BENEFITS INSIDER

Volume 342, May 1, 2024
(covering news from April 15-30, 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

Small Changes to Fiduciary Rule Unlikely to Address Plan Sponsor Concerns

You Need to Know:

- The latest DOL regulations establish new standards for retirement plan investment assistance, similar to those struck down in 2018.

- Certain aspects of the final regulations could pose practical implementation challenges and potential adverse consequences.

The U.S. Department of Labor (DOL) Employee Benefit Security Administration (EBSA) have issued final regulations establishing new standards for providers of retirement plan investment advice. Throughout the process, the Council has raised concerns about the potential impact of these rules on typical and routine services provided by employer plan sponsors.

The final documents, as formally published in the Federal Register on April 25, are as follows:

- Text of final rule
- Text of amendment to Prohibited Transaction Exemption (PTE) 2020-02
- Text of amendment to PTE 84-24
- Amendments to other exemptions which prevents them from being used for advice

Effective September 23, 2024, the regulations come with a transition period of one year for the exemptions. This timeline, notably shorter than the one provided in 2016, has raised concerns about the feasibility of implementing major changes within such a brief period.

This is the latest iteration of a DOL fiduciary rule proposal, dating back to the Obama administration, with the prior rule having been struck down by the U.S. Fifth Circuit Court of Appeals in 2018. Similarities between the current fiduciary definition and the invalidated 2016 rule suggest that future lawsuits against the regulations are forthcoming.

The final rule is very similar to the 2016 rule in that both can treat persons as fiduciaries even if the advice is not provided on a regular basis pursuant to a mutual understanding that the advice will be a primary basis for investment decisions. And both can turn sales pitches, such as responses to plan sponsor requests for proposals, into fiduciary advice.

The Council's written comments and public testimony focused on plan sponsor issues in the proposed rule, such as requesting exemptions for plan sponsor employees, call centers, and financial well-being programs. DOL provided no relief on call center employees or financial well-being programs but did address plan sponsor employees. DOL treatment of plan sponsor employees reflected an effort to address our concerns but questions remain.

While some positive changes have been made to PTE 84-24, such as eliminating limitations on commissions and clarifying exemptions for statutory employees, these modifications fall short of addressing fundamental issues.

Council Requests Extension of Surprise Billing Relief

You Need to Know:

- A provider group prevailed in litigation, at the district court level, challenging various aspects of how a key amount (i.e., the qualifying payment amount or QPA) is calculated under the No Surprises Act (NSA). As a result, plans and insurers will be required to recalculate these amounts, which will take extensive resources.

- Following the ruling by the district court last summer, the Biden administration issued relief giving plans and insurers until May 1, 2024, to recalculate these amounts – noting the possibility for future extensions of this relief.

- The Council recently requested that the tri-agencies extend this relief until the litigation is concluded (or that the tri-agencies at least extend the relief through the end of 2024).

On April 19, **the Council asked the U.S. Departments of Health and Human Services, Labor and Treasury (the "tri-agencies") to extend enforcement discretion** they previously provided in FAQs, regarding recalculation of the QPA under the NSA.

Under the NSA, the qualifying payment amount (QPA), which is generally the median contracted rate as of January 31, 2019, plays a central role. The QPA is the basis for participant cost-sharing, can be used to determine initial payments to providers, is often raised in open negotiation, and is a factor that must be considered in independent dispute resolution. And it is plans (and their service providers, usually their TPAs) that calculate the QPA, which is a complex undertaking.

Over the last few years, the Council has worked to support reasonable, predictable, market-based rules for determining the QPA, and we supported the tri-agencies' July 2021 interim final regulations (IFR), through comments and in *amicus* ("friend of the court") briefs.

However, in *Texas Medical Association et al. v. HHS et al.* ("*TMA III*"), provider plaintiffs challenged many of the core pieces of the IFR's methodology for calculation of the QPA, and, in August 2023, the district court vacated the majority of the provisions challenged by plaintiffs, requiring a massive overhaul of the QPA calculation for most plans and insurers. (Many aspects of this decision have been appealed by the tri-agencies and the appeal is pending).

Following the decision, the tri-agencies issued FAQs acknowledging the substantial work required to implement the changes required by the decision in *TMA III.* The tri-agencies provided they will exercise their enforcement discretion under the relevant NSA provisions for any plan or insurer that uses a QPA calculated in accordance with the IFR, for items and services furnished before May 1, 2024. They noted they would consider extending this relief if necessary.

On April 19, the Council submitted a letter to the tri-agencies asking that they extend the exercise of enforcement discretion until there is resolution of the legal proceedings related to *TMA III* and to allow a reasonable amount of time following final resolution in the courts for the tri-agencies to provide the needed guidance and for plans and insurers to implement the final changes. We also noted that we appreciate that the date of resolution of *TMA III* is not yet

known, and if the tri-agencies determine they must choose a date certain, we ask that the enforcement discretion be extended to items and services furnished through December 31, 2024, with the possibility of future extensions if necessary.

The Council's letter explained that an extension of the relief is needed due to the complexity and breadth of the required changes, the uncertainty caused by the ongoing nature of the litigation, and the need for additional guidance.

IRS Notice Offers Flexibility, Relief to RMD Rules

You Need to Know:

- IRS Notice 2024-35 provides relief on final RMD regulations and the "10-year rule," easing compliance for plan sponsors and beneficiaries.

- Plan sponsors and beneficiaries gain respite from potential disqualification and excise taxes for failing to make "specified" RMDs, aligning with prior guidance and extending relief through 2024.

On April 16, the Internal Revenue Service (IRS) issued Notice 2024-35 to address changes to certain provisions of the after-death required minimum distribution (RMD) rules as directed by the Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019. This notice provides valuable flexibility amidst regulatory changes, offering clarity for navigating RMD obligations in the coming years.

The notice provides plan sponsors relief on two fronts: final RMD regulations and the "10-year rule."

Final RMD regulations, expected to take effect no earlier than 2025, will determine RMDs for calendar years starting January 1, 2025.

Additionally, relief extends through 2024 regarding the IRS interpretation of the "10-year rule," as outlined in the 2022 proposed RMD regulations — on which the American Benefits Council provided comprehensive recommendations during drafting.

The 10-year rule extension provides respite to plans which adopted an alternative interpretation, allowing for flexibility in adhering to distribution requirements. Specifically, failure to make a "specified RMD" will not be penalized, nor will the IRS impose excise taxes on plan beneficiaries for such failures. This extension, mirroring prior guidance for 2021-2023, now includes 2024.

The notice defines "specified RMD" for 2024, encompassing distributions required under the proposed regulations' interpretation of the 10-year rule. This includes beneficiaries of deceased employees who passed away between 2020-2023 and beneficiaries of eligible designated beneficiaries (EDBs) utilizing the "stretch" exception.

DOL Proposes Voluntary Collection of Employer Information for Retirement Savings Lost and Found

You Need to Know:

- DOL would like retirement plan sponsors to provide, on a voluntary basis (for now), participant information to populate its statutorily required Retirement Savings Lost and Found database.

- Plans and service providers should be very cautious about the liability and privacy consequences of releasing personal information about employees.

- The DOL proposal is broad and far-reaching and includes language consistent with the counterproductive approach DOL has adopted on this issue for several years.

The U.S. Department of Labor (DOL) is **formally proposing** that retirement plan sponsors voluntarily provide certain information to populate its Retirement Savings Lost and Found program, now that the Internal Revenue Service has very appropriately declined to furnish tax data to the agency. This proposal includes language that represents a continuation of the counterproductive approach DOL has taken with respect to missing participant matters over many years, to which the Council has repeatedly and strenuously objected.

The challenge of locating missing plan participants and reuniting them with their savings has long vexed employers, who have sought reliable guidance and a safe harbor from DOL. The agency has instead responded with further scrutiny and the application of protracted and costly audits. Concerns with these audits were underscored in a September 2023 letter from U.S. House of Representatives Education and the Workforce Committee Chair Virginia Foxx (R-NC) and Health, Employment, Labor, and Pensions Subcommittee Chair Bob Good (R-VA) to Acting Secretary of Labor Julie Su.

The Council, in a frank and candid October 2023 letter to Lisa Gomez, the DOL Assistant Secretary for Employee Benefits Security Administration (EBSA), urged the agency to adopt a cooperative approach with employers to address the issue of missing retirement plan participants, put an end to lengthy audits and provide a reasonable safe harbor so plan sponsors know exactly what steps should be taken to locate missing participants.

To help plan participants, the SECURE 2.0 Act of 2022 directed DOL to establish an online, searchable database (the "Retirement Savings Lost and Found") by December 29, 2024. Initially, DOL had planned to populate the database using information collected by the Internal Revenue Service on Form 8955-SSA. However, that approach was never contemplated by Congress.

As an April 16 proposed information collection request (ICR) filed by EBSA explains, "the IRS has now declined to give this information to [DOL] to establish and maintain the Retirement Savings Lost and Found online searchable database," citing rules protecting confidentiality and limiting the disclosure of information provided on IRS returns. The IRS' response was correct, and it is unclear why DOL chose this approach.

Consequently, DOL is now proposing to collect various information *voluntarily* from retirement plans to populate the Lost and Found database. Notably, the proposal envisions voluntary

reporting on plan years from the first date that the plan was subject to ERISA, long before the plan years that are expressly contemplated by the information collection provisions of SECURE 2.0.

The April 16 notice also criticizes plan administrators for failure to adequately track participants. This assertion is particularly disappointing as the Council has been asking DOL for practical guidance on finding missing participants for over 10 years.

The voluntary nature of this proposal raises important questions about the extent to which plans and service providers will be able to share this information with DOL. Many data privacy laws and service provider agreements permit the sharing of participant data as required by law. But because DOL's proposal is voluntary, plans and service providers should be very cautious about sharing such information with the agency until they are confident such reporting does not run afoul of any data privacy rules or contractual obligations, especially given the extended time period for which information is being sought.

RECENT LEGISLATIVE ACTIVITY

Council Emphasizes Importance of ERISA in Statement for House Subcommittee Hearing

You Need to Know:

- In frequent communications with Congress, the Council is underscoring ERISA's importance for employers providing affordable, high-quality health coverage.

- The subcommittee hearing highlighted the crucial role of ERISA's preemption in benefit plan design, alongside calls for enhanced transparency and accountability in healthcare and expanding access to telehealth.

As part of the American Benefits Council's commemoration of the 50th anniversary of ERISA, **we submitted a written statement** on April 16 to the U.S. House of Representatives Committee on Education and the Workforce Subcommittee on Health, Employment, Labor and Pensions, underscoring the importance of ERISA and its federal preemption standard, which "provides the path to higher quality, lower cost care for millions of American workers and their families across the country."

The Council's statement was submitted in conjunction with the subcommittee's April 16 hearing, ERISA's 50th Anniversary: The Path to Higher Quality, Lower Cost Health Care. In addition to its discussion of the vital role of ERISA preemption, the statement also offered recommendations related to price and quality transparency, competition in the health care market and telehealth in sustaining the employer-sponsored system, which delivers high-quality health coverage to nearly 180 million Americans.

Consistent with the Council's written testimony about ERISA preemption, Scott Behrens, senior vice president and director of government relations at Lockton Companies – a member of the Council's Policy board of Directors – testified before the subcommittee on the importance of ERISA's preemption to benefit plan design.

"The preemption provision is considered [ERISA's] crowning achievement," he said. "A key reason why ERISA was developed was the disparate rules and patchwork of state regulation. And Allowing ERISA preemption to stand will encourage employers to be able to be responsive to their workforce needs."

Other witnesses included:

- Russell DuBose, vice president of human resources, Phifer Inc.
- Mairin Mancino, senior advisor, policy, Peterson Center on Healthcare
- Karen L. Handorf, senior counsel, Berger Montague

While lawmakers on both sides of the aisle differed sharply on a variety of specific health care reform measures, strengthening ERISA was roundly supported by multiple lawmakers.

"ERISA's strength lies in its preemption provisions, which provide employers with the certainty to offer consistent and comprehensive benefits across state lines," Subcommittee Chairman Bob Good (R-VA) said in his opening statement. "Without ERISA, multi-state employers would be left to navigate a patchwork of state mandates and onerous regulations."

Throughout the hearing, witnesses continued to point to the need to improved price transparency and to hold pharmacy benefit managers (PBMs) and third-party administrators (TPAs) accountable for transparent reporting obligations.

Lawmakers and witnesses alike also pointed to the House-passed Lower Cost, More Transparency (LCMT) Act (H.R. 5378), a bipartisan measure endorsed by the Council as a vehicle to improve health care transparency and rein in costs.

"We passed LCMTA in December which was intended to improve transparency," Representative Rick Allen (R-GA), said, asking what witnesses thought of the bill.

"It's a fantastic bill, we support the transparency aspects" DuBose said.

State-Run Auto-IRA Programs Continue to Spread

You Need to Know:

- There have been a number of developments at the state level related to proposal, enactment and implementation of state-level automatic IRA programs for private employers.

- Meanwhile, efforts in Congress to improve retirement coverage at the federal level continue apace.

The American Benefits Council continues to pay close attention to efforts at the state level to expand retirement coverage in ways that could burden existing employer-sponsored plans or impose alternative rules on retirement plans. Generally speaking, these laws require employers without a retirement plan to enroll its employees in an automatic payroll-deduction IRA or similar vehicle.

As in recent years, we continue to see steady interest by states that have not yet enacted a mandatory retirement program in considering legislation for an auto-IRA program. Because most Council members already sponsor retirement plans for their workforce, the Council has focused on streamlining employer compliance by urging state legislators and regulators to simplify reporting requirements and ensuring there are no conflicts with federal qualification requirements that would affect Council member companies.

New 'Washington Saves' Program

On March 28, 2024, Washington Governor Jay Inslee signed legislation establishing the Washington Saves program, another mandatory payroll deduction IRA program that requires certain private sector employers to automatically enroll their employees. The law requires the Program to be launched by July 1, 2027.

Under this state law, "covered employers" subject to the program's mandate are generally non-governmental employers that:

- have been in business in Washington for at least two years as of the immediately preceding calendar year;
- maintain a physical presence (note that this condition is not explicitly limited to employers with a physical presence *in Washington*);
- do not offer a "qualified retirement plan" to "covered employees" who have had continuous employment of one year or more; and
- employ, and at any point during the immediately preceding calendar year employed, employees working a combined minimum of 10,400 hours (which is generally the equivalent of five full-time employees).

Note that the law excludes from the program's mandate an employer that offers a "qualified retirement plan" – which is defined as including a 401(a), 401(k), 403(a), 403(b), SEP, or SIMPLE plan – to covered employees who have had continuous employment of one year or more. By limiting the employer exemption to plan sponsors whose plan is offered to covered employees who have been employed for one year or more, the law raises employer and ERISA preemption concerns because it could be interpreted to require coverage of certain employees not covered by their employer's plan, such as employees who have not attained age 21.

The Council is concerned that limiting the employer exemption to plan sponsors whose plan is offered to covered employees who have been continuously employed for one year or more raises both employer and ERISA preemption concerns for its potential interference with an employer's plan design. We are evaluating our options for outreach to state officials as rules for the program are developed.

Other Recent Developments

- Maine launches Auto-IRA program: Following a pilot, Maine's MERIT Program officially launched in January 2024. The initial employer registration deadlines are April

30, 2024 (for employers subject to the mandate with 15 or more covered employees) and June 30, 2024 (for employers subject to the mandate with 5-14 covered employees).

- Colorado-led Interstate Partnership continues to expand: The growth of the Colorado-led Partnership for a Dignified Retirement continues, as the Delaware EARNS Program announced in December 2023 that it had joined the Colorado Secure Savings Program and Maine's MERIT Program in the interstate partnership. On April 10, Vermont's state treasurer announced the VT Saves Program's intention to join the interstate partnership; in the announcement, the treasurer indicated that the program will take steps to begin negotiating a partnership agreement with Colorado. Connecticut's MyCTSavings Program has also indicated that it is in talks with other states about a potential partnership, but has not provided any additional details.

- Numerous bills under consideration in states' 2024 legislative sessions: 2024 has been a particularly busy year for the introduction of mandatory state retirement program bills. Currently, the 11 states whose legislative sessions have yet to adjourn that are considering mandatory program legislation are: Alaska, Arizona, D.C., Iowa, Massachusetts, Michigan, Pennsylvania, Rhode Island, South Carolina, Tennessee, and Wisconsin. (Two additional states, Mississippi and West Virginia, also considered mandatory auto-IRA bills in 2024, but the bills did not pass prior to the legislature adjourning for the year.)

While many of the bills under consideration in 2024 propose programs that would be very similar to the mandatory program laws that have already been enacted in other states, we continue to see new iterations of bills and unique program designs and approaches. Auto-IRA laws that implicate ERISA preemption issues by interfering with plan sponsors' plan design and imposing state-level reporting requirements on plan sponsors continue to be a concern and bear monitoring as those states develop and implement programs.

Federal Activity

Meanwhile, in Congress, some lawmakers have proposed federal approaches to boosting retirement plan coverage.

A bipartisan coterie of lawmakers in the U.S. Senate and House of Representatives have introduced legislation that would grant workers without an employer-sponsored retirement plan access to a federal program similar to the Thrift Savings Plan, the retirement system for federal employees and members of the uniformed services. Under the Retirement Savings for Americans Act (S. 3102/H.R. 6065), full- and part-time workers who lack access to an employer-sponsored retirement plan would be eligible for an account. Those workers would be automatically enrolled at 3% of their income and could choose to increase or decrease their withholding or opt out entirely at any time.

Likewise, Representative Richard Neal (D-MA), the ranking Democrat on the U.S. House of Representatives Ways and Means Committee, has reintroduced his Automatic IRA Act (H.R. 7293), requiring most employers to sponsor a retirement plan or provide an automatic payroll-reduction IRA to employees. Unfortunately, the measure as introduced does not insulate employers from state laws, providing only that an employer that participates in a state auto IRA

program is exempt from the federal requirement if the state auto IRA legislation was enacted before January 1, 2027.

RECENT JUDICIAL ACTIVITY

Employer Responds to Class Action Lawsuit Alleging Breach of Fiduciary Duties Related to Prescription Drug Benefit

You Need to Know:

- Johnson & Johnson has asked a federal district court to dismiss a recent class action lawsuit alleging breach of fiduciary duty under ERISA against the company and its benefits committee, based on the costs of certain prescription drugs covered under the health plan, in *Lewandowski v. J&J.*

- The allegations in this case are novel. It is important to watch this case because it may be the first in a new line of class action cases related to health plans.

On April 19, Johnson & Johnson (J&J) filed **a response to allegations** made against the plan fiduciaries in a recent lawsuit by a health plan participant.

Lewandowski v. J&J et al., in the U.S. District Court for the District of New Jersey, alleges breach of ERISA fiduciary duty related to prescription drug benefits in the health plan. The Council is watching this case closely due to the novel claims alleged and the potential for other similar lawsuits.

In its recent filing, the company asked the court to dismiss the case (i.e. a "motion to dismiss"). In the motion, the company notes that it covers the vast majority of the costs under the health plan and so has every incentive to obtain drug benefits for low prices. It also notes that the plaintiff asserts a novel theory, as she does not claim she was denied any benefit under the plan but instead asserts that the company breached ERISA's duty of prudence by entering into an agreement with a pharmacy benefit manager (PBM) allowing the PBM to charge allegedly excessive prices for certain prescription drugs.

The company made two primary arguments for why the case should be dismissed, as follows:

- The plaintiff lacks "standing" to bring the fiduciary breach claims before the court. (In general, a party has standing to sue if they have been injured by the alleged conduct, that the party being sued caused the injury, and that the court can fix the harm). J&J states that the plaintiff was not injured by the alleged conduct because she received all of the benefits she was contractually entitled to receive (*i.e.*, she received prescription drugs at the cost and under the terms defined in the plan).The company also noted that the plaintiff does not allege that she paid for, or was prescribed, any of the allegedly overpriced drugs referenced in the complaint.

- The complaint "fails to state a claim" because plaintiff alleged a violation of the duty of prudence (which requires a showing that the company's *process* for choosing a PBM and

negotiating drug prices was imprudent) but does not include facts about that process. J&J notes that the complaint asks the court to infer imprudence based on the price of 42 drugs (among thousands covered by the plan) and that this alone is not enough to find that the plaintiff sufficiently alleged imprudence. J&J asserts that the plaintiff would have to allege facts showing the overall package of drugs negotiated with the PBM was excessively expensive, relative to what a similarly situated health plan paid for a comparable package of drug benefits; and the plaintiff did not do so.

The company also asks the court to decline plaintiff's demand for a jury trial because relevant law does not allow a jury trial for these types of allegations.

At this early stage of the lawsuit, J&J can make legal arguments for why the case should be dismissed but is not yet allowed to dispute the facts alleged in the complaint. If the case proceeds, the company will have that opportunity.

As for next steps, the plaintiff may respond to the motion to dismiss (or might amend/revise its original complaint) and then J&J will have a chance to reply/respond again, before the court rules on the motion to dismiss. Under the current schedule, these additional filings by the plaintiff and defendant should take place in May. But with court filing schedules, that is always subject to change as requests for extensions are common.