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GRS INSIGHT

Pension Plans Legislative Update

IN THIS ISSUE

Proposed Legislation

Two Senate committees passed bills this summer with provisions that impact retirement plans. These Senate bills generally do not contain significant new governmental provisions, but they do retain the various governmental provisions contained in the House-passed *Securing a Strong Retirement Act* (SECURE 2.0).

On June 15, 2022, the Senate Health, Education, Labor and Pensions (HELP) Committee marked up and unanimously approved its version of SECURE 2.0, the *Retirement Improvement and Savings Enhancement to Supplement Healthy Investments for the Nest Egg (RISE and SHINE) Act.*

The HELP Committee bill focuses on retirement provisions within the committee's jurisdiction, with notable provisions applicable to governmental plans including: 1) an extension of current law allowing the transfer of assets from an overfunded pension plan to retiree health accounts under Internal Revenue Code (Code) Section 420; 2) an increase to the limit for mandatory distributions (where no member election/ consent is received) from $5,000 to $7,000; and 3) clarification regarding a cash balance plan's use of a variable interest crediting rate that would allow for larger pay credits for older longer service workers.

The Committee approved two amendments during the markup including:

1) an amendment from Sen. Tina Smith (D-MN) to recognize qualified domestic relations orders (QDROs) from tribal governments; and
2) an amendment from Sen. Roger Marshall (R-KS) to require the Department of Labor to study the impact of inflation on retirement savings and submit a report to Congress within 90 days.

In addition, on June 22, 2022, the Senate Finance Committee unanimously approved its SECURE 2.0 bill, the *Enhancing American Retirement Now (EARN) Act*. The Committee released its conceptual Chairman's Mark, as well as a section-by-section summary in advance of the markup. The Finance Committee operates differently than most committees in Congress, in that it holds "conceptual markups" during which lawmakers review and approve legislative concepts rather than bill text. Bill text is then drafted after the Committee has approved the conceptual mark.

The EARN Act includes many popular and impactful provisions including:

- Increasing the required minimum distribution (RMD) age from age 72 to age 75;
- Increasing the catch-up contribution limit for individuals under certain types of employer-sponsored retirement plans (including 401(k) plans, 403(b) plans and governmental 457(b) plans) that would attain age 60, age 61, age 62 or age 63 by the end of the taxable year;
- Relaxing the restrictions on increasing annuities post-retirement;

- Reducing the excise tax for the failure to take RMDs;
- Expanding the self-correction program under the IRS Employee Plans Compliance Resolution System (EPCRS);
- Allowing 403(b) plans with custodial accounts to invest in collective trusts; and
- Expanding the exception to the Code Section 72(t) early withdrawal tax for qualified public safety employees in governmental plans to include separation from service after the earlier of age 50 or 25 years of service and to include certain corrections officers.

Congressional staff has worked through the summer on combining the EARN Act with the RISE and SHINE Act and then reconciling the Senate legislation with the House-passed SECURE 2.0. Assuming they can develop a comprehensive agreement, the goal is to try to add the package to a must-pass bill before the end of the 117th Congress on January 3, 2023.

Amendment Extensions

On August 3, 2022, the IRS issued Notice 2022-33 which provided some welcome relief relating to amendments due under the *Setting Every Community Up for Retirement Enhancement Act of 2019 (SECURE Act), the Bipartisan American Miners Act of 2019 (Miners Act), and the Coronavirus Aid, Relief, and Economic Security Act* (CARES Act).

Specifically, Notice 2022-33 extends the deadline to adopt amendments for certain provisions under these acts as follows:

- For governmental qualified and 403(b) plans, the amendment deadline is extended until 90 days after the close of the third regular legislative session of the legislative body with the authority to amend the plan that begins after December 31, 2023.
- For governmental 457(b) plans, the amendment deadline is extended until the later of: 1) 90 days after the close of the third regular legislative session of the legislative body with the authority to amend the plan that begins after December 31, 2023; or 2) the first day of the first plan year beginning more than 180 days after the date of notification by the IRS that the plan was administered inconsistent with Code Section 457(b), if applicable.

These extensions apply to amendments due under the SECURE Act, which, for governmental defined benefit plans, is generally limited to an amendment to increase the required minimum distribution age from age 70½ to age 72. The extension also applies to the amendment to lower the age at which in-service distributions are permitted under pension plans from age 62 to age 59½ under the Miners Act (if implemented). For the CARES Act, this extension is limited to amendments relating to the 2020 required minimum distribution waiver – for governmental plans, other CARES Act amendments (i.e., coronavirus-related distributions and loans, if implemented) remain due by the end of the 2024 plan year.

Actuarial Equivalence Assumptions Litigation Update

As discussed in prior issues of *GRS Insight*, defined benefit plan sponsors have been facing a growing risk of litigation regarding their plan's actuarial equivalence assumptions. Since 2018, an increasing number of putative class action lawsuits have been filed against plan sponsors and fiduciaries.[1]

[1] *Masten v. Metropolitan Life Ins. Co.*, 1:18-cv-11229 (S.D.N.Y. Dec. 3, 2018); *Martinez Torres v. Am. Airlines, Inc.*, 4:18-cv-00983 (N.D. Tex. Dec. 11, 2018); *DuBuske v. PepsiCo, Inc.*, 7:18-cv-11618 (S.D.N.Y. Dec. 12, 2018); *Smith v. U.S. Bancorp*, 0:18-cv-03405 (C.D. Minn. Dec. 14, 2018); *Smith v. Rockwell Automation, Inc.*, 2:19-cv-00505 (E.D.Wis. Apr. 8, 2019); *Duffy v. Anheuser-Busch Companies, LLC,* 4:19-cv-1189 (E.D.Mo. May 6, 2019); *Herndon v. Huntington Ingalls Industries, Inc.,* 4:19-cv-00052 (E.D. Va. May 20, 2019); *Cruz v. Raytheon Company,* 1:19-cv-11425 (D. Mass. Jun. 27, 2019); *Belknap v. Partners Healthcare System, Inc.,* 1:19-cv-11437 (D. Mass. June 28, 2019); *Eliason v. AT&T, Inc.,* 3:19-cv-06232 (N.D.Cal. Oct. 1, 2019); *Brown et al. v. United Parcel Service of America, Inc. et al.,* 1:20-cv-00460 (N.D.Ga. Jan. 31, 2020); *Brown et al v. United Parcel Service of America, Inc. et al,* 1:22-cv-01672 (N.D.Ga. Apr 27, 2022); *Knight v. International Business Machines Corporation et al,* 7:22-cv-04592 (S.D.N.Y. Jun 02, 2022); *Adams et al v. U.S. Bancorp et al,* 0:22-cv-00509 (D. Minn. Feb 28, 2022); *DuVaney v. Delta Airlines, Inc. et al,* 2:21-cv-02186 (D. Nev. Dec 10, 2021); *Duke v. Luxottica U.S. Holdings Corp. et. al.,* 2:21-cv-06072 (E.D.N.Y. Nov 01,2021); *Pedersen et al v. Kinder Morgan, Inc. et al,* 4:21-cv-03590 (S.D. Tex. Nov 02, 2021); *Urlaub et al v. CITGO Petroleum Corporation et al,* 1:21-cv-04133 (N.D. Ill. Aug 03, 2021); *Berube v. Rockwell Automation Inc et al,* 2:20-cv-01783 (E.D. Wis. Dec 02, 2020); *Scott v. AT&T Inc. et al,* 3:20-cv-07094 (N.D. Cal. Oct 12, 2020); *and Drummond v. Southern Company Services, Inc.,* 2:22-cv-00174-RWS (N.D. Ga. Sep. 02, 2022).

These lawsuits primarily allege that the plan violates ERISA's requirement to provide "actuarially equivalent" benefits by using outdated mortality tables to calculate the optional forms of benefits of the class members. The plaintiffs allege that if the mortality tables set by the Secretary of the Treasury for purposes of calculating the present value of a benefit pursuant to Internal Revenue Code (Code) Section 417(e)(3) were used instead, the class members would receive a greater monthly benefit.

Plaintiffs generally also bring claims against the plan fiduciaries for breach of fiduciary duty for failure to follow the requirements of ERISA, specifically, ERISA's actuarial equivalence requirement. As noted previously, while these cases allege violations of ERISA requirements, those claims rely on the Code's requirement that actuarial equivalence assumptions be reasonable, potentially expanding the implications of these cases into the governmental defined benefit plan space.

To date, a majority of these lawsuits have either been tossed on a motion to dismiss or subject to a settlement between the parties. The reasons for dismissal vary, including the failure to adequately plead the alleged violation of ERISA or the failure by the participants to exhaust the plan's administrative remedies prior to filing suit. Cases have also taken different paths after a dismissal, such as the filing of a new complaint after curing the procedural deficiency or the pursuit of a settlement.

Where a case has settled, the settlement terms have generally remained private. However, a few court-approved settlements are public. One such settlement saw the company agreeing to pay approximately $59 million to participants and beneficiaries. In another, the company agreed to pay $2.8 million to participants and beneficiaries and to update the plan's mortality assumptions.

These cases have also forced courts to examine a number of different issues, including the requirements imposed on plans by ERISA's anti-forfeiture provision, whether ERISA requires the use of "reasonable" or "current" actuarial assumptions when calculating actuarially-equivalent optional forms of benefits like joint and survivor annuities or early retirement benefits, and whether proper relief is being sought by the plaintiffs in their pleadings.

The divergent paths taken by these cases broadens their potential reach and impact. While ERISA does not apply to governmental defined benefit plans, maintaining an understanding of these cases is warranted, as some of the claims may apply or have analogous application for governmental defined benefit plans.

Health Legislative Update

On August 16, 2022, President Biden signed the *Inflation Reduction Act of 2022*[2] (the Act) which includes a number of provisions addressing climate, health care and tax issues. The key health benefits provisions are highlighted below.

Health Provisions

Extension of ACA Subsidies

The *Affordable Care Act* (ACA) premium tax credit that was included on a temporary basis as part of the *American Rescue Plan Act*[3] is extended by three years, until 2025. This provision continues: 1) the extension of the ACA premium tax credits to those above 400% of the federal poverty level; and 2) the increased amount of the credits for eligible individuals.

Medicare Prescription Drug Pricing Negotiations and Manufacturer Rebates

The Act allows Medicare to negotiate the price of certain high-cost prescription drugs with no generic or biosimilar drug, and imposes an excise tax on drug manufacturers that do not comply with the negotiated price. The Act limits the number of negotiated drugs to:

- 10 Part D drugs in 2026;
- 15 Part D drugs in 2027;
- 15 Part B and Part D drugs in 2028; and
- 20 Part B and Part D drugs in 2029 and later years.

Beginning in 2025, the Act establishes a $2,000 cap on annual out-of-pocket prescription drug costs for Medicare Part D beneficiaries. Beginning in 2023, the Act also requires prescription drug manufacturers to pay a rebate to Medicare if certain Medicare Part B drug prices rise faster than inflation. Manufacturers that do not comply are subject to civil monetary penalties.

[2] Public Law 117-169.
[3] Public Law 117-2.

HSA Safe Harbor for Insulin

The Act creates a new statutory safe harbor that allows health savings account-compatible, high deductible health plans (HDHPs) to provide pre-deductible coverage for insulin products. The safe harbor applies to "selected insulin products" in any dosage form (e.g., vial, pump, or inhaler) of any type (e.g., rapid-acting, short-acting, intermediate-acting, long-acting, ultra-long-acting, and pre-mixed). It is effective for plan years beginning after December 31, 2022. The new safe harbor codifies and builds on relief previously provided by the IRS in Notice 2019-45, which provides that insulin and other glucose-lowering agents are "preventive care" when prescribed for individuals with diabetes if certain other requirements are met. The Act also caps the price of insulin for Medicare beneficiaries at $35 per month.

Proposed Regulations on the Premium Tax Credit "Family Glitch"

On April 7, 2022, the IRS published proposed regulations regarding premium tax credit (PTC) eligibility that are intended to fix the so-called "Family Glitch." Individuals are generally not eligible for the PTC if they are eligible for coverage under an employer plan that is affordable and provides minimum value. Under the 2015 regulations, coverage is not affordable for either the employee or the employee's family member if the portion of premium the employee is required to pay for self-only coverage exceeds 9.5% (indexed; 9.61% in 2022) of household income. The Biden Administration and other commentators have referred to this as the "Family Glitch," because family members may be ineligible for the PTC even if the cost for family coverage under the employer's plan exceeds 9.5% (indexed) of household income.

On January 28, 2021, the Biden Administration issued Executive Order 14009, *Strengthening Medicaid and the Affordable Care Act* (ACA), which directed the Secretary of Treasury to: 1) review existing regulations to determine whether they are consistent with the policy to protect the ACA; and 2) examine policies or practices that may reduce the affordability of coverage or financial assistance for coverage, including dependents. In response to this executive order, the IRS reviewed the PTC regulations.

The "Fix" in the Proposed Regulations

Under the new proposed regulations, affordability of employer coverage for the employee's family members is determined based on the cost of coverage for the employee and those family members, rather than the cost of self-only coverage.

Impact of the Proposed Regulations on Employers

The proposed regulations do not make any changes to the affordability rules for employees which is still determined based on the cost of self-only coverage. Thus, the proposed regulations do not directly impact the employer mandate penalty since only an employee's, and not a family member's, receipt of a PTC can trigger the penalty. However, more employees may choose to purchase exchange coverage since their family members could newly qualify for a PTC. Also, it is possible that the IRS may revise Form 1095-C to include the cost of family coverage so that the IRS can administer the PTC for the family members.

ACA Section 1557 Nondiscrimination Proposed Rule

On August 4, 2022, the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) published a Notice of Proposed Rulemaking on Nondiscrimination in Health Programs and Activities (Proposed Rule). The Proposed Rule largely reinstates the Obama Administration's Section 1557 requirements, which the Trump Administration had modified.

Section 1557 of the *Affordable Care Act* (ACA) provides that an individual shall not "be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, any part of which is receiving Federal financial assistance…or under any program or activity that is administered by an Executive agency or any entity established" under Title I of the ACA. The specific discrimination that is prohibited under Section 1557 is discrimination on the basis of race, color, national origin, sex, age and disability.

The Proposed Rule would apply to every health program or activity any part of which receives Federal Financial Assistance (FFA), directly or indirectly from HHS. HHS proposes an effective date of 60 days after publication of the Final Rule, except for provisions that require changes to health insurance or group health plan design, which would have an effective date of the first day of the first plan year beginning on or after the year immediately following the effective date of the Final Rule in the Federal Register. Comments on the Proposed Rule are due 60 days after publication.

The key provisions of the Proposed Rule are noted below.

Health Program or Activity

The Proposed Rule returns to a broad interpretation of "health program or activity" including providing or administering health-related services, health insurance coverage, or other health-related coverage. This includes "all of the operations of any entity principally engaged in the provision or administration" of health programs or activities, including health insurance issuers and, generally, services of a third-party administrator (TPA) to a self-funded plan.

Also, the Proposed Rule explains that the regulations do not apply to a covered entity in its capacity as an employer with respect to its employment practices, including its provision of employee health benefits.

Notably, the Proposed Rule does not include group health plans as categorically covered under Section 1557 and its implementing regulations. HHS acknowledges that many group health plans do not receive FFA, and HHS states that it will evaluate complaints against a group health plan on a case-by-case basis.

The Proposed Rule clarifies that TPAs are not liable for discriminatory benefit designs or other conduct that may violate Section 1557 *when* the TPA has no control or responsibility for benefit design or plan terms, but TPAs that develop plan or policy documents or terms that are adopted by the plan sponsor may be held responsible for Section 1557 violations. Similarly, when the alleged discrimination is based on the TPA's administration of the plan and the TPA is the entity responsible for the challenged action, the TPA may be liable.

The Proposed Rule provides that when investigating complaints involving self-funded group health plans, OCR will consider the party responsible for the allegedly discriminatory conduct. OCR also will engage in a fact-specific inquiry to determine whether the TPA is a recipient of FFA and a covered entity for Section 1557 when the TPA is legally distinct from an issuer that receives FFA. If the alleged discrimination originates with the plan sponsor, OCR will refer the complaint to the U.S. Equal Employment Opportunity Commission (EEOC) or the U.S. Department of Justice (DOJ) for potential investigation.

Prohibition on Discrimination

The Proposed Rule prohibits:

- Covered entities from denying, canceling, limiting, imposing additional cost sharing, imposing other limitations on coverage, or refusing to issue or renew health insurance or health-related coverage on the basis of race, color, national origin, sex, age or disability;
- Benefit designs that impermissibly limit coverage based on a person's sex at birth, gender identity, or gender otherwise recorded; and
- Marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age or disability.

The rule provides that discrimination "on the basis of sex" includes discrimination based on sex stereotypes, sex characteristics, pregnancy or related conditions, sexual orientation and gender identity.

The Proposed Rule requests comments on whether to include a provision specifically addressing discrimination based on pregnancy-related conditions and seeks comments on how *Dobbs v. Jackson Women's Health Organization*[4] may impact Section 1557 or the Proposed Rule. Additionally, HHS solicits input on other means to ensure nondiscriminatory access to care.

Notices

The Proposed Rule requires a covered entity to provide a notice of nondiscrimination to participants, beneficiaries, enrollees, and applicants of health programs and activities on an annual basis and upon request. Covered entities also

would be required to provide the notice in a conspicuous location on the health program or activity's website and in prominent physical locations where individuals seeking services could read or hear the notice.

In addition, the Proposed Rule requires covered entities to provide the public and participants, beneficiaries, enrollees and applicants of the covered entity's health program or activity a notice of the availability of language assistance and auxiliary aids and services via written translations or recorded audio or video annually and upon request. The notice of availability must be provided in English and at least the 15 most common languages spoken by Limited English Proficient (LEP) individuals of the relevant states and in alternative formats to ensure effective communications with individuals with disabilities.

The Proposed Rule also identifies a list of documents that *must* include the notice of availability and allows covered entities to allow individuals to opt-out of receiving the notice of availability or elect to receive communications in their primary language, instead of providing the notice of availability.

[4] 142 S. Ct. 2228 (2022).

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