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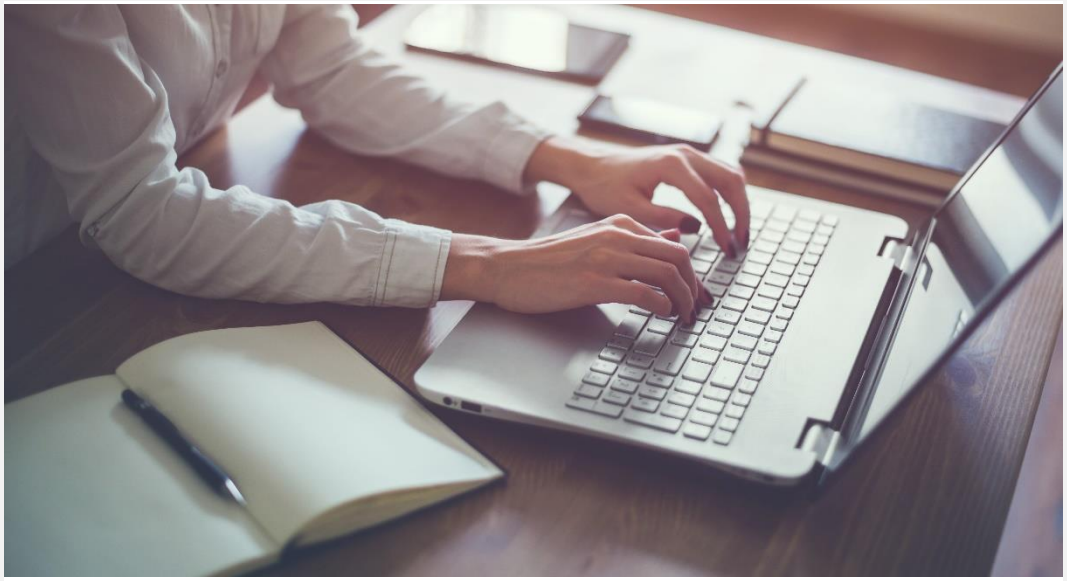

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IRS Publishes New Guidance on Long-Term, Part-Time Employees

As part of the agency's guidance project on the rules for the participation of long-term, part-time ("LTPT") employees in employer-sponsored retirement plans, the Internal Revenue Service ("IRS") released a series of Q&As that address issues relevant to 401(k) and 403(b) plans.

Background

In an effort to increase the number of part-time employees who are covered by employer-sponsored retirement plans, as part of the SECURE Act of 2019 ("SECURE 1.0"), Congress amended the Internal Revenue Code to generally prohibit 401(k) plans from establishing plan participation requirements beyond: (a) one year of service (using the so-called "1,000-hour rule"); or (b) three consecutive years of service where the employee completes at least 500 hours of service. Under the LTPT rules in SECURE 1.0, employers can exclude employees who are eligible to participate in the plan solely because of the LTPT rules from nondiscrimination testing and minimum coverage rules, among other rules. Employers are also not required to make matching or nonelective contributions on behalf of LTPT employees. SECURE 1.0's rules generally became effective for plan years beginning in 2021.

The SECURE 2.0 Act of 2022 ("SECURE 2.0") made several changes to the LTPT rules, including reducing the three-year service rule to two years and expanding the LTPT rules to apply not only to 401(k) plans, but also to 403(b) plans. These new rules generally will become effective for plan years beginning in 2025. In November 2023, the IRS published proposed regulations interpreting the LTPT rules for 401(k) plans, but not 403(b) plans. (See Rewards Policy Insider 2023-25 for a more in-depth analysis of the proposed regulations.)

New Guidance Sheds More Light on LTPT Rules

On October 3, 2024, the IRS published Notice 2024-73, which provides additional guidance on the LTPT rules. Highlights of the guidance include:

- Delayed Effective Date for 401(k) Plan Proposed Regulations. The proposed regulations were originally proposed to be effective for plan years beginning on or after January 1, 2024. This concerned many plans, because this date was just over a month after the proposed regulations were published. In a much-welcomed development, Notice 2024-73 states that the proposed regulations, once they are finalized, will apply no earlier than plan years beginning in 2026. (Note that this does *not* mean that the LTPT rules themselves will begin applying in 2026, only that the interpretations in the proposed regulations will not apply until at least then.)
- Application of LTPT Rules to 403(b) Plans. The Notice confirms that SECURE 2.0's LTPT rules for 403(b) plans only apply to 403(b) plans that are covered by ERISA. Non-ERISA 403(b) plans are exempt from the LTPT rules.
- Universal Availability Rule. 403(b) plans are required to adhere to the "universal availability" rule, which generally provides that all employees of an employer maintaining a 403(b) plan generally must be permitted to participate in the plan if any of the employer's employees are permitted to participate – in other words, the plan must be universally available to all employees, subject to certain exceptions. One exception is that certain student employees who work at a university are not required to be included. Notice 2024-73 confirms that a 403(b) plan

may exclude these student employees from the plan even if they meet the conditions to be considered a LTPT employee.

- Matching Contributions. The Notice confirms that that a 403(b) plan may exclude LTPT employees for purposes of determining whether the employer's matching contributions satisfy the actual contribution percentage ("ACP") test.

What Employers Need to Know About the Final Mental Health Parity Rules – Part 2

As reported in RPI 2024-19, the Departments of Health and Human Services, Labor, and Treasury ("Departments") have issued updated final regulations under the Mental Health Parity and Equity Addiction Act ("MHPAEA") that will start taking effect for plan years beginning on and after January 1, 2025. This is the second in a series of articles designed to take a closer look at the final regulations, and especially at what employers need to know in order to comply. The core question addressed in this article is: What is the "meaningful benefit" requirement?

Background

The Mental Health Parity and Equity Addiction Act (MHPAEA) does not require employer-sponsored group health plans to provide coverage for mental health or substance use disorder benefits. Instead, it requires plans that choose to provide coverage for mental health or substance use disorder benefits to ensure "parity" with respect to those benefits when compared with the plan's medical and surgical benefits.

In addition to the basic parity requirements relating to quantitative and non-quantitative treatment limitations, the final regulations impose a "meaningful benefit" requirement. The basic rule is, if a plan provides *any* benefits for a mental health condition or substance use disorder in any "classification of benefits," it must provide "meaningful benefits" for that condition or disorder in *every* classification in which medical/surgical benefits are provided. The relevant classifications of benefits are specified in the regulations as follows: (i) in-patient, in-network; (ii) in-patient, out-of-network; (iii) outpatient, in-network; (iv) outpatient, out-of-network; (v) prescription drugs; and (vi) emergency care.

For example, if a plan provides outpatient, in-network treatment for autism spectrum disorder (ASD), then it generally must provide "meaningful benefits" for ASD in all six classifications in which medical/surgical benefits are provided.

What Benefits are "Meaningful"?

The general rule for determining if benefits are "meaningful" is to compare the benefits provided for medical conditions and surgical procedures in each classification. At a minimum, though, the plan must provide a "core treatment"

for the condition or disorder in each classification in which the plan provides benefits for a core treatment for one or more medical conditions or surgical procedures.

The final regulations define a "core treatment" as a "standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of medical practice."

In some classifications, there may not be a "core treatment" for a covered mental health condition or substance use disorder. For example, for certain mental health conditions there may not be a generally recognized standard treatment in the emergency care classification. If that is the case, the final regulations provide that a plan is not required to provide benefits for a core treatment for the relevant condition or disorder in that classification.

How Will the Rule be Applied?

The final regulations provide several helpful examples of how the "meaningful benefit" rule will apply, including the following:

> *Facts*. A plan covers treatment for autism spectrum disorder (ASD), a mental health condition, and covers outpatient, out-of-network developmental screenings for ASD but excludes all other benefits for outpatient treatment for ASD, including applied behavioral analysis (ABA) therapy, when provided on an out-of-network basis. The plan generally covers the full range of outpatient treatments (including core treatments) and treatment settings for medical conditions and surgical procedures when provided on an out-of-network basis. Under the generally recognized independent standards of current medical practice consulted by the plan, developmental screenings alone do not constitute a core treatment for ASD.
>
> *Conclusion*. The plan violates the meaningful benefit rule. Although the plan covers benefits for ASD in the outpatient, out-of-network classification, it only covers developmental screenings, so it does not cover a core treatment for ASD in the classification. Because the plan generally covers the full range of medical/surgical benefits, including a core treatment for one or more medical conditions or surgical procedures in the classification, it fails to provide meaningful benefits for treatment of ASD in the classification.

Pharmacy Benefit Managers in the Spotlight: State and Federal Updates on PBMs

Issues surrounding pharmacy benefit managers ("PBMs") are never far from the headlines. This article focuses on three significant recent updates relating to PBMs: the status of a bill in California designed to more closely regulate PBMs; the U.S. Supreme Court considering a request to review a case involving whether ERISA preempts state regulations on PBMs; and an

administrative complaint brought by the federal government alleging that certain PBMs artificially inflated drug prices.

California Law Vetoed by Governor

On September 28, 2024, California Governor Gavin Newsom (D) vetoed a bill that would generally impose new oversight rules on PBMs operating in the state, including by requiring PBMs to file annual reports with the state Department of Insurance that disclose certain information, such as the company's contracts, revenues, and the fees it receives. A violation of these rules would result in civil penalties. In vetoing the bill, Governor Newsom said that while PBMs should be held accountable to ensure that prescription drugs remain accessible, he is not sure that the licensing scheme proposed by the bill would achieve the intended result. He also said that a state office is already working on a multi-pronged approach to improving the affordability of prescription drugs.

Whether this will be the last word on the bill remains to be seen – after the governor's veto, it returned to the legislature to consider whether they should attempt to override the veto. This seems unlikely, however, given that the California legislature historically almost never overrides a governor's veto.

Supreme Court Signals It is Considering Whether to Hear PBM Case

While PBMs in California likely won't be subject to any new regulations under state law, many other states are actively considering and enacting laws to impose restrictions on PBMs. An Oklahoma PBM reform law, which has been the subject of ongoing litigation, is one such restriction. In August 2023, the 10th Circuit Court of Appeals ruled in *PCMA v. Mulready* that ERISA preempts certain key elements of the Oklahoma law that regulates how pharmacy provider networks are designed and operated, including establishing geographic parameters for pharmacy networks, prohibiting incentives for participants to use certain in-network pharmacies – including mail-order pharmacies – over others, and imposing an "any willing provider rule" for pharmacy network participation. The 10th Circuit said that these types of network restrictions are state laws that mandate benefit structures, which ERISA explicitly prohibits. The 10th Circuit also brushed off concerns that its ruling is at odds with a prior Supreme Court ruling upholding a similar Vermont PBM reform law.

Following the 10th Circuit's ruling, Oklahoma asked the Supreme Court to review the case. While the Supreme Court has not yet made a decision on that front, on October 7, 2024, it asked the U.S. Solicitor General to weigh in on the case. This is a sign that the Court may be seriously considering whether to hear *PCMA v. Mulready*. If it does eventually decide to take up the case, the court's ultimate decision could potentially alter, in a significant way, the ability of states to regulate PBMs.

FTC Hones in on Inflated Insulin Prices

Lastly, in late September, the Federal Trade Commission ("FTC") filed an administrative complaint against multiple large PBMs, alleging that the PBMs and their affiliated group purchasing organizations ("GPOs") engaged in anticompetitive and unfair rebating practices that artificially inflated the price of insulin drugs and hindered patients' access to lower list price drugs. Similar to a lawsuit filed in federal court, an administrative complaint initiates a formal

proceeding that is considered by an administrative law judge. While this case is still in the very early stages, it is evidence that the federal government – not just states – are focusing on issues surrounding PBM reform.

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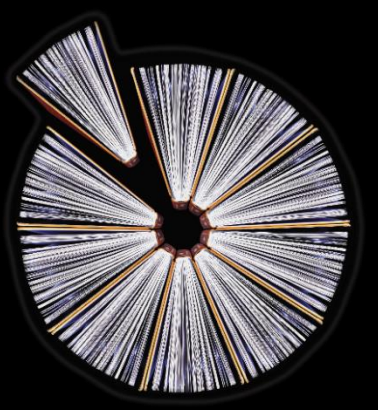

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