

IN THE
Supreme Court of the United States

FEDEx CORPORATION, ET AL.,
Petitioners,

v.

ROBERT A. WATT, ET AL.,
Respondents.

BAKERY, CONFECTIONARY, TOBACCO WORKERS AND
GRAIN MILLERS PENSION COMMITTEE, ET AL.,
Petitioners,

v.

THOMAS N. REICHERT, ET AL.,
Respondents.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

**BRIEF OF THE ERISA INDUSTRY COMMITTEE AS
AMICUS CURIAE IN SUPPORT OF PETITIONERS**

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INTEREST OF *AMICUS CURIAE*¹

The ERISA Industry Committee (“ERIC”) is a national non-profit trade association representing the interests of approximately 100 of the nation’s largest employers in their capacity as sponsors of employee benefit plans for their workers, retirees, and families. ERIC routinely participates as *amicus curiae* in cases arising under the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 *et seq.* (“ERISA”), concerning employee-benefit plan design, expense, regulatory compliance, and administration. *See, e.g., Anderson v. Intel Corp. Invest. Pol’y Comm.*, No. 25-498 (2026); *Cunningham v. Cornell Univ.*, 604 U.S. 693 (2025); *Hughes v. Nw. Univ.*, 595 U.S. 170 (2022); *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409 (2014).

¹ Pursuant to Supreme Court Rule 37.6, *amicus* states that no counsel for a party authored any part of this brief. No party or counsel for a party, and no person other than *amicus*, its members, or its counsel, made a monetary contribution intended to fund its preparation or submission. Pursuant to Supreme Court Rule 37.2, *amicus* notified counsel for all parties of its intent to file this brief.

SUMMARY OF ARGUMENT

This petition arises from a wave of litigation that seeks to transform ERISA’s requirement of “actuarial equivalence” into an unwritten mandate that pension plans continually update actuarial assumptions to satisfy a judicially-imposed standard of “reasonableness.” This theory has attracted substantial attention from the plaintiffs’ bar, but courts have reached conflicting conclusions. Actuaries have advanced competing views of which assumptions are supposedly “reasonable.” And the Sixth Circuit itself acknowledged that reasonableness is “a range, not a precise prescription.” *Reichert v. Kellogg Co.*, 170 F.4th 473, 483 (6th Cir. 2026).

The Sixth Circuit imposes its vague “reasonableness” standard into a provision of ERISA that, upon searching review of its text, legislative history, and purpose, contains *no* such requirement or evidence of such an intended requirement. This Court has long recognized that ERISA is a “comprehensive and reticulated” statute, enacted after “almost a decade of studying the Nation’s private pension plans” and, as such, has been loath to add to its terms. *Nachman Corp. v. Pension Ben. Guar. Corp.*, 446 U.S. 359, 361 (1980); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993). ERISA does not say “reasonable” in the text at issue, and this Court should not permit the lower courts to so insert it. *See M&K Emp. Sols., LLC v. Trustees of IAM Nat’l Pension Fund*, 608 U.S. 264, 274 (2026) (“We generally do not read limitations into statutes that do not appear in their text”).

The decision below is wrong for several other reasons. ERISA does not require any employer to provide benefits but affords reliability to both participants and employers needing predictable obligations and standards. Congress has repeatedly imposed express reasonableness requirements on actuarial assumptions in other parts of ERISA and required specific actions by employers and plan sponsors when it wished to do so. Congress did neither here. This judicially-created “reasonableness” requirement cannot be reconciled with Congress’s decision to protect plan-defined benefits from discretionary change by sponsors and has further created a direct and irreconcilable conflict with provisions of ERISA and the Internal Revenue Code (“IRC”).

The impact of the Sixth Circuit’s decision is substantial and extends well beyond the parties in these cases. There are over 20,000 active defined benefit plans that account for approximately \$4.3 trillion in benefit liabilities. The decision below means that a plan must pay benefits not based on what the plan says, but on what is “reasonable” in the eyes of a beholder. But what is “reasonable” to one, may be “unreasonable” to another.

Plan sponsors are now left to guess which actuarial assumptions a future court may, in hindsight, deem sufficiently “reasonable.” And the decision below imposes substantial liability whenever a court concludes that different assumptions should have been used. If allowed to stand, this decision will increase costs and risks associated with offering and maintaining defined benefit plans, which is a result

that Congress specifically and repeatedly sought to avoid in enacting and amending ERISA.

The Court should grant the Petitions to correct the Sixth Circuit's erroneous interpretation of ERISA § 1055(d) and restore the uniformity and reliability Congress intended ERISA to provide plan sponsors and participants alike.

ARGUMENT

I. The Sixth Circuit's "reasonableness" requirement conflicts with ERISA's purpose and carefully balanced statutory framework.

Two features of ERISA's statutory design demonstrate the error of the Sixth Circuit's approach. First, Congress required actuarial assumptions to be *fixed* in written plan documents and protected participants' plan-defined benefits through specific statutory safeguards. Second, Congress deliberately regulated actuarial assumptions through targeted rules and anti-cutback protections that plan sponsors would have to violate to comply with the Sixth Circuit's new "reasonableness" requirement.

A. Federal law requires actuarial assumptions to be included in plan documents.

1. Although the Petitioners amply explain the statutory framework governing the questions presented, a brief discussion of how defined benefit plans operate and how actuarial equivalence is determined helps lay the groundwork for how

Congress chose to regulate “actuarial assumptions,” generally, the safeguards it enacted to protect participants, and the role that written plan documents play in that scheme.

Defined benefit plans promise participants a specified retirement benefit, typically payable as a lifetime annuity. *See, e.g., Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 439-40 (1999). Participants ordinarily accrue benefits in the form of a single life annuity (“SLA”), under which the participant receives benefits from retirement until their death. For married participants, in particular, ERISA generally provides that unless the participant and spouse elect otherwise, their benefits must be paid through a qualified joint and survivor annuity (“QJSA”), which is a payment stream for the participant’s life and, after they die, their spouse’s life. 29 U.S.C. § 1055(a)(1), (b)(1), and (d)(1). The married participant may, however, elect alternative forms of annuities, such as a ten-year certain and life annuity, an annuity with cost-of-living adjustment, or a qualified optional survivor annuity. *See, e.g.,* 29 U.S.C. § 1055(d)(2). Importantly, no matter what alternative form is chosen, it must be the “actuarial equivalent” of the participant’s accrued benefit. 29 U.S.C. § 1055(d)(1)(B), (2)(A)(ii); 29 U.S.C. § 1054(c)(3). Though “actuarial equivalent” is undefined, three actuarial assumptions are used to determine actuarial equivalence: (1) a mortality table predicting how long a participant will live, (2) a mortality table predicting how long their spouse will live, and (3) an interest rate to discount the expected payments to present value. Together, these assumptions are used to calculate a “conversion factor,” also referred to as

an “adjustment factor.” *See* Rev. Rul. 79-90, 1979-1 C.B. 155.

When originally enacted in 1974, ERISA did not require the conversion factors to be identified in the plan documents. That changed. In 1979, the Internal Revenue Service (“IRS”) decided that employers have *no discretion* to change the conversion factors because that discretion would violate the requirement in Treasury Regulation § 1.401-1(b)(1)(i) that benefits be “definitely determinable.” *See* Rev. Rul. 79-90. Under Revenue Ruling 79-90, a plan can either specify the interest rate and mortality tables, *or* it can simply include a table of conversion factors (referred to in the revenue ruling as “adjustment factors”). At the time, IRS guidance provided that a benefit would only be “definitely determinable” if the benefit could be determined “by means of an express benefit formula contained in the plan.” *See* Rev. Rul. 71-24, 1971-1 C.B. 114; 26 C.F.R. § 1.401-1(b)(1)(i).

Around the same time, Congress became increasingly concerned about providing additional protections for employees (and their spouses) who participate in defined benefit plans.² One concern was that plans could use unusually high interest rates to value lump sum benefits, thereby reducing the amount ultimately paid to participants. H.R. Rep. No. 103-632, pt. 2, at 57 (1994) (“If plans could use high interest rates, plans could lower the single sum paid to participants.”); *see Mathews v. Sears Pension Plan*,

² Social Security Bulletin, May 1985/Volume 48, No. 5, <https://www.ssa.gov/policy/docs/ssb/v48n5/v48n5p38.pdf> [perma.cc/6Z65-HJC5].

No. 95 C 1988, 1997 WL 392245, at *1-4 (N.D. Ill. July 7, 1997), *aff'd*, 144 F.3d 461 (7th Cir. 1998); *McCarthy v. Dun & Bradstreet Corp.*, 482 F.3d 184, 206 (2d Cir. 2007) (acknowledging that employers could “manipulate” the benefits provided to a participant, “particularly in a year in which interest rates were extraordinarily high.”).

Congress acted and addressed these concerns with the Retirement Equity Act of 1984, Pub. L. No. 98-397, 98 Stat. 1426 (the “REA”). The REA codified Revenue Ruling 79-90, thus requiring plan sponsors to include conversion factors (or the mortality and interest assumptions used to compute them) in the plan documents, and expressly precluded employer “discretion” to make changes to them. 26 U.S.C. § 401(a)(25) (“**Requirement that actuarial assumptions be specified.**—A defined benefit plan shall not be treated as providing definitely determinable benefits unless, whenever the amount of any benefit is to be determined on the basis of actuarial assumptions, such assumptions are *specified in the plan* in a way which *precludes employer discretion*” (emphases added)). Thus, Congress expressly prohibited employers from “manipulating” the benefit or “play[ing] favorites.” *Brengettsy v. LTV Steel (Republic) Hourly Pension Plan*, 241 F.3d 609, 612 (7th Cir. 2001) (“The [IRC] does not require that the defined benefit be fixed, but only that it be determinable according to criteria specified in advance that do not permit the plan to play favorites.”); *McCarthy*, 482 F.3d at 206 (“The court recognizes the concern expressed in the relevant provisions of Title 26, Title 29, and the related regulations, that employers should not be able to

manipulate actuarial assumptions to their benefit and to the detriment of employees.”).

The REA also required that the interest rate used to calculate lump sum distributions not be greater than the rate used by the Pension Benefit Guaranty Corporation (“PBGC”) to calculate *lump sum* distributions. 29 U.S.C. § 1055, as amended by Pub. L. No. 98-397, 98 Stat. 1432-33; *see* H.R. Rep. No. 103-632, pt. 2, at 57 (1994) (“Congress adopted the interest rate cap to prevent plans from using unreasonably high interest rates to determine the present value of participants’ benefits.”); *accord Mathews*, 1997 WL 392245, at *3.

Tellingly, while the REA imposed a specific limitation on the interest rate used to calculate lump sum distributions, it initially imposed no limitation on mortality tables used to calculate lump sum distributions, and no restrictions at all on the actuarial assumptions used to calculate QJSAs and other alternative annuity forms for married participants, apart from the requirement that the factors be identified in the plan document. *See* 29 U.S.C. § 1055(g)(3); 26 U.S.C. § 401(a)(25); *see also* Reichert, 170 F.4th at 498 (Nalbandian, J., dissenting) (quoting from H.R. Rep. No. 103 632, pt. 2, at 57 (1994)).

2. Congress’s decision to require the actuarial assumptions to be fixed in the plan reflects ERISA’s broader commitment to protecting plan-defined benefits. When Congress enacted ERISA, it “did not require employers to establish benefit plans in the first place.” *Conkright v. Frommert*, 559 U.S. 506,

516-17 (2010); *see Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); 29 U.S.C. § 1001 (setting forth congressional findings and declarations of policy regarding ERISA). If an employer chooses to offer benefits, however, ERISA serves to protect those “contractually defined benefits.” *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (citations omitted); *U.S. Airways, Inc. v. McCutchen*, 569 U.S. 88, 100 (2013).

This Court has made clear time and again that ERISA’s statutory scheme “is built around reliance on the face of written plan documents.” *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995); *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 571 U.S. 99, 108 (2013) (noting the written terms of the plan are the “linchpin” of the ERISA system). Employees should be able to look to, and rely upon, the plan document for the benefits contractually promised to them by their employers. *Curtiss-Wright Corp.*, 514 U.S. at 83 (noting the importance of the “written [benefit] plan is [so] that every employee may, *on examining the plan documents*, determine exactly what his rights and obligations are under the plan.”). Indeed, ERISA enables a participant to bring a lawsuit “to recover benefits due to him *under the terms of his plan*, to enforce his rights *under the terms of the plan*, or to clarify his rights to future benefits *under the terms of the plan*.” 29 U.S.C. § 1132(a)(1)(B) (emphases added). The “statutory language speaks of ‘*enforc[ing]*’ the ‘terms of the plan,’ not of *changing* them.” *Heimeshoff*, 571 U.S. at 108 (alteration in original) (quoting *CIGNA Corp. v. Amara*, 563 U.S. 421, 436 (2011)). For that reason, this Court has

“recognized the particular importance of enforcing plan terms ***as written*** in § 502(a)(1)(B) claims.” *Id.* (emphasis added).

Nothing in ERISA requires the periodic updating of the actuarial assumptions used to calculate the annuity benefits at issue here—these assumptions are *required* to be identified in the plan document or else the plan can lose its tax-qualified status. See 26 U.S.C. § 401(a) and (a)(25); see also *Reichert*, 170 F.4th at 495 (Nalbandian, J., dissenting). Had Congress intended to impose an ongoing updating requirement, it would have said so and prescribed the circumstances triggering an update, the timing of that update, and the assumptions to be used. That is exactly what Congress did when it required plans to update actuarial equivalence factors periodically in the calculation of *other* forms of defined benefits not at issue here, namely *lump sums*. See, e.g., ERISA § 205(g)(3)(B)(ii), 29 U.S.C. § 1055(g)(3)(B)(ii) (“The term ‘applicable interest rate’ means . . . *for the month before the date of distribution*” (emphasis added)); ERISA § 303(h)(2), 29 U.S.C. § 1083(h)(2) (requiring factors to be updated annually based on *the plan year*). The absence of any statutory or regulatory requirement to periodically update the actuarial assumptions used to calculate the annuity benefits at issue here is dispositive.

The Second Circuit has rejected the contention that ERISA requires actuarial assumptions to be “periodically” updated after they are written into a plan. *McCarthy*, 482 F.3d at 206-07 (“ERISA does not specifically require that retirement plans periodically adjust their actuarial interest rates.”). In reaching

that conclusion, the Second Circuit pointed to the very concern that prompted Congress to enact the REA and IRC § 401(a)(25) in the first place, which was to prevent employers from manipulating actuarial assumptions after the fact to the detriment of participants. *Id.*

Historical data on life expectancy and interest rates confirm the Second Circuit's concern in *McCarthy*. Both have varied in both directions over time. See Section I.B., *infra*. The consequence of rising interest rates, for example, is that QJSA factors and QJSA benefits increase, and when interest rates fall, so do they. But, despite these fluctuations, the plan sponsor's promise and the participant's benefit do not change because the underlying assumptions are identified in the plan document and control and Congress expressly limited employer discretion to alter them.

What Congress did not do was create an ongoing, undefined, and unstated obligation to revise or update those assumptions at some unspecified time or on some unspecified schedule. And it did not impose such a duty on plan sponsors whenever a plaintiff's hired expert would prefer different actuarial assumptions, or whenever a court, looking back at a decision made years later, concludes that different assumptions might now be more "reasonable" based on changed circumstances.

Significantly, Congress imposed specific mortality-table and interest-rate requirements for lump sum calculations, required those assumptions to be determined by reference to current periods

updated annually, and mandated that actuarial assumptions used in other contexts be “reasonable.” *See, e.g.*, 29 U.S.C. § 1083(h)(1)(A); 29 U.S.C. § 1393(a)(1). But Section 1055(d) contains no reasonableness requirement, no currentness requirement, and no updating requirement. *See id.* § 1055(d). Courts therefore may not impose one. *M&K Emp. Sols.*, 608 U.S. at 274. And where Congress includes specific language in one provision but omits it in another, courts presume the omission was intentional. *Russello v. United States*, 464 U.S. 16, 23 (1983).

B. A judicially created “reasonableness” requirement produces irreconcilable conflicts with ERISA and the IRC.

Beyond departing from statutory text and well-established legislative purpose, the Sixth Circuit’s decision to “blue-pencil” a reasonableness requirement into ERISA § 1055(d) creates an irreconcilable conflict among statutory provisions that Congress had carefully designed to work harmoniously. If actuarial assumptions must be continually updated or risk being found “unreasonable,” plan sponsors will be faced with mutually incompatible obligations. Plan sponsors must, ostensibly, update actuarial assumptions to satisfy the Sixth Circuit’s unwritten, policy-based rule, yet some of those updated actuarial assumptions cannot be implemented without violating ERISA and the IRC’s anti-cutback provision, which prohibits any change to conversion factors that would *reduce* a participant’s accrued benefits. 26 U.S.C. § 411(d)(6); 29 U.S.C. § 1054(g); *see Cent. Laborers’ Pension Fund*

v. Heinz, 541 U.S. 739, 744, 746-47 (2004). Specifically, when updating the assumptions would result in lower benefits, complying with the Sixth Circuit’s rule violates Congress’s rule.

1. The anti-cutback rule reflects Congress’s decision to protect accrued benefits from subsequent reductions caused by fluctuating actuarial assumptions. In enacting the REA, Congress recognized that actuarial assumptions and conversion factors would change over time, and that some future changes could reduce the value of benefits participants had already earned. To protect against that risk, Congress amended both ERISA and the IRC to prohibit amendments that reduce certain retirement benefits, including reductions resulting from less favorable actuarial conversion factors. 29 U.S.C. § 1054(g); 26 U.S.C. § 411(d)(6); 26 C.F.R. §§ 1.411(d)-3, 1.411(d)-4. Put another way, conversion factors in a defined benefit plan can only ever be increased, *not* reduced. 29 U.S.C. § 1054(g); 26 U.S.C. § 411(d)(6); 26 C.F.R. § 1.411(d)-3 and (d)-4; *Stamper v. Total Petroleum, Inc. Ret. Plan*, 188 F.3d 1233, 1238 (10th Cir. 1999) (discussing the REA’s incorporation of Revenue Ruling 81-12 into ERISA and the IRC); *accord* 26 C.F.R. § 1.411(d)-3(g)(6)(ii)(A) (confirming the actuarial factors are part of the “Section 411(d)(6) protected benefits”).

Congress adopted those protections against a backdrop in which the actuarial assumptions used to calculate retirement benefits were expected to change over time. Mortality assumptions change as life expectancy changes. Interest rates likewise fluctuate, often dramatically. Congress therefore understood

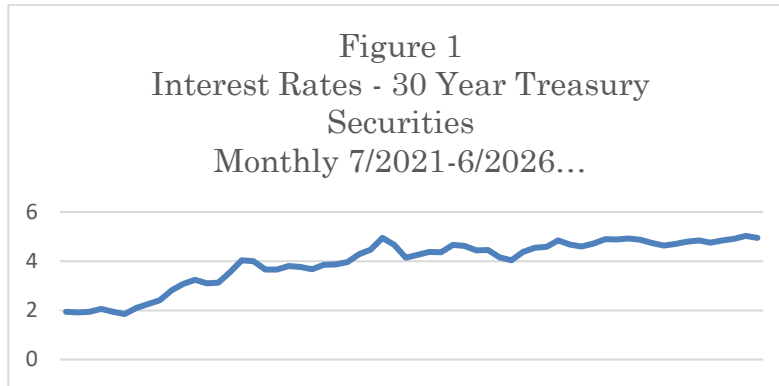
that periodically recalculating actuarial conversion factors would not always increase benefits; depending on the direction of those changes, it could just as easily reduce them.

Historical data confirms that Congress's concerns were well founded and illustrates why it chose to implement anti-cutback protections over a regime of continual updates. Life expectancy goes up and down.³ Interest rates have gone both up and down far more significantly over the last 50 years than mortality tables, ranging from 0.99% to 15.21%.⁴

³ Though the plaintiffs' bar suggests that life expectancies only increase over time, CDC statistics show that life expectancy in the United States went *down* in 2015, 2016, 2017, 2020, and 2021. See Nat'l Ctr. for Health Stat., Ctrs. for Disease Control & Prevention, Mortality in the United States, 2015, NCHS Data Brief No. 267 (Dec. 2016), <https://www.cdc.gov/nchs/products/databriefs/db267.htm> [perma.cc/2MNS-XDJJ]; *Id.*, Mortality in the United States, 2016, NCHS Data Brief No. 293 (Dec. 2017), <https://www.cdc.gov/nchs/products/databriefs/db293.htm> [perma.cc/8AQG-ZPW3]; *Id.*, Mortality in the United States, 2017, NCHS Data Brief No. 328 (Nov. 2018), <https://www.cdc.gov/nchs/products/databriefs/db328.htm> [perma.cc/L3S3-436V]; *Id.*, Mortality in the United States, 2020, NCHS Data Brief No. 427 (Dec. 2021), <https://www.cdc.gov/nchs/products/databriefs/db427.htm> [perma.cc/D7MD-YWSD]; *Id.*, 2021, NCHS Data Brief No. 456 (Dec. 2022), <https://www.cdc.gov/nchs/products/databriefs/db456.htm> [perma.cc/RN2B-EBGG]; see also S. Jay Olshansky et al., *A Potential Decline in Life Expectancy in the United States in the 21st Century*, 352 New Eng. J. Med. 1138 (2005).

⁴ The yield on 30-year treasury securities has varied from a high of 15.21% on October 26, 1981 to a low of 0.99% on March 9, 2020. See Bd. of Governors of the Fed. Rsrv. Sys., Federal Reserve Statistical Release H.15: Selected Interest Rates (Market Yield on U.S. Treasury Securities at 30-Year Constant Maturity, daily

Figure 1 shows the tremendous volatility that interest rates have had over the last five years, going from under 2% to over 5%, with swings of more than 100 basis points in periods of just a few months.



Similarly, Figure 2 shows that in the early 1980s, interest rates were historically high and trended significantly downward over the next four decades. This is important because QJSA factors and QJSA benefits rise when interest rates go up, and fall when interest rates go down.

historical data), <https://www.federalreserve.gov/releases/h15/perma.cc/7AQS-ZXBX>].

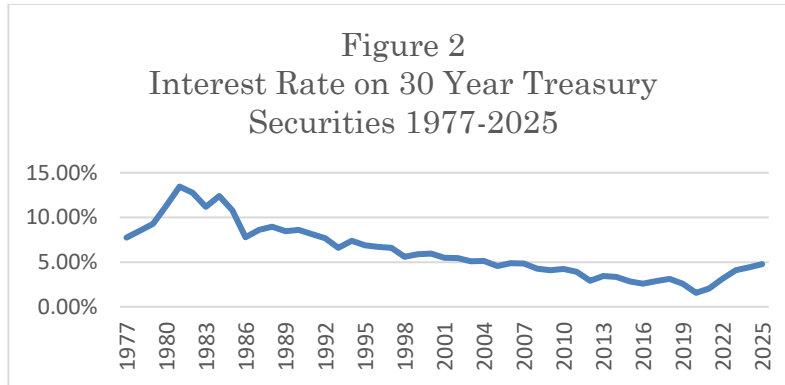
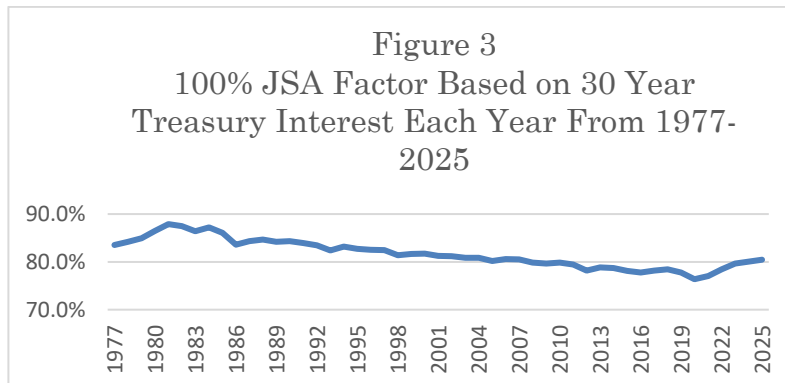


Figure 3 shows that QJSA factors would have generally trended downward over the last four decades had they been periodically updated to reflect then-current interest rates.



2. Plaintiffs would have this Court believe that updating the factors from time to time would always result in *increased* benefits for employees. Not so. Actuarial assumptions can move in either direction, and updated assumptions do not necessarily benefit *every* participant. Courts confronting these issues have recognized that updated assumptions can leave some participants worse off, that no single

methodology produces higher benefits for all participants, and that participants' interests may diverge depending on their age, benefit form, and retirement circumstances (*i.e.*, early or late retirement). *See Belknap v. Partners Healthcare Sys., Inc.*, 588 F. Supp. 3d 161, 176 (D. Mass. 2022); *Torres v. Am. Airlines, Inc.*, 2020 WL 3485580, at *10-12 (N.D. Tex. May 22, 2020) (denying class certification because plaintiffs' proposed relief, including "reforming the definition of 'Actuarial Equivalent' in the Plans," "would harm some class members [plaintiffs] seek to represent"); *Thorne v. U.S. Bancorp*, 2021 WL 1977126, at *2 (D. Minn. May 18, 2021).

In fact, depending on the benefit and participant involved, updated mortality tables or interest rates may *reduce* some participants' benefits while increasing others'. *See Torres*, 2020 WL 3485580, at *11; *see also* Defendants' Opposition to Motion for Class Certification at 20-22, *Berkeley v. Intel Corp.*, No. 5:23-cv-00343 (N.D. Cal. filed Jan. 23, 2023), Dkt. No. 80 (explaining that application of plaintiffs' preferred § 417(e) assumptions would leave many participants worse off and that plaintiffs sought certification of a class limited to participants whose benefits would increase under those assumptions); Defendants' Opposition to Motion for Class Certification at 8, *Skrnich v. Pinnacle W. Capital Corp.*, No. 2:22-cv-01753 (D. Ariz. filed Oct. 13, 2022), Dkt. No. 64 (noting that plaintiffs sought certification only for participants whose benefits would increase under plaintiffs' preferred assumptions); Plaintiffs' Proposed Renewed Motion for Class Certification with Narrowed Class Definition at 1-2, *Adams v. U.S.*

Bancorp, No. 0:22-cv-00509 (D. Minn. filed Feb. 28, 2022), Dkt. No. 181-1 (same).

If there were a requirement for plan sponsors to change factors periodically (as the plaintiffs’ bar advocates), they could only be adjusted **upward**, consistent with the anti-cutback rule in ERISA and the IRC. 29 U.S.C. § 1054(g); 26 U.S.C. § 411(d)(6)(B)(ii); 26 C.F.R. § 1.411(d). Eventually, the equivalence factors would become “unreasonable” in their parlance, because plan sponsors could not lawfully adjust or update them based on more recent events that would bring such factors **down**. Indeed, the factors would necessarily reflect the most participant-favorable conditions that ever existed. Because of the one-way impact of the anti-cutback rule, requiring unspecified “updates” to make the assumptions currently “reasonable” would produce the opposite result—unreasonably high actuarial factors that would no longer reflect current conditions when interest rates or life expectancy went down.

Congress did not intend this absurd result. Congress has repeatedly amended ERISA and the IRC to specify when various actuarial assumptions for *different* purposes need to be increased, decreased, capped, or changed. *See, e.g.*, Retirement Equity Act of 1984, Pub. L. No. 98-397, § 203(b), 98 Stat. 1426, 1441 (codified as 26 U.S.C. § 417 (1984)); Tax Reform Act of 1986, Pub. L. No. 99-514, § 1139(b)-(c), 100 Stat. 2085, 2487-2488; Retirement Protection Act of 1994, Pub. L. No. 103-465, §§ 751(a)(7), 761(a)(7), 767(a)(2), 767(c)(2), 108 Stat. 4809, 5015-5016, 5028, 5038-5039; Pension Protection Act of 2006, Pub. L. No. 109-280, §§ 102, 112, 302, 120 Stat. 780, 797-798,

800, 834-837, 920-921. Every time Congress has amended IRC § 417(e) to change the mortality table and interest rate that needs to be used for lump sum calculations, Congress has simultaneously enacted a specific and targeted exception to the anti-cutback rule at 26 U.S.C. § 411(d)(6)(B). *See e.g.*, Tax Reform Act of 1986, Pub. L. No. 99-514, § 1139(d)(2), 100 Stat. 2085, 2488; Retirement Protection Act of 1994, Pub. L. No. 103-465, § 767(d)(2), 108 Stat. 4809, 5040; Pension Protection Act of 2006, Pub. L. No. 109-280, § 1107, 120 Stat. 780, 1063. This alone confirms the fundamental conflict between the anti-cutback rule and any theory that actuarial assumptions for annuity conversions must be constantly adjusted for reasonableness.

ERISA § 1055(d) contains no reasonableness component, updating requirement, or exception to the anti-cutback rule. Over the 52 years since ERISA's enactment, Congress has not imposed such a regime for annuity-conversion assumptions, even while doing so repeatedly in other contexts. Whether such a system should exist is a policy judgment for Congress, not the courts. The Sixth Circuit erred by refusing to leave this settled matter exclusively to the Legislature. *King v. Burwell*, 576 U.S. 473, 498 (2015) (citing *Marbury v. Madison*, 5 U.S. 137, 177 (1803)); *see Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 591 U.S. 657, 677 (2020) ("It is a fundamental principle of statutory interpretation that absent provision[s] cannot be supplied by the courts." (internal quotation marks omitted)); *Honeycutt v. United States*, 581 U.S. 443, 454 n.2 (2017) ("[T]he Court cannot construe a statute in a way that negates its plain text").

II. If uncorrected, the decision below will create intolerable uncertainty and litigation risk that ERISA was intended to avoid.

A. Plan sponsors cannot navigate and comply with the growing patchwork of actuarial-equivalence rulings.

Congress enacted ERISA to replace the fragmented and often inconsistent regulation of employee benefit plans with a nationally uniform framework. *See* 29 U.S.C. § 1001 (“Findings and Declaration of Policy”); *Rutledge v. Pharm. Care Mgmt. Ass’n*, 592 U.S. 80, 86 (2020); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). But the growing division of lower court rulings is moving rapidly in the opposite direction. *See* Petition at 13-20, *Bakery v. Reichert*, No. 26-387. Some courts have followed the Sixth Circuit’s approach, others have rejected it, and still others have recognized the growing divide without identifying any workable standard for resolving it. *See id.*; *Berkeley*, 2026 WL 948725, at *4 (“District courts across the country are split”); *Landel v. Olin Corp.*, 2026 WL 785044, at *4-5 (E.D. Mo. Mar. 20, 2026); *Scott v. AT&T, Inc.*, 790 F. Supp. 3d 781, 789-90 (N.D. Cal. 2025); *Masten v. Metro. Life Ins. Co.*, 543 F. Supp. 3d 25, 34-35 (S.D.N.Y. 2021); *Drummond v. S. Co. Servs., Inc.*, 177 F.4th 1076, 1080 (11th Cir. 2026), *petition for cert. docketed*, No. 26-443 (U.S. Oct. 2, 2026). Such a regime is fundamentally inconsistent with the orderly administration of defined benefit plans upon which millions of participants, beneficiaries, and their families rely, and it is precisely the sort of “patchwork

scheme” Congress sought to eliminate when it adopted a nationally uniform framework for administering retirement benefits in the first place. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987); H.R. Rep. No. 93-533, p. 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650 (“[A] fiduciary standard embodied in Federal legislation is considered desirable because it will bring a measure of uniformity in an area where *decisions under the same set of facts may differ from state to state*” (emphasis added)).

This is a primary reason for the Court to grant the Petitions and take up this matter now. No further “split” should be necessary for the Court to address these cases.

B. An amorphous “reasonableness” standard leaves employers and plan sponsors with no clear path to compliance.

Despite holding as a matter of law that ERISA contains an implicit reasonableness requirement, the Sixth Circuit explained only that reasonableness is “a range, not a precise prescription.” The court left unanswered how often assumptions must be revisited, whether they must be independently reasonable or reasonable in the aggregate, how current they must be, which assumptions are sufficiently reasonable, who decides when an update is required, and what assumptions should replace those deemed insufficient. *See generally Reichert*, 170 F.4th at 475-488. A standard framed at that level of abstraction is of little benefit in any practical sense.

As the actuarial standards of practice (“ASOPs”) make clear, actuarial science is a matter of “professional judgment” and “***actuaries can reasonably reach different conclusions when faced with the same facts.***”⁵

In justifying its “reasonableness” standard, the Sixth Circuit suggests that a plan sponsor could rely on the professional judgment of its plan actuary. *See Reichert*, 170 F.4th at 486. That does not solve the problem. A plan sponsor may act in good faith and rely on an actuary to confirm the plan’s assumptions are “reasonable.” Nevertheless, other actuaries hired by the plaintiffs’ bar have advanced varying views regarding what assumptions they believe are “reasonable.”⁶ So the plan sponsor could still face

⁵ Actuarial Standards Bd., Actuarial Standard of Practice No. 1: Introductory Actuarial Standard of Practice § 3.1.4 (Mar. 2013) (eff. June 1, 2013), <https://www.actuarialstandardsboard.org/asops/introductory-actuarial-standard-practice> [perma.cc/224V-GRNU].

⁶ *See, e.g.*, Expert Report of Ian Altman at 22, 26, *Paieri v. W. Conf. of Teamsters Pension Tr. Fund*, No. 2:23-cv-00922 (W.D. Wash. filed June 19, 2023), Dkt. No. 98-1 (preferring IRC § 417(e) interest rates and the mortality table used by the plan’s actuary for funding purposes, modified to a unisex table assuming participants are 85% male); Expert Report of Mitchell Serota at 29, *Cruz v. Raytheon Co.*, No. 1:19-cv-11425 (D. Mass. filed June 27, 2019), Dkt. No. 52-3 (preferring interest-rate assumptions employed for GAAP purposes and under Accounting Standards Codification 715 (“ASC 715”), together with IRC § 417(e) mortality tables); Expert Report of Mitchell Serota at 42-43, *Smith v. U.S. Bancorp*, No. 0:18-cv-03405 (D. Minn. filed Dec. 14, 2018), Dkt. No. 128-3 (preferring FTSE interest rates and IRC § 417(e) mortality tables); Expert Report of David Pitts at 13, *Berube v. Rockwell Automation, Inc.*,

years of costly litigation, simply because another actuary thinks another set of assumptions would have been *more* “reasonable”—leaving district courts to continuously referee such expert battles. Simply put, a plan sponsor seeking to comply with the law *cannot* identify a set of assumptions that will reliably avoid challenge because the answer now depends on which court is asked and which expert is retained.

C. This decision will fuel costly litigation while providing little benefit to plan participants.

The incentives created by the decision below offer little prospect of improving retirement security for plan participants. Since 2018, over three dozen lawsuits have been filed against large employers—led by members of the plaintiffs’ bar who describe themselves as “pioneers” of this “novel” theory and acknowledge that it presents a “cutting-edge and complex” question under ERISA. Plaintiff’s Mem. in Support of Mot. for Final Approval of Class Action Settlement at 2, 6-8, 11, 14, 17, *Herndon v. Huntington Ingalls Indus., Inc.*, Case No. 4:19-cv-00052 (E.D. Va. filed May 20, 2019), Dkt. No. 131. Boiled down, though, this theory simply is that a plan term, expressly set forth in the plan document, has become so “old” that employers and plan sponsors supposedly have a legal duty to disregard a written term of a plan

No. 2:20-cv-01783 (E.D. Wis. filed Dec. 2, 2020), Dkt. No. 55-6 (preferring IRC § 417(e) interest rates and mortality assumptions employed for GAAP purposes under ASC 715); Expert Report of Ian Altman at 17-18, *Masten*, No. 1:18-cv-11229, Dkt. No. 139-4 (preferring IRC § 417(e) interest rates and GAAP/ASC 715 mortality assumptions).

and replace it with a term more favorable to the specific employees who the relevant plaintiff's counsel currently represent, and no others. *See id.* at 8, 20. As both Petitions explain, the decision below effectively invites claims whenever a participant can identify any alternative assumption that would have produced a larger benefit for him or her, but not necessarily *all* participants. Complex statutory schemes like ERISA and the IRC should not be based on such shifting and self-serving notions.

Even the architects of this “cutting-edge” theory acknowledge that these disputes come down to a “battle of the experts.” *Herndon*, No. 4:19-cv-00052, Dkt. No. 131 at 2, 16. Fortunately for them, and only them, that makes their “complex” theory a recipe for endless litigation, and settlements, over inherently debatable actuarial judgments, even when the alleged underpayment is negligible on a per-participant basis. The Sixth Circuit has created a new avenue for challenging virtually *any* defined benefit plan. But the true beneficiaries of this new, judicially-created cause of action are not participants—it is their counsel. *See Reichert*, 170 F.4th at 498 (Nalbandian, J., dissenting) (“These costs will be passed on and will ultimately injure the continued viability of the plans. So it’s hard to see how this standard will benefit anyone besides the attorneys who litigate these cases.”).

The costs for plan sponsors associated with defending ERISA litigation are considerable even where a claim is meritless from the start. In ERISA cases, discovery is entirely asymmetrical and comes at an “ominous” price, easily running into the millions of dollars for a defendant faced with even weak

claims.⁷ *Pension Benefit Guar. Corp. ex rel. St. Vincent Catholic Med. Ctrs. Ret. Plan v. Morgan Stanley Inv. Mgmt. Inc.*, 712 F.3d 705, 719 (2d Cir. 2013) (“PBGC”). This Court has repeatedly recognized the importance of cabining speculative ERISA claims before they proceed into expensive discovery. *See Cunningham*, 604 U.S. at 708; *id.* at 710-11 (Alito, J., concurring); *Dudenhoeffer*, 573 U.S. at 425. Yet the Sixth Circuit’s standard virtually guarantees that many disputes will turn on competing expert opinions, making early resolution substantially more difficult. The likely result is “even more litigation and higher administrative costs.” *See Reichert*, 170 F.4th at 498 (Nalbandian, J., dissenting). This is not what Congress intended. *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

The plaintiffs’ bar contends that, without a current “reasonableness” requirement, employers could theoretically use mortality tables from centuries past. *See Reichert*, 170 F.4th at 482, 485. But that speculation is not realistic. Despite nearly a decade of litigation, plaintiffs have never identified a plan using mortality tables from the 1700s, nor have they ever asserted that the mortality tables were unreasonable when written into the plan. And for good reason. ERISA and the IRC already deter a plan sponsor from adopting truly outlandish assumptions or risk losing the plan’s favorable tax treatment. Nor has Congress, the Department of Labor, or the IRS concluded that such a problem warrants intervention.

⁷ *See* Chubb, Excessive Litigation Over Excessive Plan Fees in 2023 at 3 (2023), <https://www.chubb.com/content/dam/chubb-sites/chubb-com/us-en/business-insurance/fiduciary-liability/pdfs/excessive-litigation-over-excessive-plan-fees-infographic.pdf>.

To the contrary, Congress has repeatedly demonstrated that when it believes actuarial assumptions require updating, limitations, or specific regulation, it legislates directly and with precision.

The only certainty is more litigation. Employers gain no clear rule by which to administer their plans and no workable standard for compliance. Participants gain no predictable method for determining benefits. What the decision below provides is an invitation to perpetual litigation over a standard Congress chose not to impose in the first place.

CONCLUSION

For the foregoing reasons and those in the Petitions, the Court should grant the Petitions and reverse the judgment.

Respectfully submitted,

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