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

House Committee Approves Legislation Expanding HSAs

The U.S. House of Representatives Ways and Means Committee on September 28 approved two measures, each supported by the American Benefits Council, to significantly expand health savings account (HSA) contribution limits and broaden the number of individuals eligible for HSAs.

The Bipartisan HSA Improvement Act (H.R. 5688), passed by a bipartisan vote of 28-14, would:

- Allow individuals who utilize key health services such as direct primary care arrangements and worksite health clinics to contribute to HSA funds.
- Eliminate a prohibition against an individual establishing an HSA if their spouse has an existing flexible spending arrangement.
- Allow individuals to convert their own flexible spending or health reimbursement arrangement dollars into a health savings account.

The HSA Modernization Act (H.R. 5687), passed by a party-line vote of 24-18, would:

- Expand eligibility for individuals to participate in HSAs who are veterans receiving care through the Veterans Administration, working seniors on Medicare, Native Americans, and those enrolled in certain health benefit exchange plans.

- Increase the contribution limits for health savings accounts to align with what an individual might owe in total out-of-pocket expenses and deductibles.

- Allow the use of an individual's health savings account funds to cover health care services that occurred up to 60 days prior to the establishment of an HSA.

- Allow spouses to contribute "catch-up" funds into the same health savings account rather than having to establish separate accounts for such contributions.

- Increase access to mental health and home health care services for those still contributing to an HSA.

The two bills can now proceed to the House floor for consideration by the full chamber, though such action is not imminent and all business in the chamber is on hold until the Republicans address their leadership situation.

"Many of the solutions included in these bills reflect basic common sense like ending the marriage penalty that currently bars married couples from combining their HSA contributions into a single account, ensuring eligibility of direct primary care arrangements and worksite clinics, and allowing folks to save an amount that will actually cover what they might owe in out-pocket-expenses," Committee Chair Jason Smith (R-MO), said of the bills' passage.

In a **letter sent to the committee** prior to the markup, the Council strongly advocated for passage of the of the Bipartisan HSA Improvement Act, as it would make HSAs "even more useful and effective for employers seeking to extend meaningful and affordable health coverage to their employees." The Council also offered its support for key provisions of the HSA Modernization Act The letter also recommended full House consideration of two bills previously approved by the committee to enhance HSAs:

- The Telehealth Expansion Act (H.R. 1843), which provides employers and health plans permanent flexibility to offer telehealth services on a pre-deductible basis for HSA-eligible High Deductible Health Plans.

- The Chronic Disease Flexible Coverage Act (H.R. 3800), which allows certain chronic disease prevention services to be offered pre-deductible.

RECENT REGULATORY ACTIVITY

Council Urges Clear, Transparent Implementation of SECURE 2.0 Reporting, Disclosure Requirements

In response to a recent request for information (RFI) from the U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA), **the American Benefits Council offered numerous recommendations** for proper implementation of the SECURE 2.0 Act's reporting and disclosure provisions.

Although our response focuses on the guidance Council members have identified as necessary or helpful in their implementation of the changes in law, the letter also highlights our concern with the RFI's indication that DOL may consider conditioning the continued use of its electronic disclosure safe harbors on a participant's "access in fact."

EBSA issued the RFI on August 11 seeking information on a host of SECURE 2.0 Act reporting and disclosure requirements.

Most notably, the RFI sought input on the current allowance of electronic delivery of retirement plan statements. Currently, plan sponsors are required to deliver certain statements on paper with two exceptions:

- In the case of plans that furnish benefit statements under DOL's 2002 electronic delivery safe harbors; and

- In the case of plans that permit recipients to request benefit statements to be furnished electronically, if recipients request that such statements be delivered electronically and the statements are delivered electronically.

The RFI raises the prospect of conditioning safe harbors on "access in fact," and reverting to paper if an individual forgoes access in fact. Specifically, the DOL is asking if plan

administrators are able to confirm, reliably and accurately, whether an individual actually accessed, and for what length of time, an electric document.

The Council's letter strongly recommends against conditioning the continued use of these safe harbors on access in fact, especially in the absence of a cost-benefit analysis. "Even when technologically feasible to do so, plan administrators should not be required to monitor participants' website activity any more than they should be required to monitor whether a participant opens their paper mail, let alone reads the contents inside," the Council wrote. "Plan administrators have a responsibility to furnish certain plan information to participants, and as long as the applicable furnishing standards are met—whether by paper or through electronic means—the plan administrator's responsibility very appropriately and necessarily ends at that point."

The Council's letter also addresses a number of other topics raised in the RFI, including:

- Eliminating unnecessary plan requirements related to unenrolled participants
- Emergency savings accounts linked to individual account plans
- Defined contribution plan fee disclosure improvements
- Consolidation of defined contribution plan notices
- Information needed for financial options risk management
- Performance benchmarks for asset allocation funds
- Defined benefit annual funding notices

The Council continues to lead the way in pursuing smooth implementation of other SECURE 2.0 Act requirements, as articulated in recent letters to the **DOL** and **U.S. Treasury Department**, particularly with respect to provisions that are generally effective beginning in 2024 or 2025.

Tri-Agencies Issue Guidance Related to Surprise Billing Litigation

On October 6, the U.S. departments of Labor, Health and Human Services, and Treasury (the "tri-agencies") released a set of frequently asked questions (FAQs) addressing the impact of a recent court ruling related to the No Surprises Act's (NSA) surprise balance billing protections.

In general, the regulations implementing the NSA have faced constant litigation which has created a great deal of disruption for plans and issuers.

In the new FAQs, the tri-agencies address the aftermath of the holding in the third challenge to the NSA by the Texas Medical Association in the Eastern District of Texas (*TMA III*), where the court vacated important provisions of the interim final rule (and other guidance) guiding plans and issuers in calculating the qualifying payment amount (QPA) for claims subject to the NSA. The QPA is, in general, the median in-network rate, and it is used to determine participant cost-sharing under the NSA and is an important factor in the independent dispute resolution (IDR) process established under the NSA.

Unlike previous legal challenges, which focused solely on the IDR process, the court's holding regarding the QPA methodology at issue in *TMA III* impacts not only claims that ultimately reach IDR, but also the manner in which most self-insured plans calculate cost sharing. As a result, the decision not only has economic impacts for plans, but presents meaningful challenges for plans in adjudicating these claims from the participant perspective.

The Council had previously supported the tri-agency 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 the tri-agency regulations, in which we explained that employers have an immense interest in the implementation of the NSA, especially the method for calculating the QPA given its centrality to claim administration and determining patient cost share.

In welcome news for plans and participants, the tri-agencies' new FAQs recognize the significant disruption and confusion caused by the ruling in *TMA III*, as well as the significant expenditure of time and resources necessary to re-calculate the QPA for many plans. The tri-agencies also make clear that the Department of Justice disagrees with the court's ruling and will seek an appeal to the U.S. Court of Appeals for the 5th Circuit. Notwithstanding that fact, the tri-agencies note that the district court's decision is currently in effect.

Specifically, the tri-agencies state they will exercise their enforcement discretion with respect to claims adjudicated using a QPA that relies on the now-vacated methodology (this will apply for QPAs for items and services furnished before May 1, 2024, though the agencies may consider extending this relief until November 1, 2024). The tri-agencies also stress their approach to enforcement under the vacated rules will focus on providing compliance assistance, rather than enforcement, given the significant level of complexity and burden associated with re-calculating the QPA. The FAQs also provide guidance to plans and IDR entities regarding the use of the QPA in evaluating IDR offers, which ensures that the IDR process can continue despite the current unsettled nature of the applicable regulations.

Finally, with respect to the portions of *TMA III* that apply solely in the context of air ambulance disputes, including requiring that plans adjudicate out-of-network claims within 30 days of receipt, even if the claim requires additional information from the provider, the FAQs specify that plans should seek information consistent with ERISA's generally applicable claims regulations, and then deny those claims if the information is not provided.

Agencies Announce Intent to Proceed with Prescription Drug Transparency Requirements

The U.S. departments of Health and Human Services, Labor and Treasury (the "tri-agencies") on September 27 announced plans to proceed with a transparency requirement related to prescription drugs, which had been on hold. For now — based on current guidance and informal statements from tri-agency staff — plans need not come into compliance yet, but will need to do so once guidance and a new timeline for compliance is issued.

The transparency in coverage regulations, finalized in late 2020, require plans to disclose on a public website information regarding in-network provider rates for covered items and services (the "in-network file"), out-of-network allowed amounts and billed charges for covered items and services (the "OON file"), and negotiated rates and historical net prices for covered prescription drugs (the "Rx file") in three separate machine-readable files (MRFs).

While the in-network file and OON file were required to be posted beginning July 1, 2022, in an August 2021 Frequently Asked Questions (FAQs) (Q&A 1), the tri-agencies announced they would defer enforcement of the requirement to post the Rx file.

The tri-agencies explained they were considering undertaking notice-and-comment rulemaking to determine whether the Rx file remained appropriate in light of the new prescription drug and health care cost reporting requirement under the Consolidated Appropriations Act, 2021 (CAA), which passed subsequent to the finalization of the transparency in coverage regulations. Prior to the issuance of the August 2021 FAQ, the tri-agencies had faced a lawsuit challenging the portion of the regulations requiring the posting of the Rx file.

Following the FAQ, the tri-agencies did not undergo additional rulemaking on the Rx file but did implement the prescription drug and health care cost reporting under the CAA. In the spring of 2023, the tri-agencies faced another lawsuit, this one alleging as unlawful the tri-agencies' decision to adopt a nonenforcement position regarding the Rx file requirement.

This is backdrop for the September 27 guidance, in which the tri-agencies provided they no longer intend to consider through notice and comment rulemaking whether the Rx file remains appropriate because, based on their work implementing the CAA prescription drug reporting requirements, they say it is now clear there is no meaningful conflict between the CAA reporting requirements and the Rx file. As such, the tri-agencies state they have determined a general or categorical exercise of enforcement discretion is no longer warranted and a case-by-case enforcement approach is more appropriate. They note this means they are rescinding the prior FAQ that provides for the enforcement relief.

Importantly, the tri-agencies go on to say they "intend to develop technical requirements and an implementation timeline in future guidance that sufficiently account for any reliance interests that plans and issuers may have developed" with regard to the enforcement relief provided in the prior FAQ. Our understanding, based in part on informal statements from tri-agency staff, is that this means plans need not come into compliance yet but will need to do so once guidance, and a new timeline, is issued.

The American Benefits Council, as part of its ongoing efforts to lower health care costs, has been supportive of the Rx file as a way to increase transparency on prescription drug costs. We are also aware of the burdens associated with creating another MRF, and we are considering what guidance will be needed for successful implementation of the Rx file, both in terms of substance and timing.

Agencies Request Information on Coverage of Over-the-Counter Preventive Services

The U.S. departments of Health and Human Services, Labor and Treasury (the "tri-agencies") have issued a request for information (RFI) on the application of the Affordable Care Act (ACA) requirement that health plans cover preventive services, without cost-sharing, to over-the-counter (OTC) preventive items and services available without a prescription by a health care provider.

Under the ACA, non-grandfathered group health plans must cover "preventive services" without cost-sharing. For this purpose, preventive services are:

- Items and services with an A or B rating from the U.S. Preventive Services Task Force.
- Immunizations recommended by the Advisory Committee on Immunization Practices.

- Care and screenings for infants, children and adolescents provided in guidelines from the Health Resources and Services Administration (HRSA).

- Preventive services for women as set forth in guidelines from HRSA.

The tri-agencies have issued regulations and guidance over the years implementing this provision.

The tri-agencies explain in the RFI that while most recommended preventive services require a health care provider to either provide a prescription or directly furnish the service, some preventive products are available to consumers without the involvement of a provider ("OTC preventive products"). Examples of OTC preventive products include certain types of tobacco cessation drugs, folic acid supplements, breastfeeding supplies and certain contraceptives.

However, in prior guidance, the tri-agencies have said preventive products that are available without a prescription must be covered without cost-sharing *only when prescribed by a health care provider*.

In the RFI, the tri-agencies note several executive orders regarding expanding access to care, and specifically, protecting and expanding access to the full range of reproductive health care services following the U.S. Supreme Court ruling in *Dobbs. v. Jackson Women's Health Organization*. The tri-agencies also note that in July 2023, the Food and Drug Administration (FDA) approved a birth control pill as the first daily oral contraceptive in the U.S. available without a prescription by a health care provider.

The tri-agencies therefore state that requiring plans and issuers to cover, without cost-sharing, OTC preventive products without a prescription by a health care provider is an important option to consider for expanding access to contraceptive care and more generally would align with the administration's goals of expanding use of preventive services. The tri-agencies also recognize that most plans do not currently cover OTC preventive products, and for this reason, they are issuing an RFI to solicit information to improve their understanding of the issues related to the coverage of OTC preventive products by health plans.

The tri-agencies request information and comment on several specific topics, including access to and utilization of OTC preventive products, implementation issues, including operational challenges, health equity and economic impacts.

Council Recommends Modifications to Rules for Maine Retirement Savings Program; New Washington DC Proposal Under Consideration

In October 2 **written comments to the executive director** of the Maine Retirement Savings Program (MERIT), the American Benefits Council strongly recommended certain changes to proposed regulations affecting employers subject to the new state law.

MERIT is just one example of many efforts at the state level to expand retirement coverage by requiring employers without a retirement plan to enroll their employees in an automatic payroll-deduction IRA or similar vehicle. Like other state programs, the Maine statute provides that a qualified employer that maintains a 401(k) or similar plan is exempt from the program.

The proposed regulations implementing the MERIT program addresses:

- Procedures and requirements for covered employers to register with the program.
- Establishment of and investment in the accounts for program participants.
- The procedures covered employers must follow to comply with the underlying legislation.
- The information that must be collected for program account holders.

The Council's letter suggests changes and clarifications to the proposed rules that will ensure the program (1) complements the existing employer-based retirement system without adversely affecting those employers that already offer a retirement plan to their employees and (2) reduces the risk that the program could be challenged as preempted by ERISA.

Most importantly, the Council recommends clarification of proposed rules' definition of a "Covered Employer" that would be subject to the program, asserting that it should exempt companies that have offered a retirement plan to *some or all of* its employees.

The letter also includes additional analysis on the importance of reducing burdens on exempt plan sponsors, as well as a number of miscellaneous comments.

Elsewhere in the United States

In related news, Washington, D.C. has recently joined the growing number of states and localities considering legislation to establish a state-facilitated retirement program. On July 14, six D.C. council members introduced the Automatic Retirement Savings Act of 2023 (B25-0434), a bill that would create a District-facilitated retirement savings program and require certain private-sector employers in the District to automatically enroll their employees in the program.

The bill would establish a program requiring "covered employers" (defined below) to automatically enroll certain employees. The program would be administered and implemented by an independent, seven-member Retirement Savings Board established within the D.C. government.

As drafted, the bill's employer mandate is unusually narrow in scope as compared to other state-run retirement programs in that the program's mandate would apply only to employers that are headquartered in Washington DC. The timing for consideration of the bill is unclear.