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

Combined Health Care Transparency Legislation Released in House

Lawmakers in the U.S. House of Representatives unveiled sweeping bipartisan health care legislation on September 8, combining elements of various measures approved by committees of jurisdiction this year. The package focuses on increasing the transparency of health care prices and includes a number of provisions strongly supported by the American Benefits Council, including transparency requirements for hospitals, group health plans and pharmacy benefit managers (PBMs), hospital billing and site-neutral payment reform in the Medicare program.

The **Lower Costs, More Transparency (LCMT) Act**, introduced by House Energy and Commerce Chair Cathy McMorris Rodgers (R-WA), the committee's ranking Democrat Frank Pallone (D-NJ), House Ways and Means Chair Jason Smith (R-MO) and House Education and the Workforce Chair Virginia Foxx (R-NC), draws largely from the Promoting Access to Treatments and Increasing Extremely Needed Transparency (PATIENT) Act (H.R. 3561), which was approved by the Energy and Commerce Committee in May.

The measure also incorporates elements of several bills approved by the House Education and the Workforce Committee in July, including the Transparency in Billing Act (H.R. 4509), the Transparency in Coverage Act (H.R. 4507) and the Hidden Fee Disclosure Act (H.R. 4508).

The legislation also includes elements of two measures approved by the House Ways and Means Committee in July, the Health Care Price Transparency Act (H.R. 4822) and the Providers and Payers COMPETE Act (H.R. 3284).

An **official section-by-section summary of the bill** is available. As noted above, the legislation includes Council policy priorities, including:

Site-Neutral Payment Reform and Hospital Billing

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.

The LCMT Act, drawing from H.R. 3561, would require Medicare to pay the same amount for physician-administered drugs in a hospital outpatient department as beneficiaries do in a doctor's office.

The LCMT Act also includes a provision from H.R. 3561 that would require each off-campus hospital outpatient department of a Medicare provider to obtain and include a separate identification number on billing for claims.

Hospital and Group Health Plan Price Transparency

The legislation includes provisions designed to promote greater health care pricing by codifying and enhancing the U.S. Department of Health and Human Services regulation requiring hospitals to make public standard charges, including negotiated rates. The legislation also requires group health plans to post publicly machine-readable files containing in-network negotiated rates, prescription drug prices, and out-of-network allowed amounts, and that such files are "limited to an appropriate size." The LCMT Act requires the Government Accountability Office to report on existing and new health care price transparency requirements and whether such requirements can be harmonized to reduce burden and duplication.

PBM transparency

As plan sponsors are well aware, prescription drug costs continue to represent a considerable portion of health plan costs. As the Council noted in its July 11 letter to the Education and the Workforce Committee, employers cannot effectively manage prescription drug costs unless they can see the full picture of rebates, fees and other renumeration generated from manufacturers and other parties, drug definition criteria and amounts charged to pharmacies.

In April 26 testimony before the Energy and Commerce Committee's Health Subcommittee, Ilyse Schuman, the Council's senior vice president, health policy, highlighted the need to enshrine PBM transparency into law so employers can access information needed to help manage costs.

The LCMT Act would require PBMs to report to plan sponsors the rebates and fees received from drug manufacturers and other information.

The Council has also offered its support for a broader PBM bill in the U.S. Senate, the PBM Reform Act (S. 1339), which was approved by the Senate Committee on Health, Education, Labor and Pensions in May.

The House is expected to consider this legislation in the coming weeks, before a September 30 deadline for Congress to extend funding for community health centers.

RECENT REGULATORY ACTIVITY

EAC Releases Final Recommendations to Pension Risk Transfer Rules to DOL

The ERISA Advisory Council (EAC) released its **final report** regarding recommendations on the standards applicable to pension risk transfers under Interpretive Bulletin 95-1 (IB-95-1).

The EAC is a group of benefits experts established by Congress and appointed by U.S. Department of Labor (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. 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.

The final report follows an August 29 meeting in which the EAC recommended the DOL update IB 95-1 to expand on its existing language addressing how a fiduciary should consider

an annuity provider's administrative capabilities and experience. The existing language of IB 95-1 currently addresses this issue, and fiduciaries already take into consideration the administrative capabilities and experience of annuity providers.

The EAC earlier this summer held a public listening session with 17 witnesses, including the American Benefits Council, to discuss possible modifications to IB 95-1.

RECENT JUDICIAL ACTIVITY

Council Files *Amicus* Brief in Important 401(k) Fee Case

The American Benefits Council filed **an *amicus* ("friend of the court") brief** with the U.S. Court of Appeals for the 9th Circuit on September 11, requesting a full ("*en banc*") rehearing of a 401(k) fee case. In August, a three-judge panel of the 9th Circuit ruled in *Bugielski v. AT&T* that a prohibited transaction occurs any time that a plan sponsor amends a contract with a service provider. If this ruling stands, it will be much more difficult for plan sponsors to fend off class action fee cases.

Bugielski centers on an allegation that the defendant violated ERISA by engaging in a prohibited transaction when it amended its contract with its recordkeeper to add a brokerage window and a managed account advice program. After numerous rulings in the case, a 2021 summary judgment by the U.S. District Court for the Central District of California sided with AT&T, saying the defendants acted prudently in monitoring the retirement plan's expenses. On August 4, however, the 9th Circuit's three-judge panel reversed the trial court's ruling in favor of AT&T and held that, without qualification, an ERISA prohibited transaction occurs any time a plan amends its service provider contract to add services, which could include renewals of services.

While ERISA Section 408(b)(2) provides a prohibited transaction exemption for service provider contracts if the plan pays "no more than reasonable compensation," the 9th Circuit's ruling would make it the plan sponsor's burden to prove, following discovery, that every service provider contract generates no more than reasonable compensation, rather than requiring plaintiffs to allege that service provider compensation was unreasonable.

In reaching its conclusion, the Ninth Circuit expressly rejected precedent from the 3rd and 7th circuits holding that a plan's hiring of a service provider only results in a prohibited transaction if there is "an intent to benefit" the service provider. Relevantly, the 3rd and 7th Circuits have stated that any rule to the contrary (i.e., a per se prohibited transaction rule for service provider contracts) would be "absurd" or "nonsensical," as it would prohibit plans from hiring necessary service providers.

The Council's brief—filed jointly with the ERISA Industry Committee, the SPARK Institute, and the Committee on Investment of Employee Benefit Assets—urged the 9th Circuit to rehear the *Bugielski* case, explaining that the August ruling will harm the employer-sponsored retirement plan system by opening the floodgates to speculative recordkeeping fee claims. That is, by presumptively making it a prohibited transaction for plans to amend or renew service provider contracts, the August ruling will allow class action plaintiffs to survive motions to dismiss by merely alleging that a plan amended its service provider contract. From there, it will be the plan sponsor's burden to prove that the plan paid no more than reasonable compensation

as noted above under ERISA Section 408(b)(2).

The *amicus* brief explains that shifting this burden to the plan sponsor will exacerbate all of the harms that have been created by the last decade of fee litigation. Accordingly, the brief calls on the 9th Circuit to apply the prohibited transaction rules in a way that would prevent these claims for proceeding unless plaintiffs plausibly allege that a service provider's fees were unreasonable. Absent such a rule, each amendment or renewal of a service provider contract will put plan sponsors at risk of a prohibited transaction claim that, even if meritless, will likely survive a motion to dismiss and require significant defense and discovery costs or an expensive settlement.

District Court Ruling Raises Concerns About Subregulatory Action, Duty to Monitor Brokerage Windows

A troubling ruling by the U.S. District Court for the District of Columbia on August 29 could subject retirement plan sponsors to increased regulatory action without the benefit of public comment or recourse. In the short term, the decision raises concerns about the possible need to monitor brokerage window investments.

As we have previously reported, the U.S. Department of Labor issued Compliance Assistance Release (CAR) 2022-01 in March 2022 instructing retirement plan fiduciaries to exercise "extreme care" in considering cryptocurrencies as part of any investment menu for plan participants. That guidance followed a White House executive order on Ensuring Responsible Development of Digital Assets, which asserted that government policy "must take strong steps to reduce the risks that digital assets could pose to consumers, investors and business protections." The CAR effectively stated that fiduciaries that allowed cryptocurrency as an investment, including through a brokerage window, could be the subject of an investigation based on ERISA's duties of prudence and loyalty.

In response to the CAR, the Council and 10 other employer and financial services groups called for the DOL guidance to be withdrawn because it is inconsistent with current law and was adopted retroactively without opportunity for notice and comment.

In June, ForUsAll, Inc. filed suit in the U.S. District Court for the District of Columbia to invalidate CAR 2022-01. On August 29, the court dismissed the case on two alternative grounds.

First, the district court concluded that ForUsAll—a 401(k) provider specializing in cryptocurrency investments—does not have standing to bring the case, because even if the court vacated CAR 2022-01, that would not provide any relief to ForUsAll for the injuries it alleged it suffered.

Second, the court concluded that CAR 2022-01 is not a final or "binding" agency action that can be challenged in court. While the court asserts that DOL would "face an uphill battle" if it deviated from its statements to the court in pleadings that the CAR does not have force of law, the practical effect is that this and other subregulatory guidance will have the weight of law unless and until it is contested through costly litigation.

On the specific matter of cryptocurrency as investments in plans, the court ruled that the directive to exercise "extreme care" was a colloquial reference to ERISA's prevailing fiduciary

duty. Further, the court concluded that the extent of a fiduciary's duties with respect to brokerage windows is not settled law and therefore the CAR "does not extend fiduciary obligations to a previously duty-free domain or alter existing obligations in any way."

The brokerage window issue in the CAR is very significant for the broader retirement plan community because there is no practical way to monitor all of the investments in a brokerage window. The Council will be closely following DOL's enforcement and audit activity in this area moving forward.