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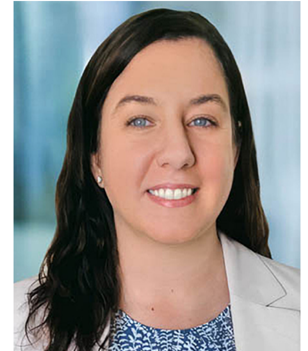
BENEFITS REPORT

New Challenges to Pension Risk Transfers



STEPHANIE PLATENKAMP

APRIL 2024

Plan sponsors have found it increasingly difficult to predict and manage the cost of their defined benefit pension plans ("DB plans") due to fluctuating interest rates, investment returns, increased costs, and participant longevity. As a result, pension de-risking has become a common way for plan sponsors to manage risk and control costs associated with their DB plans. Pension de-risking transactions take several forms, including paying lump sums to participants in a limited window and restructuring the underlying plan investments to reduce risk. Another strategy for de-risking, which has become increasingly popular, involves transferring plan liabilities to an insurance company. In these transactions, plan sponsors purchase annuity contracts from third-party insurers who then assume responsibility for future benefit payments to participants and beneficiaries covered by the transaction. We refer to these transactions as pension risk transfers.

Three class action complaints filed in March reveal that the plaintiffs' bar views pension risk transfers as an area of significant liability for sponsors of DB plans. The lawsuits, *Konya v. Lockheed Martin*, *Piercey v. AT&T* and *Schloss v. AT&T,* potentially signal a new area of litigation in an environment where plan sponsors are increasingly interested in transferring pension risk. The plaintiffs bringing these lawsuits all decry the selection of a specific annuity provider, Athene Annuity & Life Assurance Company of New York ("Athene"), as the fiduciary's wrongdoing. The three lawsuits concern risk transfers involving billions of dollars of pension liability, impacting over 100,000 participants and beneficiaries.

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Selection of Annuity Provider

By way of background, while the decision of whether to engage in a pension risk transfer is a settlor decision (carrying with it no fiduciary liability), courts have long recognized that selection and monitoring of service providers is a fiduciary function that must be carried out with the highest duties of prudence and loyalty. This includes selection of an annuity provider and the selection of the fiduciaries or consultants who recommend or select the annuity provider.

In Intrepretive Bulletin 95-1, the Department of Labor (DOL) provides guidance on the fiduciary standards for selecting an annuity provider. Under this sub-regulatory guidance, plan fiduciaries must select the "safest annuity available" and evaluate the insurer's claims paying ability and creditworthiness by considering six factors: (1) the annuity provider's investment portfolio quality and diversification; (2) the size of the insurer relative to the proposed contract; (3) the level of the insurer's capital and surplus; (4) the insurer's exposure to liability; (5) the structure of the annuity contract and guarantees supporting the annuity; and (6) the availability of additional protection through state guaranty associations.

In the SECURE Act of 2022, Congress directed the DOL to review and determine whether amendments to Interpretive Bulletin 95-1 are warranted, and to report its findings to Congress. The DOL's recommendations were due by the end of 2023, but to date have not been made public.

The safest available annuity guidelines are a critical component to the claims made by the plaintiffs' attorneys in the class action lawsuits and further emphasize the need for the DOL to consider whether updates to Interpretive Bulletin 95-1 are needed.

Class Action Lawsuits

While there is some variation in the complaints, the core allegations against AT&T and Lockheed are that the selection of Athene as an annuity provider was a breach of fiduciary duty and that the transfers were prohibited transactions. The plaintiffs claim the defendants failed to conduct a "sufficiently independent and objective evaluation of available annuity providers" when selecting Athene.

Each of the complaints asserts that the defendants breached their fiduciary duties because Athene is "not the safest available" annuity provider. The plaintiffs also allege a significant risk of "insurance failure," and illustrate this point with the collapse of the A+ rated Executive Life Insurance Company in the early 1990s, when its portfolio cratered amid a bond market meltdown. The plaintiffs go to great lengths to describe Athene as an unsafe annuity provider with a high risk of insolvency relative to other more traditional insurance companies. The plaintiffs point out that since its inception in 2009, Athene has completed 45 pension risk transfer transactions totaling $50.5 billion and covering over 550,000 plan participants. The plaintiffs describe Athene as a "private equity–controlled insurance company with a highly risky offshore structure," adding that, as such, Athene has a corporate culture that is antithetical to the interests of policyholders. The plaintiffs allege that Athene invests in lower quality, higher risk assets, specifically collateralized loan obligations, subordinated debt, and asset-backed securities, among others.

The plaintiffs assert that the selection of Athene was a prohibited transaction based on the allegation that the defendants were disloyal in the selection of Athene; and further, that the defendants received an economic benefit in Athene's selection through reduced premium payments relative to what the defendants would have paid elsewhere (without providing any comparative data to support that choice).

In the two complaints against AT&T, the plaintiffs also allege self-dealing by State Street Global Advisors, the independent fiduciary advising AT&T on the insurer selection process, based on its investments in both AT&T and Athene's parent company, Apollo. Thus, they claim, the transactions were with a party in interest and at substantial risk to participants and beneficiaries.

With other lawsuits challenging fiduciary selection of service providers, the courts have focused on whether fiduciaries have reached a selection outcome through a prudent, deliberative process. Notably, there are, at most, only conclusory allegations about the process the defendants engaged in to select Athene and no information about what the bids of other candidates were.

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The plaintiffs also attack pension risk transfers generally by noting that, with the transaction, the affected participants and beneficiaries lost both ERISA Title I and PBGC protections. This is because, after the transfer, the defendants no longer guarantee the pension benefits covered by the transaction, and benefits are protected only by state guaranty associations. The plaintiffs complain that state guaranty associations are subject to state law limits (rather than one standard limit defined by PBGC) that could "easily" be exhausted by a pensioner.

The plaintiffs seek a disgorgement of profits earned from the allegedly unlawful transaction, and a guarantee of benefits, either through the selection of other "reliable" insurers using appropriate procedures, or through the posting of security.

Practical Considerations

The defendants in these cases have not yet responded to the complaints, and thus the courts have not ruled on whether these claims will continue past the pleading stage. It also remains to be seen how federal regulators will view annuity provider selection, as we wait for the DOL's report on whether to update its 1995 guidance.

Given the attention from the plaintiffs' bar to this area and the uncertainty of whether these arguments will gain traction with the courts, plan sponsors considering a pension risk transfer strategy should work with their professional advisers to monitor developments in these cases and, importantly, undertake a well-documented and prudent process when selecting an annuity provider. Plan sponsors should also carefully consider whether to engage a qualified and independent consultant to review potential candidates and recommend insurers that meet the safest available annuity standard.

Ninth Circuit Court of Appeals Clarifies Pleading Standards Applicable to Suits for Violations of the Mental Health Parity and Addiction Equity Act

STEPHANIE LAO

APRIL 2024

In *Ryan S. v. UnitedHealth Group, Inc.*, 2024 WL 1561668 (9th Cir. Apr. 11, 2024), the Ninth Circuit Court of Appeals recently overturned a California district court's dismissal of a lawsuit brought on behalf of a putative class of group health plan participants against UnitedHealth Group, Inc. and its subsidiaries (collectively, "UHC") alleging violations of the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Employee Retirement Income Security Act of 1974 (ERISA). The Ninth Circuit held that a plaintiff may avoid dismissal by alleging the existence of a procedure used in assessing mental health and substance use disorder (MH/SUD) benefit claims that is more restrictive than those used in assessing medical/surgical claims under the same classification, as long as the allegation is adequately pled. *Ryan S.* provides valuable insight into the pleading standard plaintiffs must meet when alleging violations of MHPAEA's mental health parity requirements.

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Plaintiff's Operative Third Amended Complaint Alleges Violations of MHPAEA and ERISA

On July 11, 2019, plaintiff Ryan S. ("Plaintiff") filed a putative class action against UHC. Plaintiff amended the complaint a total of three times, once as a matter of right and twice on leave from the court. The most recent Ninth Circuit decision addresses Plaintiff's operative Third Amended Complaint (TAC).

The TAC claims that Plaintiff's group health plan, which is insured, managed and administered by UHC, provides coverage for outpatient, out-of-network mental health and substance use disorder (MH/SUD) treatment at all levels of care. The plan allegedly covers these services at 70% of covered charges until the deductible/out-of-pocket maximum is met, at which point the plan pays 100% of the covered charges.

Plaintiff, who is a participant in the plan, alleges that he completed two separate outpatient, out-of-network substance abuse disorder programs and received covered laboratory services in connection with the treatments. On both occasions, the providers obtained the required prior authorizations from UHC. However, according to Plaintiff, UHC either provided limited coverage or refused coverage of the services. The TAC asserts that UHC applied a more stringent review process to outpatient, out-of-network MH/SUD treatment claims than comparable medical and surgical (M/S) treatment claims, and that this disparity in review standa rds violates MHPAEA and ERISA's fiduciary duty of loyalty.

MHPAEA requires, among other things, that any treatment limitations applicable to MH/SUD benefits are "no more restrictive" than those applied to M/S benefits covered by a health plan. MHPAEA differentiates between quantitative treatment limitations and nonquantitative treatment limitations (NQTLs). NQTLs may only be applied to MH/SUD benefits if the internal processes used to apply NQTLs to MH/SUD benefits are no more restrictive than those applied to M/S benefits. The TAC alleges that UHC utilized Algorithms for Effective Reporting and Treatment (ALERT) that proffer a set of criteria which, if not met, subject claims to further peer review which could result in a denial of services.

Plaintiff alleges that ALERT, along with other internal processes, was applied solely to MH/SUD treatments and not to M/S treatments within the same classification. As a result, Plaintiff alleges that UHC refused or limited coverage of his substance abuse disorder treatment based on the impermissible application of ALERT and other internal protocols. In support of the allegations, the TAC cites a 2018 report by the California Department of Managed Health Care, which found UHC violated MHPAEA by applying an algorithm to MH/SUD claims that triggered an additional level of review which could result in denials, but that no additional level or review applied to M/S claims.

The TAC further claims that in violating MHPAEA by applying the ALERT algorithm solely to MH/SUD claims, UHC also violated its fiduciary duty of loyalty to participants under ERISA. The TAC likewise alleges that by refusing to provide coverage for medically necessary MH/SUD treatments, UHC violated the terms of Plaintiff's plan.

UHC's Motion to Dismiss the TAC

In its motion to dismiss, UHC argued that the TAC failed to provide sufficient detail to support a finding that a more restrictive limitation was applied to Plaintiff's MH/SUD claims than to analogous M/S claims, and that Plaintiff's claims were merely conclusory. In addition, UHC argued that Plaintiff failed to sufficiently allege the existence of a "categorical" practice applicable to the denial of his claims and to identify corresponding M/S services to which less stringent internal processes were applied. UHC also argued that Plaintiff could not rely on the cited 2018 report, as the report did not address claim denials related to Plaintiff's case. Further, UHC argued that Plaintiff failed to establish that UHC acted in a fiduciary capacity and failed to allege facts sufficient to show how UHC's alleged practices resulted in the denial of his claims. Lastly, UHC argued that Plaintiff failed to identify the specific plan term conferring the benefit to which Plaintiff claims he was entitled. The district court granted UHC's motion, and Plaintiff appealed.

Ninth Circuit Ruling and Findings

The Ninth Circuit reversed the district court's ruling as to Plaintiff's MHPAEA and ERISA fiduciary breach claims, finding Plaintiff plausibly alleged violations of MHPAEA and

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ERISA. However, the Ninth Circuit affirmed the dismissal of Plaintiff's claims based on a violation of the terms of his plan, finding Plaintiff had failed to identify any specific plan terms that the alleged practices would violate.

The court identified three types of cases involving ERISA plan violations of MHPAEA (*Ryan S.* involves the third type):

- **Facial Exclusion cases**: A plan explicitly excludes types of treatment available for MH/SUD issues that are offered for comparable M/S issues, an exclusion that is discriminatory on its face.
- **As-applied cases**: A plan applies an otherwise facially neutral plan term unequally between MH/SUD and M/S benefits.
- **Internal Process cases**: A plan applies a more stringent internal process to MH/SUD claims than to M/S claims.

The court rejected UHC's position that Plaintiff was required to support the existence of a "categorical practice," finding that handling MH/SUD claims more stringently violates MHPAEA regardless of whether the disparity in treatment results in a uniform denial of claims. Additionally, the court found Plaintiff was not required to specifically identify M/S treatments that received more gracious processing, as UHC had asserted. Instead, the court held it is sufficient for a plaintiff to define an analogous category of claims very broadly, with any other M/S treatment within the same classification being a qualified comparator. The court held that to require a plaintiff, who may not have received M/S treatment in the same classification as their MH/SUD treatment, to determine the process applied to those M/S treatments would "create a serious obstacle to meritorious [MHPAEA] claims."

Ultimately, for a plaintiff to bring an internal process case, it is sufficient to provide facts that indicate the existence of a procedure used in assessing MH/SUD benefit claims that is more restrictive than those used in assessing other claims under the same classification. A denial of claims for MH/SUD benefits by itself would not support an inference that a defendant employed processes in violation of MHPAEA. However, the court found that Plaintiff went beyond this standard by referencing the 2018 report discussed above in addition to his own denied claims, providing the additional context necessary to render Plaintiff's allegations plausible. Since the investigation underlying the report was conducted concurrently with the denial of Ryan's claims — and the report suggests that, at that time, all MH/SUD outpatient claims were subjected to a more restrictive review process — a sufficient nexus existed between the report's findings and the denials in question to support Plaintiff's claims.

The court further held that because Plaintiff sufficiently alleged his MHPAEA claim, so too did he sufficiently allege a breach of fiduciary duty claim. However, the court upheld the dismissal of Plaintiff's claim alleging violation of the plan's terms, on the grounds that Plaintiff failed to identify a specific plan term that UHC failed to follow in its administration of the plan.

Future Considerations

In light of the relatively low pleading standard the Ninth Circuit has set, group health plans and their sponsors, administrators and fiduciaries should pay carefu l attention to the internal processes they utilize in determining coverage for MH/SUD benefits as compared to M/S benefits. The Ninth Circuit's ruling may significantly impact the health care industry, especially with proposed MHPAEA regulations anticipated to be finalized this year. Considering plans have already struggled to provide adequate analyses to demonstrate that internal processes applying NQTLs to MH/SUD coverage were not more restrictive than those applied to M/S coverage, it is likely that defendants utilizing these internal processes will face similar difficulties when scrutinized by courts under the requirements of MHPAEA and the new proposed regulations.

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FIRM NEWS

Joe Faucher and **Brian Murray** co-authored an article, “Prohibited Transactions: Does ERISA Really Mean What It Says?,” which appeared in the Winter 2024 edition of the *Journal of Pension Benefits*.

April 8–9, **Joe Faucher** and **Mary Powell** participated in the ABA Joint Committee of Employee Benefits (JCEB) Government Invitational 2024 — The Expanding Universe of Benefits: Has ERISA Grown With Our World? — in Baltimore, MD. The presentations were as follows:

- **Joe** moderated a session at the ABA Section of Tort Trial & Insurance Practice: *Pension Linked Emergency Savings Accounts*.
- **Mary** moderated a session at the ABA Section of Taxation: *Prescription Drugs.*

On April 17, **Kevin Nolt** spoke at the 403(b) Summit (hosted by SageView) providing a legal update and top compliance issues for 403(b) plans. Kevin also participated on a Q&A panel at the event.

On April 18, **Brad Huss** and **Brian Murray** spoke on *ERISA Litigation: Where to Now?,* addressing recent ERISA litigation trends and other litigation issues of interest, at the Orange County Chapter of the Western Pension & Benefits Council (WP&BC).

On April 25, **Clarissa Kang** participated on the *Mediating Employee Benefit Cases* panel of the American Bar Association (ABA). Topics discussed were best practices and important considerations in mediating employee benefits cases from several perspectives — that of a mediator as well as defense and plaintiff-side attorneys.

On May 2–4, the ABA May Tax Meeting in Washington DC will include several presentations by Trucker Huss attorneys:

- On May 2, **Mary Powell** will participate in the ABA Technical Session's Meeting with IRS & Treasury Recap: *“Grab Bag” of Prescription Drug Plan Issues.*
- On May 3, **Mary Powell** will discuss *The Road Forward: Relationship of Benefit Plans and PBMs,* for the Employee Benefits Welfare Plan, EEOC, FMLA and Leave Issues Subcommittee.
- On May 3, **Angel Garrett** and **Brian Murray** will present for the Employee Benefits Litigation Subcommittee, Litigation Update. Topics include recent litigation and recent developments involving Chevron deference, company stock litigation, ESG considerations relating to plan investments, forfeiture litigation, and more.

On May 7–9, **Clarissa Kang, Mary Powell, Sarah Kanter, Robert Gower** and **Dylan Rudolph** will participate in "ERISA: Beyond the Basics," a multi-day virtual workshop of the ABA Joint Committee on Employee Benefits. **Clarissa** will co-chair the program. The presentations will be as follows:

- On May 7, **Mary** will speak on *Health Plan Design and Compliance Issues Involving Gender-Affirmative Care after* Bostock v. Clayton County.
- On May 7, **Sarah** will be a panelist addressing *ERISA & Tax Considerations for Family-Forming Benefit Plan*s. The panel will cover important ERISA and tax issues associated with offering these benefits.
- On May 8, **Robert** will be a panelist discussing an overview of the proposed Retirement Security Rule unveiled by the Department of Labor in October, 2023.
- On May 9, **Dylan** will be on a panel — *The Next Frontiers of Plan Fee Litigation* — discussing future possibilities for defined contribution plan fee and investment litigation.

On June 6, **Angel Garrett** and **Scott Galbreath** will be presenting at the Capitol Forum on Pensions hosted by the WP&BC Sacramento Chapter:

- **Angel** will participate on the *Pension Litigation Update* panel.
- **Scott** will be speaking on *The Wide World of Corrections*.

The Trucker ✦ Huss Benefits Report is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of Benefits Report are posted on the Trucker ✦ Huss web site (www.truckerhuss.com).

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In response to new IRS rules of practice, we inform you that any federal tax information contained in this writing cannot be used for the purpose of avoiding tax-related penalties or promoting, marketing or recommending to another party any tax-related matters in this Benefits Report.

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