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Knudsen v. MetLife Group, Inc.: Third Circuit Dismisses Challenge to MetLife's Retention of Prescription Drug Rebates

By Abby Blankenship

On September 25, 2024, the United States Court of Appeals for the Third Circuit upheld the dismissal of an Employee Retirement Income Security Act ("ERISA") lawsuit concerning approximately $65 million in prescription drug rebates. The class action lawsuit originated from the plaintiffs' allegations that MetLife Group ("MetLife"), the Plan sponsor and fiduciary, improperly retained prescription drug rebates from 2016 to 2021. The Third Circuit concluded that the plaintiffs' claims of financial harm—specifically, increased out-of-pocket expenses for prescription drug coverage, stemming from the employer's retention of rebates, were speculative. Consequently, the plaintiffs did not sufficiently establish Article III standing, resulting in a significant victory for employers.

Procedural History

Two former employees brought a class action under ERISA on behalf of participants in the MetLife Options & Choices Plan (the "Plan"), alleging that their employer, MetLife, misappropriated the Plan's funding by diverting tens of millions in drug rebates from the Plan to itself. The plaintiffs alleged that had the drug rebates been properly allocated, MetLife "may have reduced co-pays and co-insurance for pharmaceutical benefits" and "may have distributed rebates to participants in proportion to their contributions to the Plan." Instead, the Plaintiffs claimed that MetLife's retention of these rebates caused them to pay higher out-of-pocket costs, mainly in the form of insurance premiums. The United States District Court for the District of New Jersey (the "District Court") granted MetLife's motion to dismiss, ruling that the plaintiffs did not have standing to pursue their claims.

Background

The Plan, which holds over $1.4 billion in assets for almost $37,000 participants, is self-funded. As such, MetLife, as the employer, is financially responsible for paying the claims and bearing the financial risk associated with making those payments. Around 30% of the contributions to the Plan comes from participant contributions in the form of health insurance premiums. The remaining contributions to the Plan are paid by MetLife through the trust fund or its own assets.

From 2016 to 2021, the Plan hired Express Scripts as its exclusive pharmacy benefit manager ("PBM") and paid Express Scripts between $3.2 million and $6.3 million in annual compensation. As part of this arrangement, Express Scripts was

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required to negotiate volume discounts and rebates with drug manufacturers. The Plan documents then required that these rebates be used toward Plan expenses. However, the Plan documents expressly stated that the rebates were not to be considered in calculating co-payments or co-insurance. MetLife directed 100% of the $65 million in drug rebates to itself during this six-year period.

The plaintiffs asserted that by directing the $65 million in rebates to itself instead of to the Plan, MetLife violated ERISA. Additionally, they argued on appeal that MetLife could have used those rebates to reduce participant premiums or directed the rebates to each participant in proportion to their contributions.

The District Court's Ruling

The District Court ruled that the plaintiffs did not have standing to pursue their claims and granted MetLife's motion to dismiss. The District Court reasoned that the plaintiffs "do not have a concrete stake in the outcome of this lawsuit and have not pled facts to demonstrate an individualized injury." The District Court relied heavily on the Supreme Court's decision in *Thole v. U.S. Bank N.A.* and the Third Circuit's decision in *Perelman v. Perelman*. More specifically, the District Court concluded that these two decisions categorically prevent an ERISA plaintiff from claiming injury due to increased out-of-pocket expenses, resulting in a lack of standing for the plaintiffs. The District Court observed that the plaintiffs "do not contend that they did not receive their promised benefits" but instead are arguing that they paid "excessive out-of-pocket costs." The District Court concluded that that excessive out of pocket costs are "not an individual injury" within the context of the Plan. The District Court found the plaintiffs' allegations that MetLife "may have reduced co-pays and co-insurance" or that Plan participants "may have received a proportionate distribution of rebates" were "speculative and conclusory." Following dismissal, the District Court's opinion was appealed.

The Third Circuit's Ruling

The Third Circuit affirmed the District Court's ruling, concluding that the plaintiffs failed to sufficiently established Article III standing. Article III standing is a constitutional requirement that a plaintiff must meet in order to bring a lawsuit in federal court. These requirements include: (1) a concrete and specific injury; (2) the injury must be related to the defendant's conduct; and (3) the injury must be able to be remedied by a favorable judgment.

Notably, the Third Circuit did not agree with the District Court's interpretation that the decisions in *Thole* and *Perelman* necessitate dismissal under Article III when a participant in a self-funded healthcare plan files an ERISA suit claiming that mismanagement of Plan assets led to higher out-of-pocket costs. However, the Third Circuit held that the plaintiffs' allegations fell short of "alleging concrete financial harm" because they failed to allege "that they have or will pay more in premiums, or other out-of-pocket costs, as a result of MetLife not applying the $65 million in rebates to the Plan." More specifically, the plaintiffs did not allege "which out-of-pocket costs increased, in what years, or by how much." Additionally, the plaintiffs also failed to establish that MetLife's conduct was the but-for cause of their injury. On these allegations, the Third Circuit stated that "it is speculative that MetLife's alleged misappropriation of drug rebate money resulted in [the] plaintiffs paying more for their health insurance or had any effect at all." For these reasons, the Third Circuit held that the plaintiffs failed to assert a concrete and specific injury and that such pleadings are not "sufficient to support Article III standing." However, the Third Circuit noted the District Court's ability to exercise its discretion on remand to allow the plaintiffs to file an amended complaint.

Conclusion

The Third Circuit's dismissal of the plaintiffs' complaint marks a significant victory for employers. Based on this ruling, it appears that standing is likely to continue to be a significant barrier to lawsuits where fiduciary conduct that does not cause a direct financial loss to participants is challenged.

IRS Private Letter Ruling Allows Employees to Allocate Employer Contributions Among Several Benefit Options

By: John Collier

Introduction

This article discusses the recent Private Letter Ruling ("PLR") 202434006 (the "2024 PLR"), which grants employees greater flexibility to allocate non-elective, discretionary employer contributions based on individual needs and preferences. The 2024 PLR addresses a growing demand from employers to offer benefits structures that accommodate the diverse financial needs of their workforce, while also ensuring compliance with tax laws.

Background

Traditionally, employers have provided employees with non-elective contributions to defined benefit plans alongside employer contributions to employee assistance programs ("EAPs"), health savings accounts ("HSAs"), and retiree health reimbursement accounts ("HRAs"). In recent years, however,

employers have become increasingly interested in offering more flexible benefits structures that better address the diverse needs of today's workforce. While younger employees often prioritize managing student loan debt, others may seek to maximize retirement or health savings.

To meet the evolving needs of employers seeking more flexible benefit offerings, the IRS issued PLRs in 2015 and 2020, which allowed employees to exercise discretion in allocating employer contributions between retiree HRAs and defined contribution plans. The 2024 PLR builds on this earlier guidance, further expanding the range of benefits employees can choose from while ensuring that contributions maintain their tax-advantaged status.

Overview of the 2024 PLR

The 2024 PLR was issued in response to an employer's proposal to modify its discretionary 401(k) contributions by allowing its employees to make annual, irrevocable elections during open enrollment to allocate employer contributions across the 401(k) plan, retiree HRA, HSA, and EAP. Crucially, employees would not be able to receive these contributions in cash or any other taxable form, thus ensuring that the contributions remain within the scope of tax-favored treatment.

Key Takeaways from the 2024 PLR

A review of the IRS's reasoning in the 2024 PLR provides valuable insight for employers seeking to adopt such an arrangement. The IRS first determined that this proposal did not create a cash or deferred arrangement under Code § 401(k) because employees were not permitted to receive employer contributions as a taxable benefit.

Additionally, the IRS confirmed that the retiree HRA would remain compliant with applicable tax rules and continue to be excluded from employees' gross income because (1) employees were not allowed to have the employee contributions paid in cash; (2) employer contributions were not made via salary reduction, (3) contributions would only be used to reimburse eligible medical expenses under Code § 213(d); and (4) unused amounts would carry forward into future periods, including post-retirement.

The 2024 PLR further concluded that employer contributions to HSAs would be excludable from employees' gross income, provided that such contributions did not exceed the statutory limits and that only HSA-eligible employees could allocate contributions to these accounts.

Moreover, because employees were not given the option to choose between educational assistance and any other taxable remuneration, the ruling affirmed that payments from the EAP would remain excludable from gross income, subject to the statutory limits under the Code. The flexibility to allocate contributions among different programs, including the EAP, did not disqualify the EAP under the Code.

Additional Conditions for IRS Approval

Employers should also be aware of the following conditions for IRS approval of the type of arrangement contained in the 2024 PLR:

- Retiree HRA: HRAs under the arrangement must be limited to retiree HRAs with a contribution cap of $2,150 for plan years beginning in 2025.
- HSA: HSA eligibility is contingent on participation in a High Deductible Health Plan, with contribution limits of $4,300 for individual coverage and $8,550 for family coverage in 2025.
- EAP: EAPs must exclusively be used for qualified student loan repayments, subject to the annual limit of $5,250.
- Employees must make irrevocable elections regarding benefit allocations before the start of the plan year, with no option to receive taxable benefits
- Employee allocations must come from discretionary employer contributions to the 401(k) plan and be earmarked for the employee allocation purposes.

Employer Takeaways:

- **Non-binding Precedent:** While PLRs do provide guidance as to how the IRS may view a certain issue, it is important to note that PLRs are intended only for the parties that requested them and that they cannot be cited as legal precedent by other parties.
- **Additional flexibility:** The 2024 PLR offers employers a unique opportunity to provide eligible employees with greater flexibility to customize their benefits packages according to their individual needs. Rather than adhering to a traditional "one size fits all" approach, this ruling allows employees to actively participate in designing their own benefits coverage. This increased autonomy could lead to higher employee satisfaction, as workers can tailor employer contributions to options that best align with their financial goals, whether that's enhancing retirement savings, funding health expenses, or repaying student loans.
- **Effect on Non-discrimination Testing:** One key consideration is the potential impact on non-discrimination testing. Allowing employees to choose where employer contributions are allocated could result in non-uniform distributions across defined contribution plans, HSAs, retiree HRAs, and EAPs. Employers should model potential outcomes based on their workforce demographics and plan provisions to proactively address any testing issues.
- **Administrative Consideration:** Finally, employers should be prepared for the increased administrative complexity that comes with offering employee elections. This may require coordinating across multiple vendors and ensuring that contribution limits are not exceeded. Careful planning and clear employee communication will be essential to the successful implementation of these flexible benefit structures.

Mental Health Benefits: Final MHPAEA Regulations

By Kate Belyayeva

The proposed regulations under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), as amended by the Affordable Care Act, have been at the forefront of discussion when it comes to mental health benefits. By way of reminder, MHPAEA was signed into law to prohibit group health plans or health insurance issuers from imposing more restrictive quantitative treatment limitations ("QTLs") and nonquantitative treatment limitations ("NQTLs"), as written and in operation, on mental health or substance abuse disorder ("MH/SUD") benefits as compared to medical/surgical ("M/S") benefits in the same classification(s).

The proposed rules under MHPAEA were issued in 2023 by the U.S. Department of Labor (the "DOL"), the U.S. Department of Health and Human Services, and the U.S. Department of Treasury (collectively, the "Departments") and focused on the regulation of the QTL and NQTL comparative analyses. On September 9, 2024, the Departments released new final rules implementing MHPAEA, which reflect the comments received from the public last year. This article intends to highlight the key aspects of the final rules rather than provide a comprehensive analysis thereof. Please visit the following website for a full reading of the final rules:

https://www.federalregister.gov/documents/2024/09/23/2024-20612/requirements-related-to-the-mental-health-parity-and-addiction-equity-act

Key Aspects

Among other things, the final rules focus on the following provisions:

- The proposed rules suggested a mathematical test for NQTLs, which was not included in the final rules.
- ·The final rules revised and added some definitions, such as the terms "medical/surgical benefits," "mental health benefits," "substance use disorder benefits," "evidentiary standards," and others.
- The final rules created a "network composition" NQTL, which requires data measures related to in-network and out-of-network utilizations and certain benchmarks.
- The Departments finalized the "meaningful benefits" standard, which states that plans and issuers must provide meaningful benefits for MH/SUD conditions as they would for M/S conditions in each classification. A meaningful benefit is such a benefit that provides for a "core treatment."
- The final rules provided that a material difference in outcomes data is a "strong indicator" rather than definitive proof of non-compliance. It is a fact-specific determination; however, the Departments explained that if the differences are due to generally recognized independent professional or clinical standards or reasonable protection measures, such differences will not be treated as material.
- The proposed rules included a new fiduciary standard that would require a certification of compliance with the NQTL requirements by plan fiduciaries. This standard was revised in the final rules to instead require that plan fiduciaries certify that they engaged in a prudent selection and monitoring process to select a third party to document compliance with the NQTL requirements.
- The final rules introduced new disclosures for when information is not available or does not exist, including a detailed explanation of the lack of such information, when it will become available, etc.
- The Departments provided some important deadlines:
  - The NQTL comparative analysis must be submitted to the Secretary within ten business days of a request.
  - If the analysis is insufficient, the plan sponsor or issuer would have ten additional business days to provide additional information.
  - In the event of an initial determination of noncompliance, the plan or issuer has 45 calendar days to specify actions it will take to comply.
  - Upon a final determination of noncompliance, the plan sponsors and issuers must notify the participants, beneficiaries, and enrollees of noncompliance within seven business days of such determination.
- ·If the plan or issuer is noncompliant, the Departments may prohibit the plan sponsor or issuer from imposing an NQTL.

Effective Date

Plan sponsors and issuers must comply with most of the provisions of the final rules by the first day of the first plan year beginning on or after January 1, 2025. However, plan sponsors and issuers have until plan years beginning on or after January 1, 2026 to comply with the "meaningful benefits" standard, the data evaluation requirements, and the prohibition on discriminatory factors and evidentiary standards. However, in the light of the post-Loper litigation landscape, the meaningful benefit standard and network composition aspects of the final rules may be further reviewed by the courts.

Employer Impact

Although the final rules did not fundamentally challenge the premise of MHPAEA, and the prior requirements are generally still in force with regard to the preparation of the NQTL comparative analysis, the final rules do introduce a few substantive provisions that would impact compliance. For example, with regard to the "meaningful benefits" standard and the network composition, plan sponsors and issuers may need to expand the scope of covered MH/SUD benefits to ensure parity. Additionally, the tight response timeframe upon the DOL's and participant's request signals that plan sponsors and issuers must commence the process to create or update their NQTL comparative analyses each time they have a material change as opposed to waiting until a request arises.

Conclusion

All in all, mental health parity has been a long-running 16-year project. As the country continues to grapple with a crisis in MH/SUD disorders, the final rules mark another step in bringing that project to a conclusion. However, despite the

final rules, many questions are yet to be answered. Among the main concerns is the unwillingness of third-party administrators to assist plans and issuers with compliance and the remaining lack of clarity in the rules in general. With January 1, 2025 coming up very shortly, plans sponsors, issuers, and third-party administrators should consult with their advisors to ensure compliance under the final rules.

Compliance Corner: Understanding ACA Requirements: A Guide for Applicable Large Employers

By: Abby Blankenship

The Patient Protection and Affordable Care Act, referred to as the Affordable Care Act or "ACA" for short, is the comprehensive health care reform law enacted in March 2010. As employers prepare for upcoming open enrollment periods and compliance reviews, it is crucial to understand the ACA's requirements, reporting obligations, and the penalties for noncompliance. This month's Compliance Corner provides an overview of the ACA, its key provisions, and essential reporting requirements that employers must meet.

Background

The ACA was enacted in 2010 to expand access to healthcare in the United States. It aimed to reduce the number of uninsured Americans, lower healthcare costs, and improve the quality of care. Key features of the law included the creation of health insurance marketplaces, the expansion of Medicaid, and mandates for individuals to have insurance. Furthermore, it included protections for those with preexisting conditions and permitted young adults to remain covered on their parents' insurance plans until age 26.

Key ACA Provisions for Applicable Large Employers

- The ACA established the Employer Mandate, which requires Applicable Large Employers (ALEs) to either provide affordable healthcare insurance to full-time employees or face potential tax penalties.

- To be considered an ALE, an employer has to have had at least 50 full-time employees, full-time equivalent ("FTE") employees, or some combination of the two over the prior calendar year. Certain exceptions may apply if the workforce (a) exceeds 50 full-time or full-time equivalent employees for 120 days or fewer

- (bullet cont.) per calendar year, and (b) the employees that cause the workforce to exceed 50 are "seasonal workers." Employees who work 30 or more hours per week are considered full-time.

- An ALE's healthcare plan must be affordable, provide employees with at least a minimum value ("MV"), and have minimal essential coverage ("MEC") (i.e., applies to at least 95% of the ALE's full-time employees).

- A plan provides MV if it pays at least 60% of the cost of covered services (deductibles, copays and coinsurance). The U.S. Department of Health & Human Services ("HHS") has developed a minimum value calculator that can be used to determine if a plan provides MV.

- ALEs must also provide employees with information about the plan and submit annual reports to the Internal Revenue Service ("IRS") via forms 1094-C and 1095-C or face penalties for noncompliance.

Reporting Requirements

To ensure compliance with the ACA, employers must adhere to specific reporting obligations. This includes providing the IRS with information about health insurance coverage offered to employees. The two key forms involved are:

- **(1)** Form 1095-C: This form is issued to employees and the IRS, detailing the health coverage offered. It includes information about the employee, the employer, the months of coverage, and whether the coverage met MEC requirements.

- **(2)** Form 1094-C: This serves as a transmittal form to the IRS that summarizes the data provided on the 1095-Cs.

ALEs have the option to file these forms either in print or electronically; however, if they have 10 or more returns, electronic filing is required. Additionally, the IRS advises ALEs to retain a copy of the forms (or be able to recreate them) for a minimum of three years.

Deadlines for Reporting

For the 2024 tax year, employers must adhere to the following deadlines:

- **(1)** Distribution to Employees: Forms 1095-C must be sent to employees by January 31, 2025.

- **(2)** Filing with the IRS: Forms 1094-C and 1095-C must be filed with the IRS by February 28, 2025 (or March 31, 2025, if filing electronically).

Penalties for Noncompliance

- **(1)** No Coverage Offered ("A Penalty"): Employers are required to offer coverage to at least 95% of full-time employees and dependents.
  - Penalty amount: The 2025 A Penalty is $241.67/month ($2,900 annualized) multiplied by all full-time employees (reduced by the first 30). It is triggered by at least one full-time employee who was not offered MEC enrolling in subsidized coverage on the Exchange.

Penalties for Noncompliance Continued

- **(2)** Failure to provide affordable, MV coverage ("B Penalty"): The B Penalty applies for each full-time employee who is: (1) not offered MEC, (2) offered unaffordable coverage, or (3) offered coverage that did not provide MV. Only those full-time employees who enroll in subsidized coverage on the Exchange will trigger the B Penalty. Unlike the A Penalty, the B Penalty is not multiplied by all full-time employees.
  - Penalty amount: The 2025 B Penalty is $362.50/month ($4,350 annualized) per full-time employee receiving subsidized coverage on the Exchange.

Conclusion

Since its inception, the ACA reporting requirements have changed at both the federal and state level, making it challenging for employers to keep up. As such, it is crucial that employers familiarize themselves with ACA requirements, maintain accurate employment records, and adhere to reporting obligations in order to avoid costly penalties.

STAY IN THE KNOW…

- On September 4, 2024, the IRS updated its FAQs on the Employee Retention Tax Credit ("ERTC") to provide further clarification on "qualified wages," "related individuals" and added special rules for large eligible employers for the purposes of claiming the credit. Those new FAQs are found here:
  - https://www.irs.gov/coronavirus/frequently-asked-questions-about-the-employee-retention-credit

- In light of the upcoming elections, employers should be aware of state voting leave laws. Nearly every state provides some form of voting leave, paid or unpaid, depending on the circumstances.

- The Department of Labor ("DOL") initially issued its cybersecurity guidance on April 14, 2021, aiming to protect workers' retirement and health benefits in the U.S. However, the original guidance did not explicitly state that it applied to health and welfare plans. Following a 72% increase in security breaches affecting over 353 million people, the DOL updated its guidance on September 6, 2024, to clarify that it now applies to all employee benefit plans under the Employee Retirement Income Security Act ("ERISA"). Accordingly, plan sponsors of all ERISA plans are urged to implement best practices to safeguard participants against cyber threats in compliance with the DOL's cybersecurity guidance.

This Month's Contributors

Kate Belyayeva
Associate | kbelyayeva@maynardnexsen.com
205.488.3597

Kate joined the firm in 2022 after graduating magna cum laude from Cumberland School of Law. Her practice is largely focused on the design, implementation, and maintenance of 401(k), profit sharing, defined benefit/pension (including cash balance), employee stock ownership and welfare plans, as well as executive and deferred compensation programs.

Abby Blankenship
Associate | ablankenship@maynardnexsen.com
205.488.3607

Abby is an Associate in Maynard Nexsen's Employee Benefits & Executive Compensation practice group. Abby is experienced in advising public and private companies on various aspects of corporate and tax law, including mergers & acquisitions, private equity & venture capital, antitrust & trade regulation, and healthcare, franchise, and name, image & likeness (NIL) matters.

John Collier, Jr.
Associate | jcollier@maynardnexsen.com
205.254.3637

John is an Associate in Maynard Nexsen's Employee Benefits & Executive Compensation practice group. In his practice, John develops meaningful relationships with colleagues and clients to work towards creative solutions. John has experience supporting a variety of civil litigation matters for institutional, private, and agency clients and assists clients during all phases of litigation in both state and federal courts. He represents clients in various transactional matters, including contract negotiation, contract interpretation, and corporate governance.

Matt Stiles
Shareholder | mstiles@maynardnexsen.com
205.254.1071

Matt has over twenty years of experience representing employers in all facets of the employment relationship, including employee benefits and executive compensation, trade secrets and restrictive covenants, SCA and federal contract employer compliance, PEO, and staffing industry law. Matt regularly advises employers and benefits consultants in strategic benefit plan design, implementation, and compliance. He has extensive experience counseling employers involved in federal and state agency investigations.