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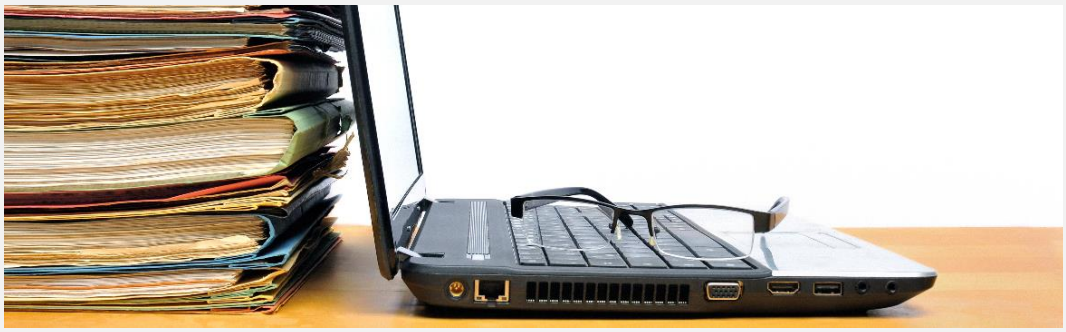

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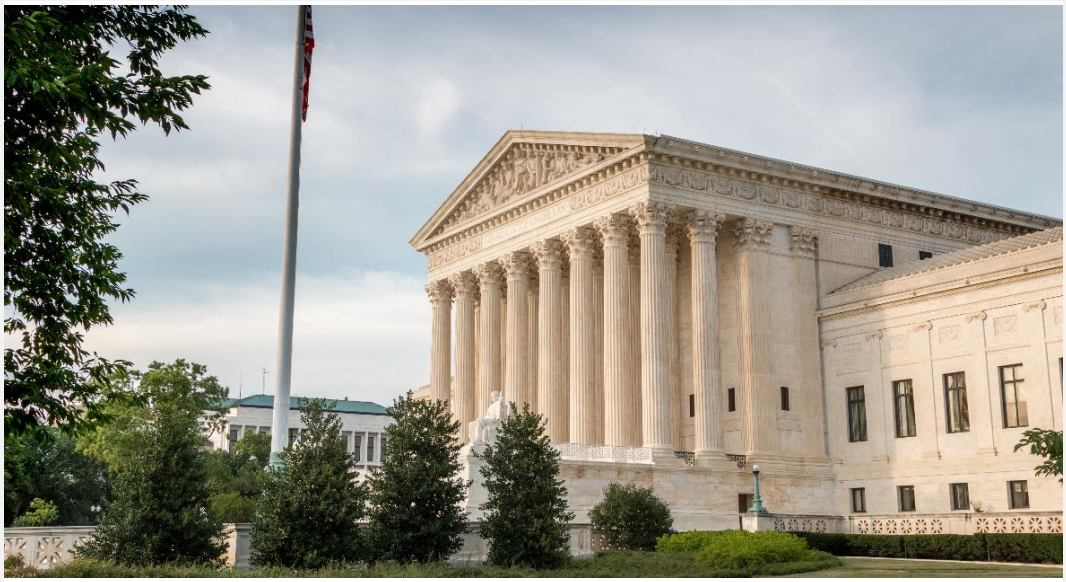

In this Issue:

Pension Risk Transfers Targeted by Wave of Class Action Lawsuits

Three recent lawsuits target employers that have engaged in pension risk transfers, under which the employers transferred billions of dollars in defined benefit ("DB") plan liabilities to insurance companies. These lawsuits have been filed as the Department of Labor ("DOL") is in the midst of developing a report analyzing whether changes to long-standing agency guidance on pension risk transfers is warranted.

Background

Under ERISA, employers are required to act as fiduciaries when selecting an insurance company to take over a DB plan's benefit liabilities. This requirement comes into play when a plan sponsor purchases an annuity from an insurance company to pay remaining DB plan benefits, which shifts the plan's pension benefit liabilities from the plan (and, indirectly, the Pension Benefit Guaranty Corporation) to the insurance company. This practice, often called a "pension risk transfer," has become more common in recent years as companies face challenges in maintaining their DB plans due in part to high administrative costs and funding volatility, coupled with the general trend away from DB plans and toward defined contribution plans. Despite the controversy that has surrounded these transfers because of the employer shifting its plan liabilities to another entity, it has not been shown that pension risk transfers have adversely affected participants' benefits.

In 1995, DOL published guidance for employers transferring DB plan liability to an insurance company. Interpretive Bulletin ("IB") 95-1 requires fiduciaries choosing an annuity provider for this purpose to take steps that are calculated to obtain the "safest annuity available." IB 95-1 contains a number of requirements that an employer must follow in order to meet the "safest annuity available" threshold, including conducting a thorough and analytical search for identifying and selecting an insurance company and evaluating certain factors, such as the insurance company's creditworthiness.

Section 321 of the SECURE 2.0 Act of 2022 ("SECURE 2.0") requires DOL to review IB 95-1, determine whether any amendments are warranted, and submit a report on its findings to Congress. While SECURE 2.0 required the report to be completed by December 29, 2023, DOL has not yet released it.

Lawsuits

In March 2024, three class action lawsuits were filed in quick succession against large employers and their investment managers for engaging in a pension risk transfer with respect to the employers' DB plans. Two of the cases were brought by separate plaintiffs against a large telecommunications company and the company's investment manager, alleging that they breached their fiduciary duties to the plan by selecting an insurance company that did not meet the "safest available annuity" requirement of IB 95-1. According to the complaints, the company's May 2023 pension risk transfer resulted in a transfer of $8 billion in pension liabilities to the insurer for 96,000 retirees and beneficiaries. The complaints are not specific about why the plaintiffs believe the transaction did not meet the safest available annuity standard, but the plaintiffs do argue that the insurer was not a safe or reasonable choice of annuity provider.

A third suit targets a defense company and contains very similar claims to the other lawsuits discussed above. The plaintiffs are challenging the $9 billion in pension risk transfers that the company has entered into since 2021.

While these lawsuits are still in the very early stages, each has the potential to add roadblocks for employers considering pension risk transfers. However, in previous cases of this type many employers have succeeded in getting the claims dismissed by producing documentation establishing that the requirements of IB 95-1 were satisfied. Employers who are currently thinking about, or in the process of, a pension risk transfer should follow the lessons of those cases and carefully document the steps they are taking to comply with IB 95-1.

Final Rules Omit Most Proposed Changes to Tax and Other Rules for Hospital Indemnity and Critical Illness Plans

Last summer, the Departments of Health and Human Services, Labor, and Treasury ("Departments") issued proposed regulations that would have significantly changed the tax rules for health-related supplemental benefit plans, as well as the criteria for hospital indemnity and other fixed indemnity plans to be "excepted benefits" and thus not subject to the ACA's group health plan mandates. The Departments have decided not to finalize most of those proposals at this time, although future rulemaking addressing these issues is possible.

Background

As reported in RPI 2023-15, the sprawling proposed regulations the Departments issued last year ("2023 proposed regulations") addressed issues related to short-term limited duration insurance (STLDI), the tax treatment of health-related supplemental benefits plans (e.g., hospital indemnity and critical illness plans) issued in the group market, and the requirements for hospital indemnity and other fixed indemnity plans to be "excepted benefits" in both the group and individual markets.

The Departments received more than 15,000 comments on all aspects of the 2023 proposed regulations from a variety of stakeholders. After reviewing those comments, the Departments published a final regulation in the April 3, 2024 edition of the Federal Register. While the final regulation adopted the STLDI proposals with relatively minor modifications, the changes to the excepted benefit rules were modified significantly. And the proposed tax changes were dropped entirely, at least for now.

The remainder of this article will focus just on the tax and group market excepted benefit issues.

"Excepted Benefit" Rules

Hospital indemnity, other fixed indemnity, and critical illness plans offered in the group market generally must satisfy certain requirements in order to be "excepted benefits" for purposes of the Code, ERISA, and the Public Health Service Act ("PHSA"). In general, they may not be coordinated with any group health plans. Also, in the case of hospital indemnity and other fixed indemnity plans (but not critical illness plans), the benefit must be a fixed dollar amount per day (or other period) of hospitalization or illness, regardless of actual medical expenses incurred.

The proposed regulations would have added to the requirements for hospital indemnity and fixed indemnity plans by explicitly requiring that the fixed dollar amount could not be based on –

- Services or items received,
- Severity of illness or injury, or
- Other characteristics particular to a course of treatment.

Additionally, the proposed regulations would have added examples of improper coordination between these plans and other group health plans, as well as a mandatory notice requirement.

The final regulations include a new mandatory notice requirement, but otherwise do not include any other proposed changes to the excepted benefit rules for these products offered in the group market.

For plan years beginning on or after January 1, 2025, hospital indemnity and other fixed indemnity policies will not be excepted benefits unless, in addition to other applicable requirements, the plan or issuer prominently displays on the front page of "any marketing, application, and enrollment materials that are provided to participants at or before the time participants are given the opportunity to enroll in the coverage," a notice specified in the final regulation. The standardized notice, which basically informs participants that the policy is not comprehensive health insurance coverage and thus is not subject to various federal consumer protections, must be printed in at least 14-point font.

No Changes to Tax Rules

In a nutshell, hospital indemnity, critical illness, and other types of fixed indemnity plans pay benefits based on the occurrence of a health-related event – such as hospitalization or a cancer diagnosis – regardless of whether the policyholder actually incurred out-of-pocket medical expenses, or the amount of such expenses.

In the proposed regulations, which were issued last July, Treasury and IRS took the position that the Code Section105(b) gross income exclusion generally does not apply to any payments from these plans, even if the policyholder incurred substantiated out-of-pocket medical expenses that equaled or exceeded the benefit amount. IRS has taken a similar position in past sub-regulatory guidance.

As noted, Treasury decided not to adopt these proposed changes at this time.

What's Next?

According to the preamble to the final regulation, Treasury and IRS are still planning to address the tax treatment of these types of benefits in future guidance. The preamble also indicates that Treasury and IRS continue to take the position that the proposed regulations represented the right interpretation of how the Code section 105(b) exclusion applies to these types of benefits, and that no contrary inference should be drawn from the decision not to finalize the proposals at this time.

Also of note, the preamble points out that Treasury and IRS understand that employers that offer hospital indemnity and other fixed indemnity products typically require employees to pay the premiums with after-tax dollars. By going this route, employers generally can avoid any questions about how benefit payments will be treated for income and employment tax purposes.

Similarly, the preamble states the Departments plan to take up the excepted benefit requirements again in future rulemaking. In the meantime, according to the preamble, plans and issuers "should not assume that current market standards that are inconsistent with" the other proposed changes are in compliance "with the existing Federal regulations that apply to fixed indemnity excepted benefit coverage."

Report Finds that Many States Fail to Comply with Medicaid Managed Care Mental Health Parity Requirements

A recent report by the U.S. Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") found that all eight states it selected for audit failed to comply with Medicaid managed care mental health and substance use disorder ("MH/SUD") parity requirements, and that the Centers for Medicare & Medicaid Services ("CMS") failed to properly monitor the states to ensure that those requirements were met.

Background

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") generally prevents group health plans and health insurance issuers that provide MH/SUD benefits from imposing less favorable benefit limitations than are imposed on medical/surgical benefits. Under regulations issued in 2016, states and their Medicaid managed care organizations ("MCOs") – insurance companies contracted by a state to manage the state's Medicaid system – are also required to comply with the MH/SUD parity rules. Specifically, the regulations require states' MCO contracts to include provisions for services to be delivered in compliance with MH/SUD parity requirements, and either states or their MCOs must conduct parity analyses to assess whether those requirements are actually being met. The MH/SUD analyses require an examination of several factors, including whether quantitative treatment limitations (e.g., annual, lifetime, and visit limits) and nonquantitative treatment limitations (e.g., limitations on benefits based on medical necessity) are applied equally to

MH/SUD and medical/surgical benefits. According to CMS, as of 2022, 43 states used MCOs to deliver services to Medicaid enrollees. CMS is required to review and approve all MCO contracts, including reviewing whether a contract contains the required MH/SUD parity provisions and, if applicable, reviewing states' parity analyses.

Report

A report published on March 28, 2024 by HHS's OIG concluded that CMS did *not* ensure that the eight states selected for study complied with Medicaid managed care MH/SUD parity requirements. Specifically, the OIG found that all eight states' contracts with Medicaid MCOs did not contain the required parity provisions by the required date (October 2017, when the 2016 regulations went into effect). The OIG also concluded that five states and their MCOs did not conduct the required parity analyses, and all eight states did not make documentation of compliance available to the public by the required date.

According to the report, MCOs in two states applied financial requirements, and MCOs in six states applied quantitative treatment limitations for MH/SUD benefits that were more restrictive than those for medical/surgical services in the same classifications. In addition, all eight states imposed nonquantitative treatment limitations on MH/SUD benefits that were more stringent than those for medical/surgical benefits in the same classifications, in violation of MHPAEA.

To address the failures identified in the report, OIG recommended that CMS improve its oversight of states' compliance with MH/SUD parity requirements, including by strengthening its follow-up procedures with the states and requiring states in which MCOs are responsible for the parity analyses to submit information that the MCOs provided regarding parity requirements. OIG also recommended that CMS require states to improve their monitoring of MCOs with respect to MH/SUD compliance.

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