

Visit the GRS website at:
www.grsconsulting.com

In This Issue

Cash Balance Plan Primer	1
New Mortality Tables for Pension Plans Finalized by the IRS	3
Recent Legal Challenges to Public Plan Benefit Changes	3
Tax Reform Update	5
Health Care Reform Update	6
Recent Litigation Involving Employee Wellness Programs	7

GRS Insight contains articles, news and commentary from the various companies comprising the GRS group. The information provided is not intended as legal, income tax, or investment advice or opinion of a similar nature. Articles attributed to individuals do not necessarily reflect the views of any company within the GRS group.

Cash Balance Plan Primer

Many governmental retirement systems have considered decreasing their reliance on traditional defined benefit plans. While not part of the customary retirement plan package, a cash balance plan may offer an alternative to defined contribution plans for governmental retirement systems. Key characteristics of cash balance plans are outlined below.

Is a cash balance plan a defined contribution or defined benefit plan?

A cash balance plan is a defined benefit plan, although similar to a defined contribution plan in some respects. A cash balance plan has defined benefit plan traits such as the lack of a cash or deferral election, the fact that investments are chosen and managed by the retirement system (rather than individual members), and the promise of a certain benefit at retirement. However, similar to a defined contribution plan, the benefit is stated as an account balance rather than a monthly benefit.

Are members' benefits guaranteed, as with other defined benefit plans?

Yes, members are guaranteed a minimum benefit and the retirement system bears the actuarial risks to ensure there is adequate funding for the promised benefits. Consequently, the retirement system (not the member) assumes the responsibility for investment gains and losses. Of course, underlying protections against cutbacks and benefit modifications remain subject to any applicable state and local law.

What is the hypothetical "account" for each member under the plan?

A hypothetical account is created for each member, and maintained on paper merely as a bookkeeping account. Each year, the hypothetical account receives the allocations defined in the plan, including "pay credits" and "interest credits."

As employer contributions are based on an actuarial valuation, they may not equal the sum of members' hypothetical account additions. Therefore, the hypothetical account is not related to actual plan assets and does not represent a member's share of actual plan assets.

What amounts are attributed to a member's account?

Each member's account grows with annual credits including: 1) pay credits, which are generally a specified dollar amount or calculated as a percentage of the member's pay; and 2) interest credits, which are calculated based on the amount of assets in the member's account. Interest credits are not usually conditioned on current service or imputed service, although in some cases they may be based on the actual return on the plan's assets. Therefore, in most cases, increases and decreases in the value of the plan's investments do not directly affect the benefits promised to members.

How are benefits paid under a cash balance plan?

As permitted by the plan document, a member can generally collect a life annuity or lump sum benefit upon retirement. Annuity benefits are generally calculated as an accrued benefit which is the actuarial equivalent of the member's cash balance account, based on actuarial assumptions defined in the plan. A lump sum benefit is based on the present value of the accrued benefit payable at normal retirement age.

What happens to a member's benefits if a traditional defined benefit plan converts to a cash balance plan?

An opening account balance will be established for each member in the cash balance plan that previously was in the traditional defined benefit plan. Generally, such amount is equal to the lump sum present value of the member's accrued benefit under the traditional formula. As employers have discretion in determining actuarial assumptions for the conversion (e.g., interest rate and mortality assumptions), a member's initial accrued benefit under the cash balance formula may vary from the amount under the traditional formula at the time of

conversion. In some cases, a traditional benefit formula is maintained as a minimum benefit for a period of time to prevent the "wear away" of existing benefits. Employees are often notified of the effect of the conversion on their benefits, for example, through personalized statements showing a member's projected benefit under both the traditional and cash balance formulas.

Is a cash balance benefit more or less favorable to employees?

Longtime employees may see smaller benefits than under a traditional formula although the actual plan cash balance benefit formula is really what matters. One reason for this potential discrepancy is that traditional formulas are generally based on a member's final working years, when a member often has their highest salary, while cash balance benefits are generally based on all working years, including those in which earnings were lower. Mid-career employees (and those subject to mid-career conversions) may also see smaller benefits under a cash balance formula, as the higher benefit values usually earned under a traditional formula towards the end of a career will not be reflected in most cash balance formulas.

What are some potential benefits to a retirement system of a cash balance plan?

A cash balance plan allows an employer to continue to provide a defined benefit to members. However, because the benefits provided by pay credits and interest credits can be lower than the benefits under traditional defined benefit plans, the corresponding risk to the system can be lower. Various cash balance designs can further reduce funding risk.

What are some potential drawbacks to a retirement system of a cash balance plan?

Cash balance plans, depending on their design, may provide larger benefits to short-term and younger employees than traditional plans, which for some government entities, may or may not be a desired result. Also, if members elect lump sum distributions of their benefits, plan assets will often be lower than if monthly benefits were paid (because payments are spread over a longer period). In some cases, this lower

level of plan assets could impact a plan's ability to invest and rely on gains from investing more assets on a long-term basis and could also lead to lower assumed rates of return and increased actuarial cost estimates.

New Mortality Tables for Pension Plans Finalized by the IRS

As noted in our January *GRS Insight*, the IRS issued a proposed regulation in late 2016 on the mortality tables used for various calculations under defined benefit plans. Recently, the IRS and Treasury finalized that regulation. See 82 Fed. Reg. 46388 (Oct. 5, 2017); IRS Notice 2017-60. The final regulation is largely unchanged from the proposed regulation and the technical changes affecting plan-specific tables for minimum funding and disclosure calculations are not applicable to public sector plans. The mortality tables themselves were adopted without change from the proposed regulation.

Effect on Public Sector Plans

While the most significant effects of the regulation do not impact public sector plans, the mortality tables prescribed by the IRS could affect the calculation of the maximum benefit limitations under section 415 of the Internal Revenue Code (the "Code"). The new mortality tables will generally become effective for plan years beginning on or after January 1, 2018.

Maximum Benefit Limitation Calculations

As noted in our January article, the new mortality tables may have an effect on the calculation of the Code section 415 maximum benefit limitations. Specifically, the maximum benefit limitation is generally adjusted for each participant to reflect their optional form of payment and their age at commencement. The calculation of these adjustments takes into account the actuarial assumptions specified in the plan and the assumptions (including the mortality tables) mandated by the IRS.

Plan Amendment

In light of the final regulation, plan sponsors may want to consider whether a plan amendment would be appropriate to reflect the new tables. If a plan's reference to the mortality tables contains language that

will automatically incorporate a newly-adopted table, such an amendment may not be necessary.

Recent Legal Challenges to Public Plan Benefit Changes

As many state pension systems continue to struggle financially, state legislatures have taken steps in recent years to modify pension benefits for public employees. These modifications typically take the form of benefit changes and cost-of-living-adjustment (COLA) reductions, both of which can serve to mitigate the effects of rising pension costs. However, these modifications often trigger numerous constitutional and statutory challenges in the courts.

Benefit Changes and Constitutional Challenges

In *Local 101 of the American Federation of State, County and Municipal Employees v. Brown*, No. 5:14-cv-05640 (N.D. Ca., Aug. 16, 2017), a federal district judge held that an amendment to the California Public Employees' Retirement Law that reduced pension benefits for prospective employees was constitutional. The union employees in *Local 101* participated in the California Public Employees Retirement System ("CalPERS"), the largest public pension fund in the United States. After the union and county agreed to a new collective bargaining agreement (CBA), the California legislature passed the Public Employees' Pension Reform Act of 2013 (PEPRA), which sought to rescue California's underfunded pension plans. PEPRA did so by, among other things, requiring that CalPERS offer new members *only* the specific benefit formula established under the statute. Under the CBA, however, the union had agreed to a more favorable formula for new members. The union therefore brought suit against the state, arguing that PEPRA substantially impaired the CBA in violation of the Contract Clause of the United States Constitution.

In finding that PEPRA did not substantially impair the CBA, the court noted that upon negotiating the CBA, the union had agreed to a provision stating that employees remained subject to any amendments to the Public Employees' Retirement Law. The court concluded that, because PEPRA constituted one such amendment, the union could not establish that PEPRA substantially impaired its "reasonable expectations"

under the CBA. To be sure, the court noted, PEPPA did significantly impact the pension benefits of employees hired after the CBA became effective, who then saw their benefits reduced by statute. But that “harsh reality” did not affect the state’s “legislative prerogative” to modify pension benefits for future CalPERS participants.

Inviolable Benefits

In *Berg v. Christie*, 225 N.J. 245 (N.J., June 9, 2016), the New Jersey Supreme Court rejected an appeal by retired state employees challenging the suspension of their pension COLAs.¹ The New Jersey legislature had enacted a statute in 1997 granting public sector pension recipients “a non-forfeitable right to receive benefits,” meaning that no participant in the “benefits program” could have his or her benefits reduced. In 2011, in an attempt to stem a potentially severe fiscal crisis, the New Jersey legislature suspended state pension COLAs for all retirees. The plaintiffs, Richard Berg and 25 other retired government employees, then brought suit against New Jersey Governor Chris Christie, asserting that they had a constitutional right to the COLAs under the Contract Clause of the United States Constitution. The case eventually made its way to the New Jersey Supreme Court.

The court’s decision rested on whether retirees’ COLAs ought to be considered part of the “benefits program” guaranteed by the state legislature. In holding that the legislature did not guarantee a non-forfeitable right to COLAs, the court examined both the statutory text and its legislative history to determine whether the legislature “clearly indicated” an intent to make COLAs non-forfeitable. The court concluded that, because the statute distinguished between pension retirement benefits and pension *adjustment* benefits, the legislature likely regarded COLAs as distinct from the pension benefit. Therefore, the plaintiffs did not have a non-forfeitable right to their COLAs.

Separately, in *In re City of Stockton, California*, 526 B.R. 35 (Bankr. E.D. Cal., Feb. 27, 2015), *aff’d in part*, dismissed in part, 542 B.R. 261 (B.A.P. 9th Cir. 2015), a federal bankruptcy judge held that, despite a California statute to the contrary, state municipal pension benefits may be modified in bankruptcy. The decision in *City of Stockton* involved the bankruptcy plan for Stockton, California, a city that had suffered tremendous financial losses in the aftermath of the recession that began in

2007-08. In challenging the proposed bankruptcy plan, one of the city’s creditors objected to the plan’s failure to reduce pension benefits for municipal employees. The city’s pension administrator responded by pointing to a California statute that insulates state pension contracts from rejection in bankruptcy. The administrator argued that because the statute prohibits any pension adjustments, the court should approve the existing bankruptcy plan.

While the court ultimately approved the plan, and did not require modifications to pension benefits, it held as a matter of law that pension contracts entered into by California municipalities may be rejected in federal bankruptcy proceedings. In reaching that conclusion, the court emphasized the exclusive power of Congress to enact laws concerning bankruptcy—the “essence of which is the impairment of contracts”—and the Supremacy Clause of the U.S. Constitution, which in the court’s view, resolves any conflict in favor of Congress. The court explained that so long as California continues to permit its municipalities to file for bankruptcy in federal court, its municipal pension benefits may be modified in bankruptcy.

Trends Going Forward

It is likely that COLA adjustments will remain one of most common forms of benefit reductions for public sector employees. These adjustments are often not seen as “core” benefits, like the benefit formula itself, but more of an ancillary benefit. The result is that COLAs appear to remain more vulnerable to legislative cutbacks than other benefit features. However, for new employees who are not yet in the system, reductions of core benefits continue to be a possibility. As state governments continue to face budgetary pressures, further legislative action—and legal challenges—in these areas may be expected.

¹ The COLAs tied all retirees’ pensions to the consumer price index, guaranteeing that their fixed incomes remained consistent in real terms.

Tax Reform Update

In addition to repealing/replacing the Affordable Care Act (ACA), a primary goal of Congressional and Administration Republicans has long been to enact comprehensive tax reform. At a high level, those efforts are focused on reducing corporate and individual tax rates and simplifying the Tax Code. To that end, on September 27, 2017, a group of prominent Republican leaders, informally called the “Big Six” (consisting of Treasury Secretary Steve Mnuchin, National Economic Council Director Gary Cohn, Speaker of the House Paul Ryan (R-WI), Ways and Means Chairman Kevin Brady (R-TX), Senate Majority Leader Mitch McConnell (R-KY), and Finance Committee Chairman Orin Hatch (R-UT)) released a framework for tax reform.² This proposal is intended to serve as a template for the House and Senate tax-writing committees to begin drafting legislation.

The framework calls for the following:

- Doubling the standard deduction to \$12,000 for single filers and \$24,000 for married taxpayers filing jointly;
- Consolidating the tax brackets into three individual tax brackets of 12%, 25%, and 35% instead of the existing seven brackets (with a possible additional top tax rate applying to the highest income taxpayers);
- Increasing the Child Tax Credit and the income limits to qualify;
- Repealing the individual Alternative Minimum Tax;
- Eliminating most itemized deductions and other exemptions, deductions and credits, but retaining tax incentives for home mortgage interest and charitable contributions;
- Repealing the death tax and generation-skipping transfer tax;
- Limiting the maximum tax rate applied to the business income of small and family-owned businesses conducted as sole proprietorships, partnerships and S corporations to 25% (with measures to prevent re-characterization of personal income into business income);
- Reducing the corporate tax rate to 20%;
- Allowing immediate expensing of new business capital investments (other than structures) made

after September 27, 2017, for at least 5 years;

- Partially limiting the net interest expense deduction for C corporations; and
- Creating a territorial tax system coupled with base erosion measures.

This proposal is only a starting place for the development of legislation with limited details about key policy decisions, including those affecting health and retirement benefits for both employers and employees.

The framework indicates that the tax benefits for retirement will be retained and encourages the tax writing committees to “simplify” these benefits to improve their “efficiency and effectiveness.” The document continues: “Tax reform will aim to maintain or raise retirement plan participation of workers and the resources available for retirement.” Importantly, changes to the tax treatment of contributions to defined contribution plans have been frequently discussed as a way of generating revenue to pay for a portion of the significant costs associated with the tax reforms outlined by the Big Six. This concept, frequently called “Rothification,” would require some or all of future elective plan contributions be made on a post-tax basis, and remains an option as a potential source of revenue to offset tax rate cuts. This proposal has been met with significant opposition from Democratic legislators who view the proposal as a budgetary gimmick in the short-term, with negative consequences for retirement savers as a policy matter.

The current framework is also silent on two primary, health-related issues. The first is the set of taxes imposed by the ACA, including the Cadillac Tax. While a tax reform bill is a logical place to repeal or amend the ACA’s primary taxes in the absence of a more fulsome repeal of the ACA, there has been little discussion of using tax reform as a vehicle for repealing these health-related taxes. Second, early ACA repeal/replace efforts by Congressional Republicans had considered capping the employer exclusion for health benefits. While these proposals were roundly rejected during the ACA repeal/replace debate, they do raise significant amounts of revenue, and so could re-emerge in the course of the tax reform debate.

² https://waysandmeansforms.house.gov/uploadedfiles/tax_framework.pdf

On October 19th, the Senate approved a budget resolution for the 2018 fiscal year. The House acted swiftly to approve the Senate budget resolution, setting the stage for tax reform. The next step is for the tax writing committees to issue proposed legislative text. The House has stated publicly that it aims to complete their consideration of the legislation by Thanksgiving. While the tax writing committees must provide much detail, and the timing of those proposals could slip significantly, employers, plans and issuers should continue to monitor the tax reform debate since a number of important proposals affecting health and welfare benefits could arise.

Health Care Reform Update

In September 2017, Senators Bill Cassidy (R-LA) and Lindsey Graham (R-SC) fronted the latest effort to repeal and replace the Affordable Care Act (ACA). The bill would have repealed some ACA taxes, given states more control over health care funding, and enabled states to opt out of certain ACA market reforms. In addition, it would have modified the Medicaid program to provide funding to states via block grants or per capita caps. Despite several legislative changes and political struggles, the Senate ultimately did not vote on the bill. Even though the bill did not pass before the FY 2017 reconciliation deadline expired on September 30, 2017, it could inform future efforts to reform health care.

Key Provisions

Some of the key provisions include:

- Repealing the individual and employer mandates retroactively, beginning in 2016;
- Allowing states to waive certain ACA requirements, including a number of market reforms, such as essential health benefits, the annual limitation on cost sharing, actuarial value metal levels, age and geographic rating requirements (except rates could not vary on the basis of sex or genetic information), the requirement to offer child-only plans, the requirement to cover preventive services without cost sharing, and the single risk pool requirement;
- Repealing a handful of taxes: taxes on over-the-counter medications; taxes on Health Savings Accounts (HSAs) and Archer medical savings accounts; and the medical device tax;

- Increasing the HSA maximum contribution, permitting HSA “catch-up” contributions, and allowing individuals to use their HSAs to pay for over-the-counter drugs, dependents’ medical expenses, and premiums for high-deductible health plan coverage;
- Repealing the enhanced federal match for Medicaid expansion at the end of 2019 for states that had expanded Medicaid prior to July 1, 2016 (or on September 1, 2017, for states that had not expanded Medicaid prior to July 1, 2016); and
- Repealing individual tax credits beginning in 2020, and replacing the tax credits, cost-sharing reductions, and the enhanced match for the Medicaid expansion with block grants (or, for Medicaid, per capita caps) to states. As a bridge to 2020, the bill provided the Centers for Medicare and Medicaid Services with a “short-term stability fund” of \$25 billion to fund state arrangements with health insurance issuers.

CBO and JCT Estimate

On September 25, 2017, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) released an analysis of the latest health reform bill. Because of time constraints prior to the expiration of FY 2017 reconciliation instructions, CBO and JCT only assessed whether any reductions in the deficit stemming from the legislation would exceed certain thresholds and considered its effects on health insurance coverage and market stability.

CBO and JCT estimated that the bill would have reduced the on-budget deficit by at least \$133 billion (relative to CBO’s March 2016 baseline). In addition, depending on how states would have implemented the legislation, the number of individuals with comprehensive health insurance would have been reduced by millions compared with the baseline projections for each year during the decade. The significant reduction would have become particularly notable in 2020 and would have occurred mainly for three reasons: 1) Medicaid enrollment would have decreased because of decreased federal funding; 2) enrollment in the individual market would have decreased because of subsidy reduction; and 3) enrollment in all health insurance markets would have decreased because the individual and employer mandates would have been repealed. CBO and JCT acknowledged, however, that coverage losses would

have been somewhat offset by enrollment in new state programs and employer-sponsored insurance.

Next Steps

While the focus in Congress has shifted to tax reform, it remains possible that Republican leaders could again pursue a partisan health care reform effort via reconciliation by including it in the FY 2018 budget, though doing so could muddle the push for tax reform. They could also choose to defer the additional efforts on health care and consider including reconciliation instructions in the FY 2019 budget resolution, though consideration of the FY 2019 budget resolution would likely be deferred until the Senate completes action on legislation pursuant to the FY 2018 budget resolution. In the meantime, President Trump appears to be taking health care into his own hands. On October 12, 2017, he issued an executive order directing federal agencies to consider policy changes to broaden the ability of small employers to buy association health plans, expand the use of Health Reimbursement Accounts (HRAs), and extend the time period for, and allow renewals of, coverage that would qualify as short-term, limited duration insurance.

Recent Litigation Involving Employee Wellness Programs

Two recent lawsuits underscore the regulatory complexity surrounding employer-sponsored wellness programs. Below we discuss two recent lawsuits involving wellness programs, both of which could have a significant impact on the administration of such programs going forward.

AARP v. EEOC

In August 2017, in *AARP v. United States Equal Employment Opportunity Comm'n*, No.16-cv-02113, 2017 WL 3614430 (D.D.C. Aug. 22, 2017), a federal district judge ordered the U.S. Equal Employment Opportunity Commission (EEOC) to reconsider its regulations under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA) relating to incentives under certain employer-sponsored wellness programs.

Many wellness programs involve health risk assessments (HRAs) and/or biometric screenings, which implicate the ADA with respect to the employee (because they require medical examinations and/or ask disability-related inquiries) and GINA with respect to the employee's spouse (because they ask about the spouse's current or past health status). Under both statutes, employers may offer employees (and their spouses) incentives for completing an HRA and/or biometric screening as part of an employee wellness program only if the employee/spouse's participation in the program is "voluntary." Neither statute defines "voluntary."

In May 2016, the EEOC promulgated new rules under the ADA and GINA that provide that an employee/spouse's participation in the program is "voluntary" so long as the incentive is generally no more than 30% of the cost of self-only coverage. In October 2016, the American Association of Retired Persons (AARP) brought suit in federal court challenging the new rules. AARP argued that because many employees/spouses cannot afford a 30% increase in premiums, such employees/spouses – who might otherwise decline to participate in a wellness program – are essentially forced to disclose their protected health information in order to avoid paying a penalty, making their participation in the program involuntary in a practical sense. AARP also argued that the EEOC failed to provide a reasoned explanation for its arrival at the 30% "voluntariness" threshold.

In August 2017, the district court ordered the EEOC to reconsider the new rules. The court rested its decision largely on EEOC's failure to offer any reasoned explanation for the 30% figure, particularly the manner in which EEOC arrived at its conclusion that a 30% penalty would not be unduly coercive. While the court noted that "voluntariness" is a matter of degree and that "some arbitrary line drawing may be necessary in determining where to set the incentive level," EEOC had failed to point to any evidence that supported where it chose to draw the line. The court therefore remanded the rules to the EEOC for reconsideration. However, because the court remanded the rules without vacating them, the rules remain in effect for the time being. When and how they will be revised remains unclear.

Acosta v. Macy's

In August 2017, the Department of Labor (DOL) filed a complaint against Macy's (and related parties) alleging

that, among other things, Macy's violated the Health Insurance Portability and Accountability Act (HIPAA) wellness rules (*Secretary of Labor v. Macy's, Inc. et al*, No. 1:17-cv-00541, S.D. Ohio). Under the HIPAA wellness rules, an "outcome-based" wellness program – one that requires an individual to attain or maintain a specific health outcome to earn a reward (e.g., being "tobacco-free") – is permissible only if it provides a "reasonable alternative standard" for those for whom cannot meet the initial standard. (Under the prior HIPAA wellness rules (effective for plan years beginning before January 1, 2014), an alternative standard was only required for individuals for whom it is unreasonably difficult or medically inadvisable to meet the initial standard.) Individuals who complete the alternative standard must be provided the full reward as those who meet the initial standard.

Macy's imposed a surcharge on individuals who were not "tobacco-free" for years that span both the prior wellness rules and the current wellness rules. Macy's tobacco program varied from year-to-year but, in general, individuals were not subject to the surcharge if they certified they were: 1) tobacco-free or 2) enrolled in a tobacco cessation program or were "working towards"

becoming tobacco-free. Macy's did not waive the incentive retroactively for any individuals who completed the alternative standard (i.e., they were not provided the full reward). In DOL's view, this meant that participants had to certify either that they had met the original standard of being tobacco-free or had stopped using tobacco products and were working towards satisfying the original standard. In other words, in order to satisfy the alternative standard, participants had to stop using tobacco products, which effectively created a false alternative.

The Macy's complaint is interesting because it confirms the agencies' position that a tobacco cessation program cannot require participants to cease using tobacco. It also potentially signals that the agencies will be stricter in enforcing the HIPAA wellness program rules.

About GRS

GRS is a national actuarial and benefits consulting firm. We help our clients develop and maintain fiscally sustainable benefit programs that preserve financial security for millions of Americans. Our reputation for providing independent advice and quality consulting services has remained unmatched for over 75 years.

Corporate Office
One Towne Square, Suite 800
Southfield, Michigan 48076-3723
800-521-0498
www.grsconsulting.com

GRS Structure

"GRS" is the national brand under which Gabriel, Roeder, Smith & Company Holdings, Inc. and its subsidiaries operate and provide professional services. The GRS companies comprise a national actuarial and benefits consulting firm and are committed to working together to provide quality service offerings for clients throughout the nation.

Each company within the GRS group can use the GRS name and draw on the resources and methodologies of the GRS group. While each company within the GRS group is a separate legal entity, "GRS" is often used to refer either to the individual companies within the group or to several or all of them collectively. However, each company within the GRS group has its own legal status and is responsible for its own services and work product and not those of any other GRS group company.

This communication should not be construed as providing tax, legal, or investment advice.