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# GRS INSIGHT

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# Normal Retirement Age Proposed Regulations: Encouraging Outlook for Governmental Plans

The Internal Revenue Service ("IRS") recently issued proposed regulations (the "Proposed Rules") to clarify the applicability of the normal retirement age rules to governmental plans. As described below, these rules adopt many favorable approaches long sought by governmental plans.

## Background and Summary of Proposed Rules

In May 2007, the IRS issued final regulations (the "2007 NRA regulations") defining normal retirement age for purposes of the tax qualification requirement that plans provide for definitely determinable benefits, generally after retirement. For governmental plans, however, the effective date of these regulations was repeatedly delayed by the IRS.

On January 27, 2016, the IRS published the Proposed Rules[1] to clarify the applicability of the 2007 NRA regulations to governmental plans. Under the Proposed Rules, governmental plans must have a normal retirement age that is not earlier than the earliest age that is "reasonably representative" of the typical retirement age of the industry in which the covered workforce is employed (e.g., public safety). Governmental plans are not required to explicitly define normal retirement age, as long as the terms of the plan specify the earliest age at which a participant has the right to retire without the employer's consent and to receive retirement benefits based upon the amount of the participant's service on the date of retirement at the full rate set forth in the plan (i.e., without actuarial or similar reduction because of retirement before some later specified age). That age will be considered the plan's normal retirement age in the absence of an explicit definition.

Notwithstanding the above, governmental plans that do not permit in-service distributions prior to age 62 are not required to include a normal retirement age that satisfies the reasonably representative requirement, as long as they satisfy certain pre-ERISA vesting rules. For governmental plans that do permit in-service distributions prior to age 62, the Proposed Rules include several new safe harbors which are deemed to satisfy the reasonably representative requirement. That said, reliance on a safe harbor is not necessarily required; a normal retirement age that does not fit any of the safe harbors may still satisfy the reasonably representative requirement based on all of the relevant facts and circumstances.

[1] 81 Fed. Reg. 4599 (Federal Register version at: https://www.gpo.gov/fdsys/pkg/FR-2016-01-27/pdf/2016-01639.pdf )

| **Governmental Plan Safe Harbors (i.e., deemed to satisfy the reasonably representative requirement)** | **Description** |
|---|---|
| **General Safe Harbor** | **Age 62** – a normal retirement age of at least age 62. |
| **Safe Harbors Specifically for General Employees** | **Age 60 & 5 years of service** – a normal retirement age that is the later of age 60 or the age at which the participant has been credited with at least 5 years of service. |
| | **Age 55 & 10 years of service** – a normal retirement age that is the later of age 55 or the age at which the participant has been credited with at least 10 years of service. |
| | **Combined age & years of service of 80 or more** – a normal retirement age where the sum of the participant's age and the years of service that have been credited to the participant under the plan equals 80 or more. |
| | **Any age with 25 years of service (in combination with another safe harbor that includes an age)** – a normal retirement age that is the participant's age when the years of service credited to the participant under the plan equals 25, *if* that age is earlier than what the participant's normal retirement age would be under another plan safe harbor. An example satisfying this safe harbor is a normal retirement age equal to the earlier of: (i) the participant's age when the participant has been credited with 25 years of service under the plan; and (ii) the later of (*a*) age 60 or (*b*) the age when the participant has been credited with 5 years of service under the plan. |
| **Safe Harbors for Qualified Public Safety Employees ("QPSEs")** | **Age 50** – a normal retirement age for QPSEs of age 50 or later. |
| | **Combined age & years of service of 70 or more** – a normal retirement age where the sum of the participant's age and the years of service that have been credited to the participant under the plan equals 70 or more. |
| | **Any age with 20 years of service** – a normal retirement age that is the participant's age when the number of years of service that have been credited to the participant under the plan equals 20 or more. Unlike the safe harbor for any age with 25 years of service applicable to non-QPSE participants in governmental plans, this safe harbor need not be combined with another safe harbor that includes an age. The IRS indicated that a normal retirement age based solely on a period of service is appropriate for QPSEs because their careers typically commence at a young age and continue over a limited period of years. |

The Proposed Rules clarify that governmental plans may use different normal retirement ages for different classifications of employees, as long as each normal retirement age is otherwise permissible under the Proposed Rules. Similarly, a different normal retirement age can be used for employees hired on or after a certain date than is used for employees hired before that date.

With respect to QPSEs, beyond the addition of two new safe harbors not included in the 2007 NRA regulations, a key difference reflected in the Proposed Rules is the elimination of the requirement that "substantially all" of the participants in the plan be QPSEs in order for the QPSE safe harbors to be available. Under the Proposed Rules, the QPSE safe harbors can be used for participants satisfying the QPSE definition under section 72(t)(10)(B) of the Internal Revenue Code of 1986, as amended (the "Code") regardless of the number of non-QPSE participants who are also covered under the plan. In these circumstances, the normal retirement age used for the other (non-QPSE) groups of participants cannot be based on one of the QPSE safe harbors.

The Proposed Rules are intended to be effective for employees hired during plan years beginning on or after the *later* of January 1, 2017, or the close of the first regular legislative session of the legislative body with the authority to amend the plan that begins on or after the date that is three months after the final regulations are published in the Federal Register. Employees hired prior to the effective date will not be subject to any changes in plan language made to comply with these regulations.

## Normal Retirement Age Implications

The concept of normal retirement age may be used for a number of purposes under a governmental plan, including:

- Prohibition of in-service distributions prior to normal retirement age;
- Full vesting on normal retirement age (as required under the pre-ERISA vesting rules for governmental plans);
- The limited exclusion from income for up to $3,000 of distributions to certain individuals from governmental plans that are used to pay for health or long-term care insurance under Code section 402(l) after disability or attainment of normal retirement age;
- Section 457 catch-up contributions, in excess of the plan ceiling that would otherwise apply, for participants who are in one of their last three taxable years before reaching normal retirement age under the plan; and
- The potential implications of a lower formal normal retirement age when plan actuaries are reviewing plan funding, actuarial, or accounting practices.

The following questions should also be considered to ensure all normal retirement ages under your plan meet a safe harbor or otherwise meet the reasonably representative requirement:

- Does the plan use different normal retirement ages for different groups of participants (and if so, on what basis are the groups differentiated)?
- Do individuals who meet the definition of a qualified public safety officer under Code section 72(t)(10)(B) and individuals who do not meet the definition participate in the same plan? If so, are the applicable safe harbors satisfied?

## Next Steps

Comments on the Proposed Rules were due to the IRS on April 26, 2016. As these rules were generally favorable to governmental plans, we think it is likely that the final rules will largely track the Proposed Rules. Therefore, sponsors of governmental plans should review plan terms to determine whether changes are required.

# Governmental Plan Determination Letters: Where Do We Go From Here?

After a year of anxiety, the window for governmental plans to submit IRS determination letter applications has closed, except for: (1) new governmental plans; (2) governmental plans that have never submitted a determination letter application; and (3) governmental plans that are terminating.

As governmental plans look forward to a world where the IRS is auditing these plans but not issuing determination letters, what is a governmental plan to do?

First, as a baseline, it is important for governmental plans to remember that their existing IRS determination letters from the most recent "Cycle C" and "Cycle E" periods (but not the prior filing cycles for Cycle C and Cycle E) remain in effect and their prior expiration dates no longer apply.[2] What this change means is that the IRS' "blessing" of plan language arguably remains in force for plan language requirements that remain unchanged after the date of the determination letter.

Second, the IRS has heard significant commentary that governmental plans (and other groups with unique plans that do not easily fit into the IRS' preapproved plan program) need a path forward given their unique characteristics. Will the IRS simply reopen the determination letter program? That outcome would be significant for governmental plans, but does not appear to be planned at this time. However, some accommodation for governmental plans may emerge in the future.

Third, there are other options that do not simply rely on the IRS. Many governmental plans have and continue to complete periodic documentary and operational compliance reviews. In addition, some larger governmental plans conduct ongoing internal controls reviews that could easily encompass plan documentation compliance as well. These reviews, along with opinions from qualified advisors and counsel, can also help to bridge that gap when utilized in conjunction with the IRS' correction programs.[3]

At this moment, it is too early to tell whether there will be a "perfect" answer in the post-IRS determination letter world, but it is certain there will be ways forward to address the concerns created by the significant changes happening at the IRS.

[2]IRS Notice 2016-3 (Jan. 4, 2016).
[3]Rev. Proc. 2013-12 (Dec. 31, 2012), as modified by Rev. Proc. 2015-27 (Mar. 27, 2015) and Rev. Proc. 2015-28 (Apr. 2, 2015).

# Medicare Part B Payment Model Proposed Rule

## Background

Medicare Part B covers medical benefit drugs, such as those administered at a physician's office or a hospital outpatient setting (e.g., injectable drugs, medicines infused through durable medical equipment ("DME"), and vaccine shots). Unlike prescription drugs in Medicare Part D, Medicare Part B drugs are not on formulary tiers. Instead, provider reimbursement for Medicare Part B drugs typically correlates to the cost of the drug administered. Currently, Medicare reimburses a provider administering a Part B drug at the average sales price ("ASP") of the drug, plus six percent of the cost of the drug ("ASP + 6 percent").

On March 11, 2016, the Centers for Medicare & Medicaid Services ("CMS") released a Medicare Part B Drug Payment Model proposed rule, which would implement section 1115A of the Social Security Act ("SSA").[4]

## Overview of Proposed Payment Model

### *Timing*

CMS proposes to implement this initiative through a two-phase model (over the course of five years) that would shift provider reimbursement incentives for Medicare Part B drugs. CMS proposes to begin Phase I in the fall of 2016, but no sooner than 60 days after the rule is finalized. Phase II would begin no earlier than January 1, 2017, and CMS expects Phase II to take several years to implement. CMS plans for both phases of the model to be fully operational during the last three years of the five-year period, so CMS can collect adequate data to evaluate the model's effects.

[4]81 Fed. Reg. 13230 (https://www.gpo.gov/fdsys/pkg/FR 2016-03-11/pdf/2016-05459.pdf )

## *Applicability*

CMS proposes to include all providers and suppliers furnishing certain Part B drugs to participate in the model. The proposed model encompasses most Part B drugs and biologicals, such as:

- Biosimilars;
- Non-infused drugs furnished by DME suppliers (e.g., immunosuppressives, oral chemotherapy, and clotting factors used with DME); and
- Intravenously and subcutaneously administered immunoglobulin.

CMS proposes to exclude the following drug categories:

- Contractor-priced drugs, including drugs that do not appear on the quarterly national ASP price file (though CMS has proposed to allow contractors to use reductions to the add-on percentage they calculate);
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines, considered preventive services;
- Drugs infused with a covered item of DME in Phase I;
- End-stage renal disease drugs;
- Blood and blood products; and
- Drugs in short supply.

## *Geographic Area Selection*

CMS proposes to separate providers and suppliers into Primary Care Service Areas ("PCSAs") based on the distribution of health professionals, primary care services, and access to primary care. CMS would apply this model to 7,048 of the 7,144 PCSAs in the U.S.; it proposes to exclude the 96 PCSAs in Maryland because the Maryland All-Payer Model involves a waiver for Medicare hospital payment rules.

## *Proposed Payment Methodology*

To test the Part B payment model, CMS proposes to assign each of the applicable PCSAs into four experimental "arms," using a "stratified random approach." Three of the arms would be "test arms," and one arm would remain as a control group. As proposed, CMS would implement changes to the Part B payment methodology in two phases: (1) Phase I, which would test changes to the ASP + 6 percent reimbursement amount; and (2) Phase II, which would add value-based purchasing ("VBP") tools.

### Phase I

In Phase I, CMS proposes to reimburse providers and suppliers in two of the experimental arms the ASP plus an add-on amount of 2.5 percent of the cost of the drug, and a flat add-on fee.

CMS requests comment regarding whether other reimbursement approaches would be more effective for Phase I. Specifically, CMS asks whether it should adopt a tiered approach, a gradient approach, or another approach that would vary the percentage or flat fee add-on amount across certain drug tiers based on their cost. CMS has also asked for comment about whether any common elements within groups of drugs might provide a basis for varying the flat fee across these groups (e.g., requirements for cold handling, special packaging, etc.).

### Phase II

Phase II of the model would further split the experimental arms by adding VBP for Part B drugs tools to two of the arms. Medicare plans typically use VBP tools in Medicare Part D, which covers prescription drugs, and commercial health plans and pharmacy benefit managers use them to manage their prescription drug pharmacy benefits. The proposed rule also states that CMS believes "private payers are currently using these tools to manage drugs under a medical benefit."[5]

CMS is currently exploring a number of VBP tools to incorporate in the model. These tools would include one or more value-based pricing strategy, such as:

- *Reference pricing:* setting a standard payment rate for a particular group of drugs;
- *Indications-based pricing:* based on a drug's varying clinical effectiveness for different indications;

[5] 81 Fed. Reg. 13242 (https://www.gpo.gov/fdsys/pkg/FR-2016-03-11/pdf/2016-05459.pdf)

- *Outcomes-based risk-sharing agreements:* linking payment with health care outcomes; and
- *Discounting or eliminating patient coinsurance amounts:* to incentivize high-value drugs.

The value-based pricing strategies would apply to select Part B drugs, and CMS would finalize which tools would apply to which drugs after soliciting public input. CMS seeks comment on the VBP tools methodology, particularly the potential groups of Part B drugs that should be tested.

CMS also proposes to incorporate a clinical decision support ("CDS") tool to provide data and education to providers in the VBP arms of the model. The rule proposes that the CDS tool consist of two components: (1) educational; and (2) evidence-based. The educational component would be an online tool that providers could voluntarily access, to help them make clinical decisions based on the up-to-date guidelines and literature. The evidence-based component would track drugs and diagnoses typically encountered in Medicare Part B, so providers could access guidelines for drug use and safety.

### *Comment Solicitation*

In addition to requesting feedback about various aspects of the proposed payment model, CMS solicits general comments regarding:

- Creating VBP arrangements directly with manufacturers (e.g., a "try before you buy" process), and issues surrounding these arrangements;
- Adopting a program similar to the Part B Drug Competitive Acquisition Program in the future; and
- Using an episode-based or bundled pricing approach in both physician offices and hospital outpatient settings.

## Conclusion

The Medicare Part B Payment Model proposed rule aims to test broad changes to how CMS reimburses providers for Medicare Part B drugs. If CMS finalizes this rule as proposed, some types of providers who administer less expensive Part B drugs (e.g., general practitioners) will likely, on the whole, profit financially, whereas specialists administering more expensive drugs (e.g., oncologists) may receive lower reimbursement amounts. This rule has sparked extensive conversation, both inside and outside of the health care industry, as part of a larger debate, about not only incentivizing providers to administer drugs based on value and health outcomes, but also addressing the cost of drugs generally. Regardless of how CMS finalizes the rule, CMS views this payment model as one step in an attempt to move the health care system toward CMS' goal of rewarding value over volume. CMS is accepting comments on this rule until May 9, 2016.

# Delay in Cadillac Tax and Moratorium on Annual Fee on Health Insurance Providers

On December 18, 2015, the President signed H.R. 2029,[6] a massive year-end spending and tax bill containing a number of provisions affecting health and welfare plans. H.R. 2029 includes both an omnibus appropriations bill that funds the government through September 30, 2016 – the Consolidated Appropriations Act, 2016 ("CAA") – and an extension (in some cases, a permanent one) of a large number of expiring or expired tax incentives – the Protecting Americans from Tax Hikes Act of 2015 ("PATH Act"). Issues of particular note include a delay in the Cadillac Tax as well as a one year moratorium on the annual fee on health insurance providers (commonly referred to as the Health Insurer Fee ("HIF").

## Delay in Cadillac Tax

The Affordable Care Act ("ACA") added section 4980I to the Internal Revenue Code. Section 4980I imposes an excise tax on certain high cost employer-sponsored health coverage (the so called "Cadillac Tax"). Generally, under section 4980I, if the aggregate cost of applicable coverage provided to an employee or retiree exceeds a statutory dollar limit,

[6] H.R. 2029 is at: https://www.congress.gov/bill/114th-congress/house-bill/2029/text

the excess amount is subject to a 40% excise tax on the "coverage provider." For insured coverage, the coverage provider is the health insurance issuer and generally for all other coverage, the coverage provider is the "person that administers the plan benefits."

The tax was originally scheduled to go into effect in 2018. However, the CAA included a two-year delay of the Cadillac Tax. The tax will now not be effective until 2020. The CAA also makes the Cadillac tax deductible for coverage providers and commissions a study by the General Accounting Office on the appropriate benchmark for adjustments in the excise tax threshold based on the employer's workforce age and gender characteristics as compared to the national workforce.

Following the CAA, the Administration released its 2017 budget proposal, which included a proposal to modify the Cadillac Tax. If adopted, the changes would modify the threshold for the Cadillac Tax's 40% levy to account for regional differences in health insurance costs. The threshold would be the greater of the current law threshold or a "gold plan average" premium that would be calculated and published for each State. The proposal would also define the cost of coverage with respect to salary reduction contributions to a health flexible spending arrangement (FSA) as the average amount elected for the year by similarly-situated employees, and the average employer contribution for such employees (rather than amounts actually contributed on an employee-by-employee basis). The proposal would cost $1.26 billion over the next decade.

The Internal Revenue Service ("IRS") and Treasury have published two notices on the Cadillac Tax and prior to the two year delay had announced that they were aiming to publish proposed regulations in 2016. IRS officials have made various informal statements that they are continuing to work on the proposed regulations.

### Moratorium on Annual Fee on Health Insurance Providers

Effective beginning in 2014, section 9010 of the ACA imposes a fee on each covered entity engaged in the business of providing health insurance for U.S. health risks. The fee is allocated among covered entities based on the prior year's market share. Covered entities must report their prior year's "net premiums written" each year so that the IRS can allocate the fee.

The CAA imposes a one-year moratorium, for the 2017 fee year, on the fee. The 2017 fee (based on 2016 premiums) will not be collected in later years.

The IRS and the Department of Health and Human Services ("HHS") have issued Frequently Asked Questions ("FAQs") on the moratorium. The IRS FAQs provide that, not only is there no fee due in 2017, but the IRS will also not require reporting of 2016 premiums for the 2017 fee year. The HHS FAQs largely echo those of the IRS with the notable addition of a question and answer dealing with the impact of the moratorium on rate changes. Per HHS, the fee is part of a health insurer's administrative costs and, as such, costs for plans "are expected to be adjusted appropriately" to account for the moratorium. HHS also states that it expects to adjust the index rate downward for single risk pool filings in the individual and small group markets.

## Mental Health Legislation

The Mental Health Reform Act (S. 2680)[7] is bipartisan legislation sponsored by the Senate Health, Education, Labor and Pensions ("HELP") Committee Chairman Lamar Alexander (R-TN), HELP ranking Democratic member Patty Murray (D-WA), and Senators Bill Cassidy (R-LA) Chris Murphy (D-CT), David Vitter (R-LA), and Al Franken (D-MN). It is intended to address mental illness by improving treatment access and quality. The bill includes additional mental health parity protections, building on the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), which prohibits health insurance issuers and group health plans that provide medical and surgical benefits and mental health or substance use disorder benefits from applying financial requirements or quantitative treatment limitations more restrictive than the predominant

[7] S. 2680 is at: https://www.congress.gov/bill/114th-congress/senate-bill/2680

financial requirements or treatment limitations that apply to substantially all medical and surgical benefits.

On March 16, 2016, the HELP Committee unanimously approved the legislation, including an amendment that would strengthen the enforcement of MHPAEA. The amendment directs the office of the Inspector General of the Department of Health and Human Services ("HHS") to issue "compliance program guidance" providing examples of compliance and non-compliance with existing mental health parity laws, specifically designed to provide stakeholders with clear examples of how MHPAEA should be applied and enforced. The amendment also requires HHS to issue guidance with examples of methods health plans may use for disclosing information to consumers and making coverage determinations, and requires HHS to produce an action plan for improved state and federal coordination of enforcement of existing mental health parity laws.

## Maximum Out-of-Pocket Limits for 2017

On March 8, 2016, the Department of Health and Human Services ("HHS") published the Notice of Benefit and Payment Parameters for 2017 Final Rule.[8] In this rule, HHS finalized the maximum out-of-pocket ("MOOP") limits for 2017 coverage that apply to all non-grandfathered coverage, including insured and self-funded plans: $7,150 for self-only coverage and $14,300 for other than self-only coverage.

[8] 81 Fed. Reg. 12204 (https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf )

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Corporate Office
One Towne Square, Suite 800
Southfield, Michigan 48076-3723
800-521-0498

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