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INSIGHT

Artificial Intelligence in Governmental Plans

IN THIS ISSUE

Artificial intelligence (AI) is everywhere in the news. As governmental plans look forward in this evolving environment, AI solutions may impact governmental plan administration and investment activities in many ways as long as they are vetted for compliance and valuation.

As a general introduction to AI for public sector plans, this article presents potential opportunities, risks and other considerations related to AI service providers and plan members. Importantly, because the environment is rapidly changing, this article focuses on key concepts that are designed to be relevant both today and in the future.

Potential Uses for Administrative Functions

The integration of AI presents numerous, potential uses in the context of administrative functions. These capabilities encompass uses by both internal staff and external vendors. Some potential uses for administrative functions include:

- **Customer Service:** Governmental plans can leverage these tools to enhance customer service operations. This extends to providing education, wellness, and support services.
- **Data Validation:** Routine operations might be streamlined through automated reconciliation and validation tasks. AI offers potential in managing recordkeeping and ensuring accurate payroll validation.
- **Responsibility:** With administrative deployments, paramount concerns are protecting the confidentiality of personal information, and establishing responsibility and protocols to address errors.

Potential Uses for Plan Investments

AI also introduces significant potential uses for plan investments. These applications involve uses by internal personnel and contracted vendors. Some potential uses for plan investments include:

- **Analysis and Screening:** AI can be deployed for sophisticated investment analysis and benchmarking. It can serve as a tool for initial and ongoing investment screening. In addition, it may be leveraged by internal teams, external teams or a combination of both.
- **Reporting:** Financial data may be managed efficiently through

automated summarization and reporting features.

- **Advice:** AI introduces the capability for more personalized member-level investment advice and possibly the potential for "virtual advisors" (whether on a general "wealth management" level or for other more specific situations, such as defined contribution plan investments).
- **Responsibility:** Applying tools to financial assets often requires strict oversight and rules addressing responsibility for errors.

Compliance and Policies

It is important to recognize that AI is not without its risks. Accuracy, privacy, security, and accountability are key concerns for governmental plans when AI is involved. Some factors to consider include:

- **Internal Compliance:** Systems should consider establishing rules governing the use of AI, including guidelines dictating what is permitted, and outlining AI solution platforms that can be used and those that cannot. Proper supervision and education are essential for systems' personnel.
- **Software Solutions:** Compliance involves addressing AI in all software including new and existing solutions.
- **Data Privacy:** A critical risk factor centers on how a system's data is used. Systems must be vigilant in addressing the use and sharing of personally identifiable information and whether it is integrated and/or used to enhance products (which is often referred to as "training"). However, ultimately, the rapidly evolving nature of AI dictates the need for policy flexibility.

AI Consideration for Vendor Compliance

Often, there can be AI-specific concerns to address with vendors including:

- **Contracting:** Systems may consider how to proactively address AI in Requests for Proposals (RFPs) and during contracting. For current relationships, processes may be considered for how to review existing contracts, negotiate vendor amendments, and maintain ongoing diligence.
- **Disclosure:** Not all vendor-provided agreements require the explicit disclosure of AI usage. Systems might consider negotiating terms regarding the use of plan/fund data for model training. Safeguarding the use of data requires developing disclosure and negotiation strategies.
- **Accountability:** A primary objective is understanding the role of AI and who is responsible for bias and errors. This term is likely to be a significant point of negotiation with vendors who normally expect a limitation on liability.

AI Considerations for Members and Bad Actors

The implementation of AI directly affects plan members, requiring specific AI considerations for members. AI may impact member services by potentially transforming call centers and online platforms. These advancements carry significant self-service implications. By offering customized solutions for members, systems might offer increased investment education and advice (to the extent a system provides this support). However, direct access that is not monitored in each case by human interaction also triggers questions about managing AI errors and risks.

On the other hand, systems must quickly anticipate AI considerations involving "bad actors". Bad actors are using AI for fraud, targeting member activities through plan/fund impersonation schemes. These threats have severe impacts on current fraud prevention measures. AI can be used to battle fraud, but it is truly an escalating challenge.

Conclusion

Navigating the integration of new technologies highlights the need for flexibility. While AI may be very beneficial, it is essential that systems should approach AI carefully with vigilance and improved security

measures. Since "best practices" change daily, and very few laws govern AI today, diligence and contracting is crucial. Rigid rules are likely to be outdated quickly – meaning that process matters.

Refresher on the Determination of Governmental Plan Status

In late 2011, the Internal Revenue Service (IRS) provided proposed guidance regarding the definition of a governmental plan, in the form of an Advance Notice of Proposed Rulemaking (ANPRM).[1] This guidance provides some helpful insight when determining whether to permit an entity to participate in a governmental plan.

Governmental Plan

Generally, a governmental plan is established and maintained for employees of the United States, any State or political subdivision of a State, or any agency or instrumentality of the foregoing. While certain related terms, such as State or political subdivision of a State are fairly clearly defined, qualification as an agency or instrumentality of the United States or a State is based on a facts and circumstances determination. To make that determination, the ANPRM presents various factors to consider.

Factors for Determining Status as a State Agency or Instrumentality[2]

The ANPRM categorizes the factors into "major" factors and "other" factors, though satisfaction of particular factors is not conclusive in determining whether an entity is an agency or instrumentality. In other words, no safe harbor was provided (e.g., the ANPRM does not provide that satisfaction of at least five factors or satisfaction of the control and membership factors means an entity is an agency or instrumentality of a State).

The factors proposed as "major" factors for determining whether an entity is an agency or instrumentality of a State or political subdivision include:

- **Control of Governing Board or Body**. The entity's governing board or body is controlled by a State or political subdivision of a State.
- **Membership of Governing Board or Body**. The members of the governing board or body are publicly nominated and elected. (Note: Satisfaction of this factor would generally not be viewed as a favorable factor in determining State agency or instrumentality status.)
- **State or Political Subdivision Responsibility for Debts and Liabilities**. A State (or political subdivision of the State) has fiscal responsibility for the general debts and other liabilities of the entity (including funding responsibility for the employee benefits under the entity's plans).
- **Treatment of Employees**. The entity's employees are treated in the same manner as employees of the State (or a political subdivision of the State) for purposes other than providing employee benefits (e.g., the entity's employees are granted civil service protection).
- **Delegation of Sovereign Powers**. In the case of an entity that is not a political subdivision, the entity is delegated, pursuant to a statute of a State or political subdivision, the authority to exercise sovereign powers of the State or political subdivision (e.g., the power of taxation, the power of eminent domain, and the police power).

The factors proposed as "other" factors for determining whether an entity is an agency or instrumentality of a State or political subdivision include:

[1] https://www.irs.gov/pub/irs-tege/reg_157714_06.pdf

[2] Similar factors, in the context of the United States rather than an individual State, are considered in determining whether an entity is an agency or instrumentality of the United States.

- **Control of Operations**. The entity's operations are controlled by a State (or political subdivision of the State).
- **Source of Funding**. The entity is directly funded through tax revenues or other public sources, but not including services provided by contracts or grants.
- **Enabling Legislation**. The entity is created by a State government or political subdivision of a State pursuant to a specific enabling statute that prescribes the purposes, powers, and manners in which the entity is to be established and operated. (Notably, the ANPRM does not consider a nonprofit corporation that incorporated under a State's corporate laws as satisfying this factor.)
- **Federal Income Taxation of the Entity**. The entity is treated as a governmental entity for federal employment tax or income tax purposes (e.g., the entity has authority to issue tax-exempt bonds under Code section 103(a) or under other federal laws).
- **Applicability of State Laws for State Governmental Entities**. The entity is determined to be an agency or instrumentality of a State (or political subdivision thereof) for purposes of State laws (e.g., the entity is subject to open meetings laws or the requirement to maintain public records that apply only to governmental entities, or the State attorney general represents the entity in court under a State statute that only permits representation of State entities).
- **Judicial Determination of Agency or Instrumentality Status**. The entity is determined to be an agency or instrumentality of a State (or political subdivision of the State) by a State or Federal court.
- **Ownership Interest**. A State (or political subdivision of the State) has the ownership interest in the entity and no private interests are involved.
- **Governmental Purpose**. The entity serves a governmental purpose.

Change in Status

The ANPRM also addresses the impact of the privatization of a governmental entity and the transition of a private entity to a governmental entity. Generally, the plan is treated as established by the resulting governmental or private entity, respectively, as of the date of such change. However, a governmental plan may maintain such status after the privatization of the entity that established the plan if a governmental entity continues to be the plan sponsor after the change and the benefits under the plan are frozen.

Other Considerations

The ANPRM does not address a number of other situations, including:

- De minimis participation by non-governmental employees, as the ANPRM does not include an explicit participation rule. Therefore, participation by a small number of non-governmental employees in a governmental plan may potentially jeopardize its Code section 414(d) status.
- The impact if final regulations would require a change to the plan that runs afoul of State contract or constitutional protections.
- Whether a correction program will be available in the event of a failure to comply with final regulations.

Conclusion

While the ANPRM provides helpful guidance for governmental plans, open issues remain. Since there is no indication that final regulations are on the horizon, many plans continue to apply a reasonable and good faith standard in operations based on the ANPRM.

Updated IRS Safe Harbor Rollover Notices

Recently, the Internal Revenue Service (IRS) issued Notice 2026-13 (Notice), which provided updated safe harbor notices to be provided to recipients of eligible rollover distributions (e.g., commonly applicable to refunds of account balances or partial lump sum distributions), as required by Code section 402(f). The Notice incorporates changes necessitated by recent legislation, such as the *SECURE Act of 2022* (SECURE 2.0).

The changes impacting governmental defined benefit plans include additional exceptions to the 10% additional tax under Code section 72(t), required minimum distribution changes, and the expanded relief for distributions to pay premiums for health and long-term care insurance.

Summary of Modifications

The Notice reflects a number of modifications intended to make the content easier to understand, such as a listing of the general options available with respect to an eligible rollover distribution and the inclusion of a table of contents to help direct recipients to sections applicable to their payment.

In addition, substantive changes were made to the Notice to reflect new rules, including the following provisions that are applicable to governmental defined benefit plans:

- Additional exceptions to the 10% additional tax under Code section 72(t) for distributions:
    - To a "qualified public safety employee" (to include State or local correction officers and forensic security employees (as well as private-sector firefighters) under the expanded definition in SECURE 2.0) after separation from service if the member has at least 25 years of service under the plan on separation, regardless of age;
    - Made to a member with a terminal illness; and
    - Made on account of a qualified disaster.
- The exception from required minimum distributions during the member's lifetime if amounts are rolled over from a governmental defined benefit plan to a Roth IRA.[3]
- The right of a retired public safety officer to exclude from taxable income the amount of the premiums paid to an accident or health plan (or a qualified long-term care insurance contract), regardless of whether such amount is paid directly from the plan to the insurer or is first received by the member prior to payment to the insurer.
- The right to roll over amounts from a governmental defined benefit plan to a SIMPLE IRA after two years of participation in the SIMPLE IRA.
- The right to repay qualified disaster recovery distributions or terminal illness distributions received from the plan.

Conclusion

The changes contained in the safe harbor notice should be incorporated into a plan's rollover notice as soon as practicable, whether or not the IRS model language is tracked. Additionally, while the requirement to provide the notice within a reasonable period of time before making the eligible rollover distribution from the plan has not changed (e.g., 30 to 90 or 180 days, as provided in your plan), the Notice also encourages distribution of the rollover notice on a member's separation from service (though this "extra" step is not required).

[3] The preamble also reflects additional required minimum distribution changes, such as the increased applicable age and the expanded surviving spouse election to be treated as the employee.

MHPAEA Report to Congress

On February 28, 2026, the Departments of Labor (DOL), Treasury, and Health and Human Service (HHS) (collectively, the Departments), published the "2025 Mental Health Parity and Addiction Equity Act (MHPAEA) Report to Congress" (Report) on the results of Non-Quantitative Treatment Limitation (NQTL) comparative analysis review activities during August 1, 2023, through July 31, 2025 (Reporting Period).[4]

MHPAEA generally requires that group health plans ensure that any financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) that apply to mental health and substance use disorder (MH/SUD) benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical (M/S) benefits in a benefits classification. In addition, MHPAEA prohibits separate financial requirements or treatment limitations that apply only to MH/SUD benefits.

The Report highlights MHPAEA implementation, enforcement, and outreach effort of HHS' Centers for Medicare & Medicaid Services (CMS). In the Report, the Departments reinforce that they continue to focus enforcement efforts on limitations that impact access to care. In line with previous enforcement priorities, this includes NQTL analyses for: 1) prior authorization; 2) concurrent care review; 3) standards for provider admissions to participate in a network; 4) out-of-network reimbursement rates; 5) treatments for mental health conditions and substance use disorders; 6) adequacy standards for MH/SUD provider networks; 7) provider reimbursement treatment limitations; and 8) pharmacy benefit formulary design.

CMS enforces MHPAEA, with respect to issuers selling products in the individual and fully insured group markets in states that fail to substantially enforce MHPAEA and with respect to non-Federal governmental plans nationwide. During the Reporting Period, CMS' MHPAEA enforcement work included:

- 43 initial letters requesting comparative analyses for 43 NQTLs. This included 33 letters to non-Federal governmental plans and 10 letters to issuers.
- 62 insufficiency letters covering 43 NQTLs.
- 9 initial determination letters finding that non-Federal governmental plans and issuers had violated MHPAEA's requirements for 9 NQTLs.
- 10 final determinations of noncompliance finding a violation of MHPAEA's requirements for 10 NQTLs. This included three final determinations of noncompliance for two non-Federal governmental plans.

In the Report, CMS notes that several insufficiency letters were issued to non-Federal governmental plans whose plan sponsors were surprised to find that responsibility for MHPAEA compliance lies with the plan, not their service provider. Many plans also assumed their service provider had a comparative analysis or would prepare one for them. CMS also notes that some service providers refused to provide a comparative analysis or were unable to give the information needed for a non-Federal governmental plan to assess its own MHPAEA compliance.

In addition, CMS is required to identify the non-Federal governmental plans and issuers that were issued a final determination of noncompliance. As such, the Report includes specific enforcement results and a list of non-Federal governmental plans and issuers that were not in compliance with MHPAEA, based on CMS' review of comparative analyses. Additionally, CMS posts all final determination letters to its website.[5]

[4] https://beta.dol.gov/system/files/research-data/2026-02/2025-mhpaea-report-congress.pdf
[5] https://www.cms.gov/marketplace/private-health-insurance/consumer-protections-enforcement

At a high level, CMS identified instances of noncompliance with MHPAEA due to impermissible separate treatment limitations and due to factors used in applying an NQTL to MH/SUD benefits, in operation, that were not comparable to those used to apply the NQTL to M/S benefits in the same benefit classification. Additionally, in all cases in which a non-Federal governmental plan or issuer received a final determination of noncompliance, CMS states that the non-Federal governmental plan or issuer did not provide sufficient information and supporting documentation in its comparative analysis. Specific examples of CMS' enforcement results for non-Federal governmental plans include:

- After an initial determination of noncompliance, a non-Federal governmental plan removed an impermissible 6-month limit on Applied Behavior Analysis (ABA) therapy prior authorization approvals. The plan also removed all prior authorization requirements for outpatient, in-network MH/SUD benefits, including for ABA therapy, and re-adjudicated claims resulting in approval of benefits for 29 individuals, totaling $91,789.10.
- After an initial determination of noncompliance, a non-Federal governmental plan removed exclusions for certain drugs to treat individuals with substance use disorders.
- After an initial determination of noncompliance, a non-Federal governmental plan established timeframes for standard prior authorization approval for elective M/S services and MH/SUD services, to ensure that approvals of elective MH/SUD services were not shorter than approvals for elective M/S services.

CMS notes that all non-Federal governmental plans and issuers that received a final determination of noncompliance were required, within seven days of the date of the final determination letter, to notify all individuals enrolled under the impacted plans and coverage that such plan or coverage was determined to be out of compliance with MHPAEA.

CMS also requires plans and issuers that receive a final determination of noncompliance to verify that they have completed their stated corrective actions.

In preparation for responding to a CMS request for an NQTL analysis, non-Federal governmental plans should consult with legal counsel regarding maintaining a sufficient NQTL comparative analysis documentation.

Proposed 2027 Notice of Benefit and Payment Parameters

On February 11, 2026, the U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), published the proposed "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program" (NBPP Proposed Rule).[6] This annual rulemaking by CMS addresses several aspects of the *Affordable Care Act* (ACA). Relatedly, CMS also recently published guidance on the annual maximum out-of-pocket limitation (MOOP) on cost-sharing for the 2027 benefit year.[7] This summary discusses the NBPP Proposed Rule and the recent MOOP guidance.

Essential Health Benefits (EHB)

The NBPP Proposed Rule prohibits issuers from including routine non-pediatric dental services as EHB. Routine non-pediatric dental services include cleanings, diagnostic X-rays, and restorative services like fillings and root canals. This is a reversal of the policy change from the 2025 NBPP Final Rule and, if finalized, would be effective for plan years beginning on or after January 1, 2027. CMS explains that the previous interpretation under the 2025 NBPP Final Rule is being reconsidered as the updated proposal better aligns the regulations with

[6] 91 Fed. Reg. 6292 (Feb 11, 2026) at: https://www.govinfo.gov/content/pkg/FR-2026-02-11/pdf/2026-02769.pdf
[7] https://www.cms.gov/files/document/2027-papi-parameters-guidance-2026-01-29.pdf

the statute, that only mentions pediatric oral care, which indicates that non-pediatric oral care was not meant to be included as an EHB.

Maximum Annual Limitation on Cost-Sharing

For the 2027 plan year, the MOOP limitation on cost sharing for group health plans is $12,000 for self-only coverage and $24,000 for other than self-only coverage. This represents an increase of approximately 13.2% from the 2026 parameters of $10,600 for self-only coverage and $21,200 for other than self-only coverage.

Civil Money Penalties

The NBPP Proposed Rule clarifies that HHS will identify the lawful purpose of a civil money penalty (CMP), and consider the enumerated factors as appropriate for the circumstances when determining the amount of CMPs as enforcement remedies against group health plans (including non-Federal governmental plans) and issuers under CMS' enforcement authority. Recently, CMS has begun to issue CMPs in response to audits and other instances of noncompliance with ACA requirements. For several years following the implementation of the ACA, CMS had sought voluntary compliance and corrective actions without resorting to CMPs. But as ACA implementation has matured, CMS has begun to wield a broader array of enforcement tools as part of its oversight of issuers and plans. Plans should evaluate their ACA compliance in light of this heightened risk for CMPs.