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 Commends Bipartisan Passage of the Lower Cost, More Transparency Act by House

On December 11, the U.S. House of Representatives overwhelmingly passed the Lower Costs, More Transparency (LCMT) Act (H.R. 5378) with a bipartisan vote of 320-71.

"The House's overwhelming, bipartisan support for this legislation shows lawmakers are in agreement with the American people: something must be done about high and rising health care costs," said Ilyse Schuman, the Council's senior vice president, health policy, in a news release applauding the vote.

Of particular significance to plan sponsors, the LCMT Act introduces key measures aimed at reducing costs through enhanced transparency and increased competition in the healthcare market, including:

- **Elimination of the Consolidation Incentives:** The act addresses the issue of hospitals exploiting the acquisition of physician practices to overcharge payers, such as employer-sponsored group health plans. By advancing site-neutral payment reform, the legislation aligns payment rates for specific services across various outpatient care locations. Additionally, it promotes fair billing practices, enabling accurate determination of where care is received.

- **Enhanced Price Transparency:** The LCMT Act bolsters transparency for hospitals and group health plans, providing employers and consumers with clearer information on healthcare costs to facilitate better decision-making.

- **Pharmacy Benefit Manager Oversight:** Recognizing the complexity and opacity of the current rebate structure, the legislation aims to provide employers with a clearer view of drug costs. This increased visibility will contribute to lowering prescription drug expenses and ensuring greater value for beneficiaries.

In addition to the **Council's endorsement**, a coalition of employer and ally coalitions, including the Alliance to Fight for Health Care, EmployersRx and ConsumersFirst, have also supported provisions of the LCMT Act.

The Alliance, a diverse coalition established by the Council to support employer-provided health care coverage, emphasized in a letter to House leadership that the bill expands site-neutral payment reform and ensures fair billing practices for care provided by off-campus hospital outpatient departments.

"American employers, providing high-quality health care coverage for nearly 180 million people nationwide, are committed to maintaining affordable coverage. The LCMT Act is a crucial initial step, and we urge the Senate to take prompt action," Schuman said.

House Paid Family Leave Working Group Releases 2023 Activity Report, Joins Bipartisan Senators in Issuing RFI

The members of the U.S. House of Representatives bipartisan Paid Family Leave Working Group issued its "A Year in Review" report on December 11, summarizing the findings from several briefings over the course of 2023 and previewing activity for the coming year.

Cited in the report are the perspectives of large employers and their representatives, including the American Benefits Council. Ilyse Schuman, senior vice president, health policy, participated in the July 18 Briefing, "Large Employers and the Paid Family Leave Landscape," in which she outlined the Council's principles on paid leave and reiterated many of the recommendations previously offered in the Council's written testimony submitted for the October 25 U.S. Senate Committee on Finance hearing exploring paid leave policy and its impacts on the workforce.

The Council has consistently stressed the value of paid leave benefits for employers and employees alike, but has frequently noted 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.

"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," the Council said in its testimony.

In related news, the bipartisan House working group collaborated with a bipartisan group of Senators, led by Bill Cassidy (R-LA), the ranking Republican on the Senate Health, Education, Labor and Pensions Committee, and Sen. Kirsten Gillibrand (D-NY), in issuing a December 13 request for information (RFI) seeking "suggestions for expanding access to paid parental, caregiving, and personal medical leave in a bipartisan and fiscally responsible way."

The RFI asks ten specific questions, most notably, "What should the federal role be, if any, in providing, promoting, and/or incentivizing paid leave? And how should this interact with the role of state government programs, and/or employer programs?"

Responses are due by January 31.

RECENT REGULATORY ACTIVITY

Council Testifies on Behalf of Employer Plan Sponsors at DOL Fiduciary Rule Hearing

Lynn Dudley, the American Benefits Council's senior vice president, global retirement and compensation policy, testified before the U.S. Department of Labor on December 12, describing employer concerns with the Biden administration's newly proposed "retirement security rule."

The DOL proposal revises the fiduciary standards for retirement plan investment advice, seeking to address potential "conflicts of interest" by extending fiduciary status to a wider array

of investment advice relationships than is done by the existing rules. 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.

This is the latest iteration of a DOL fiduciary rule proposal, dating back to the Obama administration. In past 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.

DOL is soliciting comments on the proposal through January 2. The Council is currently developing comments for submission.

In the meantime, DOL hosted a hearing (in two parts) on the proposal to collect initial responses from stakeholders. Nearly 50 witnesses testified over the course of December 12 and 13.

Dudley was the first witness to testify on December 12, reporting concerns from employers that "the proposed new rules are at odds with the direction in which employers are moving and the pressing needs of participants in terms of facilitating employee engagement with their benefit plans. … The new rules will make many plan operations more difficult and more expensive because they will add uncertainty, cost, and potential liability for employers."

Dudley highlighted a number of key issues requiring further consideration by DOL before finalizing the proposal, recommending:

- A clear exclusion from fiduciary status for human resources employees and all other employees of a plan sponsor with respect to providing assistance to plan participants.
- A similar exclusion for outsourced financial wellbeing programs.
- Preservation of DOL's current position on investment education, clearly extending to distribution education.
- Protection of call centers for employees by limiting fiduciary status to relationships of trust and confidence, which would exclude isolated calls for assistance to an unknown person at a call center.
- Establishment of a safe harbor insulating a plan sponsor from co-fiduciary liability for the acts of any plan service provider, under certain circumstances.
- A blanket exception for responses to employer requests for proposal from service providers.
- An exemption from fiduciary status for actions taken by, or at the direction of, the plan sponsor in helping employees transition from one plan to another in the context of a business transaction, such as a merger or acquisition.

These recommendations will be incorporated in the Council's written comments and further communications with agency staff.

Council Comments on Health Plan Coverage of Over-the-Counter Preventive Products

On December 4, the American Benefits Council **filed comments** in response to a recent request for information (RFI) issued by the U.S. departments of Health and Human Services, Labor and Treasury (the "tri-agencies") on a potential expansion of the Affordable Care Act (ACA) requirement that health plans cover preventive services, without cost-sharing — namely, an expansion to over-the-counter preventive items *available without a prescription*.

As a reminder, under the ACA, non-grandfathered group health plans must cover certain specified preventive services without cost-sharing. 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 without the involvement of a provider ("OTC preventive products"). Examples include certain types of tobacco cessation drugs, folic acid supplements and certain contraceptives.

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. However, in the RFI, the tri-agencies state that requiring plans and issuers to cover, without cost-sharing, OTC preventive products without a prescription is an important option to consider for expanding access to preventive care, including contraceptive care (including recently approved OTC birth control). They also recognize that most plans do not currently cover OTC preventive products so note they are issuing the RFI to improve their understanding of the related issues.

In response, the Council's comment letter begins by noting that our members highly value and prioritize providing access to preventive care, in order to improve the health of employees and their families and to reduce health care costs. We also note that our members have long been in compliance with the preventive services requirement. We thank the tri-agencies for seeking feedback before proceeding with the expansion, note we understand the goal of increasing access to preventive care, and set out several concerns, including regarding fraud, waste and abuse, costs, and operational complexity. We ask that the tri-agencies keep these issues in mind and explore ways to mitigate these concerns, including along the lines we suggest. Among other specific comments, we address the following:

- **Medical Management:** We note that currently under the preventive services regulations, plans may generally impose reasonable medical management techniques. Consistent with the current rules, we note that it is essential that plans and issuers be allowed to apply reasonable medical management techniques, including reasonable quantity limits, in the event plans and issuers are required to cover OTC preventive products without a prescription. We explain that medical management, including quantity limits, could mitigate the potential for fraud, waste and abuse and related increased health care costs for participants and plans.

- **Implementation Flexibility:** We explain the various considerations that employers and plans will need to take into account in developing new systems and processes for implementation and explain there are an array of ways this requirement could be

implemented. We note we are concerned that if the tri-agencies are overly prescriptive in how a new requirement should be implemented, that will unnecessarily add to the complexity and cost involved with implementation. Instead, our recommendation is that the tri-agencies be clear on the general requirement and guiding principles and then provide plans and issuers with the maximum flexibility on how the requirement is implemented.

- **Network Concept:** We note that currently under the preventive services regulations, for plans with a network, the preventive services requirement applies to services provided in-network but not for services that are provided out-of-network. We acknowledge that a retail setting differs from a provider setting but ask that the tri-agencies provide that plans may limit the locations at which the no-cost sharing OTC preventive products may be dispensed, so long as participants have meaningful access to the OTC preventive products, which would allow plans to steer participants to locations where the cost is reasonable and would make this policy less complex to implement. We also ask that if the tri-agencies proceed with this expanded requirement they monitor prices of future OTC preventive products and, if necessary, explore whether guidance related to dollar limits is warranted, as was the case regarding OTC COVID-19 tests.

- **Account-Based Plans:** We explain that employers offer various account-based plans which can be used to reimburse OTC medical products, mention concerns about double payment and confusion, and ask the tri-agencies to make clear that plans need not cover the cost of an OTC preventive product if the participant has been reimbursed by another source and to confirm that plans can require a related attestation.

- **Opportunity for Comment:** We ask that the agencies formally propose specific changes through the notice and comment process to allow for stakeholder feedback.

- **Implementation Timeline:** Due to the need to design new systems and processes, we ask that plans be given sufficient time for implementation (*i.e.*, until the beginning of the plan year that begins on or after the date that is one year after any final rules are issued).

Tri-Agencies Propose Surprise Billing Rules Related to Arbitration

Last month, the departments of Labor, Health and Human Services, and the Treasury (the "tri-agencies") issued a Notice of Proposed Rulemaking (the "Proposed Rule") regarding the processes governing the No Surprises Act's (NSA) negotiation and Independent Dispute Resolution (IDR) mechanisms.

The Proposed Rule is the most recent major development in the implementation of the NSA following the numerous legal challenges to the IDR process and the NSA more generally. As previously reported, the Council has been actively engaged in supporting regulations and guidance that achieves the patient protections sought under the NSA while still achieving the cost savings that Congress intended in passing the NSA.

The Proposed Rule includes detailed procedural amendments to the existing regulations that both address previous court rulings vacating prior regulations and guidance, as well as the

much larger universe of IDR submissions than the tri-agencies had anticipated in promulgating the original IDR rules. (As a reminder, under the NSA, after a plan makes an initial payment to a provider, the provider may pursue "open negotiation" with the plan to seek additional amounts and if no agreement is reached, the provider may then seek federal IDR).

In the Proposed Rule, the tri-agencies acknowledge that the volume of IDR submissions has been roughly 14-times higher than anticipated, and that IDR participants have generally not engaged in meaningful negotiation prior to the initiation of the IDR process. The tri-agencies also note that the litigation over the IDR process and the vacatur of various rules governing the IDR process have exacerbated this large volume of IDRs by pausing submission of IDRs periodically and requiring the issuance of additional guidance. The tri-agencies also note that implementation has been hampered by general confusion, including lack of accurate or correct information, in the general process.

In response, the Proposed Rule significantly modifies the processes applicable to both the NSA's 30-day open negotiation requirement and IDR and the manner in which parties submit information to IDR entities, the tri-agencies and counter-parties in the negotiation and IDR process. Among other things, the Proposed Rule:

- requires more fulsome information exchange prior to the initiation of IDR, including a requirement that plans respond, with a specific notice, to the initiation of open negotiation, to the tri-agencies as well as counter-parties.

- requires more fulsome information exchange at the initiation of IDR, including a notice by plans, to the tri-agencies as well as counter-parties.

- requires increased use of the federal IDR portal to facilitate various aspects of the process, including the exchange of information at the start of open negotiation and IDR.

- requires plans to submit information about the plan to a federal registration system, in order to receive a plan-specific registration number, which is then to be used in various communications during open negotiation and IDR.

- changes the rules, and imposes specific requirements, around the types of claims that can be batched, including in response to recent litigation.

- modifies the administrative fee paid by parties, including reducing fees paid by plans when a provider initiates IDR for a claim that is ineligible for IDR.

The Council has been very involved in working before the tri-agencies regarding the implementation of the NSA since its passage and plans to submit comments responding to the tri-agencies proposals regarding the more detailed process to be followed in resolving payment disputes under the NSA. The Council welcomes feedback on the Proposed Rule, to inform our comments.

We will continue to monitor these issues and to support efforts to ensure the NSA not only protects patients but also lowers health care costs, as intended.

Agencies Update Guidance on Health Plan Services and Notices in Non-English Languages

The U.S. departments of Health and Human Services, Labor and Treasury (the "tri-agencies") recently issued updated guidance regarding the requirement under the Affordable Care Act (ACA) that certain services and notices be provided in non-English languages.

As a reminder, under the ACA, certain services and notices must be provided in a "culturally and linguistically appropriate manner." This requirement applies to certain claims and appeals services and notices (for non-grandfathered health plans) and also to the summary of benefits and coverage (SBC) requirement.

Under the relevant regulations, a health plan is considered to provide the relevant services and notices in a culturally and linguistically appropriate manner if the plan or issuer meets several requirements with respect to "applicable non-English languages." Among other things, the plan must provide oral language services (such as a telephone customer assistance hotline) in any applicable non-English language; must provide, upon request, a notice in any applicable non-English language; and must provide in the English versions of all relevant notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan (referred to as "taglines").

For this purpose, applicable non-English languages are determined county by county — a language is an applicable non-English language in a county if 10% or more of the population residing in the county is literate only in the same non-English language, as determined based on American Community Survey (ACS) data published by the United States Census Bureau (the current list can be found here).

On November 28, the tri-agencies issued updated guidance that lists all counties that meet or exceed the 10% threshold, based on the 2016-2020 ACS data. The new list is applicable for plan years beginning on or after January 1, 2025, and until the next version of the guidance is issued and effective. The guidance also includes sample taglines in each of the applicable non-English languages.

At the same time, the tri-agencies released an FAQ explaining this update, indicating that they intend to update certain documents in the future to reflect the updates in the CLAS guidance, including the SBC template and sample completed SBCs in English (with updated taglines in applicable non-English languages), additional translated versions of the SBC and Uniform Glossary; and model notices for internal claims and appeals and external review.

MISCELLANEOUS

Council to Co-Host ERISA 50th Anniversary Symposium and Gala

American Benefits Council, in collaboration with eight other associations, will be co-hosting a symposium and gala dinner next year to celebrate the 50th anniversary of the passage of the landmark Employee Retirement Income Security Act (ERISA). It will be one of several initiatives the Council will undertake to recognize the law and advance the Council's policy agenda.

The symposium will be held September 12, 2024, and will be designed to honor, reflect upon, and envision the past, present, and future of ERISA. Recognizing the evolving landscapes of retirement, health care and other employer-sponsored benefits, the symposium will serve as a platform for engaging discussions and insights from thought leaders, including Council representatives. The symposium will be accessible virtually for those unable to join in person. A gala dinner will be held immediately following the symposium at a historic site in Washington, D.C.

Council President James Klein expressed excitement about the upcoming event, stating, "This ambitious event will bring together diverse stakeholders within the employee benefits community to not only reflect on ERISA's achievements, but also to look to initiatives that can shape the future of retirement, health and benefits policy."

The ERISA 50th Anniversary Symposium and Gala will be a collaborative effort involving host associations, including AARP, American Council of Life Insurers, American Retirement Association, AHIP, the Defined Contribution Institutional Investment Association, The ERISA Industry Committee, Investment Company Institute and the U.S. Chamber of Commerce.

In addition to the symposium and gala, planning has already begun on a series of Council efforts to use the 50th anniversary to enhance the association's advocacy. This includes an education series for Capitol Hill policymakers and commissioning research to support the Council's policy priorities, including protection of ERISA's critical federal preemption standard.

A website has been set-up www.erisa50.org that will be populated with details about the event as they are confirmed.