL and the agency provided informal, verbal guidance in response that July 10, 2023, is still the end of the outbreak period, notwithstanding the change to the end of the NE. DOL wrote in the recently issued FAQs, the agencies provided that the outbreak period continues until 60 days after the announced end of the NE *or another date announced by DOL, Treasury and the IRS.*

It is unclear whether the agencies will provide formal, written guidance, but we will report on anything that is issued. It is important to note the joint resolution does not change the end of the COVID-19 public health emergency (PHE), which is relevant for various other forms of relief and requirements.

Council Testifies Before IRS, Recommends Permanent Remote Notarization

In an April 11 public hearing, the American Benefits Council urged the Internal Revenue Service (IRS) to permanently permit remote witnessing for the spousal consents that must accompany certain qualified plan distributions and elections, arguing that remote witnessing can make the witnessing process for spousal consents more convenient, efficient and secure.

As we have previously reported, temporary relief from the physical presence requirement was originally included in IRS Notice 2020-42 and was subsequently extended three times through Notice 2021-3, Notice 2021-40 and Notice 2022-27. This temporary relief, which technically expired at the end of 2022, allowed spousal consents to be remotely witnessed by a notary public consistent with state law or through similar audio-visual technology in the case of a plan representative witnessing.

The Council first advocated for this relief at the outset of the COVID-19 pandemic and has consistently urged regulators to make the relief permanent because of the advantages of remote witnessing. In December 2022, the IRS issued proposed regulations that would permanently permit the use of remote witnessing under conditions that are very similar to the conditions that applied under the temporary relief granted in response to the pandemic. The proposed regulations may be relied upon until they are finalized. On March 29, the American Benefits Council submitted a **comment letter** generally supporting the proposed regulations.

The Council's April 11 testimony, provided by Adam McMahon, partner with Davis and Harman LLP, emphasized our strong support for the proposal because remote witnessing can offer a more secure, efficient, and convenient alternative to traditional in-person witnessing. Aside from our strong support for the overall proposal, McMahon also reiterated the Council's concerns with a revised example in the proposal suggesting that the IRS's electronic media rules apply to a pen-and-ink spousal consent witnessed in the physical presence of notary if such consent is subsequently scanned and electronically transmitted to the plan.

Also providing testimony to the IRS were:

- Amy Matsui (National Women's Law Center)
- James Fulgenzi (Notarize, Inc.)
- Norman Stein (Drexel University/Pension Rights Center)
- Michael Hadley (On behalf of SPARK Institute)

Opponents of the remote witnessing proposal recommended additional regulatory conditions that the IRS should add to both in-person and remotely witnessed spousal consents (for example, two-factor authentication for all spousal communications, a requirement to visually scan the room where a spouse is providing consent, plan liability for invalid witnessings and a recording requirement for remote notarizations). Because these conditions were not part of the proposal, one of the proposal's supporters suggested that, if Treasury and IRS intend to add new conditions to the rules for in-person witnessings, they should consider the extent to which additional notice and comment is needed.

Supporters of the rule received questions about additional remote witnessing conditions that they may be willing to support. For example, in the case of consents witnessed by a notary,

speakers were asked whether they would support an express recording requirement (a condition that only applies under the proposal when remote notarizations are performed by plan representatives). In response, one of the speakers explained that this is already required by state laws that permit remote notarization. Additionally, Treasury and IRS officials asked questions about how, and with whom, recorded notarizations are shared. These questions were apparently aimed at finding out whether plan administrators currently receive access to recordings of remote notarizations. During the hearing, Treasury and IRS officials also asked the proposal's supporters for additional information on how the proposed recording requirement could be impacted by state laws that require parties who are being recorded to provide consent.

SEC Gets Bipartisan Pushback on "Hard Close" Proposal

Lawmakers of both parties and in both houses of Congress have expressed serious concerns with the recent Securities and Exchange Commission (SEC) proposal imposing a "hard 4 p.m. close" rule on mutual funds.

The SEC's proposed rule, which was advanced by the commission on November 2, 2022, 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. Eastern Time) 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 American Benefits Council submitted written comments in February on the negative implications the "hard close" rule would have retirement plans. "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. The Council has shared our comment letter with key legislative staff and encouraged their engagement on the issue.

In recent weeks, the Council has been active in educating members of Congress and key committees on the harms of the proposal, sharing **a paper detailing plan sponsor concerns**. We encourage member companies to use these talking points in their own Capitol Hill outreach and advocacy.

Bipartisan Letter from Tax Committee Leaders

On April 20, the chairs and ranking minority members of the U.S. House of Representatives Ways and Means Committee and the Senate Finance Committee **wrote to Securities and Exchange Commission Chair Gary Gensler** to express deep concerns with the hard close proposal put forth by the SEC.

Ways and Means Chair Jason Smith (R-MO), the committee's ranking Democrat Richard Neal (D-MA), Finance Committee Chair Ron Wyden (D-OR) and the committee's ranking Republican Michael Crapo (R-ID) wrote that under the SEC's proposed changes "retirement plan participants will be harmed through no fault of their own…" and highlighted how the SEC would "create a two-tiered system that would disadvantage a significant percentage of investors."

This letter parallels similar bipartisan opposition from Congress 20 years ago when the SEC proposed a similar hard close, after which the proposal was shelved.

House Financial Services Committee Hearing

On April 18, the U.S. House of Representatives Financial Services Committee held an oversight hearing with Gensler, who faced a number of tough questions on a range of issues including bipartisan resistance from lawmakers on the agency's proposed hard 4 p.m. close rule.

During the House hearing a bipartisan group of committee members pushed back on the proposal and challenged Gensler with pointed questions on the issue. Representative Zach Nunn (R-IA) described the negative impacts of a hard 4 p.m. close, noting "The rule would limit access to trading and impose additional costs on hardworking Americans' 401(k) plans, our nurses with 457(b) plans, teachers with 403(b) plans, and in fact [the SEC] proposal acknowledges that these middle-class investors may lose their ability to manage their investment through the close of the stock market each day," he said.

The hard 4 p.m. close could lead to a bifurcated market for investors who use intermediaries such as 401(k) plans or other retirement accounts, added Rep. Steven Horsford (D-NV), who noted that investors in on the West Coast would miss out on that day's price if they can't get their trades in by nine a.m. Pacific Standard Time. Subsequently, Rep. Dan Meuser (R-PA) asked Gensler if the SEC consulted with the U.S. Department of Labor to study the costs to retirement plan investors borne from the proposed amendment.

In response to these and other "hard close" questions Gensler offered only a high-level defense of the SEC's proposal.

In a bright spot, Gensler offered a positive outlook on the future use of electronic delivery. Responding to Rep. Wiley Nickel's (D-NC) discussion on his legislation, the Improving Disclosure for Investors Act (H.R. 1807) – which would direct the SEC to permit financial firms to provide disclosures to investors electronically – Gensler said that he looks forward to reading the bill and that his believe that "what was once done in paper, can be done electronically."

The bipartisan letter and dialogue on the "hard 4 p.m. close" issue demonstrates the scope of continued congressional objections to the SEC's flawed approach. The Council will continue to educate lawmakers on the implications of this proposal for retirement plan sponsors and participants.

Council Outlines Plan Sponsor Concerns with FTC Non-Compete Proposal

In April 19 **written comments**, the American Benefits Council urged the Federal Trade Commission (FTC) to withdraw its recent notice of proposed rulemaking prohibiting certain

non-compete clauses, calling it "overly broad" and "fails to provide a framework that could be used to craft a more targeted and effective final rule."

The FTC proposal, issued on July 19, would "provide that it is an unfair method of competition for an employer to enter into or attempt to enter into a non-compete clause with a worker; to maintain with a worker a non-compete clause; or, under certain circumstances, to represent to a worker that the worker is subject to a non-compete clause."

The proposal is broadly applicable, as the Council's comment letter notes, and "would bluntly prohibit all non-compete agreements, with virtually no exceptions." In addition to concerns with the proposal's blanket prohibition on non-compete arrangements and its vague application to "de facto" non-compete arrangements, the Council emphasized the potential of the proposal to interfere with existing benefit arrangements that are offered to former employees in accordance with applicable federal law.

The Council's letter recommends the FTC not issue a re-proposal until after it has had an opportunity to further consider: (1) exceptions for non-compete agreements that serve valid public policy goals, such as forfeiture for competition clauses, and (2) additional guidance for employers on how they can draft agreements, such as non-disclosure and non-solicitation agreements, that would not be viewed by the FTC as non-compete agreements.

Council Discourages Additional Reporting or Other Requirements to Self-Corrected Loans

In **April 17 written comments** to the U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA), the American Benefits Council reaffirmed its support for the agency's proposed expansion of benefit plan self-correction processes.

The EBSA recently reopened the comment period for the proposed changes to its Voluntary Fiduciary Correction Program (VFCP) to address provisions in SECURE 2.0 that instruct DOL to treat plan loan failures that are self-corrected in accordance with the updated version of the Internal Revenue Service's Employee Plans Compliance Resolution System (EPCRS) as satisfying DOL's VFCP program.

Although Section 305 of SECURE 2.0 directs DOL to treat any plan loan failure that is self-corrected through EPCRS as also meeting the requirements of VFCP, it also authorizes — but does not require — the U.S. Secretary of Labor to impose reporting or other procedural requirements on parties who intend to rely on VFCP for self-corrected plan loans.

As stated in its April 17 letter, the Council does not believe DOL should impose any reporting or procedural requirements in connection with the self-correction of an eligible inadvertent failure relating to a plan loan beyond what is required by EPCRS, as amended by SECURE 2.0.

The Council continues to support the self-correction methods under DOL's proposed amendments to its VFCP and Prohibited Transaction Exemption 2002-51, as "we believe the proposed changes will increase the efficiency and flexibility of VFCP and encourage more employers to voluntarily correct plan errors, according to the letter.

RECENT JUDICIAL ACTIVITY

Round-up of Latest Developments in Preventive Services Litigation

In light of the recent court decision in *Braidwood Management, Inc. v. Becerra* ("*Braidwood*"), the U.S. departments of Labor, Health and Human Services and Treasury (the "tri-agencies") recently issued guidance in the form of Frequently Asked Questions (FAQs) related to health plan coverage of preventive services. The Council also recently responded to a letter from congressional Democrats on the same topic.

Braidwood relates to the requirement under the Affordable Care Act (ACA) that non-grandfathered health plans cover, without cost-sharing, certain preventive services. For this purpose, preventive services capture four categories:

1. items and services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) "recommended items and services;"
2. immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);
3. for infants, children and adolescents preventive care and screenings provided in guidelines by the Health Resources and Services Administration (HRSA); and
4. with respect to women, additional preventive care and screenings provided for by HRSA.

Braidwood relates only to the first category above. A district court judge in Texas ruled that the requirement that health plans cover USPSTF recommended items and services is unlawful with regard to recommendations on or after March 23, 2010 (the date the ACA was enacted). The ruling prevents the tri-agencies from implementing and enforcing this requirement.

The tri-agencies have stated that they disagree with the ruling and the U.S. Department of Justice (DOJ) has appealed the decision and asked the district court to "stay" (pause) the impact of the ruling while the court case plays out. The district court has not yet ruled on that request. In the event the district court fails to grant the requested stay, DOJ also is permitted to seek a stay from the appeals court.

In the recently issued FAQs, the tri-agencies note that they are providing initial guidance and anticipate issuing additional guidance. The FAQs explain the ruling and its impact and, among other things:

- Provide that until further guidance is issued, USPSTF items and services recommended on or after March 23, 2010, will be treated as preventive care for purpose of the rules that apply to Health Savings Account (HSA)-eligible high deductible health plans (HDHPs), meaning an HDHP can continue to cover these items and services pre-deductible and maintain its status as an HDHP. This is a helpful confirmation and one that the Council requested, along with other members of the Smarter HealthCare Coalition, in a March 30 letter.
- Explain which USPSTF-recommended items and services are affected by *Braidwood,* (i.e., only those recommendations issued by USPSTF on or after March 23, 2010) and that plans must continue to cover, without cost-sharing, recommendations (with an "A" or

"B" rating) that were issued by USPSTF before March 23, 2010. The tri-agencies recognize that the USPSTF recommendations have changed since March 2010 and indicate they anticipate providing additional guidance with respect to the pre-March 23, 2010, recommendations.
- Encourage plans and insurers to continue to cover all of the USPSTF recommended items and services without cost-sharing, including those issued by USPSTF on or after March 23, 2010, due to the value of preventive care and confirm that nothing in the *Braidwood* decision precludes plans from doing so.
- Explain that *Braidwood* does not affect the other categories of preventive services required to be covered by health plans without cost-sharing under the ACA (*i.e.*, immunizations recommended by ACIP (including the COVID-19 vaccine) and preventive care recommended by HRSA).
- Outline various issues to consider in determining whether a plan may change coverage in the middle of the plan year and the obligation to notify participants of coverage changes.

Meanwhile, the ranking Democrats on the U.S. House of Representatives committees on Energy and Commerce (Frank Pallone, Jr. (D-NJ)), Ways and Means (Richard Neal (D-MA)) and Education and the Workforce (Bobby Scott (D-VA)), as well as the chairs of the Senate committees on Finance (Ron Wyden (D-OR)) and Health, Education, Labor and Pensions (Bernie Sanders (I-VT)), sent a letter on this issue to the Council (as well as several other employer associations, health plan associations and health plans). The letter expressed concern about *Braidwood* and asked whether member organizations plan to continue to cover all USPSTF recommended items and services at zero cost-sharing and whether there will be any disruptions in coverage until all appellate review is concluded, including review by the Supreme Court.

On April 19, the Council responded via a **joint letter with the other employer and health plan associations** that received the letter, making clear the Council's strong support for continued access to preventive health care, and explaining that preventive care is effective and popular. The letter goes on to say that: "Our associations have long supported preventive care and continue to do so. Moreover, our sense from our members, who ultimately make coverage decisions, is that the overwhelming majority do not anticipate making changes to no-cost share preventive services, and do not expect disruptions in coverage of preventive care, while the case proceeds through the courts."

District Court Once Again Dismisses Target-Date Fund Lawsuit Against Plan Sponsor

For the second time in three months, the U.S. District Court for the Western District of Washington has dismissed a class-action lawsuit brought against a plan sponsor for selecting certain target-date funds (TDFs) in its retirement plan.

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. 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 offerings in BlackRock's TDF series underperformed four of its largest peers over a specified prior period of time.

The Council filed an *amicus* brief in *Beldock* in November 2022, emphasizing the importance of adhering to prevailing pleading standards and noting that these lawsuits will render fiduciaries vulnerable to litigation for including any fund options that prioritize low management fees, risk mitigation or any other factor a prudent fiduciary may consider over past returns.

The same district court previously dismissed this lawsuit, adopting the rationale embodied in our *amicus* brief, while allowing the plaintiffs to file an amended complaint. The plaintiffs did so by adding "comparisons of the BlackRock TDFs against S&P Target Date Indices along with a new metric (the "Sharpe ratio") to illustrate the BlackRock TDFs' risk-adjusted returns relative to comparator TDFs.

Ultimately, the court fully dismissed the amended complaint, with prejudice and without leave to amend further, stating that the Sharpe ratio metric and comparisons to the S&P Target Date Indices are "merely additional measurements of investment performance" beyond those the plaintiffs included in their original complaint. "Plaintiffs' allegations, which again are based solely on the BlackRock TDFs' alleged poor performance during a brief timeframe, are insufficient, without more, to raise Plaintiffs' claim above the level of speculation and into plausibility," the court wrote.

The court's position—that a complaint must include indications of an imprudent process to survive a motion to dismiss—has been our argument in these BlackRock cases (and for many years in the context of 401(k) fee litigation). We are encouraged and hopeful that other courts will adopt the rationale in similar cases in other venues. Accordingly, the Council will continue to monitor these cases and explore ways to weigh in against frivolous fees and underperformance litigation and to support enforcement of pleading standards.