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 Seeks Delay, Additional Guidance Regarding Roth Catch-Up Requirements

As part of its ongoing efforts to help employers comply with the many provisions of the SECURE 2.0 Act, the American Benefits Council is urging lawmakers to delay by two years a new requirement related to "catch-up" retirement contributions. Under SECURE 2.0, employees age 50 and older who earned more than $145,000 in the preceding year from the current employer must make their catch-up contributions on a Roth basis by Jan.1, 2024. The Council is actively sharing an **issue summary** with congressional and regulatory officials.

A catch-up contribution is an elective contribution made by a participant age 50 or older that exceeds a statutory limit, a plan-imposed limit, or the actual deferral percentage test limit for highly compensated employees. The Council has historically been supportive of catch-up contributions because they improve retirement security for older workers. However, unless the SECURE 2.0 requirement is immediately delayed, many employers' only means of compliance will be to eliminate all catch-up contributions for 2024.

If a delay is not announced until, for example, the fourth quarter, it will be too late to prevent this adverse result, since compliance systems need to be designed well before the effective date.

In addition to the two-year delay, the Council also asks for guidance on a number of issues and additional compliance time to give state and local governments the opportunity to consider and enact needed legislation and to avoid requiring changes during the term of a collective bargaining agreement or other applicable binding agreements.

"The $145,000 wage threshold that is integral to the mandatory Roth catch-up requirement necessitates coordination among employers, plan administrators, payroll providers, recordkeepers, and plan consultants. That work is underway, but indications are clear that, in many cases, full coordination is simply not possible by January 1, 2024."

The Council has also emphasized that, even if Congress does not act, the U.S. Department of the Treasury and the Internal Revenue Service (IRS) have the authority to unilaterally provide the necessary relief.

Some of the essential questions that need to be addressed before implementation is feasible include how to correct errors that are made in characterizing catch-up contributions as Roth or pre-tax, based on preliminary conclusions regarding prior-year wages that turn out to be incorrect.

The additional time requested would also provide Treasury and IRS, and the regulated community, the time to provide, digest, and implement such guidance.

House Committee Approves Legislation Expanding Telehealth, Chronic Disease Coverage

In a June 7 mark-up session, the U.S. House of Representatives Ways and Means Committee approved two measures **strongly supported** by the American Benefits Council:

- A substitute amendment to the Telehealth Expansion Act (H.R. 1843) would provide employers and health plans permanent flexibility to offer telehealth services pre-deductible.
- A substitute amendment to the Chronic Disease Flexible Coverage Act (H.R. 3800) would formally codify Internal Revenue Service Notice 2019-45, giving the Secretary of the Treasury the authority to allow certain chronic disease prevention items and services to be covered pre-deductible.

In addition to the Council's support, the Alliance to Fight for Health Care – a diverse coalition of stakeholders dedicated to promoting employer-provided health coverage – also offered its support for these two bills. "The Alliance supports policies that reduce barriers to high value care, including enabling plans and employers to offer more high-value care pre-deductible. Laws and rules limiting pre-deductible coverage for chronic disease prevention and telehealth inhibit employers' ability to offer high-value and potentially life-saving care to their employees on an equitable basis," the Alliance wrote.

These bills can now be taken up by the full House, though the timing for consideration and a larger legislative vehicle to which they might be attached remain uncertain.

Telehealth Expansion Act

The Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 temporarily allowed first-dollar coverage of virtual care under health savings account (HSA)-eligible high-deductible health plans (HDHPs), allowing individuals to access telehealth services without needing to first meet a deductible.

That flexibility officially expired at the end of plan years beginning in 2021. The Consolidated Appropriations Act, 2022 (CAA 2022) included a *prospective* and *temporary* extension of that expired provision allowing for pre-deductible access to telehealth services –only from April 1, 2022, through December 21, 2022. Subsequently, the Consolidated Appropriations Act, 2023 (enacted in late 2022) provided an additional two-year extension of this provision – an action applauded by the Council.

The bipartisan H.R. 1843, sponsored by Representatives Michelle Steel (R-CA) and Susie Lee (D-NV), would make the CARES Act telehealth provision permanent. The changes in the substitute amendment are described in a brief Joint Committee on Taxation (JCT) summary.

The measure is estimated to cost $5.1 billion over 10 years, which was a primary point of opposition from some Democrats on the committee, alongside a discussion of whether HSAs unfairly advantage the wealthy. Nonetheless, the bill was approved by a margin of 30-12, with five Democrats voting in support.

The Council has consistently supported increasing the ability to offer telehealth to employees, recognizing that telehealth services are valuable not just for pandemic-related reasons, but also because it expands access to care for employees, particularly for behavioral health care. In its June 7 letter to the committee, the Council explained that "telehealth has become a vital tool employers use to increase access to value-driven care and combat the nation's mental health crisis, and it is critical this flexibility be made permanent."

Chronic Disease Flexible Coverage Act

In 2019, following a recommendation pursued by the Council since 2014, the U.S. Treasury Department and IRS issued Notice 2019-45, guidance that expanded the list of preventive care benefits permitted to be covered by high-deductible health plans (HDHPs) eligible to be used with health savings accounts (HSAs) before the plan deductible is met. The appendix to the notice provides a list of specified services and medications now qualified for pre-deductible coverage, such as statins, insulin and blood pressure monitors.

The Council has applauded this guidance and called for its expansion. Most recently, as part 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 – the Council 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."

H.R. 3800, sponsored by Representative Brad Wenstrup (R-OH), would formally adopt this guidance and ensures the Secretary of the Treasury may allow additional chronic disease prevention items and services to be covered pre-deductible. (The substitute amendment merely makes a small typographical change to the bill.) A detailed JCT summary of the underlying bill is also available. The bill was approved by a vote of 34-6, with 11 Democrats voting in favor of the measure.

The Council's June 7 letter to the committee notes that, according to the Centers for Disease Control and Prevention, 90% of the nation's annual health care expenditures were for people with chronic physical and mental health conditions. "It is essential that individuals with chronic conditions have access to the care and medications they need, including allowing employers and health plans to offer more chronic disease preventive-care benefits pre-deductible in HSA-eligible high deductible health plans." The letter states that the bill "represents a recognition of the importance of greater flexibility to offer chronic disease management benefits pre-deductible" and "is a helpful step in addressing the problem."

In addition to the above two measures, the committee also approved several other bills including:

- The Paperwork Burden Reduction Act (H.R. 3797), which would (1) codify the Treasury rule that allows for 1095-B forms available to be requested online and (2) extend this flexibility to employers providing 1095-C forms. (JCT Summary of H.R. 3797)

- The Employer Reporting Improvement Act (H.R. 3801), which would establish an alternative method for furnishing certain health insurance coverage statements to individuals. (JCT Summary of H.R. 3801)

- The Small Business Flexibility Act (H.R. 3798), which would require the Treasury secretary to notify employers of the availability of tax-advantaged flexible health insurance benefits. (JCT Summary of H.R. 3798)

- The Custom Health Option and Individual Care Expense Arrangement Act (H.R. 3799), which would codify the final rules permitting employers to offer individual coverage

HRAs without violating the group health plan requirements. (JCT Summary of H.R. 3799)

Site-Neutral Transparency Legislation Unveiled in Senate with Council Support

On June 7, Senators Maggie Hassan (D-NH) and Mike Braun (R-IN) introduced the Site-based Invoicing and Transparency Enhancement (SITE) Act (S. 1869), a measure that incorporates several American Benefits Council policy priorities relating to site-neutral payment reform. (Legislative text is not yet available, but **a one-page summary of the legislation**, prepared by the bill's sponsors, is available.)

Site-neutral payment centers on the concept of aligning payment rates for similar services at different sites of outpatient care, namely hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs) and freestanding physician offices. Disparities in payment rates incentivizes consolidation of physician practices with hospitals, which results in care being provided in settings with the highest payment rates. This, in turn, increases costs without significant improvements in patient outcomes.

The Council has strongly advocated for expansion of site-neutral payment reform, as summarized in our Health Policy Priorities for the 118th Congress document shared with Congress earlier this year and in our testimony before the House Energy and Committee Health Subcommittee.

In 2015, Congress passed into law the Bipartisan Budget Act (BBA), which established site-neutral payments under Medicare for services received at off-campus outpatient departments, but created an exemption for hospital outpatient departments that existed or were under construction as of 2015.

The SITE Act advances site-neutral payment reform and transparency in hospital location-based billing practices (sometimes called "honest billing) by eliminating exemptions to the BBA provision and creating new billing requirements. Specifically, the measure would:

- End the broad exemption to the BBA site-neutral payment requirements.
- Prevent off-campus emergency departments from charging higher rates than on-campus emergency departments when standalone emergency facilities are located in close proximity to a hospital campus.
- Require that health systems establish and bill using a unique National Provider Identifier number for every off-campus outpatient department.
- Direct the U.S. Department of Health and Human Services (HHS) to treat outpatient departments as subparts of the parent organization and to issue these subparts unique provider identifiers.
- Remove liability for services rendered for payers that are not billed in accordance with these requirements.

- A portion of savings generated from these policies would be used to expand training and recruitment of skilled nurses.

In a news release issued by the Alliance to Fight for Health Care – a diverse coalition of stakeholders dedicated to promoting employer-provided health coverage – Council President James Klein said, "Site-neutral payment policies are based on the idea that patients, employers, and other payers should not pay more for care simply because their physician's office has been purchased by a hospital. Bipartisan efforts to improve health care price transparency will help ensure that patients and payers are not overpaying for care."

The SITE Act will be referred to the Senate Finance Committee for further consideration or adoption as part of a larger measure, although the timeline for committee consideration of the bill is uncertain.

RECENT REGULATORY ACTIVITY

Council Offers IRS Remedial Recommendations to Proposed Forfeiture Regulation

In a **May 30 comment letter**, the American Benefits Council provided several recommendations to the Internal Revenue Service's (IRS) proposed regulations on use of forfeitures in qualified retirement plans to help prevent any inadvertent traps that may be created by the proposal.

Because the proposed regulations are consistent with positions previously announced in informal guidance from the IRS, we believe plan sponsors and service providers will generally be able to implement them without disruption.

However, under current rules, defined contribution plans generally must use forfeitures by plan participants by the end of the plan year in which they arise, which can prove challenging for forfeitures incurred late in a plan year. The Council is recommending a modification that, if a plan cannot allocate unused forfeitures by the end of the 12-month period following the close of the plan year, the plan will not fail to be qualified as long as it allocates any unused forfeitures as soon as reasonably practicable.

The proposal would also require plan documents to specify that forfeitures be used for one or more of:

- Paying plan administrative expenses.
- Reducing employer contributions.
- Increasing benefits in other participants' accounts in accordance with plan terms.

While it is expected most plan sponsors will likely use forfeitures to pay for administrative expenses, if the forfeitures in any year are more than is required for expenses or existing required employer contributions, the proposal is effectively requiring additional benefits.

The Council suggests if a plan sponsor determines forfeitures should only be allocated for one permitted purpose, it should not be required to allocate forfeitures among all permitted uses simply because there is significant number of forfeitures in a given year.

In addition to commenting on use of unused forfeitures, the Council offered recommendations to other parts of the proposal, including:

- Clarification on the treatment of plan amendments relating to the final regulations.
- Additional relief for any defined contribution plan forfeitures incurred during any plan year that begins before January 1, 2024.

Council Submits Comments on Prescription Drug and Health Care Cost Reporting

On May 26, the American Benefits Council **submitted comments** in response to instructions issued by the U.S. departments of Labor, Treasury and Health and Human Services (the "tri-agencies") related to the prescription drug and health care cost reporting requirements included in the Consolidated Appropriations Act, 2021 (the CAA). The instructions relate to the round of reporting that is due June 1, 2023, which is based on the 2022 reference year (the "2022 instructions").

As brief background, under the CAA, 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, submitted several guidance recommendations for the reporting due in June 2023. In the 2022 instructions, the tri-agencies responded to several of our requests but did not include good faith reporting relief as we requested.

In the recently filed comment letter, we take the opportunity to reiterate our request for good faith relief and raise some areas where additional guidance is needed. We also note employers' concerns with health care costs, including drug costs. Among other things, in the draft letter we:

- Thank the tri-agencies for the continued guidance allowing more than one reporting entity to submit the same type of data file on behalf of the same plan and we ask them to make this rule permanent. This is needed because many plans, due to their plan design, are in a position where multiple reporting entities will need to submit data on their behalf, including the same data file type.
- Request, again, good faith relief for the reporting due June 1, 2023, due to the newness and complexity of the reporting. We ask that if the tri-agencies decline to provide broad-based relief that they at least provide good faith relief regarding the reporting of average employer and employee premium amounts, due to the extensive confusion surrounding how to calculate and report those amounts. We also ask for additional guidance on how to calculate employer and employee premium amounts.
- Thank the tri-agencies for all the resources they have provided, including many ongoing webinars, but request that this guidance that has been provided through so many different channels be consolidated and provided in written form.

We also include several other requests, including that the tri-agencies provide a way for plan sponsors to confirm proof of submission through the government filing system, provide additional clarity on reporting related to "carve-out" benefits, and provide future instructions well in advance of the deadline and with a chance for comment.