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Member Election Creating Cash or Deferred Arrangement

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The IRS recently released Private Letter Ruling 201722014 (June 2, 2017), which discussed a cash or deferred arrangement resulting from an election between a current payment and a subsidized early retirement benefit.

The State legislature enacted a statute[1] (the Statute) which provides employees of certain governmental employers who are subject to a separation from service with the option to elect one of the following under the governmental defined benefit (DB) plan:

- A one-time lump sum cash payment equal to a percentage of base salary times years of service; or
- A subsidized early retirement benefit under the plan, permitting an employee to retire with an unreduced retirement benefit at an earlier age or with less service than previously permitted under the plan.

The plan requested three rulings by the IRS:

- Whether the election created by the Statute would constitute a cash or deferred arrangement?
- If a cash or deferred arrangement is created, whether such arrangement would cause the plan to lose its qualified status under the Internal Revenue Code?
- If the plan loses its qualified status, what are the consequences of such disqualification?

Cash or Deferred Arrangement

A "cash or deferred arrangement" under Treasury Regulation Section 1.401(k)-1(a)(2)(i) is an arrangement under which an employee may make a cash or deferred election with respect to contributions, accruals, or other benefits under a Code Section 401(a) plan. A "cash or deferred election" is defined under Treasury Regulation Section 1.401(k)-1(a)(3)(i) as a direct or indirect election by an employee to have the employer: 1) provide a taxable benefit (e.g., cash) to the employee that is not currently available; or 2) contribute an amount to a trust or provide an accrual or other benefit under a plan, deferring the receipt of compensation.

[1] *The Statute is not effective, pending the result of a legal challenge.*

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Under the Statute, an employee participating in the plan may choose either a current cash payment or a subsidized early retirement benefit. The election permits the employee to choose between a cash payment that is not otherwise currently available and a benefit which provides deferred compensation under the plan. Therefore, the election granted to these employees with respect to the benefit received upon separation from service constitutes a cash or deferred election, which creates a cash or deferred arrangement under the plan.

Plan Qualification

Treasury Regulation Section 1.401(k)-1(a)(1) provides that a plan, other than a profit-sharing, stock bonus, pre-ERISA money purchase pension, or rural cooperative plan, does not satisfy Code Section 401(a) if it includes a cash or deferred arrangement. Since a cash or deferred arrangement is not permitted under a defined benefit plan, the governmental DB plan at issue here would not satisfy the qualification requirements of Code Section 401(a), as it would include a cash or deferred arrangement.

While the IRS confirmed that the existence of a cash or deferred arrangement would cause the plan to fail to be qualified under Code Section 401(a), the IRS declined to rule on the Federal tax consequences of plan disqualification in this situation. That said, disqualification due to an impermissible cash or deferred arrangement would cause the plan, members and beneficiaries to face tax consequences similar to those in other disqualification situations. For example, earnings under the plan would become subject to immediate taxation, participants would have to include employer contribution amounts in income, and employer deductions for contributions could be delayed.

Going Forward

With limited exceptions (e.g., the arrangement was adopted on or before May 6, 1986), a governmental plan cannot contain a cash or deferred arrangement. Although the plan discussed in this ruling is a defined benefit plan which is not permitted to contain a cash or deferred arrangement regardless of its status as a governmental plan, the ruling reinforces issues for consideration by governmental plans when implementing new features or rights under defined benefit and defined contribution plans to ensure they are not seen as providing employees with a cash or deferred election.

Reducing OPEB Liabilities Under Governmental Accounting Rules Through Changes to Benefits

In June 2015, the Governmental Accounting Standards Board (GASB) issued Statement No. 74 (GASB 74), *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, to replace certain prior Statements. GASB 74 establishes new uniform standards of financial reporting for state and local governmental postemployment benefits other than pension benefits (OPEB), such as postemployment healthcare benefits and other postemployment benefits (e.g., death benefits, life insurance, and disability). GASB 74 became effective for financial statements covering fiscal years beginning after June 15, 2016.

Generally, GASB 74, together with companion Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pension*, requires that net OPEB liabilities be calculated and reported on an employer's financial statements. These reporting requirements parallel the requirements for governmental pension plan liabilities under GASB Statement Nos. 67 and 68.

One question that arose in connection with the implementation of these requirements was whether a governmental employer can change an OPEB plan in order to reduce the amount of liabilities under that plan. Paragraph 43 of GASB 74 provided some guidance by noting that, in determining total OPEB liabilities, projected benefit payments should include all benefits to be paid through the OPEB plan under the benefit terms and any additional legal agreements to provide benefits that are in force at the end of the OPEB plan's fiscal year. Thus, a state statute authorizing or requiring a change in benefit terms should be adopted prior to the relevant fiscal year end to be taken into account.

GASB also recently finalized related guidance in the form of a proposed implementation Guide (Implementation Guide 2017-2, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*). The Implementation Guide further addresses this issue, with three question and answer sets specifically providing insight. These sets indicate that, to be recognized, the change must actually be adopted, and will only be taken into account with the plan year in which it is adopted. The guide also indicates that, if a periodic change to the formula is not "substantively

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automatic" (e.g., a cap on benefits has a history of being waived), it likely should not be taken into account. That said, under the relevant facts and circumstances, if a benefits cap is specific and real, it would be taken into account once it is enacted, even if benefits are not capped until a later year.

The three question sets include:

> **4.109. Q**—A state statute provides that the administrator of the state's retiree healthcare plan is required to make changes to the plan to maintain a specified minimum funded level. From time to time, in compliance with that statute, the OPEB plan administrator adopts changes to the OPEB plan's benefit terms. At what point in time should anticipated changes to the OPEB plan's benefit terms be included in the projection of benefit payments for purposes of Statement 74?
>
> **A**—Paragraph 43 of Statement 74 requires that projected benefit payments include all benefits in accordance with the benefit terms and any additional legal agreements to provide benefits that are in force at the OPEB plan's fiscal year-end. In addition, that paragraph requires that the projection include consideration of the established pattern of the sharing of benefit-related costs between the employer and inactive plan members. To the extent that the effects of the anticipated benefit changes are determined to be part of an established pattern of the sharing of benefit-related costs with inactive plan members, those effects should be considered in the projection of benefit payments beginning in the period in which that determination is made. Any portion of the expected effects of the anticipated benefit changes that is not determined to be part of the pattern of sharing of benefit-related costs with inactive plan members is not part of the substantive plan until the benefit change has been adopted. Therefore, although the state statute requires a change in benefit terms in the future if certain conditions arise, those effects of anticipated changes should not be incorporated into the projection of benefit payments for purposes of Statement 74 until the OPEB plan's fiscal year-end in which the benefit change has been adopted, that is, the benefit change is part of the substantive plan.
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> **4.121. Q**—Under what conditions should a legal or contractual cap on benefit payments to be provided in the current year be taken into consideration in projecting the benefit payments to be provided in future periods?
>
> **A**—A legal or contractual cap on benefit payments that is established to limit an employer's obligation for OPEB should be factored into the projection of benefit payments if both of the following conditions apply:
>
> a. The cap sets an upper limit on the benefit payments to be provided to inactive plan members each period, as distinguished from a cap on the employer's contributions to a defined benefit OPEB plan. (See also Question 4.120.)
>
> b. The cap is assumed to be effective, taking into consideration all relevant facts and circumstances, including the employer's record of enforcing the cap in the past. (For example, has the employer ever previously increased the benefit cap when the original capped amount was reached?)
>
> **4.122. Q**—If a legal or contractual cap on benefit payments meets the two conditions identified in the answer in Question 4.121, what is the assumed effect on benefits that are projected to be paid at or after the point that the benefit payments reach an effective benefit cap?
>
> **A**—If a legal or contractual cap on benefit payments meets the two conditions identified in the answer in Question 4.121, the benefit payments for OPEB each period should be projected to increase based on continuation of the historical pattern of sharing of benefit-related costs between the employer and the inactive plan members up to the point at which the benefit payments reach the capped amount. From that point forward, the benefit should be projected to not exceed the capped amount.

This guidance provides some certainty for governmental employers, outlining the steps to be taken if there is a need to modify the liability reporting on the financial statements for its OPEB plan.

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Risks Related to a Change in Interpretation

A recent court case, *Romero v. Allstate Ins. Co.*, 2017 WL 1508879 (E.D.Pa. Apr. 27, 2017), held that a new administrative interpretation of a plan term can be a cutback under the Internal Revenue Code (the Code) and the Employee Retirement Income Security Act (ERISA), even if there is no corresponding plan amendment. As this court is not alone in its conclusion, it is an additional factor to consider when contemplating an interpretation change. [2]

Facts

Allstate's insurance agent-employees were covered under the Allstate Agents Pension Plan (Plan), which included a special early retirement benefit called the "beef-up." The beef-up was available to any agent who "retire[d] prior to Normal Retirement Date after having attained age 55 and, at his actual retirement date, having completed 20 years of continuous service ..., and in accordance with the Company's voluntary early retirement policy ...." After inclusion of this provision in the Plan, the agent-employees of Allstate were converted to independent contractors under its Exclusive Agent (EA) program.

The question to the court was whether the individuals "retired" when they later terminated their agent services, for purposes of the beef-up provision. While the Plan did not define retire, after the time-frame when the agents were required to convert to independent contractor status, Allstate adopted an interpretation of the term "retire" that precluded the converted agents from eligibility for the beef-up on the basis that they had to stop performing services of any kind at the time of conversion to be eligible. Specifically, Allstate argued that a participant who converted to an independent contractor could not, by definition, retire as an employee.

The court declined to accept Allstate's interpretation, finding that – "we are required to enforce the plan as written unless we can find a provision in ERISA containing a contrary directive. Allstate offers no evidence of Plan language or interpretation allowing it to insert a temporal mandate allowing beef-up subsidy for only those who simultaneously convert to EA and leave Allstate's service." The court found that Allstate's interpretation "resulted in the improper denial of the benefit and violation of the anti-cutback rule of Section 204(g)" – a plan amendment was not required for a cutback violation, an interpretation of retire that required the addition of language not in the plan was sufficient (e.g., a *simultaneous* conversion (to independent contractor status) and termination for purposes of eligibility for the "beef-up" subsidy). Nothing in the plan required these events to happen simultaneously. Based on the court's decision, a group of affected agents became eligible for the beef-up subsidy.

Analysis

The court ruled that the employer violated the anti-cutback prohibition, despite the absence of a plan amendment. The court's finding was based on a new administrative interpretation that had the effect of denying participants a benefit under the Plan for which they were eligible before the adoption of the new interpretation.

Application to Governmental Plans

While the anti-cutback rules of the Code and ERISA do not apply to governmental plans, there are analogous concerns for such plans. Specifically, plan administrators should consider whether their governing laws contain contract provisions (or other constitutional restrictions) which restrict the adoption of laws that impair the contract for benefits between members and the plan sponsor. If a plan is subject to such restrictions, any potential change in interpretation should be considered in light of the possibility that it could be considered a violation of such provisions.

Affordable Care Act Repeal and Replace – Health Care Reform Update

On June 22, 2017, Senate Republicans released their health care bill, the Better Care Reconciliation Act (BCRA),[3] which differs in significant ways from the version passed by the House under the American Health Care Act (AHCA).

[2] *See Cotillion v. United Refining Co.*, W.D. Penn., No. 09-140 (April 8, 2013); *Redd v. Brotherhood of the Maintenance of Way Employees Division of the International Brotherhood of Teamsters*, 2010 WL 1286653 (E.D.Mich., 2010).

[3] https://www.cotton.senate.gov/files/documents/170622SENATEHEALTHCARE.pdf

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The Congressional Research Service (CRS) published a section-by-section summary of the BCRA.[4] Some of the key provisions include:

- Eliminating the penalties associated with the individual and employer mandates retroactive beginning January 1, 2016;
- Making substantial changes to Medicaid (including rolling back the expansion over three years and capping the Federal government's share of Medicaid payments);
- Restructuring the premium subsidies for individuals purchasing insurance on the exchanges beginning in 2020;
- Funding the cost-sharing subsidies for insurers through December 31, 2019;
- Simplifying the application process for State Innovation Waivers under Affordable Care Act Section 1332;
- Establishing insured "small business health plans" that allow trade and member associations to offer large group insured coverage to small employer members and be exempt from most state insurance regulations;
- Maintaining protections for pre-existing conditions;
- Establishing sunset of federal medical loss ratio requirements beginning January 1, 2019, and requiring states to establish their own medical loss ratio definition and rebate requirements;
- Repealing most of the Affordable Care Act's taxes; and
- Establishing a waiting period requirement for individuals who want to enroll in individual market coverage, but did not maintain 12 months of continuous creditable coverage.

The Congressional Budget Office (CBO) released its score for the bill on June 26, 2017.[5] The score had been highly anticipated because procedural rules for budget reconciliation require that the Senate's bill save the federal government as much or more money than the House's version. The CBO estimated that the Senate bill would trim $321 billion from the federal deficit in the next decade through deep cuts to Medicaid and smaller subsidies to help people afford premiums, compared to $119 billion for the House's version. However, the CBO estimated that the Senate bill would leave 22 million Americans uninsured over the next decade, compared to 23 million for the House version.

On June 28, 2017, Senate Republicans and the White House agreed to spend $45 billion to address the opioid crisis, up from $2 billion, in an attempt to gain additional support for the bill.

Additionally, Senator Ted Cruz (R-TX) offered an amendment that would allow insurers to sell plans that would not be required to comply with several of the Affordable Care Act's market reform requirements, as long as the insurers also sold plans that did comply with the Affordable Care Act. The amendment also shifts funds from states to the Department of Health and Human Services to provide funds to health insurers offering non-Affordable Care Act compliant plans.

On July 19, 2017, in a surprising turn of events, primarily due to a lack of support for BRCA, the Senate released the Obamacare Repeal Reconciliation Act (ORRA) of 2017.[6] The ORRA of 2017 is an updated version of the 2015 repeal legislation that passed both the House and Senate, but was ultimately vetoed by President Obama. The ORRA of 2017 would repeal the Affordable Care Act's coverage provisions, but delay the repeal until 2020, and it would also fund cost-sharing reduction payments until 2019. The CBO score is essentially the same as under the 2015 repeal bill.[7]

In another surprise move, the very next day, on July 20, 2017, the Senate Budget Committee posted a revised version of BCRA.[8] It is essentially the same legislation as the original BCRA, with minor changes, except it does not include the amendment offered by Senator Ted Cruz (R-TX). The CBO immediately provided a score[9] of this new version estimating that it would reduce the federal budget deficit by $420 billion over ten years compared to the $321 billion deficit reduction in the original BCRA.

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[4] *https://www.budget.senate.gov/imo/media/doc/CRS%20Summary%20of%20BetterCareAct.PDF*

[5] *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf*

[6] *https://www.budget.senate.gov/imo/media/doc/REPEAL7.19.17.pdf*

[7] *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf*

[8] *https://www.budget.senate.gov/imo/media/doc/ERN17500.pdf; for summary, see: https://www.budget.senate.gov/imo/media/doc/BCRA%20Section%20by%20Section%20Summary%20ERN17500.pdf*

[9] *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf*

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The main reason for the change in the deficit score is that the revised version of BCRA does not include provisions of the original bill which eliminate an increase in the Hospital Insurance payroll tax rate for certain high-income taxpayers and repeal a surtax on certain high-income taxpayers' net investment income. The estimated number of uninsured Americans in 2026 under this revised legislation is 22 million, which is not significantly different from the earlier version. Another hurdle for BCRA is that the Senate Parliamentarian issued an analysis[10] providing that several critical pieces of the draft legislation violate the Byrd Rule and would, therefore, need 60 votes to proceed. These provisions include abortion restrictions for tax credits, funding for cost-sharing subsidies, and the continuous coverage provision imposing a waiting period for individuals seeking to enroll in coverage in the individual market.

On July 25, 2017, the Senate voted 51-50 to move forward with a debate on health care reform, even though it was not clear what bill the body would be considering. Vice President Mike Pence cast the tie-breaking vote. Senator John McCain (R-AZ), who is confronting serious health issues, returned to Washington D.C. to cast his vote in support of holding the debate. Senate Majority Leader Mitch McConnell (R-KY) said the debate on health care in the Senate will be "an open amendment process." It is unclear how long this next phase will take, but Senator McConnell is hoping to finish by the end of the week. If the legislation passes the Senate, it will either go to the House for immediate consideration, or be sent to a conference committee consisting of members of the Senate and the House to reconcile differences between the two Houses, in advance of an up or down vote in both the House and the Senate.

Litigation Challenging ACA Section 1557 Nondiscrimination Final Rule

On December 31, 2016, United States District Court for the Northern District of Texas Judge Reed O'Connor issued a preliminary injunction, enjoining the Department of Health and Human Services' (HHS) Office of Civil Rights (OCR) from enforcing certain provisions of OCR's final rule implementing the Patient Protection and Affordable Care Act's (Affordable Care Act) prohibition against discrimination (Section 1557). Specifically, OCR is enjoined from enforcing the prohibition of discrimination on the bases of "gender identity" and "termination of pregnancy" in its final rule.[11]

Background

Affordable Care Act Section 1557 provides that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (race, color, national origin), Title IX of the Education Amendments of 1972 (sex), the Age Discrimination Act of 1975 (age), or Section 504 of the Rehabilitation Act of 1973 (disability), under any health program or activity, any part of which is receiving federal financial assistance, or under any program or activity that is administered by an executive agency or any entity established under Title I of the Affordable Care Act or its amendments.

On May 18, 2016, OCR published a final rule implementing Section 1557.[12] This rule prohibits discrimination on the basis of race, color, national origin, sex, age, or disability, for any health program or activity, any part of which receives federal funding or assistance, or under any program or activity that is administered by an executive agency or any program or activity administered by an entity established by Title I of the Affordable Care Act.

Court Challenge

The scope of the final rule was quite expansive, prohibiting (among other things) discrimination in health programs on the basis of sex, including significant requirements related to transgender individuals and the treatment of gender dysphoria. In August 2016, several states and private entities[13] filed suit in federal court in

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[10] https://www.budget.senate.gov/imo/media/doc/Background%20on%20Byrd%20Rule%20decisions_7.21%5b1%5d.pdf

[11] Franciscan Alliance, Inc. v. Burwell, No. 7:16-cv-00108-O (N.D. Tex. Dec. 31, 2016).

[12] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376.

[13] Arizona, Kansas, Kentucky, Louisiana, Mississippi, Nebraska, Texas and Wisconsin, joined by Specialty Physicians of Illinois, LLC, Christian Medical and Dental Associations, and the Franciscan Alliance, Inc.

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Texas, arguing that the rule forced physicians "to perform controversial and sometimes harmful medical procedures ostensibly designed to permanently change an individual's sex" and impermissibly defined "sex" to include "discrimination based upon 'termination of pregnancy' in covered programs."[14] Plaintiffs' argued that these provisions violated the:

- Administrative Procedures Act by not conforming with the text of the Affordable Care Act and Title IX, by violating various constitutional and statutory rights, and being arbitrary and capricious (among other grounds);
- First and Fifth Amendment rights of physicians;
- Religious Freedom and Restoration Act (RFRA) rights of physicians;
- Constitution's spending clause;
- Eleventh Amendment's doctrine of sovereign immunity; and
- States' Tenth Amendment rights.

The District Court was considering a request for a preliminary injunction, which required the court to determine whether the plaintiffs had: 1) a substantial likelihood that they will ultimately prevail on the merits; 2) a substantial threat that they will suffer irreparable injury if the injunction is not granted; 3) that the threatened injury outweighs whatever damage the proposed injunction may cause the opposing party; and 4) that granting the injunction is not adverse to the public interest.

The court concluded that the plaintiffs met their burden with respect to two issues: specifically, the prohibition of discrimination "on the basis of sex" does not include 'gender identity' and does not include 'termination of pregnancy.' The court issued a nationwide preliminary injunction that applies only to the prohibition of discrimination on the basis of 'gender identity' and 'termination of pregnancy.' The remainder of the rule, including the notice and language access provisions, continues to apply.

Trump Administration Response

On May 2, 2017, the Trump administration asked for a voluntary remand and stay to allow HHS the opportunity to reconsider the rule. The Administration's filing states that "new leadership at HHS has now had time to scrutinize" the challenged provision of the final rule and HHS has "concerns as to the need for, reasonableness, and burden imposed by those parts of the rule."

Although Plaintiffs' opposed the Trump administration's motion, asking the court to rule in their case to provide "guidance" to HHS about a new Section 1557 rule, the court granted the administration's request, in part. The case is stayed until further order of the court. The administration must file a status report on or before August 4, 2017, identifying any rulemaking proceedings initiated with respect to the challenged Section 1557 final rule. The preliminary injunction stays in place.

IRS Issues Guidance on Wellness/Fixed Indemnity Arrangements

For a number of years, the Internal Revenue Service (IRS) has been trying to shut down different forms of an abusive arrangement that purports to allow employees to pay pre-tax "premiums" for certain benefits and receive most or all of the "premiums" back as "benefits" on a tax-free basis. Unlike more traditional fixed indemnity insurance, the plan is self-funded, the benefit payments are not triggered by events that result in medical expenses for the participant, and the benefit payments are essentially a return of premiums. In a new, slightly different version of the arrangement, employees pay a small after-tax contribution and the self-funded plan provides a fixed cash payment benefit much greater than the contribution for participating in certain health-related wellness activities.

In the past year, the IRS issued three Chief Counsel Advices (CCAs) on these arrangements, including:

- A May 2016 CCA essentially reiterating the IRS' long-standing position that: 1) cash rewards under a wellness program are taxable wages to the employee; and 2) reimbursements of premiums for participating in a wellness program are taxable wages to the employee if the premiums were originally made by pre-tax salary reduction through a cafeteria plan.

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[14] *Franciscan Alliance, Inc. v. Burwell, No. 7:16-cv-00108-O (N.D. Tex. Dec. 31, 2016).*

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- A January 2017 CCA concluding that payments received by an employee under an employer-provided fixed indemnity health plan (such as these wellness arrangements) are taxable wages to an employee if: 1) the employer paid the premiums and the value of the coverage was excluded from the employee's wages; or 2) the employee paid the premiums on a pre-tax basis. While this was apparently intended only to shut down the abusive wellness arrangements, the CCA uses language that appears applicable to fixed indemnity coverage more generally. Notably, and contrary to the IRS' position in prior guidance (which said that only the amounts received in excess of the employee's unreimbursed medical expenses were taxable), the January CCA states that all fixed indemnity benefits attributable to pre-tax premium payments are taxable (apparently regardless of the employee's actually incurred medical expenses). Additionally, the CCA indicates that the amounts are taxable as wages and thus reportable on the Form W-2 (versus a Form 1099).
- A May 2017 CCA concluding that benefits paid under an employer-provided self-funded health plan are taxable wages to the employee if the average amounts received by the employees for participating in health-related activities predictably exceed the after-tax contributions by the employees. Also, recognizing that the January 2017 CCA was too broad and in conflict with prior guidance, the CCA clarifies that the portion of a fixed indemnity benefit that is attributable to an incurred medical expense is not taxable.

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