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 REGULATORY ACTIVITY

Agencies Issue Guidance on Retirement Plan Eligibility for Long-Term, Part-Time Employees

You Need to Know:

- Treasury and IRS issued guidance on long-term, part-time employee participation in 401(k) and ERISA-covered 403(b) plans, including a delayed effective date for proposed regulations.

The U.S. Treasury Department (Treasury) and Internal Revenue Service (IRS) recently issued Notice 2024-73, offering much-needed guidance on the treatment of long-term, part-time (LTPT) employees in 401(k) and ERISA-covered 403(b) plans, as well as a delayed effective date for the proposed LTPT regulations.

The Council has strongly advocated for such a delay, including a January 26 comment letter to the IRS, as well as testimony during a March 15 public hearing on the proposed regulations.

Highlights include:

- **Delayed applicability date for 401(k) plans**: The proposed LTPT regulations for 401(k) plans, once finalized, will apply no earlier than plan years beginning on or after January 1, 2026. However, until then, plan sponsors must apply a reasonable good faith interpretation of the rules.

- **Interaction with the Universal Availability Rule for 403(b) plans**: A key clarification in the notice addresses how the LTPT rules interact with the longstanding "universal availability" rule, which requires that if any employee is permitted to make salary reduction contributions to a 403(b) plan, all employees must generally be given the same opportunity. The notice confirms that ERISA-covered 403(b) plans can continue excluding part-time employees who work less than 20 hours per week, except when these employees meet the LTPT thresholds.

- **Detailed guidance for 403(b) plan sponsors**: The guidance provides a breakdown of the new LTPT rules for ERISA-covered 403(b) plans.

- **Anticipated future regulations for 403(b) plans**: The notice signals that Treasury and IRS will issue proposed regulations addressing LTPT employees' participation in ERISA-covered 403(b) plans, which are expected to align closely with the final rules for 401(k) plans.

Council Urges Clarifications on SECURE 2.0 Emergency Withdrawal Rules

You Need to Know:

- The Council is asking IRS for clearer guidance on emergency personal expense distributions and domestic abuse victim distributions under the SECURE 2.0 Act to facilitate smoother implementation for retirement plan sponsors.

The American Benefits Council is urging the Internal Revenue Service (IRS) to provide clear guidance on new withdrawal options introduced by the SECURE 2.0 Act, including emergency personal expense distributions (EPEDs) and domestic abuse victim distributions (DAVDs).

In an **October 7 comment letter** responding to IRS Notice 2024-55, the Council raised concerns about administrative burdens and requested additional clarifications to ensure smooth implementation for retirement plan sponsors. The Council's letter underscores the need for practical guidance that aligns with the intent of SECURE 2.0, making it easier for plan sponsors to offer these withdrawal options while minimizing complexity.

At the center of the Council's feedback is the need for flexibility in how these new in-service distributions are administered. EPEDs allow participants to access funds for unforeseen personal expenses, while DAVDs provide financial relief to individuals escaping domestic abuse situations.

Specifically, the Council is asking the IRS to confirm that plan sponsors can restrict or eliminate these options without violating the anti-cutback rule, a safeguard that protects participants' benefits from being reduced.

The letter also voiced strong opposition to creating exceptions for self-certification, arguing it simplifies plan administration and reduces the need for employers to collect sensitive employee data. "Introducing exceptions would undermine one of the core goals of SECURE 2.0 — reducing administrative burdens," the letter reads, emphasizing the risk of data privacy concerns if employers were required to substantiate financial emergencies. However, a no-exceptions approach would not preclude companies from having additional restrictions.

In addition, the Council urged the IRS to allow plan administrators to rely on employee self-certification for repayment of EPEDs and DAVDs, a move that would further ease administrative strain. This would permit employees to repay amounts without the need for cumbersome verification processes.

Other requests for clarification include how the three-year restriction on EPEDs should be applied and whether the $10,000 limit for DAVDs is a lifetime or annual cap.

RECENT LEGISLATIVE ACTIVITY

California Governor Vetoes PBM Bill Threatening ERISA Preemption

You Need to Know:

- The governor of California has vetoed a bill that raised significant ERISA preemption concerns and would have undermined the ability of self-insured plans to design pharmacy networks. The Council had urged the governor to veto the bill.

- It is likely that California will again consider legislation focused on PBMs next year, so the Council will continue to monitor and advocate to protect ERISA preemption.

California Governor Gavin Newsom (D) has vetoed legislation related to pharmacy benefit managers (PBMs) that directly conflicted with ERISA preemption. This was welcome news and an outcome for which the American Benefits Council had advocated.

California Senate Bill 966 (S.B. 966) aimed to regulate PBMs in California in various ways and construed all PBM activities to be the "business of insurance" for purposes of the California insurance code, without regard to whether the activities are performed on behalf of, or with respect to, a self-funded ERISA group health plan. This conflicts with ERISA's preemption standard, which prohibits states from deeming self-funded plan activity to be insurance.

If this bill had been enacted it could have resulted in the imposition of state-level requirements on self-insured health plans. Key provisions of the bill that should be preempted by ERISA if applied to self-insured health plans included restrictions on PBMs' ability to administer certain network designs and a requirement that PBMs accept "any willing pharmacy" into their network.

While the state legislature was considering this legislation over this past summer, the Council submitted comments addressing the scope, value and beneficial policy impact of ERISA preemption over its 50 years of existence. We also explained the ways in which the bill should be preempted by ERISA and asked the legislature to specifically exempt self-insured employer health plans from the scope of S.B. 966.

On September 17, after the bill passed both houses of the California legislature and was sent to the governor, **the Council urged Newsom to veto S.B. 966** due to the ERISA preemption issues raised by the bill.

On September 28, Newsom issued a veto of the bill, expressing concerns about the cost of prescription drugs. "I believe that PBMs must be held accountable to ensure that prescription drugs remain accessible throughout pharmacies across California and available at the lowest possible price," Newsom said. "However, I am not convinced that S.B. 966's expansive licensing scheme will achieve such results." Newsom instead directed California's Health and Human Services Agency to propose a legislative approach for next year "to gather much needed data on PBMs."

Technically, the veto could be overridden by the California legislature, but that is not expected to happen. We will continue to monitor and advocate on this issue as it evolves.

RECENT JUDICIAL ACTIVITY

Council Weighs in with 9th Circuit in Pension Offset Case

You Need to Know:

- A three-judge panel of a federal appeals court recently issued a judgment in favor of plaintiffs related to a pension offset dispute from nearly 40 years ago.

- The Council is urging the full 9th Circuit Court of Appeals to rehear the case, which has important long-term implications for ongoing plan administration under ERISA.

In **an *amicus* ("friend of the court") brief** filed with the U.S. Ninth Circuit Court of Appeals on September 26, the American Benefits Council requested a full rehearing of a class-action case in which participants accuse the defendant of improperly applying an offset to the company pension plan. Now at issue is whether the plaintiffs have continued standing to sue the employer in this case and whether the issuance of a summary plan description (SPD) allows plaintiffs to circumvent a statute of limitations.

The case *Baleja et al vs. Northrop Grumman* centers on pension plan participants who were merged into a defined benefit plan after an acquisition nearly 40 years ago. At that time, to avoid a duplication of benefits, the acquiring plan offset the acquired employees' benefits by the value of the benefit they had accrued under the prior retirement plan.

In 2017, the plaintiff filed a complaint alleging that (a) the offset was not sufficiently disclosed in the 1985 SPD and (b) Northrop's pension plan did not provide for the offset. Following a trial in which the U.S. District Court for the Central District of California concluded that the plan did indeed provide for the offset, the plaintiffs raised a new argument that the plan provided for a minimum benefit of $20 for each year of service, regardless of the offset.

Although this claim had neither been pleaded nor tried, the district court resolved it by ruling that the offset applied to the minimum benefit, denying the plaintiffs' claim under that separate plan provision. However, this ruling was subsequently reversed by a three-judge panel of the 9th Circuit, which held that the disclosure claim was timely because the plan continued to provide SPDs to class members through 2014.

In addition, despite the plaintiff's failure to plead the minimum benefits claim, the court ruled that it could decide the merits of the claim. The appeals court held that the plan unambiguously provided for the minimum benefit after application of the offset. It is noteworthy that the lead plaintiff would not receive any increase in his benefit on account of the minimum benefit claim because his existing benefit exceeds the minimum.

The Council's *amicus* brief, filed in partnership with the National Association of Manufacturers, requests an "*en banc*" rehearing of the case before the full 9th circuit, arguing three key points:

- *Standing*: As the Supreme Court has held, an ERISA plan participant must have an injury to bring a claim. Here, the lead plaintiff would receive no additional benefit under the minimum benefit claim no matter how the plan provision is interpreted. Accordingly, he lacks standing to assert the claim individually. Because he personally lacks standing, he cannot bring the claim on behalf of class members.

- *Deference to Plan Administrator*: Courts are required to defer to a plan administrator's reasonable interpretation of ambiguous plan provisions. This doctrine requires a plan administrator to be given the opportunity to present evidence that a latent ambiguity

exists. As courts have recognized, even when that language appears to be clear on its face, evidence may show an "extrinsic ambiguity." Denying the plan administrator an opportunity to present evidence is not "harmless."

- *Limitations Period for SPD Claims:* Congress determined that breach of fiduciary duty claims should have a six-year statute of repose (i.e. certain rights are cut off if they are not acted upon by a specified deadline). There is no exception with respect to a challenge to the sufficiency of an SPD. Reissuing SPDs (as is required by ERISA) should not eviscerate the statute of repose by reviving stale claims based on old disclosures.

If allowed to stand, the 9th Circuit's decision will disrupt plan administration nationwide by conflicting with the well-established standards imposed by ERISA.