BENEFITS INSIDER

Volume 346, July 1, 2024
(covering news from June 16-30, 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.

TABLE OF CONTENTS:

RECENT REGULATORY ACTIVITY

IRS Provides Guidance on Early Emergency Retirement Distributions Tax Exceptions

You Need to Know:

- The IRS recently issued Notice 2024-55, detailing exceptions to the additional tax on early retirement plan distributions for emergency personal expenses and victims of domestic abuse.
- The notice clarifies the definitions, eligible plans, limitations and repayment options for these distributions, while highlighting that plans are not required to offer them.

On June 20, the Internal Revenue Service (IRS) issued Notice 2024-55, detailing exceptions to the additional tax on early retirement plan distributions for emergency personal expenses and victims of domestic abuse. These provisions, effective January 1, 2024, were added by the SECURE 2.0 Act of 2022.

The notice permits taxpayers to receive distributions from eligible retirement plans for unforeseeable or immediate financial needs related to personal or family emergencies. Additionally, taxpayers who are victims of abuse by a spouse or domestic partner can receive distributions from eligible retirement plans under certain circumstances. The U.S. Treasury Department and IRS plan to issue further regulations on the 10% additional tax and its exceptions.

Council Challenges DOL's Proposed Data Collection for Retirement Savings Database

You Need to Know:

- The Council expressed concerns over the DOL's proposed data collection request for the Retirement Savings Lost and Found database, emphasizing the need for practical guidance and collaboration with plan sponsors.
- In a detailed letter, the Council highlighted risks such as potential data breaches and overreach beyond statutory requirements, urging the DOL to withdraw the proposed information collection request.

For several years, the American Benefits Council has communicated serious concerns with the U.S. Department of Labor's (DOL) approach to the problem of missing and unresponsive retirement plan participants. We have repeatedly urged the DOL to work with the plan sponsor community to develop workable guidance including a safe harbor for plan sponsors rather than conduct unconstructive and unnecessary multi-year audits. The Council continued its message in a recent response to the DOL's proposed information collection request (ICR) for the newly established Retirement Savings Lost and Found database.

In a **detailed letter to DOL**, the Council outlined its support for the creation of the Lost and Found database while highlighting several issues with the proposed ICR. The Council emphasized its commitment to ensuring workers receive their entitled retirement benefits and criticized the DOL's approach of attributing the problem of missing participants to plan administrators' practices.

This database, mandated by the SECURE 2.0 Act of 2022, aims to assist individuals in locating lost retirement accounts.

Among the concerns raised in the letter, the Council points out:

- **A need for workable guidance:** The letter reiterated the Council's long-standing efforts to address missing and unresponsive participants, urging DOL to collaborate with plan sponsors rather than conducting multi-year audits. The letter noted that participants often become missing for reasons beyond administrators' control and the Council called for clear, practical guidelines from the DOL.
- **Risks of the proposed ICR:** The letter highlighted the risks associated with voluntary data submission which the DOL has called for, including potential liability in case of data breaches and compliance with privacy laws. The Council noted that DOL's request contradicts its own cybersecurity guidelines and SECURE 2.0 provisions prohibiting the use of collected information in audits against employers.
- **DOL exceeding its authority:** The Council also pointed out that the proposed ICR sets forth requests for historical plan information and expanded participant data beyond what is required by ERISA. The letter stressed that such requests could impose undue burdens on plan administrators and create incomplete or inaccurate data in the Lost and Found database.
- **Premature data collection:** The Council noted that the DOL's plan to begin data collection with the 2023 Form 5500 is inconsistent with the statute, which specifies starting with plan years beginning after December 31, 2023. The Council points out that DOL should align its timeline with statutory requirements to avoid unnecessary costs and administrative burdens.

The letter underscores the Council's long-time message regarding the importance and value of collaboration between the DOL and plan sponsors to meet the common goal of ensuring that participants receive the benefits they have earned. To that end the Council calls on DOL to withdraw the proposed ICR and engage in a notice and comment rulemaking process as required by law.

EBSA Concludes Review of Pension Risk Transfers Requires More Time

You Need to Know:

- EBSA recently concluded its review of IB 95-1, governing the selection of an annuity provider for the purpose of a pension risk transfer.
- In accordance with Council recommendations, EBSA upheld its principles-based guidance for fiduciaries and recommended no current changes, though it also acknowledged the need for ongoing evaluation and potential updates.
- Again, in accordance with a Council recommendation, EBSA recognized the need for notice and comment prior to making future changes to IB 95-1.

In a comprehensive review of Interpretive Bulletin (IB) 95-1, the U.S. Department of Labor Employee Benefits Security Administration (EBSA), in consultation with the ERISA Advisory Council (EAC), reaffirmed the framework of Interpretive Bulletin (IB) 95-1 in helping

fiduciaries assess annuity providers for the purpose of distributing benefits under a defined benefit pension plan (often referred to as a "pension risk transfer"). However, EBSA stated that ongoing review may be needed to determine if updates or additional guidance are necessary.

Issued in 1995, IB 95-1 sets forth the standards for evaluating annuity providers' claims-paying abilities and financial soundness. EBSA's review – required under the SECURE 2.0 Act of 2022 – stressed the principles-based nature of the current guidance, favoring its continuation. EBSA also believes that further exploration into the life insurance industry's evolution and pension risk transfer practices may be warranted, including assessing if the IB 95-1's factors require revision or supplementation.

The Council is very pleased that the report follows the key recommendations that we made in our **June 9, 2023, letter** to EBSA by preserving the principles-based nature of IB 95-1, recommending no current changes, and noting that the notice and comment process will be used to make changes to IB 95-1

The Council strongly supports defined benefit plan sponsorship. However, given the numerous regulatory and financial burdens imposed on defined benefit plans, we also strongly support the ability of employers to transfer risk as necessary.

Some public and private stakeholders have expressed concerns about various developments in the life insurance industry that could affect insurers' claims-paying abilities and creditworthiness. Specific issues include insurers' ownership structures, exposure to risky assets, and the use of affiliated and offshore reinsurance. Some stakeholders attribute these concerns to the increased involvement of private equity firms. The **Council has studied** this set of issues, concluding that pension risk transfers are even safer than the very safe pension system, based on hard data that disproves the concerns of some stakeholders.

There is no current consensus on whether any changes to IB 95-1 are needed. Opinions among EAC members were divided, with some advocating for no changes and others supporting various modifications.

EBSA also highlighted the possible need for better disclosure following partial buyouts, recognizing significant impacts on plan participants and beneficiaries. Coordination with the Pension Benefit Guaranty Corporation and public commentary will be essential in shaping any future guidance. Regarding other issues, IB 95-1 does not mandate equal weighting of its factors, allowing fiduciaries to apply them based on individual plan circumstances.

Finally, EBSA noted that many concerns related to preserving ERISA rights and obligations after pension risk transfer annuity purchases are already addressed by existing regulations or industry practices. The agency will continue to monitor these issues to protect the interests of plan participants and beneficiaries.

Council Defends ERISA Preemption Regarding Application of Texas Laws to Health Plans

You Need to Know:

- The Council recently submitted comments to the Texas Attorney General asserting that several Texas laws that affect pharmacy benefit plan design and administration are preempted by ERISA.

- The Council invites members to join our efforts in addressing high priority issues – such as defense of ERISA preemption – in light of increased state activity.

As part of the American Benefits Council's ongoing advocacy to protect ERISA federal preemption the Council submitted a comment letter on June 17 to Texas Attorney General Ken Paxton regarding the applicability of several Texas laws to employer health plans.

As background, Texas legislator Charles Schwertner (R) recently wrote a letter to Paxton asking for a legal opinion on several questions, expressing concern that two Texas laws are not being enforced against either pharmacy benefit managers (PBMs) administering benefits for ERISA plans or against plans based outside of Texas.

The two Texas laws at issue relate to PBMs. One (H.B. 1919) provides, among other things, that a PBM or insurer may not steer or induce patients to an affiliated pharmacy, including through cost-sharing incentives. The other law (H.B. 1763) imposes restrictions on PBMs' ability to set standards for pharmacy networks. Neither law explicitly addresses ERISA-covered self-insured plans. Both laws took effect in 2021.

In general, Schwertner asks the Texas Attorney General for an opinion as to whether these two laws are enforceable against : (1) a PBM administering benefits under an ERISA plan (and against an ERISA plan insurer), and (2) a PBM or insurer where the plan, based outside of Texas, provides coverage to Texas residents and the PBM contracts with a network of providers that includes Texas pharmacy providers. Schwertner's letter asserts e that the laws should be enforced in both cases.

The Texas Attorney General (AG) has until November 12, 2024, to issue an opinion — and as part of that process, the AG's office accepted comments from interested parties.

The Council took this opportunity to submit a letter, addressing the scope, value and beneficial policy impacts of ERISA preemption over the last 50 years. The letter also explained the ways in which key elements of the Texas laws at issue are preempted by ERISA, if applied to self-insured plans through their PBMs, by dictating pharmacy network design and undermining the ability of employers to steer patients toward specific pharmacies.

The Council also explained that prior unsuccessful efforts to expand the current Texas laws at issue to cover all types of plans, including self-insured plans, is evidence that the current statutes do not apply to self-insured plans (otherwise legislative efforts to expand the laws would not have been necessary).

Council's Advocacy on Mental Health Parity Continues

You Need to Know:

- The Council continues to advocate for critical improvements to major regulations proposed last summer by the tri-agencies on mental health parity, including in several recent meetings with agency staff.
- Council staff expects the agencies to issue final regulations this year, as soon as possible.

During the first half of June, the Council has had several meetings with staff from the U.S. departments of Health and Human Services, Labor, and Treasury (the "tri-agencies") to discuss regulations proposed last summer under the Mental Health Parity and Addiction Equity Act (MHPAEA).

In July 2023, the tri-agencies proposed significant regulations on the mental health parity requirements that apply to group health plans. The proposed regulations included guidance on the comparative analysis requirement enacted by the Consolidated Appropriations Act, 2021 (CAA) and would also make significant changes to the long-standing substantive mental health parity regulations.

The Council submitted extensive comments, expressing support for access to high-quality, affordable mental health coverage but also noting a number of substantial concerns with the proposed rules, including the possible impact on the ability of plans to use medical management techniques to ensure high-quality mental and behavioral health treatment, several key areas where more clarity and detail is needed to support compliance, and issues raised by the proposed requirement that a named fiduciary certify the CAA comparative analysis.

Over the past several months, the tri-agencies have been reviewing the almost 10,000 comments received on the proposed regulations and the sense of Council staff is that the tri-agencies intend to issue final regulations this year, as soon as possible.

With that in mind, over the past several weeks Council staff has met with tri-agency staff to reiterate the top issues we raised in our comments and to answer questions from the tri-agencies. In addition to a meeting with tri-agency staff and the Council, Council staff also participated in a meeting with the tri-agencies as part of a broader coalition of employer and insurer groups to amplify the same messages. These meetings have been productive and very well attended by tri-agency staff.

IRS Issues Educational Assistance Program Guidance

You Need to Know:

- The IRS and Treasury issued guidance clarifying tax exclusions for educational assistance programs.
- The guidance explains that taxpayers can exclude up to $5,250 per year in educational benefits provided by employers, covering expenses such as tuition and qualified education loan payments.

On June 18, the Internal Revenue Service and U.S. Treasury Department **issued guidance** addressing questions related to educational assistance programs.

The FAQ-style guidance provides answers to questions about Section 127 of the tax code, which permits taxpayers to exclude certain educational assistance benefits from their gross income if they are provided under an educational assistance program.

The IRS noted that educational assistance benefits include payments for tuition, fees, and similar expenses, as well as books, supplies, and equipment. They also include principal or

interest payments on qualified education loans made by an employer after March 27, 2020, and before Jan. 1, 2026.

Taxpayers do not need to pay tax on benefits of up to $5,250 per calendar year, and employers should not include the benefits in wages, tips, and other compensation shown in box 1 of Form W-2.

However, any tax-free education expenses cannot be used as the basis for any other deduction or credit, including the lifetime learning credit. If benefits are received under a program that does not comply with the requirements for an educational assistance program under the tax code or if the benefits exceed $5,250, the amounts may still be excluded if certain requirements are satisfied. Amounts paid under an educational assistance program are generally deductible by the plan sponsor as a business expense.

The FAQ page answers nine specific questions such as:

- The total amount an employee can exclude from gross income per year;
- Are employer payments of qualified education loans for spouses and dependents excluded from gross income; and
- If there are other exclusions from gross income for educational assistance.

RECENT LEGISLATIVE ACTIVITY

Council Proposes Retirement Security Enhancements for Gig Workers

You Need to Know:

- In response to a recent request for information from the ranking Republican on the Senate HELP Committee, the Council offered a series of recommendations for improving gig workers' retirement security.
- The Council's five-part plan recommends building on the Pooled Employer Plan and Defined Contribution Group advancements made under the SECURE Act.

The American Benefits Council, in an effort to expand retirement savings through the employer-sponsored system, is encouraging policymakers to enhance opportunities for gig workers to save for retirement.

The Council's **June 26 letter** is a detailed response to a request for information (RFI) by Senator Bill Cassidy (R-LA), ranking Republican member of the Senate Health, Education, Labor and Pensions (HELP) Committee. The RFI seeks information on "ways to remove federal legal and regulatory barriers to portable benefits for independent workers while protecting their flexibility and freedom to earn a living as they best see fit."

The Council's letter proposes a five-part plan to vastly expand retirement savings opportunities for independent workers. These proposals build on the establishment of pooled employer plans (PEPs) and defined contribution groups (DCGs) in the Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019:

1. Clarify that contributions by a company directly to a PEP or DCG in which an independent worker participates as an employer would have no effect on the worker's independent contractor status with respect to the company.
2. Direct the regulatory agencies to facilitate arrangements for independent workers PEPs, DCGs and Simplified Employee Pensions (SEPs) through guidance providing appropriate relief from unnecessary regulatory burdens.
3. Modify the audit rules for PEPs to exempt participating employers with fewer than 100 participants in the PEP, which would reduce audit costs and would mean that PEPs could become available to gig workers without having to charge them for part of the audit costs.
4. Allow plans in a DCG that are subject to the audit requirement to jointly file a single audit as if they were part of the same plan. This could reduce costs by over $6,000 per employer with 100 or more participants.
5. Increase the plan asset threshold that exempts plans for independent workers from burdensome paperwork requirements.

As Lynn Dudley, the Council's senior vice president, global retirement and compensation policy, said in an accompanying news release, "Over the last five years, in the course of enacting the landmark SECURE and SECURE 2.0 Act retirement policy legislation, Congress has established a very sound framework for providing gig workers with the same level of benefits as employees. What is needed now is not an overhaul of the system but rather specific fine-tuning of the excellent framework that Congress has already established."

RECENT JUDICIAL ACTIVITY

Supreme Court Issues Major Ruling Governing How Courts Review Regulations

You Need to Know:

- The U.S. Supreme Court last week overturned a 40-year-old decision establishing that courts will no longer defer to agency interpretations of statutes in the absence of a clear grant of interpretative authority to the agency by Congress. This will make it easier to successfully challenge regulations.
- The ruling does not immediately affect previously decided cases. However, parties may seek to bring new challenges to regulations previously upheld by courts under the prior deferential standard of review.
- While the case decided by the Supreme Court did not involve employee benefits, the sweeping nature of this ruling will have an impact on essentially all federal rulemaking, making it more difficult for agencies to defend rules they have issued.
- Commenting on the impact of the ruling for employee benefits policy, Council president James A. Klein noted in a statement: "The demise of Chevron has upended the respective roles of all three branches of government. Congress will be challenged to pass more detailed legislation rather than deferring to regulators. Agencies will issue more sub-regulatory guidance rather than formal rulemaking where stakeholders have greater opportunity for input. Now that courts are granted greater power, the already contentious judicial confirmation process will take on even greater importance as judges

are free to rely less on regulators' subject matter expertise. Weakening executive branch decision-making will sometimes work in favor of, and sometimes work against, employee benefit plan sponsors."

Background

For 40 years, U.S. Supreme Court case law has provided a two-step analysis for reviewing agency regulations. Under step one, the court determines if the meaning of the statute is ambiguous. If it is not ambiguous the court rules consistent with the clear meaning of the law. If the statute is ambiguous, the court defers to an agency's interpretation of the statute as long as it is reasonable. This rule was set forth in 1984 in *Chevron v. Natural Resources Defense Council* and the resulting doctrine is known as "*Chevron* deference."

New Standard

On June 28, the Supreme Court case issued a judgment in *Loper Bright Enterprises v. Gina Raimonde and Relentless, Inc. v. Department of Commerce*. In a 6-3 opinion (with the six conservative justices overturning *Chevron* and the three liberal justices defending it) authored by Chief Justice John Roberts, the court held that:

- *Chevron* is overruled because it conflicts with the Administrative Procedure Act (APA) (a law enacted in 1946 that addresses judicial review of agency actions) because under the APA "courts must exercise independent judgment in determining the meaning of statutory provisions."
- As to the standard courts should now apply: "[W]hen a particular statute delegates authority to an agency consistent with constitutional limits, courts must respect that delegation, while ensuring that the agency acts within it. But courts need not and under the APA may not defer to an agency interpretation of the law simply because a statute is unambiguous." As a result, where an agency interpretation regarding a matter of law is not the result of express congressional delegation, no such deferential review standard applies by a reviewing court.
- The opinion notes that courts may pay "careful attention" to federal regulations and agency decisions, to inform their work. Interpretations of statutes by agencies "issued contemporaneously with the statute at issue, and which have remained consistent over time, may be especially useful in determining the statute's meaning." The court describes agencies as having the "power to persuade, if lacking power to control."
- The court explained that its decision does "not call into question prior cases that relied on the Chevron framework. … Mere reliance on *Chevron* cannot constitute a "special justification" for overruling such a holding." However, parties may seek to bring new challenges to existing regulations that were previously upheld.

The dissenting opinion, written by Justice Elena Kagan, defended deference to agencies under *Chevron*, due to agency expertise and political accountability, explaining ambiguity in statutes as an implicit delegation by Congress to the agencies that are supposed to implement the laws. Justice Kagan wrote that "[i]n one fell swoop, the majority today gives itself exclusive power over every open issue – no matter how expertise-driven or policy-laden – involving the meaning of regulatory law. As if it did not have enough on its plate, the majority turns itself into the country's administrative czar." Justice Kagan even invoked a health policy related example to make her point, writing: "…[H]ow should the Medicare program measure a

'geographic area' when calculating reimbursements to hospitals based on the wage levels in certain regions?"

Implications

It is expected that it now will be easier for parties challenging regulations to prevail, which likely means there will be increased litigation challenging regulations, more regulations struck down and more uncertainty as to the fate of any given final regulation. Also, different courts in different parts of the country could rule in different ways on the same regulations, which could mean inconsistent interpretations of regulations across the country, until the Supreme Court rules on any given issue.

In addition to the litigation impact, this ruling is expected to have broader effects on policymakers as well. On one hand, Congress may now feel compelled to enact more detailed legislation as a way to avoid ambiguity, even though members of Congress will generally not possess the same substantive expertise as a regulatory agency. Conversely, the need to enact more specific legislation may increase the likelihood that lawmakers are unable to agree upon the details and, therefore, less legislation is enacted. The ruling could affect not just the types of rules that agencies issue but also the ways in which they draft those rules (e.g., putting greater emphasis on their enforcement), as well as increase the time it takes to draft regulations, in order to make their expertise and justifications clear in an attempt to be persuasive to the courts that may review their rules.

Supreme Court Review Sought in ERISA Preemption Case

You Need to Know:

- The Oklahoma Insurance Commissioner has asked the U.S. Supreme Court to review an important case regarding ERISA preemption. The relevant appeals court had ruled that the Oklahoma statute at issue (which had restricted self-insured plan design) was preempted by ERISA, in a favorable opinion.
- In the next few months, the Supreme Court will decide whether to hear the case. If it decides to do so, there will be a months-long process where the merits will be argued before the high court.

Last month, Oklahoma Insurance Commissioner Glen Mulready asked the U.S. Supreme Court to review a ruling by the U.S. Court of Appeals for the 10th Circuit, which found that ERISA preempts an Oklahoma law regulating pharmacy networks that directly restricts self-insured plan design.

The ruling by the 10th Circuit, in *Pharmaceutical Care Management Association (PCMA) v. Mulready*, reversed a lower court decision and was an important and positive step toward bolstering ERISA preemption, which the American Benefits Council worked to support. The 10th Circuit ruling was especially welcome news in the face of many recent efforts to undermine ERISA preemption, both at the state level and in certain federal courts.

As background, in 2019, Oklahoma enacted the Patients' Right to Pharmacy Choice Act (the Act), regulating pharmacy benefit managers (PBMs) and pharmacy networks. Among other things the Act: (1) requires pharmacy networks to meet certain geographic restrictions,

effectively eliminating mail-order only networks, including specialty networks, (2) requires inclusion of 'any willing pharmacy' in a plan's preferred network and (3) prohibits cost-sharing discounts to incentivize the use of particular pharmacies.

PCMA challenged the law as preempted by ERISA, but the district court found the Act was not preempted. PCMA appealed, arguing that key provisions in the Act are preempted by ERISA because they dictate plan design and regulate central matters of plan administration.

The Council, along with several other employer groups, submitted an *amicus* ("friend of the court") brief to the appeals court (which was unfortunately not officially accepted by the court, but which the court may have nevertheless reviewed). The brief emphasized the practical importance of ERISA preemption for employer plan sponsors and explained how the Act directly affects plan design.

In a very thorough opinion, the 10th Circuit set out the history and purpose of ERISA preemption, found the Act cannot escape ERISA preemption just because it regulates PBMs and ruled that the challenged provisions are preempted by ERISA.

In May, as the most recent development in the case, Mulready and the Oklahoma Insurance Department requested that the U.S. Supreme Court review the case and reverse the 10th Circuit. They argued the 10th Circuit's decision was inconsistent with Supreme Court precedent and another appeals court opinion, setting out a narrow interpretation of ERISA preemption (*i.e.*, that it only applies to state laws requiring specific benefit structures or specific benefits).

Mulready and the Oklahoma Insurance Department also argue that the Act operates only on PBMs and that it does not operate on benefit plans. However, they also assert that even if the Court believes regulation of PBMs can be considered regulation of health plans, the challenged provisions should be saved from preemption under ERISA's "savings clause," which provides that laws regulating insurance are saved from ERISA preemption, which is an issue that was raised by the U.S. Department of Labor in an *amicus* brief filed with the 10th Circuit.

In mid-June, several *amicus* briefs were filed in support of Mulready and the Oklahoma Insurance Department asking the Supreme Court to grant review and reverse the 10th Circuit, including a brief filed by 32 states, supporting the ability of states to regulate PBMs and a brief filed by pharmacy associations, among the other briefs. (Although *amicus* briefs may be filed asking the Court to hear a case, it is not the convention for *amici* to ask the court not to hear a case, and so the Council is not participating as *amici* at this stage).

PCMA has until July 15 to file a brief in response to Mulready's request for Supreme Court review. After that, it will likely take the Supreme Court a few months to decide if it will hear the case. If the Supreme Court agrees to hear the case, there will then be an opportunity for the parties to argue the merits before the court and for *amici* on both sides (including the Council) to file briefs as well.

In the broader context, the Council continues to work to defend ERISA preemption, at the federal and state level, and will report on additional significant developments.

Appeals Court Rules on Affordable Care Act Preventive Services Requirements

You Need to Know:

- The U.S. Court of Appeals for the 5th Circuit has ruled that although some aspects of the preventive services requirement under the Affordable Care Act are unconstitutional, those requirements still apply to health plans nationwide, except for the health plans sponsored by the specific employers who brought the lawsuit.
- This ruling essentially leaves the preventive services requirement intact, for now.

On June 21, the U.S. Court of Appeals for the 5th Circuit issued a ruling in *Braidwood Management, Inc. v. Becerra*, regarding group health plan coverage of certain mandated preventive services. While the court describes the ruling as a "mixed bag," in practical terms it leaves the preventive services requirements under the Affordable Care Act (ACA) in place for health plans, except for the plans of the employers who brough the lawsuit.

Background

Under the ACA, non-grandfathered health plans must cover, without cost-sharing, certain preventive services. Among other things, this includes items and services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) "recommended items and services." (Referred to here as the "USPSTF preventive services requirement", to distinguish from other aspects of the preventive services requirement).

A district court judge in Texas had ruled the USPSTF preventive services requirement is unlawful with regard to recommendations on or after March 23, 2010, (the date the ACA was enacted) because the USPSTF was unconstitutionally appointed by Congress. The ruling prevented the U.S. departments of Health and Human Services, Treasury and Labor (the "tri-agencies") from implementing and enforcing this requirement nationwide.

The U.S. Department of Justice (DOJ) appealed this decision to the appeals court. In response to a request from DOJ, in May 2023, the 5th Circuit "stayed," or paused, the impact of the lower court's ruling while the appeals court considered the case. This meant that the USPSTF preventive services requirement remained in effect until the 5th Circuit ruled on the merits in the case.

Also in the spring of 2023, the tri-agencies issued Frequently Asked Questions addressing *Braidwood* confirming that, among other things, until further guidance is issued, USPSTF items and services recommended on or after March 23, 2010, are preventive care for purpose of the rules that apply to health savings account (HSA)-eligible high deductible health plans (HDHPs). This means that HDHPs can continue to cover these items and services pre-deductible.

5th Circuit Ruling

On June 21, the 5th Circuit ruled that:

- The appointment of the USPSTF members was unconstitutional (*i.e.*, because the members of the USPSTF were not nominated by the President and confirmed by the Senate.
- But that the district court was not justified in effectively striking down the USPSTF preventive services requirement *for all plans nationwide.*

- Instead, the appropriate remedy for the ruling that the USPSTF appointments violated the constitution is that the tri-agencies are prevented from enforcing the USPSTF preventive services requirement specifically against the *Braidwood* plaintiffs (that the district court found had "standing" to sue), in contrast to all employers nationwide.

The 5th Circuit also addressed the plaintiffs' allegations that other entities that make preventive services requirement recommendations (*i.e.*, the Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices (ACIP)) were also unconstitutionally appointed. The lower court had ruled that the Secretary of HHS properly ratified HRSA and ACIP recommendations, even if HRSA and ACIP had defects in their appointments. The plaintiffs appealed that ruling and raised several new arguments to the 5th Circuit related to procedural defects with the ratification of the ACIP and HRSA recommendations. Because these issues were new and not raised with the district court, the 5th Circuit declined to rule on them and instead sent those issues back to the district court for further consideration.

As next steps, the issues noted above regarding the HRSA and ACIP will be presented to the district court. The government may also seek rehearing by the full 5th Circuit to consider the constitutional issue, or the government may seek Supreme Court review of the issue. The plaintiffs in *Braidwood* might also seek an appeal of the 5th Circuit's determination on the nationwide injunction. However, they may face hurdles in doing so because they are no longer subject to the preventive services requirements and thus no longer being harmed by the unconstitutional appointments.

One additional issue for consideration is the extent to which the preventive services requirements found to be unconstitutional will be enforced by the tri-agencies in light of the court's ruling with respect to plans/insurers within the 5th Circuit (and more generally). In this vein, it remains to be seen whether the tri-agencies will issue guidance to explain the impact of this ruling and their plans regarding enforcement. For now, guidance has not been issued.

Council Files Amicus Brief in Support of AEP's Severance Benefits Denial

You Need to Know:

- The American Benefits Council filed an *amicus* brief supporting American Electric Power in an ERISA case, arguing for deference to benefit determinations.
- The Council contends that overturning established legal precedents would disrupt the predictability and efficiency essential for benefit plan sponsors.

On June 12, the American Benefits Council filed an ***amicus* ("friend of the court) brief** in support of American Electric Power (AEP) in an Employment Retirement Income Security Act of 1974 (ERISA) case. The case challenges AEP's denial of severance benefits to a former executive, a decision made by AEP's chief human resources officer and affirmed by the plan's committee.

The Council's involvement underscores the importance of maintaining established legal principles that protect plan sponsors from burdensome litigation and ensure the stability of employee benefit plans.

The brief seeks to uphold the principle that benefit determinations made by administrators with discretionary authority should be given deference. Additionally, the Council argues that claimants seeking relief under 29 U.S.C. § 1132(a)(1)(B) do not have a right to a jury trial.

After the former executive's termination, AEP determined he was not eligible for severance benefits because he was terminated for cause. The district court applied U.S. Court of Appeals for the 6th Circuit precedent and denied the employee's demand for a jury trial and additional discovery related to the benefits determination. The former employee is now appealing, arguing the U.S. Supreme Court's decision in *United States v. Tsarnaev* abrogates the precedent set in *Wilkins v. Baptist Healthcare System*, and that he is entitled to a jury trial under the Seventh Amendment.

The Council argues these claims are without merit and overturning established rules would have widespread negative implications for benefit sponsors. The former employee's request to overturn longstanding 6th Circuit precedent can only be granted by an *en banc* panel, and their reliance on *Tsarnaev*, which pertains to jury selection in a death penalty case, is misplaced.

The *amicus* brief emphasizes that a reversal of the district court's ruling would disrupt the efficiency and predictability plan sponsors rely on to avoid costly litigation and uncertain plan interpretations. Furthermore, granting the former employee a right to a jury trial would conflict with consistent precedent that relief under section 1132(a)(1)(B) is equitable.

ERISA aims to balance the interests of plan sponsors and beneficiaries. The Council contends the former employee has not presented a compelling argument to reverse the district court's rulings, which align with ERISA's goals of balance, predictability and efficiency.

MISCELLANEOUS

Council Continues ERISA Briefings for Congressional Staff

You Need to Know:

- The American Benefits Council co-hosted the second in a series of Capitol Hill briefings to educate congressional staff on the significance of ERISA.
- The event is part of the Council's broader ERISA@50 campaign, culminating in a 50th anniversary symposium and gala this September.

On June 25, the American Benefits Council, in partnership with the Employee Benefit Research Institute (EBRI) and the International Foundation of Employee Benefit Plans (IFEBP), hosted the second in a series of briefings on Capitol Hill to educate congressional staff about the Employee Retirement Income Security Act of 1974 (ERISA) and explain how its federal preemption standard allows plan sponsors to provide benefits that meet the needs of their workforce.

The latest session, "Health and Retirement Benefit Trends: Facts and Figures," was held in the Rayburn Office Building in the U.S. House of Representatives. In addition, to sharing data and trends related to benefit plans, the Council, EBRI and IFEBP conducted a "deeper dive" discussion of ERISA preemption that was covered during the initial program held in May.

Given the centrality of ERISA federal preemption, it is likely to figure prominently in the final two Capitol Hill briefings as well.

Speakers included:

- Ilyse Schuman, senior vice president, health & paid leave policy at the Council
- Craig Copeland, director of wealth benefits research at EBRI
- Paul Fronstin, director of health research and education at EBRI

The series of "lunch-and-learn" events is one of many initiatives under the Council's **ERISA@50 campaign** to commemorate the 50th anniversary of this landmark law.

In addition to these events, the Council is collaborating with EBRI on policy research and, as always, advocating for the preservation and protection of ERISA as the cornerstone of the employer-sponsored benefits system. This effort will culminate in a 50th anniversary symposium and gala in September.

Questions on the ERISA@50 Symposium Gala or other elements of the Council's year-long campaign, contact Jim Klein, president, or Jason Hammersla, vice president, communications.