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GRS INSIGHT

Circuit Court Review of Actuarial Equivalence

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As noted in prior issues of *GRS Insight*, defined benefit plan sponsors are facing challenges to their determinations of actuarial equivalence, with more than 30 lawsuits filed since 2018. These cases largely allege a breach of fiduciary duty for failure to follow ERISA requirements, along with the primary allegation that the plan is not providing "actuarially equivalent" benefits, as required by ERISA, generally due to the plan's use of outdated mortality tables.

The actuarial assumptions at issue are used in calculating optional forms of benefits (e.g., calculating a joint and survivor benefit payable for the joint lives of the member and the beneficiary that is equivalent to a single life annuity payable for the life of the member) or benefits that commence prior to normal retirement date. The outcomes of these lawsuits at the district court level have been inconsistent, with a number of settlements.

Sixth Circuit Court Review

Recently, the Sixth Circuit Court of Appeals consolidated and reviewed two cases that were dismissed by the respective district courts, *Reichert v. Kellogg Co.* and *Watt v. FedEx Corp*.[1]

The plaintiffs' argument centered on the fact that mortality rates have greatly improved over the last several decades, and continuing to use higher mortality rates leads to artificially lower monthly payments under optional forms of benefit.

In granting the motions to dismiss, the district courts found that ERISA does not explicitly set forth a "reasonableness" standard for actuarial assumptions used to convert benefits into optional forms. The district courts concluded that because other areas of ERISA contain an explicit reasonableness standard, the omission here was intentional, and granted dismissal on that basis.

The Sixth Circuit Court overturned the dismissals, generally holding that plans' actuarial assumptions are subject to a "reasonableness" requirement under ERISA, with the use of reasonable assumptions implied by the phrase "actuarially equivalent."

The Court found a link between actuarial equivalence and reasonableness based on actuarial texts and past court decisions, while also concluding that reading a "reasonableness" requirement into the

[1] 170 F.4th 473 (Mar. 16, 2026); https://www.opn.ca6.uscourts.gov/opinions.pdf/26a0081p-06.pdf

provision is necessary to ensure the forms of benefit actually have a present value that is equivalent.

Importantly, the Sixth Circuit Court included the caveat that reasonableness "is a range, not a precise prescription," and referenced the deference provided to plan actuaries in assessing reasonableness under other ERISA provisions. These cases have now been remanded back to their respective district courts for further proceedings, with plan sponsors awaiting the implications of the Sixth Circuit's reasonableness determination.

Looking Forward

The mixed results in these cases have left plan sponsors facing uncertainty in their path forward. Adding to this uncertainty, shortly after the Sixth Circuit Court ruled on these cases, another district court held that no reasonableness standard applies.[2] In addition, the implications of these cases could also be felt by governmental defined benefit plans since the Internal Revenue Code's requirement that actuarial equivalence assumptions be reasonable underlies these claims.

IRS Issues Guidance on Rollover Contributions

In accordance with the *SECURE 2.0 Act of 2022* (SECURE 2.0) mandate to issue sample forms for direct rollovers to eligible retirement plans and transfers from individual retirement accounts (IRAs), the Treasury Department and Internal Revenue Service (IRS) issued Notice 2026-49 (Notice).[3] The Notice includes sample forms, along with procedures designed to simplify and streamline the direct rollover process.

Background

Current rollover regulations allow plan administrators to establish a reasonable procedure for electing a direct rollover, including placing reasonable requirements on a distributee (e.g., providing information or documentation to facilitate the rollover). In the same vein, reasonable procedures may be established by the administrator of the receiving plan, designed to verify the validity of the rollover contribution (e.g., the distribution originated from a qualified plan or IRA and is otherwise a valid rollover contribution). These procedures and requirements vary widely from plan to plan, leading to confusion and frustration for members who are trying to complete a rollover.

Relief

The Notice provides a new process, along with sample forms, to be used for direct rollovers between qualified plans, 403(b) plans, governmental 457(b) plans, traditional IRAs, SEPs and SIMPLE IRAs (but not to transfers between IRAs). The relief is intended to:

1) Protect members' personal identifying information through encrypted data transfers and the use of a unique "rollover identification number" assigned by the receiving plan;

2) Require coordination and communication between plans to minimize the burden on members;

3) Use common terms throughout the process;

4) Require plans to verify the accuracy of the information and legitimacy of the rollover request before transferring funds; and

5) Require electronic transactions to the maximum extent possible (though the sample forms include protocols where an electronic rollover is not possible).

Forms and Process

The Notice provides four sample forms that comply with the proposed rollover process including:

- **Form 1:** Member's Rollover Request, which includes the Member's Rollover Request Authorization

[2] Landel v. Olin Corp., 2026 WL 785044 (Mar. 20, 2026).
[3] https://www.irs.gov/pub/irs-drop/n-26-49.pdf

- **Form 2:** Receiving Plan's Request to Distributing Plan
- **Form 3:** Distributing Plan's Rollover Certification
- **Form 4:** Receiving Plan's Rollover Acceptance

As set forth in the Notice, the proposed rollover process includes the following five steps to complete a member's rollover request:

Step 1 – The member submits a completed Form 1 to the receiving plan, along with a signed Rollover Request Authorization, which authorizes the receiving plan to request a rollover from the distributing plan on the member's behalf.

Step 2 – The receiving plan assigns a rollover identification number to the transaction and sends a completed Form 2 to the distributing plan, along with a copy of the Rollover Request Authorization that has been signed by the member.

Step 3 – The distributing plan takes steps to independently verify the information on Form 2 and then sends a completed Form 3 to the receiving plan, along with any other required information not addressed on the Form (e.g., any required spousal consent).

Step 4 – The receiving plan sends a completed Form 4 to the distributing plan, designating the rollover method to be used (e.g., paper check versus electronic method).

Step 5 – The distributing plan transfers the requested rollover to the receiving plan.

Limitations

The relief only works if both the distributing plan and the receiving plan adopt the sample forms and process. Further, at this point, the Notice does not provide a "safe harbor" for plans; however, following the process will likely provide a streamlined rollover process.

In addition, the distributing plan is still required to provide the Code section 402(f) rollover notice and any other communications members otherwise receive in connection with a plan distribution.

Next Steps

While plans are not required to use this new process or sample forms, the Notice provides an alternative common framework to rely on when handling direct rollovers. The Treasury Department and IRS are considering additional guidance, such that waiting to implement the new process may be the prudent approach. Comments were requested in a number of areas by October 23, 2026, including those related to electronic rollovers and potential safe harbors.

The Departments Provide Enforcement Relief for Wellness Programs

On August 26, 2026, the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments) issued FAQs Part 74,[4] which address the *Health Insurance Portability and Accountability Act* (HIPAA) and *Affordable Care Act* (ACA) wellness program rules.

In the *Frequently Asked Questions* (FAQs), the Departments announced that they would not take enforcement action against a plan or issuer that provides a health-contingent wellness program reward only prospectively. The Departments also clarified which plan materials must include the required disclosures.

Class Action Lawsuits

The Departments issued the FAQs in response to the more than 80 class action lawsuits involving:
1) whether employers can only prospectively remove the premium surcharge when a participant who uses

[4] https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-74

tobacco completes a wellness program's "reasonable alternative standard," (which is typically a tobacco cessation course); and 2) whether employers failed to comply with the wellness program regulation's requirements regarding the disclosure of the availability of a reasonable alternative standard.

FAQs

Relief on Retroactive Rewards

The FAQs acknowledge that the regulatory text "does not clearly require retroactive application of the reward" and provide that, until further guidance or regulations are issued, the Departments will not take enforcement action against a plan or issuer with a health-contingent wellness program for failing to provide a reward retroactively to the first day of the plan year, provided the plan or issuer otherwise complies with the wellness program regulations.

The FAQs note that HHS encourages states with primary enforcement authority over the *Public Health Service Act* (PHSA) wellness rules to adopt a similar nonenforcement approach. HHS will not treat a state that adopts such enforcement discretion as having failed to substantially enforce Title XXVII of the PHSA.

Reiteration of Plan Notice Requirements

The FAQs emphasized the statutory and regulatory requirement that the availability of a reasonable alternative standard (and, if applicable, the possibility of a waiver of the otherwise applicable standard) must be disclosed in all plan materials describing the terms of a health-contingent wellness program and must include:

- A statement that a reasonable alternative standard (or, if applicable, a waiver) is available;
- Contact information for obtaining the alternative standard; and
- A statement that the recommendations of an individual's personal physician will be accommodated.

The FAQs clarify that the mere mention of a wellness program without describing its terms, such as in a *Summary of Benefits and Coverage*, does not trigger the notice requirement.

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