Benefits Counselor – March 2022

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RETIREMENT PLAN DEVELOPMENTS

IRS Publishes Proposed Regulations Regarding Required Minimum Distributions

On February 24, 2022, the Internal Revenue Service (IRS) published proposed regulations addressing the calculation and payment of required minimum distributions (RMDs) under qualified retirement plans (the Proposed Regulations). The Proposed Regulations are generally designed to address the changes to a participant's required beginning date and payment of death benefits enacted under the Setting Every Community Up for Retirement Enhancement Act of 2019 (the SECURE Act). While the proposed regulations are not final, the IRS directs plan sponsors to calculate distributions in accordance with the Proposed Regulations beginning January 1, 2022.

The Proposed Regulations provide additional detail on who qualifies as an eligible designated beneficiary. In particular, the Proposed Regulations provide guidance on how plan sponsors should determine whether a beneficiary has achieved the age of majority, whether a beneficiary is disabled, and whether a beneficiary is chronically ill. The Proposed Regulations also provide extensive rules regarding payment of RMDs to see through trusts, which are designed to allow retirement assets to pass through to a beneficiary following death.

Where a participant dies prior to commencing benefits, the Proposed Regulations confirm that plan sponsors can apply the 10 year rule or the life expectancy rule to an eligible designated beneficiary, provided the plan document is clear regarding the plan terms. For situations where a participant dies after commencing benefits, the Proposed Regulations provide guidance on determining which timing rules should be used to determine payment of death benefits depending on factors, including whether the beneficiary is an eligible designated beneficiary, whether the beneficiary is a minor, and whether there are multiple beneficiaries.

Finally, the Proposed Regulations clarify the portion of death benefit payments that are deemed to be an RMD and provide guidance on how to calculate this portion, noting that it generally depends upon the period of payment. This calculation is vital given that RMDs cannot be rolled over to another eligible retirement plan or individual retirement account.

For an in depth explanation of the Proposed Regulations, please see the alert published on March 4, 2022.

IRS Publishes Updated Form 8950 and Instructions

The IRS has published an updated version of Form 8950, Application for Voluntary Correction Program (VCP) and an updated version of the corresponding instructions. The changes reflect the new anonymous pre submission conference program under the VCP made available in the recent restatement of the Employee Plans Compliance Resolution System (EPCRS).

The EPCRS restatement, published in Revenue Procedure 2021 30, eliminated the ability of plans and their representatives to make anonymous submissions under the VCP and replaced it with the ability to request anonymous pre submission conferences related to certain corrections. Plan sponsors and their representatives may now request such a conference by submitting the updated Form 8950. The updated Form 8950 instructions provide that a request for a pre submission conference should include information regarding the number of participants impacted, the period of time when the failure occurred, an explanation of the method used to compute any earnings owed to participants and a narrative that both proposes a correction and explains why the correction is consistent with the principles of the EPCRS.

Plan representatives should note that the updated instructions require a plan representative requesting a pre submission conference to be designated on a power of attorney by the plan sponsor (or plan administrator in the case of a multiemployer plan), and that the representative must be willing to submit a signed Form 2848, Power of Attorney and Declaration of Representative, with any subsequent VCP submissions.

District Court Grants Summary Judgement to Defendants in Actuarial Equivalence Case

On March 4, 2022, the U.S. District Court for the District of Massachusetts granted summary judgement for the defendant plan sponsor in *Belknap v. Partners Health System*, the latest in a string of actuarial equivalent cases filed against plan sponsors in recent years. The plaintiff in the case was a former employee of the defendant who retired early and began receiving benefits in the form of a joint and survivor annuity. He alleged that the actuarial assumptions the defendant plan sponsor used to determine his benefit were outdated, and thus unreasonable, in violation of the Employee Retirement Income Security Act of 1974 (ERISA). The plaintiff requested that the court certify the suit as a class

action on behalf of all similarly situated participants.

The plaintiff's complaint alleged that the defendant used typical and up to date actuarial assumptions when calculating the value of plan benefits for its internal financial statements, including an interest rate of 3.7 percent and a mortality table from 2000 projected forward to 2014. The complaint further alleged that when calculating the value of optional forms of benefits under the plan, such as joint and survivor annuities, the defendant used an interest rate of 7.5 percent and a 1951 mortality table. The complaint argued that the use of this higher interest rate and older mortality table was unreasonable, and that as a result participants who received their benefits in optional forms were not receiving benefits that were actuarially equivalent to a single life annuity paid at normal retirement age, the standard form of benefit under the plan. The plaintiff's prayer for relief included equitable and declaratory relief for breach of a fiduciary duty by the defendant and recovery of lost benefits.

In its opinion, the court stated that the main issue in the case was whether ERISA's statutory requirement that optional benefits be "actuarially equivalent" to a plan's standard form of benefit required the plan sponsor to use "reasonable" actuarial assumptions when determining actuarial equivalence. The court noted that no subsection of ERISA defines the phrase "actuarial equivalence" or expressly provides that the calculation of actuarial equivalence requires a plan to use "reasonable" assumptions. As far as the court could reason, a plan sponsor fulfilled their legal duties so long as they performed actuarial equivalence calculations according to the actuarial factors provided in the plan document. From a legal standpoint, ERISA neither specified what factors a plan sponsor must use, nor required that those factors be "reasonable" individually or in the aggregate.

Based on this analysis, the court granted summary judgment for the defendants. The decision represents a departure from the reasoning offered by other district courts in recent similar actuarial equivalency suits. Notably, the U.S. District Court for the Northern District of Illinois denied a defendant's motion to dismiss in *Urlaub v. CITGO Petroleum Corporation*, a similar case, on February 22, 2022.

Second Circuit Affirms That Doctrine of Successor Liability May Apply to Withdrawal Liability Claims

In its January 27, 2022, opinion in *New York State Teamsters Conference Pension and Retirement Fund v. C & S Wholesale Grocers, Inc.*, the U.S. Court of Appeals for the Second Circuit became the latest circuit court to hold that the doctrine of

successor liability may be applied to claims for withdrawal liability brought by multiemployer pension plans.

The case focused on two corporate entities. The first, Penn Traffic Company (Penn Traffic), operated several retail grocery stores and warehouses where it stored wholesale groceries for distribution. Employees at one of these warehouses in Syracuse, New York, were represented by Teamsters Local 317, and Penn Traffic contributed to the New York State Teamsters Conference Pension and Retirement Fund (the Fund) on their behalf. The second entity, C & S Wholesale Grocers, Inc. (C & S) was also in the grocery wholesale business. In 2008, C & S acquired most of Penn Traffic's locations and employees, but purposefully did not purchase the Syracuse warehouse or assume employment of its employees because of the potential withdrawal liability associated with the location and employees. Following the transaction, the Syracuse warehouse continued to distribute to the retail grocery stores now owned by C & S pursuant to an independent contractor agreement, under which Penn Traffic retained responsibility for the employees working at the Syracuse warehouse.

In 2009, Penn Traffic filed for Chapter 11 bankruptcy. As a result, the Syracuse warehouse closed the following year, leading the Fund to claim that Penn Traffic owed $63.6 million in withdrawal liability. After only recovering approximately $5 million during Penn Traffic's bankruptcy proceedings, the Fund sought to recover the remaining $58 million in withdrawal liability from C & S.

The Fund's complaint against C & S offered four theories for why withdrawal liability should apply to C & S. The U.S. District Court for the Northern District of New York dismissed three of the theories, but allowed the Fund's claim based on the theory of successor liability to proceed.

Following discovery, the parties filed cross motions for summary judgment. The district court granted C & S's motion, holding that although the doctrine of successor liability could be applied in the withdrawal liability context – a question previously unaddressed in the Second Circuit – the evidence did not show that C & S had substantially continued Penn Traffic's business at the Syracuse warehouse.

On appeal, the Second Circuit affirmed the district court's ruling on all issues. The court analyzed whether the doctrine of successor liability could appropriately be applied to claims for withdrawal liability. The court noted it had previously approved application of the doctrine to claims for delinquent pension fund

contributions under ERISA. It also looked to rulings from the Seventh and Ninth Circuits holding the doctrine could appropriately be applied to claims for withdrawal liability. Finding these factors persuasive, the court held successor liability could be applied to withdrawal liability claims.

Returning to the facts of the case, the court affirmed the district court's ruling that the doctrine of successor liability could not appropriately be applied to C & S. The court again emphasized what it believed to be the key fact in the case – that despite its ongoing relationship with Penn Traffic as an independent contractor, C & S never purchased the Syracuse warehouse or employed the Teamsters members who worked there.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Court Vacates Portions of No Surprises Act's Independent Dispute Resolution Regulations

On February 23, 2022, the U.S. District Court for the Eastern District of Texas vacated key portions of regulations regarding the independent dispute resolution (IDR) process under the No Surprises Act, ruling the regulations violated the Administrative Procedure Act. As a result of the decision, the Departments of Health and Human Services, Labor, and the Treasury (together, the Departments) issued a memorandum stating that while they were considering next steps, all guidance documents which referred to the invalidated portions of the regulations would be withdrawn.

The IDR Regulations and the QPA Presumption

At issue in the challenge was the IDR process, a central component of the No Surprises Act that allows group health plans and insurers and out of network providers who cannot reach an agreement regarding the appropriate price for certain services furnished to a participant to submit the dispute to an IDR entity for arbitration. The No Surprises Act requires both parties to submit a proposed payment amount and explanation to the arbitrator, who must then select one of the two proposed amounts based on numerous factors, including the provider's level of training and experience, the provider's market share, the patient's acuity, and the "qualifying payment amount" (the QPA), as determined for the participant's cost-share amount.

On September 30, 2021, the Departments issued an interim final rule (the Rule) implementing the IDR process. Under the Rule, the arbitrator must select the proposed payment that is closest to the QPA unless the arbitrator determines

that credible information submitted clearly demonstrates the QPA amount is "materially different" from the appropriate out of network rate. The Rule defines "materially different" as a "substantial likelihood that a reasonable person with the training and qualifications of a certified IDR entity making a payment determination would consider the submitted information significant in determining the out of network rate and would view the information as showing that the QPA is not the appropriate out of network rate." As a result, the Rule created a rebuttable presumption that the proposed payment amount closest to the QPA is the proper payment amount.

Decision by Texas Court

The challenge to the regulations was commenced by the Texas Medical Association, a trade association representing more than 55,000 Texas based physicians. The Association argued that the Rule would require IDR entities to give "outsized weight" to a single statutory factor, the QPA, in conflict with the No Surprises Act. The court agreed, ruling the Rule would require IDR entities to presume the correctness of the QPA and impose a heightened burden on the other statutory factors to overcome the presumption that the proposal closest to the QPA was correct. The court ruled the Departments further violated the Administrative Procedure Act by issuing the Rule without going through the notice and comment rulemaking procedure. As a result, the court violated the portions of the Rule that prioritize the QPA over other factors during the IDR process.

Response by Departments

Following the ruling, the Departments issued a memorandum stating they were reviewing the decision and considering next steps. The memorandum emphasized that the ruling did not affect any of the Departments' other rulemaking under the No Surprises Act. The memorandum further stated the Departments were withdrawing guidance documents which referred to the invalidated portions of the Rule, would provide training on the revised guidance to IDR entities and disputing parties, and would open the IDR process for submissions through the IDR portal.

It is unclear at this time whether the Departments will challenge the Texas court ruling. Notably, a similar challenge brought by the American Medical Association, the American Hospital Association, and a number of providers is set to be argued in the U.S. District Court for the District of Columbia on March 17, 2022.

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Court Allows Suit by COVID-19 Testing Lab Against Plans and TPAs to Proceed

The U.S. District Court for the Southern District of Texas has ruled that a COVID 19 testing laboratory's lawsuit against several health plans and third-party administrators (TPAs), relating to failure to cover diagnostic testing the laboratory provided to plan participants, may proceed. The laboratory, Diagnostic Affiliates of Northeast Houston, LLC (Diagnostic Affiliates), filed the lawsuit in 2021 against a group of defendants which include numerous employer healthcare plans and United Healthcare Group, the parent company of subsidiaries that administer health insurance plans.

Central to the case are the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) which require group health plans and insurers to cover COVID 19 diagnostic testing without cost sharing for participants or any other medical management requirements. In the event an insurer does not have a negotiated rate in place with a testing provider, the insurer must pay for the testing administered to their insureds at the cash rate published by the provider on its website. In this case, Diagnostic Affiliates did not have a negotiated rate in place with any of the defendants, and insists the defendants are therefore required to pay Diagnostic Affiliates at the cash rate published on their website: $900 per diagnostic test.

Diagnostic Affiliates' complaint alleges that despite being entitled to payment at the $900 rate, the defendants have engaged in a number of improper tactics to avoid paying, and have delayed, denied or reduced payment of the claims for testing by Diagnostic Affiliates.

Although it dismissed several claims, the District Court ruled the case could proceed based on three principal theories of recovery. First, the District Court ruled that Diagnostic Affiliates could bring a claim against the defendants under both the FFCRA and CARES Act because both statutes include an "implied private right of action" which allows a provider to sue for reimbursement. Second, the District Court ruled that Diagnostic Affiliates could bring a claim under (ERISA for failure of payment against the defendants because it had obtained assignments of benefits from many of the participants who had received testing. Finally, the District Court held that Diagnostic Affiliates could also proceed with its claim against the defendants under the Racketeer Influenced and Corrupt Organizations Act (RICO) after alleging that the defendants engaged in a coordinated effort to delay, deny and reduce payments to Diagnostic Affiliates for COVID 19 testing and to profit by doing so.

The case raises the question of whether any recourse is available to plans and insurers when providers charge arguably unreasonable rates for testing required to be covered under the FFCRA and CARES Act. The District Court noted in a footnote that despite allowing the case to proceed, nothing in its ruling foreclosed the defendants from bringing a counterclaim against Diagnostic Affiliates challenging the propriety of the pricing. Notably, Diagnostic Affiliates has also filed a similar suit against major insurer Cigna.

UPCOMING DEADLINES AND REMINDERS

RETIREMENT PLANS

ADP/ACP Corrective Distributions. Calendar year defined contribution plans must process corrective distributions for a failed Actual Deferral Percentage (ADP) and/or Average Contribution Percentage (ACP) test by March 15, 2022.

Form 1099 R. Plans must e file Forms 1099 R with the IRS by March 31, 2022.

RMDs. Plans must begin to pay initial RMD payments by April 1, 2022.

Annual Funding Notice. Calendar year defined benefit plans with more than 100 participants must provide the Annual Funding Notice by May 2, 2022 (later than usual due to April 30 falling on a weekend).

HEALTH AND WELFARE PLANS

Affordable Care Act Information Reporting. Plan sponsors and applicable large employers (ALEs) must file the transmittal Forms 1094 B and 1094 C with their corresponding Forms 1095 with the IRS by March 31, 2022, if e filing.