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INSIGHT

Legislative Proposals and the Future of Code Section 415(m) and 457(f) Plans

IN THIS ISSUE

Tax reform and other legislative proposals in recent years have raised implications for deferred compensation plans that many governmental systems provide as part of their benefit packages to highly paid employees. Since tax incentives for retirement savings are one of the largest tax expenditures in the Internal Revenue Code of 1986 (the "Code"), they are often targeted in order to raise revenue, meaning this is not an issue that is likely to go away.

Proposals and Legislation

There have been multiple proposals in the past few years, including the bill proposed by Rep. Dave Camp (R-MI) in 2014. Under the proposal, deferred compensation earned for services performed after 2014 (including earnings on such amounts) would have been taxed at the time there was no longer a substantial risk of forfeiture (i.e., upon vesting), rather than upon receipt. Further, any earlier deferred compensation would have been taxed by 2023 (if not otherwise previously taxed due to the lapse of a substantial risk of forfeiture).

Early versions of the tax reform bill (H.R. 1), known as the "Tax Cuts and Jobs Act" signed into law on December 22, 2017, also included similar provisions. If such a provision were implemented, governmental Code Section 415(m) excess benefit plans ("415(m) plan") would likely be affected.

The final version of H.R. 1 affected the benefits of deferred compensation in another way, through the introduction of new Code Section 4960. This Section imposes an excise tax on employers, including governmental systems, for amounts paid to a covered employee in excess of $1 million for a tax year, beginning with the 2018 taxable year.

Covered employees include the five highest compensated employees for the tax year, as well as any employee who was a covered employee in any preceding tax year beginning on or after January 1, 2017. For purposes of this excise tax, compensation is defined to include amounts deferred under a Code Section 457(f) plan ("457(f) plan") once such amounts become includible in income. (e.g., contributions, once vested, and any earnings on such amounts).

Considerations Going Forward

Since amounts deferred under a 415(m) plan are not currently subject to taxation until receipt by the employee, rather than upon vesting, elimination of

deferred income recognition beyond vesting would be a significant change for employees. In effect, the actual implementation of such a provision, if it were to occur, may call into question the future of 415(m) plans.

Under H.R. 1 as adopted, amounts in a 457(f) plan are taken into account in determining whether an employer will be subject to the Code Section 4960 excise tax. Although it is unlikely this threshold will come into play for many governmental employers, depending on a covered employee's other compensation, such excise tax should be kept in mind when determining the feasibility of offering a 457(f) plan.

With executive compensation on the legislature's radar, there could be significant implications. The Code Section 4960 changes decrease the appeal of 457(f) plans for employees and employers, potentially eliminating an important recruiting and retention tool for governmental systems. Further, with the reoccurrence of proposals affecting Code Section 415(m) plans, it will be vital to monitor any future developments in this area and to consider these (or similar) potential changes when developing a benefits package for your employees.

Potential Expansion of IRS Determination Letter Program

In 2016, the Internal Revenue Service (IRS) and Treasury Department (Treasury) significantly downsized the determination letter program for individually designed plans, effective as of January 1, 2017. Under the current program, plans may seek a determination letter only for: 1) initial plan qualification; 2) qualification upon plan termination; and 3) certain other limited circumstances identified in published guidance. To date, no additional circumstances have been identified.

However, in connection with their annual review of the program and the IRS' resources, the IRS and Treasury recently issued Notice 2018-24, requesting comments on the potential expansion of the program for the 2019 calendar year.

In particular, comments are requested regarding specific types of plans for which determination letter applications should be allowed outside of the initial qualification and plan termination contexts. The comments should identify not only the type of plan, but specific issues applicable to that plan type that would make review appropriate.

For example, consideration could be given to requests for review of significant plan changes, new designs that could impact benefit formulas or participant coverage, and the inability of certain types of plans to convert to pre-approved plan documents.

Public sector plans may be an example of plans that may not easily convert to a pre-approved plan document (if at all), in light of the fact that such plans are often delineated in statute and have unique structures with multiple tiers. Although public sector defined benefit plans may also be interested in review of pick-up arrangements, that issue may pose a significant challenge since such review may have been carved out of prior determination letter reviews.

The comment deadline is June 4, 2018.

If expansion of the determination letter program is granted, the IRS and Treasury will issue guidance detailing such expansion.

Impact of Tax Reform on Health and Welfare Benefits

On December 22, 2017, President Trump signed into law H.R. 1, known as the "Tax Cuts and Jobs Act," which significantly changed the Internal Revenue Code and has a considerable impact on the rules governing the taxation of employers and employees with respect to health and welfare benefits.

Specifically, the Tax Cuts and Jobs Act modified certain exclusions for employee benefits, such as qualified transportation fringe benefits, qualified bicycle commuting reimbursements, and qualified moving expenses.

In addition, the Tax Cuts and Jobs Act modified indexing for health flexible spending arrangements (FSAs), contributions to health savings accounts (HSAs), and the Cadillac Tax dollar thresholds.

Under prior law, the dollar thresholds for employee contributions to health FSAs, contributions to HSAs, and the Cadillac Tax were adjusted annually for inflation based on the consumer price index (CPI-U).

Beginning in 2018, under the Tax Cuts and Jobs Act, the dollar thresholds are adjusted annually for inflation based on "Chained CPI-U" rather than CPI-U. This is expected to result in the dollar thresholds increasing at a slower rate than under prior law.

Indeed, on March 5, 2018, the Internal Revenue Service (IRS) issued Revenue Ruling 2018-18, in which it reduced the 2018 HSA contribution limit for individuals with family high-deductible health plan (HDHP) coverage by $50 – from $6,900 to $6,850. (However, on April 26, 2018, the IRS issued transition relief which generally allows individuals to contribute up to $6,900 in 2018 without penalties.)

The IRS did not change the 2018 HSA contribution limit for individuals with individual HDHP coverage or the 2018 FSA limits – those amounts remain at $3,450 and $2,650, respectively.

HHS Notice of Benefit and Payment Parameters for 2019 Final Rule

Background

In the January 2018 edition of *GRS Insight*, we reported on the *Notice of Benefit and Payment Parameters for 2019 Proposed Rule* (Proposed Rule). *See* 82 Fed. Reg. 51052 (published November 2, 2017). On April 9, 2018, the Department of Health and Human Services (HHS) posted the Notice of Benefit and Payment Parameters for 2019 Final Rule (Final Rule). *See* 82 Fed. Reg. 16930 (published April 17, 2018).[1]

HHS publishes the Notice of Benefit and Payment Parameters (Payment Notice) annually to update requirements for the individual and group markets, health insurance Exchange standards, and premium stabilization programs. Each year, this rule establishes the updated annual limitation on cost sharing (*i.e.*, maximum out-of-pocket (MOOP)) amounts. This year's Payment Notice also allows for greater state flexibility in selecting the essential health benefit (EHB) base-benchmark plan.

Below is an overview of the following issues that have been finalized: 1) EHBs; and 2) 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 Final Rule, HHS is providing States more flexibility when selecting their EHB-benchmark plans for plan years beginning on or after January 1, 2020. 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 under its benchmark plan with the same 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*.

These three options are subject to two additional

[1] https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07355.pdf?utm_campaign=pi%20subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email

requirements:

First, the EHB-benchmark plan must provide a scope of benefits that is equal to, or greater than, (to the extent any supplementation is required to provide coverage within each EHB category) the scope of benefits provided under a typical employer plan.

The final rule defines a typical employer plan as either: 1) one of the selecting State's 10 base-benchmark plan options from the 2017 plan year; or 2) the largest health insurance plan by enrollment in any of the five largest large group health insurance products by enrollment in the selecting State, provided that: a) the product has at least 10% of the total enrollment of the five largest group health insurance products by enrollment in the selecting State; b) the plan provides minimum value; c) the benefits are not excepted benefits; and d) the benefits in the plan are from a plan year beginning after December 31, 2013.

Second, the State's EHB-benchmark plan must not exceed the generosity of the most generous of a set of comparison plans for the 2017 plan year. 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.

HHS will also allow States to choose whether to allow issuers in the State to substitute benefits across EHB categories starting in 2020. The State must notify HHS of its decision to allow substitution between benefit categories.

In addition, the Final Rule would require a State to provide reasonable public notice and opportunity for public comment (as determined by the State) on any changes to the State's EHB benchmark, but must post a notice of its opportunity for public comment with associated information on a relevant State website. The State would also be required to notify HHS whenever it changes its benchmark and submit certain documentation. The rule proposes a deadline of July 2, 2018 for a State to submit the documents required for its benchmark plan options for the 2020 plan year.

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

The Final Rule sets the 2019 maximum annual limitation on cost sharing – or MOOP – levels, which apply to both the individual and group markets.

For 2019, the MOOP amounts will be **$7,900 for self-only coverage** and **$15,800 for other than self-only coverage**. This 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 sets different MOOP amounts for enrollees with household incomes between 100-250 percent of the federal poverty level (FPL). For 2019, the amounts are as follows:

- 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)

Update on Recent Health Litigation

AARP v. United States Equal Employment Opportunity Comm'n

In the October 2017 edition of *GRS Insight*, we reported on wellness program litigation, *AARP v. United States*

Equal Employment Opportunity Comm'n, No.16-cv-02113, 2017 WL 3614430 (D.D.C. Aug. 22, 2017).

In this litigation, a federal district judge ordered the U.S. Equal Employment Opportunity Commission (EEOC) to reconsider its regulations under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA) relating to incentives under certain employer-sponsored wellness programs.

In the decision, the District Court for the District of Columbia ordered the EEOC to reconsider rules issued in May 2016 which provided that, under the ADA and GINA, an employee/spouse's participation in the program is "voluntary" so long as the incentive is generally no more than 30% of the cost of self-only coverage.

The American Association of Retired Persons (AARP) challenged the rules, arguing that because many employees/spouses cannot afford a 30% increase in premiums, such employees/spouses – who might otherwise decline to participate in a wellness program – are essentially forced to participate in order to avoid paying a penalty, making their participation in the program involuntary in a practical sense. AARP also argued that the EEOC failed to provide a reasoned explanation for the 30% "voluntariness" threshold.

The court's decision was premised largely on EEOC's failure to offer any reasoned explanation for the 30% limit, and the court remanded the rules to the EEOC for reconsideration. However, because the court remanded the rules without vacating them, the rules remain in effect, at least until the end of 2018.

On March 30, 2018, the EEOC filed a status report with the court stating that it does not currently have plans to issue new rules addressing wellness incentives and is awaiting confirmation of the new commission chair. The EEOC noted that it has a number of policy options available for making changes to the wellness program rules, but that no plans have been made to revise the rules.

The delay by the EEOC in acting means that employers lack the necessary guidance on the permissible incentives that can be offered under a wellness program. The current EEOC wellness program rules expire at the end of 2018, and without new rules, this leaves employers in a difficult position for designing wellness programs for the 2019 plan year.

Texas et al. v. U.S. Department of Health and Human Services et al.

On February 26, 2018, Texas and several other states brought suit against the Department of Health and Human Services (HHS) in the U.S. District Court for the Northern District of Texas alleging that the Affordable Care Act (ACA), as recently amended, "forces an unconstitutional and irrational regime onto the States and their citizens."

The Complaint claims that the recent amendment to the ACA under the Tax Cuts and Jobs Act of 2017 (which eliminates the tax penalty of the ACA in 2019 for not having insurance, but does not repeal the individual insurance mandate itself) renders legally impossible the Supreme Court's prior holdings regarding the individual mandate. Because both Congress and the Supreme Court viewed the mandate as essential to the operation of the ACA, the Plaintiffs argue that the district court should find that the ACA is unlawful and enjoin its operation.

The Complaint relies on the holdings in *NFIB v. Sebelius* and *King v. Burwell* for two main premises: 1) Congress lacked the constitutional authority to compel citizens to purchase insurance, but the mandate and tax penalty can be treated as a single "tax," which Congress may enact under its taxing authority (i.e., it's a tax primarily because the penalty for not having insurance raises revenue); and 2) the guaranteed issue and community rating requirements would not work without the requirement for individuals to buy health insurance.

With repeal of the individual mandate's tax penalty, the Complaint argues that the individual mandate has become unconstitutional and must be struck down. The plaintiffs go on to argue that because the individual mandate itself was "essential" to the ACA's design and structure, the rest of the ACA must fall with the individual mandate. The Plaintiffs are seeking to enjoin the Defendants (i.e., HHS et al.) from implementing and enforcing the ACA.

On April 9, 2018, several states filed a motion to intervene as defendants in this case, arguing that intervention as of right is warranted because the States' interests in preserving the ACA diverge from and will not be adequately represented by the federal defendants (*i.e.*, HHS et al.), and the States' interests will be gravely impaired if they are not permitted to intervene. The district court granted the States' motion to intervene as defendants in this litigation.

While still very early in the legal proceedings, this litigation, if successful, could have significant implications for the future of the ACA.

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