BENEFITS INSIDER

Volume 345, June 17, 2024
(covering news from June 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 Continues Urging Treasury, IRS to Support Repurposing of VEBA Assets

You Need to Know:

- The Council recently submitted a letter to Treasury and IRS requesting guidance confirming that assets in overfunded welfare benefit funds may be re-purposed for other health and welfare benefits and other employees.

- Over the last four years, the Council has continually advocated on this issue, formally and informally. This is an important issue for many large employers due to the significant amount of "stranded" funds.

The American Benefits Council is once again requesting confirmation from regulators that companies may repurpose assets from overfunded welfare benefit funds (such as voluntary employees' beneficiary associations (VEBAs)) for other employees and other health and welfare benefits without being subject to a 100% excise tax.

The Council submitted **written comments** on May 31 in response to Notice 2024-28, the U.S. Department of Treasury and Internal Revenue Service's (IRS) annual request for recommendations for items to be included on the agency's next Priority Guidance Plan. The Council understands the significance of this longstanding issue and has continued to advocate for clarifying guidance, formally and informally, over the past four years.

Employers commonly set aside assets in welfare benefit funds to fund a reserve for employee benefits, such as post-retirement medical benefits. Many welfare benefit funds have accumulated significant surplus assets and some sponsoring employers would like to repurpose the assets to fund other welfare benefits, such as active medical benefits. However, there is a concern that, in some circumstances, the IRS could consider such repurposing an employer "reversion," which would be subject to a 100% excise tax under the Internal Revenue Code.

Neither Treasury nor the IRS have published guidance of general applicability as to whether repurposing of welfare benefits to provide other welfare benefits would give rise to the excise tax. The Council's letter argues that the excise tax should not apply, citing legislative history and prior IRS memoranda. As the Council's letter stated, we "strongly urge that Treasury and the IRS take action to provide employers with the certainty needed to enable them to access substantial welfare benefit fund assets … to provide benefits to employees and their beneficiaries."

In the past, the IRS would issue rulings for specific employers confirming that the excise tax does not apply, which were extremely helpful to plan sponsors and the individuals served by those employer-provided benefits. However, the IRS stopped issuing these rulings in 2019. The Council has asked the IRS to begin issuing these rulings again, at least in the absence of clarifying guidance.

Based on recent conversations with agency staff, the sense of Council staff is that Treasury and IRS continue to work this project, but no guidance has yet been issued and we are concerned about the pace of work on this project. Council staff will follow-up with Treasury and IRS staff

to amplify and reiterate the points made in the letter and to encourage the release of favorable guidance as soon as possible.

RECENT LEGISLATIVE ACTIVITY

Council, Others Push Back on Proposals to Tax Employer-Provided Health Coverage

You Need to Know:

- Influential conservative and Republican groups continue to signal strong support for proposals to limit the current-law tax exclusion for employer-provided coverage.
- The Council, individually and through participation in numerous coalitions, will continue to voice its strong opposition to such proposals.

The American Benefits Council and 70 other employer, labor, patient and disease advocacy groups sent **a letter to Congress** on June 11, underscoring the value of employer-provided health care coverage and explaining why it should not be subjected to tax.

Under current law, employees are not taxed on the value of their employer-provided health coverage. According to the White House Office of Management and Budget, this resulted in forgone individual 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.

Past calculations by the American Benefits Council have shown that for every one dollar in tax "expenditures" employers spend roughly four to five dollars on health benefits. Nevertheless, some lawmakers on both sides of the aisle have opposed this tax exclusion, for a variety of reasons.

The Republican Study Committee (RSC) – a conservative group within the U.S. House of Representatives that includes a majority of the Republican conference and the entire House GOP leadership – issued a budget proposal on March 20 budget proposal for the upcoming fiscal year that "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."

On May 29, the Paragon Health Institute – a conservative research firm led by former Republican White House officials – issued a paper, Follow the Money: How Tax Policy Shapes Health Care. While the paper acknowledges some of the benefits of employer-sponsored insurance, it recommends "capping the tax exclusion for employer sponsored health insurance at 125 percent of the national average, adjusted for the age of the workforce."

Together, these proposals suggest strong sympathy within influential conservative and Republican circles for taxing employer-provided coverage. While both policies are limited in their detail, and the actual approach will likely depend on the party's overall tax reform strategy in 2025, the Council believes it is critical to make clear its opposition to these proposals.

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.

The June 11 group letter reiterates these points, expressing deep concern "about proposals that will jeopardize the affordability and accessibility of health coverage. In addition to broad societal benefits and underpinning the stability of our health care system, the current tax-favored treatment of employer-provided health coverage delivers critical value and investment return for employers, workers and their families, and the federal government itself."

In a news release issued by the Alliance to Fight for Health Care – a multistakeholder coalition established by the Council to support employer-provided coverage – Council President James Klein noted, "Today, some believe that taxing employee health care will promote 'consumerism' in health care, lower health care costs and the trajectory of health care inflation, as well as increase wages. Unfortunately, 'wishing' for outcomes in a world that does not exist does not make these wishes come true. Taxing employment-based health care will predictably result in less health care coverage and potentially worse health outcomes."

The Council and the Alliance to Fight for Health Care will continue our efforts to educate policymakers on the problematic results of this tax proposal.

House Subcommittee Advances Broad Federal Data Privacy Legislation

You Need to Know:

- Lawmakers have released draft legislation, the American Privacy Rights Act (ARPA), establishing national data privacy rights and protections.
- Following the bill's approval by a key subcommittee, the Council is carefully evaluating the legislation as it relates to employee benefits and will continue to engage with Congress about any implications for employee benefits plans.

On April 7, The U.S. House of Representatives Committee on Energy and Commerce Chair Cathy McMorris Rodgers (R-WA) and U.S. Senate Committee on Commerce, Science and Transportation Chair Maria Cantwell (D-WA) released a discussion draft of the American Privacy Rights Act (ARPA), presenting a bipartisan, bicameral proposal for comprehensive federal data privacy legislation.

According to a statement from the two lawmakers, the ARPA would establish foundational uniform national data privacy rights for Americans, including by eliminating the patchwork of state laws by setting one national privacy standard, stronger than any state. McMorris Rodgers and Cantwell describe the draft legislation as "the best opportunity we've had in decades to establish a national data privacy and security standard that gives people the right to control their personal information."

Specifically, the measure would establish national consumer data privacy rights and set standards for data security and would require covered entities to be transparent about how they use consumer data and give consumers the right to access, correct, delete, and export their

data, as well as opt out of targeted advertising and data transfers. The ARPA would provide for enforcement by the Federal Trade Commission and states attorneys general and also allows consumers to file private lawsuits against entities that violate their rights under the measure.

A section-by-section summary of the discussion draft is available here.

On May 23, the House Energy and Commerce Subcommittee on Innovation, Data and Commerce approved a modified version of the ARPA discussion draft by voice vote. The legislation now goes to the full Energy and Commerce Committee for consideration. The bipartisan, bicameral legislation represents an important step toward federal privacy legislation and is a priority for McMorris Rodgers, who is retiring at the end of this Congress. Nonetheless, the prospect for enactment of the legislation remains uncertain with limited time and opportunity for significant legislation to pass the remainder of this Congress.

RECENT JUDICIAL ACTIVITY

Appeals Court Finds ERISA Preempts Efforts by Out-of-Network Providers to Seek Payment from Health Plans Under State Law

You Need to Know:

- A federal appeals court recently held that the state law claims for out-of-network payment are preempted by ERISA, as recommended by a Council *amicus* brief.

- Many third-party administrators have been subjected to state law claims asserting that the TPA entered into oral contracts during "verification of benefits" calls to pay providers a certain rate for out-of-network benefits—posing substantial problems in state courts that are often unfavorable to plans.

On May 31, the U.S. Court of Appeals for the 9th Circuit **upheld a lower court ruling** finding that an out-of-network provider's state law claims against a third-party administrator (TPA) were preempted by ERISA. This is a favorable result in a case in which the American Benefits Council, along with several other groups, had filed an *amicus* (or "friend of the court") brief in support of the TPA, in an attempt to dampen litigation by out-of-network providers bringing state law contract claims against employer plan sponsors.

In this case (*Bristol SL Holdings, Inc. v. Cigna Health Life Ins. Co.*), an out-of-network substance use disorder center ("the clinic") sued the TPA to several self-insured plans for its denial of benefits for several individuals, which the TPA had denied due to fraud by the out-of-network clinic, consistent with the terms of the plans. The clinic claimed benefits on behalf of plan participants under ERISA and alleged a contractual right to payment, under California law, based on conversations the TPA's staff had with staff of the clinic in the process of verifying plan benefits.

The lower court ruled for the TPA, finding that its denial of benefits was not unreasonable and that the clinic's state law claims were preempted by ERISA. The clinic then appealed.

As part of the appeal to the 9th Circuit, the Council filed its brief in support of the TPA because the district court's decision represented an important victory in a contested area of importance to plan sponsors and their TPAs. This is because many TPAs have been subjected to state law claims asserting that the TPA entered oral contracts during "verification of benefits" calls to pay providers a certain rate for out-of-network benefits.

While these allegations are generally not accurate, they can pose substantial problems in state courts that are often unfavorable to plans. Maintaining ERISA's strong preemption principles is an important tool to defeat these claims.

The Council's brief explained the real-world impacts of these lawsuits, including how important it is for plan sponsors:

- To be able to make coverage decisions to disincentivize low-quality, low-value care,
- To ensure providers will be paid as set forth in the plan,
- To ensure economic viability of plans, and
- To continue to use pre-authorization to prevent unnecessary and excessive out-of-network expenditures.

The brief also illustrated the connection of these points to the legal framework of ERISA preemption as a means to protect national uniformity on these central plan design decisions.

In its opinion, the three-judge panel for 9th Circuit upheld the lower court's ruling, finding the clinic's claims that the TPA was contractually obligated, under state law, to pay the clinic based on the pre-authorization call was preempted by ERISA, and that that legal claim was an attempt to make a claim for ERISA benefits "in the garb of state law." The court also affirmed the plan's denial of benefits under ERISA.

The clinic could decide to seek review by the full 9th Circuit or by the U.S. Supreme Court. Though both are unlikely, we will continue to monitor this case.