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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 REGULATORY ACTIVITY

IRS Announces Two-Year Roth Catch-Up Requirement Transition Period

The Internal Revenue Service (IRS) on Friday **announced a transition period** that extends until 2026 for the implementation of the new Roth "catch-up" contributions rule. The decision represents critical relief for many plan sponsors who were bracing themselves for these changes to take effect in the upcoming tax year and is consistent with a request from the Council for a two-year delay of the provision. In the same Notice, the IRS clarified that plan participants who are age 50 and older can continue to make catch-up contributions after 2023, regardless of income.

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.

Under the SECURE 2.0 Act (enacted in late 2022 as part of the Consolidated Appropriations Act, 2023), 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 (post-tax) basis. This provision would have taken effect on January 1, 2024. Because compliance systems need to be designed well before the effective date, a delay was needed as soon as possible to avoid adverse results.

The IRS says the administrative transition period will help transition smoothly to the new Roth catch-up requirement and is designed to facilitate an orderly transition for compliance with that requirement. The notice also clarifies that the SECURE 2.0 Act does not prohibit plans from permitting catch-up contributions, so plan participants who are age 50 and over can still make catch-up contributions after 2023.

The Council has been engaged with congressional and regulatory officials many times over the past several months requesting relief from the provision. To underscore the broad impact of the catch-up provision, the Council delivered **a letter to Congress and the U.S. Treasury Department** on June 29 in which more than 225 organizations called for a two-year delay. The letter was subsequently resubmitted with signatures from nearly 250 organizations.

The Council reiterated the urgency of the matter in an August 14 letter. "We are hearing from a number of companies that they are beginning to work on a complete shutdown of all catch-up contributions for 2024 because no delay has been announced. Their view is that without an announced delay, such a shutdown is the only way that they can ensure that their plan is in compliance," the Council wrote.

The U.S. Treasury Department and IRS say they plan to issue future guidance.

IRS Announces 2024 Adjustment to Employer Mandate Affordability Percentage

As it does each year, the Internal Revenue Service (IRS) has announced the affordability percentage that will apply for purposes of the Affordable Care Act (ACA) employer health

insurance mandate for plan years beginning in 2024. Because the change in the percentage for 2024 is fairly substantial (dropping from 9.12% to 8.39%), plan sponsors should take note.

In general, under the employer mandate, large employers must offer coverage to their full-time employees that is affordable and that provides minimum value. An offer of coverage to a full-time employee is considered affordable if the employee's required contribution for self-only coverage is no more than 9.5% (as annually adjusted) of the employee's household income (HHI). Under final regulations governing the ACA employer mandate, because employers generally do not have access to employees' HHI, affordability safe harbors were provided allowing employers to base affordability on Form W-2 wages, rate of pay or the federal poverty line.

Each year, the affordability percentage (*i.e.*, 9.5%) is adjusted based on various inflation factors. Since the employer mandate has been in effect, the percentage has changed each year, going up and down. (See IRS FAQs, Q&A 40 for the full list).

Under IRS Revenue Procedure 2023-29, for plan years beginning in 2024 the percentage will be 8.39%. This is a drop from last year (for which the applicable percentage was 9.12%) and is the lowest percentage that has applied since the employer mandate took effect. Due to this change in the percentage for 2024, large employers should confirm that offers of coverage will continue to be affordable and make necessary adjustments. (For more information on the other limited purposes for which the 9.5% (as adjusted) is relevant under the employer mandate see Notice 2015-87, Q&A 12.)

RECENT JUDICIAL ACTIVITY

Surprise Billing: Round-up of Recent Activity

Over the last month, there have been several noteworthy developments related to the surprise billing provisions in the No Surprises Act (NSA), legislation that prohibited nearly all "surprise" medical billing effective in 2022. Unfortunately, many of these developments undermine efforts to efficiently implement the NSA.

On August 24, a federal district court judge ruled largely in favor of provider plaintiffs in the third round of litigation filed by the Texas Medical Association (TMA) challenging various tri-agency regulations implementing the NSA (referred to as the "TMA III litigation"). Like the previous two cases, in which TMA challenged regulations establishing the independent dispute resolution (IDR) process between plans and providers, the suit was filed in the U.S. district court for the Eastern District of Texas. In this case, the provider plaintiffs shifted their focus to the tri-agency regulations establishing how the qualifying payment amount (QPA) is to be calculated, asserting that certain aspects of the regulations deflate the QPA and therefore reduce the amounts they could receive through IDR. The QPA is a key concept under the NSA, providing the basis for participant cost-sharing, and is a key factor in IDR.

The court agreed in large part with the plaintiffs and struck down several pieces of the regulations that address how the QPA is to be calculated, including several rules that made the calculation less burdensome for plan sponsors (the court held for the tri-agencies on a handful of the challenged provisions). Following the ruling, the tri-agencies posted a statement noting

that because of the decision, the federal IDR process is temporarily suspended until the tri-agencies can provide additional instructions. The tri-agencies note that disputing parties should continue to engage in open negotiations. Further guidance from the tri-agencies is expected.

As has already been seen, this ruling is likely to be disruptive, as the QPA calculation is complex and it now appears many of the rules used to calculate this amount have been struck down. The disruption means more backlog and delay in an already overwhelmed IDR system. We will report on any updates on the practical impact of this decision, including additional tri-agency guidance.

The Council had supported these regulations as reasonable and fully consistent with the NSA and its goals. The Council also coordinated and filed an *amicus* ("friend of the court") brief in support of these tri-agency regulations, explaining that employers have an immense interest in the implementation of the NSA and that the QPA calculation is particularly important for plans and participants.

In related news, earlier in August, the same judge ruled in a different case, also brought by TMA, which challenged an increase in the fees parties must pay to arbitrators in the IDR process and certain other provisions. The judge ruled that the IDR fee increase, as well as certain provisions related to batching claims for IDR, violate the Administrative Procedures Act. In response, the tri-agencies briefly froze the IDR process and then IDR resumed for some disputes but, as noted above, the IDR process was then suspended again following the TMA III ruling.

Also on the regulatory front, the tri-agencies are continuing to work on proposed regulations that will address the IDR process. As we understand, those regulations were close to being complete but with the recent court rulings in August, the process has slowed.

Also in August, U.S. Senator Bill Cassidy (R-LA), the ranking Republican on the Senate Health, Education, Labor and Pensions (HELP) Committee, sent a letter to the tri-agencies asking a series of detailed questions about implementation of the NSA, expressing concern about implementation and its impact on providers. He asks for a response by September 15.

Federal Appeals Court Rules in Favor of ERISA Preemption

Late on August 15, a three-judge panel of the U.S. Court of Appeals for the Tenth Circuit **ruled** that an Oklahoma law regulating pharmacy networks, which has directly restricted self-insured plan design, is preempted by ERISA.

The ruling, in *Pharmaceutical Care Management Association (PCMA) v. Mulready*, reverses a lower court decision and is an important and positive step towards bolstering ERISA preemption, which the Council worked to support. This is especially welcome news in the face of many recent efforts to undermine ERISA preemption, both at the state level and in certain federal courts.

In 2019, Oklahoma enacted the Patients' Right to Pharmacy Choice (PRPC) Act, regulating pharmacy benefit managers (PBMs) and pharmacy networks. Among other things the PRPC Act: (1) requires pharmacy networks to meet certain geographic restrictions, effectively eliminating mail-order only networks, including specialty networks, (2) requires inclusion of

'any willing pharmacy' in a plan's preferred network and (3) prohibits cost-sharing discounts to incentivize the use of particular pharmacies.

PCMA challenged the law as preempted by ERISA, but the district court found that the PRPC Act was not preempted. PCMA appealed arguing that key provisions in the PRPC Act are preempted by ERISA because they dictate plan design and regulate central matters of plan administration.

The Council, along with several other employer groups, submitted an *amicus* ("friend of the court") brief to the appeals court (which was unfortunately not officially accepted by the court, but which the court may have nevertheless reviewed). The brief emphasized the practical importance of ERISA preemption for employer plan sponsors and how the PRPC Act directly affects plan design. This was an important effort not only because of the Council's long history of supporting ERISA preemption but also because numerous members indicated they were being forced to change plan design (for example, ceasing to provide mail-order only pharmacy programs with regard to Oklahoma residents).

In a very thorough opinion, the appeals court sets out the history and purpose of ERISA preemption, finds that the PRPC Act cannot escape ERISA preemption just because it regulates PBMs (because the PRPC Act effects ERISA plans) and rules that the challenged provisions are preempted by ERISA, stating that: "Together, these three provisions effectively abolish the two-tiered network structure, eliminate any reason for plans to employ mail-order or specialty pharmacies, and oblige PBMs to embrace every pharmacy into the fold …These network restrictions are quintessential state laws that mandate benefit structures. ERISA forbids this." (And, although the U.S. Department of Labor, in its previously filed *amicus* brief, essentially asserted that ERISA does not preempt state insurance laws that indirectly apply to the plan when the plan uses a third-party administrator to administer the benefits at issue, the appeals court did not address this issue, finding those arguments had been waived by Oklahoma).

In concluding the opinion, the appeals court observed that in passing laws like the PRPC Act, states have expressed their concern with PBMs, noting that while the PRPC Act is impermissible, "[t]he States have an avenue by which to meaningfully seek redress. They may approach Congress, the architect of ERISA …, to take up the mantle."

Oklahoma may now choose to seek additional appeals to the full appeals court or the U.S. Supreme Court, and the Council will continue to closely monitor this case. In the broader context, the Council continues to work to defend ERISA preemption, at the federal and state level, and will report on additional significant developments.