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GRS INSIGHT

IN THIS ISSUE

Deferred Retirement Option Plans Primer

In seeking to manage employee retention, deferred retirement option plans (DROPs) offer governmental retirement systems yet another option. Generally, DROPs allow members who satisfy certain eligibility conditions (e.g., become eligible for normal retirement or reach their maximum benefit) to participate in the DROP and retire at a future date. Key characteristics of DROPs are outlined below.

What is a DROP?

A DROP is a defined benefit plan feature offered to employees when they are eligible for retirement. Employees who exercise a DROP option elect to "retire" for the purposes of their pension benefit calculation, but can continue to work and collect their usual salary and non-pension benefits. If an employee elects to participate in the DROP, benefits cease to accrue under the regular part of the plan (i.e., the employee's benefit is frozen), but retirement payments do not commence. In exchange for continuing to work beyond attainment of retirement eligibility, DROP participants agree to have an amount equal to what otherwise would be their monthly pension payments had they actually retired deposited into an earnings-bearing account for a set number of years. In accordance with the plan design, cost-of-living adjustments (COLAs) may be added to the monthly benefit and employer and/or employee contributions may be permitted into the DROP account. An employee generally takes a distribution of their DROP account as a lump sum distribution upon termination of employment, at which time regular retirement benefits commence.

Are DROPs cost-neutral?

A DROP can be cost-neutral if the actuarially-determined value of the pension benefit does not change when an employee exercises a DROP option. However, since actuarial costs are dependent on assumptions about when employees will decide to retire, how much assets will earn, and other factors, if these assumptions are not met, DROPs could prove to be more costly than defined benefit plans without a DROP option. For example, costs may increase if a DROP leads to a trend toward earlier retirement (i.e., commencement of the DROP period). Retirement programs may minimize the risk of inflated costs through effective plan design.

Are benefit amounts deposited into a DROP account considered contributions subject to IRC Section 415(c) limitations?

The Internal Revenue Service (IRS) has issued guidance clarifying that accrued benefits credited to a DROP account are normally not considered annual additions for the purposes of the Internal Revenue Code (IRC) Section 415(c) limit for defined contribution plans. For defined benefit plans, the 415(b) limit must still be met by the plan as a whole, including the DROP. However, in the case of DROPs that allow employers or employees to make additional contributions, these contributions will be subject to IRC Section 415(c) limitations if all of the following apply: 1) the DROP is designed such that each plan participant has a separate account; 2) DROP account earnings are based on investment earnings rather than a guaranteed interest rate; and 3) earnings in the DROP account do not cease to accrue while assets remain in the DROP (e.g., earnings do not cease at the end of the plan's stated deferment period).[1]

What are key advantages and disadvantages of DROPs for retirement systems?

Many governmental plans incentivize early retirement, which can lead to the loss of valuable employees. DROPs can reduce new hire costs by encouraging these retirement-eligible employees to keep working. This also helps employers manage turnover since they can plan in advance for the departures of key personnel. A drawback of DROPs is that employers have no control over which employees choose to take advantage of the DROP or when the option is exercised – employers may be forced to retain less desirable employees or may lose those they would rather keep.

Do employees benefit from DROPs?

While this is an individual determination, DROPs can be a favorable option for employees who have maxed out their pension benefits, do not anticipate significant salary increases, and/or want to delay retirement due to insufficient 457 or 403(b) plan savings. Employees with lower credited service years are less likely to benefit from a DROP since working additional years during which credited service accrues is generally more advantageous for these employees. In addition, employees with high member contribution rates that cease upon DROP entry may be incentivized to enter the DROP, which would effectively raise their take-home pay.

Pension Plans Legislative Update

On May 23, 2019, the House of Representatives overwhelmingly passed the *Setting Every Community Up for Retirement Enhancement Act of 2019* (the "SECURE Act," H.R. 1994) on a vote of 417-3. Its passage marked significant progress for retirement legislation after years of negotiations among lawmakers and various retirement industry groups. However, the bill's path through the Senate is uncertain at best.

The SECURE Act passed by the House on May 23rd is similar to the bill approved by the Ways and Means Committee in April,[2] with two notable changes. First, the House-passed bill removed a provision permitting tax-favored 529 college savings plans to be used for certain homeschooling school expenses. However, the House-passed bill would still expand 529s to be used for apprenticeship program expenses and qualified student loan repayments. Second, the House-passed bill added a provision to correct a provision of the *Tax Cuts and Jobs Act* that resulted in additional taxes on children of military members and first responders killed in the line of duty.

Senate Majority Leader Mitch McConnell (R-KY) appears unwilling to bring the bill up for full floor consideration this year. Therefore, Senate leadership is attempting to move the bill via unanimous consent, which is only possible if no Senator objects. Currently, there are a number of objections, and while Senate Finance Republicans are looking for a way forward, they have not

[1] *See* Internal Revenue Manual 4.72.7.4.4 and 7.11.1.31.1.
[2] *See* April 2019 *GRS Insight*.

yet identified one. One possible option is to attach the SECURE Act to a larger, must-pass bill, such as an appropriations bill later this year.

Expansion of Self-Correction and Determination Letter Programs

The Internal Revenue Service (IRS) recently provided guidance expanding both the Self-Correction Program (SCP) offered under the Employee Plans Compliance Resolution System (EPCRS) and the determination letter program.

Self-Correction Program

The SCP allows certain failures to be corrected without the burden of fees or the requirement of filings to the IRS. This program, which is available for governmental plans, was updated in April 2019 in Revenue Procedure 2019-19, expanding the types of failures eligible for self-correction.

While additional failures are now eligible for self-correction, the general parameters of the SCP still apply, including application primarily to Internal Revenue Code (IRC) Section 401(a) and 403(b) plans (and not Section 457(b) plans), the "two-year" correction period for significant operational failures and plan document failures, and the requirement of a favorable letter by the IRS. Specifically, the program update has affected corrections of three types of failures: 1) certain plan loan failures; 2) additional operational mistakes; and 3) certain plan document failures.

Plan Loan Failures

The expansion of plan loan failures eligible for SCP includes:

- *Defaulted Loans.* These failures may now be corrected outside of a voluntary correction program (VCP) filing, through a single lump sum payment equal to the missed payments and/or reamortization of the outstanding balance over the remaining period of the loan, plus accrued interest. However, self-correction is not allowed if the maximum period for repayment has expired.
- *Spousal Consent.* If spousal consent is required by the plan, the affected participant and spouse may be notified of the need for spousal consent and may self-correct without filing. However, if spousal consent cannot be obtained, self-correction is not available and correction must be made under VCP or Audit Closing Agreement Program (Audit CAP).
- *Excessive loans.* If the number of plan loans to a participant exceeds the number permitted by plan terms, a retroactive plan amendment may be adopted. However, the plan and amendment must comply with the IRC, and the additional loans must be available to all participants or only to one or more non-highly compensated employees.
- *Reporting.* If the loan failed to meet the requirements of IRC Section 72(p)(2) and/or was not corrected after default, the loan may now be reported as a deemed distribution in the year of correction, rather than the year of the failure, without a VCP filing. Importantly, if withholding applies under Treas. Reg. Section 1.72(p)-1, Q/A-15, the requirement that it be paid by the plan sponsor remains.

Operational Failures

While operational failures are not new to correction under SCP, additional opportunities to self-correct via retroactive plan amendment to conform the plan document to operations are now allowed. However, these amendments are permitted only when the following conditions apply: 1) the corrective amendment results in an increase of a benefit, right or feature; 2) the specific increase applies to all employees eligible to participate in the plan; and 3) provision of the increase is permitted under the IRC and satisfies the correction principles and other rules of EPCRS.

Plan Document Failures

Plan document failures have been expanded to include late amendments (e.g., required or interim amendments), not including the initial failure to adopt a plan. However, corrective amendments for demographic failures and the late adoption of discretionary amendments are still not included under the plan document allowances.

Determination Letter Program

The IRS has also made welcome changes to the determination letter program in Revenue Procedure 2019-20, effective September 1, 2019. These changes are not the first for the program, having seen much larger changes in 2017 with the elimination of the 5-year remedial amendment cycle system. Since 2017, the determination letter program allowed submissions only for initial plan qualification, qualification upon plan termination, and "other circumstances." These other circumstances were to be based on IRS determinations of need, such as new approaches to plan designs, the inability to convert plans to pre-approved documents, or significant law changes. Prior to this Revenue Procedure, no such other circumstances had been identified.

In this guidance, the IRS expanded the determination letter program to include statutory hybrid programs during a one-year window and for merged plans on an ongoing basis.

Statutory Hybrid Plans

Statutory hybrid plans may now submit applications for determination letters for a limited period, beginning September 1, 2019 and ending August 31, 2020. Eligible plans are defined benefit plans that contain a lump sum based formula, or a formula with a similar effect – this includes governmental plans with a cash balance formula or a pension equity formula in their defined benefit plans – even if the plan also includes a traditional final average pay formula.

Merged Plans

Although unlikely to be helpful for governmental plans, merged plans will also be able to submit applications for determination letters, on an ongoing basis, beginning September 1, 2019. To qualify for the program, a corporate merger or acquisition must occur involving at least two entities that were not in the same controlled or affiliated service group. The plans of these entities must then be merged into a single individually designed plan in connection with the corporate merger, and the plan merger must occur during the IRC Section 410(b)(6)(C) transition period, meaning no later than the last day of the first plan year that begins after the plan year of the business transaction. Plan sponsors are eligible to submit a determination letter application between the date of the plan merger and the last day of the merged plan's first plan year that begins after the effective date of the plan merger.

Sanctions

In addition, Revenue Procedure 2019-20 reduces or waives sanctions in the case of certain plan document failures discovered by the IRS during the determination letter review. Specifically, sanctions are waived for plan document failures if such plan language relates to the implementation of the final hybrid regulations or effectuates the plan merger. Further, sanctions are reduced for other plan document failures where the amendment creating the failure was adopted timely and in good faith with the intent to maintain the qualified status of the plan (or it was reasonably and in good faith determined that no amendment was necessary in connection with a change in qualification requirements).

End in Sight for Initial 403(b) Plan Remedial Amendment Period

As announced in Revenue Procedure 2017-18, March 31, 2020 will be the last day of the initial remedial amendment period for 403(b) plans. During the remedial amendment period, an eligible employer may retroactively self-correct defects in the form of its written 403(b) plan (i.e., plan provisions that fail to meet Internal Revenue Code (IRC) Section 403(b) requirements) by timely adopting a 403(b) pre-approved plan or otherwise timely amending its individually designed plan by March 31, 2020, retroactive to the later of January 1, 2010 or the effective date of the plan.

Adoption of a pre-approved 403(b) plan that has a favorable opinion or advisory letter will automatically correct any defects in an employer's prior written 403(b) plan (but not defects in any documents incorporated by reference into the prior plan). Correcting plan provisions may involve adding required provisions to the plan or correcting defective provisions in the plan. Importantly, this guidance does not permit correction of operational failures or a failure to adopt a written plan by the end of 2009 (though such failures can be corrected under

Revenue Procedure 2019-19 (EPCRS)).

The Internal Revenue Service has provided some examples to help clarify those failures that qualify for self-correction during the remedial amendment period, including:

Eligible Failures

- Absence of a required plan provision – e.g., language limiting participants' annual additions to the IRC Section 415(c) limit is not in the plan document.
- Erroneous required provision – e.g., plan language providing that participants may make elective deferrals up to $19,500 in 2019, exceeding the annual deferral limit of $19,000.
- Erroneous optional provision – e.g., plan language permitting participants, age 50 and older, to make catch-up contributions up to $6,500 in 2019, exceeding the annual IRC Section 414(v) catch-up contribution limit of $6,000.

Ineligible Failures

Compliance in form, but not operation (failure to follow plan terms) – e.g.,

- plan language permitting all employees to make deferrals, but excluding employees who work fewer than 20 hours per week from participation; or
- plan language providing for a 5% employer contribution, but only making a 4% employer contribution.

Departments Issue Final Regulations Expanding Availability of HRAs

On June 13, 2019, the Departments of the Treasury, Labor, and Health and Human Services (Departments) issued final regulations (Final Regulations) that expand the use and availability of health reimbursement arrangements (HRAs). The Final Regulations do so by creating two new types of HRAs: 1) the "Individual Coverage HRA" or "ICHRA," which employees can use to purchase individual health insurance coverage or Medicare (and other medical expenses); and 2) the "Excepted Benefit HRA" or "EBHRA," which employees can use to pay for most out-of-pocket medical expenses. However, an employer may not offer both an ICHRA and an EBHRA to the same group of employees.

Individual Coverage HRAs

In 2013, the Departments issued guidance that, in order to satisfy the Affordable Care Act's market reform requirements, the HRA for active employees must be "integrated" with another group health plan. The Final Regulations change that guidance and allow for the HRA to be integrated with *individual* health insurance coverage or Medicare, if the following conditions are met:

1. Any participant covered by the HRA must be enrolled in **individual health insurance or Medicare coverage** for each month that they are covered by the ICHRA.
2. Employers generally may not offer **both an ICHRA and a traditional group health plan to the same class of employees**.
3. To the extent employers offer an ICHRA to a class of employees, employers must offer the ICHRA **on the same terms and conditions to all employees within the same class**. (However, the Final Regulations allow certain exceptions based on a participant's age and number of dependents.)
4. Employers that offer ICHRAs must allow participants to **opt-out** of and waive future reimbursements from the ICHRA at least annually and upon termination of employment.
5. ICHRAs must implement reasonable procedures to **verify** that participants and dependents are actually enrolled in individual health insurance coverage or Medicare.
6. Employers must provide written **notice** to eligible employees, generally at least three months before the beginning of each plan year, that participation in an ICHRA will make them **ineligible for the premium tax credit (PTC)** for coverage purchased on an Exchange.

An employer can use the ICHRA to satisfy the employer mandate requirements – the preamble states that Treasury/IRS will be issuing future guidance addressing this issue.

Excepted Benefit HRAs

The Final Regulations also allow employers to offer an EBHRA to active employees, regardless of whether they are enrolled in other health coverage. Notably, individuals enrolled in an EBHRA *are* permitted to receive the PTC, and an employer cannot use the EBHRA to satisfy the employer mandate requirements. Like the ICHRA, the EBHRA must meet certain requirements:

1. The employer must offer **other, non-account based group medical coverage** to employees that is **not an excepted benefit** (e.g., not dental- or vision-only), but the participant does not need to be enrolled in such other coverage.
2. New employer contributions **cannot exceed $1,800 per year** (indexed for inflation).
3. Participants cannot use an EBHRA to **reimburse premiums for individual and non-COBRA group health insurance**.
4. Employers must make the EBHRA available on a **uniform basis to all similarly-situated employees**.
5. For non-federal governmental plan EBHRAs, the Department of Health and Human Services (HHS) will propose a **notice** requirement in future guidance.

The ICHRA and EBHRA provisions apply to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020.

ACA Section 1557 Proposed Rule

In a proposed rule released on May 24, 2019, and published in the Federal Register on June 14, 2019, the Department of Health and Human Services (HHS), Office of Civil Rights (OCR) proposed a number of changes to the regulation implementing Section 1557 of the Affordable Care Act (ACA).

Section 1557 is the nondiscrimination provision of the ACA. It prohibits discrimination in the provision of health care on the basis of race, color, national origin, sex, age, or disability by an entity that is receiving federal financial assistance. Specifically, the statute prohibits discrimination "on the grounds prohibited" by several pre-existing civil rights statutes through a set of cross-references. Section 1557 itself has been effective since the ACA went into effect on March 23, 2010, and on May 18, 2016, the Obama Administration OCR issued a final rule further implementing the Statute.

The Trump Administration's proposed rule, if finalized, would mark a substantial change from the current rule. Among other changes, it would reverse the Obama Administration's position that Section 1557's prohibition against sex discrimination includes gender identity, remove the current rule's notice of nondiscrimination and taglines requirements for aiding individuals with limited English proficiency, and would specify that Section 1557 does not compel health care entities to provide or pay for abortion services, if they have a religious objection. The proposed rule also specifies that OCR believes that Section 1557 does not create a new private cause of action, and would exempt many health insurance issuers' activities from the scope of the rule.

The Trump Administration generally disagrees with the Obama Administration's approach to gender identity, and the current rule's application on that point has been enjoined since District Court Judge Reed O'Connor issued a nationwide preliminary injunction against OCR's enforcement of this provision in *Franciscan Alliance v. Burwell*. Nonetheless, certain changes would likely have a significant impact on covered health care entities. For example, the current notice and taglines requirements have been estimated as costing health care entities $3.6 billion over the next five years.

However, the proposed rule will not have an immediate impact. The 60-day comment period ends on August 13, 2019, and the OCR must review the comments it receives before finalizing the rule. Moreover, if the rule is finalized in its current form, litigation is likely. For example, the American Civil Liberties Union has already

announced that it will challenge the rule in court.[3]

Health Legislation Update

Lower Health Care Costs Act

On June 26, 2019, the U.S. Senate Health, Education, Labor and Pensions (HELP) Committee voted to approve the *Lower Health Care Costs Act*, an expansive health care package that would target rising health care costs and billing practices. Released on a bipartisan basis by Senators Lamar Alexander (R-TN) and Patty Murray (D-WA), the bill targets "surprise" balance medical bills and proposes a number of measures addressing prescription drug costs and price transparency. While the bill's passage remains uncertain, it has significant bipartisan support and is worth monitoring as it proceeds through Congress.

The bill contains a variety of proposals seeking to eliminate surprise balance billing. For example, the bill would hold patients harmless against surprise balance bills by requiring them to pay only the in-network cost-sharing amount in certain situations that generate surprise balance bills. The bill would also require that emergency health care charges are counted toward the patient's in-network deductible and out-of-pocket maximum, regardless of whether care is rendered by an in-network or out-of-network provider. Significantly, the bill proposes that payers and providers resolve disputes over surprise balance bills by requiring health plans to pay the provider or facility an amount equal to the median contracted rate for the same or similar services offered by the plan or issuer in that geographic area.

Aside from surprise balance billing, the bill addresses prescription drugs by proposing various reforms to the drug patent system. For example, the bill would accelerate the citizen petition process for generic drug applications, potentially ameliorating an obstacle that can delay generic drugs from making it to market. The bill also would prohibit individuals from utilizing the petition process in order to unnecessarily delay the approval of a drug application. Finally, the bill contains a series of measures aimed at making it more difficult for brand-name drugs to maintain exclusive patents.

The bill also includes measures designed to improve health care cost transparency. For example, the bill would require greater transparency for pharmacy benefit managers (PBMs) by requiring them to provide reports to plan sponsors on costs, fees, and drug manufacturer rebates. The bill would also eliminate the practice of "spread pricing"—i.e., charging a patient more for a drug than the PBM paid to the pharmacy for the same drug. PBMs would also be required to pass along to plan sponsors 100% of any rebates received from drug manufacturers. Finally, the bill would require health care facilities and providers to give patients certain information on services and expected out-of-pocket costs and to bill patients within 45 calendar days.

Having been approved by the HELP Committee, the bill will now move toward consideration in the full Senate. If passed, the House of Representatives would then take it up.

No Surprises Act

On July 17, 2019, the U.S. House Energy and Commerce Committee passed legislation containing the *No Surprises Act* on a voice vote. The legislation bans providers from balance billing patients for emergency services and for non-emergency out-of-network services received at an in-network facility. The legislation proposes settling billing disputes by establishing a federal benchmark rate, and allows parties to arbitrate billing disputes when the amount in question exceeds $1,250. The U.S. House Education and Labor Committee is expected to exert jurisdiction over the bill and a hearing is likely to be scheduled after Congress' August recess.

Cadillac Tax

On July 17, 2019, the U.S. House of Representatives overwhelmingly passed legislation to repeal the "Cadillac

[3] https://www.aclu.org/press-releases/aclu-responds-proposed-changes-health-care-rights-law

tax" on employer-sponsored health care plans. The implementation of the tax has been delayed a number of times, most recently until 2022. It is unclear whether or when the Senate will take up the legislation, meaning employers could still be subject to the tax in 2022 if no action is taken before then.

Health Litigation Update: *Texas v. United States*

As discussed in prior editions of *GRS Insight*, litigation regarding the validity of the Affordable Care Act (ACA) remains ongoing before the 5th Circuit Court of Appeals.

The case, *Texas v. United States*, was decided by Judge Reed O'Connor of the Northern District of Texas in December of 2018. In a declaratory judgment, Judge O'Connor ruled that the entirety of the ACA is invalid, due to the individual mandate amendments passed by the Tax Cuts and Jobs Act of 2017. Judge O'Connor sided with Texas (joined by several other states), holding that, because the individual mandate was upheld as a tax by the Supreme Court, and because the amendments have changed the mandate so it no longer raises revenue, it is no longer a valid tax. Therefore, Judge O'Connor held that the individual mandate is unconstitutional, and, since it is incapable of being severed from the rest of the law, the ACA in its entirety is unconstitutional as well.

Nonetheless, the Court stayed its decision pending appeal, and the Administration continues to implement and enforce the ACA. Importantly, the Department of Justice has declined to defend the law on appeal, but intervenors have stepped in to defend it instead: 21 states, led by California, and the Democratic-controlled U.S. House of Representatives.

Oral arguments were held on July 9, 2019 before a panel consisting of Judge Carolyn Dineen King (a President Carter appointee), Judge Jennifer Walker Elrod (a President George W. Bush appointee), and Judge Kurt D. Engelhardt (a President Trump appointee). The arguments addressed both the merits of the District Court's decision as well as whether the appellants have standing to bring the appeal.

The 5th Circuit Court has several options before it. The panel could rule for or against the District Judge's decision on the merits, setting up a likely petition to the Supreme Court. In either case, the Administration is likely to continue implementing and enforcing the ACA while the appeal is expected or pending. The panel could also rule that the intervenors lack standing. The 5th Circuit Court is clearly considering that outcome: it specifically requested briefing on the issue on June 26, 2019. If the 5th Circuit Court concludes the intervenors lack standing, it could dismiss the appeal entirely.

In any event, the 5th Circuit Court's decision is unlikely to conclude the case and an appeal to the Supreme Court is likely regardless of the panel's decision. As in previous disputes over the constitutionality of the ACA, this controversy will likely be ultimately decided by the Supreme Court, either through an opinion or a denial of certiorari.

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