OCTOBER 2018

GRS INSIGHT

Executive Order—Impact on Required Minimum Distributions

IN THIS ISSUE

On August 31, 2018, President Trump signed Executive Order 13847 addressing several retirement plan issues (the "Executive Order"), including the calculation of required minimum distributions (RMDs).[1] Specifically, the Executive Order addresses the life expectancy tables used in calculating RMDs.

Under the Executive Order, the Treasury Department ("Treasury") has 180 days to review the RMD rules to see if changes can be made to allow retirees to keep their savings in retirement plans longer.

As discussed in the July 2018 edition of *GRS Insight*, the Internal Revenue Code generally requires that plan participants begin drawing their retirement benefits by April 1 of the calendar year following the later of the calendar year in which the participant retires or attains age 70½. The rate at which RMDs must be paid is set forth in life expectancy tables reflected in the Treasury Regulations, which were finalized in 2002.

The Executive Order directs the Treasury to consider updating these life expectancy tables to reflect current mortality data, which would generally stretch out the period over which RMDs are paid (as current mortality rates take into account a longer expected life span). The Executive Order also contemplates the possibility of requiring annual or other periodic updates to the tables.

While the agencies have a considerable amount of flexibility in implementing the Executive Order, it is expected that they will move quickly to develop proposed rules and other guidance.

Proposed Legislation Affecting Employer Pick-Up Contributions

In September 2018, the U.S. House of Representatives approved a package of three bills known as "Tax Reform 2.0." One of the bills in the package, the Family Savings Act (H.R. 6757, "FSA"), contains numerous retirement provisions, including a provision to expand pick-up arrangements under Internal Revenue Code Section 414(h)(2).

[1] 83 Fed. Reg. 45321 (Sept. 6, 2018).

The FSA would clarify the treatment of certain retirement plan contributions that are "picked up" (i.e., employee contributions which qualify to be treated as employer contributions) by governmental employers for new or existing employees.

Current Rules

Under IRC § 414(h)(2), governmental employers can "pick up" mandatory employee contributions such that the employee's contributions are tax deferred. Revenue Ruling 77-462 holds that picked-up contributions are excluded from employees' gross income until distributed and do not constitute wages subject to federal income tax withholding.

Furthermore, under Revenue Ruling 2006-43, the IRS clarified that the current rules for pick-up arrangements provide that a contribution to a qualified plan established by a State or local government will not be treated as "picked up" by the employer unless the employer:

1) Specifies that contributions, although designated as employee contributions, are being paid by the employer (which requires formal and contemporaneous written action by a duly authorized person which must only apply prospectively); and

2) Does not permit a participating employee to have the option of choosing to receive amounts directly instead of having them paid by the employer directly to the plan.

Proposed Expanded Rules

The FSA would expand the arrangement under which employee contributions may be deemed "picked up" by the employer. As noted above, under the current rules, no employee election is permitted. However, under the FSA, employee contributions to a governmental plan may still be treated as tax-deferred pick-up contributions even if the employee makes an irrevocable election between two formulas with the same or different levels of employee contributions (e.g., under a traditional defined benefit plan or defined contribution plan).

The current version of the FSA, as passed by the House, likely will not advance in its current form in the Senate. However, it is expected that the two chambers will try to reach a bipartisan consensus and pass a compromise bill in the post-election lame duck session.

Automatic Beneficiary Revocation Ruling

In a recent case (*Sveen v. Melin*), the Supreme Court ruled that retroactive application of a state law, which automatically revokes spousal beneficiary designations upon divorce, does not violate the Federal Constitution's Contracts Clause (the "Contracts Clause").[2]

Although the contract at issue was a life insurance policy which is not subject to the Employee Retirement Income Security Act ("ERISA"), this case may impact governmental retirement plans that are similarly not subject to ERISA or applicable state law preemption clauses.

Background

In 2001, the Court addressed this issue in the ERISA context. In that case (*Egelhoff v. Egelhoff*), the participant named his current spouse as the beneficiary of his ERISA plan benefits.[3] After the parties divorced, payment was made to his ex-spouse. The participant's children from a prior marriage sued to recover the amounts, relying on a state statute revoking spousal

[2] *Sveen v. Melin*, 138 S.Ct. 1815 (2018).
[3] *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001).

beneficiary designations upon divorce, enforcement of which would mean the death proceeds would go to the participant's heirs-at-law. The Court found for the ex-spouse, generally holding that ERISA's requirement of making payments to named plan beneficiaries preempted the state "revocation" statute.

The Sveen case addressed the payment of the proceeds of a non-ERISA life insurance policy after the policyholder's death. At the time of his death, the decedent's life insurance policy retained the beneficiary designations he made during his marriage, i.e., the ex-spouse (who he named prior to the divorce) remained the primary beneficiary, and his children from a prior marriage were the contingent beneficiaries.

The Minnesota statute at issue provides that divorce automatically revokes the designation of a spouse as beneficiary if the parties later divorce. Therefore, the Court was asked to resolve the dispute – the statute would require the plan's administrator to pay the proceeds to the contingent beneficiaries, while the decedent's beneficiary designation four years before the statute's enactment would require payment to his ex-spouse as beneficiary.

The Decision

The decedent's children relied on the Minnesota state statute for their claim, while the ex-spouse claimed retroactive application of the state statute would violate the Contracts Clause. After differing conclusions in the lower courts, the Court granted certiorari and held that retroactive application of the state statute did not violate the Contracts Clause.

The Court stated that a violation of the Contacts Clause will be found on a court's determination that application of a state law causes a substantial impairment of the pre-existing contractual relationship. To find a substantial impairment, the Court looked to the extent to which the law:

1) Undermines the contractual bargain;

2) Interferes with a party's reasonable expectations; and

3) Prevents the party from safeguarding or reinstating his rights.

If these factors support a finding of substantial impairment, the Court then looks to whether the state law is "appropriate and reasonable" as a means to advance "a significant and legitimate state purpose."

In this case, the Court did not reach the second inquiry, finding the Minnesota law did not substantially impair the contractual arrangement, as the Court concluded that:

- The statute is designed to support a policyholder's intent because a policyholder would generally prefer his heirs receive the proceeds of the policy over his ex-spouse.
- The statute does not interfere with expectations, as divorce courts have wide discretion in dividing property, meaning a policyholder cannot know what would happen to a beneficiary designation on divorce.
- The statute supplies a default rule, one which requires minimal paperwork to change if a policyholder wants to maintain an ex-spouse as his beneficiary.

Therefore, the Court held that retroactive application of the statute does not violate the Contracts Clause.

Observations

While the Sveen case did not specifically address a retirement plan, it does provide guiding principles in the non-ERISA context. Therefore, public retirement plans should review applicable state laws, and consider the effects of such laws and this decision on their plans. At a minimum, members in all plans should be encouraged to review their beneficiary designations upon divorce to be sure they continue to reflect their intent in light of the applicable law.

Health Legislation Update

In 2018, Congressional efforts to enact health care legislation were meaningful, as Congress considered a number of bills proposing various changes to both tax-preferred health savings accounts (HSAs) and the Affordable Care Act (ACA). However, the Congressional efforts to revamp the U.S. health care delivery system were minimal compared to the repeal-replace efforts of 2017.

In July 2018, two measures addressing HSA coverage passed the U.S. House of Representatives, and at least seven other bills were reported out of the House Ways and Means Committee. More recently, the House took up significant legislation that would alter or eliminate an array of employer-related requirements under the ACA.

Although there are no current indications that the Senate will consider these bills in the lame duck session, it is possible that one or more of these proposals will be considered when the Senate returns to Washington after the election in November.

Health Savings Account Legislation

In July 2018, the House passed two health care bills that would make significant changes to HSA coverage and contributions requirements.

On July 25th, the House passed the Restoring Access to Medication and Modernizing Health Savings Accounts Act (H.R. 6199), which would allow individuals to use tax-favored health accounts to purchase over-the-counter medical products. The bill does so by amending the definition of "qualified medical expenses" in the Internal Revenue Code to include certain over-the-counter medical products as qualified medical expenses (e.g., menstrual care products). The bill also includes in the definition of "qualified medical expenses" certain sports and fitness expenses, including gym memberships, up to a limit of $500 per year for individuals and $1,000 per year for families. By including these items within the definition of qualified medical expenses, the bill would allow individuals to use tax-advantaged health care accounts such as HSAs to purchase those items.

The bill would also make certain structural changes to HSA coverage. For example, the bill would permit high-deductible health plans (HDHPs)—to which HSAs are linked—to cover (on a pre-deductible basis) certain non-preventive services that HDHPs currently may not cover outside of the deductible (e.g., treatment for a chronic condition). The bill would also allow individuals who qualify for HSA family coverage to contribute to an HSA even if their spouse has a flexible spending account (FSA)—a scenario the HSA rules currently prohibit. Finally, the bill would allow individuals with HSAs to utilize onsite medical clinics for services such as physical exams, immunizations, and hearing or vision screenings, without risking their HSA eligibility.

In addition, the House passed the Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act (H.R. 6311), which modifies the definition of "qualified health plan" under the Internal Revenue Code for purposes of the health insurance premium tax credit. In doing so, the bill would allow individuals purchasing health insurance in the individual market to purchase a lower-premium "copper plan."

Currently, the ACA's premium tax credit for low-income earners is only available for bronze, silver, gold, and platinum health plans purchased on an ACA exchange. By adding lower value plans, the bill would allow individuals to apply the ACA's premium tax credit when purchasing lower-premium, "catastrophic" copper plans. The bill would also permit individuals to buy copper plans outside of the Exchanges.

Employer Mandate Legislation

In September 2018, House leadership sought to bring to the floor H.R. 3798, the Save American Workers Act of 2018. The bill generally seeks to relieve the burden on employers of both tax liability and reporting caused by the ACA.

Specifically, the Save American Workers Act would change the definition of a full-time employee under the ACA employer mandate from workers who work an average of 40 hours or more per week, up from the current 30 hours per week.

The bill would also:

- Delay the imposition of the ACA's Cadillac tax until 2023;
- Provide a moratorium on the employer mandate for 2015-2018;
- Provide that the ACA Form 1095-B health insurance coverage statements must be furnished to individuals only upon request; and
- Repeal the ACA indoor tanning tax.

House leadership was unable to bring the bill to the floor for consideration during September, so action has been delayed until at least November. Should the House pass the bill during the lame-duck session, there is no indication that the Senate will act on it. The Joint Committee on Taxation estimates the legislation would cost the government $58.5 billion over 10 years.

Conclusion

Although some of these legislative efforts have received bipartisan support, they are generally GOP-backed efforts. Subject to the results of this November's mid-term elections, they likely signal the types of efforts to be expected by Congressional Republicans in addressing the ACA's perceived shortcomings, particularly efforts to suspend or repeal both the employer mandate penalty and the Cadillac tax. While there is broader-based support for the proposed changes to the rules governing HSAs and HDHPs, the political situation in the new Congress will likely dictate whether these are considered on a stand-alone basis or as part of a larger effort to bolster the remaining provisions of the ACA.

Health Litigation Update: Texas v. U.S.

As noted in the May and June 2018 editions of *GRS Insight*, litigation is ongoing in the Northern District of Texas among Texas (joined by several other states), the Department of Health and Human Services (HHS), and California (also joined by several other states) concerning the constitutionality of the ACA.

Texas is claiming that the ACA's individual mandate, as amended by the Tax Cuts and Jobs Act of 2017, is unconstitutional because, in *NFIB v. Sebelius*, the Supreme Court upheld the individual mandate as a tax and, starting January 1, 2019, the individual mandate will no longer be a tax because it will not raise any revenue.

Since both Congress and the Supreme Court viewed the mandate as "essential" to the operation of the ACA, Texas is arguing that the district court should find that the ACA is unlawful and enjoin its operation.

In an unusual move, the Department of Justice (DOJ) has sided with Texas as to the constitutionality of the individual mandate, but has argued that only certain ACA provisions, including guaranteed issue and community rating, must be struck down along with the individual mandate as of January 1, 2019. California and 16 other states have been defending the ACA.

On September 5, 2018, District Judge Reed O'Connor held a hearing on Texas' motion for a preliminary injunction to enjoin the ongoing application and enforcement of the ACA. While it is difficult to predict a judge's decision based on a hearing, Judge O'Connor aggressively questioned the lawyers for California and the intervener states, leading to speculation that he might issue a preliminary injunction in favor of Texas or the federal government's position. Such a decision could cause confusion in the national health insurance market.

Judge O'Connor's decision could come at any time and could take several forms, leading to differing results. He could, for example, simply deny a preliminary injunction, leading to the ACA staying in place pending

an appeal or trial on the merits. He could issue a nation-wide preliminary injunction, or, as suggested by Texas, a preliminary injunction only covering those states challenging the law. Furthermore, he could simply issue a ruling on the merits, potentially going into effect January 1, 2019, likely leading to an immediate appeal.

Any ruling in favor of Texas or the DOJ's position would likely lead to an immediate appeal and possibly (though not necessarily) a stay pending review by the Fifth Circuit. This result would avoid immediate disruption to the national health insurance market, but, because an appeal would likely take months (and would almost certainly lead to a further appeal to the Supreme Court), it would not lift the uncertainty this case has caused the national health insurance market.

Finally, there is the potential for another case to cause further confusion. On September 13, 2018, the State of Maryland filed suit against the Administration in the District of Maryland, requesting that the court issue a declaratory judgment finding the ACA constitutional. The Maryland case is still in the very early stages and is unlikely to progress far before Judge O'Connor issues his decision in Texas. Nonetheless, it has the potential to create a split between the courts as the ACA's constitutionality that would necessitate expedited appellate – and potentially Supreme Court – review.

About GRS

GRS is a national actuarial and benefits consulting firm. We help our clients develop and maintain fiscally sustainable benefit programs that preserve financial security for millions of Americans. Our reputation for providing independent advice and quality consulting services has remained unmatched for more than 80 years. To locate a GRS office, visit our website at: www.grsconsulting.com.