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 Proposes Important Reforms to Defined Benefit Pension System

The American Benefits Council launched a campaign to bolster the single-employer defined benefit pension system on October 31 by sharing **a new set of policy proposals** with lawmakers on Capitol Hill.

"As the single-employer pension plan system has declined over the past few decades, some have sought to incorporate elements of the defined benefit plan system into the defined contribution system. Those efforts are laudable, but the most effective way to promote the beneficial components of the defined benefit system is to strengthen that system," said Lynn Dudley, American Benefits Council senior vice president, global retirement and compensation policy, in a news release.

These proposals, developed by the Council's Pension Policy Project, The Council's proposals begin with a brief description of the cause of the decline of the defined benefit plan system — including a discussion of the important role of Pension Benefit Guaranty Corporation (PBGC) premiums in causing that decline — and consists of eight specific recommendations:

- Adjust PBGC premiums based on the PBGC's funded status, so that if PBGC is so well funded that it does not need the current level of premiums, premiums would be reduced.

- Take premium increases and decreases off budget, because premiums cannot be used for any purpose other than paying benefits and PBGC administrative costs.

- Prevent an anticipated wave of plan terminations by permitting non-terminated plans to use surplus assets in a manner similar to what would be permitted if the plan were terminated.

- Permit unusable surplus assets in retiree health 401(h) accounts in pension plans to be used to shore up the retirement benefits in the pension plan and to provide other benefits.

- Protect employers by reducing funding volatility and protect participants from benefit restrictions that take away earned rights.

- Facilitate a growing type of traditional defined benefit plan, where benefits are adjusted to some extent based on plan asset returns.

- Update the accounting rules for market-based cash balance plans to base the valuation generally on the value of the notional account balances, which would materially improve the accuracy of the valuations.

- Correct a glitch in the law that punishes plans that provide more generous lump sum benefits.

The trade magazine *Pensions & Investments* wrote prominently about the Council's proposals on October 31, highlighting the need to reduce PBGC premiums.

Council Submits Written Testimony in Senate Committee Paid Leave Hearing

The American Benefits Council **submitted written testimony** following an October 25 U.S. Senate Committee on Finance hearing exploring paid leave policy and its impacts on the workforce.

The Senate hearing follows efforts in both chambers to explore federal legislative solutions to expand access to paid leave, including by a group lawmakers in the House of Representatives who formed the Bipartisan Working Group on Paid Family Leave.

During these debates the Council has stressed the value of paid leave benefits for employers and employees alike, and also described the challenges of complying with a growing patchwork of state and local paid leave laws. Currently, 13 states, plus Washington, D.C., have enacted a patchwork of inconsistent mandatory paid family and paid family medical leave programs.

Council Statement for the Hearing Record

"It has become increasingly difficult for multistate employers to consistently offer and administer paid leave to employees nationwide," the Council wrote in its statement for the record. "Compliance, administrative simplicity and equity – cornerstones of nationwide benefit policies – are becoming ever more challenging to achieve."

The Council urged the committee to work with employers toward a federal solution that fills in the gaps for those without access to generous paid leave benefits. "A federal legislative solution to expand access to paid family and medical leave benefits cannot be realized without leveraging private-sector solutions. Nationwide harmonization of paid leave benefits for multistate employers is foundational to leveraging employer-provided paid leave benefits."

Senate Finance Committee Hearing

"What I want to do is be part of a bipartisan effort with my colleagues to make sure paid leave is a source of economic growth in America and a source of help for families," Chairman Ron Wyden (D-OR) said to open the hearing.

In response to ranking Republican member Mike Crapo (R-ID) questioning the inherent inflexibility found in many of the current national paid leave proposals, Rachel Greszler, a senior research fellow at the Heritage Foundation, testified on the importance of flexibility.

"Most leaves are not predictable, and you need access to those benefits quickly," Greszler said. It's like the difference between quickly emailing a boss to say you'd be out versus a bureaucratic application process to get medical approval and then have someone who doesn't know you determine your strict eligibility, she added.

Anything that happens has to keep the relationship between the employer and employee so they can flexibly work things out, Greszler added.

Elizabeth Milito, executive director of the Small Business Legal Center at the National Federation of Independent Business, said mandated leave laws represent a significant challenge

for small business owners since flexibility is critical for a small business, and mandated leave laws are generally anything but flexible, simple to comply with, and affordable.

Responding to Sen. Thom Tillis' (R-NC) request for suggestions on how to approach a federal leave policy, Milito replied, "Simplicity is very, very important and the carrot is more important than the stick."

Council Recommends Health Care Cost-Lowering Measures in Letter to House Committee Task Force

The American Benefits Council offered **a series of policy recommendations** to the U.S. House of Representatives Budget Committee Health Care Task Force on August 13, explaining "the only way to truly make health care more affordable is to understand and address the root causes of rising health care spending."

The task force issued a request for information on August 25, seeking feedback on actions Congress could take to improve outcomes while lowering health care spending. While the House Budget Committee does not have direct jurisdiction over health care policy, the committee is very influential in the legislative process and with the Congressional Budget Office, the body that prepares revenue estimates for pending bills.

The Council's letter echoes numerous recommendations previously outlined in its health policy priorities for the 118th Congress:

- Expand site-neutral payment reforms.
- Restrict hospital billing practices that fuel consolidation and mask what should be the appropriate payment amounts.
- Restrict anti-competitive contracting provisions between group health plans and providers that impede value-driven care.
- Ensure greater price transparency in the health care system by codifying and improving price transparency for hospitals and group health plans.
- Support meaningful drug pricing transparency, competition and value and increased Pharmacy Benefit Manager (PBM) accountability.
- Remove barriers that impede employer initiatives to prevent or manage chronic conditions.

Specifically, the Council reiterated its support for the bipartisan Lower Costs, More Transparency (LCMT) Act (H.R. 5378), which follows through on several of these recommendations and represents "positive and important steps toward lowering health care costs through increased transparency and competition."

Council, Others Urge Senate Support for Permanent Telehealth Expansion Act

The American Benefits Council joined 168 other physician, insurer and health advocacy groups in **signing a letter** urging the Senate to support the passage of the Telehealth Expansion Act of 2023 (S. 1001/H.R. 1843), which the House Ways & Means Committee advanced on a bipartisan basis earlier this year.

As previously reported, the CARES Act temporarily allowed first-dollar coverage of virtual care under health savings account (HSA)-eligible high-deductible health plans, allowing individuals to access telehealth services without needing to first meet a deductible. That flexibility originally expired at the end of plan years beginning in 2021 (for most plans that meant expiration on 12/31/21). However, the Consolidated Appropriations Act, 2022, enacted in March of last year, included a *prospective* and *temporary* extension from April 1, 2022, through December 31, 2022, only.

Congress then passed last year's $1.7 trillion-dollar year-end "omnibus" spending bill which included an additional two-year extension of the COVID-era telehealth flexibility for HSA-eligible plans.

The Council has long supported increasing the ability to offer telehealth on a permanent basis, recognizing that it is valuable not just for pandemic-related reasons but also because it expands choice of health providers and access for employees. It has been especially important as a means of addressing obstacles to accessing mental and behavioral health providers.

In a June 7 letter ahead of the House committee's mark-up session, the Council explained that "telehealth has become a vital tool employers use to increase access to value-driven care and combat the nation's mental health crisis, and it is critical this flexibility be made permanent."

RECENT REGULATORY ACTIVITY

DOL Unveils Long-Awaited Fiduciary Definition Rule, Reviving Familiar Battle

The U.S. Department of Labor (DOL) issued its **Retirement Security Rule: Definition of an Investment Advice Fiduciary** on October 31, reigniting what has been a contentious topic over more than a decade. Aside from the **proposed rule** itself, the regulatory package includes:

- Proposed Amendment to PTE 2020-02
- Proposed Amendment to PTE 84-24
- Proposed Amendment to PTEs 75-1, 77-4, 80-83, 83-1, and 86-128
- An official fact sheet
- A news release
- A blog written by Lisa Gomez, DOL Assistant Secretary for the Employee Benefit Security Administration

Very generally, the proposed regulations revise the fiduciary standards for retirement plan investment advice. The Biden administration is touting the proposal as a means of improving retirement security by doing away with "excess fees and costs, and financial losses" by participants.

The DOL, particularly under Democratic leadership, has long sought to combat "conflicts of interest" by extending fiduciary status to a wider array of investment advice relationships than is done by the existing rules. Sweeping regulations to this effect were published in 2016 under the Obama administration. In 2018, these final rules were invalidated by a federal court, which determined that the DOL overstepped its statutory authority in imposing broad new

requirements that were inconsistent with the text of ERISA and the Internal Revenue Code, as well as with the common-law meaning of "fiduciary."

In 2020, the DOL issued subregulatory guidance in the form of the preamble to prohibited transaction exemption (PTE) 2020-02 and a set of FAQs that impose greater fiduciary responsibility on those that provide investment advice, including in the context of workplace retirement plans. However, a federal court has since invalidated DOL's interpretation of a fiduciary in the context of rollover advice – which, along with other court rulings, could form the basis of a challenge to the new proposal.

Since the previous fiduciary rule was struck down, a number of individual states (and other entities) have sought to regulate fiduciary conduct with potential implications for ERISA retirement plans and plan participants. The new rules do not preempt state action and additional localities could choose to pursue fiduciary rulemaking if they think the DOL standards do not go far enough.

Throughout these many debates, the Council has voiced serious concerns about the scope of previous DOL rulemaking in this area and the potential effects on large plan sponsors (including health and welfare plans) and their participants. The Council will be reviewing the new proposal with the same level of scrutiny.

The deadline for feedback to the DOL on the proposal is expected to be sometime in early January 2024.

Council Files Comments on Mental Health Parity Proposed Regulations

On October 17, the American Benefits Council **filed comments** in response to proposed regulations related to the Mental Health Parity and Addiction Equity Act (MHPAEA), issued by the U.S. departments of Treasury, Labor (DOL) and Health and Human Services (the "tri-agencies").

The proposed regulations amend the current MHPAEA final regulations (issued in 2013), with the revisions focused on requirements related to nonquantitative treatment limitations (NQTLs) (*i.e.*, treatment limitations that are not expressed numerically, such as prior authorization) imposed on mental health and substance use disorder benefits, as compared to medical/surgical benefits.

The proposed regulations introduce several substantial modifications to the existing NQTL rules, which largely extend the scope of these requirements. Additionally, the proposed regulations specifically outline the criteria for the NQTL comparative analyses mandated by the Consolidated Appropriations Act, 2021 (CAA). Under these provisions, plans are obliged to thoroughly document their adherence to the NQTL rules.

Due to the importance of these issues and broad scope of proposed changes, our comments are extensive. To frame our more specific comments, the letter begins by emphasizing the importance of mental health, acknowledging the current mental health crisis and explaining employers' efforts and commitment to providing high-quality mental health coverage. We also note challenges to those efforts, including the mental health provider shortage and difficulties with getting mental health providers to join networks.

The letter makes clear the Council's support of mental health parity and explains employers' extensive efforts to comply, notwithstanding the lack of clear guidance. While the Council views the proposed regulations as well intended, the letter identifies several aspects of the rules that raise significant concerns because they would have unintended negative impacts on participants, are unworkable or require substantial additional clarification. As to the specific recommendations:

- **List of NQTLs:** In the proposed regulations, the tri-agencies decline to provide an *exhaustive* list of NQTLs. We explain that it is extremely difficult, and in some cases impossible, to have a comparative analysis at the ready, for each NQTL, if the full scope of what constitutes an NQTL is not known or understood. To enable compliance, we ask that the tri-agencies provide a list of NQTLs for which plans and issuers must have a comparative analysis prepared, and that in the event the tri-agencies identify additional NQTLs, the tri-agencies would be able to request a comparative analysis for those NQTLs. However, plans and issuers should be given sufficient time to provide the additional information.

- **Substantially All/Predominant Test:** The proposed regulations provide that for an NQTL to apply to a mental health or substance use disorder condition, it must first apply to "substantially all" (at least two thirds) of medical/surgical conditions in the same class, and then, only the most common (predominant) variation of the NQTL that applies to medical/surgical conditions may apply to mental health/substance use disorder conditions. We explain this could substantially undermine the ability of plans to apply medical management to mental health and substance use disorder benefits and why medical management is essential to manage quality and cost, confirm the level of care is appropriate, ensure treatments are safe and medically necessary and help prevent unexpected costs for participants. As such, we ask that the tri-agencies decline to finalize the application of the "substantially all/predominant" test to mental health and substance use disorder benefit NQTLs.

- **Required Use of Outcomes Data and "Material" Differences in Outcomes:**
    - The proposed regulations require plans to collect and evaluate relevant outcomes data when designing and applying an NQTL. Except as provided below, if the data shows a material difference in access to mental health/substance use disorder benefits as compared to medical/surgical benefits, the differences will be considered a "strong indicator" of noncompliance. In our comments, we acknowledge the tri-agencies' focus on objective data and also note concerns with the proposal. We ask that the tri-agencies specify a uniform set of outcomes data that must be collected and analyzed; that "material difference" be defined; for more information on how a plan can take a reasonable action to address a material difference; and that a *lack* of a material difference be used to deem a plan compliant or create a presumption of compliance.
    - These same rules apply to the NQTL for network composition except that as proposed, there are additional data elements required and if there is material difference in data the plan is automatically considered to be noncompliant. In the comment, we explain that we understand the focus on the quality of networks and how the immense shortage of providers has undermined efforts to build

mental health networks. With that context in mind, we ask that instead of applying a heightened material difference standard (*i.e.*, a per se violation) to the network composition NQTL, the final rules should apply the material difference standard that applies to all other NQTLs. We also ask for more information on how a plan or issuer could demonstrate a provider shortage and its impact on network composition.

- **Exceptions:** The proposed regulations provide exceptions to some of the NQTL tests for NQTLs based on independent medical or clinical standards and NQTLs designed to detect or prevent and prove fraud, waste and abuse. The letter expresses strong support for these exceptions and asks that additional clarity, and definitions, be provided for each exception.

- **Provision of Meaningful Benefits:** Under the proposed rules, if a plan provides benefits for a mental health condition or substance use disorder in any class of benefits, "meaningful" benefits for the condition or disorder must be provided in every class in which medical/surgical benefits are provided. In the letter, we ask that the term "meaningful benefits" be defined, for clarity and administrability. We are concerned that without a definition this term could be over-interpreted, contrary to the fact that MHPAEA is not a coverage mandate. Specifically, we suggest defining "meaningful benefits" as the plan provides at least one primary treatment for the condition or disorder at issue, in each classification.

- **NQTL Comparative Analysis:** Regarding the comparative analysis:
    - We thank the tri-agencies for responding to our requests for more detailed guidance, ask for examples of compliant comparative analyses and emphasize the role third party administrators (TPAs) play in preparation of the comparative analyses.
    - We ask the tri-agencies decline to finalize the requirement that a named fiduciary certify the comparative analysis, as it will be extremely difficult for plan fiduciaries to make this certification, because of the complexity of the rules, and the unique and numerous data comprising the analysis.
    - We ask for additional clarification on the circumstances in which a plan must provide a comparative analysis to participants and beneficiaries (and in some cases providers), in the event of an adverse benefit determination.
    - We ask for procedural guardrails for plans and issuers prior a final determination of noncompliance, including a form of independent review. We also ask several other more technical questions.

- **Applicability Date and Good Faith Standard:** We express concerns with the proposed 2025 applicability date and explain the extensive work that will be needed to implement final rules. We ask that the tri-agencies provide at least a year between finalization and application of any final rules. We also ask that the tri-agencies apply a good faith compliance standard during the initial period of implementation, due to the complexity of the rules.

- **Technical Release:** In conjunction with the release of the proposed regulations, DOL issued a technical release requesting comment on relevant data requirements for the network composition NQTL and proposed an enforcement safe harbor, for plans whose data meet certain standards, with respect to the network composition NQTL. We express support for the development of an enforcement safe harbor for plans to demonstrate through data that they meet or exceed standards with respect to the NQTL for network composition and request clarity and provide other comments on the data to be analyzed.

In addition to our letter, the Council worked with a coalition of other employer and insurer groups on **a joint letter**, also filed on October 17, amplifying our suggestions to the tri-agencies. According to the joint letter, "Coalition members have significant concerns that some of the proposals could inadvertently reduce the quality and efficacy of the MH/SUD care received by patients by restricting health plans' ability to protect patients through plan standards that ensure high-quality providers and safe, effective treatment for patients."

Due to the anticipated number and scope of comments, we do not expect final regulations would be issued until well into 2024. We will continue to engage with the tri-agencies on these important issues and will report on any significant developments.

Council Seeks Further Guidance for Roth "Catch-Up" Contribution Rule

The American Benefits Council on October 24 **submitted comments** to the Internal Revenue Service (IRS) on their recent guidance under Section 603 of the SECURE 2.0 Act of 2022 relating to Roth "catch-up" contributions.

Section 603 of SECURE 2.0 requires catch-up contributions for certain highly compensated individuals be made on a Roth basis, effective January 1, 2024. However, the IRS announced earlier this summer a transition period that extends until 2026 for the implementation of the new Roth "catch-up" contributions rule. This announcement followed an extensive campaign by the Council advocating for the delay, including a **July 14 letter** to Congress and the U.S. Treasury Department signed by more than 225 organizations.

While we appreciate the relief and clarifications already provided, there are still a number of outstanding questions regarding the implementation of Section 603 with respect to which further guidance will be needed.

For example, while supportive of the two-year administrative transition period, the Council asks Treasury to consider an additional delay to give state and local governments time to consider and enact any needed legislation, and to avoid requiring changes during the term of a collective bargaining agreement.

With respect to the latter point, the Council suggests the transition period should extend to the end of any already-started term of a collective bargaining agreement.

The letter also requests additional specific guidance under the Roth catch-up provision, including:

- **Limiting catch-up contributions**: The Council requests that Treasury confirm it is also permissible for a plan with Roth features to limit catch-up contributions to participants who earned $145,000 or less in FICA wages for the prior year.
- **Determining FICA wages for eligible participants:** The Council requests that a plan administrator would be treated as operating the plan in accordance with its terms if the determination is based upon the amount of FICA wages as reported on the employee's Form W-2 for that year, and not as ultimately determined by IRS, if different.
- **Indexing the $145,000 threshold:** The Council requests guidance confirming that the 2025 indexed limit will determine which employees are high earners in 2025 (based on 2024 wages).
- **Controlled Group**: The Council requests that Treasury address how the Roth catch-up requirement applies to an employee who transfers to another employer within the same controlled group.
- **Roth catch-up requirement for all participants:** The Council requests that Treasury issue guidance addressing whether a plan may require that all catchup contributions be made on a Roth basis, including catch-up contributions made by those participants whose wages for the preceding calendar year did not exceed $145,000.

Council Responds to IRS Question Regarding 15% Corporate Minimum Tax, Defined Benefit Plans

In response to recent guidance issued by the Internal Revenue Service (IRS), the American Benefits Council **strongly recommended** a clear and consistent approach to the 15% corporate tax and the statutory exception provided to defined benefit plans.

The Inflation Reduction Act of 2022 (IRA) included, as a revenue raiser, a 15% alternative minimum tax on corporations with annual income in excess of $1 billion. As recommended by the Council's Pension Policy Project and advanced by the Senate Finance Committee, the final version of the legislation exempted pension plan assets by treating defined benefit plans and other defined benefit post-retirement benefit plans in the same way they are treated for income tax purposes: essentially, (1) contributions to such plans would be *deductible* for minimum tax purposes, and (2) changes in plans' asset values or liabilities *would not give rise to income or loss.*

In a December 2022 letter to Treasury and IRS, the Council explained why defined benefit pension plans were exempted and how the agencies should distinguish between defined benefit welfare benefits and defined contribution welfare benefits, as required by the statute. "The legislation applied the same defined benefit plan adjustment for 'any other defined benefit plan which provides post-employment benefits other than pension benefits.' Clearly, this was aimed at retiree welfare plans like retiree health and life insurance plans that could have experienced the same adverse effects as defined benefit pension plans had the defined benefit exception not been included."

IRS Notice 2023-64, issued on September 10, requested further input on this topic, asking specifically:

- Whether an account-based retiree-only group health plan that makes payments for retirees from an aggregated account (rather than from assets that have been allocated to

individual retirees' accounts) meets the definition of a defined benefit plan for purposes of the exception.

- Whether a plan that provides post-employment benefits in a lump sum or over a short period of time (for example, 24 months) is a plan that provides benefits other than pension benefits, as required for the plan to qualify for the exception.

As the Council's October 12 letter explains, the most effective and comprehensive approach would be to define a defined benefit post-employment benefit plan as a plan that is accounted for similarly to a defined benefit pension plan under US generally accepted accounting principles (GAAP) or another applicable accounting standard, based on changes in liabilities and changes in plan assets.

"Congress did not want companies taxed on inaccessible plan asset gains or on liability swings due to overall market volatility. So, Congress included a rule to prevent that result both for pension plans and for welfare plans," the Council wrote. "In order to fulfill that clear intent, the definition of a 'defined benefit plan which provides post-retirement benefits' has to cover all welfare benefit plans that are accounted for on a defined benefit plan-type basis, rather than on a cash basis (like defined contribution plans)."