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

Biden Administration Proposes Rules Regarding Coverage of OTC Contraceptives, Other Preventive Services

You Need to Know:

- New proposed regulations would require that plans and insurers cover OTC contraceptive items and services without cost-sharing, beginning in 2026. This follows an agency RFI on which the Council noted some concerns and made recommendations, many of which were reflected in the proposed rules.

- The proposed regulations also include a related transparency requirement, new guidance on the scope of the requirement to cover contraceptive and rules on the extent to which plans can impose medical management on preventive services. The agencies also issued FAQs on various preventive services issues.

- The Council will be submitting comments on the proposed regulations, as they directly impact plan sponsors, and welcomes member input.

On October 21, the U.S. Departments of Treasury, Labor, and Health and Human Services (collectively, the "tri-agencies") released **proposed regulations** that would expand coverage of over-the-counter (OTC) contraceptives and address other preventive services issues.

According to a tri-agency news release, the proposed regulations are intended to expand access to contraceptives, particularly in light of the overturning of *Roe v. Wade*, and to address ongoing reports of "barriers to contraceptive coverage." The tri-agencies also issued ACA Implementation FAQs, Part 68, which address the coverage of HIV pre-exposure prophylaxis (PrEP) and the processing of preventive care services medical claims.

The ACA requires group health plans and insurers to provide coverage for certain preventive services without cost-sharing. The tri-agencies have issued extensive guidance over the years on this requirement. The proposed regulations build on the prior guidance as follows:

Coverage of Contraceptive Items

Currently the requirement to cover OTC contraception only applies if the individual has a prescription. Under the proposed regulations, plans and insurers would be required to provide coverage without cost sharing of contraceptives that can be lawfully obtained without a prescription and for which the applicable preventive care recommendation or guideline does not require a prescription. (The tri-agencies explain that this is intended to support access to contraceptives, with a focus on women's health and health equity. While the tri-agencies note their support for all preventive services, they indicate this requirement is limited to contraceptives because they understand the associated burden and, therefore, will proceed on an incremental approach. They seek comment, among other things, on whether the proposals related to OTC contraceptive items should be extended to other or all recommended preventive services.

In 2023 the tri-agencies issued a request for information on the issue of requiring coverage of OTC preventive items without a prescription. In response, the Council provided comments noting various concerns, including the potential for fraud/waste/abuse, cost, and administrative complexity. The Council asked the tri-agencies to provide that any proposed rule continue to allow the use of medical management techniques, including reasonable quantity limits, and to permit a "network" concept so plans are only required to cover these OTC items "in-network." We also recommended that plans be provided operational flexibility because of the many different ways this requirement could be implemented.

In general, the proposed rules favorably responded to these requests, by confirming plans can create a network system where this requirement will apply and by providing guidance regarding the ability to impose medical management. The tri-agencies did include many questions for stakeholders on these issues, and the Council plans to respond with a specific focus on these issues in our comments.

Therapeutic Equivalent Approach

The proposed regulations would require that plans and insurers provide coverage (without cost-sharing) of the full range of FDA-approved contraceptive items that are drugs and drug-led combination products, other than those items for which there is at least one "therapeutic equivalent" drug or drug-leg combination product that is covered (without cost-sharing). This proposed therapeutic equivalence approach was described in previous tri-agency guidance but in prior guidance, this approach was optional and just one way to comply with the requirements. The tri-agencies are proposing that this approach be required, not optional, based on ongoing reports of issues with access to contraceptive coverage in health plans. For plans that have not been using the therapeutic equivalent approach, shifting to this approach is likely to result in an expansion of coverage.

Transparency in Coverage

Under current regulations, plans and insurers are required to provide an on-line tool for participants that provides cost-sharing information. The proposed regulations expand these requirements. Under the proposed regulations, if a participant requests cost-sharing information for any covered contraceptive item or service, the plan or insurer would need to provide a statement explaining that OTC contraceptive items are covered without a prescription and with no cost-sharing, along with a phone number and internet link for a participant to learn more about the plan's contraceptive coverage. This is intended to ensure participants are aware of the change to the rule. The tri-agencies ask for specific comments on numerous related issues, including what the disclosure should include.

Reasonable Medical Management Techniques

Under current regulations, plans and insurers may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for preventive care, to the extent not specified in the relevant recommendation or guideline. The proposed rules maintain this provision but also add that for a medical management technique to be considered "reasonable," the plan or insurer would need to have an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome on the participant or

provider. The exceptions process must allow an individual to receive coverage with no cost-sharing for a preventive service that is medically necessary with respect to the particular individual, as determined by the individual's provider. This rule has been set out by the tri-agencies in prior guidance, regarding specific preventive services, but in the proposed rule the tri-agencies confirm the requirement and clarify that it applies to all preventive services (*i.e.*, this is not limited to contraceptives).

The tri-agencies note that while most plans already have exceptions processes, there are reports that these are not sufficient to ensure access to care or are not effectively communicated to participants. The tri-agencies ask for comments on several related issues, including how to define newly added terms and where more guidance is needed, including whether a model exceptions process would be helpful.

These rules are effective for 2026 plan years. However, the exceptions process requirement is proposed to apply on the effective date of the final regulations.

The Council intends to file comments by the December 27 deadline since, as these new rules have direct implications for plan sponsors. We welcome member input as we work to develop those comments. Also, the tri-agencies note that they anticipate issuing another notice of proposed rulemaking in the "near future" to address additional issues related to coverage of all preventive services.

In addition to the proposed regulations, the tri-agencies issued ACA FAQs regarding the coverage of PrEP and addressing challenges and providing guidance and examples related to coding of preventive services to ensure compliance. The FAQs also address the requirement of plans to cover certain breast reconstruction surgery under the Women's Health and Cancer Rights Act.

Council Urges DOL to Revisit Latest Guidance on Missing Participants

You Need to Know:

- The Council is urging DOL to provide clearer guidance and adopt a cooperative approach for addressing missing retirement plan participants.
- The Council is highlighting concerns about liability risks and administrative burdens from DOL's proposed approach to the Lost and Found system.

On October 15, The American Benefits Council **submitted a letter** to the U.S. Department of Labor (DOL), urging the agency to issue more practical guidance for plan sponsors dealing with missing and unresponsive participants (or their beneficiaries).

The letter acknowledges some favorable changes in the department's revised Information Collection Request (ICR) related to the "Lost and Found" system — addressing recommendations offered by the Council in its comments on a previous ICR. However, the Council's latest letter underscores ongoing concerns with both the department's approach and the potential challenges posed by voluntary data submissions.

The Council, in a candid October 2023 letter to Lisa Gomez, the DOL Assistant Secretary for Employee Benefits Security Administration (EBSA), noted that plan sponsors and DOL share a common goal – enabling retirement benefits to be paid to missing participants or their beneficiaries. It is not appropriate for the agency to take an adversarial stance with plan sponsors who are expending large amounts of time and financial resources – often more than the amount of the benefit that is owed – trying to locate any pay-out the funds. Both last year's letter and the one the Council just sent echo our longstanding advocacy, expressed both in-person and in writing to DOL urging the agency to adopt a cooperative approach with employers, put an end to lengthy audits and provide a reasonable safe harbor so plan sponsors know exactly what steps should be taken to locate missing participants.

The October 15 letter expressed concerns about the department's decision to establish and populate the Lost and Found system — designed to help individuals or their beneficiaries locate retirement accounts — with information provided by employers on a voluntary basis, without following the statutory requirement for DOL to establish formal regulations. While employers typically prefer voluntary measures rather than mandates, the nature of the revised ICR raises significant legal and operational questions for plan sponsors, who may hesitate to provide sensitive participant information due to liability risks, data privacy concerns and even potential conflicts with *existing* DOL cybersecurity guidance.

In particular, the Council pointed out that voluntarily disclosing employee information may expose plan administrators to liability in the event of a data breach at DOL. The Council also noted that without clear rules in place, plan sponsors could be asked to provide employee data multiple times, resulting in unwarranted increased administrative costs and burdens.

The Council's letter encourages the department to abandon its approach to populating the Lost and Found system with information about missing participants and, instead, engage in a notice-and-comment rulemaking process as required by the SECURE 2.0 legislation which called for the establishment of the Lost and Found database. The Council believes the absence of formal regulations creates too much uncertainty for plan sponsors, which could limit participation in the Lost and Found and thereby unintentionally diminish its effectiveness in meeting the DOL's and employers' shared goal of enabling people to receive the benefits to which they are entitled.

Additionally, the Council submitted several technical questions related to the data submission process under the revised ICR, including how plan administrators should update previously submitted participant data and whether non-ERISA plans, such as non-electing church plans, may voluntarily participate in the system without inadvertently becoming an "ERISA plan".

As the department continues to move forward with its plans for the Lost and Found system, the Council will continue to monitor developments and advocate for policies that support plan sponsors and protect participants.

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.

Treasury, IRS Issue Guidance on Retirement Plan Overpayments under SECURE 2.0

You Need to Know:

- Treasury and IRS recently issued interim guidance addressing retirement plan overpayments to beneficiaries.

- The guidance incorporates a number of suggested clarifications requested by the Council shortly after the enactment of SECURE 2.0.

- The interim guidance applies immediately but Treasury and IRS are soliciting comments through December 16.

On October 15, the U.S. Treasury Department and Internal Revenue Service (IRS) issued **Notice 2024-77**, guidance on the new rules regarding retirement plan overpayments added to the Internal Revenue Code by the SECURE 2.0 Act of 2022. We are pleased to report that the guidance addresses a number of concerns we had voiced to the Biden administration.

SECURE 2.0 added two new rules to the Internal Revenue Code related to retirement plan overpayments to beneficiaries. The first rule addresses the qualification requirements in connection with overpayments, while the second rule relates to whether and when an overpayment may be eligible for a rollover.

Notice 2024-77, presented in the form of questions and answers, is intended as "interim" guidance and the agencies will accept public comments through December 16, 2024. The guidance focuses solely on the provisions of Section 301 of SECURE that modified the Internal Revenue Code. That provision of the law also added a new subsection to ERISA addressing the fiduciary rules associated with overpayments.

Shortly after the enactment of SECURE 2.0 in late 2022, the Council presented Treasury and IRS with a series of recommendations for guidance under the new law.

In a February 2023 letter, the Council requested confirmation that:

- With respect to rollovers, the new rules apply to inadvertent overpayments made prior to the date of enactment. Therefore, a rollover of an inadvertent overpayment made before the date of enactment may be treated as having been paid in an eligible rollover distribution (if it otherwise qualifies as such). This was confirmed by Notice 2024-77.

- To the extent that the EPCRS is consistent with the new rules set forth in SECURE 2.0, everything else in the EPCRS remains in effect. While this was not explicitly stated, the notice's discussion of the EPCRS effectively confirms this position.

- There is no need to recoup inadvertent overpayments that are in excess of the Section 415 limits or that are due to a violation of Code Section 401(a)(17), which restricts the amount of compensation that a plan may take into account. The guidance states that whether or not the amount is repaid, the plan sponsor or another party must make a corrective payment.

In an August 2023 letter, the Council further requested guidance on the meaning of certain terms included in the statute, such as "inadvertent benefit overpayment." Notice 2024-77 includes a definition of "inadvertent benefit overpayment" that includes a premature distribution.

Other definition clarifications requested by the Council – such as "hardships" to be taken into account in determining the amount of a proposed recoupment and when a participant is "culpable," such that the participant is not entitled to all the protections of the law are not

addressed by Notice 2024-77 because they are more germane to the ERISA provision and are therefore subject to U.S. Department of Labor guidance.

The guidance in Notice 2024-77 applies immediately. For previous periods, a taxpayer may rely on a good faith, reasonable interpretation. The notice confirms that the new rollover treatment applies as of December 29, 2022 (the date of enactment of SECURE 2.0), regardless of when an overpayment was made.

IRS Expands, Clarifies List of Preventive Care for HDHP Purposes, Provides that Condoms are Medical Care

You Need to Know:

- The IRS has issued two formal notices expanding the list of items and services that qualify as "preventive care" under HSA-compatible HDHPs and as medical care expenses under group health plans, including health FSAs, HRAs and HSAs.
- Under the guidance, condoms are to be considered medical care expenses and can be covered/reimbursed by group health plans, including FSAs, HRAs and HSAs.
- The guidance also clarifies that HSA-eligible HDHPs can permit pre-deductible coverage of certain over-the-counter contraceptives, continuous glucose monitors, insulin and breast cancer screening services.

On October 17, the Internal Revenue Service (IRS) issued two Notices, which update and clarify the list of items and services that qualify for pre-deductible coverage under the preventive care safe harbor for HSA-eligible high-deductible health plans (HDHPs). The guidance provides that condoms are to be considered "medical care" under health flexible spending accounts (FSAs) and health reimbursement accounts (HRAs). Specifically, the guidance addresses the items and services related to contraception, diabetes treatment and breast cancer screening.

The American Benefits Council has consistently supported policies that support coverage of preventive care, as chronic and preventable conditions constitute a large share of U.S. health spending.

Notice 2024-71

Notice 2024-71, "Expenses Treated as Amounts Paid for Medical Care," provides a safe harbor under the Internal Revenue Code (Code) for amounts paid for condoms. The IRS noted that, under the general Code Section 213(d) definition of "medical care," amounts paid for condoms would not always be considered medical expenses. However, the guidance makes clear that under the safe harbor, all condoms are treated as medical care pursuant to that section of the law.

The Code Section 213(d) definition of medical care expenses is used for numerous purposes, including for determining permitted payments and reimbursements from health FSAs and HRAs and coverage/reimbursements with respect to other health plans, as well as what is eligible for tax-free distribution from HSAs. That means HSA distributions used to pay for

condoms will not be taxable, and health FSAs and HRAs can permit account holders to use available funds to pay for condoms.

Notice 2024-75

Notice 2024-75, "Preventive Care for Purposes of Qualifying as a High Deductible Health Plan under Section 223" expands and clarifies the list of benefits that HSA-eligible HDHPs can treat as "preventive care," and thus provide on a pre-deductible basis. These benefits include:

- **Oral Contraceptives:** The notice clarifies that *all* over-the-counter (OTC) oral contraceptives for a participant potentially capable of becoming pregnant – including OTC birth control pills and emergency contraception – are preventive care for HDHP purposes, regardless of whether they are obtained with a prescription. This is effective for plan years beginning on or after December 30, 2022.

- **Male Condoms:** The notice provides that all benefits for male condoms, regardless of whether obtained with a prescription and regardless of whether purchased by a man or woman, are preventive care for HDHP purposes. This is effective for plan years beginning on or after December 30, 2022.

- **Breast Cancer Screenings:** Breast cancer screenings previously have been treated as preventive care for HDHP purposes, but, in earlier guidance (Notice 2004-23), mammograms were listed as the only example of such screenings. The notice clarifies and confirms that other types of breast cancer screenings, including MRIs and ultrasounds, are also preventive care for HDHP purposes. This is effective as of April 12, 2004, which is the date Notice 2004-23 was published.

- **Continuous Glucose Monitors (GCMs):** The Notice clarifies that, in accordance with Notice 2019-45, CGMs are preventive care for HDHP purposes as long as they measure glucose levels using a similar detection method or mechanism as other glucometers (i.e., by piercing the skin). A footnote in the notice states that this does not include smartwatches or smart rings. This is effective as of July 17, 2019, the publication date of IRS Notice 2019-45, which addressed glucometers as preventive care for individuals diagnosed with diabetes. The notice provides that, if the continuous glucose monitor also performs other medical functions, then those functions also must be preventive care for an HDHP to be able to cover the device on a pre-deductible basis. A CGM that both monitors and provides insulin may be treated as preventive care as provided above. However, if the CGM also provides additional medical or non-medical functions that are not preventive care (other than minor functions, such as time and date functions), the HDHP cannot cover the CGM pre-deductible.

- **Insulin:** The Inflation Reduction Act of 2022 amended Code Section 223(c) to permit HDHPs to provide pre-deductible coverage for "selected insulin products." The notice clarifies this rule applies "without regard to whether the insulin product is prescribed to treat an individual diagnosed with diabetes or prescribed for the purpose of preventing the exacerbation of diabetes or the development of a secondary condition." This section of the tax code includes any devices used to administer or deliver the insulin products

described in that section. This is effective for plan years beginning after December 31, 2022.

Notice 2024-75 only addresses items that may be treated as preventive care for purposes of the HDHP preventive care safe harbor. It does not address what non-grandfathered group health plans must cover on a first-dollar basis pursuant to the Affordable Care Act's preventive coverage mandate.

Council Urges IRS to Delay Applicability of RMD Rules, Provide Good-Faith Relief for Beneficiaries

You Need to Know:

- The Council is asking the IRS to delay the applicability date and provide good-faith relief for plan sponsors and beneficiaries interpreting new RMD regulations on Roth and non-Roth accounts.

- If left unchanged, the proposed regulations will be applicable as of January 1, 2025.

The American Benefits Council has submitted **supplemental comments** to the Internal Revenue Service (IRS) on required minimum distributions (RMDs) from qualified retirement plans and IRAs, in response to ongoing concerns from plan sponsors and questions raised by the agency during a recent hearing at which the Council testified.

The Council is urging the U.S. Treasury Department and IRS to delay the January 1, 2025, applicability date for these provisions and provide good-faith relief for beneficiaries and plan sponsors who have already acted under reasonable interpretations.

As part of an ongoing regulatory process led by Treasury and IRS, the Council testified before the agencies on September 25 recommending a number of changes and clarifications to recently proposed regulations governing RMDs. The Council also recommended a host of other modifications to the recently proposed regulations on matters such as spousal elections, exemptions for designated Roth accounts and annuity purchases.

The Council's October 18 letter emphasizes the need for a delayed applicability date and good-faith relief to prevent penalties for beneficiaries and plans implementing RMD rules in the absence of clear guidance.

The Council's supplemental comments focus on ambiguity surrounding how the RMD rules apply when an employee dies on or after their required beginning date and holds both Roth and non-Roth accounts. Currently, the final and proposed regulations address how to treat RMDs when a deceased employee only had a Roth account but do not clarify the rules for "partial Roth accounts." The Council is asking IRS and Treasury to provide specific guidance on whether different rules should apply to the Roth and non-Roth portions of these accounts, particularly regarding the "at-least-as-rapidly" rule or the 10-year deferral rule for beneficiaries.

The letter also addresses the potential consequences of unclear guidance, highlighting that beneficiaries and plans have been forced to interpret the SECURE 2.0 changes in good faith.

Without official clarification, there is a risk that incorrect RMD procedures have been applied to partial Roth accounts, leading to either premature or delayed distributions.

Council Requests Key Clarifications in IRS Guidance on Student Loan Match Under the SECURE 2.0 Act

You Need to Know:

- The Council is urging the IRS to clarify and modify certain aspects of the student loan matching provision under the SECURE 2.0 Act.
- The statute allows employer plan sponsors to make contributions to a retirement plan matching employees' student loan payments.

One of the American Benefits Council's core objectives is to shape public policy in a way that eases compliance and improves employers' flexibility to design their benefit programs. In that spirit, the Council recently **submitted comments** to the Internal Revenue Service (IRS) with recommendations for improving a federal provision that allows employers to provide student loan benefits.

IRS Notice 2024-63 provided question-and-answer guidance on the provisions of the SECURE 2.0 Act of 2022 allowing employers to make matching retirement plan contributions corresponding with student loan payments by employees.

In October 18 written comments on Notice 2024-63, the Council acknowledged the practical and flexible approach the U.S. Treasury Department has taken in the guidance but outlined a few key issues where additional clarification or adjustments would be appropriate.

Uniformity Requirement

One of the conditions for employers to offer matching contributions on student loan repayments (QSLPs) is that all employees eligible for regular matching contributions must also be eligible for QSLP matches. While this ensures uniformity, Treasury's interpretation requires QSLP matches to apply across all employee groups, which raises concerns for plans that include more than one employer.

For multiple employer plans and pooled employer plans, the Council supports Treasury's approach that allows employers to adopt the QSLP match feature independently. However, for plans where the disaggregation rules do not apply, the Council urged Treasury to reconsider its stance. We noted that plan sponsors should have the flexibility to offer QSLP matches on a per-employer or per-business-unit basis.

Aggregated Employer Contribution Limit

The Council also highlighted concerns about the aggregation of matching contributions. If a plan imposes a combined limit on both elective deferral matches and QSLP matches, employees who receive one type of match early in the year may be excluded from receiving the other

match later. The Council is encouraging Treasury to clarify that offering both types of matches under an aggregated contribution limit would not violate the uniformity requirements.

Claim Deadlines and Excise Tax Concerns

The guidance allows plans to set deadlines for submitting claims for QSLP matches, with a reasonable timeframe being three months after the end of a plan year. While the Council supports this flexibility, we asked for further clarification on what constitutes a "reasonable" deadline if the employer uses something shorter than three months. The letter suggested a deadline of one month after the end of the plan year should be explicitly deemed reasonable.

We also asked Treasury to confirm that plans can set separate QSLP claim deadlines for employees who terminate midyear to avoid administrative burdens and confusion.

Coordination with the Department of Education

One key challenge for employers using third-party providers to verify student loan payments is access to federal student loan data. Recent regulations under the Stop Student Debt Relief Scams Act limit third-party access to this data. The Council asked Treasury to work with the U.S. Department of Education to resolve these barriers, as allowing third-party services to help certify QSLP claims could simplify the process and encourage plan sponsors to offer a QSLP match feature.

RECENT LEGISLATIVE ACTIVITY

Sign Group Letter Urging Congress to Extend Telehealth Flexibility

You Need to Know:

- Statutory flexibility for Health Savings Account (HAS)-eligible high-deductible employer-sponsored health plans to offer telehealth coverage pre-deducible is slated to expire at the end of 2024.
- Companies are encouraged to sign a group letter urging Congress to extend this flexibility, with a deadline of November 11.

The American Benefits Council encourages plan sponsors and other organizations to sign their company's name to a **group letter** urging Congress to extend flexibility for HSA-eligible health plans to offer telehealth services pre-deductible, a provision set to expire at the end of 2024. This flexibility, originally introduced under the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act of 2020, allows individuals to access telehealth services without first meeting a deductible in high-deductible health plans (HDHPs). The letter encourages Congress to extend this critical policy as part of any year-end legislative package.

As the letter explains, telehealth services — particularly for mental health and substance use disorder treatment — have become essential in expanding access to care. The bipartisan

Telehealth Expansion Act (H.R. 1843/S. 1001) seeks to make this flexibility permanent, but immediate action is needed to ensure the policy's continuation beyond 2024.

Council members are urged to add their organization's name to the letter, which highlights the importance of preserving affordable, pre-deductible telehealth options. The letter, circulated by the Alliance to Fight for Health Care (a broad-based coalition established by the Council) is also being shared among a diverse collection of stakeholders including employers, patient advocates, health care companies and consumer groups.

To participate, please complete the **Google form by November 11**.

For more information on this initiative, contact Ilyse Schuman, senior vice president of health and paid leave policy. For technical or logistical questions about the letter, contact Tara Bradshaw with Washington Counsel Ernst and Young.

Latest Updates on State Abortion Laws in Georgia, Texas

You Need to Know:

- The Council continues to monitor activity with respect to state abortion laws.

While the Council is not directly advocating on abortion policy at the federal or state levels, the American Benefits Council continues to monitor related issues, such as medical travel coverage.

Since the U.S. Supreme Court's ruling in *Dobbs v. Jackson Women's Health*, numerous states continue to pursue different approaches to abortion regulation, including proposed constitutional amendments, legislative actions and ongoing litigation.

Recent developments include:

- **Georgia's six-week abortion ban** has been reinstated following a recent ruling by the Georgia Supreme Court. On September 30, a Fulton County Superior Court judge struck down the state's "fetal heartbeat" law, making abortion legal in Georgia up to 20 weeks. However, the Georgia attorney general quickly appealed, and on October 7, the Georgia Supreme Court stayed the lower court's decision, reinstating the six-week ban while the case is under appeal.

- **U.S. Supreme Court's decision on Texas abortion case**: Also on October 7, the U.S. Supreme Court declined to hear a case challenging Texas' strict abortion ban. The Biden administration had argued Texas' law conflicts with the Emergency Medical Treatment and Labor Act of 1986, but the lower court ruling upheld the state law, and the Supreme Court's refusal to intervene means the Texas law remains in effect.

RECENT JUDICIAL ACTIVITY

Supreme Court Asks Government for Its Views in ERISA Preemption Case, Council Weighs in to Support of ERISA Preemption

You Need to Know:

- The Supreme Court has asked the U.S. Solicitor General's office for the views of the federal government in an important case regarding ERISA preemption. The court has made this request to gather more information as it decides whether to hear the case on appeal.
- The relevant appeals court had ruled, in a favorable opinion, that the Oklahoma statute at issue (which had restricted self-insured plan design) was preempted by ERISA.
- The Council has submitted a letter to the administration explaining the central importance of ERISA preemption and encouraging the government to advise the Supreme Court not to review the case.

The U.S. Supreme Court has asked the U.S. Solicitor General for the view of the U.S. government in the case of *Pharmaceutical Care Management Association (PCMA) v. Mulready*, an important case regarding ERISA preemption, as the Supreme Court considers whether to hear the case. The American Benefits Council is urging the Biden administration to advise the court not to review the case.

The U.S. Court of Appeals for the 10th Circuit held that ERISA preempts an Oklahoma law regulating pharmacy networks through regulation of pharmacy benefit managers (PBMs) in a way that restricts self-insured plan design. This was a reversal of a lower court decision and was an important and positive step toward bolstering ERISA preemption, which the Council worked to support as a signatory to an *amicus* ("friend of the court") brief. 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.

Subsequently, the Oklahoma Insurance Department (OID) requested that the U.S. Supreme Court review the case and reverse the 10th Circuit decision. The OID argued the 10th Circuit's decision was inconsistent with Supreme Court precedent and another appeals court opinion, setting forth an interpretation that, if adopted, would significantly narrow ERISA's preemptive effect. Several *amicus* briefs were filed in support of the OID, including a brief filed by 32 states. In response, PCMA filed a brief explaining why further review is unwarranted, as the 10th Circuit faithfully applied settled Supreme Court precedent.

Instead of deciding whether to hear the case based solely on the briefs from the parties and other *amici*, the Supreme Court asked the U.S. Solicitor General's office to provide its view of the case. This is not uncommon, especially in ERISA cases. The Solicitor General's office will very likely decide to file a brief in the coming few months advising the Supreme Court whether to hear the case.

On October 30, the Council submitted **a letter to the Solicitor General's office and the U.S. Department of Labor (DOL)**, asking that the government recommend that the Supreme Court refrain from taking up Oklahoma's appeal in this case, including because the 10th Circuit decision is consistent with Supreme Court and other ERISA preemption precedent. The Council also explains for the government the importance of ERISA preemption to employers and employees and the myriad problems that would result if it were to be undermined. The letter also addresses some very concerning arguments made by DOL in a previous *amicus* brief in the case that would substantially undermine the scope of ERISA preemption.