2018 Academy Legislative/Regulatory Review

The American Academy of Actuaries presents this summary of select significant regulatory and legislative developments in 2018 at the state, federal, and international levels of interest to the U.S. actuarial profession as a service to its members.

Introduction

Key public policy debates in the Academy’s focus in 2018 included health care reform, pensions and retirement savings issues, the National Flood Insurance Program (NFIP), and the structure and scope of financial services and insurance regulatory bodies, among other topics.

The NFIP, funding for the Children’s Health Insurance Program (CHIP), and multiemployer pension reform were key issues for lawmakers in the U.S. House of Representatives and the U.S. Senate in 2018. Federal agencies were also active in responding to executive orders from President Trump by proposing and implementing regulations focused on health insurance and retirement plans, including expanding access to multiple employer retirement plans and short-term, limited duration health insurance plans, association health plans, and health reimbursement arrangements. In addition, federal courts were also active in considering challenges to the Affordable Care Act (ACA) and Medicaid work requirements.

Many of the issues the Academy worked on in 2018 will carry into 2019 including health care reform, changes to public programs such as Social Security, Medicare, and Medicaid; and consideration of certain federal legislation and regulation of the financial and insurance markets, among others. As the beginning of this 116th Congress, legislation to address health care coverage and retirement security may receive significant attention from the Democrat-led House of Representatives and the Republican-led Senate. Lawmakers may also take up reauthorization of the NFIP, which is scheduled to expire on May 31, 2019, following several short-term extensions passed in 2018.

In 2019, the Academy will continue to comment and engage on key issues with policymakers, including the Trump administration, Congress, state insurance commissioners, state regulators and legislators, and national and international standards setters.
Practice Area Issues

Casualty Practice Issues

Crop Insurance
The president signed a bill into law (PL 115-334) on Dec. 20 reauthorizing agriculture and nutrition programs, including changes to the federal crop insurance program. Notable provisions in the legislation include removing hemp from being designated as a controlled substance, thereby allowing hemp farmers to apply for crop insurance, and clarifying the definition of cover crop termination to ensure that farmers who use cover crops (plants that are used for conservation purposes such as to slow erosion, improve soil health, enhance water availability, smother weeds, help control pests and diseases, increase biodiversity) do not risk losing their crop insurance. In addition, the legislation: expands insurance coverage to new crops, including certain fruits, vegetables, hops, and barley; improves access to crop insurance for veterans, beginning farmers, and fruit and vegetable growers; and increases disaster assistance coverage options for crops that are not eligible for insurance.

The Congressional Budget Office (CBO) cost estimate for the bill projects a reduction in direct spending for crop insurance over the 10-year budget window to be just over $100 million. In addition, CBO released a report, Options for Reducing the Deficit: 2019 to 2028, on Dec. 13 providing cost estimates for a range of additional public policy proposals that would decrease federal spending or increase revenues over the next decade. Crop insurance provisions considered in the report included: reducing the federal subsidy for crop insurance premiums; limiting reimbursement to crop insurance companies for administrative expenses; and limiting the rate of return on investment for crop insurance companies.

National Flood Insurance Program (NFIP)
The NFIP received several short-term reauthorizations over the course of the year, with the latest extending the program until through May 31, 2019. The straight reauthorizations passed by Congress throughout 2018 did not include provisions to significantly revise the NFIP.

Congress passed a bill on Dec. 19 directing the U.S. Fish and Wildlife Service to update existing coastal barrier maps across the country under the Coastal Barrier Resources Act with more accurate, digitized maps created under the Digital Mapping Pilot Program. Under the legislation, properties identified by these updated maps will be ineligible to participate in any federally subsidized program, including participation in the NFIP. Conversely, properties on previous, non-digital versions of these maps that are not on the updated maps will become eligible for federal subsidies. An estimate by CBO in July found that the legislation could increase NFIP premium collections by under $1 million annually; however, the new revenue would be offset by new mandatory spending for underwriting, administrative expenses, and new flood insurance claims over the next decade. The bill was signed into law by the president on Dec. 21.

CBO released a report, Options for Reducing the Deficit: 2019 to 2028, on Dec. 13 providing cost estimates for a range of public policy proposals that would decrease federal spending or increase flood insurance revenues over the next decade. Flood insurance provisions considered in the report included: eliminating discounted rates for households that bought insurance through
the NFIP for properties constructed before their community’s first flood insurance rate map was created; eliminating annual surcharges for primary residences and other properties; and increasing the NFIP’s reserve fund assessment.

Health Practice Issues

Affordable Care Act (ACA)
The ACA faced several changes and challenges from the U.S. Congress, the administration, and U.S. Courts throughout 2018. Key developments included:

Challenges to the ACA

- A federal judge for the U.S. District Court for the Northern District of Texas issued a decision in Texas v. Azar on Dec. 14 declaring the law’s individual mandate for health insurance coverage to be unconstitutional and, further, inseverable from the rest of the ACA, thus declaring the entire law invalid. The court issued a stay of the ruling on Dec. 30 allowing the ACA to remain in effect pending an expected appeal to the U.S. Fifth Circuit Court of Appeals.

The Dec. 14 decision addressed a lawsuit filed in February by 20 state attorneys general alleging that the individual mandate was no longer constitutional following the reduction of its tax penalty to $0, beginning in 2019, under the December 2017 enactment of the Tax Cuts and Jobs Act. The U.S. Department of Justice (DOJ) announced on June 8 that it would not defend the ACA against the lawsuit. In its filing, DOJ argued that the individual mandate, guaranteed-issue, and community-rating provisions are inseverable from one another, but should be severed from the rest of the ACA provisions, such as the law’s premium subsidies, Medicare provisions, and Medicaid expansion, which should remain in place.

- A tax bill passed by the U.S. House of Representatives, by a vote of 220-183, on Dec. 21 included provisions affecting taxes established under the ACA, including: extending the suspension of an annual fee on health insurance providers until Dec. 31, 2021; delaying the excise tax on high-cost, employer-sponsored health insurance plans through 2022; and delaying the medical device excise tax through 2024. The bill did not reach a vote by the U.S. Senate before the end of the 115th Congress.

- The U.S. House of Representatives passed H.R. 6311 on July 25 by a vote of 242-176. The legislation would have removed age and hardship requirements for purchasing catastrophic plans with lower premiums (known as copper plans) through the individual market and would have allowed individuals in bronze and copper plans, as well as working seniors with high-deductible plans enrolled in Medicare Part A, to contribute to a Health Savings Account (HSA). The bill would have also extended the suspension of the ACA’s annual tax on health insurers through 2021. The bill did not reach a vote by the U.S. Senate before the end of the 115th Congress.

- The U.S. House of Representatives passed H.R. 6199 on July 25 by a vote of 277-142. The bill would have made several changes to HSAs, including: allowing plans to pay for certain medical services before the plan's deductible takes effect; allowing individuals with other types of health care coverage to have an HSA in addition to a high-deductible plan; and allowing individuals to use HSAs to pay for over-the-counter medical products...
and some fitness expenses. The bill did not reach a vote by the U.S. Senate before the end of the 115th Congress.

- The U.S. House of Representatives passed H.R.184 on July 24 with a vote of 283-132, which would have permanently repealed the ACA’s 2.3 percent excise tax on sales of medical devices, effective Jan. 1, 2020. The bill did not reach a vote by the U.S. Senate before the end of the 115th Congress.

- A three-judge panel at the U.S. Court of Appeals for the Federal Circuit ruled on June 14 that the federal government is not required to provide payments that were promised under the risk corridors program established by the ACA to two insurers that were participating in the marketplace. Two of the three judges on the panel found that the federal government does not owe the two insurers the money under the risk corridors program because the insurers’ agreements with the U.S. Department of Health and Human Services (HHS) did not sufficiently constitute contractual agreements.

- The president signed an appropriations bill into law (PL 115-120) on Jan. 22 that included a delay in the implementation of three taxes established by the ACA. The legislation delayed the 2.3 percent excise tax on medical devices through 2019, and the excise tax on high-cost employer-sponsored health care plans (known as the Cadillac tax) through 2021. A third tax, an annual fee on health insurance providers, was suspended through 2019.

**Regulatory Activities**

- The Centers for Medicare & Medicaid Services (CMS) announced on Dec. 19 that 8.5 million Americans enrolled in health care coverage for 2019 through the federal health insurance exchange established by the ACA. This marks a slight decline from the 2018 enrollment numbers, when 8.8 million Americans enrolled for health care coverage through the federal exchange, and a 15.4% decline of new consumers. CMS expects to release final estimates of health insurance enrollment in all 50 states and the District of Columbia in March 2019.

- CMS issued a final rule on Dec. 10 regarding the methodology for the risk-adjustment program operated by the HHS for the 2018 benefit year. The finalized rule followed a Feb. 28 decision by the U.S. District Court for the District of New Mexico, which found that “HHS’ use of statewide average premiums in its risk adjustment methodology is not contrary to law, but is arbitrary and capricious,” and vacated HHS’ rules for assessing payments to insurers under the risk adjustment program. According to CMS, the final rule reissued the risk-adjustment methodology established for the 2018 benefit year with additional explanation and allows CMS to continue normal operations of the risk-adjustment program, which it temporarily suspended on July 7-24. The litigation under which the program’s original rules were vacated is still ongoing.

A summary of comments on its proposed rulemaking provided by CMS in the final rule referenced a comment citing an April 2016 Academy Risk Sharing Subcommittee issue paper, *Insights on the ACA’s Risk Adjustment Program*.

- CMS released a discussion paper on Nov. 29 providing four concepts intended to be used by states to provide flexibility when designing their health insurance markets. The discussion paper followed guidance released by HHS, CMS and the U.S. Department of the Treasury on Oct. 22 that relaxes several requirements of states for waivers issued
under Section 1332 of the ACA while still ensuring the guardrails are in place (comprehensiveness, affordability, coverage, and federal deficit neutrality). According to CMS, these waiver concepts are intended “to serve as a springboard for innovative ideas that may improve the health care markets in individual states.”

- CMS’ Center for Consumer Information & Insurance Oversight (CCIIO) on Oct. 26 released public use data on health insurance exchanges and rates for 2019. The data included health insurance exchange public use files and rate review data.

- HHS released a research brief, 2019 Health Plan Choice and Premiums in Healthcare.gov States, on Oct. 26 providing information on qualified health plans (QHPs) in states using the federal individual insurance enrollment platform (HealthCare.gov). The brief includes estimates for issuer participation, consumer options, average premiums, and subsidies in the upcoming open enrollment period.

- CMS released a statement on July 10 announcing that it would reduce funding for the Federally-facilitated Exchange (FFE) Navigator Program, from $36 million in federal grants for the 2018 open enrollment period, to $10 million for the 2019 enrollment period. The agency also encouraged navigators to provide information about plans that originally did not meet the requirements for sale on the individual health insurance exchanges under the ACA, including association health plans, short-term, limited-duration insurance, and health reimbursement arrangements. This was the second year that CMS significantly reduced funding for the program, following a 41 percent reduction in August 2017.

- CMS and HHS issued the final rule for HHS’ Notice of Benefit and Payment Parameters for 2019 on April 9. According to the CMS fact sheet, the final rule:
  - Allows states to choose how they select their essential health benefits (EHB)-benchmark plan;
  - Eliminates the meaningful difference requirement for QHPs for insurers;
  - Amends the federally operated risk adjustment data validation program to reduce burdens on issuers;
  - Increases checks on validity before issuing advanced premium tax credits (APTC);
  - Amends medical loss ratio (MLR) requirements by reducing reporting requirements, and;
  - Increases the role of state regulators in the rate review process by increasing the threshold for review of reasonableness from 10 percent to 15 percent.

**Association Health Plans (AHPs)**
The U.S. Department of Labor (DOL) released a final rule on June 19 broadening the scope and availability of AHPs on a staggered basis. Beginning Sept 1, 2018, a fully-insured AHP may be formed by any association; on January 1, 2019, existing associations with an AHP may establish a self-funded AHP; and on April 1, 2019, all other associations may establish self-funded AHPs. States will continue to have regulatory authority over self-insured AHPs, and will share enforcement authority with the federal government.

Eleven states and the District of Columbia filed a lawsuit against the final rule on July 26 arguing that the DOL violated the Administrative Procedures Act by redefining the term “employer” in a manner conflicting with the ACA and the Employee Retirement Income.
Security Act (ERISA). In their filing, the states cited comment letters on the proposed rule, including a March 5 letter from the Academy’s Individual and Small Group Markets Committee addressing policy implications and concerns over the potential effects of broadened AHP eligibility on the stability and sustainability of the existing ACA-compliant individual and small group markets.

**Children’s Health Insurance Program (CHIP)**
The president signed an appropriations bill into law (PL 115-120) on Jan. 22 that included a six-year extension of CHIP, following $2.8 billion in stopgap funding approved on Dec. 22, 2017. An omnibus bill signed into law (PL 115-123) by the president on Feb. 9 further extended the program for an additional four years, through 2027.

CBO reported on Jan. 11 that extending CHIP through 2027 would decrease federal deficits by an estimated $6 billion—in contrast with previous estimates that extending the program would increase the deficit. In particular, CBO noted that a longer-term extension of CHIP would result in net savings to the federal government due to the higher federal costs of providing alternatives to the program, such as the individual marketplace, Medicaid, and employer-sponsored insurance.

**Health Care Costs**
The CMS Office of the Actuary on Dec. 6 released official estimates of total health care spending in the U.S. for 2017. According to the study, in 2017:

- Health care spending in the United States grew at a rate of 3.9 percent to $3.5 trillion, or $10,739 per person.
- The growth in health care spending slowed for the second consecutive year (following increases of 4.8 percent in 2016 and 5.8 percent in 2015) after expanded insurance coverage and increased spending on prescription drugs contributed to elevated rates of growth in 2014 and 2015.
- The low rate of growth in spending was similar to the average annual rate of 3.9 percent from 2008–2013, which predated the expansion of health care coverage under the ACA. The share of gross domestic product represented by health care spending stabilized at 17.9 percent (compared to 18 percent for 2016); the first year since 2013 that this share did not increase.

HHS released a “blueprint, American Patients First, in May addressing reducing costs for health care and prescription drugs. The blueprint identifies major challenges affecting health care costs, and provides policy proposals to address these challenges.

**Health Reimbursement Arrangements (HRAs)**
The U.S. Departments of the Treasury, HHS, and DOL released a proposed rule on Oct. 23 aimed at expanding HRAs. The proposed rule would:

- Allow employees of large businesses to use funds from HRAs to pay for individual health insurance plans, which is prohibited under existing regulations;
- Allow employers that offer traditional group coverage to provide HRAs of up to $1,800 annually; and
• Provide safeguards requiring employers to offer the same type of coverage (either an HRA or a traditional group plan) to all workers within the same class (such as seasonal or part-time workers), as well as a disclosure provision intended to ensure that employees understand the benefits they are receiving.

The Academy’s Health Practice Employee Benefits Committee and Individual and Small Group Market Committee submitted comments on the proposed rule in December.

**Medicaid**

CBO released a report, *Options for Reducing the Deficit: 2019 to 2028*, on Dec. 13 providing cost estimates for a range of public policy proposals that would decrease federal spending or increase revenues over the next decade. Medicaid provisions considered in the report included: establishing a cap on per-enrollee Medicaid spending; limiting state taxes on health care providers (through reduction in safe harbor thresholds); and reducing federal matching rates to state Medicaid programs.

CMS reapproved a Section 1115 Medicaid waiver request from Kentucky on Nov. 20. The waiver, which was originally approved by CMS in January, was vacated by the U.S. District Court for the District of Columbia in June in response to a lawsuit filed by certain Kentucky Medicaid enrollees. Following the court’s ruling, CMS exposed the waiver’s provisions for a new public comment period. The re-approved waiver includes requirements for work or community activities as a condition of Medicaid eligibility.

CMS released a proposed rule on Nov. 8 that would affect the Medicaid and CHIP managed care programs. The proposed rule makes changes to standards for provider network adequacy, requirements for states’ alternative managed care quality rating systems, capitation rates, fee schedules, and payment models.

Measures on expanded eligibility criteria in state Medicaid programs were on the November ballot in several states during the 2018 elections: Voters in Idaho, Nebraska, and Utah approved ballot initiatives to expand Medicaid eligibility. A similar ballot initiative was rejected in Montana that would have extended the state’s Medicaid expansion, funded in part by increased tobacco product taxes. Montana’s current Medicaid expansion is set to expire in 2019.

The CMS Office of the Actuary released a report, *2017 Actuarial Report on the Financial Outlook for Medicaid*, on Sept. 20, providing projections of expenditures and enrollment. According to the report, Medicaid expenditures were projected to increase at an average annual rate of 5.7 percent and to reach $1,005.7 billion by 2026, or from 3.1 percent of GDP in 2016 to 3.7 percent of GDP in 2026. Medicaid enrollment was projected to increase at an average annual rate of 1.3 percent over the next 10 years, reaching 82.3 million in 2026.

The CMS sent a letter to state Medicaid directors on Jan. 11 announcing a new policy to allow state efforts to include work requirements for participation in “work or community engagement activities (e.g., skills training, education, job search, caregiving, volunteer service)” as a condition of Medicaid eligibility for adults who are not elderly, pregnant, or who qualify on the basis of a disability.
**Medicare**

CBO released a report, *Options for Reducing the Deficit: 2019 to 2028*, on Dec. 13 providing cost estimates for a range of public policy proposals that would decrease federal spending for Medicare or increase revenues over the next decade. Medicare provisions considered in the report included: changing Medicare cost-sharing rates and restricting coverage through Medigap insurance plans; increasing premiums for Medicare Parts B and D; raising the Medicare eligibility age to 67; reducing Medicare coverage of uncollected out-of-pocket costs (known as bad debt); requiring manufacturers to pay rebates to the Medicare Part D program for brand-name drugs sold to low-income subsidy enrollees; reducing payments to Medicare Advantage (MA) plans for health risk; reducing quality bonus payments to MA plans; and increasing the payroll tax rate for Medicare Part A.

The Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds Board of Trustees issued the *2018 Medicare trustees’ report* on June 5. According to the report, Medicare’s Hospital Insurance (HI) trust fund will have sufficient funds to cover its obligations until 2026, three years sooner than projected in the 2017 report, with dedicated revenues covering 91 percent of HI costs in 2026. In addition, the projected HI deficit over the next 75 years is 0.82 percent of taxable payroll, an increase from 0.64 percent in 2016. The Supplementary Medical Insurance (SMI) trust fund is expected to remain solvent indefinitely, and SMI spending is expected to grow from 2.1 percent of gross domestic product (GDP) in 2017 to 3.7 percent of GDP over the next 25 years, and then more slowly to 3.9 percent of GDP by 2092.

An omnibus bill signed into law (PL 115-123) by the president on Feb. 9 included several Medicare provisions: a provision to close the Medicare Part D coverage gap (known as the donut hole); a repeal of the Medicare Independent Payment Advisory Board (IPAB); and inclusion of the *CHRONIC Care Act*, which would make the MA Special Needs Plan (SNP) program permanent, and would expand the range of extra benefits that MA plans are allowed to offer chronically ill beneficiaries.

**Short-Term, Limited-Duration Insurance (STLDI) Plans**

The U.S. Departments of the Treasury, HHS and Labor issued a final rule on Aug. 1 aimed at expanding coverage under health STLDI plans. The rule expands restrictions on coverage under STLDI to a period of 364 days, and allows plans to be extended for insureds up to a maximum period of 36 months. STLDI are likely to contribute to premium increases in Affordable Care Act (ACA) individual markets, while creating new insurance options for some consumers that provide fewer benefits at lower premiums than ACA-compliant plans. The Academy’s Individual and Small Group Markets Committee submitted a comment letter on the proposed rule to HHS in April and highlighted the potential implications of expanding STLDI.
Life Practice Issues

National Association of Insurance Commissioners (NAIC)
The NAIC’s Variable Annuities Issues (E) Working Group (VAIWG) voted on and passed a new framework on July 31 dealing with statutory reserves and risk-based capital requirements for all variable annuities. The Academy’s AG43/C3 Phase II Work Group provided comments throughout the development, including expressing concerns over the process by which the framework was developed. Currently, the NAIC is now working on the implementation details and timing of the new requirements.

Principle-Based Reserving (PBR)
With legislation enacted in Alaska and New York in 2018, (as well as a bill enacted in Massachusetts on Jan. 2, 2019), all 50 states have adopted a new Standard Valuation Law to enact PBR.

The NAIC completed a comprehensive review of the PBR reports filed by insurers in 2017, and, in October, released a review report containing findings and observations as well as considerations to improve the readability of PBR reports and interpret results. These proposals will take the form of valuation manual amendments, expected to be discussed by the Life Actuarial (A) Task Force (LATF) in 2019.

Tax Reform
State regulators reviewed the December 2017 Tax Cuts and Jobs Act (TCJA) and its impact on insurers' financial statements. In addition to a decrease in the corporate income tax rate from 35 percent to 21 percent, the TCJA affects the calculation of tax reserves, the deferred tax asset, and the Life Risk-Based Capital (LRBC) calculation. Since the LRBC calculation is a post-tax calculation, the TCJA could trigger regulatory action that would not have otherwise been triggered under the tax code. Changes were made to the LRBC calculation, effective Dec. 31, to reduce the impact of unintended consequences on an insurer's solvency position as a result of the TCJA's passage.

Pension Practice Issues

Defined Benefit (DB) and Defined Contribution (DC) Plans
The Internal Revenue Service (IRS) issued Notice 2018-69 on Aug. 24 extending through 2019 the temporary nondiscrimination relief for closed defined benefit plans provided in Notice 2014-5, 2014-2 I.R.B. 276. This notice furthered a previous extension announced in Sept. 2017. The remaining provisions of the nondiscrimination regulations under Sec. 401(a)(4) will continue to apply.

Multiemployer Plans
An omnibus bill signed into law (PL 115-123) by the president on Feb. 9 included a provision establishing a joint select congressional committee to “provide recommendations and legislative language that will significantly improve the solvency of multiemployer pension plans and the Pension Benefit Guaranty Corporation.” The committee was given until Nov. 30 to publish a report of its findings and proposed legislative reforms. It was announced on Nov. 29 that the
committee was unable to reach a bipartisan agreement to address the multiemployer pension crisis. The committee’s co-chairs, Sen. Orrin Hatch (R-Utah) and Sen. Sherrod Brown (D-Ohio), said that the committee had made “significant progress” and that they believe a bipartisan consensus is possible; however, more time was needed. In addition, they stated that the committee would continue its work beyond the Nov. 30 deadline.

Ted Goldman, the Academy’s Senior Pension fellow, testified before the congressional Joint Select Committee on Solvency of Multiemployer Pension Plans at an April 18 hearing on “The History and Structure of the Multiemployer Pension System.” Subsequently, responses were provided to questions submitted by Joint Committee members and a comment letter was submitted by the Pension Practice Council on options under consideration by the Joint Committee. In May, the Multiemployer Plans Committee released an issue brief on the costs and risks associated with multiemployer loan programs, and the ways in which these programs could benefit troubled plans and their participants.

**Pension Benefit Guaranty Corporation (PBGC)**

The PBGC released its Fiscal Year (FY) 2018 Annual Report on Nov. 15, reporting that the multiemployer program deficit decreased to $53.9 billion, from $65 billion in FY 2017, while the single-employer program deficit of $10.9 billion in 2017 was eliminated, leaving the program with a surplus of $2.4 billion. According to the report, PBGC assumed responsibility for benefit payments for an additional 28,000 people in 58 trusted single-employer plans in FY 2018, and paid $5.8 billion in benefits to over 861,000 retirees from 4,919 failed single-employer pension plans. The report also notes that the agency provided $153 million in financial assistance to 81 insolvent multiemployer plans, an increase from $141 million paid to 72 plans in FY 2017.

The PBGC published a notice on April 4 regarding multiemployer plan alternative payment rules for satisfying employer withdrawal liability. The policy statement is intended to apply to multiemployer plans that request the PBGC’s review of such alternative proposals, and provides an explanation of PBGC’s review process, required information, and the factors considered when reviewing proposals.

**Retirement Security and Lifetime Income**

Legislation (Retirement, Savings, and Other Tax Relief Act of 2018 and the Taxpayer First Act of 2018) passed by the U.S. House of Representatives, by a vote of 220-183, on Dec. 21 included provisions affecting retirement security. The bill did not reach a vote in the Senate before the end of the 115th Congress. Retirement-related provisions in the legislation would have provided for:

- Eliminating a prohibition against contributing to individual retirement accounts (IRAs) for individuals above the age of 70 ½ (the requirement that IRAs must begin distributing benefits for such individuals would be maintained).
- Allowing individuals to make penalty-free withdrawals from retirement plans in the event of the birth or adoption of a child.
- Eliminating a requirement that employers must have some relation to each other in order to participate in a pooled provider plan.
- Permitting employers to allow current employees with defined contribution accounts invested in annuities to choose to keep such investments by rolling the annuity into an IRA if the annuity is discontinued as an investment option.
- Increasing the 10 percent cap on allowable automatic escalation of employee deferrals in automatic enrollment safe harbor plans to a 15-percent cap of employee pay.
- Increasing the small employer retirement plan start-up tax credit by $500 per year for employers that create new section 401(k) plans and SIMPLE IRA plans that include automatic enrollment features, or those that add automatic enrollment features to an existing plan.
- Exempting individuals with total defined contribution or IRA account balances of $50,000 or less from required minimum distribution rules.
- Allowing expanded cross-testing between an employer’s defined benefit plans and defined contribution plans for purposes of the nondiscrimination rules.
- Providing a safe harbor to fiduciaries for satisfying the prudence requirement with respect to the selection of insurers for a guaranteed retirement income contract. In addition, protecting fiduciaries from liability for any losses that may result to the participant or beneficiary due to an insurer’s inability in the future to satisfy its financial obligations under the terms of the contract, provided that the fiduciary obtains certain written representations from the insurer.
- Requiring employers sponsoring defined contribution plans to provide a lifetime income disclosure to each plan participant (in a manner to be specified by DOL) with information about the lifetime income stream equivalent of the participant’s total account balance if the participant were to purchase an annuity.

President Trump signed an executive order on Aug. 31 aimed at reducing regulatory burdens for employer-sponsored retirement plans and expanding access to retirement plans for employees of small businesses. The order directs DOL and the U.S. Department of the Treasury to take steps to expand access to multiple employer plans (MEPs); to improve the effectiveness of required notices and disclosures, and reduce their costs to employers; and to update life expectancy and distribution period tables for the purposes of required minimum distribution rules. Many of these issues and provisions from the retirement legislation were discussed at a Capitol Hill briefing on the topic of lifetime income held in April and Pension Forum held at the National Press Club on modernizing the pension system.

**Social Security Solvency**

CBO released a report, Options for Reducing the Deficit: 2019 to 2028, on Dec. 13 providing cost estimates for a range of public policy proposals that would reduce Social Security benefits or increase revenues over the next decade. Social Security provisions considered in the report included: increasing the full retirement age for Social Security to 70; linking initial Social Security benefits to average prices instead of average earnings; making the Social Security benefit structure more progressive; eliminating eligibility for starting Social Security Disability benefits after age 62; using the chained consumer price index to index cost-of-living adjustments on Social Security benefits; taxing Social Security benefits in the same way that distributions from defined benefit plans are taxed; increasing the payroll tax rate for Social Security contributions; increasing the cap on earnings subject to Social Security payroll taxes; and extending Social Security coverage to newly-hired state and local government employees.

The Social Security Board of Trustees issued the 2018 Social Security trustees’ report on June 5. According to the report, the combined retirement program (Old-Age and Survivors Insurance...
(OASI)) and disability program (Disability Insurance (DI)) of Social Security have sufficient resources to fully cover benefits until 2034, following which annual revenues will be sufficient to fund about three-quarters of scheduled benefits. Social Security’s reserves, along with projected program income, are estimated to exceed its total cost over the next decade; however, the Social Security DI trust fund will exhaust its reserves in 2032. The 75-year actuarial deficit for the combined OASDI trust funds is estimated at 2.84 percent of taxable payroll, up from 2.83 percent from the previous year.

Risk Management and Financial Reporting Issues

Accounting Standards
The International Accounting Standards Board (IASB) announced on Nov. 14 that it voted to propose a one-year deferral of the effective date for Insurance Financial Reporting Standard (IFRS) 17 Insurance Contracts. The new effective date will now be January 1, 2022. The IASB also decided to propose extending to 2022 the temporary exemption for insurers to apply the financial instruments standard, IFRS 9, so that both IFRS 9 and IFRS 17 can be applied at the same time. A public consultation on the proposed deferral is expected in 2019, before a final decision is made. The Academy’s Risk Management and Financial Reporting Council sponsored a highly successful webinar in August on implementation of IFRS 17 for long duration contracts.

Federal Insurance Office (FIO)
FIO Director Steve Dreyer left office on Nov. 16, following his appointment to the position in June. FIO Deputy Director Steven Seitz is serving as acting director until a new director is appointed.

The U.S. House of Representatives passed a bill by a voice vote on July 10 that would place restrictions on international insurance agreements made by the federal government. The legislation did not reach a vote in the U.S. Senate before the close of the 115th Congress. H.R.4537, the International Insurance Standards Act of 2018, would have:
- Prohibited representatives of the federal government from entering into an international insurance agreement that conflicts with federal and state laws;
- Required parties representing the U.S. federal government in an international insurance agreement to coordinate with state regulators;
- Required that any covered international agreement made by FIO apply only on a prospective basis; and
- Given the U.S. Congress the power to review and disapprove, by joint resolution, any covered agreement.

Financial Stability Oversight Council (FSOC)
FSOC published its 2018 Annual Report on Dec. 19, providing an overview of FSOC’s activities, as well as significant financial markets and financial regulatory developments over the past year, including insurance and accounting regulations and standards, along with an assessment of those developments on the stability of the financial system. The 2018 report emphasized that addressing regulatory burdens should be a major focus of the Council, and stated that “the Council notes the potential for an increasing federal government debt burden to negatively impact long-term financial stability.” Other aspects of the report include:
• A finding that risks to overall U.S. financial stability remain moderate, while financial stability risks outside of the U.S. are appearing to increase;
• A recommendation that agencies continue to monitor levels of nonfinancial business leverage, trends in asset valuations, and potential implications for the entities they regulate in order to assess and reinforce their ability to manage severe, simultaneous losses in those markets;
• A recommendation that member agencies work closely with market participants to identify and mitigate risks from potential dislocations during the process of transitioning to a new alternative reference rate; and
• A recommendation that member agencies ensure a robust and consistent standard of cybersecurity monitoring and examinations of financial markets, institutions, and infrastructures.

The U.S. Senate confirmed Thomas E. Workman as the independent member with insurance expertise on FSOC by a voice vote on March 21. Workman, who will serve a six-year term, is the second person to serve in the role of voting member with insurance expertise since FSOC was established under the 2010 Dodd–Frank Wall Street Reform and Consumer Protection Act. He was nominated to the position late last year by President Trump.

Insurance Industry
The U.S. House of Representatives passed a bill by a voice vote on Sept. 12. The bill did not reach a vote in the U.S. Senate before the close of the 115th Congress. The bill would have relaxed supervision of certain insurance companies by the Board of Governors of the Federal Reserve System (the Federal Reserve). The legislation would have established a new category of insurance savings and loan holding companies exempt from Federal Reserve reporting requirements, consisting of savings and loan companies that have an insurer as their top tier holding company, or companies that hold at least 75 percent of their assets in insurance subsidies.

The president signed a bill into law (PL 115-174) on May 24 loosening regulations on banks and rolling back parts of the 2010 Dodd-Frank Wall Street Reform and Consumer Protection Act. The legislation establishes an insurance policy advisory committee on international capital standards and other insurance issues at the Board of Governors of the Federal Reserve System. The committee is required to issue annual reports and testimony on the regulation and supervision of insurance globally. In addition, the bill requires the Secretary of the Treasury, the Chairman of the Federal Reserve Board, and the Director of FIO to issue a joint report on the potential effects of international insurance proposals on U.S. consumers and markets before such proposals are agreed to. The Academy’s Financial Regulatory Task Force sent a letter to U.S. Senate leadership on Jan. 17 providing comments on the proposed insurance language in the bill, and a similar letter to members of the House of Representatives on May 21.

International Monetary Fund (IMF)
The International Monetary Fund (IMF) released its April 2018 Global Financial Stability Report, which provides an overview of major factors affecting financial stability on an international level, on April 2. The report contains several conclusions and recommendations of note:
• A recommendation that financial regulators ensure strong risk management standards due to asset valuations remaining stretched, and the possibility that rising interest rates could be accompanied by repricing of risky assets and increases in volatility. In particular, the report recommends two macroprudential tools for the nonbank financial sector:
  o Supporting “a clear and common definition of financial leverage in investment funds;” and
  o Continuing to improve supervisory frameworks for liquidity management in investment funds.

• A finding that credit exposures in the U.S. leveraged loan market have increased for nonbank financial institutions. The report notes that increased holdings of such loans “may affect market dynamics during times of stress.”

Office of Financial Research (OFR)
The OFR published its 2018 Annual Report to Congress on Nov. 15, describing key research findings and highlighting priorities for 2019 and beyond. The report describes the current level of overall financial risk as “remaining in the medium range,” reflecting a mix of high, moderate, and low risks to the financial system, and summarizes a variety of current and emerging financial risks, including:

• Market risk is highest, reflected in historically high stock prices and the sensitivity of bond prices to changes in interest rates.
• Macroeconomic risks remain moderate, with risk rising over the next year even though currently unemployment is exceptionally low, growth remains healthy, and inflation is close to the Federal Reserve’s target.
• Credit risk is moderate, with risk rising from leveraged lending, tempered somewhat by risks from consumer credit.
• Solvency and leverage risks remain low under most conditions, with large banks and insurers holding capital well above regulatory minimum requirements.
• Cybersecurity remains a key risk, with digital assets, commonly known as cryptocurrencies, are continuing to be monitored because their use is rapidly growing and evolving.

Reinsurance
The U.S. Department of the Treasury and the Office of the U.S. Trade Representative (USTR) announced on Dec. 11 that they have finalized, and intend to sign, the Bilateral Agreement between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance (covered agreement). This mirrors a similar agreement between the U.S. and the European Union (E.U.) that was signed in September 2017, and would ensure that terms of the 2017 agreement will be maintained with the U.K. following its scheduled departure (“Brexit”) from the E.U. in March 2019. The Treasury and the USTR issued letters announcing their intent to sign the agreement to the U.S. Congress, which will have 90 days to review the finalized agreement. They also noted in their announcement that they intend to release a policy statement on the implementation of the covered agreement.

If you have any questions regarding this Academy Alert, please contact Stephanie Connolly, legislative and regulatory analyst (connolly@actuary.org; 202-785-6924).

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