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 Supports Bipartisan Legislation Encouraging Honest Hospital Billing

On May 24, bipartisan lawmakers in the U.S. House of Representatives introduced the Facilitating Accountability in Reimbursements Act (FAIR Act) to provide health care payers with greater transparency regarding the cost and site of care.

In recent years, hospitals have been purchasing off-campus physician practices and using their national provider identification (NPI) number to bill private insurance and the government hospital rates, even though they offer the same services as physician offices. The American Benefits Council has cited this practice as a driver of hospital consolidation that has broadly increased health care costs.

Supported by the Council, the FAIR Act, introduced by Representatives Kevin Hern (R-OK) and Annie Kuster (D-NH), would address this issue by ensuring all off-campus outpatient departments have separate NPIs by January 1, 2025. Unlike a similar provision included in the Transparent PRICE Act (H.R. 3281), recently approved by the House Energy and Commerce Health Subcommittee, the FAIR Act would extend this transparency to commercial plans as well as Medicare.

Additionally, the bill will direct CMS to prioritize an audit of recently converted facilities to ensure they are meeting the requirements governing remote location of a hospital facility.

The trajectory of health care costs is both unsustainable and exacerbated by opaque billing practices. The [FAIR] Act is an important step to correct this problem by shining a light on disparities in cost of care at hospital and non-hospital settings — and extending this transparency to private-sector plans," Council President Jim Klein said. "We applaud Representatives Hern and Kuster for recognizing the challenges faced by employers and families who pay for health care services and for their bipartisan leadership in addressing this serious issue."

Among the other supporters of the legislation are the Alliance to Fight for Health Care (a coalition of diverse stakeholders supporting employer-provided health care coverage, founded by the Council), Better Solutions for Healthcare (of which the Council is also a member), the Blue Cross Blue Shield Association and the National Federation of Independent Business.

The Council has consistently encouraged Congress and the Biden administration to increase competition in health care and to strengthen efforts related to hospital price transparency and site-neutral payments, and earlier this year included such policies in a letter to Congress outlining health care legislative priorities.

Retirement Plan Parity Bill Passes House Committee with Council Support

Legislation allowing 403(b) retirement plans to invest in collective investment trusts (CITs), as other retirement plans can, was approved by the House Financial Services Committee in a bipartisan 35-12 vote on May 24.

Participants in 403(b) plans, which function as a 401(k)-type plan for charities and public educational institutions, are currently unable to invest in CITs and unregistered insurance

company separate accounts on the same basis as participants in all other types of plans like 401(k) plans, governmental 457(b) plans and the Federal Thrift Savings plan.

The Retirement Fairness for Charities and Educational Institutions Act (H.R. 3063), sponsored by committee members Frank Lucas (R-OK), Andy Barr (R-KY), Bill Foster (D-IL) and Josh Gottheimer (D-NJ), would amend federal securities laws to delete this restriction.

On May 10, the American Benefits Council submitted a letter to sponsors in support of the bill. "Eliminating this anomalous penalty on 403(b) plan participants would be a great step forward," the Council wrote in the letter to the bill's sponsors. "The advantages are clear — less expensive investments."

All committee Republicans present and voting supported an official substitute amendment to the bill, along with nine Democrats, after rejecting an amendment from Rep. Sylvia Garcia (D-TX) that would lift the restriction only for 403(b) plans that were also ERISA plans.

House Committee Advances Bills Aimed at Increasing Transparency, Lowering Health Costs

On May 24, the U.S. House of Representatives Energy and Commerce Committee held a markup of more than a dozen bills including six health care measures aimed at improving transparency, lowering costs and expanding access to care.

By a unanimous 49-0 vote, the committee approved the Promoting Access to Treatments and Increasing Extremely Needed Transparency (PATIENT) Act (H.R. 3561), as amended, which seeks to increase price transparency to lower health care costs and requires pharmacy benefit managers (PBM) to report certain information to plan sponsors.

Some of the measures included in the bipartisan PATIENT Act would:

- Codify and build upon the hospital price transparency rules and group health plan transparency in coverage rules.
- Require off-campus hospital outpatient departments (HOPDs) to include a modifier when billing Medicare indicating where the patient received care and require payment parity between physician office rates and HOPDs for certain drugs administered in HOPDs. This provision is similar to the bipartisan Facilitating Accountability in Reimbursements Act (FAIR Act), introduced earlier in the week by Representatives Kevin Hern (R-OK) and Annie Kuster (D-NH) and supported by the Council (see story above), though the FAIR Act would extend this transparency to commercial plans as well as Medicare.
- Requires PBMs to annually provide plan sponsors with detailed data on prescription drug spending, including the acquisition cost of drugs, total out-of-pocket spending, formulary placement rationale, and aggregate rebate information.
- Increase transparency into the negotiated prices PBMs pay for Part D drugs and the direct and indirect renumeration pharmacies pay PBMs for Part D drugs.
- Increase transparency on the effects of vertical consolidation in health care.

- Require pass-through pricing and prohibit spread pricing for payment arrangements with PBMs under Medicaid.

Americans "see the corporations responsible for providing and paying for care go to great lengths to hide costs, deny payment for care, and weigh patients down in complexity," Committee Chair Cathy McMorris Rodgers (R-WA) said of the PATIENT Act. "I have said this is just a first step towards addressing the problems we face. But we can be proud of the meaningful, bipartisan policies included in this amendment that will lower costs and improve transparency for patients."

The Council has stressed the importance of transparency and site-neutral payments in a May 17 letter to the Energy and Commerce Health Subcommittee Chair Brett Guthrie (R-KY) and ranking Democrat Anna Eshoo (D-CA) in advance of the subcommittee's consideration of the legislation, in testimony before the subcommittee, and earlier this year in a letter to Congress outlining health care legislative priorities.

Other bills approved by the committee include:

- The Animal Drug User Fee Amendments (H.R. 1418), which would reauthorize the Food and Drug Administration's (FDA) animal drug user fee programs.

- The Securing the U.S. Organ Procurement and Transplantation Network Act (H.R. 2544), which would modernize U.S. Organ Procurement and Transplantation Network (OPTN) and allow the Health Resources and Services Administration to award multiple contracts to support different functions of the OPTN process.

- The Medicaid Value-Based Purchases for Patients (MVP) Act (H.R. 2666), which aims to increase Medicaid beneficiaries' access to innovative cures for rare diseases by updating the Medicare framework for value-based purchasing arrangements to allow for varying best price points.

- The Providers and Payers COMPETE Act (H.R. 3284), which would require the U.S. Department of Health and Human Services secretary to submit an annual report on the impact of certain Medicare regulations on provider and payer consolidation.

- H.R. 3290, which would add new transparency requirements for hospitals participating in the 340B Drug Discount Program.

Council Voices Support for Bill to Promote Competition in Health Care Market

As a part of ongoing efforts to advocate for measures that would lower health care costs and promote higher-quality care, the American Benefits Council offered its strong endorsement of bipartisan legislation to crack down on anti-competitive practices in health care, thereby lowering costs and improving quality for patients.

The Healthy Competition for Better Care Act (S. 1451), introduced in the U.S. Senate by Senators Tammy Baldwin (D-WI) and Mike Braun (R-IN), previously passed the Senate Health, Education, Labor and Pensions (HELP) Committee in 2018 as Section 302 of the Lower Health

Care Costs Act. Representative Michelle Steel (R-CA) has also introduced the measure in the House of Representatives and is seeking bipartisan cosponsors.

Specifically, the measure would:

- Allow discounts or incentives for enrollees who choose high-quality and low-cost providers.
- Allow insurers and employers to contract with the hospitals and providers of their choice, without requirements to enter into additional contracts with other affiliated providers or hospital.
- Allow health insurance issuers to negotiate their own rates with other providers who are not party to the contract of the provider involved.
- Allow hospitals and issuers to freely negotiate prices, without requirements to pay higher amounts for items or services than those to which other issuers have agreed.

The bill includes exceptions for certain group model issuers, including health maintenance organizations, and value-based network arrangements, such as an exclusive provider network or accountable care organization.

As the Council noted in a May 8 news release, "The only way to lower health care costs effectively is by addressing the root causes of rising prices – including anti-competitive contracting that stifle choice and competition. The bill introduced today will help lower costs by promoting competition in the health care market and employer innovations that prioritize high-value care. We applaud the senators for their leadership and urge Congress to pass this legislation."

Earlier this year, the Council issued its priority legislative health care objectives for the 118th Congress, which prominently included enhancing competition in health care markets. In 2019, the Council prepared a comprehensive set of recommendations for lowering health care costs and supported passage of the LHHCA. The Council will continue to advocate for passage of this legislation or its inclusion in other measures under consideration by Congress.

Prospects for committee consideration of the bill, or inclusion in broader legislation, are uncertain at this time.

RECENT REGULATORY ACTIVITY

IRS Issues Interim Guidance on SECURE 2.0 Expansion of EPCRS

The Internal Revenue Service (IRS) on May 25 released guidance on expansion of the Employee Plans Compliance Resolution System (EPCRS) under Section 305 of SECURE 2.0.

Taking effect immediately, Notice 2023-43 provides interim support until Revenue Procedure 2021-30 is updated to reflect Section 305 of SECURE 2.0.

The guidance expands the EPCRS to allow any qualified plan, 403(b) plan, SEP or SIMPLE IRA to self-correct inadvertent tax compliance failures through the EPCRS without a submission to the IRS. The American Benefits Council included a request for this guidance in its February 7 letter to Treasury and IRS outlining immediate regulatory needs after the enactment of SECURE 2.0.

According to the guidance, a plan sponsor may self-correct an eligible inadvertent failure before Rev. Proc. 2021-30 is updated if certain conditions are satisfied and certain exceptions do not apply. However, an IRA custodian or an individual retirement annuity may not correct an eligible inadvertent failure under EPCRS before Rev. Proc. 2021-30 is updated.

The eligibility requirements for a plan sponsor to be able to self-correct an eligible inadvertent failure include:

- The plan sponsor must have established practices and procedures reasonably designed to promote and facilitate overall compliance with applicable code requirements.
- The plan sponsor must apply the correction principles and rules of general applicability set forth in section six of EPCRS.
- The plan sponsor has the option to self-correct using a correction method set forth in Appendix A or B of EPCRS.
- A plan sponsor may not use a correction method that is prohibited under EPCRS.

Types of failures that ***may not*** be self-corrected include:

- A failure to initially adopt a written plan.
- A significant failure in a terminated plan.
- An operational failure that is corrected by a plan amendment that conforms the terms of the plan to the plan's prior operations in a manner that is less favorable for a participant than the original terms of the plan.

The agency is asking stakeholders to comment on Notice 2023-43, and any other aspect of Section 305 of SECURE 2.0 to the IRS are due by August 23, with particular interest in:

- Additional correction methods that are required to be used to correct eligible inadvertent failures, including general principles of correction if a specific correction method is not specified by Treasury.
- A description of common IRA failures and suggested correction methods for those failures, and the possibility of expanding EPCRS to be available for both IRA custodians and IRA owners.

Lawmakers Outline SECURE 2.0 Technical Corrections in Letter to Treasury, IRS

In **a May 23 letter** to the U.S. Treasury Department and Internal Revenue Service (IRS), the leaders of the tax-writing committees in Congress clarifying congressional intent on a number of key provisions of the SECURE 2.0 Act and previewing technical corrections legislation on these and other topics. The American Benefits Council called attention to numerous important and urgent issues in a February 7 letter to Treasury and IRS and our list of needed SECURE 2.0 technical corrections.

The SECURE 2.0 Act, named after the original Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019, was enacted in late 2022 as part of the Consolidated Appropriations Act 2023. 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.

The May 23 letter to Treasury and IRS, signed by U.S. House of Representatives Ways and Means Committee Chair Jason Smith (R-MO) and ranking Democrat Richard Neal (D-MA) along with U.S. Senate Finance Committee Chair Ron Wyden (D-OR) and ranking Republican Mike Crapo (R-ID), identifies four priority issues. The lawmakers clarify:

- There was no congressional intent to eliminate all catch-up contributions for 2024.
- There was no intent to have SIMPLE and SEP contributions reduce the Roth IRA contribution limit.
- The intent was to increase the required minimum distribution age to age 75 for individuals who turn 73 after 2032 (not for individuals who turn 74 after 2032).
- SECURE 2.0 increased the regular small business start-up credit, and also created a new start-up credit based on employer contributions. Congress' intent was for the new contribution-based start-up credit to be separate from the regular credit and not to be subject to the limits applicable to the regular credit.

The purpose of the letter is to provide Treasury and the IRS with a basis to make a formal announcement that it will enforce the laws in accordance with congressional intent with respect to these four issues.

The authors also state their intention "to introduce technical corrections legislation to correct erroneous statutory language, which may include items not addressed in this letter, so that the provisions carry out Congressional intent."

The Council will continue to advocate for inclusion of our priority corrections in a technical corrections bill, though the process of developing that legislation and finding an appropriate legislative vehicle is expected to move slowly – making Treasury and IRS guidance all the more important.

Medicaid Changes May Affect Employer-Sponsored Coverage

A substantial number of employees could seek to enroll in employer-sponsored coverage as a result of recent changes to Medicaid and Children's Health Insurance Program (CHIP) eligibility rules.

During the COVID-19 pandemic, state Medicaid agencies were not permitted to terminate the enrollment of Medicaid or CHIP beneficiaries. This rule lapsed on March 31, 2023, and now state Medicaid and CHIP agencies are in the process of resuming regular eligibility practices. The Biden administration estimates tens of millions of people will have their Medicaid or CHIP eligibility redetermined, over the next several months.

According to the U.S. Department of Health and Human Services (HHS), many Medicaid beneficiaries ages 19-64 are employed (42%, or 13.5 million) and more than 4 million people could move to employer-sponsored coverage due to the unwinding of the Medicaid "continuous enrollment" provision.

Under long-standing law, group health plans must provide a special enrollment period for employees and their dependents to enroll in the group health plan if they lose eligibility for state Medicaid or CHIP coverage, if they are otherwise eligible to enroll in the plan. The employee typically must request coverage under the plan within 60 days after termination of Medicaid or CHIP coverage. However, under the emergency relief notices issued by the U.S. departments of Labor and Treasury, individuals who lose Medicaid or CHIP coverage from March 31, 2023 (the end of the continuous enrollment condition) until July 10, 2023 (the end of the "outbreak period") are eligible for relief and can request special enrollment until the date that is 60 days after the end of the outbreak period.

The U.S. departments of HHS, Labor and Treasury (the "tri-agencies") recently issued frequently asked questions (FAQs) addressing this issue and reiterating the rules described above. They also noted that the law does not prevent a group health plan from allowing for a longer special enrollment period and the tri-agencies, in several forums, have encouraged employers and group health plans to do so, emphasizing the role of employers in helping employees maintain coverage. (The FAQs also explain that individuals who lose Medicaid or CHIP are eligible for a special enrollment period in the individual market, including the Marketplace).

The tri-agencies have also encouraged employers to ensure that their benefits staff are aware of the resumption of Medicaid and CHIP eligibility determinations and to encourage their employees who are enrolled in Medicaid or CHIP coverage to update their contact information with the state Medicaid or CHIP agency. They also ask employers to encourage employees to respond promptly to any communication from the state.

The tri-agencies have also provided some resources for employers on this topic including a webinar, an employer fact sheet and a flyer for employees.

More resources are also available on the website for the Connecting to Coverage Coalition, of which the Council is a member and which is a diverse collection of stakeholders partnering to minimize disruptions in health coverage associated with the resumption of state Medicaid redeterminations.

IRS Releases 2024 Indexed Amounts for HSAs, HDHPs, Excepted Benefit HRAs

The Internal Revenue Service (IRS) released Revenue Procedure 2023-23 on May 16, listing the 2024 indexed amounts (adjusted for inflation) for health savings accounts (HSAs), high deductible health plans (HDHPs) and excepted benefit health reimbursement arrangements (HRAs).

Individual and family annual contribution limits for HSAs, HDHP minimum deductibles, and HDHP out-of-pocket limits will be substantially increased for 2024.

The following table lists the current 2023 amounts and the new 2024 amounts:

	Calendar Year 2023		Calendar Year 2024	
	Self-only	**Family**	**Self-only**	**Family**
Annual Contribution Limit	$3,850	$7,750	**$4,150**	**$8,300**
HDHP Minimum Deductible	$1,500	$3,000	**$1,600**	**$3,200**
HDHP Out-of-Pocket Limit (includes deductibles, co-payments and other amounts but not premiums)	$7,500	$15,000	**$8,050**	**$16,100**

Rev. Proc. 2023-23 also provides that for plan years beginning in 2024, the maximum amount that may be made newly available for the plan year in an excepted benefit HRA is $2,100 (up from $1,950 in 2023).

RECENT JUDICIAL ACTICITY

Impact of Preventive Services Litigation Paused for Now

On May 15, the U.S. Court of Appeals for the Fifth Circuit issued a ruling that "stays," or pauses, the impact of a lower court's recent ruling in *Braidwood Management, Inc. v. Becerra* ("*Braidwood*"), regarding group health plan coverage of preventive services.

As previously reported, under the Affordable Care Act (ACA), non-grandfathered health plans must cover, without cost-sharing, certain preventive services. Among other things, this includes

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."

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) and the ruling prevented the U.S. departments of Health and Human Services, Treasury and Labor (the "tri-agencies") from implementing and enforcing this requirement nationwide.

The tri-agencies have stated they disagree with the ruling and the U.S. Department of Justice (DOJ) appealed the decision to the Fifth Circuit. DOJ asked the Fifth Circuit to stay the impact of the ruling while the court case plays out.

The May 15 stay means the requirement that plans cover USPSTF recommended items and services (with an A or B rating) is in effect until the Fifth Circuit rules on the merits in the case. Looking ahead, parties will submit briefs to the court in June and July (barring any extensions), followed by oral arguments to the court before a decision is made.