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***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*](mailto:djohnson@abcstaff.org)*.*

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# RECENT LEGISLATIVE ACTIVITY

## Health Care Legislation Addressing Transparency, Competition Approved in Separate Congressional Committees

Federal legislation to improve health plan price transparency was the subject of two separate committee mark-ups in Congress on July 26.

The American Benefits Council continues to push for legislation that will (1) ensure greater price transparency in the health care system by codifying and improving hospital and health plan price transparency requirements, (2) restrict hospital billing practices that fuel consolidation and mask what should be the appropriate payment amounts, (3) expand site-neutral payment reforms and (4) require greater transparency and oversight of pharmacy benefit managers (PBMs).

House Ways and Means Committee

The U.S. House of Representatives Ways and Means Committee [considered two health care bills on July 26](https://waysandmeans.house.gov/event/markup-of-h-r-4822-and-h-r-3284/):

The [Health Care Price Transparency Act (H.R. 4822)](https://gop-waysandmeans.house.gov/wp-content/uploads/2023/07/H.R.-4822-Bill-Text.pdf) would:

* Promote the availability of health insurance pricing information, including drug prices, by codifying the [2020 transparency in coverage rule](https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage).
* Codify U.S. Department of Health and Human Services (HHS) hospital transparency regulations with some notable changes.
* Take aim at hospital billing practices that fuel consolidation and mask what should be the appropriate payment amount as well as extend site-neutral payment policy in Medicare for physician-administered drugs in off-campus hospital outpatient departments.
* Require PBMs to report to plan sponsors detailed information on prescription drug pricing, including rebates.

[A substitute amendment to H.R. 4822](https://gop-waysandmeans.house.gov/wp-content/uploads/2023/07/Description-of-AINS-to-H.R.-4822.pdf) was approved by a party-line vote of 25-16. A [Joint Committee on Taxation (JCT) summary of the original bill](https://gop-waysandmeans.house.gov/wp-content/uploads/2023/07/JCT-Description-of-the-Tax-Provisions-of-H.R.-4822-.pdf) and a [committee summary of the substitute amendment](https://gop-waysandmeans.house.gov/wp-content/uploads/2023/07/Description-of-AINS-to-H.R.-4822.pdf) are also publicly available.

In [a July 25 letter to the Ways and Means Committee](https://www.americanbenefitscouncil.org/pub/?id=C35FC81D-EA4F-37A2-16FF-8B5976DE3E2A), the Council referred to H.R. 4822 as “an important first step toward lowering health care costs” and called on the committee “to strengthen and increase enforcement of hospital price transparency requirements, expand and accelerate site neutral payment policies and advance additional PBM reforms to help ensure that prescription drug pricing is aligned with value.”

In particular, the Council voiced its strong support for Section 202 of H.R. 4822, which would require hospitals’ off-campus outpatient departments to include a unique identification number on claims for services, which will help payors distinguish between sites of service to apply the appropriate payment amount.

The Council also specifically supported Section 103 of the bill, which addresses transparency and accountability by PBMs to employers.

The letter noted that requiring hospitals to make public standard charges, including negotiated rates, is critical to transparency efforts. The Council voiced its concern with provisions in Section 101 of H.R. 4822 that will not do enough to strengthen compliance and enforcement and will weaken the current hospital reporting requirement to disclose negotiated rates. Specifically, The Council remains concerned with changes to the machine-readable file requirement that reduces its utility for plan sponsors.

The House Education and the Workforce Committee resoundingly approved a package of four bipartisan measures aimed at improving price transparency and competition in the health care system, [as recommended by the Council](https://www.americanbenefitscouncil.org/pub/?id=C8C21B99-EAA8-F5DA-7A3D-0EED1FBAE176). On May 24, the House Energy and Commerce Committee approved the [Promoting Access to Treatments and Increasing Extremely Needed Transparency (PATIENT) Act (H.R. 3561)](https://www.congress.gov/bill/118th-congress/house-bill/3561), which also included measures to increase transparency and competition. Since these bills overlap in a number of respects but also have notable differences, the committees will likely need to reconcile the differences before a bill advances to the House floor.

The committee also approved, by a vote of 23-17, a [substitute amendment](https://gop-waysandmeans.house.gov/wp-content/uploads/2023/07/AINS-to-H.R.-3284.pdf) to the [Providers and Payers COMPETE Act (H.R. 3284)](https://gop-waysandmeans.house.gov/wp-content/uploads/2023/07/H.R.-3284-Bill-Text.pdf), which would require the Secretary of Health and Human Services to submit an annual report on the impact of certain Medicare regulations on provider and payer consolidation. A [committee summary of the substitute amendment](https://gop-waysandmeans.house.gov/wp-content/uploads/2023/07/Description-of-AINS-to-H.R.-3284-Green-Sheet.pdf) is also publicly available.

Senate Finance Committee

Also on July 26, the U.S. Senate Finance Committee held an [executive session](https://www.finance.senate.gov/hearings/open-executive-session-to-consider-the-modernizing-and-ensuring-pbm-accountability-mepa-act-of-2023) to review the Modernizing And Ensuring PBM Accountability (MEPA) Act. The measure would, among other things, prohibit practices in Medicare Part D and Medicaid such as “spread pricing” (charges health plans for prescription drugs more than they pay the pharmacy) and remuneration based on the price of a drug.

A substitute amendment prepared by Committee Chair Ron Wyden (D-OR) was approved by a bipartisan vote of 26 to 1. Now available are [a list of modifications to the chairman’s amendment](https://www.finance.senate.gov/download/modification-of-the-chairmans-mark-of-the-modernizing-and-ensuring-pbm-accountability-mepa-act), a [description of the chairman’s amendment](https://www.finance.senate.gov/download/description-of-the-chairmans-mark-for-the-modernizing-and-ensuring-pbm-accountability-mepa-act-of-2023), a [section-by-section analysis of the original bill](https://www.finance.senate.gov/download/section-by-section-analysis-of-the-modernizing-and-ensuring-pbm-accountability-mepa-act-of-2023) and [a Congressional Budget Office cost estimate](https://www.finance.senate.gov/download/cbo-estimate-of-the-modernizing-and-ensuring-pbm-accountability-mepa-act) of the legislation.

## 

## Council Applauds Bill Encouraging Automatic Re-Enrollment

The American Benefits Council voiced support for the Auto Re-enroll Act in a [**July 24 letter**](https://www.americanbenefitscouncil.org/pub/?id=C5E639B1-E5CE-EE56-854E-89B902953E40) to sponsors of the bill in the U.S. Senate Health, Education, Labor and Pensions Committee, Senator Tim Kaine (D-VA) and the committee’s ranking Republican, Bill Cassidy (R-LA).

The Pension Protection Act of 2006, the landmark statute that validated the practice of retirement plan automatic enrollment at the plan sponsor’s option, clarified that state law is preempted with respect to automatic contribution arrangements that meet specified conditions. This provision clarified that state laws that prohibit deductions from an employee’s pay without the employee’s consent are preempted with respect to such automatic contribution arrangements.

Under the [Auto Re-enroll Act](https://www.kaine.senate.gov/imo/media/doc/auto_re-enroll_text.pdf), employers may voluntarily include provisions in their plans such that employees who initially opted out of contributing to their employer’s retirement plan would be “re-enrolled” in the plan within the next one to three years, giving them another opportunity to begin making contributions without the need to take any other action.

“Automatic reenrollment is an especially meaningful tool for low- and middle-income employees who may have had other financial needs and priorities when they were first subject to automatic enrollment in a plan,” the Council’s letter reads. “Without an automatic reenrollment feature, employees who initially opted out are less likely in the future to re-evaluate whether they are now in a position to begin saving for retirement and take the steps necessary to begin making contributions.”

Similar legislation was introduced last year by Kaine in the Senate and the U.S. House of Representatives by Rep. Kathy Manning (D-NC).

# RECENT REGULATORY ACTIVITY

## Array of Mental Health Parity Guidance Issued Including Proposed Rules, Report to Congress

On July 25, the U.S. departments of Treasury, Labor and Health and Human Services (the “tri-agencies”) released [much-anticipated guidance](https://www.dol.gov/agencies/ebsa/at-a-glance) on the Mental Health Parity and Addiction Equity Act (MHPAEA). The Council will soon provide a more detailed summary and analysis of the guidance issued, which includes:

* [**Proposed regulations**](https://www.dol.gov/sites/dolgov/files/ebsa/temporary-postings/requirements-related-to-mhpaea-proposed-rules.pdf) amending the current [MHPAEA final regulations](https://www.federalregister.gov/documents/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act) (issued in 2013), focused on requirements related to nonquantitative treatment limitations (NQTLs) (e.g., prior authorization) imposed on mental health and substance use disorder benefits, as compared to medical/surgical benefits. The proposed regulations include a new proposed requirement regarding collection and evaluation of data by plans and insurers about the impact of NQTLs on access to mental health and substance use disorder benefits and medical/surgical benefits and a related proposed requirement on network composition. The Proposed Regulations also address the content requirements of the NQTL comparative analyses required by the Consolidated Appropriations Act, 2021 (CAA 2021), in which plans must document compliance with the NQTL rules under MHPAEA. The proposed regulations also request comments on several other aspects of mental health parity. The proposed regulations, which are almost 400 pages long, provide a 60-day window for comments.
* [**A technical release**](https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/guidance/technical-releases/23-01.pdf) that sets out principles and seeks public comment to inform future guidance on the proposed requirement that plans and insurers collect and evaluate certain data to assess the impact of NQTLs on access to mental health and substance use disorder benefits and medical/surgical benefits. The technical release also notes that the tri-agencies intend to create an enforcement safe harbor with respect to NQTLs related to network composition for plans and insurers that meet or exceed specific data-based standards, and the tri-agencies request comments on such a safe harbor. This document includes many specific questions and issues for comment by October 2, 2023.
* The [**2023 MHPAEA report to Congress**](https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis), which describes the tri-agencies’ recent enforcement efforts related to the NQTL comparative analyses required by CAA 2021. The report, which is over 100 pages long, focuses on the tri-agencies’ enforcement efforts regarding NQTLs during the second year of implementation of the CAA 21 requirements (DOL’s portion of the report is focused on the period of November 2021 through July 2022, referred to as the “reporting period”) but the report also includes more general data and information as well. In addition to enforcement findings, the report includes a list of common deficiencies in NQTL comparative analyses and examples of how deficiencies have been cured. As required by CAA 21, the report also identifies by name plans that received a final determination of noncompliance, of which there were three. In the report, DOL observes that it requested fewer comparative analyses (25 requests) during the reporting period than in the previous year because of the large number of reviews of NQTLs that were ongoing from the prior reporting period. DOL also notes that in the second year of CAA 21 implementation, it has not seen a marked improvement in the sufficiency of the initial comparative analyses received by the DOL (noting that during the reporting period, none of the comparative analyses initially submitted were sufficient to demonstrate compliance) but noted a handful of instances in which a few plans and insurers provided more detailed responses to insufficiency letters, which were promising improvements, and that in many cases, additional information cured an aspect of an identified deficiency.
* The [**Fiscal Year 2022 MHPAEA Enforcement Fact Sheet**](https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2022), which gives a general overview of the tri-agencies’ mental health parity enforcement efforts and findings for the 2022 fiscal year. This is an annually released document from the agencies, and it addresses the full range of mental health parity enforcement (not just NQTLs or the NQTL comparative analysis). The fact sheet includes enforcement facts (including that DOL conducted 86 investigations, finding 18 violations in 11 investigations), an overview of the enforcement process and examples of violations the agencies identified and that were corrected. The agencies note that during fiscal year 2022 in response to CAA 21 they significantly increased their NQTL enforcement activity. However, the fact sheet does not fully capture the results of those investigations because many of the investigations were ongoing at end of the reporting period and are not captured in the report.
* A [**MHPAEA guidance compendium**](https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2022-fact-sheet-appendix), listing guidance the tri-agencies have released on mental health parity, organized by topic, and focused on certain specific rules with respect to which the tri-agencies have found violations.
* A [**fact sheet**](https://www.whitehouse.gov/briefing-room/statements-releases/2023/07/25/fact-sheet-biden-harris-administration-takes-action-to-make-it-easier-to-access-in-network-mental-health-care/), issued by the White House, and [**news release**](https://www.dol.gov/newsroom/releases/ebsa/ebsa20230725), issued by the tri-agencies, on the new guidance.

As previously reported, the Council has strongly advocated for MHPAEA guidance over the last two years, focused on the NQTL comparative analysis requirement in the CAA 21. We have done so due to the extensive confusion among plan sponsors as to how to comply with this new requirement, notwithstanding employers’ strong commitment to mental health coverage and compliance with mental health parity. The new batch of guidance is wide-ranging and provides substantial new guidance, including on the NQTL comparative analysis.

Council staff is reviewing the new guidance and plan to submit comments to the tri-agencies.

The only additional mental health parity guidance document that is still anticipated is an updated [Self-Compliance Tool for MHPAEA](https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf), which the tri-agencies have indicated they are continuing to work on, and which is not expected imminently.

## EAC Considers 2023 Topics, Updates to Pension Risk Transfers Rules

The ERISA Advisory Council (EAC) recently met to discuss its 2023 topics and hear public input on the matter of pension plan de-risking strategies. The American Benefits Council provided input on the subject of de-risking, urging the EAC to perform its statutorily required study.

The EAC is a group of benefits experts established by Congress and appointed by DOL to identify emerging benefits issues and advise the Secretary of Labor on health and retirement issues. The EAC holds hearings on the topics it selects and submits a report of findings and non-binding recommendations to the Secretary of Labor.

2023 Discussion Topics

The formal discussion topics for 2023 are [Long-Term Disability Benefits and Mental Health Disparity](https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/about-us/erisa-advisory-council/2023-advisory-council-issue-statement-long-term-disability-benefits-and-mental-health-disparity.pdf) and [Recordkeeping in the Electronic Age](https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/about-us/erisa-advisory-council/2023-advisory-council-issue-statement-recordkeeping-in-the-electronic-age.pdf).

Pension Plan De-Risking

During its official hearings on the 2023 discussion topics, the EAC also held a public listening session with 17 witnesses, including the American Benefits Council, to discuss possible modifications to [Interpretative Bulletin (IB) 95-1](https://www.govinfo.gov/app/details/CFR-2022-title29-vol9/CFR-2022-title29-vol9-sec2509-95-1).

IB 95-1 was issued by the U.S. Department of Labor (DOL) in 1995 and describes the fiduciary standards for selecting an annuity provider for a pension risk transfer. The rule requires pensions to select the safest available annuity and, in doing so, consider the provider’s:

* Investment portfolio
* Size relative to the annuity contract
* Level of capital and surplus
* Liability exposure
* Availability of state government guaranty associations

The SECURE 2.0 Act of 2022 requires DOL to review IB 95-1 and recommend possible modifications to Congress by the end of 2023.

Dovetailing with the recommendations of other witnesses, Kent Mason, partner with Davis and Harman, testified on behalf of the Council that the factors being raised by other witnesses, such as liquidity issues, riskiness of investment strategy and offshore reinsurance, are already considered by fiduciaries under the current law and IB 95-1 guidance. Therefore, there would be no problem amending IB 95-1 to explicitly recognize those issues as factors to consider. He also cited the Council’s study of IB 95-1, which showed that, based on hard data, former participants holding annuities are safer than participants in the pension system, as discussed further below. Finally, he urged the EAC to study the IB 95-1 issues and issue findings, consistent with the congressional mandate to consult with DOL on these issues.

In a presentation to the EAC, Jeff Turner, deputy director of DOL’s Employee Benefits Security Administration (EBSA) Office of Regulations and Interpretations, shared recent research regarding IB 95-1 and highlighted three trends identified by stakeholders:

* Stakeholders indicated that plan sponsors are employing various types of de-risking activities; however, the report required by SECURE 2.0 focuses only on total de-risking annuity purchases and partial de-risking annuity purchases.
* Stakeholders indicated a rise in pension risk transfers. Turner stated that pension risk transfer annuity purchases have increased by 33% since 2021, and he explained potential reasons for the increase.
* DOL noticed a trend in private equity firms increasing insurer ownership in the space.

Regarding whether or not IB 95-1 should be changed, Turner said many stakeholders took the position that IB 95-1 identifies the appropriate considerations for fiduciaries and therefore no changes are warranted. He commented that those stakeholders further suggested if IB 95-1 changed significantly, plan sponsors may elect to use other forms of de-risking, such as a lump sum offering, which may not be the best policy outcome.

Although the EAC will meet again for further discussion, they felt unanimously that 95-1’s principles-based approach had worked very well and should be fully or largely preserved.

Possible changes that might be recommended included: (1) including the insurer’s ownership structure as a factor that the fiduciary should consider, (2) including reinsurance as a factor to be considered, likely including whether the reinsurance is offshore, and (3) elimination of the availability of state guaranty associations as a factor.

Last year, the Council began educational efforts to show policymakers the unintended negative consequence in restricting annuity-based risk transfers.

In that paper, the Council noted the safety of annuities is based on a number of important factors, including:

* Insurance company expertise in managing risk
* Stringent state regulation of insurers
* Review of insurers by ratings agencies
* The availability of insurance company separate accounts
* State insurance guaranty associations

That paper also found the following. Even though insurance companies have, on the rare occasion, experienced financial difficulties or become insolvent, the authors of this paper are aware of no instances in which promised pension benefits from an annuity buy-out contract ultimately failed to be provided. On the other hand, in a study of 500 plans trusteed by the PBGC between 1988 and 2012, the PBGC found that its three primary guarantee limitations reduced the benefits of 16% of all vested participants in those plans, totaling 187,000 individuals, reducing benefits by almost $8.5 billion, which was an average of over $45,000 per affected participant.

## GAO Recommends DOL Issue 403(b) Plan Educational Guidance

In a [recently released report](https://www.gao.gov/assets/830/827172.pdf), the U.S. Government Accountability Office (GAO) recommended the U.S. Department of Labor (DOL) should improve educational materials directed toward 403(b) plan sponsors and participants as a way help improve participant outcomes.

The GAO is an independent, non-partisan agency that is intended to provide Congress and federal agencies with analysis to help the government save money and work more efficiently. In June, Representative Bobby Scott (D-VA), the ranking Democrat on the U.S. House of Representatives Education and the Workforce Committee, formally asked GAO to review the extent of federal agencies’ 403(b) plan oversight, state actions that could improve 403(b) participant outcomes and options that could improve outcomes for 403(b) participants.

The GAO had limited comments but noted in its report that DOL doesn't provide the same level of detailed information for 403(b)s as it does 401(k)s. Updating educational materials, including information that could help participants understand plan fees, could help savers invested in those plans ensure they meet their financial goals, the GAO added in the report.

In conducting its research, the GAO spoke with officials from five states—California, Connecticut, Delaware, Kansas and Texas—on improving 403(b) plan participant outcomes. Officials in four of the selected states said they enhanced transparency by providing participants with additional information on plans' investment options and fees or by making it available elsewhere, the GAO said.

Additionally, stakeholders and experts that were interviewed identified actions they said could improve 403(b) participant outcomes. For example, they suggested establishing fiduciary duties for non-ERISA plans in some states that are not subject to such protections can help protect participants’ interests, according to the report.

The officials interviewed also said requiring distribution of standardized information on investment options’ returns and fees for participants in non-ERISA plans would promote transparency, according to the report.

Experts also called for letting 403(b) plans put assets in collective investment trusts and other investment vehicles, such as real estate investment trusts.

DOL neither agreed nor disagreed with the GAO's recommendation, but noted it has a webpage dedicated to 403(b) plan issues and that the information in its 401(k) publications could be helpful to ERISA-covered 403(b) plan sponsors, participants and other interested parties evaluating fees and expenses in those plans, according to the GAO.

## IRS Announces 2023 Relief from Required Minimum Distributions, As Council Requested

The Internal Revenue Service (IRS) released [**Notice 2023-54**](https://www.irs.gov/pub/?id=irs-drop/n-23-54.pdf) on July 14, providing much-needed relief from the required minimum distribution (RMD) rules under provisions of the Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019 and the SECURE 2.0 Act of 2022.

Notice 2023-54 extends for one year, through 2023, the relief the IRS previously provided in [Notice 2022-53](https://www.irs.gov/pub/?id=irs-drop/n-22-53.pdf) regarding (1) the effective date of forthcoming final RMD regulations, and (2) relief from the IRS interpretation of the “10-year rule” as reflected in the [2022 proposed RMD regulations](https://www.americanbenefitscouncil.org/pub/?id=8F3C5816-1866-DAAC-99FB-8BF6F5F2C729) that the IRS released following the original SECURE Act.

Notice 2023-54 also provides relief under the rollover rules for certain distributions made in 2023 that were mischaracterized as RMDs as a result of the change that SECURE 2.0 made to the “required beginning date” (RBD) for commencing RMDs.

The Council had requested SECURE 2.0-related relief as part of [a package of priority SECURE 2.0 Act guidance recommendations](https://www.americanbenefitscouncil.org/pub/?id=C14CE351-960C-0886-F5E1-ED9D3490CC28) sent to Treasury and IRS earlier this year.

# RECENT LEGISLATIVE ACTIVITY

## Council Files Another Amicus Brief in Support of Surprise Billing Regulations

The American Benefits Council filed [an amicus (“friend of the court”) brief](https://www.americanbenefitscouncil.org/pub/?id=B86A75F2-99DA-B3CA-B66F-90216CEBEADE) with the U.S. Court of Appeals for the Fifth Circuit on July 19, in support of final regulations issued by the U.S. departments of Health and Human Services, Labor and Treasury (the “tri-agencies”), implementing the arbitration process set up under the No Surprises Act (NSA). This case presented an opportunity to defend the tri-agencies’ regulations and the integrity of the arbitration process at the appeals court level for the first time.

The NSA formally prohibited “surprise bills” – balance bills for out-of-network emergency services, services provided by out-of-network providers in in-network settings and out-of-network air ambulance services. Instead, plans pay an initial amount to the health care provider and the provider can then seek additional amounts, through negotiation and then through independent dispute resolution (IDR). The IDR entity is to choose between the payment amount proposed by the plan and the payment amount proposed by the provider. The NSA lists various factors for the IDR entity to consider in making this determination — including the median in-network rate or “qualifying payment amount” (QPA) and other factors.

The tri-agencies issued regulations in 2021 that directed the IDR entity to select the offer closest to the QPA unless additional information clearly demonstrated the QPA is materially different from the appropriate out-of-network rate (the “QPA presumption”). Provider groups successfully challenged the QPA presumption (which the Council had supported) and in response to that lawsuit, the tri-agencies issued [final regulations](https://www.govinfo.gov/content/pkg/FR-2022-08-26/pdf/2022-18202.pdf) that removed the QPA presumption and instead provided that the IDR entity is to consider the QPA first and in considering factors other than the QPA should not give weight to information if it is not credible, doesn’t relate to the offers or is already accounted for by the QPA.

The same plaintiffs filed a lawsuit in the same court challenging the final rules, arguing that they have the same effect as the QPA presumption and the district court ruled for provider plaintiffs. (The Council coordinated and filed with the district court an amicus brief with several other employer groups in support of the final rules noting that although we would have strongly preferred the QPA presumption, we support the final rules because they are preferable to what plaintiffs suggest, which is an IDR system without clear guidelines, open to abuse, and leading to increased health care costs for plans and participants).

The tri-agencies appealed to the Fifth Circuit and the Council coordinated, and filed, an amicus brief in support of the tri-agencies final regulations, because of the importance of taking actions to avoid abuse of the IDR process by providers, and because this is the first time this issue has reached a federal appellate court. Similar to the [amicus brief the Council filed in the district court](https://www.americanbenefitscouncil.org/pub/?id=460CAA53-9C48-BF25-315E-D4D2E47751ED) in this same case, our brief expresses support for the final rules that provide some reasonable guardrails for the IDR process and conveys the importance of avoiding abuse and overuse of IDR, for plans and participants.

## Another Target-Date Fund Lawsuit Dismissed in District Court

Once again, a federal court has tossed out a class-action lawsuit brought against a plan sponsor for selecting certain target-date funds (TDFs) in its retirement plan.

In the case of Luckett, et al v. Wintrust Financial, [the plaintiffs’ complaint](https://si-interactive.s3.amazonaws.com/prod/plansponsor-com/wp-content/uploads/2022/08/03082913/LuckettvWintrustFinancialComplaint.pdf) 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 (friend of the court) brief](https://www.americanbenefitscouncil.org/pub/?id=09206E6D-BE72-603B-2A2F-6CE6E79DBFBD) 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.

On July 14, the U.S. District Court for the Northern District of Illinois [dismissed the suit](https://storage.courtlistener.com/recap/gov.uscourts.ilnd.417789/gov.uscourts.ilnd.417789.71.0.pdf) on the grounds that the four TDFs to which the BlackRock TDFs were compared “do not provide a sound basis for comparison in order to state an imprudence claim.” Of these comparators, two were actively managed, while the BlackRock funds were passively managed. The other two TDFs were “through retirement” funds, and the BlackRock TDFs were “to retirement” funds. While the court dismissed the suit on those grounds, the plaintiffs were granted leave to try to amend the complaint to avoid a dismissal with prejudice.

While the outcome is positive for plan sponsors, this court’s rationale is less strong than those in similar cases like [Beldock v. Microsoft](https://scholar.google.com/scholar_case?case=9972806903068200943&q=beldock+v.+microsoft&hl=en&as_sdt=6,47&as_vis=1), [Hall v. Capital One](https://www.americanbenefitscouncil.org/pub/?id=6C20C20E-D559-545E-3E27-56ED94086EAE)and [Tullgren v. Booz Allen Hamilton](https://www.americanbenefitscouncil.org/pub/?id=6C2BFCF0-EB00-D42B-BC0E-8593965F4D44), all of which asserted that a complaint must include indications of an imprudent process to survive a motion to dismiss and were therefore dismissed.

In related news, a new, similar class-action complaint was filed in [the U.S. District Court for the District of Colorado on June 13.  Macias et al. v. Sisters of Charity of Leavenworth Health System](https://www.americanbenefitscouncil.org/pub/?id=1C70E075-BA37-B3E5-3F53-75B19EFBDB23) makes similar allegations as the above cases but focuses on the JPMorgan SmartRetirement series of TDFs rather than BlackRock TDFs. The Council is considering filing an amicus brief in this case.

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.