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 Paid Family Leave Working Group Releases Legislative Framework Including 'Harmonization Across States'

On January 8, the members of the U.S. House of Representatives bipartisan Paid Family Leave Working Group released **a framework for possible legislative options**, advancing the possibility of a bipartisan measure this year. The release of this document follows the issuance of its "A Year in Review" report on December 11, which summarized the findings from several briefings over the course of 2023 and previewing activity for the coming year (including insights from the American Benefits Council).

The working group's framework states that it is not comprehensive but reflects current consensus among the working group. It is organized in four "pillars" for potential legislation.

Most notably, one of these pillars is "Coordination and Harmonization of Paid Leave Benefits Across States," targeting states that provide leave benefits (or might provide benefits in the future) as well as multi-state employers and employees who offer and utilize benefits.

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.

The working group's legislative framework proposes the creation of an "Interstate Paid Leave Action Network (I-PLAN)" that would drive improvements in coordination and harmonization of these benefits across the growing number of states with their own paid leave programs/

It is a notable and encouraging development that the bipartisan House Working Group recognizes the need for coordination and harmonization of paid leave across states.

The other three pillars are:

- Establishment of a public-private partnership paid leave pilot program, for states who want to set up a new paid leave program.
- Small employer pooling for paid leave insurance, targeting small businesses.
- Improvements to paid leave tax credits for small businesses and working families.

The House working group is collaborating with a bipartisan group of Senators on a **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 Council continues to develop a response to the RFI, based on the Council's principles on paid leave and its written testimony submitted for the October 25, 2023, U.S. Senate Committee on Finance hearing exploring paid leave policy and its impacts on the workforce. Responses are due by January 31.

RECENT REGULATORY ACTIVITY

Council Comments on Prescription Drug-Related Guidance from HHS

The American Benefits Council recently filed **written comments** in response to the U.S. Department of Health and Human Services' (HHS) Proposed Notice of Benefit and Payment Parameters for 2025 (also known as the "2025 payment notice"). While this annual guidance from HHS covers a wide range of issues, the Council's draft comments were focused on certain programs that have been developed related to prescription drug costs.

Background

Under the Affordable Care Act (ACA), non-grandfathered group health plans must ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided under the ACA (the maximum out-of-pocket (MOOP) limit). However, only cost-sharing for essential health benefits (EHBs) counts toward the MOOP limit.

To determine which benefits are EHB for purposes of applying the MOOP limit, self-insured plans and large group insured plans may use any definition of EHB that has been authorized by HHS. This generally means plans can use the benchmark plan in any state. In the context of prescription drug benefits, EHB are defined as the greater of one drug from each United States Pharmacopeia (USP) category and class or the number of drugs in the EHB-benchmark plan, set by the applicable state.

Applying these rules, some group health plans characterize some prescription drugs as EHBs and others as non-EHBs. For the drugs that are EHBs, cost-sharing is subject to the MOOP limit and for the non-EHB drugs, cost-sharing is not subject to the MOOP limit. Under these rules, working with third-party vendors, some plans have implemented programs to control drug spend, often referred to as "co-pay or cost-sharing maximizers" or "variable copay programs." In general terms, the health plan determines cost-sharing for a non-EHB drug based on the maximum amount of copay assistance that a patient could receive from a drug manufacturer. Because the drug is considered non-EHB, this cost-sharing amount could exceed the annual MOOP limit and would not be subject to the MOOP limit (but the idea is that cost-sharing will be covered by the drug manufacturer assistance).

These programs are designed to allow plans to use the full benefit of drug manufacturer payment assistance. But they have been criticized, including by some consumer groups, for being complex and leaving open the possibility for the consumer to have high cost-sharing if they do not utilize the drug manufacturer assistance. There is also ongoing litigation related to these programs. Copay maximizers aside, the ability of plans to characterize some prescription drugs as non-EHBs also allows plans to cover certain high-cost drugs (which might otherwise be cost-prohibitive), because they are able to impose more substantial cost-sharing and not count the cost-sharing to the MOOP limit.

2025 Payment Notice and Council Comment Letter

In the proposed 2025 payment notice, HHS provides that, in general, if a health plan covers prescription drugs in excess of the prescription drugs required to be covered as EHB under the current definition, the additional prescription drugs are considered an EHB and are subject to the MOOP limit. HHS states that it has explained this rule in prior preambles but that it is now

codifying the rule in response to requests from stakeholders for clarity. HHS notes it has heard of some plans that have developed programs to provide some drugs as non-EHB, and it asks for comments on these types of programs.

The Council's comment letter explains that our members are committed to supporting access to comprehensive prescription drug benefits to improve the health and well-being of employees and their families and to reduce overall health care costs.

The letter also states that, as we understand, the proposed rules only apply to the individual and small group insured markets, and not the large group insured and self-insured markets, based on the placement of the regulatory text. We explain that declining to apply the proposal to the large group and self-insured markets is consistent with the ACA. We also express concerns with applying the proposed rule to these markets, as such a rule could undermine access to drug coverage and the ability of employers to continue to use innovative plan designs intended to address drug costs. We ask HHS to state in the preamble to the final rule that the policy change does not apply to the large group and self-insured markets.

DOL Finalizes New Independent Contractor Rule

The U.S. Department of Labor's (DOL) Wage and Hour Division published **final regulations on employee or independent contractor classification under the Fair Labor Standards Act** on January 9, along with a set of 21 Frequently Asked Questions (FAQs) providing additional insights into the DOL's views.

The DOL final rule formally repeals the previous administration's 2021 independent contractor rule and establishes a revised economic reality test for determining whether a worker is an employee or an independent contractor. The final text of the rule, while generally mirroring the version proposed by the Biden administration in 2022, includes some notable modifications and language refinements to address concerns raised by stakeholders.

The final DOL independent contractor rule is effective on March 11, 2024.

Council Comments on DOL Fiduciary Rule Highlights Concerns of Plan Sponsors

The American Benefits Council offered a detailed critique of the U.S. Department of Labor's proposed "retirement security rule" in **written comments to the agency** on December 29, arguing that the proposal is "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 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.

The Council's comments focused exclusively on the impact of these rules for employer sponsors of retirement plans, emphasizing that the proposed rules would make many plan operations more difficult and more expensive because they would add uncertainty, cost and potential liability for employers. (The Council previewed these comments in a public hearing (in two parts) on the proposal on December 12 and 13.)

Specifically, the comments describe the potential impact on:

- Plan sponsor employees
- Financial wellness programs
- Financial education
- Call center assistance
- Requests for proposal from service providers
- Use of the "hire-me" exception
- Discretionary fiduciaries
- Mergers and acquisitions
- Routine agreements, such as a change in investment managers
- General assistance from financial professionals
- Health and welfare plans

The comment letter also recommends the addition of a safe harbor to protect plan sponsors from co-fiduciary liability.

The final version of the rule is expected to be issued on an expedited timeline to avoid being recalled under the Congressional Review Act by a new Congress in 2025. The regulations are proposed to be effective within 60 days of finalization. The Council's comments urge the agency to establish a long transition period (at least one year) following finalization of the rule and a clarification that existing agreements are protected from the application of the new rules.

PBGC Participant and Plan Sponsor Advocate Issues 2023 Report, Calls for Legislative Reforms to Support Defined Benefit Plans

The Pension Benefit Guaranty Corporation's (PBGC) Participant and Plan Sponsor Advocate, Constance Donovan, issued her **annual report** to Congress and the PBGC Board of Directors on December 29, 2023, highlighting the clear need for legislative reforms to prevent an acceleration of the exodus from the defined benefit plan system.

The advocate position was established by the Moving Ahead for Progress in the 21st Century (MAP-21) Act of 2012 to assist participants and sponsors in resolving issues related to the agency. Since the beginning of her tenure in 2013, Donovan has worked extensively with the American Benefits Council as part of her commitment to reaching out to both the plan sponsor and participant community.

The latest report includes several observations consistent with the Council's messages to PBGC on several topics.

- **The single-employer plan program's "extraordinary" $44.6 billion surplus:** The advocate's report notes that PBGC's single-employer program surplus "is not taxpayer money, but money from plan sponsors who, for years now, have not only made significant contributions to their pension plans but have also overpaid PBGC premiums to cover a level of risk associated with the defined benefit system that simply no longer exists." Donovan asserts that policymakers and legislators should develop options to relieve this extraordinary financial burden, which is driving plan sponsors from the defined benefit system.

- **Possible proposals warranting further consideration:** The report cites numerous ideas included in the Council's **set of eight proposals to bolster the defined benefit pension system** by addressing issues that compel well-funded plans to freeze or terminate. These include:

    - "Alternative PBGC premium structures, such as automatically adjusting single-employer premium levels based on PBGC's average funded status and considering a PBGC premium holiday. One specific proposal raised by the plan sponsor community suggests automatic premium decreases or increases when PBGC funding climbs above or dips below certain levels."

    - "Taking PBGC [premium increases and decreases] 'off-budget,' to ensure that premiums are no longer counted in general fund revenue, as these funds cannot be used for governmental purposes other than funding PBGC programs."

    - "Capturing value and other potential uses for the surplus when a plan is above full funding, such as using the surplus to fund defined contribution plan benefits, which would require legislation since current law only permits such use if the overfunded plan terminates. Similarly, surplus amounts in Section 401(h) health arrangement accounts could be used to fund both defined benefit and defined contribution plans."

    - "Renewing interest in cash balance plans and exploring ways to promote the structure, including legislative and regulatory changes to facilitate administration of cash balance plans. This should include updating the accounting rules of cash balance plans to accurately reflect plan sponsors' future benefit obligations."

    - "Other alternative defined benefit structures that offer flexibility, portability, and limited risk-sharing between the employer and employee. This includes, for example, variable annuity plans, which protect plan sponsors from risk by adjusting benefits based on returns on the plan's assets, but also include participant protections, such as benefit stabilization by way of an asset reserve."

    - "Making defined benefit plans more attractive to plan sponsors, including reforming reporting and compliance requirements to reduce administrative burdens."

The report also includes other proposals, including conforming defined benefit plan vesting rules to the defined contribution plan rules (requiring 3 years to vest or a 2-6 year graded vesting), coupled with higher mandatory cash-out limits would likely address potential plan sponsor concerns about having to administer and paying premiums for participants with very small benefits.

The Council remains concerned about one talking point in Donovan's report, which praised the interagency coordination with the U.S. Department of Labor's Employee Benefits Security Administration to attempt to locate PBGC's 80,000 missing participants. While DOL has engaged in often fruitless missing participant audits of private employers lasting seven years of more, DOL has basically overlooked 80,000 missing participants at PBGC, recovering benefits for 200 out of 80,000, or one-quarter of 1%. As chair of the PBGC, DOL can and should make this internal problem a higher priority than private audits.

The Council is actively communicating its defined benefit proposals to lawmakers and will continue to actively pursue reforms at all levels to improve various agency processes and address employer concerns about missing plan participants.