BENEFITS INSIDER

Volume 343, May 15, 2024
(covering news from May 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

IRS Releases 2025 Indexed Amounts for HSAs, HDHPs, Excepted Benefit HRAs

The Internal Revenue Service (IRS) released Revenue Procedure 2024-25 on May 9, listing the calendar year 2025 indexed amounts (adjusted for inflation) for health savings accounts (HSAs), high deductible health plans (HDHPs) and excepted benefit health reimbursement arrangements (HRAs).

Individual and family annual contribution limits for HSAs, HDHP minimum deductibles, and HDHP out-of-pocket limits will be increased for 2025.

The following table lists the current 2024 amounts and the new 2025 amounts:

	Calendar Year 2024		**Calendar Year 2025**	
	Self-only	**Family**	**Self-only**	**Family**
Annual Contribution Limit	**$4,150**	**$8,300**	**$4,300**	**$8,550**
HDHP Minimum Deductible	**$1,600**	**$3,200**	**$1,650**	**$3,300**
HDHP Out-of-Pocket Limit (includes deductibles, co-payments and other amounts but not premiums)	**$8,050**	**$16,100**	**$8,300**	**$16,600**

Rev. Proc. 2024-25 also provides that for plan years beginning in 2025, the maximum amount that may be made newly available for the plan year in an excepted benefit HRA is $2,150 (up from $2,100 in 2024).

DOL Rescinds Rule on Association Health Plans

You Need to Know:

- The DOL recently finalized regulations rescinding rules that broadened the ability of small employers to join to offer health coverage through the large group insurance market.
- The rescission of the prior rule does not impact health plans sponsored by large employers.

In late April, the U.S. Department of Labor (DOL) issued final regulations to rescind regulations promulgated back in 2018 (the "2018 rule"), which had made it easier to establish association health plans (AHPs) and which had largely been struck down by a court. The regulations that were rescinded are most relevant for small employers.

An AHP is a health plan in which a group or association of employers may participate and, if it meets certain criteria, the DOL considers a single ERISA plan, albeit a multiple employer health plan. This allows small employers, who would otherwise only be allowed to participate in the small group insurance market, to participate together in the large group insurance market (or

on a self-funded basis, if permitted under applicable state law). Some substantial requirements in the small group market (such as the essential health benefit requirements and the single risk pool requirement) do not apply in the large group market.

Prior to the 2018 rule, in various pieces of guidance, DOL provided rules for when a group or association of employers is a bona fide employer group or association that may sponsor a group health plan (the "pre-2018 rule guidance").

In the 2018 rule, DOL broadened the types of employer groups and associations that may sponsor a qualifying AHP by loosening the prior requirements. While the 2018 rule built on and expanded the pre-2018 rule guidance, it also kept the pre-2018 rule guidance intact. As a result, AHPs could qualify under the pre-2018 rule guidance or, alternatively, under the more expansive 2018 rule.

Subsequently, several states filed a lawsuit challenging major provisions of the 2018 rule, and in 2019 a district court set aside large portions of the 2018 rule.

In late December 2023, DOL proposed to rescind the 2018 rule in its entirety, to resolve any uncertainty following the court's decision and ensure the guidance being provided to the regulatory community is consistent with ERISA. The American Benefits Council did not comment on these regulations as they do not impact large employer health plans.

In late April of this year, the proposal was finalized, as proposed. DOL notes that it is finalizing the recission because the 2018 rule substantially weakened the AHP criteria in a way that would have enabled the creation of AHPs functioning effectively as health insurers, in a way that DOL now believes is inconsistent with ERISA.

In the final rule, DOL also makes clear the recission leaves in place the pre-2018 rule guidance, which still allows the formation of AHPs under the more strict pre-2018 rule guidance. DOL states the pre-2018 rule guidance fosters a sufficient employer-employee nexus and proper oversight of AHPs, while remaining consistent with ERISA. DOL had asked for comments on whether it should codify the pre-2018 rule guidance (which is currently found in various guidance documents) but DOL did not do so in the final rule.

Agencies Grant Extension of Relief Related to No Surprises Act

You Need to Know:

- A provider group prevailed in litigation, at the district court level, challenging various aspects of how a key amount is calculated under the surprise billing law. As a result, plans and insurers will be required to recalculate these amounts, which will take extensive resources.

- Following the ruling, 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.

- In April, the Council requested that the tri-agencies extend this relief and, helpfully, the tri-agencies recently granted that request, so the relief is extended until November 1, 2024.

On May 1, the U.S. Departments of Health and Human Services, Labor and Treasury (the "tri-agencies") issued Frequently Asked Questions guidance (FAQs Part 67) providing an extension of enforcement discretion they had provided in prior guidance (FAQs Part 62), regarding recalculation of the qualifying payment amount (QPA) under the No Surprises Act (NSA).

Under the NSA, the 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. It is health 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* (or "friend of the court") briefs.

However, in *Texas Medical Association et al. v. HHS et al.* ("*TMA III*"), medical 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 Part 62 acknowledging the substantial work required to implement the changes required by the decision in *TMA III*. The tri-agencies provided they would 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, and they noted they would consider extending this relief if necessary.

In April, the Council asked the tri-agencies to extend this relief until there is resolution of the legal proceedings, or, if that wasn't possible, until the end of the year. We explained that an extension of the relief was needed due to the complexity and breadth of the required changes, the uncertainty of the ongoing litigation, and the need for additional guidance.

In FAQs 67, the agencies noted that they had received requests for additional relief and said, based on the feedback, it was appropriate to extend the enforcement relief, meaning plans and insurers may use the QPA methodology set out in the IFR for items and services furnished before November 1, 2024. The tri-agencies note that they will continue to assess the status of QPA calculations but that they do not expect to further extend the enforcement relief.

The Council will continue to monitor and report on this issue, including when a decision is issued by the appeals court in the *TMA III* case.

GAO Highlights Variability in TDF Performance, Recommends DOL Update Guidance

You Need to Know:

- The GAO is recommending DOL update its 2013 guidance for plan sponsors and its 2010 guidance for plan participants on selecting TDFs.

Target date funds (TDFs) have surged in popularity within 401(k) plans, thanks to their allocation of assets based on participants' retirement dates. However, an **April 26 report** from the Government Accountability Office (GAO) shows significant variability in TDF performance and risk, particularly within ten years of the target retirement date. The American Benefits Council was interviewed as part of the GAO's research.

Asset managers design these funds to transition from high-risk to low-risk assets over time, but the extent of this shift varies widely among different TDFs, according to the report. This variability became evident during the financial upheaval of March 2020 due to COVID-19, where the GAO says TDFs closer to their target dates incurred smaller losses but exhibited greater performance disparities due to differences in their investment compositions.

Despite the oversight of regulatory bodies such as the U.S. Department of Labor (DOL), Office of the Comptroller of the Currency (OCC) and Securities and Exchange Commission (SEC), "DOL's guidance has not been updated and lacks detail," according to the report. The existing guidance, last updated in 2013, was issued prior to numerous trends, such as the rise of TDFs structured as collective investment trusts. These trusts, administered by banks exclusively for qualified plans like 401(k)s, have a less comprehensive disclosure regime, exacerbating the challenge of understanding and selecting suitable investment options.

In light of these findings, GAO concludes that updated guidance is essential to ensure plan sponsors and participants can navigate the complexities of TDFs effectively, particularly amid evolving investment landscapes and market uncertainties.

Specifically, GAO recommends DOL update (1) its 2013 guidance for plan sponsors and (2) its 2010 guidance for plan participants on selecting TDFs. In a written response included with the report, DOL disagreed with both recommendations. However, GAO continues to believe both are warranted.

RECENT JUDICIAL ACTIVITY

Council Urges Supreme Court to Consider 401(k) Fee Case From 9th Circuit

You Need to Know:

- The Council is asking the Supreme Court to review a lower court decision against a 401(k) retirement plan sponsor.
- At issue in the case is whether the amendment of a contract with a service provider to add or renew services constitutes a prohibited transaction under ERISA.

As a part of ongoing efforts to push back on harmful and ill-founded litigation against employee benefit plans, the American Benefits Council is **urging the U.S. Supreme Court** to review an appellate court decision with sweeping implications for 401(k) retirement plan sponsors. If the decision is allowed to stand, it will be much more difficult for plan sponsors to fend off class action fee cases.

The case of Bugielski v. AT&T centers on an allegation that the employer violated ERISA by engaging in a prohibited transaction when it amended its contract with its recordkeeper to add a brokerage window and a managed account advice program.

A 2021 summary judgment by the U.S. District Court for the Central District of California sided with AT&T, saying the defendants acted prudently in monitoring the retirement plan's expenses. On August 4, however, a three-judge panel of the U.S. Court of Appeals for the 9th Circuit reversed the trial court's ruling and held that, without qualification, an ERISA prohibited transaction occurs any time a plan amends its service provider contract to add services, which could include renewals of services.

While ERISA Section 408(b)(2) provides a prohibited transaction exemption for service provider contracts if the plan pays "no more than reasonable compensation," the 9th Circuit's ruling would make it the plan sponsor's burden to prove, following discovery, that every service provider contract generates no more than reasonable compensation, rather than requiring plaintiffs to allege that service provider compensation was unreasonable.

In reaching its conclusion, the Ninth Circuit expressly rejected precedent from the 3rd and 7th circuits holding that a plan's hiring of a service provider only results in a prohibited transaction if there is "an intent to benefit" the service provider. Relevantly, the 3rd and 7th Circuits have stated that any rule to the contrary (i.e., a per se prohibited transaction rule for service provider contracts) would be "absurd" or "nonsensical," as it would prohibit plans from hiring necessary service providers.

After the panel's decision, the American Benefits Council (along with the ERISA Industry Committee, the SPARK Institute, and the Committee on Investment of Employee Benefit Assets) filed an *amicus* ("friend of the court") brief with the U.S. Court of Appeals for the 9th Circuit on September 11, requesting a full ("*en banc*") rehearing of a 401(k) fee case. With that request denied, the defendants are petitioning the Supreme Court for a rehearing. In an *amicus* brief filed with the high court on May 9, the Council and its allies offered support for the petition.

The Council's brief explained that the August ruling will harm the employer-sponsored retirement plan system by opening the floodgates to speculative recordkeeping fee claims. That is, by presumptively making it a prohibited transaction for plans to amend or renew service provider contracts, the August ruling will allow class action plaintiffs to survive motions to dismiss by merely alleging that a plan amended its service provider contract. From there, it will be the plan sponsor's burden to prove that the plan paid no more than reasonable compensation as noted above under ERISA Section 408(b)(2).

The *amicus* brief explains that shifting this burden to the plan sponsor will exacerbate all of the harms that have been created by the last decade of fee litigation. Accordingly, the brief calls on the court to apply the prohibited transaction rules in a way that would prevent these claims for proceeding unless plaintiffs plausibly allege that a service provider's fees were unreasonable. Absent such a rule, each amendment or renewal of a service provider contract will put plan

sponsors at risk of a prohibited transaction claim that, even if meritless, will likely survive a motion to dismiss and require significant defense and discovery costs or an expensive settlement.

MISCELLANEOUS

Council's Klein Again Ranks Among Washingtonian Magazine's 500 Most Influential People Shaping Policy

You Need to Know:

- The Council, specifically President Jim Klein, was recognized by Washingtonian magazine for influence in shaping health care policy.

American Benefits Council President Jim Klein was again named to *Washingtonian* magazine's list of the 500 most influential people in the nation's capital shaping public policy, in a special supplement to the magazine's May 2024 issue.

Divided into 18 categories, the list emphasizes policy influencers in areas such as "economic policy," "energy", "foreign affairs," "banking & finance," "national security & defense," and "business & labor." Klein was recognized in the field of "healthcare."

Influencers are determined by several factors, including having "deep subject-matter expertise and a significant understanding of how the nation's capital works," according to the magazine.

The magazine highlighted Klein and the Council's involvement in vigorous advocacy for passage of legislation to address hospital facility fees — which mark up costs for patients, employers, and the government — adding up to what Klein describes as "billions of dollars in unnecessary and unwarranted charges."

"Receiving this recognition is deeply meaningful, yet it's a testament to the combined 182 years of dedication and excellence of our entire Council staff. From the tireless efforts of our health team to the unwavering support of every individual contributing to our mission, this achievement belongs to us all," Klein said of the honor. "It's a tribute not only to our team's advocacy on Capitol Hill and regulatory fronts but also to the steadfast commitment of our member companies. Together, we provide essential health coverage and financial security for countless American families, empowering our advocacy efforts and driving positive change."