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 Urges House Passage of Bipartisan Health Transparency Bill; Other Groups Line Up in Support

In **a letter sent to U.S. House of Representative leadership** on September 15, the American Benefits Council offered its strong endorsement of the Lower Cost, More Transparency (LCMT) Act (H.R. 5378), the bipartisan health care measure that incorporates several health policy priorities for the Council. The measure could be brought up for a vote by the full U.S. House of Representatives soon, although the timing remains uncertain.

The LCMT Act was 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). An official section-by-section summary of the bill is now available.

"The LCMT Act represents an important step forward in lowering health care costs through increased transparency and competition," the Council wrote. As detailed in the letter, the Council's offers its support for the provisions of the measure that would:

- Ensure greater price transparency in the health care system by codifying and improving price transparency for hospitals and group health plans.
- Require greater transparency and oversight of pharmacy benefit managers (PBMs).
- Restrict hospital billing practices that fuel consolidation and mask what should be the appropriate payment amounts.
- Expand site-neutral payment reform.

Other Groups Offer Support

Numerous other employer and ally coalitions in which the Council participates have also endorsed provisions of the LCMT Act, including:

- The Alliance to Fight for Health Care – a coalition of diverse stakeholders supporting employer-provided health care coverage, founded by the Council – wrote a letter to the bill's sponsors, saying that the LCMT Act "demonstrates the committees' commitment to lowering health care costs for workers, employers and the federal government."
- EmployersRx, a coalition of which the Council is a member and whose mission entails "public policies that drive down the cost of drugs while preserving true innovation as part of a value-based health care system," also wrote, "Large employers urge the House the pass the bipartisan Lower Costs, More Transparency Act. The bipartisan LCMT Act is a critical step forward in addressing the underlying drivers of rising health costs.
- "The bipartisan Lower Costs, More Transparency Act aims to address a primary driver of increasing health care costs – the high and rising prices charged by large hospital systems – by improving price transparency and advancing site-neutral payment

reform," wrote the Alliance for Fair Health Pricing, a non-partisan coalition representing patients, consumers, businesses, purchasers and health care providers.

- Consumers First, an alliance that brings together the interests of consumers, employers, labor unions, and primary care clinicians, sent a letter writing "We believe this legislation contains policies that would set critical groundwork to reduce inflated spending throughout the system and make health care more affordable and value driven for consumers."

- "Corporate hospital systems have been engaged in dishonest billing practices for too long, and patients and employers have been paying the price. It is clear there is now bipartisan consensus that we must put an end to these alarming price markups," wrote Better Solutions for Healthcare, a national coalition representing a broad range of employers and consumers.

The sponsors of the LCMT Act continue to seek support from the stakeholder community in advance of a House vote.

The Council will continue to report on the legislative outcome of the LCMT Act as the bill progresses.

House Lawmakers Criticize Slow EBSA Enforcement Protocols

A U.S. House of Representatives oversight committee is demanding information from the U.S. Department of Labor over why enforcement action the agency takes against pension plans is dragging on so long.

House Education and the Workforce Committee Chair Virginia Foxx (R-NC) and Health, Employment, Labor, and Pensions Subcommittee Chair Bob Good (R-VA) sent a letter to Acting Secretary of Labor Julie Su raising concerns about the DOL's Employee Benefit Security Administration (EBSA) and its failure to conduct investigations in a directed and timely manner.

"Prolonged investigations carried out by federal agencies, such as EBSA, create tremendous strain on retirement plan sponsors," the lawmakers write in the letter. "Plan sponsors report that many of EBSA's investigations have persisted for years while investigators assigned to these cases are turned over several times."

The letter asks that in order "to understand the steps EBSA has taken to provide effective management of its resources in the Office of Enforcement, we seek responses to the following requests."

- A list of all open investigations by the initial date the investigation opened (grouped by calendar quarter), the duration of the investigation, and the specific purpose of the investigation. The name of the plan sponsor does not need to be disclosed, but the regional office responsible for the investigation should be listed.

- An explanation of any timeframes or internal guidance imposed on the timeliness of conducting and closing out investigations, as well as procedures that are taken to ensure those timeframes are honored.

- A sample copy of personnel appraisal criteria for ensuring investigations are timely and efficiently carried out and closed.

- An explanation of the specific steps taken to close all persisting investigations and the consequences to investigators, their supervisors, and EBSA management if investigations are allowed to languish beyond efficient timeframes.

Foxx and Good are requesting completed responses to this oversight letter by October 3.

RECENT REGULATORY ACTIVITY

Agencies Extend Mental Health Parity Guidance Comment Period

The U.S. departments of Labor, Treasury and Health and Human Services (the "tri-agencies") will continue to accept comments for the Mental Health Parity and Addiction Equity Act (MHPAEA) proposed rule and associated guidance for an additional 15 days (from the original October 2 deadline to October 17). The tri-agencies indicate they are providing this extension in response to requests from stakeholders and because they value public feedback as they consider whether and how to issue final rules and future guidance.

Earlier this summer, the tri-agencies released important guidance on the MHPAEA, including:

- Proposed regulations amending the current MHPAEA final regulations (issued in 2013)
- Technical Release 2023-01P with request for comments
- The 2023 MHPAEA Comparative Analysis report to Congress ("2023 Report")
- A Fiscal Year 2022 MHPAEA Enforcement Fact Sheet

The Council is in the process of drafting comments in response to the proposed regulations.

Council Voices Support for Transparency, Site-Neutrality in Comments to CMS

In a **September 11 letter** to the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS), the American Benefits Council provided employer recommendations to the proposed Medicare Outpatient Prospective Payment System (OPPS) rule for 2024.

While the proposed rule largely covers Medicare-specific topics outside the Council's purview, the Council provided comments on several issues relevant to employer plan sponsors.

Hospital Price Transparency Reporting Requirements

In the 2024 proposed rule, CMS proposed several changes related to the requirement that hospitals publicly disclose their standard charges (including negotiated rates) ("hospital price transparency requirements"), which has been in effect since 2021. The proposed changes would enhance CMS' enforcement capabilities, standardize the reporting format and expand the data that is to be reported.

In the comment letter submitted by the Council, we expressed support for these proposals as they support widespread compliance with the rules by hospitals and also improve the quality and usability of the reporting, in order for this reporting to meet its intended policy purpose of supporting the ability of health care purchasers and consumers to compare and understand prices and, ultimately, support higher-value care and lower health care costs. The comment letter also notes that we support efforts to increase penalties for hospital noncompliance and we ask CMS to make greater efforts to ensure the data reported is usable.

Site-Neutral Payments

Over the past several years as part of the annual OPPS rulemaking, HHS has implemented rules that support "site-neutral payment" policy, under which hospital off-campus provider-based department (HOPD) outpatient office visits are reimbursed under the Medicare equivalent to what a stand-alone physician's office will be reimbursed. These changes have helped address a previously payment differential (in which HOPDs were paid higher rates) that incentivized hospitals to purchase physician practices and drive care to higher-cost settings.

Although CMS didn't address site-neutral payment reform in the proposed regulations, the Council still took the opportunity in the letter to urge HHS to consider future expansions to the policy, including to other items and services (not just evaluation and management office visits), to other settings (including on-campus provider offices and emergency departments), and to "grandfathered" hospitals that aren't currently subject to the rules.

Other Issues

The proposed regulations also address various aspects of hospital quality reporting programs under the purview of CMS. As a general comment, the Council noted our support for CMS' continued efforts to improve reporting of clinical care measures to evaluate quality and emphasized that it is essential for CMS to continue to integrate health equity into measures and overall data collection to support efforts to effectively close the equity gap across the health care system.

Also submitting comments on the OPPS rule was Consumers First, a diverse coalition of health policy stakeholders, of which the Council is a steering committee member. The Consumers First comment letter includes comments consistent with those made in the Council's letter, supporting hospital price transparency, site-neutral payments and health equity.

Council Urges Modifications, Clarifications to Rules for Fixed Indemnity Insurance

The American Benefits Council emphasized the value of fixed indemnity insurance and requested modifications to recently proposed regulations in written comments to the Biden administration on September 11.

The U.S. departments of Treasury, Labor and Health and Human Services (the "tri-agencies") recently issued proposed regulations addressing various types of insurance, including hospital indemnity or other fixed indemnity insurance. According to the tri-agencies, these changes are intended to "distinguish [short-term, limited-duration insurance] and fixed indemnity insurance from comprehensive medical coverage" and "protect consumers from low-quality coverage." The regulations package also includes proposed regulations by Treasury and IRS focused on the taxation of benefits under certain employer plans, including fixed indemnity policies.

The Council's letter focused on the topics most relevant for employer plan sponsors – the proposed changes to fixed indemnity insurance excepted benefits in the group market and the proposed changes to the tax treatment of benefits paid under those plans.

Underscoring the value of fixed indemnity insurance to employers and employees, the Council made clear that employers offer fixed indemnity insurance in addition to, rather than instead of, comprehensive medical coverage, and acknowledge the tri-agencies' concerns about "bad actors" that engage in deceptive marketing. "It is equally important to acknowledge that these bad actors are an exception to the rule and that there are many good actors in this space, who have worked hard for years to provide fixed indemnity insurance … and we believe that employees generally do understand the differences between their major medical coverage and fixed indemnity coverage."

The letter also discusses:

- **Excepted Benefit Regulations:** Because the policies on the market today allow variation in benefits based on severity of illness or injury or on specific services received per-period, and those designs appear to be prohibited by the proposed regulations, the proposed changes would undermine the value, affordability and availability of fixed indemnity insurance in the group market. We ask the tri-agencies to take a more tailored approach to defining permissible benefit structures to allow for more variation in benefits so the policies retain their value, affordability and availability. We also ask that the tri-agencies clarify the example they provided on "coordination of benefits" and ask for an extended applicability date.

- **Tax Regulations:** For fixed indemnity policies where the premiums are paid pre-tax, while currently only the amount of benefits paid in excess of unreimbursed medical expenses are subject to tax, under the proposed regulations all of the benefits would be taxed. This is a major change from longstanding IRS guidance and will have the unfortunate result of increasing the cost of policies for employees and will have a chilling effect on employers offering, and employees enrolling in, these policies. We recommend Treasury and IRS focus on enforcement of current rules and that, if they still believe new rules are necessary, that they develop a more targeted rule. We also ask for clarification on an issue that has arisen about how these regulations might impact major medical plans and ask for more time on the applicability date. (Note: It continues to be the case that if premiums for a fixed indemnity policy are paid after-tax, benefits paid are excluded from tax. The proposed regulations do not change that rule).

- **Specified Disease Coverage:** In response to the tri-agencies' request for comments on specified disease coverage excepted benefits, we explain that, like fixed indemnity

insurance, this coverage is valuable to employers and employees and that we are not aware of any issues that would merit additional guidance or rulemaking at this time.

Council Urges SEC to Withdraw Predictive Data Analytics Rule Proposal

The American Benefits Council on **Sept. 21 sent a comment letter** to the Securities and Exchange Commission (SEC) expressing concerns on a proposed rule aimed at addressing conflicts of interest associated with broker dealers' and investment advisers' use of predictive data analytics (PDA) technologies.

Generally speaking, the proposed rule—Conflicts of Interest Associated with the Use of Predictive Data Analytics by Broker-Dealers and Investment Advisers—would impose broad and potentially burdensome conflict-of-interest requirements on broker-dealers and investment advisers that use even simple technologies to communicate with clients and fund investors or manage clients' assets. This would negatively affect plan sponsors and participants in company retirement plans.

While the Council is supportive of regulations on new technologies that can be used in a way that is harmful to investors, the proposed rules would apply to virtually all technologies used in connection with investment issues, including longstanding common technologies that are part of everyday life and raise no conceivable issue, such as Excel spreadsheets.

For example, such spreadsheets can be used by individuals to determine how much they should be saving annually for retirement, and this use would need to be tested under the proposal.

The proposal would similarly cover basic technologies that enable retirement participants to determine:

1. How much in total they need to have saved by retirement age, or
2. How much money they can afford to spend annually during retirement.

Other covered technologies provide retirement plans and plan sponsors with the tools they need to help their participants and to operate a plan.

The letter dovetails with a second September 19 group letter signed by the Council—and other signatories urging the SEC to withdraw the proposal due to "numerous irreparable flaws."

RECENT JUDICIAL ACTIVITY

Federal Court Backs DOL in ESG Rule; House Republicans Advance Bills to Block ESG in ERISA Plans

A U.S. District Court recently ruled against 26 states and other plaintiffs in their lawsuit challenging the legality of the Department of Labor's (DOL) final rule regarding how retirement

plan fiduciaries may use environmental, social and governance (ESG) considerations in their decision making about investments.

However, the U.S. House of Representatives Education and the Workforce Committee has advanced four bills aiming to restrict the use of ESG in ERISA plans.

A DOL rule, finalized late last year, makes it easier for retirement plans to take into account climate change and other ESG factors when they choose investments.

Judicial Challenges

A Sept. 21 ruling by the U.S. District Court for the Norther District of Texas in *Utah v. Walsh* held that the DOL rule does not violate ERISA because ERISA does not forbid ESG investing or a tiebreaker test that includes non-economic factors.

The plaintiffs alleged that the DOL rule, by broadly permitting ESG in fiduciary decision making, impermissibly subordinates financial interests to politically or philosophically motivated interests.

However, the judge ruled that the proposal does not explicitly violate ERSA because ERISA does not forbid ESG investing or a tiebreaker test that includes non-economic factors. The rule, the judge added, requires fiduciaries to act prudently and not subordinate financial interests when considering ESG.

Legislative Challenges

The House Education and the Workforce Committee advanced four Republican-led bills out of committee aimed at blocking ESG considerations in ERISA-governed retirement plans.

- Roll Back ESG To Increase Retirement Earnings Act—clarifies that fiduciaries must generally base decisions on an investment solely on economic factors.

- Retirement Proxy Protection Act— would specify plans' obligations relating to proxy voting. It would reinstate many of the provisions included in the December 2020 rule "Fiduciary Duties Regarding Proxy Voting and Shareholder Rights" and would prohibit voting proxy and exercising shareholder rights that would advance policies that are not in the economic interest of the plan.

- No Discrimination in my Benefits Act—would require that any selection of plan employees or service providers be made "without regard to race, color, religion, sex, or national origin."

- Providing Complete Information to Retirement Investors Act— would require defined contribution plans to notify plan participants about the differences between "choosing from investments selected by ERISA fiduciaries and choosing from investments through a brokerage window."

A bill earlier this year cleared Congress that would have repealed the administration's ESG rule but was later vetoed by President Biden.

MISCELLANEOUS

Council Joins Data Equity Coalition

The American Benefits Council has joined a new coalition to address health equity challenges through inclusive data collection.

The **Data Equity Coalition**, a new partnership comprised of several organizations including the National Minority Quality Forum and the Blue Cross Blue Shield Association, has been established with a goal to improve health outcomes through better, more accurate and more representative data on race, ethnicity and language (REL) and sexual orientation and gender identification (SOGI).

A press release announcing the formation of the coalition stressed that "developing a standardized approach to this important data can be critical to ensuring everyone in America has an equal opportunity to attain their highest level of health." The release highlights that many racial, ethnic, socioeconomic and LGBTQIA+ communities are underserved and underrepresented, and as a result, experience higher rates of diabetes, hypertension, obesity, asthma, heart disease, cancer, and preterm birth. "The lack of comprehensive data to better understand these challenges as well as archaic standards for collecting it are contributing factors to the growing health equity gap."

The Data Equity Coalition will focus on:

- Education on the importance of data as a critical pillar in advancing health equity.
- Accelerating data advocacy to influence policy standards.
- Effective data collection standards as a necessity to improve health outcomes.

Advancing health equity is a high priority for the Council's member companies. The Council's participation in the coalition builds on the work of the Council's partnership with the Urban Institute and the Deloitte Health Equity Institute on a project—supported by Elevance Health—to examine one of the most significant barriers to health equity: incomplete and inconsistent collection and sharing of race and ethnicity data.