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CHANGES AT THE NLRB: LEADERSHIP SHAKEUPS, LEGAL BATTLES, AND A SHIFT IN LABOR POLICY

As of April 2025, the National Labor Relations Board (NLRB) is facing one of its most turbulent periods in recent history. Political battles, legal uncertainty, and internal restructuring are shaping the agency's trajectory, as it attempts to fulfill its mandate of safeguarding workers' rights and overseeing labor relations.

One of the most significant developments was the removal of Democratic member Gwynne Wilcox by President Donald Trump earlier this year. This dismissal, which was ruled illegal by a federal judge in early March, has triggered a broader debate over the limits of executive power and the independence of federal agencies like the NLRB. Although Wilcox has been reinstated twice following the court's decision, the Trump administration has appealed, leaving the future composition of the Board unsettled. This action mirrors a larger trend, as similar terminations occurred at other agencies, such as the Federal Trade Commission.

Operationally, the NLRB has been slowed by the change in leadership. Wilcox's removal left the agency without a quorum for several weeks, stalling its ability to issue decisions and effectively halting the processing of cases.

In the midst of these challenges, the NLRB has continued to take action on high-profile labor disputes. In March, the agency filed a complaint against REI Co-op, alleging the company unlawfully withheld raises and bonuses from employees at unionized stores. In another major development, the Board intervened in a long-running dispute involving Via 313, a pizza chain in Austin, Texas. Following a successful union vote, the NLRB ordered the reinstatement of several unlawfully terminated employees and mandated that the company begin good faith negotiations with the newly formed union.

These actions demonstrate the Board's commitment to its enforcement role, even as it undergoes these changes in governance. That commitment is being steered under new leadership, with President Trump's appointment of William B. Cowen as Acting General Counsel following the removal of Jennifer Abruzzo, a Biden-era appointee.

Cowen began his NLRB career in 1979. Over the decades, he has held numerous positions, including counsel to Board Member Howard Jenkins, Jr., field attorney in Cleveland, attorney in the Division of Enforcement Litigation, and even a short stint as a Board Member during the George W. Bush administration. Most recently, Cowen served as the Regional Director of the NLRB's Los Angeles office, where he oversaw labor law enforcement across Southern California.

Since taking office, Cowen issued new policy guidance, including Memorandum GC 25-05 which rescinded Biden-era guidance issued by his predecessor. Among the rescinded policies were memos addressing the legality of noncompete agreements, the status of college athletes as employees, the permissibility of mandatory employer meetings on unionization, and various remedies in unfair labor practice cases. Cowen justified the rescissions by citing an overwhelming backlog of cases, arguing that regional offices needed greater flexibility to allocate resources and resolve disputes more efficiently.

The rescission marks a clear pivot in the agency's approach, signaling a potential shift in how labor law will be enforced during Trump's current term. Observers from both labor and management are closely watching for further guidance from Cowen, which will shape the Board's policy direction in the months ahead. For now, the NLRB operates in a state of flux.

EMPLOYEE'S RELIANCE ON ERROR IN BENEFIT ELECTION FORM DEEMED UNREASONABLE BY SIXTH CIRCUIT

The United States Court of Appeals for the Sixth Circuit recently reviewed a case in which an employer mistakenly informed an employee that his long-term disability ("LTD") benefits would be nearly $32,000 more than what he was actually entitled to. In *Higgins v. Lincoln Elec. Co.*, the employer offered an employee welfare benefits plan that included LTD benefits. No. 23-5862, 2025 U.S. App. LEXIS 1199 (6th Cir. Jan. 16, 2025). Under the plan, eligible employees could elect between two coverage options: one with LTD benefits capped at approximately $40,000 and another with LTD benefits capped at approximately $60,000.

In this case, the employer gave the employee a Benefit Election Form that erroneously indicated that his annual LTD benefits would amount to $92,260.80. However, it was not until after the employee became disabled that he discovered the plan documents limited those benefits to $60,000.

After the employer failed to honor the benefit amount listed in the Benefit Election Form, the employee filed suit against the employer, arguing that that the employer should be prevented from denying him the higher benefits, as he relied on this information when deciding not to purchase additional disability insurance coverage. After the lower court dismissed the lawsuit for failing to state a claim, the employee appealed to the Sixth Circuit.

Under ERISA, written plan documents hold significant authority, and courts are required to enforce clear and unambiguous terms as written. In this case, the Sixth Circuit found that the official plan documents, which the employee had access to, explicitly capped the employee's LTD benefits at $60,000 per year. Although the Benefit Election Form identified a higher amount, the form was not a plan document that could modify the plan's benefit limits. Thus, the Court concluded that the employee's reliance on the form was unreasonable, as it was clear that it contradicted the official plan documents.

Ultimately, because the benefit limits outlined in the plan documents were clear and unambiguous, the Court upheld the lower court's decision to dismiss the employee's lawsuit. Despite the confusion created by the Benefit Election Form, the Court adhered to the ERISA principle that plan documents govern the terms of benefits, and any discrepancies between a summary form and the official documents must be resolved in favor of the written plan.

NEW IRS RULE TARGETS HIGH EARNERS

IRS and Treasury propose mandatory Roth catch-up contributions for high earners in multi-employer retirement plans, effective 2026

The Internal Revenue Service ("IRS") and the U.S. Department of the Treasury ("Treasury") have released proposed regulations, set to take effect on January 1, 2026, regarding mandatory Roth catch-up contributions for defined contribution plans. These regulations will have a significant impact on our multi-employer plans, specifically plans that include "high-earners."

Catch-up contributions apply to participants aged 50 and older and are designed to help participants save more for retirement in the later years of their careers by increasing the contribution limits for their defined contribution plans. The proposed regulations affect participants who earned more than $145,000 in the previous year (adjusted for inflation), referred to as "high-earning participants" and mandates that any catch-up contributions from these participants be made as Roth contributions. "Roth" contributions means that the

contributions must be made by the employees with their post-tax earnings.

Of specific note in multi-employer plans, the $145,000 designation of "high-earners" only refers to income from one employer, earnings from different employers are not aggregated to meet that standard. So, if an employee makes $90,000 from Employer A and $80,000 from Employer B, they would not quality as a "high-earner" and would not be subject to the rule on mandatory Roth catch-up contributions because the employee did not meet the threshold for one employer.

WHAT TO DO:

If a defined contribution plan does not allow for Roth contributions, that is, currently only pre-tax contributions are allowed, Trustees will need to decide what, if any, next steps they want to take:

- The Plan can be amended to accomodate high earners by introducing a Roth contribution, subject to the new mandate. If a plan chooses to do the Roth option, the new regulations require that the Plan make the Roth option available to all employees, even those employees who are not considered high-earners.
- If the Plan chooses not to add the Roth contribution, individuals who are not high-earners will still be able to make the catch-up contributions, but the high-earners will not be able to make catch-up contributions. For example, if an employee is age 52, earned $180,000 last year and his plan does not offer Roth contributions, he will not be permitted to make a catch-up contribution (even though he is eligible by age) because the Plan is noncompliant with the Roth catch up rule for high earners.
- The Plan could eliminate the catch-up contributions all together, if it is deemed too administratively complex.

WHAT TO DO IF CATCH-UP CONTRIBUTIONS ARE WRONGLY MADE PRE-TAX:

If catch-up contributions are wrongly made on a pre-tax basis, when they should have been made as a Roth contribution, the proposed regulations dictate two options for correction of the mistake:

1) From W-2 Correction – This option is only available if the mistake is made before a W2 is issued and taxes are filed, one can simply adjust the participant's W-2 to recharacterize the contributions as post-tax, or Roth contributions;

2) In-Plan Roth Rollover Correction: This option requires directly rolling over the wrongly made pre-tax deferral (must be adjusted for gain or loss) to the participant's Roth account that is within the plan and reporting this amount as an in-plan Roth rollover while issuing a Form 1099-R for the year of the rollover.

The proposed regulations could pose unique challenges for compliance in the multiemployer space. Specifically, tracking Roth accounts (which are maintained separately from the pre-tax contribution accounts) and eligibility could be a significant burden for multiemployer plans, where multiple employers with different systems are involved. Coordinating and monitoring a participant's income, contributions, and eligibility could pose complex and administratively challenging.

Plans that offer catch-up provisions should educate their members about the new rules and review the plan documents to ensure compliance. Please contact our office if you have any questions.

IRS: EXISTING RETIREMENT PLANS EXEMPT FROM SECURE 2.0 AUTO-ENROLLMENT

The Department of the Treasury and the Internal Revenue Service issued proposed regulations on January 10, 2025, addressing certain provisions of the SECURE 2.0 Act of 2022. A significant clarification pertains to multi-employer plans (MEPs), including pooled employer plans (PEPs), and the implications of adding new participating employers.

Under the proposed regulations, "unless an employee opts out, a plan must automatically enroll the employee at an initial contribution rate of at least 3% of the employee's pay and automatically increase the initial contribution rate by one percentage point each year until it reaches at least 10% of pay."[1]

Under Section 101 of the SECURE 2.0 Act, 401(k) and 403(b) plans established on or after December 29, 2022, are required to include an eligible automatic contribution arrangement (EACA) beginning with the 2025 plan year. However, the mandatory automatic-enrollment requirements do not apply to pre-enactment plans that were in place before December 29, 2022, the date of SECURE 2.0's enactment.[2] For 401(k) and 403(b) plans in place before this date, they are considered "grandfathered" and are exempt from the mandatory requirement to adopt auto-enrollment features.

These pre-enactment plans are exempt from the auto-enrollment mandate and are allowed to continue their current arrangement, without having to install an EACA unless the plan sponsor opts to do so voluntarily. This exemption applies broadly to both single-employer plans and certain MEPs and PEPs as well, ensuring that these existing retirement plan designs remain unaffected by the new legislation.[3]

Furthermore, the proposed regulations also offer flexibility for transactions such as mergers, spinoffs, and plan amendments. For instance, if two pre-enactment plans merge, the surviving plan can retain its pre-enactment status, allowing the plan to continue without having to adhere to the automatic-enrollment requirements.[4] Even if a company merges with another that operates under a new plan, the merged plan could retain its exemption from automatic-enrollment provisions if it meets certain criteria. This means that if a new employer joins a grandfathered MEP, the plan does not lose its exempt status solely due to the addition of that employer.

While the SECURE 2.0 Act does impose new requirements on new plans and on plans that adopt the mandate for the first time, it is crucial to recognize the significant leeway provided for existing plans. Employers with pre-enactment plans are not required to amend their current plan structure to incorporate automatic enrollment unless they choose to voluntarily adopt these elements. These exemptions are especially beneficial for long-standing plans with established savings strategies that are already in place helping advance the retirement goals of employees.

CONCLUSION

In summary, the SECURE 2.0 Act's auto-enrollment mandate does not drastically affect the operations of 401(k) and 403(b) plans that were in place before the legislation's enactment on December 29, 2022. SECURE 2.0 offers comprehensive exemptions and rules to allow pre-existing plans to continue their current structure without having to incorporate the auto-enrollment provisions required for new plans. Employers with existing plans are generally not subject to the new requirements unless they opt to voluntarily adopt auto-enrollment features.

This clarification provides valuable flexibility for MEPs and PEPs, allowing them to expand their participating employer base without inadvertently subjecting the plan to new automatic enrollment mandates. Plan administrators should review these proposed regulations in detail and consult with legal or benefits advisors to ensure compliance and optimal plan design.

[1] https://www.irs.gov/newsroom/treasury-irs-issue-proposed-regulations-on-new-automatic-enrollment-requirement-for-401k-and-403b-plans
[2] https://www.milliman.com/en/insight/secure-2-irs-regulations-mandatory-automatic-enrollment
[3] https://www.groom.com/resources/irs-issues-guidance-on-mandatory-automatic-enrollment/
[4] *Id.*

DANIEL ARONOWITZ NOMINATED TO LEAD EMPLOYEE BENEFITS SECURITY ADMINISTRATION: A SHIFT IN REGULATORY FOCUS?

Daniel Aronowitz, an executive in management liability insurance, has been nominated by President Donald Trump to lead the U.S. Labor Department's Employee Benefits Security Administration ("EBSA"). If confirmed by the Senate, he will oversee the regulation of health, retirement, and welfare plans that cover around 153 million employees.

Aronowitz is known for his critical perspective on what he refers to as "frivolous" class-action lawsuits aimed at employers. His nomination indicates a potential change in regulatory strategy, focusing on strengthening defenses for businesses against increasing litigation from employees and retirees. Industry leaders and benefits attorneys are optimistic that his leadership could result in a more proactive EBSA in addressing legal challenges faced by plan sponsors.

In recent years, the number of class-action lawsuits against employers has surged, particularly concerning alleged violations of fiduciary conduct standards under federal benefits law. This rise has raised concerns among employers and industry stakeholders, who argue that the current legal environment often forces them to settle claims instead of contesting them in court.

Aronowitz's background is somewhat unconventional for an EBSA chief, as previous leaders typically had significant experience in Washington or direct involvement in employee benefits. His career has focused on providing insurance solutions for plan administrators, especially in relation to the Employee Retirement Income Security Act (ERISA). He currently serves as president of ENCORE Fiduciary, a Virginia-based insurer specializing in fiduciary liability insurance.

In a recent blog post, Aronowitz advocates for the establishment of a specialized court for ERISA cases. He argues that the current legal framework leads to inconsistent rulings on fiduciary issues, resulting in increased litigation costs and uncertainty for plan sponsors. He points to conflicting judicial decisions on similar ERISA matters, suggesting this inconsistency amounts to "regulation by litigation."

He advocates for a dedicated ERISA court to ensure judges possess the necessary expertise, fostering uniformity and predictability in legal standards. Additionally, Aronowitz stresses the importance of higher pleading standards to eliminate meritless lawsuits and suggests implementing a stay of discovery until motions to dismiss are resolved. While he would not have the authority to establish such a court, he could promote legislative reforms to address ERISA-related litigation challenges.

Currently, his nomination is under review by the Senate Committee on Health, Education, Labor, and Pensions. As he awaits Senate confirmation, the potential impact of Aronowitz's leadership on EBSA's regulatory approach remains uncertain. His nomination could mark a new chapter in the agency's relationship with employers and employees alike, as it seeks to balance the interests of plan sponsors with the protections available to beneficiaries.

BATTLE OVER BENEFITS

Employer group takes mental health parity rule to court

On January 17, 2025, the ERISA Industry Committee ("ERIC"), which represents large employers, filed a lawsuit against the U.S. Department of Health and Human Services ("HHS"), challenging the Final Mental Health Parity and Addiction Equity Act ("MHPAEA") Rule that was released in September 2024 by the Departments of Treasury, Labor and HHS ("Departments").

As a background, the MHPAEA was passed in 2008 to prevent group health plans and insurers providing mental health and substance abuse disorder ("MH/SUD") benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits ("M/S"). In 2021, the Consolidated Appropriations Act, 2021 added new obligations for plans to make a comparative analysis of the design and application of nonquantitative treatment limitations ("NQTLs") available to the Departments upon request.

On September 9, 2024, the Departments issued the Final Rule with two implementation dates. As it relates to this lawsuit, effective January 1, 2025, the Final Rule does the following:

1. It requires plans to provide a written list of all NQTLs to a named plan fiduciary;
2. It sets forth specific content requirements for the NQTL comparative analysis; and
3. It requires the named fiduciary to certify that it has selected a prudent service provider to perform the NQTL comparative analysis.

Effective January 1, 2026, the Final Rule does the following:

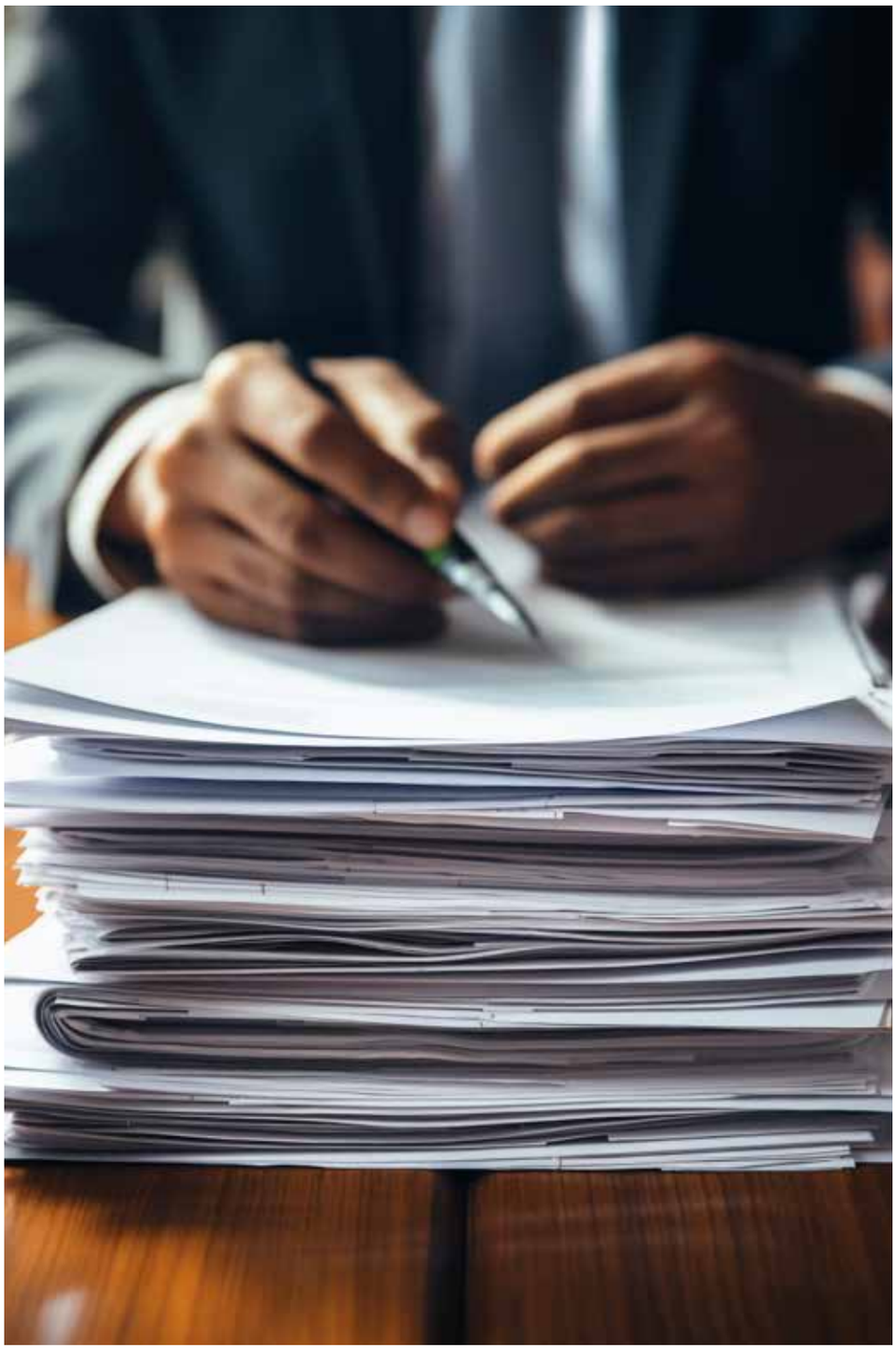
1. Requires plans to offer benefits for MH/SUD conditions to provide "meaningful benefits" for that condition in every classification (such as in-patient hospitalization) that M/S benefits are provided and to offer coverage for a core treatment of that condition. The determination of what constitutes a meaningful standard is based on a comparison with the benefits provide for M/S in the same classification. For example, if a health plan covers hospitalization for heart disease but only provides limited outpatient for major depressive disorder without inpatient options, under the meaningful benefit standards, the plan must make sure that the individuals with the major depressive disorder have access to inpatient mental health treatment if similar hospitalization benefits exist for heart disease in the same classification.
2. Requires plan to examine data, and if the data suggests that NQTLs contribute to a "material difference in access" to MH/SUD benefits, the plan must take reasonable action to address the difference, noting that a material difference is a strong indicator of a MHPAEA violation. For example, if a plan applies strict prior authorization requirements for MH/SUD treatments but not

for M/S treatments, resulting in longer approval times or denial of care, this disparity would result in a material difference in access. To identify these disparities, the Final Rule requires plans to collect and evaluate data on the impact of NQTLs (rates of claim denials, utilization rates, network metrics and provider reimbursement rates). If the data indicates that NQTLs cause a material difference in access to MH/SUD benefits compared to M/S benefits, the plans must take action to correct it.

In its Complaint, ERIC argued, among many allegations, the following:

1. the "meaningful benefits" standard mandates benefits when MHPAEA stipulates that it is not a benefit mandate, and MHPAEA only requires parity in plan terms and the application of the plan terms, it does not impose a disparate (i.e. unintentional) impact standard when deciding parity;
2. the fiduciary requirement is unlawful because Congress did not authorize the mandate in its prior MHPAEA amendments;
3. many parts of the Final Rule concerning "meaningful benefits" and "material differences in access" standards, and the January 1, 2025 effective date are arbitrary and capricious (i.e. random and inconsistent); and,
4. the Departments violated the Administrative Procedure Act ("APA") by overstepping the intent of the MHPAEA and failing to comply with notice-and-comment requirement when it included the above-referenced standards in the Final Rule and failed to allow parties to submit comments prior to the enactment of the Final Rule.

The Final Rule remains in effect and the lawsuit is currently in the briefing stage. After the last year's loss of the *Chevron Doctrine* (the legal principle that directs courts to defer to a federal agency's reasonable interpretation of an ambiguous statute), the Court in this case can give less importance to the Department's interpretations of the Final Rule. This means that ERIC will have a much easier time challenging the Final Rule than it would have a two years ago. Our Office will continue to monitor the litigation.



[1] Reeves, Meredith. *New Lawsuit Challenges Final MHPAEA Rule and Tests Limits of Federal Agency Authority.* Thomson Hine. January 21, 2025.

A NEW ERA FOR MEDICAL PRICING

Understanding President Trump's Executive Order on Healthcare Transparency

The current lack of price transparency plaguing the U.S. healthcare system often leaves patients not knowing the upfront cost of services, which makes it difficult to budget, compare prices, or make informed decisions about treatment and care. Meanwhile, hospitals and insurers negotiate rates behind closed doors, and the actual cost to the consumer varies widely based on location, provider, and insurance coverage, which makes it difficult to determine a standard cost for a procedure.

On February 25, 2025, President Donald Trump signed an executive order titled "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information" aimed at enhancing healthcare price transparency. The order builds upon previous efforts from his administration to make healthcare costs more transparent and accessible to consumers.[1] Key directives of the executive order include:

Enforcement of Existing Transparency Regulations. The order mandates the Departments of the Treasury, Labor, and Health and Human Services ("HHS") to rigorously implement and enforce existing healthcare price transparency regulations, which had experienced delays in enforcement by prior administrations. This includes ensuring that hospitals and insurers disclose actual prices, not estimates, making pricing information comparable across providers and insurers, including estimates for prescription drugs.[2]

Standardization and Accessibility of Pricing Data. Federal agencies are instructed to issue guidance on standardizing pricing information and enforcement policies by May 26, 2025. This effort seeks to make already-required price data more accessible and usable, facilitating meaningful and actionable price information for consumers, employers, and policymakers.[3]

The healthcare industry has expressed concerns that such measures could compromise private negotiations and competitive practices. However, the administration emphasizes that increased transparency will benefit patients by enabling them to make more informed decisions about their healthcare.[4] Consumer pricing in the U.S. medical field is problematic due to several systemic issues:

- **Complex Billing and Hidden Fees.** Medical bills are often difficult to decipher, with multiple charges from different providers for a single procedure. Surprise billing occurs when out-of-network providers, such as anesthesiologists, are involved in a procedure at an in-network hospital.
- **Lack of Competitive Pricing.** In many areas, a few major hospital systems dominate the market, reducing competition and keeping prices high. Pharmaceutical

companies often set high drug prices with limited regulation, making medications expensive.

- **Fee-for-Service Model.** Providers are incentivized to perform more procedures and tests rather than focus on preventive care, leading to higher costs.
- **Insurance Complications.** Insurance policies have different co-pays, deductibles, and out-of-pocket limits, making it hard to predict total costs. Some treatments require pre-approvals, and denied claims can lead to unexpected expenses.
- **High Administrative Costs.** The U.S. spends more on healthcare administration than any other country, driving up costs for patients. Hospitals, insurers, and billing departments require extensive paperwork, adding layers of complexity and expense.

These factors contribute to high and unpredictable costs, making healthcare unaffordable and stressful for many Americans. In response, the U.S. has implemented several healthcare price transparency regulations to empower consumers with clear pricing information. These initiatives reflect a concerted effort to promote transparency in healthcare pricing, enabling consumers to make informed decisions and fostering a more competitive healthcare market. As of March 2025, the following renewed enforcement efforts are underway to ensure adherence to transparency requirements.

Enhanced Enforcement of Existing Transparency Regulations: The Departments of HHS, Labor, and the Treasury have been directed to rigorously enforce existing price transparency rules for hospitals and health plans. This includes ensuring the disclosure of actual prices for items and services, rather than estimates.

Standardization of Pricing Information: Federal agencies are tasked with issuing updated guidance or proposing new regulations to standardize pricing information. This standardization aims to make pricing data easily comparable across hospitals and health plans, facilitating more informed decision-making by consumers.

Updated Enforcement Policies: Guidance or proposed regulatory actions are being developed to update enforcement policies. These updates are designed to ensure compliance with transparency requirements, promoting the reporting of complete, accurate, and meaningful pricing data.[5]

These initiatives build upon previous efforts to promote transparency in healthcare pricing, aiming to empower patients with the information necessary to make informed healthcare decisions and to foster a more competitive and efficient healthcare system.

[1] Thomas Sullivan, *President Trump Signs Executive Order to Boost Healthcare Price Transparency*, Policy & Medicine (Feb. 27, 2025) www.policymed.com/2025/02/president-trump-signs-executive-order-to-boost-healthcare-price-transparency.html.

[2] *Fact Sheet: President Donald J. Trump Announces Actions to Make Healthcare Prices Transparent*, The White House (Feb. 25, 2025) http://www.whitehouse.gov/fact-sheets/2025/02/fact-sheet-president-donald-j-trump-announces-actions-to-make-healthcare-prices-transparent.

[3] Stacy Pogue, *New Executive Order Outlines Next Steps For Health Care Price Transparency*, Health Affairs (Mar. 19, 2025) www.healthaffairs.org/content/forefront/new-executive-order-outlines-next-steps-health-care-price-transparency

[4] Reuters, *Trump Signs Healthcare Price Transparency Executive Order* (Feb. 25, 2025) www.reuters.com/world/us/trump-signs-price-transparency-executive-order-2025-02-25

[5] Michael Lisitano & Conor Duffy, *Trump Administration Issues Executive Order Prioritizing Hospital Price Transparency Enforcement*, Health Law Diagnosis (Feb. 28, 2025), www.healthlawdiagnosis.com/2025/02/trump-administration-issues-executive-order-prioritizing-hospital-price-transparency-enforcement

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