OCTOBER 2019

INSIGHT

Windfall Elimination Provision and Government Pension Offset Primer

IN THIS ISSUE

While Social Security coverage is a well-known consideration in retirement planning, it is important for governmental employees to understand the extent to which such coverage applies to them. For governmental employees who receive employer-sponsored retirement benefits and have not paid into the Social Security system (i.e., noncovered pensions), the "windfall elimination provision" (WEP) and "government pension offset" (GPO) are two separate provisions that may affect the level of Social Security benefits available.

Social Security Benefits Generally

When an employee works and pays Social Security taxes based on that employment, credits are earned toward Social Security benefits. Social Security benefit payments are based on these credits, which are based on an employee's earnings during his or her working career (i.e., higher lifetime earnings generally result in higher Social Security benefits). Any years in which an employee did not work or had low earnings may decrease the benefit amount. Further, the age at which an employee decides to retire affects the benefit, as retirement prior to full retirement age (based on the employee's year of birth) will mean a reduced benefit. Governmental employees who receive a retirement (or disability) benefit from employment that is not covered by Social Security should be aware of other potential reductions.

Legislative History of the WEP and the GPO

Prior to the passage of the WEP and the GPO, if a governmental worker did not pay Federal Insurance Contribution Act (FICA) taxes, the Social Security Department was unaware that the individual had a governmental job. This led to governmental workers who received pensions outside of Social Security, and did not pay into the Social Security system, receiving Social Security benefits in higher than intended amounts. To address this problem, Congress established a bi-partisan commission to explore potential solutions.

The commission introduced the GPO and the WEP to avoid overpaying Social Security benefits to government workers who did not pay into the Social Security system. Although the GPO initially passed as a provision in a Social Security amendment in 1977, it was amended in 1983 per the bi-partisan commission's recommendation. As passed under the 1983 Refinancing Act, the WEP was intended to bolster the financing of the Social Security Trust Fund.

What is the WEP?

The regular Social Security benefit formula applies to replace a greater percentage of earnings for lower paid workers than for higher paid. Governmental employees who worked in noncovered positions were shown as having no earnings for those years

and, as such, would receive Social Security benefits as if they were a lower paid worker. Their receipt of a governmental pension in addition to these Social Security benefits was seen as a "windfall," spurring introduction of the WEP.

The WEP makes an adjustment to reduce Social Security worker benefits for employees in positions not covered by Social Security. The amount of the reduction is based on an employee's years of substantial earnings (the minimum amount of Social Security-covered earnings necessary to be credited with a year of coverage). The greater number of years of substantial earnings an employee has, the lower the reduction. There are a few exemptions from the WEP, as it will not apply to employees who have 30 or more years of substantial earnings or survivor benefits.

What is the GPO?

Individuals may be eligible for both a worker's benefit and a spousal (or survivor) benefit under Social Security. Under this "dual entitlement" rule, a Social Security spousal benefit to which an individual is entitled is offset by a Social Security worker benefit, with any excess spousal benefit then added to the worker benefit – in effect, the individual receives the higher of the two benefits, but not both. Prior to enactment of the GPO, an individual who worked in a noncovered position did not have a Social Security spousal benefit offset by the amount of their noncovered pension, such that he or she received the full noncovered pension amount and Social Security spousal benefit. The GPO was enacted to eliminate this inequity.

The GPO is a benefit reduction for spousal, widow, or widower's Social Security benefits where an employee also earns a retirement benefit from a governmental employer and did not pay Social Security taxes. The amount of the reduction under the GPO is equal to two-thirds of the employee's noncovered pension payment.

> For example, an employee's monthly noncovered pension is $600 (two-thirds of which is $400). Further, the employee is otherwise eligible for a spousal benefit equal to $500 per month. After application of the GPO, the employee will receive a monthly spousal benefit of $100.

There are a number of exemptions from the GPO, the most applicable being receipt by an employee of a governmental pension that is not based on the employee's earnings, or for certain governmental retirement benefits where Social Security taxes were paid.

Who is affected by the WEP and GPO?

As previously noted, the WEP and GPO affect Social Security benefits to employees who are receiving a noncovered pension. Certain individuals may be affected by both the WEP and GPO – i.e., if they: 1) are dually entitled to worker and spousal benefits under Social Security; and 2) receive a noncovered pension.

The WEP affects employees with respect to their own Social Security benefits, while the GPO affects employees who are also eligible for spousal, widow, or widower's Social Security benefits. Importantly, the GPO applies only if the employee is collecting a noncovered pension based on the employee's own work and is also eligible to receive a spousal, widow, or widower's Social Security benefit. A noncovered pension earned by an employee's spouse has no bearing on the employee's own Social Security benefits, even upon inheriting the pension after a spouse's death.

Why are the WEP and the GPO important considerations for governmental employees?

The WEP and the GPO are benefit reductions aimed at employees who receive noncovered pensions, typical of state and local governmental employers, where Social Security taxes are not withheld from governmental salaries. These reductions can cause governmental employees who are subject to these provisions to lose large portions of their Social Security benefits, depending on their years of substantial earnings.

Does the WEP or the GPO eliminate an individual's entire Social Security benefit?

The WEP does not entirely eliminate an individual's Social Security benefit since it can only reduce an employee's benefit up to half of the amount to which the employee is entitled. However, the GPO reduces an employee's spousal, widow, or widower's benefit by up to two-thirds of the employee's noncovered pension amount. If two-thirds of the noncovered pension is greater than the Social Security benefit, then the entire Social Security benefit will be eliminated.

What issues are caused by the WEP and GPO?

Dually-entitled individuals who are affected by both the WEP and the GPO have caused issues for the Social Security Administration in calculating the proper Social Security benefit amounts. In fact, many of these individuals have been overpaid when their Social Security benefits were not calculated to properly take into account the WEP and/or the GPO. Other overpayments have occurred where

individuals affected by the WEP and/or GPO did not properly report their noncovered pensions (e.g., changes in noncovered pension amount).

Pension Plans Legislative Update

On September 27, 2019, President Trump signed a short-term spending bill or "continuing resolution" ("CR," H.R. 4378) that funds the government at current levels through November 21, 2019. The CR is a stopgap measure intended to give lawmakers time to negotiate an appropriations package for the 2020 fiscal year.

Many lawmakers had hoped that the upcoming appropriations bill could serve as a vehicle for passing the *Setting Every Community Up for Retirement Enhancement Act of 2019* ("SECURE Act," H.R. 1994), the broad retirement legislation that has been stalled in the Senate after passing the House 417-3. However, the odds of such an outcome appear to be waning.

Senate leadership has attempted several times to pass the SECURE Act by unanimous consent, but those efforts have been repeatedly blocked by a small group of Republican senators. As Congress grapples with a number of higher priorities, the SECURE Act and possibly even the 2020 appropriations may fall by the wayside as lawmakers punt government funding through a series of CRs.

Currently, there are two bills in the House of Representatives that seek to modify Social Security's windfall elimination provision (WEP). Ways and Means Committee Ranking Member Kevin Brady (R-TX) introduced the *Equal Treatment of Public Servants Act* (H.R. 3934) on July 24, 2019. In addition, on September 27, 2019, the Ways and Means Committee Chairman Richard Neal (D-MA) introduced a similar bill, the *Public Servants Protection and Fairness Act* (H.R. 4540).

Both bills propose the same new formula for calculating benefits. In the words of the Social Security Administration's Chief Actuary, Stephen C. Goss, under the new formula "beneficiaries will receive a benefit that reflects the replacement rate applicable for a worker with the same career earnings, where all earnings had been covered."

Rep. Brady previously introduced this bill in the 115th Congress, and it did not advance. Unfortunately, for many governmental employees, progress is equally unlikely in this Congress, as House lawmakers have just passed the SECURE Act and significant multiemployer pension issues loom on the horizon.

IRS Provides List of Preventive Care Benefits for HSA Participants to Include Certain Care for Chronic Conditions

On July 18, 2019, the Internal Revenue Service (IRS) released Notice 2019-45, which provides a list of preventive care benefits that a health savings account (HSA)-compatible high deductible health plan (HDHP) can provide on a pre-deductible basis for individuals who are diagnosed with certain chronic conditions.

Preventive Care Benefits that HDHPs Can Provide Pre-Deductible

Under the Internal Revenue Code's rules governing HDHPs and HSAs, an individual is eligible to contribute to an HSA only if the individual is covered by an HDHP that satisfies certain requirements. One of those requirements is that the HDHP generally may not provide benefits for any year until the individual satisfies the HDHP's minimum deductible, which is established by statute. However, an exception exists for services and benefits classified as preventive care, whereby an HDHP may provide preventive care benefits without any deductible or with a deductible below the minimum annual deductible that would otherwise be required for an HDHP.

Generally, IRS guidance provides that preventive care does not include any service or benefit intended to treat an existing illness, injury, or condition. The IRS stated in Notice 2019-45 that this definition can prove problematic for individuals diagnosed with certain chronic conditions, as cost barriers may preclude those individuals from seeking necessary care that would prevent exacerbation of the chronic condition. The IRS explained that the failure to address chronic conditions has been demonstrated to lead to consequences such as amputation, blindness, heart attacks, and strokes that require considerably more extensive medical intervention.

To address this concern, Notice 2019-45 provides a list of services and items that constitute preventive care if purchased to treat specified chronic conditions. Effective July 17, 2019, the IRS considers these services and items as preventive care and, therefore, can be covered before the deductible only when prescribed to treat an individual diagnosed with the associated chronic condition specified on the list and only when prescribed for the purpose of preventing the exacerbation of that specific chronic condition or the development of a secondary condition.

The new services and items are as follows:

PREVENTIVE CARE FOR SPECIFIED CONDITIONS	FOR INDIVIDUALS DIAGNOSED WITH
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or cononary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

The IRS states that, in consultation with the Department of Health and Human Services, it will periodically review the list of preventive care services and items every five to ten years to determine whether certain services or items should be added to or removed from the list.

Tri-Agencies Announce Intent to Clarify Confusion over Drug Manufacturers' Coupons and Maximum Out-of-Pocket Rules

On August 26, 2019, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments), published a new FAQ (ACA FAQs Part 40) regarding implementation of the Patient Protection and Affordable Care Act (ACA). In the FAQ, the Departments acknowledged confusion around the rules governing the treatment of drug manufacturers' coupons toward annual cost sharing limits under the ACA. Due to this confusion, the Departments announced a non-enforcement position until a new rulemaking is issued.

Limitations on Cost Sharing Under the ACA

As part of its market reforms, the ACA added a requirement that all non-grandfathered group health plans ensure that any annual cost sharing imposed under the plan for essential health benefits does not exceed certain maximum annual limitations. Earlier this year, HHS issued its Notice of Benefit and Payment Parameters for 2020 (2020 NBPP Final Rule).

The 2020 NBPP Final Rule stated that, for plan years beginning in 2020, health plans and health insurance issuers are permitted to exclude the value of drug manufacturers' coupons from counting toward the annual limitation on cost sharing when a medically appropriate generic equivalent is available. The Departments acknowledged in ACA FAQs Part 40 that this provision could be interpreted to imply that, in all other circumstances, group health plans and issuers must count drug manufacturers' coupons toward the annual limitation on cost sharing.

The Departments admitted that such a requirement could conflict with the rules for high deductible health plans (HDHPs) and health savings accounts (HSAs). Specifically, current guidance under those rules requires an HDHP to disregard drug manufacturers' coupons when determining whether an individual has satisfied the HDHP's minimum deductible, meaning the HDHP can only count amounts actually paid by individuals when tracking cost sharing. The Departments also acknowledged that this requirement could place plan sponsors of an HDHP/HSA in the impossible position of complying with rules that both require and preclude plans from counting the value of drug manufacturers' coupons toward certain limits.

To resolve that conflict, the Departments announced in ACA FAQs Part 40 that they intend to undertake a rulemaking in the forthcoming HHS Notice of Benefit and Payment Parameters for 2021 to clarify their policy toward drug manufacturers' coupons.

In the meantime, the Departments stated that they will not initiate an enforcement action if an issuer or group health plan excludes the value of drug manufacturers' coupons from the annual limitation on cost sharing, including in circumstances in which there is no medically appropriate generic equivalent available.

MHPAEA FAQs and Model Disclosure Form

The recent FAQ guidance issued by the Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments) provides examples of how the Mental Health Parity and Addiction Equity Act (MHPAEA) final regulations apply under different circumstances and includes a model disclosure form that individuals may use to request MHPAEA information from their plan.

Nonquantitative Treatment Limitations (NQTL) FAQs

The guidance focuses on the application of NQTLs. The FAQs first clarify that a plan may consider a wide array of factors in developing and applying NQTLs, and that an NQTL analysis is a process, not outcome, determinative inquiry. However, dissimilar outcomes, while not determinative of compliance, may be a warning sign or potential indicator of parity noncompliance in operation.

The FAQ guidance restates the NQTL rule, specifically that the "processes, strategies, evidentiary standards, or other factors" used to develop an NQTL that applies to mental health and substance use disorder (MH/SUD) benefits must be comparable to, and applied no more stringently than, the "processes, strategies, evidentiary standards, or other factors" used in developing an NQTL that applies to medical/surgical benefits.

Below are some of the key points in the FAQs:

- An NQTL must comply with MHPAEA, both as written and in operation;
- The exclusion of all benefits for a particular condition is not a treatment limitation under MHPAEA;
- Medical management standards that limit or exclude benefits based on medical necessity, medical appropriateness, or other factors are NQTLs even if expressed as numeric limitations. For example, the use of a Pharmacy and Therapeutics (P&T) committee to set dosage limits is not a per se violation of MHPAEA, but these processes must be comparable in practice for both MH/SUD and medical/surgical benefits; and
- A plan's standards for admitting a provider to participate in a network, including reimbursement rates for providers, is an NQTL under MHPAEA. While MHPAEA does not require a plan to pay identical provider reimbursement rates for medical/surgical and MH/SUD providers, it does require a comparable methodology for developing or determining reimbursement rates or ensuring network adequacy for both MH/SUD and medical/surgical benefits.

MHPAEA Disclosure Requirements

The Departments provide additional clarification on disclosures for MH/SUD benefits, including a new model disclosure form. MHPAEA-specific disclosures are: 1) criteria for medical necessity determinations with respect to MH/SUD benefits must be made available by the plan administrator or the health insurance issuer to any current or potential participant, beneficiary, or contracting provider upon request; and 2) reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits in the case of any participant or beneficiary must be made available to the participant or beneficiary.

The Departments developed a model form that individuals may—but are not required to—use to request information that may affect their MH/SUD benefits. Individuals can use this form to request: 1) general information about MH/SUD benefits and treatment limitations, like a plan's preauthorization policies for both medical/surgical and mental health treatment; and/or 2) specific information about why benefits were denied to support an appeal. The Departments note that plans may use their own disclosure forms to help facilitate disclosure requests, and importantly, the form includes a note to make clear to participants and beneficiaries that this form does not replace a plan's claims procedures.

Health Legislation Update

This year has been another busy year in Congress for health care legislation, as Congress has introduced a variety of bills designed to address surprise balance billing, prescription drug costs, and coverage for pre-existing conditions. Although it remains unclear whether these bills will pass by the end of the year, they nevertheless demonstrate some of the prevailing legislative proposals in the health benefits space.

Surprise Balance Billing Update

A number of different bi-partisan bills addressing "surprise balance billing" continue to percolate on Capitol Hill. These bills seek to protect patients from charges arising when a patient unexpectedly receives care from an out-of-network

provider (e.g., when a patient receives emergency care, or when a patient receives treatment from an out-of-network provider at an in-network facility).

The main issue of contention for surprise balance billing is how to reimburse out-of-network providers, and the two bills that are primarily in play have differing solutions. The *Lower Health Care Costs Act* (S. 1895), which the Senate Committee on Health, Education, Labor, and Pensions voted to send to the full Senate, proposes that payers and providers resolve disputes over balance bills by requiring health plans to pay the provider or facility an amount equal to the median contracted rate for services in that geographic area.

Conversely, the House Energy and Commerce Committee's *No More Surprises: Protecting Patients from Surprise Medical Bills* approved by the Committee in July 2019, proposes to set the payment amount for out-of-network doctors based on the average of what other doctors in the area are paid for the service, but also includes arbitration in the event a provider does not agree with the set reimbursement amount. However, the arbitration can only be used if the amount at issue is more than $1,250 and the arbitrator can only consider the complexity of the patient's case and the quality of care.

Drug Pricing

On September 19, 2019, House Speaker Nancy Pelosi (D-CA) unveiled the *Lower Drug Costs Now Act* (H.R. 3), a highly-anticipated drug pricing bill that would allow the Secretary of Health and Human Services to negotiate the prices of up to 250 brand-name drugs in Medicare that lack competitors. Once negotiated, the new prices would apply to all prescription drug buyers, not just those enrolled in Medicare. The bill would also place a $2,000 annual cap on out-of-pocket costs for Medicare beneficiaries. Finally, to the extent drug manufacturers have raised their prices above inflation since 2016, the bill would require them either to lower their prices or otherwise refund the excess portion back to the U.S. Treasury.

Pre-Existing Condition Coverage

On August 2, 2019, Representative Denver Riggleman (R-VA) introduced the *Maintaining Protections for Patients with Preexisting Conditions Act of 2019* (H.R. 4159), which would amend the Health Insurance Portability and Accountability Act (HIPAA) to add the Affordable Care Act's (ACA) provisions regarding pre-existing conditions, guaranteed availability, rating, and nondiscrimination, meaning those provisions would remain law even if the ACA is struck down.

Representative Riggleman's bill is the latest bill to be introduced in response to *Texas v. United States*, a lawsuit challenging the constitutionality of the entire ACA, including its coverage of pre-existing conditions. The case is currently sitting before the Fifth Circuit Court of Appeals, where a panel of judges heard oral arguments in July 2019 over the lower court's decision to hold the entire ACA unconstitutional. A ruling from the Fifth Circuit Court is expected this fall. Although it is difficult to predict precisely how the Fifth Circuit Court will resolve the case, some legislators have already begun preparing for the possibility that the ACA will be struck down in its entirety, as evidenced by Representative Riggleman's bill.

About GRS

Founded in 1938, Gabriel, Roeder, Smith & Company (GRS) is a national actuarial and benefits consulting firm. GRS is dedicated to bringing clients innovative, sustainable solutions that the firm helps put into action. The firm supports the long-term success of pension, OPEB, and health and welfare benefit plans. Associates deliver high-quality services that reflect GRS' core values, which include professionalism and ethics in all aspects of business. The firm attracts the best talent in the industry by providing a collaborative work environment that respects the diversity and professional aspirations of our associates.

To locate a GRS office, please visit our website at: www.grsconsulting.com.