JANUARY 2018

INSIGHT

The Tax Cuts and Jobs Act of 2017

IN THIS ISSUE

On December 22, 2017, President Trump signed into law H.R. 1, the Tax Cuts and Jobs Act of 2017, the first major overhaul of the Internal Revenue Code in over 30 years. The bill passed along largely partisan lines in both the House of Representatives and the Senate, with no Democrats supporting the legislation. In the months prior to enactment of the reform, a number of proposals were considered by House and Senate Republicans that would have materially impacted a wide variety of employee benefit plans, including executive compensation, retirement, and health and welfare benefits.

Much of the debate over the tax reform bill focused on the manner and extent to which Congress would offset the cost of significant cuts to the income tax rates for corporations and individuals. Early statements by Republican leadership suggested massive changes to the treatment of defined contribution pension benefits, like 401(k) plans, could be used to generate necessary revenue. Under these initial approaches, individuals would have lost all or some of the ability to contribute pre-tax earnings, with the tax benefit being deferred until the plans' assets were used by not imposing a tax on any earnings attributable to the plan. This approach was termed "Rothification" and was viewed as a viable source of significant revenue, but was highly criticized both for its effect on savings and the fact that the savings associated with the change would be somewhat illusory, as revenue would be lost in the period outside of the budget window.

Conversely, Republican leadership made clear throughout the year that it intended to avoid including the Affordable Care Act's (ACA) tax related provisions, and the tax treatment of health benefits generally, in any comprehensive tax reform. Republican health care reform repeal-replace efforts faltered throughout the year; however, the political and procedural pressures to include some or all of the ACA repeal provisions increased.

Despite these early intentions to reform the treatment of retirement savings and to avoid including health related taxes, the final Tax Cuts and Jobs Act largely avoided an overhaul of the tax treatment of defined contribution plans, but included an effective repeal of the ACA's personal responsibility provision, the Individual Mandate.

Retirement Provisions

The law does include a number of targeted retirement-related provisions:

- **Extended rollover period for plan loans.** Previously, an individual had 60 days to pay back or roll over a plan loan to avoid a taxable event. Now, an individual has until their tax filing deadline (and extension) to avoid having a loan treated as a taxable distribution, if the reason for failure to meet the repayment terms is plan termination or severance of employment.
- **IRA recharacterization**. In the past, if an individual converted a traditional IRA to a Roth IRA, the individual had a

period of time to undo the conversion (i.e., recharacterization). These recharacterizations typically arose in the following instances: if the individual was not in a financial position to pay the taxes associated with the conversion; if there was a clear signal that rates were going down; or if the market declined eliminating any taxable gains. Under the bill, the recharacterization option is gone. So, if an account holder converts to a Roth, then the IRA remains a Roth account.

- **Chained CPI-U.** The government uses a few measures for inflation that are used for indexing numbers. One is the Consumer Price Index for All Urban Consumers (CPI-U), and another is Chained CPI-U. CPI-U accounts for greater inflation and thus provides for increased indexing. Chained CPI-U, on the other hand, sees less inflation so numbers increase more slowly. In the past, when the Internal Revenue Service (IRS) determined how much to increase annual IRA contribution limits (and in the numbers it released in December for 2018), it used CPI-U. The new law provides that for years beginning after 12/31/2017, Chained CPI-U is to be used. It is unclear, as a matter of implementation, whether the IRS must issue new numbers for 2018 or if it can leave the numbers in place for 2018 and use the new Chained CPI-U numbers for 2019. Consequently, in the longer term, contribution amounts can be expected to increase more slowly than in past years.
- **Special relief for 2016 disaster victims.** This is a less generous version of the relief we have seen Congress provide after other hurricanes and natural disasters. It allows individuals who suffered a disaster during calendar year 2016 to take distributions of up to $100,000 and avoid the 10% early withdrawal tax.

Health Provisions

The only specific health provision included in the Tax Cuts and Jobs Act was the zeroing out of the penalties associated with the Individual Mandate. Because of the arcane rules governing passage of Reconciliation Bills in the Senate, a full repeal of the Individual Mandate was ruled out of order. Therefore, effective for months beginning after December 31, 2018, individual taxpayers will no longer be subject to a tax penalty for failing to purchase minimum essential coverage. The Congressional Budget Office estimated that the repeal of the penalty will potentially increase the number of uninsured individuals by four million in 2019 moving to thirteen million by 2027. CBO also projected that the repeal will reduce federal deficits by $338 million over the next ten years. While these numbers were strongly contested during the debate of the bill, the repeal will have direct impact on the individual insurance markets and indirect impacts on the group insurance markets. For the individual and small group markets, fewer healthy individuals will have incentives to enroll in coverage further destabilizing risk pools, and likely increasing premiums. This impact is likely to be more extreme in the individual markets, but could be material in the small group markets as well. While the impacts on large groups are less clear, large groups face potentially higher numbers of individuals seeking COBRA continuation coverage as individual market rates rise, and small groups could have direct impacts on their own risk pools as eligible employees elect not to enroll in coverage.

Implementation

The Tax Cuts and Jobs Act left the retirement system largely intact, and made one material change to the health care landscape. As the agencies implement this massive piece of legislation on an expedited basis, a number of questions are likely to arise that could impact how retirement plan participants' benefits are treated, particularly in 2018. Plans and service providers should be aware that implementation guidance could materially impact plan operations.

House Provision Applying UBIT to Governmental Pension Plans Falls Short

When the U.S. House Committee on Ways and Means marked up its version of H.R. 1, the House version of what would later become the Tax Cuts and Jobs Act, a surprise awaited state and local governmental pension plans. The bill proposed to subject governmental plans to unrelated business income tax (UBIT), potentially overturning governmental plans' longstanding exemption from the UBIT regime. While the bill passed the House with the UBIT proposal included, the provision ultimately was not included in the Senate version or the final conference report that was enacted into law, resulting in a sigh of relief to governmental plans and their participants. Still, the proposal could appear again in future legislative efforts. In this article, we explain both the general rules surrounding UBIT and the House proposal to subject governmental pension plans to the tax. We also provide general guidelines for plans to assess their exposure to UBIT going forward.

UBIT Overview

Private pension plans described in section 401(a) of the Internal Revenue Code (the Code) are generally exempt from federal income tax under section 501(a) of the Code. However, under section 511(a), otherwise tax-exempt organizations must pay UBIT on income derived from a trade or business that is "unrelated" to the organization's tax-exempt purpose. The basic rationale is that without UBIT, tax-exempt investors would be willing to pay more than private investors for the same investment if they did not have to pay federal income tax on investment gains. By putting private and tax-exempt investors on the same playing field, UBIT prevents tax-exempt investors from gaining an unfair economic advantage.

UBIT arises in two ways. First, tax-exempt organizations generally pay UBIT on net income derived from any unrelated trade or business. For example, a private pension plan that invests in a fund that operates an active trade or business (*e.g.*, a retail clothing outlet) generally pays UBIT on gains derived from that investment. Second, tax-exempt organizations pay UBIT on so-called "debt-financed" income, that is, income derived from investments acquired either directly or indirectly by borrowing. For example, a private pension plan that purchases real property, 75% of which is funded with debt, pays UBIT on 75% of the rental income derived from the investment (unless an exception applies). So-called "passive" income streams (*e.g.*, dividends, interest, royalties, and rents) remain exempt from UBIT unless derived from debt-financed property. Where UBIT does apply, tax-exempt organizations incur it either directly or on a pass-through basis (*i.e.*, through a partnership or LLC in which it invests). Unrelated business income is taxed at trust rates, which accelerate quickly to 37%.

Historically, many state and local governmental pension plans have taken the position that, because they perform an "essential government function" with income that is exempt from federal income tax under section 115(1) of the Code, they remain exempt from UBIT. While there is limited guidance addressing this position, to date, the IRS has not challenged plans on this point. Thus, even though governmental plans are described in section 401(a) of the Code and would, therefore, generally incur UBIT under section 511(a)(2)(A), for decades governmental plans have treated themselves as exempt from UBIT.

Tax Cuts and Jobs Act (H.R. 1)

On November 16, 2017, the U.S. House of Representatives passed H.R. 1, the House version of what would later become the Tax Cuts and Jobs Act of 2017. Section 5001 of the House bill would have amended Code section 511 to provide explicitly that organizations or trusts exempt from taxation under Code section 501(a) (such as state and local governmental plans) would **not** be exempt from UBIT solely because they excluded amounts from gross income under another Code provision. That is, the House bill would have subjected state and local governmental plans to UBIT under Code section 511 regardless of Code section 115 (or any other Code section under which a plan may claim tax-exemption). The Joint Committee on Taxation estimated that this provision would raise $1.1 billion in revenue over the next ten years. Certainly, many governmental plans recoiled at the bill's potential impact on investment earnings, portfolio construction, and plan funding.

Fortunately for governmental plans, neither the Senate bill nor the final conference report included the UBIT-governmental-plan provision. Therefore, for the moment, governmental plans and investment managers can rest easy. Still, important questions remain: If a similar provision emerges in future legislation, how should governmental plans analyze their sensitivity to UBIT? Should plans consider alternative investment structures? What strategies are available for avoiding UBIT, and what are the costs?

UBIT Sensitivity

While the House bill would have placed governmental plans on the same footing as private pension plans, it would not, of course, have exposed *all* plan investments to UBIT. Plans must instead assess each investment on a case-by-case basis. While the UBIT rules are highly technical and nuanced, some basic considerations include:

- If an investment generates passive income (such as dividends, interest, royalties, and rents), such income will generally remain exempt from UBIT.
- If the plan invests in a pass-through entity (*i.e.*, a partnership or LLC), trade or business operating income (usually small amounts) may pass through to the plan to the extent the entity regularly carries on a trade or business.
- If the plan invests in a pass-through entity that, itself, invests in other partnerships or LLCs (but not corporations, which generally do not generate UBIT unless debt-financed), UBIT may pass through to the plan.

- If the plan invests in a fund that borrows money to finance its investments, the investment may generate debt-financed UBIT.
    - In general, otherwise tax-exempt passive income (including dividends, interest, rents, royalties, and capital gains) is subject to UBIT to the extent it is debt-financed (in proportion to the amount borrowed), whether by the exempt entity itself or by a pass-through investment fund.
    - Exemptions or exceptions from debt-financed UBIT exist for securities lending transactions, real estate, short sales of stock, futures, and options, among others.
- If the plan obtains any kind of commitment from a fund (in either its investment agreement or a side letter) to avoid structuring investments to generate UBIT, the plan may afford itself some protection from UBIT.
    - Similarly, the plan may obtain a "tax distribution" commitment from the fund to make it whole for UBIT costs.
- Finally, governmental plans may wish to consider shifting investments into so-called "blocker" entities that effectively turn otherwise "bad" income into passive (non-taxable) dividends. But blockers come with their own set of problems. For blockers investing substantially in the United States, certain U.S.-source income (*e.g.*, operating income, real estate capital gains) generally is subject to withholding at the source. Particularly with real estate and private equity funds, this tax could exceed the anticipated amount of UBIT and negate the benefits of using the blocker.

Looking Ahead

While the provision subjecting governmental plans to UBIT was not included in the final tax reform bill, governmental plans are not entirely off the hook going forward. After all, the House introduced a similar proposal back in 2014, so the UBIT provision has now been considered twice in the House over the past three years. Therefore, it may appear again in future legislative efforts, particularly due to its revenue-generating potential. Thus, going forward, governmental plans should continue to assess their exposure to UBIT. Plans that remain sensitive to UBIT should consider obtaining commitments from funds either to avoid UBIT or otherwise permit them to restructure their investments in the event that Congress revisits the UBIT issue. Plans should seek qualified legal and/or investment advice as deemed appropriate.

Health Care Executive Order and Association Health Plans Proposed Rule

Executive Order

On October 12, 2017, the Administration took steps to change the health coverage landscape by issuing an Executive Order (No. 13813),[1] "Promoting Healthcare Choice and Competition Across the United States" (the Executive Order). The Executive Order directed the Departments of Treasury, Labor (DOL) and Health and Human Services (HHS) (collectively, the Departments) to consider proposing regulations or revising guidance in three areas: 1) allowing more employers to form association health plans (AHPs); 2) extending the duration of, and allowing individuals to renew, short-term, limited-duration insurance (STLDI); and 3) broadening the use of health reimbursement arrangements (HRAs). The Executive Order directed the Departments to consider making these changes within 60 days for AHP and STLDI rules, and within 120 days for HRA rules.

On January 4, 2018, the DOL released a Proposed Rule aimed at expanding employers' ability to form AHPs. More information regarding the AHP Proposed Rule is below.

AHP Proposed Rule

Background

On January 4, 2018, the DOL released a proposed rule,[2] *Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans* (Proposed Rule). *See* 83 Fed. Reg. 614 (published Jan. 5, 2018). This rule would modify the DOL's interpretation of the definition of "employer" under ERISA section 3(5) to allow additional employer groups or associations to be treated as single multiple employer plans able to sponsor ERISA group health plans. If associations meet certain requirements, as discussed below, the size of the AHP itself would determine the size of the group health

[1] https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/

[2] https://www.gpo.gov/fdsys/pkg/FR-2018-01-05/pdf/2017-28103.pdf

plan (*i.e.*, there would be no "look through" provision to the size of employers comprising the AHP). If finalized, this rule would significantly expand the number of AHPs that could be considered a single large group plan not subject to certain Affordable Care Act (ACA) requirements that apply only to the individual and small group markets (*e.g.*, essential health benefits and rate review requirements). The Proposed Rule has a 60-day comment period, with comments due March 6, 2018.

Broadened Interpretation of "Employer"

ERISA section (3)(5) defines the term "employer" as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." The Proposed Rule would significantly broaden the interpretation of "employer" by "clarifying" who may act as an "employer" when sponsoring a multiple employer group health plan.

Specifically, the regulation would redefine the meaning of a bona fide group or association of employers, allowing an association to establish an ERISA group health plan if it meets the following requirements:

- It exists for the purpose, in whole or in part, of sponsoring a group health plan that it offers to its employer members;
- Each employer member of the association participating in the group health plan is a person acting directly as an employer of at least one employee who is a participant covered under the plan (including a "working owner" as defined in the proposed regulation);
- It has a formal organizational structure (*e.g.*, by-laws or other indications of formality);
- The functions and activities of the association, including establishing and maintaining the group health plan, are controlled by its employer members, either directly or indirectly (*i.e.*, through representatives that control the group or association and the group health plan);
- The employer members have a commonality of interest;
- The association does not make health coverage through the association available to anyone other than to employees and former employees (and their family members or beneficiaries);
- The association, and the health coverage it offers, complies with certain nondiscrimination provisions; and
- The association is not, or is not owned or controlled by, a health insurance issuer.

Expanded "Commonality of Interest" Test

As mentioned above, the employer members of an association would be considered employers capable of forming an ERISA group health plan even if they band together for the sole purpose of issuing the group health plan, as long as they have a commonality of interest. The Proposed Rule creates a more flexible "commonality of interest" test for employer members, proposing to require that the employers meet one of the following requirements: 1) they are in the same trade, industry, line of business, or profession; or 2) they have a principal place of business in a region that does not exceed the boundaries of the same state or the same metropolitan area (even if the metropolitan area includes more than one state). The DOL seeks comment on, among other issues, whether it should define a metropolitan area using a designation by the U.S. Census Bureau or the Office of Management and Budget, and whether stakeholders are concerned that associations could manipulate geographic classifications to avoid offering coverage to certain employers that would be more likely to incur higher health costs.

Treatment of Working Owners (Including Sole Proprietors)

The Proposed Rule would allow for a working owner of a trade or business – including a sole proprietor – to be both an employer and an employee of a trade, business, or partnership, for the purposes of being covered by the AHP, as long as the individual: 1) works at least 30 hours per week; 2) works 120 hours per month; or 3) has earned income from the business equaling at least the working owner's cost of the group health plan coverage. The DOL solicits comments regarding how to address how owners can reasonably predict working hours and income. In addition, to be eligible for the AHP, the working owner would not be permitted to be eligible for other subsidized group health plan coverage under a group health sponsored by any other employer of the individual or by a spouse's employer. The Proposed Rule explicitly states that the DOL would permit the formation of an AHP solely comprised of working owners. In addition, the DOL proposes, but seeks comment on, allowing the AHP to rely on written representations from the individual seeking to

participate as a working owner. These proposals, if adopted in a final rule, would result in considerable changes to current requirements.

Nondiscrimination Requirements

The Proposed Rule would require that a bona fide group or association not condition employer membership on any health factor of the employer or employees (or their beneficiaries). In addition, the AHP would not be able to create eligibility rules based on a health factor and would be prohibited from varying premiums for similarly-situated individuals based on health factors.

As proposed, a bona fide group or association would not be able to treat different employer members of the group or association as distinct groups of similarly-situated individuals. However, while the rule would prohibit different treatment *within* groups of similarly-situated individuals, it would not prohibit different treatment *across* groups of similarly-situated individuals. Therefore, AHPs would be able to treat participants as distinct groups if the groups could be distinguished based on a bona fide employment-based classification consistent with the employer's usual business practice (e.g., full-time versus part-time status; different geographic location; membership in a collective bargaining unit; date of hire; length of service; current versus former employee status; and different occupations). Notwithstanding these proposals, AHPs would still be required to comply with the anti-abuse provision, which prohibits treating different groups of individuals differently if the different treatment is directed at individuals or beneficiaries based on any health factor.

The Proposed Rule also clarifies that beneficiaries could be treated as distinct groups based on factors that are not considered health factors (e.g., relationship to participant; marital status; age; or student status). The DOL solicits comments on the nondiscrimination proposals, including asking how these proposals balance risk selection issues with the stability of the AHP market.

State Regulation

The DOL expressly states that the Proposed Rule would not alter existing ERISA requirements governing self-funded Multiple Employer Welfare Arrangements (MEWAs) and would not modify the authority of states to regulate health insurance issuers or the insurance policies they sell to AHPs. The DOL requests comments regarding how best to ensure compliance with ERISA and ACA standards governing AHPs. The Proposed Rule also solicits comments regarding whether the final rule should include additional provisions to assist existing employer associations (including MEWAs that are not currently AHPs) to adjust their business structures to become AHPs under the final rule.

Next Steps

The Proposed Rule, if finalized, would result in considerable changes to AHP coverage. In particular, the proposal to broaden the requirements for employers to form AHPs, as well as the ability for working employers (including sole proprietors) to be considered employers and employees of an association, would likely increase the number of AHPs. Allowing the size of the AHP (as opposed to the size of each underlying employer group) to determine the size of the group health plan would also likely result in more AHPs meeting the criteria for large group health coverage and, therefore, would exempt them from certain ACA requirements (*e.g.*, essential health benefits and rate review). These changes could have significant effects on the risk pools of the individual and small group markets.

HHS Notice of Benefit and Payment Parameters for 2019 Proposed Rule

Background

On October 27, 2017, the U.S. Department of Health and Human Services (HHS) released the *Notice of Benefit and Payment Parameters for 2019 Proposed Rule* (Proposed Rule).[3] *See* 82 Fed. Reg. 51052 (published Nov. 2, 2017). HHS publishes this rule annually to update requirements for the individual and group markets, health insurance Exchange standards, and premium stabilization programs, specifically the risk adjustment program. Each year, the Proposed Rule also proposes updated annual limitation on

[3] https://www.gpo.gov/fdsys/pkg/FR-2017-11-02/pdf/2017-23599.pdf

cost sharing (*i.e.*, maximum out-of-pocket (MOOP)) amounts, and it has done so again this year, for 2019. This year's rule also proposes greater state flexibility in a number of areas, including essential health benefits (EHBs), medical loss ratio, rate review, and state certifications of qualified health plans (QHPs) in the Federally-facilitated Exchanges and State-based Exchanges using the federal platform. In addition, HHS proposes changes to certain special enrollment periods (SEPs), risk adjustment and risk adjustment data validation programs, Exchange user fees, and Exchange programs, including changes to the Small Business Health Options Program (also known as SHOP).

Comments on the Proposed Rule were due by November 27, 2017. Below is an overview of the following pertinent issues: EHBs and the annual limitation on cost sharing levels for 2019.

Greater State Flexibility for EHBs

Under the Affordable Care Act (ACA), health insurance plans in the individual and small group markets are required to offer EHBs in 10 categories, and specific benefits are linked to benchmark plans chosen by each state. In the Proposed Rule, HHS has proposed to give states more flexibility when selecting EHB benchmark plans for plan years beginning on or after January 1, 2019. Under this proposal, states would be able to change their benchmark plans annually, but would keep their current benchmark if they take no action. States could use one of the following three options when choosing a benchmark plan:

- ***Option 1:*** *Selecting the EHB-benchmark plan another state used for the 2017 plan year.*
- ***Option 2:*** *Replacing one or more EHB categories from another state's EHB-benchmark plan for the 2017 plan year.* A state could "mix and match" benefits from other states' EHB-benchmark plans to form its own EHB-benchmark plan.
- ***Option 3:*** *Selecting its own set of benefits for its EHB-benchmark plan.* A state could select its own set of benefits to form its own EHB-benchmark plan, as long as the new benchmark plan does not actuarially exceed the generosity of the most generous of a set of comparison plans for the 2017 plan year. The state would determine generosity using the methods HHS would use to measure whether the plan is equal in scope of benefits to a "typical employer plan," which would be defined as either: 1) an employer plan within a product with substantial enrollment in the product of at least 5,000 enrollees sold in the small or large group market; or 2) a self-insured group health plan with substantial enrollment of at least 5,000 enrollees. Under this option, the EHB-benchmark plan would also be required to provide EHB in each of the 10 benefit categories required by the ACA, and it must have an "appropriate balance" among the 10 categories.

Regardless of the option a state chooses, states with any state-mandated benefits enacted after December 31, 2011, would be required to defray those costs, as is currently required. HHS also proposes to allow states to substitute non-prescription drug benefits within the same EHB category and between EHB categories, as long as a substituted benefit is actuarially equivalent to the benefit being replaced.

In addition, the Proposed Rule would require a state to give reasonable notice and an opportunity for the public to comment on any changes to the state's EHB-benchmark. The state would also be required to notify HHS whenever it changes its benchmark. The rule proposes deadlines for a state to submit the documents required for its benchmark plan options: March 16, 2018, for the 2019 plan year; and July 1, 2018, for the 2020 plan year. For plan years further in the future, HHS is considering creating a federal default definition of EHB, but is also considering allowing states to continue to choose their own EHB-benchmark plans. HHS has requested comments, specifically regarding whether it should set a national prescription drug benefit standard under a federal default EHB definition.

Changes to EHB requirements could result in notable changes to benefit offerings and requirements for health benefits in all health insurance markets. While the requirement to offer EHBs applies only to the individual and small group health insurance markets (inside and outside of the Exchanges), health insurance issuers and group health plans – including self-insured group health plans – in the small and large group markets are prohibited from placing annual or lifetime dollar limits on EHBs and must count cost sharing for EHBs towards the annual limitation on cost-sharing (*i.e.*, the MOOP limit). Hence, if states have less stringent EHB requirements, fewer benefits would be subject to the prohibition on annual and lifetime dollar limits and fewer benefits would count towards the MOOP limit.

MOOP Amounts for 2019

As is customary in this annual rule, the Proposed Rule proposes the 2019 maximum annual limitation on cost sharing – or MOOP – levels, which apply to both the individual and group markets. For 2019, HHS proposes that the MOOP amounts be **$7,900 for self-only coverage** and **$15,800 for other than self-only coverage**. This proposal is approximately a 7% increase from the 2018 amounts, which are $7,350 for self-only coverage and $14,700 for other than self-only coverage. As has been the case in the past, HHS also proposes different MOOP amounts for enrollees with household incomes between 100-250 percent of the federal poverty level (FPL):

- 100-150 FPL: $2,600 (self-only); $5,200 (other than self-only)
- 150-200 FPL: $2,600 (self-only); $5,200 (other than self-only)
- 200-250 FPL: $6,300 (self-only); $12,600 (other than self-only)

Next Steps

HHS typically publishes the Notice of Benefit and Payment Parameters final rule in the first few months of the year. Therefore, the Notice of Benefit and Payment Parameters for 2019 final rule will likely be released in early 2018, to inform health insurance issuers, states, and other stakeholders as they prepare for the 2019 plan year.

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