The Benefits Insider is a bimonthly member exclusive publication prepared for WorldatWork 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 WorldatWork or its membership. To inquire about membership with the American Benefits Council, contact Deanna Johnson at (202) 289-6700 or djohnson@abcstaff.org.

February 3, 2020
(coversing news from January 16-31, 2020)

Table of Contents
RECENT REGULATORY ACTIVITY ................................................................. 2
HHS Proposes Rules Addressing Drug Manufacturer Coupons and Other Issues........ 2
IRS Issues Relief for SECURE Act RMD Changes ............................................. 4
Council Recommends Modifications to Health Price Transparency Proposed Regulation 5
RECENT LEGISLATIVE ACTIVITY .................................................................. 7
Council Outlines Principles for Federal Paid Leave Legislation in Submission to House Committee .............................................................................................. 7
Council Supports Bipartisan Bill to Increase Retirement Plan Cash-out Limits ........ 8
RECENT JUDICIAL ACTIVITY ....................................................................... 9
U.S. Supreme Court Declines to Review Case Involving Fiduciary Breach, Excessive Plan Fees .................................................................................................................. 9
Supreme Court Urged to Hear Fiduciary Breach Claims in Retirement Plan Case .......10
RECENT REGULATORY ACTIVITY

HHS Proposes Rules Addressing Drug Manufacturer Coupons and Other Issues

As part of regulations issued annually to implement selected aspects of the Affordable Care Act (ACA), on January 31, 2020, the U.S. Department of Health and Human Services (HHS) released the proposed proposed Notice of Benefit and Payment Parameters (NBPP) for 2021. This proposed rule addresses a key issue regarding drug manufacturer coupons following continued advocacy by the American Benefits Council and proposes a handful of other changes that affect employers and group health plans, in addition to addressing other ACA topics such as risk adjustment and risk corridors.

Drug Manufacturer Coupons

Most notably, the proposed 2021 NBPP includes regulations regarding how drug manufacturer coupons accrue toward the annual limitation on cost sharing, including for self-funded and large group market health plans. Specifically, HHS proposes to revise the regulations to provide that, to the extent consistent with applicable state law, amounts paid toward reducing the cost sharing incurred by an enrollee using any form of direct support offered by drug manufacturers for specific prescription drugs may be, but are not required to be, counted toward the ACA’s annual limitation on cost sharing.

HHS provides that “this proposal would enable issuers and group health plans to continue longstanding practices with regard to how and whether drug manufacturer coupons accrue towards an enrollee’s annual limitation on cost sharing.” HHS also notes that it expects issuers and group health plans to be transparent with enrollees and prospective enrollees regarding whether the value of drug manufacturer coupons accrue to the annual limitation on cost sharing but the proposed regulations don’t include a specific notice requirement. The expectation is that issuers and plans would include this information in materials that consumers use to select and understand their benefits.

This proposed guidance is a favorable response to an issue on which the Council has been advocating over the past year. The previous year’s 2020 NBPP provided that group health plans and issuers would be prohibited from excluding the value of drug manufacturers’ coupons when applying the annual limitation on cost-sharing, unless a generic equivalent of the drug is available. This would have imposed material additional costs on plans and issuers. Further, the requirement raised a conflict with Internal Revenue Service (IRS) rules related to high-deductible health plans (HDHPs), which generally require HDHPs to disregard drug and other discounts in determining if the minimum deductible has been satisfied.

Council staff spoke with the U.S. departments of Treasury, Labor and HHS last summer and expressed these concerns. In response to the concerns raised by the Council and other stakeholders, the departments issued Frequently Asked Question guidance issued in August 2019, announcing that the provision would not be enforced for 2020 and would instead be addressed in the 2021 NBPP rulemaking. In anticipation
of the upcoming proposed 2021 NBPP, in a December 3 letter to U.S. regulatory officials, the Council reiterated our position that health plans and issuers should be permitted to disregard the value of drug manufacturers’ coupons when administering the annual limitation on cost-sharing under the ACA, regardless of the availability of a generic equivalent. “This will ensure that plans and issuers remain free to design plans that provide for meaningful drug coverage, while also ensuring the application of certain cost-sharing tools and strategies designed to manage utilization of, and the costs associated with, prescription drug benefits,” the Council said.

Other Relevant Proposed Changes

The proposed 2021 NBPP also contains some other proposals relevant to employers and group health plans:

Maximum annual limitation on cost-sharing: The proposed annual limitation on cost-sharing under the ACA, for 2021, increases to $8,550 for self-only coverage and $17,100 for other than self-only coverage. (The annual limitation on cost-sharing for 2020 was $8,150 for self-only coverage and $16,300 for other than self-only coverage).

Excepted benefit HRAs: The proposed 2021 NBPP would require excepted benefit health reimbursement arrangements (HRAs) sponsored by non-federal governmental plan sponsors to provide a notice to participants that contains specified information about the benefits available under the excepted benefit HRA. HHS solicits comments on a number of specific items related to this new notice requirement. Rules allowing excepted benefit HRAs were finalized in June 2019 and in the preamble to those rules, the departments noted that long-standing notice requirements under ERISA already apply to private-sector, employment-based plans. As such, the HRA regulations did not separately impose a notice requirement on excepted benefit HRAs. However, HHS, which has jurisdiction over non-federal governmental plans, noted it intended to impose a notice requirement similar to the one under ERISA for non-federal governmental plan excepted benefit HRAs.

ACA employer mandate and premium tax credit (PTC) annual indexing: As it does each year, HHS proposes the amounts used to adjust the employer mandate penalty for 2021 and the amount used to adjust the PTC affordability percentage for 2021 (which carries over to affordability under the employer mandate rules). IRS will provide updated amounts for 2021 once the 2021 NBPP is finalized. See IRS FAQ #40 for prior year adjustments to the PTC affordability percentage and IRS FAQ # 55 for prior year adjustments to the employer mandate penalty.

Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs): HHS proposes to provide individuals and dependents in a QSEHRA, which is a type of HRA available only to small employers, with a non-calendar year plan year special enrollment period for coverage in the individual market for each new QSEHRA plan year.
HHS is soliciting comments on these proposals through March 2. The Council intends to provide comments, in particular in support of the drug coupon guidance, and we welcome feedback as we develop those comments.

**IRS Issues Relief for SECURE Act RMD Changes**

On January 24, the Internal Revenue Service (IRS) released Notice 2020-6, providing relief for financial institutions who provided erroneous information to IRA account holders who reach the age of 70 ½ in 2020 because the Setting Every Community up for Retirement Enhancement (SECURE) Act (H.R. 1994), increased the age for required minimum distributions (RMDs) from 70 ½ to 72. The guidance is the agency’s first step toward providing administrative relief related to SECURE Act provisions enacted on December 20, 2019, as a part of the Further Consolidated Appropriations Act of 2020 (H.R. 1865).

In its notice, the IRS specifies that financial institutions must file a 2019 “IRA Contribution Information” form (Form 5498) for IRA account holders that have an RMD due in 2020 by June 1, as well as an RMD statement by January 31. Since financial institutions may not have had enough time to make necessary system changes, the guidance also includes relief for institutions that already provided 2020 RMD statements to individuals turning 70 ½ in 2020 (in accordance with prior law), stating that it will not consider the statements to be incorrect as long as the institution notifies the IRA account holders by April 15 that they are not required to take an RMD in 2020. The notice also clarifies that SECURE Act changes do not affect RMD start dates for IRA account holders who reached the age of 70 ½ before January 1 and asks institutions to remind individuals who reached 70 ½ in 2019 to take their RMD before April 1.

In a January 17 comment letter to Treasury and IRS, the American Benefits Council requested immediate guidance on a number of SECURE Act provisions that are effective on enactment, or for plan or tax years after December 31, 2019. Among this list of issues was the matter addressed here regarding RMDs for participants turning 70 ½ in 2020. If changes to the law had not occurred, a participant receiving a withdrawal in 2020 and who would reach the age of 70 ½ in 2020 would have all or a portion of the withdrawal treated as a RMD. However, since the withdrawal is no longer an RMD, it should be subject to mandatory 20% withholding. Due to the short window between the passage of the SECURE Act and the effective date, a plan administrator might erroneously not withhold the proper amount.
Council Recommends Modifications to Health Price Transparency Proposed Regulation

In written comments filed with the Trump Administration on January 29, the American Benefits Council applauded the Trump Administration for “taking steps intended to increase price transparency in order to reduce health care costs” and offered a number of recommendations to mitigate “the increased burden and liability imposed by certain aspects” of proposed regulations issued in November 2019.

As we have previously reported, pursuant to a White House executive order (EO), the U.S. departments of Treasury, Labor and Health and Human Services recently published proposed rules requiring group health plans and insurers to disclose cost-sharing information to consumers in advance of the care being provided and to publicly disclose negotiated rates for in-network providers and historical allowed amounts for out-of-network providers.

With high health care costs emerging as an urgent concern for employer plan sponsors and policymakers alike, the Council has frequently called for greater transparency of health price and quality information. The Council’s long-term strategic plan, A 2020 Vision: Flexibility and the Future of Employee Benefits, recommended greater quality and price transparency in the health care system and stated that “public policy should not impede employers’ access to information needed to design and operate their plans.” Similarly, in 2019 written recommendations to the U.S. Senate Health, Education, Labor and Pensions (HELP) Committee, we urged Congress to increase employers’ access to health data, especially their own.

While the proposed regulations seem to assume that employers have access to their plan’s pricing information, some employers have faced challenges in obtaining their own plan data from TPAs and issuers. The Council’s letter asserts that “this needs to be rectified by the Administration or Congress” and recommends that final regulations include a safe harbor to address the situation in which a plan is unable to obtain data that is required to be disclosed.

Additionally, the Council’s January 29 letter:

- Supports the proposed cost-sharing estimate tool, but urges some changes to mitigate the substantial burdens associated with its development and maintenance, including limiting disclosure to the most common items and services, with phased-in expansions.
- Calls for new rules requiring pre-service disclosures by providers to participants, of the services included in their treatment and the pricing for the services, in acknowledgment of the essential role health care providers play in health care transparency.
• Strongly recommends that plans have two years, rather than one, to implement any final rules, as one year is not realistic even for the most sophisticated employers and issuers.

• Calls for a safe harbor to guard against the potential for increased litigation under ERISA due to the disclosure of negotiated rates, akin to the litigation that has befallen 401(k) plans.

• Supports increased transparency where it is expected to bring down costs, reduce consumer confusion, and result in more value-driven, informed and efficient consumption of health care services.

• Notes that, in certain markets, for some items and services, the public disclosure of negotiated rates could increase competition and potentially lead to lower health care costs, yet, in highly concentrated markets or as a result of anticompetitive behavior, may increase health care costs. The Council requests that the final rule be structured to avoid the unintended consequence of higher prices resulting from the public disclosure of negotiated rates.

• Strongly supports additional rules with respect to the transparency of health quality, acknowledging that “price is just one piece of the puzzle and, in terms of value, the price of the health care service does not always correlate with the quality of care.”

Also submitting comments on the proposed regulations was Consumers First, a diverse coalition of health policy stakeholders, of which the Council is a steering committee member. The Consumers First comment letter expresses support for significantly strengthened public transparency on the part of health plans but asserts that “rather than assuming health care consumers, on their own, can be the primary drivers of higher-quality, lower-cost health care, we urge the Administration to review transparency in a holistic way that includes employers and other payers, plans, providers and patients as vital consumers of transparency pricing and quality information.” The Consumers First comment letter recommends a number of changes to the proposed regulations’ underlying assumptions and several policy changes to maximize consumer benefit. Consumers First also makes recommendations about the Administration’s overall efforts to improve health care value and transparency.

The three federal departments are expected to work to finalize the proposed regulations later in 2020. So far, over 22,000 comments have been filed, and the Council will report on future regulatory developments.

In addition to our support for regulatory efforts to increase transparency to lower health care costs, the Council continues to support transparency efforts in Congress, including those contained in the Lower Health Care Cost Act (S. 1895), as approved by the Senate HELP Committee, which would:
• Remove “gag clauses” in contracts between providers and health plans that prevent enrollees, plan sponsors, or referring providers from seeing cost and quality data on providers.

• Ban anticompetitive terms in facility and insurance contracts, such as “anti-tiering,” “anti-steering,” “all-or-nothing” and “most-favored-nation” clauses, that prevent plans from directing or incentivizing patients to use specific providers and facilities with higher quality and lower prices.

RECENT LEGISLATIVE ACTIVITY

Council Outlines Principles for Federal Paid Leave Legislation in Submission to House Committee

In conjunction with a recent hearing of the U.S. House of Representative Ways and Means Committee on legislative proposals for paid family and medical leave, the American Benefits Council filed a written statement for the record outlining policy priorities for federal paid leave legislation.

In his statement opening the hearing, Committee Chairman Richard Neal (D-MA) observed the 27th anniversary of the enactment of the Family and Medical Leave Act, which allows workers to take unpaid leave to care for a child, a parent, or a spouse, or to deal with their own serious medical condition. He then argued that “the FMLA alone is not enough. … because while the FMLA entitles workers to leave, if that leave isn’t paid leave many workers simply can’t afford to take it.”

Noting that “less than one fifth of workers are offered paid family leave by their employers,” Neal offered an endorsement of the Family and Medical Insurance Leave (FAMILY) Act (H.R. 1185/S. 463), which establishes a national paid family and medical leave program providing all workers with up to 12 weeks of partial income for time off, funded through a new employer/employee payroll tax.

The Council’s statement notes that “The vast majority of large employers already sponsor excellent paid leave programs that enable employees to address their health and family needs” and stresses that, as more states and political subdivisions enact paid leave laws, it has become increasingly difficult for large, multistate employers to consistently offer and administer paid leave. The Council’s statement outlines a set of principles for a national paid leave policy, endorsing approaches that are:

Practical, promoting ease of communication and use for employees as well as ease of administration by the employer.

Voluntary on the part of the employer, allowing large companies to maintain uniform paid leave practices across the country.

Uniform and do not vary based on the state or local jurisdiction in which they operate.
Flexible, enhancing the evolution of workplace practices like telecommuting, job sharing and dynamic scheduling.

During the hearing, the committee heard from a panel of House lawmakers including:

- Representative Rosa DeLauro (D-CT), lead House sponsor of the FAMILY Act.
- Rep. Ann Wagner (R-MO), lead House sponsor of the competing New Parents Act (H.R. 1940/S. 920), legislation that creates a voluntary option for paid parental leave by allowing parents to choose a Social Security benefit of one, two, or three months to finance parental leave after the birth or adoption of a child (an official one-page summary is available).
- Rep. Elise Stefanik, cosponsor of the Advancing Support for Working Families Act (H.R. 5296/S. 2976), which allows families the option to advance up to $5,000 of their child tax credit in the first year of a child’s life or the first year a family adopts a child.

The committee also heard testimony from a second panel of employee advocates and other witnesses, many of whom expressed support for paid family and medical leave generally and the FAMILY Act in particular. One witness, Rebecca Hamilton, Co-CEO of W.S. Badger, voiced concerns with the FAMILY Act, suggesting that the payroll tax funding mechanism is overly regressive and would discourage employers from providing paid leave.

During the question-and-answer period, Democratic and Republican committee members alike expressed support for paid family medical leave, but focused on their different views regarding how it should be paid for. Republicans strongly criticized the tax increase included in the FAMILY Act while the Democrats assailed the tapping of Social Security funds as in the New Parents Act.

**Council Supports Bipartisan Bill to Increase Retirement Plan Cash-out Limits**

In a January 30 letter to House Education and Labor subcommittee leaders, the American Benefits Council expressed support for the Retirement Plan Modernization Act (H.R. 5676), bipartisan legislation to increase and index the amount of accrued benefits that a retirement plan can distribute upon termination of employment. The bill, introduced in the House on January 24, is in accordance with the Council’s previous testimony before the U.S. House of Representatives and the Council’s public policy strategic plan, A 2020 Vision: Flexibility and the Future of Employee Benefits, which called for policymakers to “increase the $5,000 threshold for employers to cash-out retirement plan accounts. This will reduce administrative expenses associated with small accounts.”

Currently, a plan can distribute to an employee his or her accrued benefit or account balance upon job change, provided the value is under $5,000. The employee can then
rollover the distribution into an IRA or another employer’s plan. H.R. 5676, introduced in the House on January 24, would increase the current $5,000 cash-out limit (for the first time since 1997) to $8,000 to account for inflation.

The bill also includes automatic increases for the future based on the cost of living rules that are applied to other retirement limits. The Council’s letter argues that “Standardizing inflation adjustments with other retirement limits in the Internal Revenue Code is a sensible way to ensure our retirement system works in a cohesive manner for the mutual benefit of employer plan sponsors and participants.”

H.R. 5676 would continue to allow employees with an account balance over $200 to have his or her distribution directly contributed tax-free to an IRA or a new employer plan. Measures that are focused on individual issues typically do not usually move on their own but more often get added to larger more comprehensive legislative initiatives, so H.R. 5676 could be considered for inclusion when comprehensive retirement policy legislation is next considered by Congress.

**RECENT JUDICIAL ACTIVITY**

**U.S. Supreme Court Declines to Review Case Involving Fiduciary Breach, Excessive Plan Fees**

The U.S. Supreme Court has denied a request to review the matter of Brotherston v. Putnam, a retirement plan fiduciary breach case in which the American Benefits Council filed an amicus ("friend of the court") brief at the appeals court stage. The lack of resolution maintains a split in federal appeals courts regarding who bears the burden of proving “loss causation” when fiduciary duty has been breached.

In Brotherston v. Putnam, the plaintiffs allege that Putnam Investments was imprudent and engaged in prohibited transactions by including Putnam mutual funds in its employees’ retirement plan. The plaintiffs claim that this resulted in fiduciary breach and excessive fees.

The U.S. District Court for the District of Massachusetts ruled in favor of the defendant in June 2017, stating that the fees were reasonable as a matter of law and that the plaintiffs had failed to make a case that the alleged fiduciary breach caused a loss for plaintiffs, citing precedent from a number of circuit courts placing the burden of that proof on the plaintiffs.

On appeal to the U.S. Court of Appeals for the First Circuit, the Council (along with the U.S. Chamber of Commerce and the Securities Industry and Financial Markets Association) urged the court to uphold the district court decision, arguing that the plaintiffs did not prove that a fiduciary breach resulted in a loss to the plaintiffs. The brief concurred with the district court that the plaintiffs have the legal burden to prove the loss and that the burden of proof never shifts to the ERISA defendant to disprove loss causation.
Nevertheless, the First Circuit concluded in an October 2018 decision that (1) ERISA defendants bear the burden of disproving loss causation, citing alternative circuit court precedent, and (2) the fact that particular investment options did not perform as well as a set of index funds, selected by the plaintiffs with the benefit of hindsight, suffices as a matter of law to establish “losses to the plan.” The appeals court remanded the case back to the circuit court, but the defendants subsequently petitioned the U.S. Supreme Court to review the case.

Following an amicus brief issued by the U.S. Department of Labor suggesting that the case did not warrant review by the high court, the petition for review was denied.

As observed in the Council’s earlier brief, the legal standard for “loss causation” embraced by the First Circuit could have significant repercussion to “sponsors, fiduciaries, and beneficiaries of every plan subject to that rule—harm from crimping investment decisions; raising the costs of services, indemnification, and insurance; and ultimately diverting resources from other key aspects of employee-benefit programs, such as 401(k) matching contributions or subsidization of healthcare premiums.”

Since the Supreme Court has declined to review the case, it will now be remanded back to the district court as instructed by the First Circuit.

**Supreme Court Urged to Hear Fiduciary Breach Claims in Retirement Plan Case**

In an amicus (“friend of the court”) brief filed jointly with the U.S. Chamber of Commerce on January 17, the American Benefits Council urges the U.S. Supreme Court to hear *University of Pennsylvania, et al. v. Sweda*, in which Sweda claimed excessive fees and imprudent investment options in a 403(b) plan. The Council argues that Supreme Court guidance is urgently needed by lower courts, and that the “inconsistent approaches taken by lower courts undermine ERISA’s promise of uniformity and predictability.”

In *Sweda et al. v. University of Pennsylvania*, the plaintiffs sued the university retirement plan investment committee for breach of fiduciary duty, prohibited transactions, and failure to monitor plan administration. The U.S. District Court for the Eastern District of Pennsylvania dismissed the lawsuit. However, the U.S. Court of Appeals for the Third Circuit partially reversed the district court ruling, upholding fiduciary duty claims but dismissing prohibited transaction claims, and remanded the case for further proceedings.

In its brief, the Council argues that fiduciary actions should not be measured in hindsight, but rather by the process in which decisions were made. The Council also argues that the district court correctly applied a pleading standard established by the Supreme Court in *Bell Atlantic Corp. v. Twombly*. Under the *Twombly* standard, courts must scrutinize circumstantial factual allegations in a complaint to determine whether they plausibly suggest wrongdoing or are instead “just as much in line with” lawful conduct. In the latter circumstances, the complaint must be dismissed. The district court applied this standard in dismissing the case but the Third Circuit reversed the
decision stating the *Twombly* pleading standard applies only to antitrust cases. However, the Council’s brief pointed out that the Third Circuit’s decision conflicts with the Supreme Court’s decision in *Ashcroft v. Iqbal* where the Supreme Court rejected assertions that the plausibility pleading standard should be limited to antitrust disputes.

The Council alludes to the steady growth of ERISA lawsuits over the past years, many of which are founded on circumstantial, hindsight-based allegations like the plaintiffs’ allegations in *Sweda*, as another reason why the Supreme Court should intervene and provide clarification for lower courts.