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Department of Labor Releases Proposed Regulations on SECURE 2.0 Automatic Portability Transactions

The Department of Labor ("DOL") released proposed regulations to implement a SECURE 2.0 provision that expands the use of "auto-portability programs," under which an employee can have certain benefits transferred by default to a subsequent employer plan when they change jobs.

Background

Under existing "automatic portability programs," an employee whose benefits have been transferred to an IRA provider under the automatic rollover IRA rules can have their benefits transferred as a default to a subsequent employer plan when they change jobs. These programs rely on "automatic portability providers" ("APPs") to facilitate the transfers by connecting automatic rollover IRAs to participant accounts in workplace retirement plans. APPs are considered fiduciaries of the IRA involved in the transfer for purposes of the Internal Revenue Code's ("Code's") prohibited transaction rules, which require the entity involved to pay a tax. As a result of this fiduciary status, any fees that the APP receives from the transactions are considered a prohibited transaction. Prior to the enactment of SECURE 2.0, DOL provided an individual prohibited transaction exemption ("PTE") to one company that does business as an APP, thus allowing the APP to receive compensation without running afoul of the prohibited transaction rules. Only the company that received the individual PTE, however, was allowed to rely on it.

Section 120 of SECURE 2.0 created a statutory PTE for these types of transactions, which the statute calls "automatic portability transactions" ("APTs"). Under similar conditions imposed on the individual PTE, all APPs that meet those conditions may receive relief from receiving fees and compensation in connection with an APT. Thus, under SECURE 2.0, companies other than the single company that received the individual PTE can act as an APP and receive fees without being penalized under the prohibited transaction rules.

Proposed Regulations

On January 18, 2024, DOL released proposed regulations to implement section 120 of SECURE 2.0. The proposal largely addresses the technical workings of how the PTE would function. For instance, the proposal would require, as a condition for relief under the PTE, that the APP ensure that each plan that receives an APT and for whom the APP performs such transactions designates a plan official to be responsible for monitoring transfers into the plan and confirming that amounts received on behalf of the participant are invested properly. In addition, the proposal would require that plans both distributing and receiving benefits to include a description of the automatic portability program in the plan's summary plan description. APPs also would be required to send a notice to the plan administrator of each participating plan informing the administrator that they must fully describe the automatic portability program and disclose fees related to an APT in the summary plan description (or summary of material modifications, if applicable).

In accordance with SECURE 2.0's requirement that APPs offer APTs "on the same terms" to any plan receiving such benefits, the proposal explains that, at any given time, the fees paid for APTs should be the same for any receiving plan that engages the APP.

Additionally, under SECURE 2.0, the PTE relief for APTs is only available for automatic cash-outs that exceed $1,000. The proposal requests comments

from the public on, among other aspects of the proposal, whether DOL should use its authority under ERISA to allow for distributions of $1,000 or less.

Agencies Release Initial Guidance on SECURE 2.0 Emergency Savings Accounts

The Internal Revenue Service ("IRS") and the Department of Labor ("DOL") released twin pieces of guidance – a Notice and a set of FAQs, respectively – addressing questions regarding the treatment of Pension-Linked Emergency Savings Accounts ("PLESAs"), which were created by the SECURE 2.0 Act of 2022 ("SECURE 2.0") to encourage retirement savers to also save for emergencies.

Background

Enacted as part of SECURE 2.0, PLESAs are a new option for retirement plan participants to save for emergencies. Under section 127 of SECURE 2.0, a 401(k), 403(b), or governmental 457(b) defined contribution plan is permitted – but not required – to include a PLESA as a separate part of the plan specifically for emergency expenses. Participant contributions to a PLESA are made to a designated Roth account, and plans may provide for automatic enrollment up to 3%. PLESAs are subject to a variety of restrictions, including that no contributions to such an account may be accepted if it would cause the PLESA to exceed $2,500 (excluding any earnings), but otherwise a PLESA must have no minimum contribution or account balance requirements. While no employer contributions to PLESAs are permitted, if an employer makes matching contributions to the plan itself, then any PLESA contributions must be matched at the same rate and will go to the participant's non-PLESA account in the plan. The provision gives both DOL and the IRS the authority to issue guidance addressing PLESAs.

DOL and IRS Guidance on PLESAs

On January 12, 2024, the IRS issued Notice 2024-22, which specifically addresses the statutory provision that permits plans to use "reasonable" procedures to limit the frequency or amount of matching contributions with respect to PLESA contributions, solely to the extent necessary to prevent matching contributions from exceeding the intended amounts or frequency. The guidance confirms that the use of such "anti-abuse" provisions by plans is optional. Interestingly, the Notice also provides that a plan sponsor "may" consider a participant as *not* manipulating the matching contributions if the participant made a $2,500 contribution in one year, received the matching contribution, and then withdrew the $2,500 that same year, and repeated that pattern in subsequent years. Many plan sponsors believed that this circumstance was the exact type of behavior that the anti-abuse provision in section 127 was meant to address. In addition, the Notice lists some types of procedures that would be unreasonable for a plan sponsors to implement as an anti-abuse provision, such as providing that matching contributions already

made to a participant's account by reason of contributions to the PLESA will be forfeited if a participant withdraws funds from a PLESA.

Lastly, the Notice states that this is only initial guidance on PLESAs and does not address many of the other outstanding questions. Because more complete guidance will require coordination between the IRS and DOL, it may be some time before such guidance is released.

Shortly after the release of Notice 2024-22, DOL – in consultation with the IRS – released a set of FAQs providing general compliance information about PLESAs. With respect to the statute's prohibition on PLESAs having a minimum contribution or account balance requirement, the FAQs explain that this prohibits plans from establishing a minimum amount for opening a PLESA. The FAQs also state that the prohibition on account minimums forbids (1) any policy requiring the closure and distribution of a PLESA based on a minimum balance requirement; (2) the imposition of any penalty (e.g., fees or the suspension of withdrawal rights) for PLESAs that fall below a specified account balance; and (3) any policy requiring a minimum contribution amount per pay period. However, the FAQs provide that it would not be unreasonable to (1) require contributions to be made in whole dollar amounts or (2) require percentage-based contributions to be no less than 1% (or to be made in whole percent increments within certain limits). Among other topics, the FAQs also clarify that participants are not required to demonstrate or certify the existence of an emergency or other need or event in order to withdraw funds from their PLESA.

This initial guidance on PLESAs may help facilitate more plans moving forward with adopting this optional emergency savings account feature. Employees may find PLESAs attractive because they can use them as frequently as monthly for any purpose without incurring the tax penalties normally associated with early withdrawals from a qualified retirement plan.

Agencies Announce New Therapeutic Equivalence Standard for Contraceptive Coverage Mandate

Citing an ongoing lack of compliance with the ACA's requirements for group health plans to cover "the full range of contraceptives and contraceptive care to prevent unintended pregnancies and improve birth outcomes," the Departments of Health and Human Services, Labor and Treasury ("Agencies") have established a new "therapeutic equivalence" standard that plans can use to satisfy the obligation to cover FDA-approved contraceptive drugs and drug-led devices.

Overview

In general, the ACA requires all non-grandfathered group health plans to cover, without cost sharing, certain preventive services. With respect to women, this

mandate extends to recommendations by the Health Resources and Services Administration (HRSA). Pursuant to the HRSA-supported Women's Preventive Services Guidelines, women should have access to "the full range of contraceptives and contraceptive care" – which includes "the full range of U.S. Food and Drug Administration (FDA)-approved, -cleared, or -granted contraceptives, effective family planning practices, and sterilization procedures." The guidelines further define this by reference to the 17 categories of contraception listed in the FDA's Birth Control Guide.

Based on the HRSA guidelines, existing guidance provides that the ACA requires plans, among other things, to cover without cost-sharing (1) at least one form of contraception in each of the categories listed in the HRSA-supported Guidelines; and (2) FDA-approved, -cleared, or -granted products that an individual and their attending provider have determined to be medically appropriate for the individual, whether or not those services or products are specifically identified in the categories listed in the HRSA-supported Guidelines.

The second requirement includes newer contraceptive products as they are approved, cleared, or granted by the FDA, even if they are not within the categories listed in the current HRSA-supported Guidelines. In this case, plans and issuers may use reasonable medical management techniques to determine which specific products or services to cover without cost sharing if more than one substantially similar products or services are available and medically appropriate for the individual.

Reasonable medical management techniques also are permitted within a specified category of contraception, but only to the extent the HRSA-supported Guidelines do not specify the frequency, method, treatment, or setting for the contraceptive service or FDA-approved, -cleared, or -granted product.

Even though the Agencies have issued guidance on what they believe constitutes reasonable medical management techniques, they are concerned that some plans are continuing to impose inappropriate barriers to contraceptive coverage. As a result, this new guidance is designed to offer an alternative "therapeutic equivalence approach, which plans and issuers may adopt (in combination with an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome) to comply with" the contraceptive coverage requirements.

Summary of Therapeutic Equivalence Alternative

According to the FAQs issued on January 22, 2024, the therapeutic equivalence alternative is designed to supplement – and not replace – prior guidance on complying with the contraceptive coverage mandate.

Under this new option, when medical management techniques are allowed, the Agencies will consider them to be reasonable if "the plan or issuer covers all FDA-approved contraceptive drugs and drug-led devices in that category (or group of substantially similar products) without cost sharing, other than those for which there is at least one therapeutic equivalent drug or drug-led device that the plan or issuer covers without cost sharing." However, there still must be an exceptions process that allows participants to obtain the therapeutic equivalent contraceptives without cost-sharing if their attending provider determines them to be medically necessary.

Whether a contraceptive is therapeutically equivalent to another is determined solely by reference to the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations ("Orange Book").

The FAQs illustrate this new standard with the following example:

> *Example:* Within the category of "oral contraceptives (combined pill)," a plan covers all FDA-approved oral contraceptives (combined pill) products without cost sharing, other than those for which there is a therapeutic equivalent that is covered without cost sharing. Specifically, the plan covers Pill A, Pill B, and generic Pill D without cost sharing. Neither Pill A nor Pill B has a therapeutic equivalent product according to the Orange Book. Pill W, Pill X, and Pill Y, as well as Pill Z (which is a more expensive brand name product) are all classified in the Orange Book as therapeutic equivalents to Pill D and are not covered by the plan without cost sharing. However, the plan provides an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome on an individual or their provider (or other individual acting as the individual's authorized representative). The plan's exceptions process allows an individual to receive coverage without cost sharing for a therapeutic equivalent to Pill D (i.e., Pill W, Pill X, Pill Y, or Pill Z) if the therapeutic equivalent product is determined to be medically necessary with respect to the individual, as determined by the individual's attending provider.
>
> *Conclusion:* The plan's medical management techniques with respect to the category of "oral contraceptives (combined pill)" are generally reasonable. However, the plan's medical management techniques could be considered unreasonable if the plan imposes additional medical management techniques that are problematic, such those highlighted earlier in these FAQs.

Impact on Group Health Plans

The new therapeutic equivalent standard may be helpful to group health plans that want to avoid any questions about whether the medical management techniques they apply with respect to FDA-approved contraceptives are “reasonable.” However, plans that choose to take advantage of this option will still need to be sure that they maintain an exceptions process that allows participants to obtain, without undue burden, any non-covered therapeutic equivalent contraceptives without cost-sharing if their attending provider determines them to be medically necessary.

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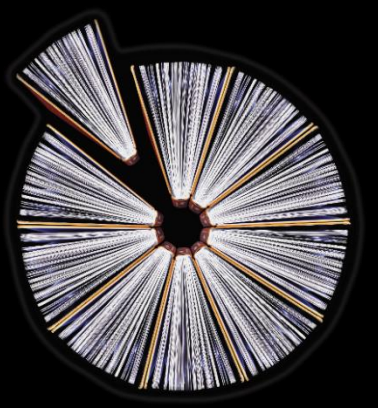

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