What’s at Stake for Health Care Organizations with Church Pension Plans

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Introduction

Pension plans sponsored by health care organizations affiliated with churches face serious risks as a result of recent lawsuits challenging the church plan status of these plans. Hospitals that have treated their pension plans as church plans will want to understand the changes in contributions and administrative practices that would be required if these plans were subject to ERISA. In addition, some health care organizations may find that recent lawsuits not only put ERISA-compliance risks to the forefront but also highlight implications for enterprise financial risks.

Church Plan Lawsuits Continue

A number of class-action lawsuits have been filed contending that pension plans sponsored by religiously affiliated health care systems and hospitals are not church plans because these plans were not established by the affiliated church. As illustrated in Exhibit 1, a number of courts, including the first three federal courts of appeals that have addressed this issue, have agreed with the challengers. The decisions of these appellate courts were appealed to the United States Supreme Court and on December 2, 2016, the Supreme Court agreed to hear a consolidated appeal. The Supreme Court’s decision should be issued by next summer. The decision will likely resolve the key challenges to the church plan status of pension plans maintained by church-affiliated hospitals. If the Supreme Court disagrees with the decisions of the Courts of Appeals, then church-affiliated hospitals may be able to continue to operate their retirement plans without fear of an ERISA lawsuit. If the Supreme Court agrees with the decisions of the Courts of Appeals and Congress does not intervene, then the focus will shift to resolving the plan’s past nonconformity with ERISA and the Code, converting the plan to ERISA status, and otherwise adjusting to the court’s decision.

While there have been a few dozen lawsuits filed there have only been a handful of settlements reached to date. The terms of each settlement have had their own particular set of requirements that the health care organization, as defendant, must follow. Examples of settlement terms include:

- Large cash funding requirements which must be contributed over a set period of time, often seven years or longer,
- Guarantees for long periods of time that all benefits will be paid to participants and/or guarantees of full payment of benefits upon a future plan termination,
- Special payments to certain groups of participants felt to be impacted negatively by the plan’s non-ERISA compliance,
- Additional disclosures of plan information to participants, and
- Seven figure payments to plaintiff’s attorneys and plaintiffs for expenses.

None of the settlements to date have required that the church plan be made to fully comply with ERISA and the Code. However, based on the large cash funding settlement terms it appears that plaintiffs continue to be acutely aware of the plan’s funded status and find ERISA funding requirements helpful as a common standard for the measurement of the plan’s financial health. The settlement terms that guarantee the payment of future benefits are likely in response to the fact that these plans do not have Pension Benefit Guaranty Corporation (“PBGC”) insurance protection.
Exhibit 1: Summary of Court Decisions

Understanding the Impact on Your Pension Plan

For plans currently classified as church plans that have been treated as exempt from ERISA and certain Code requirements, it is important to note that while there is a significant amount of attention on these plans today, the end result may be that no changes will be required. For example, the courts may decide that these plans do in fact meet the requirements of church plans and may continue to be operated as such. However, as part of the organization’s overall review of risks, now may still be an opportune time to evaluate the impact of changes that would be required to comply with ERISA or address potential litigation settlements. Each health care organization must determine the depth to which these risks are evaluated.

Compliance with ERISA would mean adhering to a large number of new requirements including increased reporting and disclosures, payment of minimum annual pension contributions under complex Pension Protection Act of 2006 rules, payment of annual premiums under the Pension Benefit Guaranty Corporation (PBGC), and making changes to the plan’s design and administrative practices to comply with ERISA. To understand the various potential risks we have found that the following approach, with each step going into more depth than the last, has been helpful: First, educate senior leaders within the organization on the latest litigation as well as the history and current funded status of the pension plan,

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1 Source: Aon Hewitt analysis compiled from widely available court decisions, as of Dec 2016

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second, **analyze** the impact ERISA may have on plan costs and other plan risks, and third, **strategize** on how to mitigate costs and risks.

**Educate**

It’s important to keep abreast of the latest litigation and the outcomes of any settlements. In addition, for those not already familiar with ERISA, it may be helpful to complete an educational review of its requirements. Much has changed over the years, especially with the introduction of the Pension Protection Act of 2006 and later regulations. A basic understanding of the latest ERISA and Code requirements, IRS funding rules, PBGC premiums, and pension plan provision requirements may help plan sponsors better prepare to answer questions about the potential impact on their own plans. As part of this educational process, it may be helpful to train plan service center representatives to provide appropriate responses if participants inquire about the plan’s church plan status.

To answer senior management’s initial questions it may also be helpful to review the plan’s history and the participants covered. For example, was the plan established by a church organization to cover religiously affiliated participants or was there another intent? How has this changed over time? Have contributions been made historically in order to improve and maintain the funded status of the plan? A positive answer to this question may demonstrate a commitment to providing pension benefits for participants for many years to come. Have plan provisions been changed over time to follow generally accepted (and often ERISA-based) practices? A plan that has been somewhat neglected in this area over time increases risk to plan sponsors since more drastic plan amendments may be necessary in order to satisfy ERISA requirements. Additional perspectives can be gained by comparing the overall plan health to that of other plans maintained by similar health care employers.

**Analyze**

Health care employers sponsoring church plans may want to analyze the financial impact of being subject to ERISA. While less intrusive litigation outcomes are possible, as settlements have so far shown, a more in-depth level of analysis may at least provide senior management a potential worst-case scenario. The analysis is also likely to lead to some initial thoughts on funding approaches and other strategies to mitigate the impact.

Many church plan sponsors may point to dramatically increased cash contributions as their biggest fear of complying with ERISA. This fear is not unfounded. While a church plan may be reasonably well-funded using its current funding policy and measurements, the funded status under ERISA may be dramatically different. This is due to a myriad of complexities that apply to funding pension plans under ERISA, not the least of which is the use of interest rates based on corporate bond yields.

As an example, Exhibit 2 shows the impact on a church plan assuming it must begin to fund under ERISA on a go-forward basis. ERISA nearly doubles the cash contributions needed over the next 15 years. As is often the case of the funding requirements under ERISA after the Pension Protection Act of 2006, much of this increase occurs in the first few years as the plan is forced to improve its funded status quickly until it reaches a fully-funded level. The current ‘Church Plan Funding’ pattern, totaling $130 million, shows somewhat level cash requirements which are designed to slowly improve the plan’s funded status (the plan in this illustration is frozen so no future benefit accruals are increasing costs over time). In contrast, ERISA minimum required contributions of $185 million must be made, and relatively quickly. In addition,
another $60 million of cash is needed to pay PBGC premiums (we’ve assumed contributions from the plan sponsor are used to pay PBGC premiums directly).

PBGC premiums, which are paid to provide PBGC ‘insurance’ coverage of plan benefits for participants, are the sum of two components – a flat rate premium and a variable rate premium. The flat rate premium is based on the number of participants in the plan and is $69 per participant for 2017, increasing to $80 for 2019, and indexed thereafter. The variable rate premium is based on the underfunding of the plan (using the PBGC’s assumptions) and is $34 per $1,000 of underfunding for 2017, increasing to an estimated $44 per $1,000 for 2019, and indexed thereafter. These premium costs, which have increased dramatically in recent years, should be factored into any cost analysis.

Assuming the plan is subject to GAAP accounting, it will also be helpful to determine the impact on balance sheet liabilities and accounting expense. Balance sheet liabilities will only be impacted to the extent plan benefits are changed due to the need to comply with ERISA (for example, accelerating vesting or providing certain death benefits). Accounting expense will be impacted for the same reasons. However, due to significant increases in cash contributions to the plan the accounting expense may very well decline as assets increase rapidly.

In addition to plan funding costs there are other costs and risks that may need to be evaluated. This may start with a review of the Plan Document with an ERISA attorney to determine if updates would be needed for any plan provisions to satisfy ERISA compliance rules. These might include such provisions as vesting, death benefits, benefit formula accrual rates, and the cash out provisions for terminated vested participants which may not comply with ERISA as currently written. The plan may also need to begin performing nondiscrimination tests if it isn’t currently doing so (to compare the benefits of highly compensated to non-highly compensated participants under Code rules). There may be material costs associated with changes to the plan if they result in the need to provide higher benefits to some or all participants. Other new costs include the need for a Form 5500 and PBGC premium filings. Annual notices regarding the plan and its funded status will also be required to be sent to all plan participants.
Exhibit 2: ERISA Increases Cash Needs

Strategize

Following an educational review of the issues described herein and an analysis of the costs, an initial assessment of potential strategies to mitigate risks and the impact of increased costs may be in order. In some cases, it may be premature to implement these strategies but a quick assessment can provide a healthy review of potential approaches to reduce risks should they become a reality due to future court decisions or legislation. The main strategies often follow from the result of two major changes to the plan’s financial profile under ERISA – 1) liabilities are determined at much lower interest rates, and 2) PBGC premiums.

As a church plan, with a long-term view of funding, plan liabilities are often determined using the plan assets’ rate of return or some other such measurement of discount rates. In contrast, under ERISA’s rules, corporate bond rates will be used to determine liabilities, similar to how GAAP accounting principles work today. The use of these lower interest rates introduces liability reduction strategies that may not have been deemed necessary for a church plan. For example, it may be financially desirable to cash out terminated vested participants since the cash outflow may now be similar to the reduction in liabilities. Purchasing annuities from an insurance company for retirees in payment status is another approach to reduce liabilities. And, while the cost may currently be prohibitive due to the plan’s funded status, it may still be helpful to have a discussion regarding the termination of the entire plan (if frozen) or a portion of the plan (if ongoing).

As PBGC premiums have increased so has the need to find strategies to reduce them. The strategies above, which eliminate terminated vested and/or retirees from the plan, will directly decrease the flat rate portion of the overall PBGC premium as participant counts drop. And, any strategy that improves the plan’s funded status through cash contributions, asset performance, or decreases in the plan’s liabilities, will reduce the variable rate portion of the overall PBGC premiums. One particular strategy to issue pension-related debt will be discussed in more detail in the next section.

Source: Aon Hewitt internal calculations

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Broader Impact on Enterprise Financial Profile

Having evaluated the impact of ERISA compliance, we believe the risk assessment could continue from an enterprise risk management standpoint as plan sponsors would benefit from getting ahead of broader risks stemming from a potential negative outcome for the hospital or health system. A negative outcome on church plan status could adversely affect the enterprise financial profile and the credit rating of the hospital and/or obligated group. In fact, any risk that could result in increased cash outlay could adversely affect the enterprise financial profile.

Enterprise Credit Rating Risk

Of particular consideration is the potential impact on hospital credit ratings in different operating and market environments. Generally, pension benefit obligations are recognized against unrestricted reserves, which serve as the general operating pool for operating expenses, capital expenditures, and other general outlays. Without a separately designated reserve to cover settlement costs, all or a substantial amount of funding may need to be sourced from operating assets, which at some hospitals, may already be under pressure for its ability to support debt service and liquidity. In our analysis of lawsuits filed since 2013 to date, the underfunded amount as a percentage of unrestricted reserves is estimated to average 18% and ranges from a low of 4% to a high of 238%. While settlements generally are much lower than the whole underfunded level, and plan sponsors are given a multi-year timeline to make contributions, it is clear that for some hospitals and health systems with weaker reserves, the risk of insolvency is very real.

Metrics, such as MADS (maximum annual debt service) and DCOH (days’ cash on hand), are key to supporting a hospital’s credit rating potentially altering its cost of capital structure. As an example, some plan sponsors may consider issuing debt as a strategy to improve their plan’s funded status and generate an immediate benefit in lower operating expenses. However, in some cases the benefit can be more than offset by the adverse impact to debt service capacity and other liquidity ratios (such as lower MADS, lower unrestricted cash to long-term debt ratio) due to an increase to the longer term debt burden. Depending on the organization’s enterprise financial strength, flexibility, regional market dynamics and the budget plan, “borrow to fund” has the potential to adversely affect credit rating. For plan sponsors, fully quantifying the longer term financial implications may be further challenged by an already difficult business environment of escalating cost and margin compression, as well other concurrent events that add to financial pressure, such as declining or variable operating performance, potential M&A activity (particularly if the target also sponsors a church plan), new debt issuance (possibly to fund settlement costs), or expansion projects.

Asset Pool Investment and Implementation Risks

Finally, in assessing the broader impact on the enterprise, it may also be prudent to consider how the investment policies of pension and operating asset pools can further support the credit rating. This would entail better aligning the investment risks with the relevant financial metrics, as well as evaluating how changes on the financial side could impact investments and vice versa. As the financial profile and financial needs of the enterprise evolve, the investment allocation of the unrestricted reserves can be calibrated in response to changes in the business environment in addition to changes in the capital markets.
In Conclusion

In light of the complex requirements for operating a pension plan in compliance with ERISA and the Code and the extensive impact on the plan sponsor, health care organizations will want to evaluate, in a coordinated way, the various risks and the steps that may be taken to reduce those risks. Given the interlinked nature of these risks with other business and financial risks and their impact on the total enterprise, the time is ripe to consult health care and church plan industry experts who can help employers sponsoring church plans to address and evaluate these risks in an integrated manner. For example, health care organizations may wish to do the following:

- Keep up to date on the results of the ongoing church plan status litigation and its impacts on the affected employers;
- Improve their knowledge of ERISA, the Pension Protection Act, and IRS funding and PBGC rules;
- Train plan service center representatives to respond appropriately to inquiries from participants about the church plan status of a particular plan;
- Review historical funding and current funded status to understand the plan’s overall health;
- Determine potential future costs if ERISA-required cash contributions and PBGC premiums were to apply;
- Evaluate potential plan administration changes and nondiscrimination regulations as required by ERISA;
- Assess the impact on accounting expense and liabilities;
- Consider liability settlement strategies that may become more palatable due to added costs of PBGC premiums;
- Evaluate the impact on key financial metrics to support credit rating such as DCOH (days' cash on hand) and MADS (maximum annual debt service);
- Address potential solvency risk\(^3\) by looking at liquidity, debt and other capital needs; and
- Align and integrate investment risks of managing asset pool investments with broader financial risks to further support the enterprise credit rating.

\(^3\) In our analysis of lawsuits filed since 2013 to date, the underfunded amount as a percentage of unrestricted reserves is estimated to average 18% and ranges from a low of 4% to a high of 238%. While settlements generally are much lower than the whole underfunded level and plan sponsors are given a multi-year timeline to make contributions, it is clear that for some hospitals and health systems with weaker reserves, the risk of insolvency is very real.
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