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Insider

Mandatory coverage of COVID-19 testing and small employer paid leave signed into law

By Ann Marie Breheny and Ben Lupin

On March 18, the Senate approved the Families First Coronavirus Response Act (H.R.6201), and President Trump signed it into law. The legislation requires group health plans to provide first-dollar coverage for COVID-19 (coronavirus) testing and related medical office, urgent care and emergency room costs, effective immediately and lasting through the emergency period. In addition, beginning on April 2, 2020, certain employers must provide emergency paid sick leave and paid Public Health Emergency Leave under the Family and Medical Leave Act (FMLA) for specified situations related to COVID-19. The paid leave provisions would sunset on December 31, 2020.

General discussion and observations

Mandatory coverage of COVID-19 testing

Group health plans (including self-insured plans) and health insurance issuers offering individual and group coverage (including fully insured plans) are required to cover COVID-19 testing without imposing cost sharing on the patient. Prior authorization and medical management practices may not be applied. The mandate does not include treatment for COVID-19, only testing.[1] The Departments of Health and Human Services (HHS), Labor (DOL) and Treasury may implement the requirement through sub-regulatory guidance, program instructions or other methods.

Medicare, Medicaid, Children's Health Insurance Program and other federal health programs must also provide first-dollar coverage for testing.

Emergency paid sick leave

The legislation requires employers with fewer than 500 employees and all governmental employers, regardless of size, to provide emergency paid sick leave. Full-time employees would receive 80 hours of emergency paid sick leave, and part-time employees would receive the average number of hours worked over a two-week period. The leave will be available regardless of length of employment with the employer.

Emergency paid sick leave will be available to employees who are unable to work or telework due to:

- Being subject to a federal, state or local isolation order related to COVID-19
- Being advised to self-quarantine
- Experiencing symptoms of COVID-19
- Caring for an individual who is subject to an isolation order or who has been advised to self-quarantine

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[1] The requirement applies to costs associated with the diagnostic product; administration of the diagnostic product; and items and services furnished during office (including telehealth), urgent care center and emergency room visits that result in an order for, or administration of, COVID-19 testing.

- Caring for a son or daughter because the child's school or place of care is closed, or the childcare provider is unavailable due to COVID-19 precautions
- Experiencing any other substantially similar conditions specified by the Secretary of HHS, Treasury and Labor

The leave generally will be paid at the employee's regular rate of pay, to a maximum of $511 per day (and a maximum of $5,110 for the two-week emergency paid sick leave period). For employees taking leave to care for a family member under the above stated conditions, or experiencing conditions specified by HHS, Treasury and the DOL, the leave will be paid at two-thirds the employee's regular rate of pay, up to $200 per day (to a maximum of $2,000). Payroll tax credits will offset the cost of providing emergency paid sick leave.

The emergency paid leave can be used by the employee before any existing leave available to the employee.

Employers may not discharge, discipline or otherwise discriminate against employees who take emergency leave under the legislation. The legislation does not diminish the rights or benefits an employee is entitled to under other federal, state or local laws; collective bargaining agreements; or existing employer policies. Nor does it require that the employer pay or reimburse an employee for unused emergency paid leave upon the employee's separation from service.

Employers must post a notice informing employees of their rights to emergency paid leave. The DOL is instructed to issue a model notice within seven days of enactment.

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The DOL may exempt businesses with fewer than 50 employees. The DOL — and employers — may exclude employees who are health care providers and emergency responders.

Paid Public Health Emergency Leave

A new, temporary leave provision under the FMLA applies to employers with 500 or fewer employees as well as governmental employers, regardless of size. Public Health Emergency Leave is *paid* leave (unlike general FMLA leave) available for employees who have been employed by the employer for at least 30 calendar days.

The first 10 days would be unpaid; however, employees may elect to substitute paid leave during the first 10 days, but employers may not require such substitution. After the initial 10 days, the employee would be paid two-thirds the regular rate of pay, up to $200 per day (up to a $10,000 maximum). Payroll tax credits for the employer would help offset the costs of providing paid leave.

The DOL may exempt certain health care providers, emergency responders and businesses with fewer than 50 employees. Employers may also exclude employees who are health care providers or first responders.

Going forward

Plan sponsors of fully insured and self-insured group health plans should discuss coverage for COVID-19 testing with their third-party administrators and insurance carriers to ensure compliance with the testing coverage mandate.

Employers subject to the paid leave requirements should review the final paid leave provisions, watch for guidance, and prepare for implementation and administration.

Employers not covered by the paid leave provisions — in general, those with more than 500 employees — should discuss paid leave alternatives with qualified legal counsel.

Employers should also watch for additional legislative action. Congress began working on additional COVID-19 relief legislation before the Families First Coronavirus Response Act was approved by the Senate. New legislation could include provisions that affect employer-sponsored benefit and compensation programs.

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IRS guidance on first-dollar coverage for COVID-19 testing and treatment

By Maureen Gammon, Anu Gogna and Ben Lupin

Given the current spread of COVID-19 (coronavirus), and in response to employer concerns, the IRS issued **Notice 2020-15**, which provides that sponsors of health savings account (HSA)-qualifying high-deductible health plans (HDHPs) may cover *testing and treatment* for COVID-19 with reduced cost sharing or without any cost sharing (i.e., on a first-dollar basis). The IRS guidance aims to avoid administrative delays or financial disincentives that might impede testing for and treatment of COVID-19 for HDHP participants. The guidance remains in effect until further notice.

Notice 2020-15 does *not* modify previous guidance on the requirements to be an HDHP other than that related to the relief for testing and treatment of COVID-19. In addition, vaccinations continue to be considered preventive care under Internal Revenue Code section 223(c)(2)(C) for purposes of determining whether a plan is an HSA-qualifying HDHP.

This news should come as welcome relief for employers that sponsor HSA-qualifying HDHPs and are looking to cover the costs of COVID-19 testing and treatment for plan participants without application of a deductible, or with a deductible below the applicable minimum annual HDHP deductible amount.

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Substance use disorder confidentiality rules may impact contracts

By Maureen Gammon and Kathleen Rosenow

In 2018, the Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the Department of Health and Human Services, amended regulations protecting the confidentiality of certain substance use disorder (SUD) patient records. The amendments allow the records to be shared for payment and/or health care operations activities if specific requirements are met. Recipients of SUD patient records needing to re-disclose those records for payment and/or health care operations — including employers sponsoring group health plans that want to share those records with their contractors, subcontractors or legal representatives who carry out payment and/or health care operation activities on their behalf — must comply with the regulations.

Effective February 2, 2020, under the amended rules, written agreements between the parties must include specific language that complies with the SUD confidentiality regulations.

Background

The Confidentiality of Substance Use Disorder Patient Records Final Rule (42 CFR Part 2) protects the confidentiality of SUD patient records held by SUD treatment programs receiving federal funding and limits how such records may be used or disclosed. In general, it prohibits the disclosure of SUD patient records without written patient consent, even for the purposes of treatment, payment or health care operations.

In an effort to provide greater flexibility on sharing patient records while still protecting confidentiality, Part 2 regulations were amended in 2017 and again in 2018 to expand on the circumstances under which SUD patient records may be disclosed. Prior to these amendments, lawful holders of Part 2 patient records (i.e., recipients of patient information who are named in the patient consent form) were only permitted to share the records if authorized to do so in the patient consent form.

Part 2 amendments

Under the 2018 regulations, lawful recipients are permitted to further disclose those records to their contractors, subcontractors or legal representatives in order to perform the payment and/or health care operation functions designated on the consent form, such as billing, claim management, collections activities, obtaining payment under a contract for reinsurance, claim filing and related health care data processing. Note that the 2018 regulations do not affect the requirements for disclosures related to diagnosis, treatment or referral.

As of February 2, lawful recipients of SUD patient records who wish to re-disclose them for payment and/or health care operations must:

- Have a written contract or other legal instrument with the contractor, subcontractor or legal representatives that states they will comply with Part 2's requirements when they receive SUD patient records. Contractual language regarding general compliance with applicable federal laws is not sufficient for this purpose: Part 2 must be specifically mentioned in the contract. Only information necessary for performance of duties under the terms of the contracts can be disclosed to the contractor, subcontractor or legal representative.
- Require contractors, subcontractors or legal representatives to take reasonable steps to prevent unauthorized uses and disclosures and to report on any unauthorized uses, disclosures or breaches of patient-identifying information.
- Provide contractors, subcontractors or legal representatives with a notice prohibiting re-disclosure that is mandated by Part 2.

If lawful holders choose not to re-disclose patient identifying information to contractors, subcontractors or legal representatives, then these requirements do not apply.

Going forward

Group health plan sponsors who receive and may need to share SUD patient records with any third-party vendor for purposes of payment or health care operations activities should review the confidentiality requirements, ensure that the third-party vendor is aware of its compliance obligations and confirm that there is a written agreement between the parties with the necessary Part 2 language.

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News in Brief

Supreme Court to hear latest challenge to the ACA

By Maureen Gammon and Ben Lupin

The U.S. Supreme Court has agreed to hear *California v. Texas* (formerly known as *Texas v. Azar*), the third major challenge to the Affordable Care Act (ACA) that will reach the Court since the law's passage in 2010.

On December 14, 2018, a Texas federal District Court concluded that, since Congress eliminated the individual mandate penalty (as of January 1, 2019), the ACA individual mandate is no longer permissible under Congress's taxing power and is therefore unconstitutional. The District Court judge further reasoned that because Congress labeled the individual mandate as "essential" to the goal of creating effective health insurance markets, it could not be severed from the rest of the ACA and would therefore invalidate *the entire law.*

The Fifth Circuit Court of Appeals upheld the District Court's decision; however, the appellate court *did not* rule on the severability issue. Rather, it sent the severability issue back to the District Court to analyze what (if any) provisions of the ACA are inseverable from the individual mandate. That decision was appealed to the Supreme Court.

Oral arguments will likely be held in fall 2020 (during the Court's next term) with a decision issued in the spring or summer of 2021 (and after the November elections). The Supreme Court previously declined to expedite the case, which would have allowed it to be argued in spring 2020.

Final regulations clarify UBTI calculation for VEBAs

By Bob Jablonowski, Bill Kalten and Kathleen Rosenow

In December 2019, the U.S. Treasury Department and IRS released final regulations providing guidance on calculating unrelated business taxable income (UBTI) for certain tax-exempt organizations that provide employee benefits, including voluntary employees' beneficiary associations (VEBAs). Effective for taxable years beginning on or after December 10, 2019, UBTI is calculated based on the extent to which the VEBA's assets at the end of the taxable year exceed the tax code limitation, without regard to whether income was allocated to pay VEBA benefits during the year.

Background

Under the Tax Reform Act of 1984, Congress limited deductions for employer contributions to VEBAs and added Internal Revenue Code section 512(a)(3)(E) to limit the extent to which a VEBA's income is exempt from tax — the section referred to as unrelated business taxable income. While the UBTI rules apply to all VEBA-funded benefits, they significantly affect post-retirement medical benefits because employers often accumulate large amounts of assets for those benefits.

1986 temporary regulations: Under temporary regulations proposed by the IRS in 1986, a VEBA's UBTI was the lesser of (1) the VEBA's investment income or (2) the excess of the total amount set aside as of the close of the taxable year (including member contributions and excluding certain long-term assets) over the section 419A "qualified asset account" limit (calculated without regard to the otherwise permitted reserve for post-retirement medical benefits) for the taxable year.[1] This meant that virtually all investment income of a post-retirement medical VEBA was taxable because the qualified asset account limit for post-retirement medical pre-funding is zero.

Several court cases arose after the 1986 proposed regulations were issued:

- In the 2003 case ***Sherwin-Williams Co. Employee Health Plan Trust v. Commissioner***, the Sixth Circuit Court of Appeals held that a VEBA's income spent on administrative costs is not subject to taxation. Some VEBAs under the Sixth Circuit's jurisdiction likely have been calculating UBTI in accordance with the Sherwin Williams decision since 2003.
- Opposite positions were taken in two later cases: ***CNG Transmission Management VEBA v. United States*** (2009) and ***Northrop Corp. Emp. Ins. Benefit Plans Master Trust v. United States*** (2012). Both federal circuit court decisions held that a VEBA cannot avoid UBTI by allocating investment income to pay welfare benefits during the year.

2014 proposed regulations: In 2014, the IRS proposed new replacement regulations reiterating its position that UBTI is calculated based on the extent to which the entity's assets at the end of the year exceed the section 512(a)(3)(E) limitation, disregarding whether income was allocated to pay VEBA benefits and administrative expenses during the year.

Going forward

The final rules adopt the regulations proposed by the IRS in 2014 with no modifications to the rules pertaining specifically to VEBAs. It is likely that many VEBAs have been calculating UBTI in accordance with the final regulations. Those that have been calculating UBTI differently (most likely those in the Sixth Circuit jurisdiction) will need to begin calculating UBTI under the final regulations for 2020.

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[1] There are exceptions to the account limit rules for collectively bargained plans and life insurance under $50,000.

House committees approve proposals to end surprise medical bills

By Precious Abraham and Ann Marie Breheny

Competing bills to limit surprise medical billing practices were recently approved by two House committees. Both bills would limit balance billing for emergency care and scheduled care performed by non-network providers at in-network facilities, as well as provide other consumer protections. They differ on the payment methodology for non-network providers.

Surprise medical bills occur when patients unexpectedly receive care from a non-network health care provider or facility. They typically occur in emergencies and when non-network providers participate in care that the patient scheduled at an in-network facility. In such cases, patients often face higher deductibles and copayments from their health plans and balance billing from the non-network facilities or providers.

Ban Surprise Billing Act

The Ban Surprise Billing Act (H.R.5800) approved by the Education and Labor Committee on February 11 would prohibit balance billing for emergency care (including air ambulance services) and scheduled care performed by non-network providers at in-network facilities, except in certain cases when advance notice was provided and the patient provided consent. When balance billing is prohibited, the patient would be responsible for cost sharing as if the services were provided by in-network health care providers. The legislation also includes provisions addressing the accuracy of provider directories, disclosure of cost-sharing obligations to patients, information that must be included on insurance cards, and disclosure of direct and indirect compensation received by brokers and consultants for referrals.

The legislation would base payments to non-network providers on the median in-network rate for the geographic area. A dispute resolution provision would allow providers to pursue an arbitration process if the charges under dispute exceed $750 ($25,000 for air ambulance services). The dollar thresholds would be indexed for inflation.

The committee's contentious debate over the provider payment provisions in the legislation highlighted the strong legislative disagreement over the issue. Attempts to remove the default payment methodology from the legislation were defeated.

The Ban Surprise Billing Act is similar to a proposal released in December by House Energy and Commerce Committee Chair Frank Pallone (D-NJ); Energy and Commerce ranking member Greg Walden (R-OR); and Senate Health, Education, Labor and Pensions Committee Chair Lamar Alexander (R-TN).

Consumer Protections Against Surprise Medical Bills Act

The Ways and Means Committee approved the Consumer Protections Against Surprise Medical Bills Act (H.R.5826) on February 12. It would prohibit balance billing for emergency care and scheduled care by non-network providers practicing at in-network facilities and includes provisions that address the accuracy of provider directories, require advance explanations of patient cost-sharing obligations for scheduled care, address information that must be included on insurance cards and require health plans to provide a price comparison tool.

In contrast to the Ban Surprise Billing Act, it would direct providers and health plans to negotiate payment rates. If agreement could not be reached through negotiation, an arbitration process would be available.

Next steps

Protecting patients from surprise medical bills has bipartisan support in Congress. Controversy over payments for non-network providers has slowed legislative action. Health care providers generally support negotiation and arbitration while health plans, employer groups and some other stakeholders have expressed concern that arbitration could add costs and complexity. Resolving the disagreement has been difficult, but House leaders are seeking to resolve the differences between the two legislative approaches. Legislation to extend expiring Medicare and Medicaid provisions must be enacted by May 22, and lawmakers hope to include surprise medical billing and other health care issues in such legislation.

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CMS issues proposed regulations for assessing MSP reporting penalties

By Anu Gogna and Ben Lupin

The Centers for Medicare and Medicaid Services (CMS) has issued **proposed regulations** and an accompanying **fact sheet** that establish when civil monetary penalties can be imposed for Medicare Secondary Payer (MSP) reporting errors and failures pursuant to Section 111 of the Medicare and Medicaid SCHIP Extension Act of 2007.[1] Section 111 reporting is intended to help CMS recover conditional and mistaken Medicare primary payments, and prevent future mistaken payments, in MSP situations (i.e., when Medicare is not the primary payer of claims).

Under Section 111, responsible reporting entities (RREs) must report specific information to CMS for individuals who may be eligible for Medicare. RREs are generally the insurers of fully insured group health plans and the third-party administrators (TPAs) of self-insured group health plans. An employer that sponsors a *self-insured, self-administered* group health plan would also qualify as an RRE.

The proposed rule specifies how penalties would be calculated when RREs for group health plans fail to meet Section 111 reporting obligations in any of the following ways:

- **Failure to report.** If an RRE fails to timely report any group health plan beneficiary record (i.e., no more than one calendar year after the group health plan coverage effective date or the Medicare beneficiary's entitlement date, whichever is later), the penalty would be $1,000 (as adjusted annually) for *each calendar day* of noncompliance *for each individual,* counted from the day after the last day of the RRE's assigned reporting window through the day CMS received the information. The maximum penalty is $365,000 (as adjusted annually, currently $572,685) *per individual per year*.
- **Inaccurate information reported and/or maintained.** If an RRE's response to CMS efforts to recover conditional payments contradicts its Section 111 reporting, the penalty would be based on the number of calendar days that the RRE failed to appropriately report updates to beneficiary records. For a group health plan, the penalty would be $1,000 (as adjusted annually) for *each calendar day* of noncompliance for *each individual* (no maximum penalty).
- **Poor quality of reported data.** If an RRE's report exceeds any error tolerance(s) in any four out of eight consecutive reporting periods, then the initial and maximum error tolerance threshold would be 20% (representing errors that prevent 20% or more of the beneficiary records from being processed). CMS is only considering significant errors that prevent a file or individual beneficiary record from processing. The penalty for a group health plan would be $90,000 (as adjusted, currently $141,210) *for each individual*, per reporting period where a penalty may be imposed.

The proposed penalties would be levied *in addition* to any MSP reimbursement obligations. Note, as of January 1, 2020, reporting of prescription drug coverage that is primary to Medicare is mandatory instead of voluntary.

CMS proposes a five-year statute of limitations (five years from the date when the noncompliance was identified). Once the final regulations are issued and take effect, CMS will enhance its monitoring of recovery process disputes and appeals that contradict reported data, as well as begin auditing the reported data and performance over time to identify reporting errors.

Going forward

CMS is accepting comments on the proposed regulations through April 20. Pending issuance of the final regulations, employers that sponsor group health plans will want to review procedures with their insurers or TPAs to make sure they are submitting timely and accurate reports to CMS and that procedures are in place to avoid potential penalties. Insurers and TPAs might also ask employers to provide them with necessary reporting information (e.g., the number of full-time and part-time employees, social security numbers of employees and dependents) in order to comply with the Section 111 reporting requirements.

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[1] CMS maintains a **web page** and a **reporting guide** with general information on Section 111 reporting requirements.

2018 asset allocations in *Fortune* 1000 pension plans

By Mercedes Aguirre and Brendan McFarland

Up until the third quarter of 2018, plan sponsors were in a position to close out the year with improved funding levels due to tailwinds from higher discount rates and — what was until then — decent market returns. Expectations turned south in the fourth quarter when equity markets suffered significant downturns, wiping out the gains from earlier in the year. Nevertheless, the positive effect stemming from higher discount rates helped bring liabilities down, and record levels of employer pension contributions helped sponsors close the year with funding levels almost unchanged. Over the past decade, there have been various swings in funding levels, but plan sponsors have witnessed limited increases in funded status since the global financial crisis. In this context, plan sponsors continue to balance their need for de-risking strategies — both in terms of asset allocation and risk transfer activities — with their need to maintain focus on their growth portfolios in order to gain meaningful returns to cover liabilities and fund further pension risk transfers. Further, achieving fully funded levels is becoming more time-sensitive as funding relief nears an end and Pension Benefit Guaranty Corporation premiums for underfunded plans continue to rise.

The Financial Accounting Standards Board began requiring more detailed pension disclosures in 2009, and Willis Towers Watson has been analyzing asset allocations ever since.[1] These analyses track asset allocation trends and patterns over time in *Fortune* 1000 plans. This 10th edition looks at fiscal year-end 2018 pension allocations by asset class, such as cash, equity, debt and alternatives, as well as by a variety of other attributes of both the assets and the plans.

The analysis is performed on both an aggregate-sponsor (weighted by plan assets) and average-sponsor basis as well as by plan size, plan status (open, frozen or closed) and funded status (defined as the ratio between total fair value of assets over total liabilities, considering both U.S. and non-U.S. plans). We examine the prevalence and amount of pension assets invested in company securities. Finally, we compare asset holdings from 2009 through 2018 for a consistent sample of sponsors, and examine the relationship between risk-reduction strategies and asset allocations.

Over the past nine years, the shift from equities to fixed income investments has been consistent.

Analysis highlights

- There is a clear correlation between a pension plan's status and its portfolio's risk profile, with frozen plans holding more liability-hedging investments compared with closed and open plans. On average, frozen pension plans held almost 60% of their assets in fixed income and cash, versus only 49% for sponsors of open plans.
- Despite the investment market downturn experienced during the fourth quarter, sponsors in this analysis closed the year with an average funding status of 86%, showing a minor increase from 2017 (85%). Two main factors are behind this: From an asset perspective, 2018 was a year of record contributions, while from a liability perspective, rising discount rates helped push liabilities down, counteracting the negative impact of depressing market performance.
- Over the past nine years, the shift from equities to fixed-income investments has been consistent. Since 2009, average allocations to public equities declined by roughly 16 percentage points, while allocations to debt increased by close to the same amount. Sponsors show a gradual search for returns via low equity beta investments, with allocations to alternatives (including hedge funds, private equity and real estate) increasing from 6.6% in 2009 to 8.6% in 2018.
- In 2018, around 8% of *Fortune* 1000 defined benefit (DB) plan sponsors held pension assets in the form of company securities, and among that group, such securities averaged 5.8% of plan assets.

Larger plans allocated more than twice as much as smaller plans to other return-seeking investments (14.1% versus 5.7%), which might reflect larger plans being in a better position to access alternative investment strategies that seek to provide better risk-adjusted returns.

[1] See "2016 Asset allocations in Fortune 1000 pension plans," Willis Towers Watson *Insider*, January 2018.

Figure 1a**. Aggregate asset distribution by class and level, 2018 ($ thousands)**

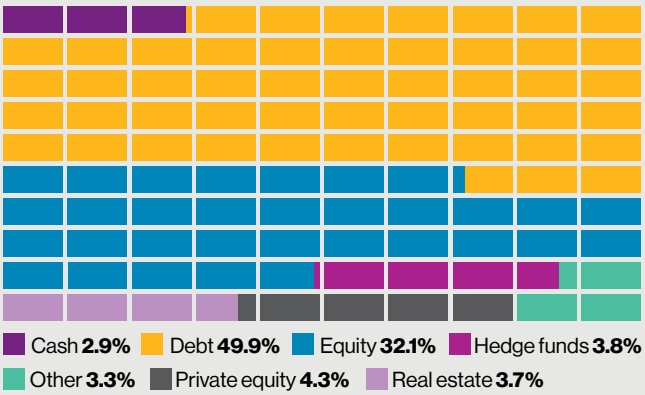
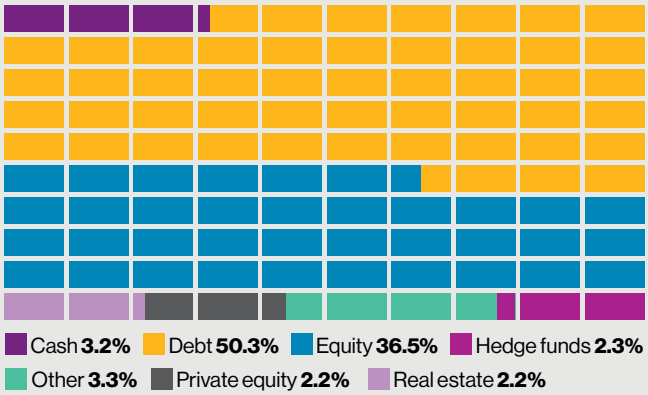


Figure 1b**. Average asset distribution by class and level, 2018 ($ thousands)**



Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.
Source: Willis Towers Watson

2018 aggregate and average asset allocations

Willis Towers Watson's analysis of 2018 fiscal year-end asset allocations takes a detailed look at 472 *Fortune* 1000 plan sponsors' pension disclosures.[2, 3]

Figure 1a summarizes aggregate asset allocations weighted by the value of the sponsor's plan assets and shows total-dollar allocations. As of year-end 2018, the 472 companies in this analysis held more than $1.8 trillion in pension assets, composed of cash, public equity, debt and alternative investments (real estate, private equity, hedge funds and other).

As shown in Figure 1a, at year-end 2018, 32.1% of pension assets were allocated to public equity and 49.9% were allocated to debt, with the remaining assets spread among the other various categories.

Figure 1b depicts average asset allocations (not weighted by plan assets) for the same companies. The average *Fortune* 1000 pension plan sponsor in the analysis held roughly $3.8 billion in assets at year-end 2018.

The average allocation to public equity was 36.5% (versus an aggregate allocation of 32.1%), while the average debt allocation was 50.3%. As for alternative assets — real estate, private equity, hedge funds and other investments — allocations averaged 10%, while aggregate allocations were 15.1%. The difference between the aggregate and average reflects differences in plan size: Larger plans were more likely than smaller plans to invest in alternatives and less likely to invest in public equity.

Asset allocation changes over the year reflected both a continuing effort to de-risk plan assets and poor equity market performance.

Asset allocation changes over the year reflected both a continuing effort to de-risk plan assets and poor equity market performance (as well as a possible failure to rebalance portfolios). During 2018 average public equity holdings declined by roughly 6 percentage points, whereas average debt holdings increased by 5.4 percentage points. In a consistent sample of 421 plan sponsors from 2017 to 2018, equity holdings increased for only 16% of these sponsors and decreased for 83% (Figure 2, next page).

Over 20% of plan sponsors reduced their equity share by more than 10 percentage points (with an average decrease of 20.4%), while only 3.6% increased it by more than 10 percentage points (average increase of 18.1%).

[2] The analysis consists of those *Fortune* 1000 DB plan sponsors that provided comprehensive asset allocation disclosures in their annual reports and that managed assets for domestic pensions.

[3] In previous studies, asset allocation analysis differentiated among the three levels under which fair value of assets is measured. Since the standard of reporting under Net Asset Value (NAV) became available to companies a couple of years ago, sponsors have increasingly been switching their valuation level to NAV (30% of aggregate assets surveyed were reported under NAV); therefore, this approach was discontinued from our analysis.

Figure 2. **Average annual changes in equity and debt allocations, 2018**

Change magnitude	Equity allocations		Debt allocations	
	% of sponsors realizing a change in their equity allocations	Average change realized in equity allocations	% of sponsors realizing a change in their debt allocations	Average change realized in debt allocations
Increase of over 10%	3.6%	18.1%	21.9%	21.3%
5% – 9.9% increase	3.3%	7.4%	13.5%	7.4%
0% – 4.9% increase	9.3%	1.9%	42.3%	2.3%
No change	1.0%	0.0%	0.5%	0%
0% – 4.9% decrease	39.6%	–2.6%	13.8%	–1.8%
5% – 9.9% decrease	22.1%	–7.3%	3.8%	–7.1%
Decrease of over 10%	21.1%	–20.4%	4.2%	–17.2%

Source: Willis Towers Watson

Asset allocations by plan size

Aggregate and average asset allocations for smaller, medium and larger plan sponsors are shown in Figures 3a and 3b. The analysis divides these sponsors into three equal groups by total pension assets: Smaller plan sponsors held less than $526 million, midsize plan sponsors held between $526 million and $2.0 billion, and large plan sponsors held more than $2.0 billion. The largest sponsor held pension assets worth more than $84 billion. Weighting smaller, medium and larger sponsors by plan assets emphasizes the large share of pension assets held by very large plans,[4] as well as the pronounced differences in investing behavior between smaller and larger plans (Figure 3a).

The larger the plan, the lower the allocation to public equity, which averaged 35.1% for large plans versus 39.3% for small plans.

The larger the plan, the lower the allocation to public equity, which averaged 35.1% for large plans versus 39.3% for small plans. This difference is even more striking for aggregate allocations. These results are also consistent with those shown in Figures 1a and 1b, where public equity holdings were lower when assets were weighted by plan size. Overall, larger plans allocated less to public equities and more to other return-seeking investments (real estate, private

[4] The 10 largest plans held 30.5% of all plan assets.

Figure 3a. **Aggregate asset allocations by plan size, 2018**

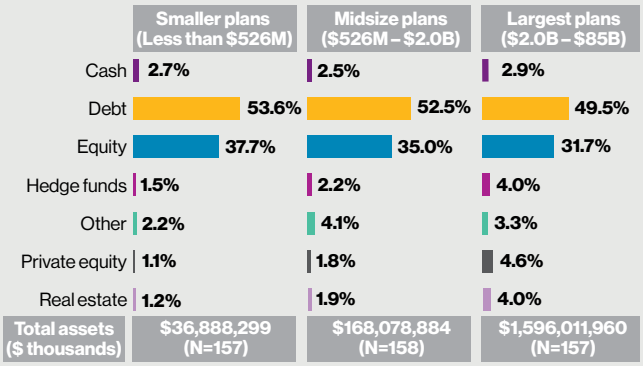
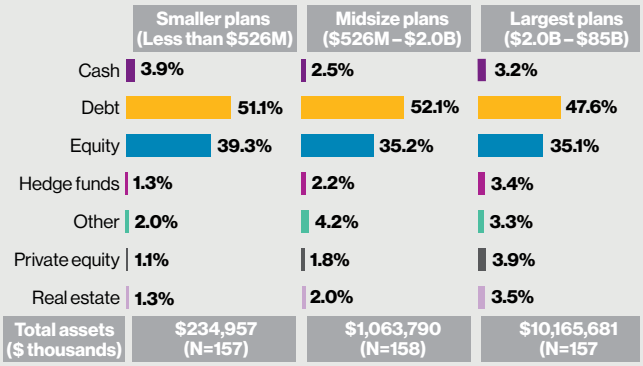


Figure 3b. **Average asset allocations by plan size, 2018**



Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.
Source: Willis Towers Watson

Figure 4a. **Aggregate asset allocations by plan status, 2018**

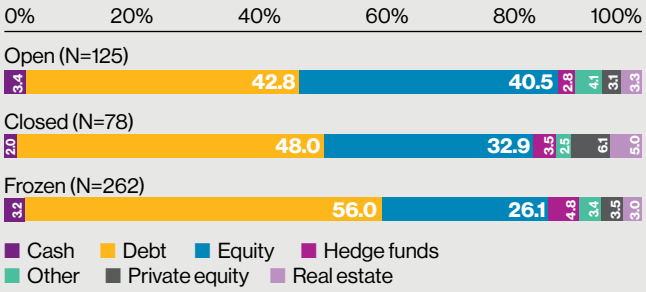
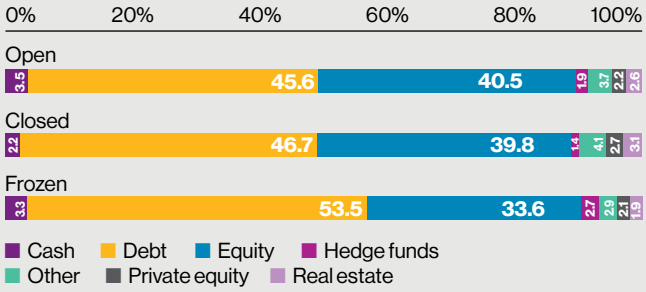


Figure 4b. **Average asset allocations by plan status, 2018**



Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.
Source: Willis Towers Watson

equity and hedge funds). On average, larger plans allocated more than twice as much as smaller plans to other return-seeking investments (14.1% versus 5.7%), which might reflect larger plans' access to economies of scale and in-house investment structures that enable them to effectively manage alternative assets.

Asset allocations by plan status

For this part of the analysis, we divided plan sponsors into three mutually exclusive categories by the current status of their primary pension plan: open, closed to new hires or frozen. Open DB plans are those still offered to newly hired employees, while closed plans stopped being offered to new hires after a fixed date. In frozen plans, accruals by service, pay or both have ceased for plan participants. Roughly three-quarters of the companies in our analysis sponsored either a closed or a frozen pension plan, while the remaining still offered open plans.

Figures 4a and 4b show asset allocations by plan status and demonstrate a relationship between the plan's current status and the portfolio's risk profile, with the correlation strongest on an aggregate basis (Figure 4a). Frozen pensions held more risk-averse investments compared with plans — either open or closed — in which workers were still actively accruing pensions. In aggregate, sponsors of frozen plans held almost 60% of their assets in fixed income and cash, versus only 46.2% for sponsors of open plans.

Unfortunately, during the fourth quarter of 2018 markets took a turn for the worse, wiping out previous gains in funded status.

Asset allocations by funded status

During the beginning of the second half of 2018, plan sponsors witnessed positive market conditions materializing into significant improvements for their pension funding levels. Unfortunately, during the fourth quarter of 2018 markets took a turn for the worse, wiping out previous gains in funded status witnessed just a few months earlier. Nevertheless, sponsors of *Fortune* 1000 DB plans in this analysis closed the year with an average funding status of 86%, showing a minor increase in levels compared with 85% at the end of 2017. While equity markets tanked over the last quarter of 2018, two main factors kept funding levels from witnessing significant declines: 1) record employer contributions showing — in part — sponsors' interest in reaching September's deadline to lock in the 35% corporate tax rate deduction; and 2) rising discount rates, which helped push liabilities down.

Figure 5a**. Average asset allocations by plan funded status, 2018**

	Funded status				
Asset class	Less than 70%	70% to 79%	80% to 89%	90% to 99%	100% or more
Cash	2.5%	3.3%	2.8%	3.3%	3.6%
Debt	43.0%	46.3%	51.0%	54.8%	56.8%
Equity	42.6%	39.3%	34.1%	32.6%	33.4%
Hedge funds	4.0%	2.6%	2.9%	2.2%	0.4%
Other	4.2%	3.6%	3.5%	2.2%	2.0%
Private equity	1.2%	1.9%	3.2%	2.3%	2.3%
Real estate	2.5%	3.0%	2.5%	2.6%	1.5%
Total %	100%	100%	100%	100%	100%
N	45	94	109	91	49

Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.
Source: Willis Towers Watson

Our 2018 analysis shows a correlation between funded status and asset allocations (Figure 5a). As sponsors get closer to full funding levels, their portfolios tend to become more conservative in nature, typically as a result of investment de-risking strategies such as liability-driven investment (LDI) and asset glide paths.[5] This year, average debt holdings surpassed equity investments across all funding levels, evidencing the sponsors' continuous efforts toward de-risking.

While plans tend to become more risk averse as their funded status nears full funding, a closer look also uncovers a further link between debt allocations and benefit accruals.[6] Figure 5b depicts the relationship between higher allocations to debt, and the plan's funded status and benefit accrual rate. Well-funded plans with lower benefit accrual rates are typically associated with higher allocations to fixed-income assets, while higher accrual rates (reflecting active pensions) correspond with higher allocations to return-seeking assets.

[5] LDI strategies typically use fixed-income assets as a hedge against interest-rate-driven movements in plan liabilities. In years when long-term, high-quality corporate bond interest rates decline, with corresponding increases in plan obligations, corporate bonds will produce positive returns and vice versa. In a glide path strategy, future target allocations are based on the plan's funded status, with the sponsor shifting assets from equities to debt as funding levels climb to mitigate risk and volatility.

[6] The accrual rate is the ratio between the pension's service cost and the year-end projected benefit obligation.

Figure 5b**. Allocations to debt by funded status and benefit accrual rates, 2018**

	Funded status									
	Less than 70%		70% to 79%		80% to 89%		90% to 99%		100% or more	
Accrual rate	N	Debt %	N	Debt %	N	Debt %	N	Debt %	N	Debt %
Less than 0.5%	12	34.7%	33	51.2%	43	59.1%	38	61.1%	22	69.3%
0.5% to 0.99%	9	38.0%	14	44.0%	20	48.1%	9	58.7%	9	66.7%
1.0% to 1.9%	11	54.4%	29	46.0%	32	47.0%	31	49.8%	10	44.4%
2.0% to 2.9%	8	40.4%	20	45.5%	18	48.0%	18	45.8%	10	45.6%
3.0% or more	15	45.4%	11	41.2%	17	41.5%	11	46.8%	15	45.8%
N	55		107		130		107		66	

Source: Willis Towers Watson

Figure 5c. **Average asset allocations by annual change in funded status, 2018**

Asset class	Annual change in funded status			
	More than –5%	–5% to 0%	0% to 5%	Greater than 5%
Cash	4.3%	2.6%	3.4%	3.7%
Debt	47.2%	50.3%	50.6%	51.9%
Equity	42.1%	36.1%	34.5%	35.1%
Hedge funds	1.0%	2.2%	3.2%	3.0%
Other	2.0%	3.6%	3.2%	2.1%
Private equity	1.8%	2.4%	2.6%	1.9%
Real estate	1.6%	2.8%	2.5%	2.3%
Average change in funded status	–8.0%	–2.0%	1.9%	12.5%
Return on investments	–6.4%	–5.1%	–3.8%	–3.4%
Employer contributions*	2.9%	2.7%	11.5%	13.2%
N	26	187	111	57

Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.

*Employer contributions are defined as contributions over year-end plan assets.

Source: Willis Towers Watson

Figure 5c illustrates the key role played by both asset allocation and employer contributions in plan funded status by year-end 2018. While those plans avoiding a large deterioration of their funding levels are characterized by holding more than 50% of their investments in fixed-income assets, those that contributed substantial amounts of cash to their pensions were the ones avoiding a drop in their average funding levels. Although investment returns were in the red across the board (Figure 6), those with larger equity positions coupled with relatively low contributions took the greatest hit.

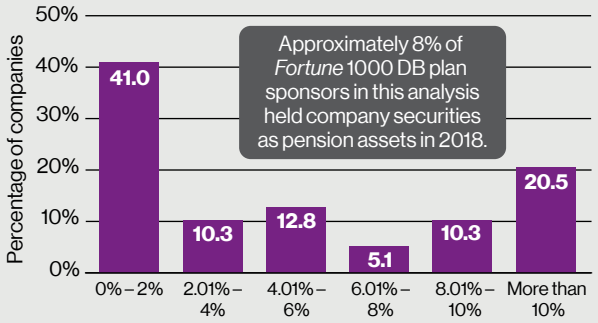
Figure 6. **Investment returns, 2009 – 2018**

Year	Equity index returns*			Bond index returns		
	S&P 500	Russell 2500	MSCI EAFE	Barclays Long Treasury	Barclays Long Credit	Barclays Aggregate
2009	26.5%	34.4%	32.5%	–12.9%	16.8%	5.9%
2010	15.1%	26.7%	8.2%	9.4%	10.7%	6.5%
2011	2.1%	–2.5%	–11.7%	29.9%	17.1%	7.8%
2012	16.0%	17.9%	17.9%	3.6%	12.7%	4.2%
2013	32.4%	36.8%	23.3%	–12.7%	–6.6%	–2.0%
2014	13.7%	7.1%	–4.5%	25.1%	16.4%	6.0%
2015	1.4%	–2.9%	–0.4%	–1.2%	–4.6%	0.5%
2016	11.9%	17.6%	1.5%	1.3%	10.2%	2.7%
2017	21.8%	16.8%	25.6%	8.5%	12.2%	3.5%
2018	–4.4%	–10.0%	–13.4%	–1.9%	–6.8%	0.0%

*Standard and Poor's 500 is an American stock market index based on the market capitalizations of 500 large companies listing common stock on the New York Stock Exchange or NASDAQ. The Russell 2500 is a subset of the Russell 3000® Index, which includes roughly 2,500 of the smallest securities based on a combination of their market cap and current index membership. The MSCI EAFE index measures the equity market performance of developed markets outside the U.S. and Canada.

Source: Bloomberg

Figure 7. **Allocations to company stock, 2018**



Source: Willis Towers Watson

Alternatives seem to have also played a role: Plans that experienced larger decreases in their funding levels held, on average, fewer alternatives. Larger alternative holdings between those experiencing gains or small drops in their funding levels can show the benefits of holding assets with low correlation to equity beta as part of the plan's portfolio.

Pension assets held in company securities

Around 8% of *Fortune* 1000 DB plan sponsors held company securities as pension assets in 2018. These allocations averaged 5.8% of pension assets in 2018 (4.4% when weighted by end-of-year plan assets). The weighted average is lower than the simple average because larger plans allocated lower percentages to company securities than did smaller plans.

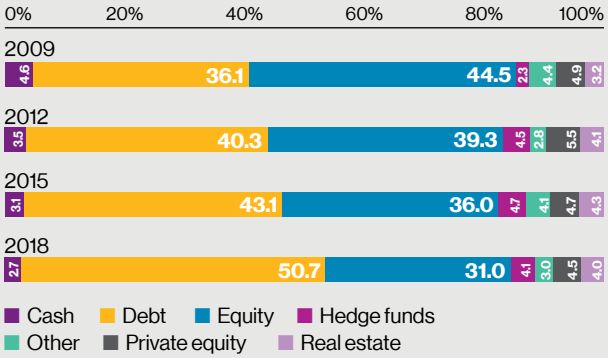
None of the 39 sponsors that held company securities explicitly noted plan contributions in the form of company securities in 2018.

In 2018, company securities constituted 4% or less of pension assets in 51.3% of these plans and made up more than 10% of pension assets in 20.5% of them (Figure 7).[7]

Trends in allocations since 2009

To track asset allocation trends from 2009 to 2018, this part of the analysis is based on a consistent sample of 224 pension sponsors that have been in the *Fortune* 1000 over the past 10 years. Figures 8a and 8b show asset allocations for these companies on an aggregate and average basis for 2009, 2012, 2015 and 2018.

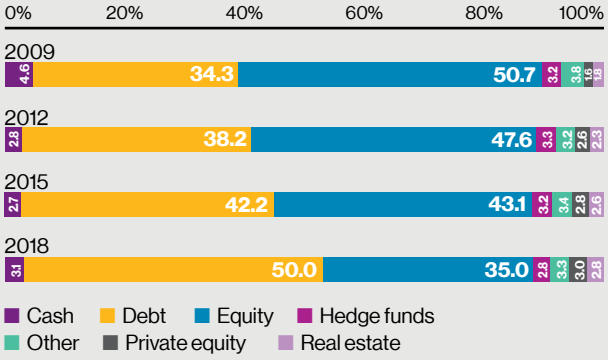
Figure 8a. **Aggregate asset allocations by investment class for consistent sample of *Fortune* 1000 companies (%), 2009, 2012, 2015 and 2018**



Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.

Source: Willis Towers Watson

Figure 8b. **Average asset allocation by investment class for consistent sample of *Fortune* 1000 companies (%), 2009, 2012, 2015 and 2018**



Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.

Source: Willis Towers Watson

Over the period of this analysis, the shift from equities to fixed-income investments has been consistent. Since 2009, average allocations to public equities declined by 15.7 percentage points, while allocations to debt increased by roughly the same amount. Sponsors show a gradual search for return via low equity beta investments, with allocations to alternatives (including hedge funds, private equity and real estate) increasing from 6.6% in 2009 to 8.6% in 2018.

[7] To promote asset diversification, pension law does not allow U.S. DB plans to invest more than 10% of pension assets in company securities.

The total number of sponsors holding private equity and real estate in their alternative assets portfolios has increased from 30.4% and 49.1% in 2009 to 46.9% and 53.6% in 2018, respectively. Not only has the prevalence of companies holding these assets as part of their alternatives portfolio increased, but also the average holdings have ticked up slightly over the same period. Looking only into those plan sponsors with real estate assets in their portfolios, property investments represented an average of 3.6% of total plan assets in 2009 but ticked up slightly to 5.3% in 2018. Similarly, private equity holdings in 2009 averaged 5.3%, while by year-end 2018 the average was 6.3%.

Liability de-risking strategies and asset allocation

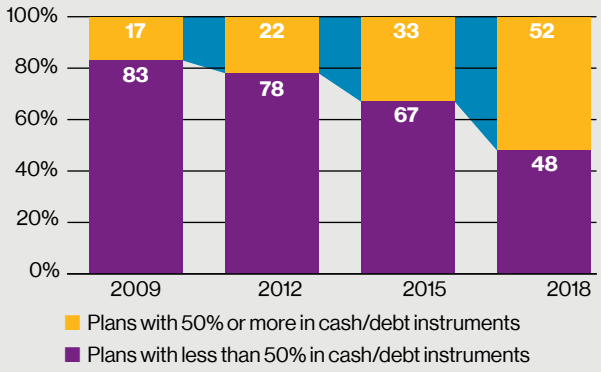
Between 2009 and 2018, among a consistent sample of 224 sponsors, the number of plans whose pensions held 50% or more in cash and fixed-income assets tripled, rising from 17% to 52% (Figure 8c). On average, this group consistently maintained significant amounts of risk-averse investments: 61.9% of cash and debt in 2009, and 67.2% in 2018.

The analysis shows a clear de-risking trend, with plan sponsors focusing more on hedging liabilities and less on higher returns. Many sponsors have also implemented liability-reduction strategies, such as offering lump sum buyouts, purchasing annuities and terminating their plans.

Conclusion

The year 2018 was evidence of the volatile scenarios for which plan sponsors need to prepare. After nine months of promising investment returns that left sponsors with strong expectations of significantly reducing their plans' shortfalls, the fourth quarter's downturn resulted in sponsors barely improving funding, mostly at the cost of employer contributions. In this sense, the role played by investment de-risking strategies such as glide paths or LDI — coupled with large contributions — is particularly noteworthy, where plans with more than 50% of their holdings invested in fixed income assets experienced the lowest funding drops or even showed improvements in their funding when coupled with substantial contributions.

Figure 8c. **Prevalence of companies with more than 50% of pension assets in cash/debt instruments for consistent sample of *Fortune* 1000 companies, 2009, 2012, 2015 and 2018**



Source: Willis Towers Watson

Larger plans seem to be in a better position to access alternative investment strategies that seek to provide better risk-adjusted returns. For larger plans, alternative asset holdings are more than twice those of smaller plans — 14.1% versus 5.7% on average. In terms of plan status, frozen plans displayed conservative portfolios of almost 60% investments in cash and fixed income. Open and closed plans show a slightly less conservative risk profile, with each investing roughly 49% invested in cash and fixed income assets.

Since 2009, plan sponsors have been steadily shifting allocations away from public equities into debt and implementing LDI portfolios as part of a broader risk management strategy, a strategy that is likely to continue — or at least be reinforced — in the future.

For comments or questions, contact Mercedes Aguirre at +598 2 626 2510, mercedes.aguirre@willistowerswatson.com; or Brendan McFarland at +1 703 258 7560, brendan.mcfarland@willistowerswatson.com.

News in Brief

No statute of limitations for ACA employer mandate penalty

By Anu Gogna and Ben Lupin

The IRS released a **Chief Counsel Memorandum** stating there is *no* applicable statute of limitations on an employer shared responsibility payment (ESRP) assessment under Internal Revenue Code section 4980H. Under the Affordable Care Act, certain employers (applicable large employers, or ALEs) must either offer affordable minimum essential coverage that provides minimum value to their full-time employees or potentially make an ESRP to the IRS.

As background, the general IRS statute of limitations on tax return matters is three years from the date of filing or due date, whichever is later; however, in the memo the IRS concludes that there is no statute of limitations for ESRP assessments because no tax return is filed to report an ALE member's liability.

The IRS determines an ALE member's potential liability for the ESRP using the information provided on Forms 1094-C and 1095-C, and Form 1040 filed by full-time employees. Because Forms 1094-C and 1095-C *do not* contain sufficient data to calculate an ALE member's ESRP liability — nor can they be used to determine a full-time employee's eligibility for the premium tax credit — an ALE member cannot know whether an ESRP payment is required. Finally, the IRS states that because Congress did not provide any other limitations period for assessing the ESRP, none would apply.

Employers should review any assessment letters with qualified legal counsel and maintain appropriate records on assessment resolutions. Even if an employer has not yet received an ESRP assessment letter for prior tax years, an assessment is still possible. As the memo does not specify an effective date or compliance deadline, it appears that the guidance is applicable immediately.

News in Brief

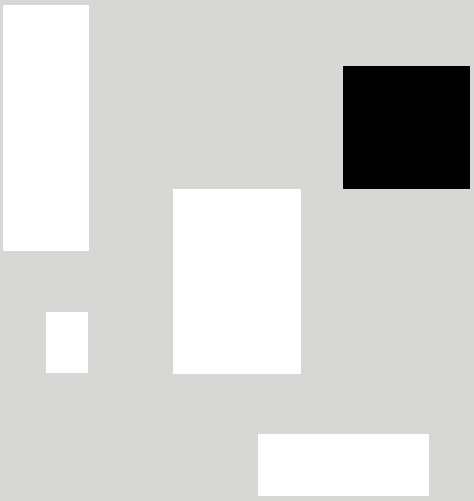
IRS 'no rule' position on VEBA trust reallocation PLRs now official

By Bill Kalten and Kathleen Rosenow

In January, the IRS released its annual list of "no rule" areas in **Revenue Procedure 2020-3**, formally announcing that it has stopped issuing private letter rulings (PLRs) addressing several tax issues associated with the use of surplus voluntary employees' beneficiary association (VEBA) trust assets originally contributed for retiree medical benefits to pay medical benefits for active employees. The revenue procedure is effective immediately and will remain in effect until further notice.

Under the tax code, an employer may prefund certain welfare benefits for employees and/or retirees through a VEBA trust and take a tax deduction for such contributions (up to allowable limits). Often an employer establishes a VEBA trust to prefund retiree medical benefits. A VEBA trust can eventually become overfunded due to increased cost shifting to participants, lower participation, investment performance or changes in plan design. When this happens, to avoid unrelated business income tax (UBIT) and to more effectively and efficiently use the excess assets, the employer may consider transferring some or all of the surplus to a subaccount within the VEBA trust (or to another VEBA trust) to pay for other welfare benefits, such as active employee medical benefits. Pursuing a PLR from the IRS when considering such a transfer became best practice because VEBAs must be qualified as tax-exempt by the IRS, and a change in the stated purpose of the VEBA or change in use of assets contributed for another purpose may affect such qualification.

While the suspension of rulings remains in effect, VEBAs should determine with their legal counsel whether reallocating assets without an IRS PLR is viable, taking into account potential tax risks.



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