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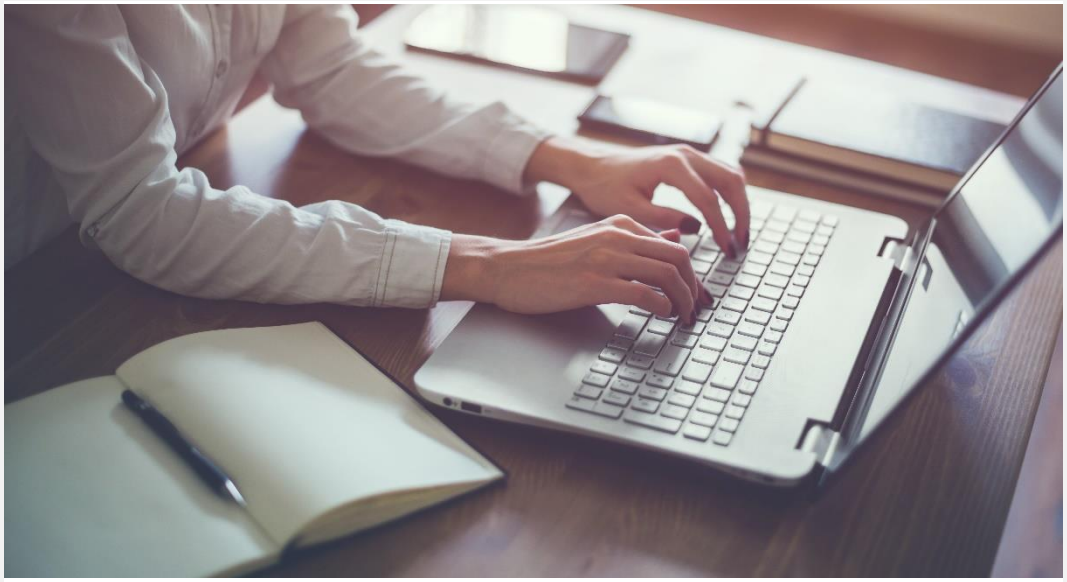
United States | Human Capital | 18 April 2025

Rewards Policy Insider
2025-08



In this Issue:

DOL Provides Guidance on SECURE 2.0 Changes to the Pension Plan Annual Funding Notice

Just ahead of the deadline for calendar year pension plans to provide their 2024 Annual Funding Notice (AFN) to participants, but probably still a bit too late to be as helpful as plan sponsors and administrators would like, the Department of Labor's Employee Benefits Security Administration released Field Assistance Bulletin (FAB) 2025-02 on April 3, 2025. The purpose of the FAB is to provide guidance on changes to the AFN enacted pursuant to SECURE 2.0, that are effective for plan years beginning after December 31, 2023. That means that the first AFN that must comply with the new rules is for the 2024 plan year, which is due April 30, 2025 for large calendar year plans.

In addition to the FAB, the DOL also published an updated model notice that plans can rely on to meet the updated AFN requirements. However, the model notice may be too late for plans that have already printed and/or sent their AFNs for 2024. Unfortunately, the FAB also provides that plans may no longer rely upon the previous model notice (which generally applies to notice years beginning in 2023 or earlier) for the 2024 notice year.

Background

Defined benefit plans that are insured by the Pension Benefit Guaranty Corporation (PBGC) must provide the AFN to the PBGC, participants, and beneficiaries (among other recipients) by no later than 120 days after the end of the plan year. A later due date applies for plans with 100 or fewer participants.

The purpose of the AFN is to provide participants, beneficiaries, and the PBGC an overview of the plan's funded status. For participants and beneficiaries, it also provides information about the extent of PBGC's benefit guarantees in the event the plan is unable to meet its obligations.

SECURE 2.0 made a number of changes to content requirements for AFNs. For example, the requirement to provide the plan's funding target attainment percentage (FTAP) for the notice year and the 2 immediately prior years is replaced by a requirement to disclose the "percentage of plan liabilities funded" for the same period. And in addition to including a statement of the plan's funding policy and asset allocation, SECURE 2.0 also requires plans to disclose the average return on plan assets for the notice year. The FAB provides 2 safe harbor methods for calculating the average rate of return for this purpose.

Summary of FAB 2025-02 Guidance

Although SECURE 2.0's changes to the AFN content requirements are generally meant to streamline the information that the AFN must include, they did raise some questions about how to comply with the new rules.

Replacing FTAP with "percentage of plan liabilities funded." The "percentage of plan liabilities funded" is stated as a ratio between the fair market value of plan assets on the last day of the plan year and the value of plan liabilities as of the last day of the plan year using a "market-related interest assumption." The FAB clarifies that plans can use "reasonable estimates, based on standard actuarial techniques, to determine year-end plan liabilities for the notice year, but not the 2 preceding years." Additionally, the FAB confirms the AFN only has to include this information once, in spite of duplicative statutory requirements.

Disclosure of "at-risk" liabilities. The FAB also confirms that SECURE 2.0 eliminated the requirement for plans to disclose "at-risk" liabilities if the plan is "at-risk" under the current pension plan funding rules. In general, a plan is "at-risk" when it fails to satisfy certain statutory funding thresholds. When a plan is "at-risk," the plan sponsor generally cannot fund any nonqualified deferred compensation for certain "applicable employees."

Estimated participant counts. Before Secure 2.0, the AFN was required to include certain demographic data as of the valuation date (typically the first day of the plan year) for the notice year. However, SECURE 2.0 amended the rule to require the AFN to provide the number of participants and beneficiaries as of the end of the year. Given the relatively short turnaround from the end of the plan year until the AFN is due, the FAB specifies that estimated participant counts are permitted. Specifically, according to the FAB: "[T]he Department is of the view, pending additional guidance, that a plan administrator of a large plan will not be considered in violation of section 101(f)(2)(B)(iii) of ERISA if it uses a reasonable, good faith estimate of the number of participants and beneficiaries for the counts for the notice year. With respect to the 2 preceding plan years, however, the plan administrator of a plan of any size must enter the actual number of participants and beneficiaries as of the last day of those plan years in the table." However, "A large plan using a reasonable, good faith estimate of participant and beneficiary counts for the notice year must disclose that those counts reflect such an estimate."

What Does this Mean for the 2024 AFN?

The FAB acknowledges that many plan sponsors may have already sent their 2024 AFN, or are at least very far along in the process of getting them ready to distribute. However, the FAB warns that plans must "consider [this] guidance … in evaluating whether the disclosures were consistent with a reasonable, good faith interpretation of section 101(f), as amended, and to take appropriate corrective action to the extent the plan administrator concludes that the disclosures did not meet that standard."

Update on Pension Risk Transfer Lawsuits

During the last year several class-action lawsuits have been filed against defined benefit (DB) pension plan fiduciaries relating to their decision to transfer certain plan liabilities to a private insurer. Recently, one federal district court ruled that a so-called pension risk transfer

(PRT) case could proceed, while a second granted the defendants motion to dismiss on procedural grounds.

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") required DOL to review IB 95-1, determine whether any amendments are warranted, and submit a report on its findings to Congress.

Cases

The issue in both cases, along with others like them, is whether the plans' fiduciaries failed to satisfy the "safest annuity available" standard when selecting an annuity provider. The annuity provider in both cases is the same, and the allegations focus in part on the fact that the annuity provider is owned by an offshore private equity company as opposed to a more traditional life-insurance company.

Neither of the courts involved in either case reached this substantive issue in their most recent decisions. Instead, the immediate questions related to whether the plaintiffs had legal standing to sue.

In the first case, the U.S. District Court for the District of Maryland found the plaintiffs did have standing because their allegations relating to the annuity provider's "risky" practices raised the "very real possibility" of imminent harm to the participants.

By comparison, in the second case the U.S. District Court for the District of Columbia ruled that the plaintiffs' monthly annuity payments had not been affected, and thus they had not been harmed. As a result, the district court granted the defendant's motion to dismiss the case.

Outlook

With at least one case surviving a motion to dismiss and others like it still pending, DB plan sponsors that are considering PRT transactions will want to pay close attention to how the courts end up interpreting and applying the "safest annuity available" standard. In the meantime, sponsors and fiduciaries should review the complaints to understand the specific concerns raised in the various lawsuits so that they can take steps to mitigate the related risk as part of their own due diligence processes.

District Court Dismisses Lawsuit Against Group Health Plan Fiduciary Based on its Use of a PBM

A Minnesota district court dismissed a lawsuit against an employer alleging that the company mismanaged its group health plan and caused employees to overpay for prescription drugs as a result of contracting with a pharmacy benefit manager ("PBM"). The court found that the plaintiffs did not have standing to bring the lawsuit because their claims that they were harmed by the alleged mismanagement were speculative.

Background

In July 2024, a group of former employees of the company filed a lawsuit claiming that the company mismanaged its health plan, allegedly causing the employees to overpay in premiums and out-of-pocket costs for certain prescription drugs. According to the plaintiffs, the company agreed to pay its PBM high prices for drugs that were available at much lower prices. For example, the plaintiffs claimed that one generic drug used to treat multiple sclerosis could be filled – even without insurance – at a number of local pharmacies for up to $900. But the company allegedly agreed to make the plan and its participants pay over $9,000 for the same drug, which the plaintiffs claimed benefited the PBM.

The lawsuit also claimed that the company paid excessive administrative fees to the PBM and squandered its bargaining power that it should have used to lower those fees.

The plaintiffs alleged that all of these actions caused the company, in its capacity as a fiduciary of its group health plan, to violate its fiduciary duties under ERISA.

District Court Dismisses Case

On March 24, 2025, the U.S. District Court for the District of Minnesota dismissed the case. The court concluded that the plaintiffs lacked standing – i.e., they did not have the right to bring the lawsuit in the first place – because they had not shown that they had suffered concrete harm that the court could remedy. The court pointed out that only a small subset of drugs covered by the plan had the extreme price differences that the plaintiffs highlighted in their complaint.

The court also explained that the plaintiffs would not benefit from any equitable relief the court could grant, such as replacing the plan's PBM, because all of the plaintiffs were former participants of the plan. Similarly, the court found that the allegations of excessive administrative fees should be dismissed because it was speculative that the allegedly excessive fees had any effect at all on the costs the plaintiffs paid. Despite dismissing the case, the court said that it was sympathetic to the plaintiffs and understood their frustration about the high cost of prescription drugs.

Outlook

This case is just one of many similar lawsuits that have been brought against health plan sponsors alleging that plan participants are paying higher prices to the benefit of PBMs profit. Health plan sponsors should ensure that they can demonstrate they have compared fees and costs and negotiated appropriate terms and fees with their service providers, such as PBMs.

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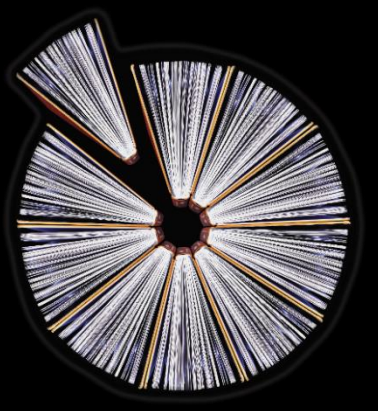

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