APRIL 2019

GRS INSIGHT

Pension Plans Legislative Update

IN THIS ISSUE

Ways and Means Committee Chairman Richard Neal (D-MA) has made retirement reform legislation a key priority for his chairmanship. On April 2, 2019, the House Ways and Means Committee approved bipartisan retirement legislation entitled the *Setting Every Community Up for Retirement Enhancement Act of 2019* ("SECURE Act," H.R. 1994). The bill is similar to the *Retirement Enhancement and Savings Act* ("RESA," S. 2526; H.R. 5282; 115th Congress), which was first passed by the Senate Finance Committee in 2016, but includes several changes and new provisions.

The SECURE Act's new provisions include:

- **Part-Time Employees.** The legislation requires that long-term, part-time employees who work at least 500 hours in three consecutive 12-month periods be eligible to participate in plans.
- **Child Birth or Adoption Withdrawals.** Individuals would be permitted to take penalty-free withdrawals of up to $5,000 from their qualified defined contribution, 403(b), and governmental 457(b) plans for expenses related to the birth or adoption of a child.
- **Required Minimum Distribution Age.** The age at which required minimum distributions must begin is increased from 70½ to 72.

Senate Finance Committee Chairman Chuck Grassley (R-IA) and Ranking Member Ron Wyden (D-OR) have recently reintroduced RESA in the Senate, and lawmakers from both chambers will work to resolve the differences between the two bills. Negotiators will have to reach a consensus on an approach to a "stretch IRA" provision, which raises much of the revenue necessary to offset the cost of the retirement package, and a potential expansion of 529 plans. At this point, it appears promising that a compromise bill could move through both chambers of Congress.

Outdated Mortality Tables Lead to Participant Claims

Calculating retirement benefits requires the coordination of several factors, leading to risk for plans and plan sponsors. In this vein, multiple complaints were filed in December 2018 that alleged that defined benefit plan participants and beneficiaries were paid optional benefits that were not actuarially equivalent to their normal retirement benefit, causing an illegal forfeiture of vested benefits.[1] The complaints allege that plan fiduciaries breached their duties by utilizing inappropriate actuarial

[1] *Masten v. Metropolitan Life Ins. Co.*, 1:18-cv-11229 (S.D.N.Y. Dec. 3, 2018); *Martinez Torres v. Am. Airlines, Inc.*, 4:18-cv-00983 (N.D. Tex. Dec. 11, 2018); *DuBuske v. PepsiCo, Inc.*, 7:18-cv-11618 (S.D.N.Y. Dec. 12, 2018); and *Smith v. U.S. Bancorp*, 0:18-cv-03405 (C.D. Minn. Dec. 14, 2018). See also *Smith v. Rockwell Automation, Inc.,* 2:19-cv-00505 (E.D.Wis. Apr. 8, 2019).

equivalence factors to calculate optional benefits – in these cases, joint and survivor annuities and early retirement benefits.

The complaints specifically allege that the plans referenced outdated actuarial factors to calculate optional forms of benefits, including mortality tables from the 1970's and 1980's, that, when taken together, were unreasonable. The complainants further allege that increases in life expectancy have caused the use of decades-old mortality tables to lead to impermissibly reduced benefit payouts.

Underlying Claims

The complaints rely on several aspects of ERISA and the Code that govern the calculation of benefits in making their claims. As noted below, many of these claims are applicable to, or have analogous application to, governmental defined benefit plans.

1. All optional benefits must generally be actuarially equivalent to the plan's normal (or default) retirement benefit.
2. All benefits must be definitely determinable in a manner that precludes employer discretion in benefit calculations.
3. All actuarial assumptions used for benefit calculations must be reasonable.

Considerations

Although many of the claims put forth would not be directly applicable to governmental plans as framed, the cases should put governmental defined benefit plans on notice that retaining the "status quo" may not always be beyond challenge by plaintiffs' counsel.

Governments Retain Some Flexibility in Altering Statutory Pension Provisions

In a recent case, *Cal Fire Local 2881 v. California Public Employees' Retirement System*, 7 Cal. App. 5th 115 (Cal. App. 2016), *aff'd*, 435 P.3d 433 (Cal. Mar. 4, 2019), the California Supreme Court affirmed that a statutory provision permitting a governmental employee to purchase nonqualifying service credit at cost was not a vested contractual right. Thus, prospective removal of such provision did not violate the contracts clause of the California Constitution.

Facts

Prior to 2013, the California Public Employees Retirement System (CalPERS) allowed public employees who had at least five years of service credit to elect to purchase an additional one to five years of nonqualifying service credit ("airtime") at cost. In 2012, the legislature passed the California Public Employees' Pension Reform Act of 2013 (PEPRA) to strengthen the State's public pension system and ensure its ongoing solvency. PEPRA prospectively removed the option for employees to purchase airtime after 2012. However, eligible employees still had a 15-week window of opportunity to purchase airtime before PEPRA went into effect.

Plaintiffs representing a putative class of CalPERS members claimed that the option to purchase airtime was an express vested contractual right that employees relied on as part of their decision to perform services for the state. Thus, the plaintiffs claimed that PEPRA's removal of the airtime purchase option through amendment of the applicable statute was a violation of the contract clause of the California Constitution. Plaintiffs also relied on material that CalPERS had distributed to public employees titled, "Vested Rights of CalPERS Members: Protecting the Pension Promises Made to Public Employees" (July 2011), which stated:

> "Public employees obtain a vested right to the provisions of the applicable retirement law that exist during the course of their public employment. Promised benefits may be increased during employment, but not decreased, absent the employees' consent.
>
> These rules apply to all active CalPERS members whether or not they have yet performed the requirements necessary to qualify for certain benefits that are part of the applicable retirement law. For example, even if a member has not yet satisfied the five-year minimum service prerequisite to receiving most service and disability benefits, the member's right to qualify for those benefits upon completion of five years of service vests as soon as the member starts work."

Analysis

In denying participants' claims, the California Supreme Court stated that constitutional protection arises only if one of these two conditions are satisfied:

> "(1) when the statute or ordinance establishing a benefit of employment and the circumstances of its enactment clearly evince an intent by the relevant legislative body to create contractual rights or,
>
> (2) when, even in the absence of a manifest legislative intent to create such rights, contractual rights are implied as a result of the nature of the employment benefit, as is the case with pension rights."

The appellate court determined, and the California Supreme Court affirmed, that public employees do not have a vested contractual right to purchase airtime. First, the appellate court provided that generally statutory provisions do not create contractual rights, and plaintiffs were unable to meet their heavy burden to overcome that presumption by establishing that one of the exceptions above applied. Second, the appellate court acknowledged that public employees do not have a right to any fixed or definite benefits, but only a right to a substantial or reasonable pension. Third, it was also noted that the airtime provision was actually in conflict with the primary purpose of a pension system of providing retirement benefits based on work performed – the repeal of such provision actually eliminated this conflict.

In prior case law, the California Supreme Court provided that pension plan changes which result in a disadvantage to employees should be accompanied by comparable new advantages.[2] However, the appellate court suggested that even if the removal of the option to purchase airtime would be a disadvantage to employees, removing the option did not require any addition of comparable new advantages. The court focused on the prior case law language which provided that a disadvantageous alteration of benefits *should* be accompanied by comparable new advantages, instead of requiring that such benefit alterations *must* be accompanied by comparable new advantages.

The California Supreme Court affirmed and expanded on the appellate court's decision. The California Supreme Court concluded that, while pension benefits are protected by the contract clause as deferred compensation, the opportunity to purchase airtime was not "deferred compensation" based on the employee's service. The California Supreme Court continued by suggesting that even if a contractual right to purchase airtime was intended by the legislature, the contractual right was, at best, a unilateral contractual right that may only be accepted by employee performance. Thus, the legislature could properly revoke the option to purchase airtime anytime before an employee accepted the offer by purchasing airtime.

All of these factors led both courts to determine that the legislature did not intend to create a contractual right to purchase airtime and that no contractual right was implied.

Application to Government Plans

This case may provide a roadmap for some governmental plan sponsors to avoid contract clause concerns when altering statutory pension provisions. However, caution is still warranted and any future changes should be considered based on their facts, as this decision was in many ways based on the circumstances of airtime and the extent to which this decision will reverberate is unclear.

Cybersecurity for Retirement Plans

In February 2019, Robert Scott, Chair of the House Committee on Education and Labor, and Patty Murray, Ranking Member of the Senate HELP Committee, sent a letter to the Government Accountability Office ("GAO") asking for examination of cybersecurity issues. Although the request is in the context of private defined contribution retirement plans, the underlying issues apply to public and private plans alike, as cyberattacks

[2] *See e.g., Miller v. State of California*, 18 Cal. 3d 808, 816 (1977).

could compromise valuable member data and the retirement system in general.

Risk

Cybersecurity regulations continue to rapidly evolve as plan member data has transformed from being stored in hard records, to digital records, and now—the cloud. While this provides ease of access to plan information for members, it also opens doors to new risks. It is impossible to ignore the value that exists in member data such as names, addresses, Social Security numbers (SSNs), ages, salary information, and plan asset amounts. For example, cyber attackers can use this information for identity theft purposes, sell it to be monetized for targeted product offerings and advertising, or, as relevant here, to access retirement plan information and assets.

The lack of clear guidance clarifying the responsibility that governments, plan sponsors and administrators have to protect retirement plan data increases the vulnerability of such information. There is also growing concern among plan sponsors and administrators that emerging cybersecurity regulations, which are enacted to help offset this vulnerability (such as the European Union's "Right to be Forgotten"), may cause plan recordkeeping to become an increasingly heavy burden. The question is how to balance the protection of plan data with a plan sponsor's or administrator's responsibilities.

Considerations

Governmental plans should be cognizant of cybersecurity regulatory concerns and be proactive about protecting member data. While the risks and liabilities for plan sponsors and administrators remain unclear, safeguarding member data should be a priority.

Health Legislation Update

In recent months, Congress has introduced a variety of bills aimed at curtailing the rising costs of health care. Last fall, Senator Bill Cassidy (R-LA) introduced draft legislation designed to address the problem of "surprise" balance billing, which has become an increasingly difficult challenge for individuals, group health plans, and insurers. More recently, legislation was introduced in the Senate that would repeal the so-called "Cadillac Tax" under the Affordable Care Act (ACA). A separate bill would also dramatically alter the rebate system for prescription drugs by prohibiting pharmacy benefit managers (PBMs) from receiving any rebates or reductions in price from drug manufacturers. Each proposal is described in more detail below.

"Surprise" Balance Billing Legislation

Over the last decade, "surprise" balance billing by out-of-network providers has become an increasingly prevalent problem for group health plans, health insurers, and the enrollees covered under those plans. The disputes that can arise from this billing practice can impose financial and psychological burdens on individuals and their families, and can present significant challenges for group health plans and insurers.

What is often referred to as "surprise" balance billing arises primarily in two scenarios, both of which involve the patient having limited ability to know whether a provider is in- or out-of-network, including: 1) an emergency room visit in which services are provided by an out-of-network provider; and 2) services provided by an out-of-network provider at an in-network facility. In the first scenario, a patient in need of emergency services requires stabilizing care and often has no choice regarding the facility. In the second, the patient selects an in-network facility and in-network provider for a procedure, but generally does not have the option to select an in-network provider that provides ancillary services, such as an anesthesiologist, radiologist, or pathologist. In both cases, after the individual's insurer or self-funded group health plan pays the benefits under the terms of the policy or plan, the provider submits a bill to the individual for the difference between the amount paid by the plan and the billed charges, which can often be well in excess of what the individual expected.

Last fall, Senator Bill Cassidy introduced draft legislation intended to address "surprise" balance billing in both the emergency and non-emergency contexts (the Cassidy Proposal).

The Cassidy Proposal addresses balance billing in the emergency setting by first requiring plans and insurers to pay the difference between cost-sharing for in-network benefits under the plan and billed charges. The Cassidy Proposal would prevent covered service providers from

balance billing the patient beyond the amount collected as cost-share. Despite the mandate that the plan or insurer pay the difference between cost-share and billed charges, those amounts would be limited to an amount determined under state law (if applicable), or if no state law applies, the greater of: 1) the median in-network rate, or 2) the usual, customary, and reasonable charge for the service (i.e., greater-of-two methodology).

In addition, the proposal would impose notice requirements for post-stabilization services. Specifically, the out-of-network facility would be required to provide the patient with a notice that includes information regarding the potential for higher out-of-network cost-sharing if services are received at the out-of-network facility; a written acknowledgement of the notice prior to receiving additional services; and an opportunity to transfer to an in-network facility.

In the non-emergency services setting, the Cassidy Proposal would expand the scope of the existing emergency services protections under federal law by applying the same new payment rules to services provided by out-of-network providers where services are provided at in-network facilities. Therefore, patients would be protected from both out-of-network cost shares as well as balance billing under this scenario. Plan payments to these out-of-network providers would also be limited, as the Cassidy Proposal uses the same greater-of-two methodology as for emergency services.

The Cassidy Proposal has bipartisan support, as three Democrats and two other Republicans have signed on as co-sponsors. Although no surprise billing legislation has been introduced in the 116th Congress, interest in a comprehensive federal solution remains strong. The Cassidy Proposal—by prohibiting surprise balance billing and setting up a minimum reimbursement rate—could serve as a model for future federal legislation.

Cadillac Tax Legislation

In March 2019, Senators Martin Heinrich (D-NM) and Mike Rounds (R-SD) introduced the *Middle Class Health Benefits Tax Repeal Act* (S. 684), which would permanently repeal the ACA's so-called "Cadillac Tax" on high-cost health plans. The bill is the companion to H.R. 748 introduced in January by Reps. Joe Courtney (D-CT) and Mike Kelly (R-PA). Combined, the bills have 250 co-sponsors in both chambers; a similar bill in the last Congress had over 300 co-sponsors. Over 500 stakeholder groups signed onto a letter in early March urging lawmakers to repeal the tax, which has been delayed several times by Congress—most recently until 2022.

The Cadillac Tax imposes a 40% excise tax on employer coverage that is considered high cost. The tax was one of the few provisions in the ACA intended primarily to "bend the cost curve" and reduce overall health care spending, and the Obama Administration defended it vigorously. However, the tax remains unpopular with both parties, and it is difficult to envision a scenario in which Congress would allow the tax to go into effect.

Opposition groups have criticized the Cadillac Tax for its projected impact on working Americans. While the tax was designed to affect only Americans with "gold-plated" plans, critics have alleged that much more modest plans covering low- and moderate-income employees are projected to trigger the tax. They also view the tax as disproportionately penalizing small businesses, which already struggle to offer health care coverage.

However, the primary challenge to full repeal has been cost. The Joint Committee on Taxation estimates that even delaying the tax for an additional year—from 2022 to 2023—would cost $13.6 billion. Thus, it remains to be seen whether Congress can tolerate the cost of a full repeal. Instead of further delaying or repealing the tax, Congress might consider more limited measures, such as amending the tax to address particular concerns or replacing it with an alternative measure designed to reduce health care costs.

Prescription Drug Cost Legislation

Lastly, in March of this year, Senator Mike Braun (R-IN) introduced the *Drug Price Transparency (DPT) Act* (S. 657), which would prohibit Pharmacy Benefit Managers (PBMs) from retaining rebates received from drug manufacturers.

PBMs are hired by group health plans and insurers to assist in administering their prescription drug benefits. In a typical group health plan-PBM arrangement, the PBM performs a variety of different services for the plan,

including designing benefits (*i.e.*, copays, deductibles, and formulary specifics), arranging retail pharmacy networks and pricing, and processing prescription drug claims. In exchange for making certain drugs cheaper to the patient on the plan's formulary (thus promoting sales), drug manufacturers often negotiate rebates to the PBM. The PBM then passes along an agreed-upon share of the rebates to the plan.

Although beneficial in certain respects, PBM rebating has come under intense scrutiny in recent years. Critics believe that the rebate system ultimately hurts consumers because the value of the rebate is not reflected in the amount of cost share paid by the consumer. Critics also allege that volume-based administrative fees paid by pharmaceutical manufacturers to PBMs create unnecessary cost in the health care system.

Senator Braun's bill would amend federal law to prohibit plans and health insurers or their PBMs from receiving the value of any reductions in price from drug manufacturers unless the reduction is reflected at the point-of-sale to the consumer, and any other payment is a flat, fee-based service fee that a drug manufacturer pays to a PBM for services provided to the manufacturer, if certain conditions are met.

While the bill has laudable goals, some remain concerned that this policy would result in increased premiums. Since plans would no longer apply drug manufacturer rebates to reduce consumer costs, there is a concern that plans and insurers would have to make up the difference by raising premiums or reducing other benefits. Senator Braun, to his credit, has acknowledged that possibility and has suggested that any final legislation should take that concern into account.

Conclusion

Although it is unclear whether these legislative proposals will garner enough support to pass into law, they reflect a clear shift in Congress toward addressing the rising costs of health care.

Health Litigation Update: *Texas v. United States*

As discussed in previous issues of *GRS Insight*, litigation regarding the constitutionality of the Affordable Care Act (ACA) is ongoing before the Fifth Circuit Court of Appeals in the *Texas v. United States* case. On December 14, 2018, District Court Judge Reed O'Connor of the Northern District of Texas ruled that the entirety of the ACA is invalid, but stayed his decision pending appeal.

Texas (joined by several other states) is arguing that the ACA's individual mandate, as amended by the Tax Cuts and Jobs Act of 2017, is unconstitutional and, therefore, the rest of the law is invalid as well. The crux of Texas' argument is that, in *NFIB v. Sebelius*, the Supreme Court upheld the individual mandate as a tax and, as of January 1, 2019, the individual mandate is no longer a lawful tax because it does not raise any revenue.

Since both Congress and the Supreme Court originally viewed the mandate as "essential" to the operation of the ACA, the entire law is thus unlawful and must be invalidated, with its operation enjoined. The litigation has generated a great deal of controversy, with the Department of Justice (DOJ) siding with Texas, and over 16 states, led by California, intervening to defend the ACA.

In a victory for Texas, Judge O'Connor held that the zeroed-out individual mandate penalty can no longer be construed as a lawful tax, and that the rest of the ACA is, therefore, inseverable and invalid. His decision created immediate confusion: Texas had requested a preliminary injunction, but Judge O'Connor issued a partial declaratory judgment (reserving certain ancillary issues for further review) without ordering the Administration to cease the operation of the ACA *or* ordering a stay of his judgment.

To prevent disruption, the Centers for Medicare and Medicaid Services (CMS), the primary agency charged with implementing the ACA, quickly announced it would continue implementing the law while any appeal was pending. Furthermore, the intervener defendants moved to allay confusion, with California immediately asking Judge O'Connor to clarify his order by issuing a stay and allowing the issue of the ACA's constitutionality to proceed to an immediate appeal.

Judge O'Connor agreed to this approach, and, on December 30, 2018, he granted a stay and partial final judgment, ensuring that the Administration would continue implementing the law while the appeal was

pending. California promptly appealed, and the House of Representatives, with its newly elected Democratic majority, voted to intervene to defend the ACA on the same date. The Fifth Circuit granted the House's motion on February 14, 2019.

The case has remained in the news: on March 25, 2019, the DOJ, which had previously only asked the law be *partially* invalidated at the trial level, announced that it would no longer defend the ACA *at all*. This announcement created a significant amount of media attention.

The appellate briefing is just now beginning, so a decision is unlikely before Fall 2019. An appeal to the Supreme Court may follow, and if so, a final decision is unlikely before mid-2020.

The outcome remains uncertain: while many legal commentators have been critical of Texas' arguments and the DOJ's decision to decline to defend the law, the plaintiffs have already convinced one court that the ACA is invalid, and both the Fifth Circuit and Supreme Court have conservative-leaning majorities that have been historically unsupportive of the ACA. Moreover, the controversy created by this case is likely to be a major issue during the 2020 campaign season.

HHS Releases Notice of Benefit and Payment Parameters for 2020 Final Rule

On April 18, 2019, the Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services (HHS) issued the Notice of Benefit and Payment Parameters for 2020 (Final Rule). The Final Rule makes several changes, including updating the premium adjustment percentage, maximum annual limitation on cost-sharing (i.e., maximum out-of-pocket, or MOOP) amounts for 2020 and modifying cost-sharing requirements for prescription drugs.

Generally, the standards would be effective for plan years beginning on or after January 1, 2020.

A brief summary of some of the key issues in the Final Rule include the following:

Premium Adjustment Percentage

The premium adjustment percentage, which is a measure of premium growth, must be determined by the Secretary of Health and Human Services on an annual basis. The premium adjustment percentage is used to set the rate of increase for the maximum annual limit on cost-sharing, the required contribution percentage used to determine eligibility for certain exemptions, and the employer shared responsibility payment amounts. The rule finalizes a technical change to the methodology that determines the premium adjustment percentage for the 2020 benefit year.

Specifically, under the new methodology, CMS will use the CMS Office of the Actuary (OACT) estimates of projected health insurance premiums for both the private individual and group market (excluding expenditures for Medigap and property and casualty insurance). This change would replace the current methodology which utilizes only employer-sponsored group market insurance premiums.

Based on the new methodology, CMS finalizes a premium adjustment percentage of 1.2895211380. This is an increase in private individual and group market health insurance premiums of approximately 28.9% over the period from 2013 to 2019. This is important because a higher premium adjustment percentage means a higher maximum annual limit on cost-sharing, a higher required contribution from subsidy-eligible consumers, and higher employer mandate penalties.

Annual Limitation on Cost-Sharing

As is customary in this annual rule, HHS finalizes the updated annual limitation on cost-sharing—also known as the MOOP—which applies to both health insurance issuers and group health plans (including those that are self-funded). For 2020, HHS proposes a MOOP of $8,200 for self-only coverage and $16,400 for other than self-only coverage (an approximately 3.8% increase above the 2019 parameters of $7,900 for self-only coverage and $15,800 for other than self-only coverage).

Prescription Drug Benefits

CMS also finalizes a change with respect to prescription drugs.

Drug Manufacturer Coupons

CMS finalizes that amounts paid toward cost-sharing using any form of direct support offered by drug manufacturers to reduce or eliminate immediate out-of-pocket costs for prescription brand drugs that have a generic equivalent are *not* required to be counted toward the MOOP.

CMS limited the rule's application only to those drugs with generic equivalents and that are medically appropriate, which may limit the helpfulness of this change, because in many instances coupons are used for brand drugs and very expensive specialty drugs that do not yet have generic equivalents. Note that the preamble provides that coupons for drugs that do not have a generic equivalent must be counted toward the MOOP.

This provision applies to insured coverage and self-insured plans.

About GRS

Founded in 1938, Gabriel, Roeder, Smith & Company (GRS) is a national actuarial and benefits consulting firm. GRS is dedicated to bringing clients innovative, sustainable solutions that the firm helps put into action. The firm supports the long-term success of pension, OPEB, and health and welfare benefit plans. Associates deliver high-quality services that reflect GRS' core values, which include professionalism and ethics in all aspects of business. The firm attracts the best talent in the industry by providing a collaborative work environment that respects the diversity and professional aspirations of our associates.

To locate a GRS office, please visit our website at: www.grsconsulting.com.