# *BENEFITS INSIDER*

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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 LEGISLATIVE ACTIVITY

### Council Pushing Congress to Address Health Care Market Consolidation, Competition

*You Need to Know:*

- As the end of the legislative session approaches, the Council is urging lawmakers to pursue measures that would address health care market consolidation and promote price transparency – two precursors to high health care costs.

The American Benefits Council's health care policy advocacy continues to center on addressing high and rising health care costs, with a focus on two of the root causes of high costs: market consolidation and a lack of price transparency.

These priorities were summarized in **a joint statement to the U.S. Senate Special Aging Committee** on July 11, in conjunction with its hearing, "Health Care Transparency: Lowering Costs and Empowering Patients."

The statement, submitted under the auspices of the Consumers for Fair Hospital Pricing coalition and the Consumers First alliance – of which the Council is a charter member – urges the committee and the Senate to "take on rising health industry consolidation among hospitals, insurers, and other health care organizations that enables anticompetitive behaviors, prevents healthy competition, and results in monopolies that set outrageous and unjustifiable prices."

*Health Care Provider Competition*

As described more fully in the Council's May 10 written comments to the U.S. Department of Health and Human Services (HHS), the U.S. Department of Justice and the Federal Trade Commission (FTC), health care market consolidation – particularly among hospitals and physician practices – has led to increased, unsustainable costs.

We are strenuously pursuing a number of strategies to address these market failures, including:

- **Site-neutral payment reforms:** One way to decrease incentives for consolidation is for Congress and/or HHS to expand implementation of "site-neutral payment reform", which means aligning payment rates across the sites of outpatient care (*i.e.*, hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs) and freestanding physician offices). Current rates are generally higher for HOPDs and ASCs and this disparity incentivizes consolidation of physician practices with hospitals, which result in care being provided in settings with the highest payment rates.
- **Transparent billing:** After hospitals acquire physician practices, the prices for the services provided increase and this is a contributing factor to the increase in the use by hospitals of billing practices that portray services delivered at these sites as "hospital services" as opposed to "professional services." This is done in order to receive the higher facility reimbursement fee. This billing practice serves to incentivize vertical hospital-physician consolidation and increase costs for employers and patients. As such, we note our support for legislation requiring each off-campus outpatient department of

a hospital to include a unique identification number on claims for services, to help payors distinguish between sites of service to apply the appropriate payment amount.

- **Antitrust enforcement:** As the Council has done before, we ask that the FTC establish stricter review and enforcement of hospital and physician practice consolidation.
- **Anti-competitive contracting:** Large hospital systems sometimes attempt to leverage their significant market share by requiring plans and insurers to contract with all affiliated facilities and by preventing education of patients about lower-cost, higher-quality care. We explain that these anti-competitive contract terms foster inflated costs and limit plan sponsors' flexibility in plan design. As such we note that we continue to urge Congress to address anti-competitive contract terms that disrupt market dynamics and raise the cost of health care.

*Health Care Price Transparency*

Further stifling a competitive and innovative health care market is the lack of actionable price and quality information. As detailed in the Council's July 2023 letter to the U.S. House of Representatives Ways and Means Committee, removing barriers to accessing and using price information is foundational to unleashing the power of transparency to help employers drive lower cost and higher value health care.

The Council strongly supports codifying and strengthening HHS regulations requiring hospitals to publicize standard charges, including the disclosure of negotiated rates in dollars and cents. We also recommend establishing standard formats for disclosing those rates (including a machine-readable format), eliminating loopholes and enforcing greater compliance from hospitals and insurance carriers.

The bipartisan Lower Costs, More Transparency (LCMT) Act (H.R. 5378), which passed the House in December 2023 and would advance many of the Council's health care policy priorities, is one of the few health care legislative measures that could receive further consideration for enactment before the end of the year. The Council has endorsed the bill, noting that it lays "essential groundwork" for achieving the goal of lower health care costs.

The Council is also leading the Alliance to Fight for Health Care – the diverse coalition of stakeholders committed to preserving and strengthening employer-provided health care coverage – and engaging with the Better Solutions for Health Care coalition and the Alliance for Fair Health Pricing coalition in support many of these initiatives.

**EBSA Chief Offers Tepid Defense of ERISA Preemption in House Subcommittee Hearing**

*You Need to Know:*

- At a recent House of Representatives subcommittee hearing, DOL Assistant Secretary for EBSA Lisa Gomez referred to her agency's application of ERISA's preemption standard as "complicated" and "fact-specific," declining to commit to a strong defense of preemption moving forward.
- This response provides further clarity – in addition to the DOL's *amicus* brief in the *PCMA v. Mulready* case considered last year by the 10th Circuit Court of Appeals –

that the Biden administration views ERISA preemption as less than absolute, and is, instead, a "fact specific" determination.

One of the central principles of the American Benefits Council's advocacy is a strong defense of ERISA and its federal preemption standard, which allows a multi-state employer to provide uniform, consistent and equitable benefits across its workforce. In recent years, even as we prepare to celebrate ERISA's 50th anniversary in September, threats to this preemption standard have emerged raising concerns about the future of this critical element of the law.

In particular, the Council is alarmed by the reluctance of the U.S. Department of Labor (DOL) to mount a full-throated defense of ERISA preemption as it arises in federal courts. In the case of *Pharmaceutical Care Management Association (PCMA) v. Mulready, a case dealing with an Oklahoma PBM law,* before the U.S. Court of Appeals for the 10th Circuit, the U.S. Department of Justice, in consultation with DOL, filed an *amicus* ("friend of the court") brief asserting that ERISA preemption applies where a plan sponsor self-administers its benefit plan, but not if it engages a third party to do so. Given the reality of how benefit plans are administered, this was a very narrow interpretation of preemption. Fortunately, the 10th circuit ultimately rejected this view and upheld ERISA preemption. Oklahoma is seeking Supreme Court review of that decision.

In formal testimony before the House of Representatives Education and the Workforce Health, Employment, Labor and Pensions Subcommittee on June 27, the leader of DOL's Employee Benefits Security Administration refrained from providing a strong defense of the breadth of ERISA preemption.

During the hearing, Examining the Policies and Priorities of the Employee Benefits Security Administration, Lisa Gomez, DOL Assistant Secretary for the Employee Benefits Security Administration (EBSA), was asked a direct question by full committee chair Virginia Foxx (R-NC). The following is a transcript of that exchange (courtesy of Bloomberg Government):

**FOXX:** Last year the Labor Department submitted an *amicus* brief in the case of *Pharmaceutical Care Management Association v. Mulready*. The brief suggests that ERISA, which is the linchpin of multi-state group health plans, does not preempt state regulation of health plan administration. Why did the department take this position?

**GOMEZ:** Congresswoman, thank you for that question. With respect to preemption, ERISA preemption, it can be a very complicated and fact-specific question. And there was litigation on that where we took the position that under those specific circumstances that that was the result that the department took. Again, we...

**FOXX:** OK. You're saying that ERISA is very complicated. ERISA preemption is very complicated. It hasn't been complicated for a long time. It's only since the Biden administration that it appears to be complicated. So, will you fully commit? Will you commit to fully defunding – defending, excuse me, defending strong ERISA preemption moving forward?

**GOMEZ:** Congresswoman, I can commit to working together with the department and with the Department of Justice on fully evaluating any case that comes before us that involves preemption and determining whether in that specific case a position by the department, either advocating for preemption or indicating that preemption is not appropriate under

those circumstances would be appropriate. But we – it's difficult to answer without knowing the specific facts of any future case. Preemption is not always the way.

[Click here to view the above exchange in a recording of the hearing.]

The Council continues to provide advocacy and educational support for policymakers on the importance of ERISA preemption. Most recently, we invoked the vital importance of ERISA federal preemption in written comments submitted to Texas Attorney General Ken Paxton regarding the applicability of several Texas laws to employer health plans.

## RECENT REGULATORY ACTIVITY

### Updated SEC Agenda Reveals Two Council Victories: Agency to Revisit 'Hard Close,' Predictive Analytics Proposals

*You Need to Know:*

- In the face of strong opposition from the Council, the SEC will withdraw and reconsider two controversial proposals that would have negatively affected retirement plan participants.

The Biden administration unveiled its spring 2024 regulatory agendas on July 8, revealing two important developments within the Securities and Exchange Commission (SEC). Two projects strongly opposed by the Council – the so-called "hard 4 p.m. close" proposal and the "predictive analytics" proposal – will be reproposed upon further consideration.

*Hard 4 p.m. Close*

The SEC's proposed rule on fund pricing, which was advanced by the commission on November 2, 2022, would require a mutual fund, its designated transfer agent or a registered securities clearing agency to receive any orders before the fund's pricing time (typically 4 p.m. Eastern Time) to obtain the current day's price. Consequently, this "hard 4 p.m. close" would prevent current-day pricing, as permitted under the SEC's existing rules, when a direction to purchase or redeem mutual fund shares is received by an intermediary (such as a retirement plan recordkeeper or third-party administrator) before the 4 p.m. deadline and subsequently transmitted to the fund after such deadline.

The Council submitted written comments on the negative implications the "hard close" rule would have on retirement plans. "The Council is concerned that the ongoing costs that would be incurred [because of the rule] will be more harmful to fund investors than the dilution problems it is seeking to address," we wrote. "Moreover, the harms that would result from a hard close far outweigh any benefits that plan investors would experience."

The proposal also received pushback from key members of Congress, with the bipartisan leaders of the U.S. House of Representatives Ways and Means Committee and the Senate Finance Committee expressing deep concerns with the proposal. SEC Chair Gary Gensler also faced pointed questions on the proposal at an April 18, 2023, oversight hearing in the U.S. House of Representatives Financial Services Committee.

The spring 2024 regulatory agenda formally states that SEC will repropose the rule in April 2025 (though target dates in the agenda are speculative and subject to change).

Because the "hard close" proposal echoes previous initiatives in the SEC, it could continue to arise periodically. The Council will remain vigilant to prevent its finalization.

*Predictive Analytics*

Originally issued in August 2023, the SEC's proposed rule Conflicts of Interest Associated with the Use of Predictive Data Analytics by Broker-Dealers and Investment Advisers would impose broad and potentially burdensome conflict-of-interest requirements on broker-dealers and investment advisers that use even simple technologies to communicate with clients and fund investors or manage clients' assets.

As the Council explained in **September 2023 comments on the proposal**, while plan sponsors are supportive of regulations on new technologies that can be used in a way that is harmful to investors, the proposed rules would apply to virtually all technologies used in connection with investment issues. This includes longstanding common technologies that are part of everyday life and raise no conceivable issue, such as Excel spreadsheets. This would negatively affect plan sponsors and participants in company retirement plans.

In May, Gensler indicated that the proposal would be reproposed. The spring 2024 regulatory agenda confirms this and targets October 2024 for the re-proposal (though, as noted, the target dates in the agenda are not reliable).

**Council Seeks to Streamline Process of PBGC Termination Notice Requirements**

*You Need to Know*:

- PBGC regulations currently require plan administrators to send termination notices to all affected parties, which can cause confusion if participants are no longer owed benefits.
- The Council is asking DOL to exempt terminating plans from sending benefit notices to former participants to streamline the termination process and reduce confusion.

In our continued effort to streamline reporting and disclosure requirements for retirement plans, the American Benefits Council is following up with the U.S. Department of Labor (DOL) in response to the agency's January 19 request for information seeking public input on current reporting and disclosure requirements.

On May 21, the Council urged DOL to simplify and streamline required retirement plan disclosures to the extent possible, including through expanded electronic delivery. The Council also emphasized the severe litigation risk associated with the potential collection of additional information by the agencies that could be used by third parties other than the agencies, plan sponsors and participants.

In a **July 5 follow-up letter to DOL**, the Council submitted supplemental comments related to the notice of plan benefits that an administrator of a terminating plan is required to send to individuals who are plan participants as of the termination date.

Under current Pension Benefit Guaranty Corporation (PBGC) regulations, plan administrators of terminating plans must issue a notice of plan benefits to each affected party by the time the standard termination notice is filed with the PBGC. This notice must include the proposed termination date, contact information for inquiries, and details about the participant's plan benefits.

In practice, these notices can be sent up to 180 days after the plan's termination date, leading to confusion when sent to individuals who are no longer plan participants. For example, participants who received a lump sum payment between the plan termination date and the notice mailing date may receive notices about benefits they no longer have.

To reduce misunderstandings, the Council has requested PBGC not require notices to be sent to individuals who are no longer plan participants as of the notice date. This change would streamline the plan termination process and minimize confusion among former participants. The Council believes that terminating plans should not be required to send any communications, especially those referencing specific benefits, to individuals who are no longer participants as of the notice date.

By implementing this proposed change, the PBGC would help make the plan termination process more efficient and clearer for all parties involved.

**Council Requests Guidance on Paper Filing of Form 5330**

*You Need to Know:*

- The Council typically favors electronic filings, but in this unique situation, we have requested confirmation from Treasury and the IRS that Form 5330 can be filed on paper due to the specific challenges posed by the electronic filing process.

As part of the American Benefits Council's ongoing effort to alleviate challenges associated with retirement plan administration, the Council recently **sent a letter** to the U.S. Department of the Treasury and Internal Revenue Service (IRS) to request guidance confirming that all employers are currently permitted to file the Form 5330 on paper, rather than filing the Form 5330 electronically.

The Form 5330 is used by employers to report excise taxes related to employee benefit plans, such as late deposits of employee contributions. Although employers have long been permitted to file the Form 5330 on paper, recent regulatory changes newly require employers that file at least 10 returns to file the Form 5330 electronically, subject to a series of regulatory exceptions. As discussed in our guidance request, the Council believes that guidance confirming the current application of these exceptions is appropriate and warranted.

While the Council typically favors electronic filings and considers them more efficient, this situation presents unique challenges. The Council's July 8 letter, filed in partnership with the SPARK Institute, highlights several issues, including:

- **No direct filing option**: Employers cannot electronically file Form 5330 directly with the IRS online; they must use the single authorized third-party provider.

- **High costs**: The only third-party e-filing service is significantly more expensive than paper filing.
- **Lack of integration**: Retirement plan service providers cannot integrate with the current e-filing provider, complicating the process for employers.
- **Unclear exemptions**: There is no clear guidance on how to claim exemptions or waivers for undue hardship or unsupported IRS systems.

Given these challenges, the Council and the SPARK Institute are requesting that the IRS confirm that employers can continue to file Form 5330 on paper. This would be consistent with the regulatory exceptions for forms that are not supported by IRS systems and the Commissioner's authority to grant waivers in the case of undue hardship.

Without this confirmation, employers may face unnecessary costs and risks, which is especially concerning in the case of small businesses that may only file a Form 5330 once and only owe a nominal amount. Clear guidance from Treasury and IRS would provide much-needed certainty and prevent undue financial burdens on employers.

**Regulation Watch: Final Mental Health Parity Rules Coming Soon**

*You Need to Know*:

- Final mental health parity rules were submitted to the White House Office of Management and Budget on July 1.
- The submission to OMB requires release of the regulations within 90 days (although this timing is not always met), but the Council expects the mental health parity final rules to be issued in the next three to four weeks.

Final rules by the U.S. departments of Treasury, Labor and Health and Human Services (the "tri-agencies") implementing certain provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) were submitted to the White House Office of Management and Budget (OMB) on July 1. The OMB is the executive branch agency that conducts final review of federal regulations before they are released to the public. This means the mental health parity rules, eagerly anticipated by employer plan sponsors, should be issued soon, most likely in the next few weeks.

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 detailed guidance on the comparative analysis requirement enacted by the Consolidated Appropriations Act, 2021 (CAA) and also made significant changes to the long-standing substantive mental health parity regulations.

The Council submitted extensive comments on the proposed regulations, expressing support for access to high-quality, affordable mental health and substance use disorder coverage but also noting a number of substantial concerns, including:

- the possible impact on the ability of plans to use medical management techniques to ensure high-quality mental and behavioral health and substance use disorder treatment.

- several key areas where more clarity and detail are needed to support parity compliance.
- issues raised by the proposed requirement that a named ERISA plan fiduciary certify the CAA comparative analysis for compliance.

The tri-agencies last summer also provided its second public report to Congress (as required by the CAA) on their enforcement efforts related to MHPAEA.

## RECENT JUDICIAL ACTIVITY

### Plan Sponsors Face Renewed Legal Challenges Over BlackRock Target Date Funds

*You Need to Know*:

- A court ruling against Stanley Black & Decker (SBD) signals increased litigation risk for retirement plan sponsors.
- The ruling suggests that allegations of investment fund underperformance, combined with claims of an inadequate fiduciary process, can survive a motion to dismiss and lead to increased defense costs.

In a recent twist to an ongoing litigation trend, the U.S. District Court for the District of Connecticut denied most of an employer defendant's motion to dismiss a lawsuit alleging improper selection of target date funds (TDFs) and excessive recordkeeping fees for its 401(k) plan. This decision marks a shift in a series of cases involving alleged TDF underperformance where plan sponsors have generally seen favorable outcomes.

*Background*

In 2022, 12 large retirement plan sponsors were sued for their choice of BlackRock's TDFs. These lawsuits diverge from typical defined contribution plan litigation by focusing on alleged investment underperformance rather than excessive fees. Of the 12 cases, nine were dismissed by the courts, one was not dismissed (involving Genworth Financial in the Eastern District of Virginia), and two were pending decisions until now.

This current string of lawsuits is notable because, unlike other fiduciary claims brought against plan sponsors in recent years (which have largely focused on fees), the plaintiffs in this string of lawsuits based their claims exclusively on the fact that some of the offerings in BlackRock's TDF series underperformed four of its largest peers over a specified prior period of time.

In response to these suits, the Council has filed numerous *amicus* (friend of the court) briefs emphasizing the importance of adhering to prevailing pleading standards and noting that these lawsuits could render more fiduciaries vulnerable to litigation, including those who have chosen prudent low-cost funds.

*Kistler v. Stanley Black & Decker Inc.*

Historically, courts have dismissed claims based on fund underperformance, emphasizing that such allegations alone do not indicate a fiduciary breach under the Employee Retirement

Income Security Act (ERISA). However, the Connecticut court's decision in *Kistler v. Stanley Black & Decker Inc.*, combined with the Genworth decision referenced above (and other cases not involving BlackRock TDFs), marks a potential shift, signaling that underperformance allegations can keep a lawsuit alive despite positive reviews and approvals from investment consultants and fiduciaries.

The district court's decision to deny SBD's motion to dismiss rests on several significant points.

- Firstly, it addressed whether the comparator TDFs selected by the plaintiffs were appropriate. The court deferred this question to the discovery phase, aligning with the broader trend in this particular Circuit to postpone such determinations. Due to the large size of the plan, using the largest TDFs as comparators was deemed sufficient for the lawsuit to proceed.
- Secondly, the court evaluated the extent of the BlackRock TDFs' underperformance. While it noted that underperformance alone was insufficient to substantiate a claim of imprudence, the plaintiffs' allegations regarding SBD's fiduciary process were deemed critical. The court found that even though SBD's investment consultant reviewed the TDFs positively, the fiduciary committee's minutes did not specifically discuss by name BlackRock TDFs' performance, raising questions about the thoroughness of their review process.
- In addition to the investment-related claims, the court also addressed allegations of excessive recordkeeping fees. The plaintiffs argued that SBD charged higher fees per participant than other similarly sized plans, failed to reduce fees as the plan grew, did not conduct competitive bidding and used a flawed fee measurement method. The court accepted these claims, highlighting that per-participant fee analysis is critical in defending against excessive fee allegations.

The Council will continue to monitor these cases and explore ways to weigh in against frivolous fees and underperformance litigation and to support enforcement of pleading standards.