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GRS INSIGHT

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Washington Update: 2017 – A New Administration

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On January 20, 2017, Donald Trump was sworn in as the 45th President of the United States. With Republican control of both chambers of Congress and the White House after eight years of a Democratic presidency, numerous potential legislative and regulatory changes are poised to move forward quickly.

Key areas for governmental entities and plans to focus on include the following:

- ***Health Care.*** Since its enactment in 2010, the Patient Protection and Affordable Care Act (ACA) has led to significant governmental entity and plan compliance efforts. In 2017, it is likely that key Internal Revenue Code (Code) provisions in the ACA will be repealed. Notably, support from Senate Democrats will be required to repeal the non-tax related portions of the ACA. Given that details of this process are still developing, it is likely that, in the short term, governmental entities and plans will continue with their ongoing implementation and administration of the ACA. However, the outlook for regulatory requirements in 2018 and later years is likely to remain unclear in 2017.

- ***Defined Benefit Plans***. In 2017 and 2018, a key priority for congressional leadership is expected to be comprehensive tax reform. Notably, most tax reform proposals from both Democrats and Republicans in recent years have mainly focused on defined contribution (DC) plans. If comprehensive tax reform proceeds, it is possible that the maximum amount that may be paid from governmental plans could be limited in the future and nonqualified "qualified excess benefit arrangements" (QEBA) under Code Section 415(m) could be curtailed as part of general restrictions on nonqualified deferred compensation arrangements. Separately, it is also possible that legislation mandating increased governmental plan disclosures could move forward in the coming years.

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- ***Defined Contribution Plans***. If comprehensive tax reform proceeds, significant changes could be in store for governmental DC plans. Aside from potential limits on annual DC plan contributions, since the George W. Bush administration, a number of proposals have considered reducing and consolidating the types of defined contribution retirement arrangements provided under the Code. If these changes continue to be considered, state and local government programs under Code Sections 403(b), 457(b) and 457(f) will likely face significant changes.

Given the significant uncertainty about the details of upcoming legislative changes, governmental entities and plans should continue to monitor legislative changes to evaluate what, if any, compliance activity changes they might need or want to consider in 2017.

Treasury/IRS Issue Proposed Mortality Table Regulation

In a long-anticipated move, on December 29, 2016, the Treasury Department and Internal Revenue Service (IRS) issued a proposed regulation on the mortality tables used by defined benefit pension plans.

While the most significant effects of the regulation would be on the calculation of minimum funding requirements and lump sum optional forms of benefits under ERISA, it could also have an impact on public sector plans that are generally not subject to ERISA. Specifically, the mortality table prescribed by the IRS can affect the calculation of the maximum benefit limitations under Code Section 415.

The proposed regulation would be effective for plan years beginning on or after January 1, 2018. The comment period on the proposed regulation is open through March 29, 2017, and a public hearing is scheduled on April 13, 2017. Mortality tables for 2019 and beyond will be published in future Internal Revenue Bulletins.

Background

Federal law requires that ERISA-covered pension plans calculate their funding and disclosure requirements using a prescribed mortality table. This prescribed mortality table is also used to determine lump sum benefit distributions and can have an impact on maximum benefit calculations under Code Section 415. Most of these requirements do not apply to public sector pension plans that are generally not subject to ERISA, with the exception of the 415 limits.

Since the Pension Protection Act (PPA) went into effect in 2008, the regulations have mandated the use of the RP-2000 mortality table, adjusted annually with mortality projection scale AA. In 2014, the Society of Actuaries (SOA) released a new mortality table called RP-2014. The SOA has also released several new mortality projection scales, the most recent of which is MP-2016. The new tables generally anticipate lower rates of mortality, which correspond to longer expected lifetimes.

The Proposed Regulation

The proposed regulation updates the mandated mortality basis to the RP-2014 mortality table and a static mortality projection scale MP-2016. For public sector plans, the new mortality table could affect the calculation of the maximum benefit limitations under Code Section 415. 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 is complex, and considers both the actuarial assumptions specified in the plan and the assumptions mandated by the IRS (including the mortality table). The use of an updated mortality table will affect these calculations, though the

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impact will vary based on individual circumstances.

The proposed regulation also provides plans with sufficient mortality experience the option of using an alternate mortality table based on that experience. However, this option only applies to minimum funding and disclosure calculations and, therefore, it is not applicable to public sector pension plans.

We note that while the proposed regulation will generally not affect public sector pension plans outside of Code Section 415 maximum benefit limitation calculations, it may have an indirect impact by drawing attention to a public employee retirement system's rationale if using tables other than the RP-2014 mortality table and MP-2016 projection scale for other purposes.

Updated IRS Plan Correction Program

On October 14, 2016, the IRS updated its guidance on qualified plan corrections. Revenue Procedure 2016-51 updates the Employee Plans Compliance Resolution System (EPCRS) previously provided in Revenue Procedure 2013-12. This new version of EPCRS should be followed for any corrections on or after January 1, 2017.

Under EPCRS, qualified plans, including governmental plans, may correct certain errors: (i) by "self-correction" (where a plan sponsor or other entity takes reasonable steps to correct an issue); or (ii) in tandem with the IRS via its "voluntary compliance program" (VCP) (where a plan sponsor or other entity submits a proposed correction to the IRS for review and approval). In addition, EPCRS includes a program whereby an error identified by the IRS during an audit may be corrected ("Audit CAP").

Key Updates

This updated EPCRS does not make sweeping changes to the prior guidance, but some of the key changes include:

- ***Determination Letters*:** In light of the elimination of the staggered 5-year determination letter cycles for individually-designed plans, such plans need not have a current determination letter in order to qualify for the self-correction of a significant error.
- ***User Fees*:** The "user fees" section is deleted. User fees will now be included in the annual "user fee" revenue procedure.
- ***Anonymous Applications*:** If a VCP application is filed on an anonymous basis, and the applicant and the IRS fail to agree on a correction methodology, no portion of the user fee will be refunded to the applicant (previously, 50% of the fee was typically refunded).
- ***Audit CAP*:** Previously, the sanction was a negotiated percentage of the "maximum payment amount," which is the maximum tax that the IRS could collect if the plan were disqualified for all open tax years. Under the updated guidance, the sanction is a negotiated amount based on the relevant facts and circumstances, including the maximum payment amount and other related factors listed in the prior EPCRS (*e.g.*, a plan sponsor's efforts to avoid and identify failures). For nonamender failures, the sanction is based on a percentage of the VCP fee that would otherwise apply.
- ***Clarifications*:**
    - Amendments correcting interim amendment and nonamender failures must be adopted before a VCP application is

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submitted to the IRS; proposed amendments are not permitted.

- A compliance statement approving correction via a plan amendment only covers the correction of the error (*e.g.*, the corrective amendment will be treated as if it was timely adopted), but is not evidence that the amendment or plan meets qualification requirements.

Outlook for HRAs in the New Administration

It has become increasingly common for governmental employers to offer reimbursement arrangements to their employees, such as Health Reimbursement Arrangements (HRAs). Some employers offered an HRA along with other comprehensive medical coverage, such as paired with a high deductible health plan or to fund wellness incentives earned by employees. However, other employers offered an HRA to employees who did not enroll in the employer's comprehensive medical coverage to reimburse them for premiums for non-employer sponsored coverage.

Since 2013, through a series of Notices and other guidance issued by the Internal Revenue Service (IRS), the Department of Labor (DOL), and the Department of Health and Human Services (HHS) (collectively, "the agencies"), an employer's ability to offer an HRA to employees who are not enrolled in the employer's or another employer's comprehensive medical coverage (i.e., "non-integrated" HRAs) has been severely limited. As part of this guidance, the agencies provided temporary transitional relief to small employers through July 1, 2015.

Looking ahead, some health policy experts expect the new Trump Administration to view HRAs much more favorably than the Obama Administration and possibly relax some of the restrictions on providing reimbursements to employees who are not enrolled in employer-sponsored coverage. President Trump has been vocal about his support for Health Savings Accounts (HSAs), which could translate to other account-based plans, such as HRAs. Indeed, on December 13, 2016, even before Trump was sworn in as President, President Obama signed into law the 21st Century Cures Act, which includes a provision that permits certain small employers to provide non-integrated HRAs that reimburse employees for health care expenses, including premiums for non-employer sponsored coverage.

Note that even if the Trump Administration relaxes the restrictions imposed by the Obama Administration, there could still be state law considerations. A number of states have enacted laws that treat individual, comprehensive medical policies as subject to the state small group rules if they are funded by an employer. However, if the federal government signals approval of such arrangements, the state governments may follow suit.

Mental Health Parity Update

Mental Health and Substance Use Disorder Parity Task Force

On March 29, 2016, President Obama established the Mental Health and Substance Use Disorder Parity Task Force ("Task Force"). The Task Force published its final report on October 27, 2016. The final report highlights the work of the Task Force, including: providing a summary of stakeholder comments; detailing actions taken during the Task Force's tenure; and presenting the Task Force's recommendations. The final report focuses on the complexities of analyzing compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and discusses the need to support consumers through increased parity awareness and education, improved parity implementation, and enhanced parity compliance and enforcement.

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The Task Force took several actions and made several recommendations including:

- Creating a one-stop consumer web portal to help consumers navigate parity and understand their rights and how to exercise them.

- Providing MHPAEA disclosure tools to provide information for consumers, plans and issuers.

- Releasing a *Consumer Guide to Disclosure Rights: Making the Most of Your Mental Health and Substance Use Disorder Benefits*[1] to help consumers understand what type of information to ask for when inquiring about a plan's compliance with parity and to explain the various federal disclosure laws that also require disclosure of information related to parity.

- Awarding $9.3 million in grants to the following states to assist state regulators with monitoring compliance with MHPAEA protections: California, Colorado, Hawaii, Illinois, Indiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Utah and Washington, DC. (Note that California, Massachusetts, New York, Oregon and Rhode Island were cited as models of promising enforcement efforts.)

- Announcing two learning academies regarding parity compliance: 1) focusing on parity compliance in the commercial market; and 2) focusing on parity in Medicaid and the Children's Health Insurance Program (CHIP).

- Issuing a Compliance Assistance Materials Index, which provides a single resource of parity guidance.

- Publishing information regarding parity violation "Warning Signs."

- Increasing the audit capacity of the federal agencies for parity compliance.

- Recommending that Congress enact legislation giving the Department of Labor (DOL) the authority to assess civil monetary penalties for parity violations.

- Recommending that Congress enact legislation eliminating the HIPAA opt-out process for self-funded non-federal governmental plans.

- Releasing annual data from DOL and the Department of Health and Human Services (HHS) on closed federal parity investigations.

21st Century Cures Act

On December 13, 2016, President Obama signed into law the 21st Century Cures Act. This bipartisan legislation addresses biomedical innovation and research, and includes provisions on mental health parity.

The specific provisions amending MHPAEA include requirements for:

- Enhanced compliance with mental health and substance use disorder coverage, specifically requiring DOL, HHS, and IRS/Treasury to release compliance program guidance providing illustrative examples of past findings of compliance and noncompliance with mental health parity requirements, including disclosure requirements and nonquantitative treatment limitations.

- Mandatory audits of a health plan if the health plan has violated mental health parity five times.

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[1] https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/disclosure-guide-making-the-most-of-your-mental-health-and-substance-use-disorder-benefits.pdf

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- Enhanced enforcement of mental health and substance use disorder coverage, specifically requiring HHS to hold a public meeting within six months of enactment to produce an action plan for improved federal and state coordination related to enforcement of mental health parity.
- A report on investigations regarding mental health parity, specifically requiring the Centers for Medicare and Medicaid Services (CMS) to conduct an annual report for five years summarizing the results of all closed federal investigations completed during the preceding year with findings of any serious violation regarding mental health parity compliance.
- A GAO study on mental health parity.
- Treating eating disorders as mental health conditions providing that, if a health plan provides coverage for eating disorder benefits (including residential treatment), those benefits must be in parity.

Conclusion

There will likely be many changes in health care in the coming years under the Trump Administration. Given the recent enactment of the MHPAEA provisions in the bipartisan 21st Century Cures Act, it is reasonable to infer that mental health parity will continue to be an important issue for health plans.

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