BENEFITS INSIDER

Volume 341, April 15, 2024
(covering news from April 1-15, 2024)

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 REGULATORY ACTIVITY

Council Meets with Biden Administration in Last-Ditch Effort to Improve Final Fiduciary Rule

You Need to Know:

- Final regulations modifying the definition of "fiduciary" with respect to retirement plan investment advice are expected to be released imminently.
- The Council met with Biden administration officials emphasizing the negative implications for plan sponsors, as previously articulated in testimony and written comments.

The American Benefits Council is making its final push to modify the U.S. Department of Labor's (DOL) proposed Retirement Security Rule: Definition of an Investment Advice Fiduciary before the rule is published in the coming months.

The DOL proposal – including two modified prohibited transaction exemptions – 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.

The Council had numerous discussions with plan sponsors regarding the plan sponsor perspective on these proposals. Based on these discussions, the Council testified on the proposal in December 2023 and offered a detailed critique of the U.S. Department of Labor's proposed "retirement security rule" in **written comments to the agency**, 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."

On March 8, DOL sent final rules to the White House Office of Information and Regulatory Affairs (OIRA) for review. On April 4, the Council had a virtual meeting with OIRA and DOL to urge OIRA to review the final rule's effect on plan sponsors and their participants.

Since the final rule is not public, at the meeting, the Council reiterated the points made in its testimony and comment letter: the proposed 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 proposal would make many plan operations more difficult and more expensive because they will add uncertainty, cost, and potential liability for employers at a time when plan sponsors are trying to efficiently utilize internal and outside resources so they can continue to provide meaningful employee benefits for their employees.

More specifically, the Council advocated for the following:

- We strongly supported an exclusion from investment advice fiduciary status for human resources employees and all other employees of a plan sponsor with respect to providing assistance to plan participants. Otherwise, it is participants who will suffer by getting less help.

- For the same reasons, outsourced financial wellness programs should be excluded from the definition of a fiduciary. Unless there is an exclusion, such programs may not be able to address key issues such as the advisability of plan loans or hardship distributions.

- We also emphasized the need to exclude call centers from the definition of a fiduciary. We discussed the numerous critical functions of call centers, and how the proposed rules would cause call centers to provide far less information about investment and distribution options. We also addressed at length the burden the proposed rules would have put on employers to monitor call centers.

- We noted that if responses to requests for proposal (RFPs) include any investment-related ideas, such responses would be fiduciary advice under the proposal. We asked for that to be changed. Since it is not workable for those marketing materials to be fiduciary in nature, responses to RFPs would not contain key ideas, and would accordingly be far less helpful to plan sponsors. This would make the vendor selection process less effective.

- We described to OIRA and DOL how it is common for buyers in a corporate acquisition to help acquired employees roll their old 401(k) plan assets into similar investments in the buyer's plan. However, the proposal would make that help fiduciary advice, thus preventing the help from occurring. We urged that to be fixed.

- Finally, we asked that the compliance date be at least one year after finalization and that the new rules should not be applicable to existing service agreements.

As is typical for such meetings, neither OIRA nor DOL asked questions, which is the norm. However, OIRA did note how helpful the meeting was, especially on the call center issue.

DOL Finalizes Amendments to QPAM Exemption

***You Need to Know*:**

- DOL finalized amendments to Prohibited Transaction Exemption 84-14, effective June 17, 2024, despite some positive changes, retaining concerning conditions like new recordkeeping requirements and expanded disqualifying events.
- While pleased with certain alterations to proposed amendments, the Council remains concerned about the overall impact of the finalized QPAM amendments, citing unnecessary costs and burdens for investment managers and plan sponsors, particularly regarding recordkeeping, transition periods, and disqualification criteria.

On April 2, 2024, the Department of Labor (DOL) released final amendments to Prohibited Transaction Exemption 84-14, which is the class exemption generally referred to as the qualified professional asset manager, or QPAM, exemption. The final amendments will generally become effective on June 17, 2024.

While the American Benefits Council was pleased to see some of the most concerning aspects of the proposed amendments were changed in response to comments filed by the Council

on **October 11, 2022**, and **January 6, 2023**, and the testimony we provided as part of the associated hearing, we are concerned about this overall rulemaking, and the unnecessary costs and burdens that the final amendments will create for investment managers and their plan sponsor clients when seeking to engage in routine plan transactions that incidentally run afoul of ERISA's prohibited transaction rules.

The Council was pleased, for example, to see that, unlike the proposal, the final amendments:

- Remove the requirement for every QPAM to amend their investment management agreements with their clients;
- Eliminate the process that would have allowed DOL to unilaterally disqualify a QPAM through the issuance of a written ineligibility notice;
- Provide a much more workable transition period in the event that a QPAM is disqualified by extending transition relief to new transactions entered into by a QPAM on behalf of existing clients; and
- Remove the proposal's per se prohibition on QPAMs entering into transactions that are "planned, negotiated, or initiated" by a party in interest, such as a plan sponsor or other plan service provider.

With respect to this last point, we were pleased to see the final amendments make helpful changes to the portions of the proposal that raised doubts about the extent to which plan sponsors could continue to engage in routine monitoring of their investment managers or continue to coordinate investment strategies across multiple investment managers. This potential interference with a plan's sponsors ability to oversee its investment managers was one of the Council's top concerns with the proposal.

Despite these helpful changes, the final QPAM amendments retain many very concerning changes and continue to impose new conditions that will unnecessarily jeopardize a plan's ability to continue relying on the investment managers that they have selected. This includes the retention of unnecessary new recordkeeping and reporting requirements, an expansion of the events that can disqualify a QPAM, an unnecessarily short transition period if a QPAM is disqualified, and a very fast-approaching effective date. The Council is concerned with these changes as we continue to believe that DOL should not be adding new categories of QPAM conditions that make it more difficult for plan sponsors to retain their investment managers.

New Notice Requirements for Fixed Indemnity Insurance Finalized; Other Proposed Rules Not Finalized

You Need to Know:

- In response to comments from the American Benefits Council and others, the tri-agencies declined to finalize portions of proposed regulations that would have undermined the ability of employers to offer fixed indemnity insurance to employees.
- However, the tri-agencies note they are considering future guidance that might raise issues similar to those raised by the proposed regulations; the Council will continue to advocate for the ability of employers to offer fixed indemnity insurance.

- The tri-agencies did adopt a new notice requirement for fixed indemnity insurance coverage offered by employers, which will first apply for plan years beginning in 2025.

On March 28, the U.S. Departments of Treasury, Health and Human Services and Labor (tri-agencies) issued final rules regarding hospital indemnity and other fixed indemnity coverage ("fixed indemnity insurance") and other types of non-major medical coverage. The rules are generally motivated by tri-agency concerns about consumer harm if individuals misunderstand these types of coverage as major medical coverage. This rulemaking follows the tri-agencies issuance of proposed regulations.

The elements of the final regulations most relevant to plan sponsors relate to fixed indemnity insurance, which is often offered by employers in addition to major medical coverage as an ancillary benefit, and the taxation of accident and health plan benefits.

- **Excepted Benefits – Definition and Scope.** Currently, to qualify as an excepted benefit, fixed indemnity insurance sold in the group market must pay a fixed dollar amount per day (or other period) of hospitalization or illness regardless of the amount of expenses incurred. The proposed regulations would have added to this definition that the fixed dollar amount must be paid regardless of the services or items received, severity of the illness or other characteristics of treatment, and not on a per-item or per-service basis. In the Council's comments, we noted that 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. Among other things, we asked 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.

  To provide more time to study the issues and concerns raised in comments, the tri-agencies did not finalize any provision of the proposed regulations relating to fixed indemnity insurance except the notice requirement (described below). However, the tri-agencies note that they remain concerned about the potential for consumer harm. They note that they will address issues raised by commenters in future rulemaking and that no inference should be drawn from their decision not to finalize the rules. They also emphasize that, to be fixed indemnity insurance, benefits must be paid only on a per-period basis and that "plans and issuers should not assume that current market practices that are inconsistent with the [proposed regulations] comply with the existing Federal regulations."

- **Excepted Benefits – Notice Requirement.** Currently, there is no notice requirement associated with group fixed indemnity coverage. However, many carriers voluntarily provide notices to employees making clear that fixed indemnity coverage is not major medical coverage. To address concerns by the tri-agencies about consumer confusion, the proposed regulations proposed to add a consumer notice requirement (in which the tri-agencies provide the language to be used), to be displayed on the first page of marketing, application and enrollment materials, noting the coverage is not

comprehensive coverage and is not subject to most federal consumer protections.

In the Council's comments, we noted that we support efforts to ensure that consumers understand the insurance they are purchasing. In the final regulations, the tri-agencies adopt the notice requirement but make changes to the notice language that must be used, in response to comments and consumer testing. The notice requirement applies for plan years beginning on or after January 1, 2025.

- **Tax Exclusion.** Currently, for accident and health plans, including fixed indemnity policies, where the premiums are paid pre-tax, only the amount of benefits paid in excess of unreimbursed medical expenses are subject to tax. Under the proposed regulations, all of the benefits received under an accident or health plan that pays amounts regardless of the amount of medical expenses actually incurred would have been taxed. In the Council's comments on the proposed regulations, we emphasized that this is a major change from longstanding IRS guidance and would have the unfortunate result of increasing the cost of policies for employees and would have a chilling effect on employers offering, and employees enrolling in, these policies. As such, we recommended 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. (Note: Even under the proposed rules, it would continue to be the case that if premiums for a fixed indemnity policy are paid after-tax, benefits paid are excluded from tax.)

  In the preamble to the final regulations Treasury and IRS state that, to provide more time to study the issues raised in comments, the final regulations do not finalize any provision of the proposed regulations relating to the taxation of accident and health plans, including fixed indemnity insurance. In the preamble, Treasury and IRS reiterate that they are concerned about some arrangements in the market that abuse these rules and note they intend to address issues raised by commenters on the exclusion and the related federal income and employment tax withholding and reporting in future rulemaking. They also note that no inference should be drawn from their decision not to finalize the rules as to whether Treasury and IRS agree with any comments on the scope of the rules.

The final regulations also address short-term, limited duration insurance (STLDI) and fixed indemnity coverage in the individual market but, as those provisions are not directly relevant to employers, the Council's comments did not address those issues.

While the aspects of the proposed regulations most concerning to employers were not finalized, the tri-agencies have made clear their concerns persist and that they plan to address various issues in future guidance. The Council will continue to advocate and report on these issues as they evolve.

Council Urges Continued Flexibility, Suggests Revoking Redundancies in Emergency Savings Guidance

***You Need to Know*:**

- As PLESAs are implemented, the Council is emphasizing the importance of flexibility for employer plan sponsors.
- The Council welcomes the optional adoption of anti-abuse procedures for plan sponsors as outlined in IRS Notice 2024-22.
- The Council urges IRS to revoke Revenue Rulings 74-55 and 74-56, arguing they introduce unnecessary complexity to plan designs.

The American Benefits Council recently underscored the critical role of flexibility in plan sponsors' successful implementation of pension-linked emergency savings accounts (PLESAs).

PLESAs, established under the SECURE 2.0 Act of 2022, allow individuals to save for emergencies by making special post-tax ("Roth") contributions to a dedicated account within a defined contribution plan.

In an **April 5 letter** to the Internal Revenue Service (IRS), the Council shared our appreciation to the degree of flexibility, particularly regarding the optional adoption of anti-abuse procedures for PLESAs, in the agency's initial guidance. This flexibility allows plan sponsors to structure their PLESAs as they see fit, essential for the efficacy of this new savings vehicle.

While acknowledging the benefits of the existing flexibility, the Council is nevertheless concerned about potential overregulation of PLESAs, which could impede plan sponsors' ability to offer them. Therefore, the Council is urging the IRS to continue providing flexibility in any forthcoming guidance related to PLESAs.

In our letter, the Council called for the revocation of Revenue Rulings 74-55 and 74-56. These rulings, which dictate restrictions on employer contributions based on after-tax employee contributions that can be immediately withdrawn, are irrelevant to PLESAs, where matching contributions are made on elective contributions that may be withdrawn immediately.

"If a plan wishes to impose limitations to prevent this type of manipulation, it has the ability to do so voluntarily," the letter reads. "Plans should not, however, be compelled to do so as a matter of plan qualification."

The Council believes these rulings introduce unnecessary complexity into plan designs and create uncertainty, without compelling policy or legal justification. Additionally, employers already have mechanisms in place to prevent manipulation within their plans, making additional qualifications redundant and potentially burdensome.

HHS Finalizes Prescription Drug-Related Guidance and Addresses Application to Self-Insured Plans

You Need to Know:

- HHS recently finalized rules addressing the situations in which prescription drugs are considered "essential health benefits" (EHBs), an important standard under the ACA for determining whether certain rules/prohibitions apply, including the prohibition on annual and lifetime dollar limits and the limit on out-of-pocket spending.
- In response to comments from the American Benefits Council and others, HHS clarified in the final rule (and related frequently asked questions (FAQs)) that the guidance does not apply to self-insured group health plans or large group market plans.
- However, the agencies noted they intend to separately propose guidance that would apply the new rules to self-insured and large group market plans. Because guidance along these lines could undermine some current plan designs, the Council will continue to monitor and advocate on these issues.

On April 2, U.S. Department of Health and Human Services (HHS) issued the final 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 focus, including our comments on the proposed 2025 payment notice, has been on rules that would affect certain group health plan programs that have been developed related to prescription drug costs.

Background

Under the ACA, non-grandfathered group health plans must ensure that any annual cost-sharing imposed under the plan does not exceed the maximum limitations provided under the ACA (the maximum out-of-pocket (MOOP) limit). However, only cost-sharing for EHBs counts toward the MOOP limit. Also, group health plans may not impose annual or lifetime dollar limits on EHBs.

To determine which benefits are EHBs for purposes of applying the MOOP limit or the annual or lifetime dollar limit prohibition, 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 EHB-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 prescription drugs may constitute EHBs and others not. To the extent a drug is non-EHB, generally cost-sharing need not count for purposes of applying the ACA's maximum out-of-pocket limit. Additionally, the ACA's prohibition on annual and lifetime limits on EHBs would not apply to non-EHB drugs.

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 would not be subject to the MOOP limit and, therefore, could exceed 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.

Co-pay 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 the plan is able to impose more substantial cost-sharing, and not count the cost-sharing to the MOOP limit, and/or impose annual or lifetime dollar limits.

2025 Payment Notice and Council Comment Letter

In the proposed 2025 payment notice, HHS provided 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 would be considered EHBs. This essentially means all covered prescription drugs would be EHB and, therefore, subject to the MOOP limit and annual and lifetime dollar limit prohibition. HHS stated it was just codifying a rule it had noted in the past and was motivated by consumer protection.

The Council's comment letter noted 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 explained that declining to apply the proposal to the large group and self-insured markets would be consistent with the ACA. We also expressed 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.

Final Regulations and FAQs

In the final 2025 payment notice, HHS finalized the proposed policy summarized above but noted in the preamble and in FAQs issued contemporaneously, that the final rule primarily addresses application of the policy to individual and small group market plans and does not address the application of the policy to large group market or self-insured group health plans.

However, HHS and the U.S. Departments of Labor and Treasury (the "tri-agencies") state they intend to propose rulemaking that would align the standards applicable to large group and self-insured plans with those applicable to small group and individual market plans, so that all group health plans subject to the MOOP limit and the annual and lifetime dollar limit prohibition would be required to treat prescription drugs covered by the plan in excess of the applicable EHB-benchmark plan as EHB. They state they plan to undertake this rulemaking for the sake of consumer protection. HHS also notes it will consider copay maximizer programs, as relevant, in other subsequent policy making about drug manufacturer assistance programs.

As noted in the Council's comment letter and as explained above, application of this policy to large group and self-funded plans could undermine programs and plan designs some self-insured plans have used to address drug costs and to enable coverage of a wide range of

prescription drugs. As such, the Council will continue to advocate for the maintenance of plan sponsors' current flexibility and we will report on future developments, including future guidance.

Final Instructions on Medicare Part D Program Include Helpful Guidance

***You Need to Know*:**

- Final instructions related to the Medicare Part D program favorably address a request made by the Council to ease burdens on employers that offer coverage to Medicare-eligible employees and retirees.

On April 1, the U.S. Department of Health and Human Services (HHS) released final instructions, which had recently been updated in draft form, addressing the contract year 2025 Medicare Part D program redesign enacted as part of the Inflation Reduction Act of 2022 (IRA). The final instructions reflect, and provide guidance on, changes to Part D that could affect employers that offer health coverage to Medicare-eligible employees and retirees.

In general, the IRA made substantial changes to benefits for Part D beneficiaries, including providing a cap (of $2,000) on out-of-pocket spending beginning in 2025. These improvements affect the richness or "actuarial value" of the Part D benefit. This is relevant to some employers for several reasons, including because employers are required to notify Medicare-eligible plan participants as to whether their plan constitutes "creditable coverage." A plan constitutes creditable coverage if it has an actuarial value that equals or exceeds standard Part D coverage. (If an individual has creditable coverage, they avoid the penalty for joining Part D late (*i.e.*, after they are first eligible)).

In the draft instructions, HHS proposed to eliminate a method to do a simplified calculation of actuarial value for employer-sponsored plans that had been available for 15 years, thereby requiring plan sponsors to use a more complex and costly method.

In comments submitted by the Council, we asked HHS not to eliminate this simplified method and instead develop a new simplified creditable coverage determination methodology that is updated based on the IRA's enrichment of the Part D benefit. We explained that all of the sound policy rationales that supported HHS's development of a simplified methodology in the past persist today. We also expressed a general concern that because the actuarial value of Part D has increased due to the benefit improvements of the IRA, some employer-sponsored plans for Medicare-eligible employees and retirees (based on plan design) may no longer have an equivalent actuarial value and so may not qualify as creditable coverage. In our letter, we urged HHS to consider a simplified creditable coverage determination methodology that will preserve access to these plans.

In the final instructions, HHS acknowledges receiving numerous comments expressing concern that the Part D benefit changes in the IRA will increase the actuarial value of the Part D benefit in 2025 to the point where group health plans meeting previous creditable coverage requirements may no longer meet the requirements. HHS recognizes changes to the Part D benefit may require group health plans to make changes to their plan benefit offerings to meet creditable coverage requirements, which may result in higher costs for group health plan

sponsors and enrollees—regardless of Part D eligibility—and, in other cases, may result in some plans no longer providing creditable coverage. HHS also notes that all comments on this topic opposed elimination of the creditable coverage simplified determination methodology.

In light of these considerations and to mitigate potential disruptions, HHS provides in the final instructions it will continue to permit use of the creditable coverage simplified determination methodology for calendar year 2025 (for those sponsors not applying for the retiree drug subsidy). This extension allows for more time to assess the redesign's impacts, with HHS' commitment to re-evaluate the continued use of this method, or a revised alternative, for calendar year 2026 in future guidance.

RECENT LEGISLATIVE ACTIVITY

Council Urges Lawmakers to Provide Retirement Investment Parity

You Need to Know:

- The Council is urging the Senate to support a bipartisan amendment ensuring retirement investment fairness, aligning with SECURE 2.0 objectives.
- The proposed amendment seeks to grant 403(b) plans access to lower-cost institutional funds, rectifying disparities in retirement investment options.

The American Benefits Council has long taken a firm stance in advocating for retirement investment parity and is urging Congress to throw its weight behind a bipartisan amendment poised to rectify longstanding disparities in retirement plans.

In **April 9 letter** addressed to the Senate Banking Committee, the Council underscored the need for support in enacting the proposed amendment to the Expanding Access to Capital Act of 2023 (H.R. 2799)—offered by Representatives Frank Lucas (R-OK), Josh Gottheimer (D-NJ) and Bill Foster (D-IL)—that passed in the U.S. House of Representatives on a bipartisan vote of 301-125.

The amendment would grant 403(b) plans access to the same cost-effective institutional funds available to other retirement plans, such as 401(k) plans, governmental 457 plans and the federal Thrift Savings Plan. Specifically, the amendment seeks to pave the way for collective investment trusts (CITs) and unregistered insurance company separate accounts within 403(b) plans.

Originally, 403(b) plans were confined from investing in CITs or unregistered insurance company separate accounts due to their retail-oriented inception, characterized by direct sales from insurers to employees. However, with the evolution of 403(b) plans, predominantly managed by employers similar to 401(k) plans, the restrictions have become antiquated, imposing undue financial burdens on millions of employees, particularly those affiliated with charities and public educational institutions.

The proposed amendment builds upon the momentum generated by the Retirement Fairness for Charities and Educational Institutions Act of 2023 (H.R. 3063), which shared bipartisan support in the House Financial Services Committee last year and Council endorsement.

The proposed amendment would build on the overarching objectives of SECURE 2.0. While SECURE 2.0 addressed tax-related reforms, the pending amendment focuses on rectifying securities-related disparities, paving the way for comprehensive retirement investment parity.

RSC Budget Proposal Recommends Dramatic Changes to Health System, Including Cap on Tax Exclusion

***You Need to Know*:**

- An influential subgroup of the House Republican conference established an aggressive agenda for health policy that will likely guide their action after 2024.

- Most notably, the proposal would cap the health care tax exclusion and encourage states to make greater use of waiver authority under the ACA

The Republican Study Committee (RSC), a conservative group within the U.S. House of Representatives Republican conference, **issued a budget proposal on March 20** that recommends seismic changes to the employer-sponsored health benefits system.

The RSC includes in its membership more than four-fifths of the House's Republican members and all of its leadership, making this proposal more than a mere messaging exercise. If Republicans retain the gavel in the House after the 2024 election, and especially if they assume control the Senate and the presidency, this document could serve as a blueprint for the party's legislative agenda.

Capping the Health Benefits Tax Exclusion

Under current law, employer-provided health coverage is deductible by employers, but not taxable for employees. According to the White House Office of Management and Budget, this resulted in forgone income tax revenue to the federal government of approximately $237 billion in 2023 and is projected to represent nearly $3.2 trillion in lost revenue over the next ten years.

This tax incentive is designed to encourage employers to provide high-quality health coverage to employees. Past calculations by the American Benefits Council have shown that for every one dollar in tax "expenditures" employers spend roughly four dollars on health benefits. Nevertheless, some lawmakers both sides of the aisle have opposed this tax exclusion, for a variety of reasons.

The RSC proposal argues that the tax exclusion reduces labor flexibility, drives inflation and reduces efficiency. It stops short of advocating for full repeal of the tax exclusion, but "would reform the tax treatment of private health insurance in a revenue-neutral manner by providing a capped exclusion for all spending on health insurance by and on behalf of the tax filer, as well as for related dependents."

The Council, as part of its core advocacy agenda, has consistently argued against eliminating or limiting the tax exclusion; noting, among other reasons, the great variability in the cost of the

identical coverage depending on geographic location and other factors. Historically, proposals to curtail the tax-favored treatment of employer-sponsored health coverage have been turned back in Congress in the face of strong public opposition.

Expand State Innovation Waivers

Under Section 1332 of the Affordable Care Act (ACA), states can apply for a "State Innovation Waiver" to pursue innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA. For such waivers to be approved, the U.S. departments of Treasury and Health and Human Services must determine that the waiver will (1) provide coverage that is at least as comprehensive as the coverage provided without the waiver, (2) provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver, (3) provide coverage to at least a comparable number of residents as without the waiver and (4) not increase the federal deficit.

Citing success stories with several State Innovation Waivers, the RSC proposal "would empower all states to implement these innovative models to lower costs and ensure guaranteed access to affordable coverage for all Americans regardless of health status."

Since enactment of the ACA, the Council has expressed concerns with respect to Section 1332 waivers, emphasizing that any state waiver must not undermine the uniform design and administration of multi-state employer plans and must avoid imposing costs on employers.

As Council members know, a core element of the Council's advocacy is to enable nationwide uniformity for multi-state employers. Preserving ERISA preemption is essential to employer innovation and the ability to provide affordable, high-value care to workers. In 2022, the House Republicans' Healthy Futures Task Force also examined changes to Section 1332 waivers. Our communication to the task force at the time noted that "To ensure the employer-sponsored system is adequately protected, waivers should only apply to specific ACA provisions, such as insurance coverage, and not allow states to impose mandates, assessments or new reporting requirements on self-funded group health plans. Otherwise, Section 1332 waivers could be a means to circumvent ERISA preemption, which, in turn, could erode long-standing interests in, and recognition of, the need for national uniformity for ERISA-governed plans."

Health Savings Accounts

In a potentially positive development, the RSC budget proposes to "drastically expand access to Health Savings Accounts (HSA) by eliminating the requirement that health savings accounts be tied to a high-deductible plan, increasing maximum contributions, and expanding the scope of eligible health care expenditures, such as to Direct Primary Care (DPC) arrangements."

The Council supports a number of initiatives to increase the usefulness of HSAs, including expanding access to telehealth and preventive medicine.

The Council, through its own advocacy agenda and that of the Alliance to Fight for Health Care – a diverse coalition of stakeholders committed to promoting employer-sponsored health benefits – will be in close communication with Republican lawmakers to underscore the importance of federal tax incentives and ERISA to a successful health benefits system.

As noted above, the RSC report provides a framework of the health policy goals of the House of Representatives Republican conference. Likewise, the Biden Administration's budget proposal for Fiscal Year 2025 that starts October 1 sets forth the administration's health policy goals. While neither document will be adopted in whole, they are useful in understanding the parties' philosophies and objectives for health policy.