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INSIGHT

IN THIS ISSUE

Required Minimum Distributions for Governmental Pension Plans

While pension plans provide employees with a savings vehicle for retirement, the ability to defer the distribution of amounts from such plans is not absolute. Under Section 401(a)(9) of the Internal Revenue Code of 1986, as amended ("the Code"), certain distributions are required from a pension plan.

To maintain their federal tax-qualified status, all retirement plans, including governmental plans, are subject to the required minimum distribution (RMD) rules under Code Section 401(a)(9). Generally, a governmental plan is deemed to comply with the RMD rules by using a "reasonable and good faith interpretation" of Section 401(a)(9).

General RMD Rules for Defined Benefit Plans

Timing

Once a member turns age 70½, the Code may require the member to take money out of a pension plan every year. Specifically, Code Section 401(a)(9) provides that the RMDs are required to begin by April 1 of the calendar year following the later of the calendar year in which a member turns age 70½ or retires – the member's "required beginning date."[1] The deadline for taking subsequent RMDs is December 31 of each year. A member's RMD is the amount that must be paid each year to satisfy these rules – generally, this amount is actuarially increased for a member who retires after age 70½.

Payment of RMDs

If a member must begin receiving RMDs during the member's lifetime, benefits under the plan must, no later than the member's required beginning date: 1) be distributed in full; or 2) begin to be distributed over the life of the member or the lives of the member and designated beneficiary (i.e., as an annuity).

After the member's death, RMDs must continue to be paid to the member's beneficiary. If the member dies after commencing distributions, any remaining amounts must be distributed to the beneficiary at least as rapidly as they were paid to the member prior to death. If the member dies prior to beginning receipt of benefits, the entire interest of the member generally must be distributed within five years of the member's death. However, if the member has a designated beneficiary, amounts may be distributed

[1] Alternatively, a plan may track the rule for 5% owners and require a member to begin receiving distributions by April 1 of the calendar year after the member reaches age 70½, even if the member has not retired.

over the life expectancy of the beneficiary if distributions begin by the end of the calendar year following the calendar year of the member's death. Special rules apply if the designated beneficiary is the member's spouse.

Taxation and Withholding

RMDs are taxed as ordinary income at the member's federal income tax rate. Further, since RMDs are not eligible rollover distributions, 10% voluntary withholding will apply.

Failure to Take a RMD

If a member fails to withdraw the full amount of a RMD for any year, any portion of the required amount not timely withdrawn is taxed by the Internal Revenue Service (IRS) at 50% of the amount by which the RMD exceeds the actual amount distributed during the calendar year. For example, if the member fails to take a RMD of $10,000, the member will owe an additional tax of $5,000.

The IRS is authorized to waive the 50% tax on a case-by-case basis. The member can request the waiver by filing Form 5329, *Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts*, along with the federal tax return for the year in which the full amount of the RMD was not taken. The waiver request should include a letter of explanation providing that the shortfall in distributions was due to reasonable error and that reasonable steps are being taken to remedy the shortfall.

Beneficiaries

The Code provides specific rules for payments to beneficiaries as well. The requirements for these payments vary based on the relationship of the beneficiary (e.g., a spouse or non-spouse) and whether the member died before or after the required beginning date.

Applicability of Rules to Governmental Plans

The regulations affect all tax-qualified governmental retirement plans established by federal, state and local government agencies. Of notable relevance, the Code specifically exempts governmental plans from the RMD requirements relating to: 1) 5% owners; and 2) actuarial adjustments for members who retire after age 70½. Notwithstanding this, the requirements of Section 401(a)(9) generally apply to governmental plans, but they are subject to a *reasonable and good faith* interpretation of the requirements when determining if the plan is in compliance. Unfortunately, neither the Code nor related guidance provides further explanation of what a reasonable and good faith interpretation entails. Therefore, in most cases, governmental pension plans strive to meet the general rules for defined benefit plans in the payment of RMDs.

Due to the complexity of the rules, it would be advisable to consult with qualified legal counsel to ensure that the plan provisions comply with the reasonable good faith standards as well as the applicable laws and regulations.

Missing Members

The IRS recently provided guidelines regarding missing members in the context of paying RMDs. In certain cases where a plan is unable to make a RMD to a member (or beneficiary) due to the plan's inability to locate the member, the IRS will not find an operational failure if the plan has taken the following steps:

- Searched plan and related plan, sponsor, and publicly-available records or directories for alternative contact information;
- Used a commercial locator service, a credit reporting agency, or a proprietary internet search tool to locate individuals; and
- Sent a letter via U.S. Postal Service certified mail to the last known mailing address and attempted to make contact through appropriate means for other known addresses or contact information (including email addresses and telephone numbers).

If a pension plan has not completed the steps above, the IRS may assert that the plan has violated the RMD standards in connection with its failure to commence or make a distribution to a member to whom a payment is due. In such case, the plan could be subject to

disqualification, unless the failures are corrected with the IRS in accordance with Revenue Procedure 2016-51 under the Employee Plans Compliance Resolution System (EPCRS).

The IRS Audit Process

The old saying goes that only "death and taxes" are inevitable. Unfortunately, with taxes comes the chance for an Internal Revenue Service (IRS) audit, and governmental plans – both defined benefit and defined contribution plans – are certainly on the IRS radar.

How an IRS Audit Starts

An IRS audit often begins with a letter from the IRS informing the plan that it is now under audit. The opening letter for an audit will often include a scheduled "first appointment date" (or a request to schedule an appointment) and an initial request for information. These requests for information are called "Information Document Requests" (IDRs). In some audits, there can be multiple rounds of IDRs.

What an IRS Audit Means to Voluntary Correction Activities

When an IRS audit starts, the Voluntary Correction Program (VCP) under the IRS' Employee Plans Compliance Resolution System, commonly called "EPCRS," becomes unavailable to a plan. However, self-correction of certain failures under EPCRS remains available. Notably, while not a formal IRS "rule," the IRS has historically (but informally) taken the position that if a correction is 65% or more completed prior to audit, it may accept the correction – even if it is not yet completed. This rule of thumb can be very helpful to governmental plans that have identified errors for correction as they often do and are well along in correcting them when the IRS audit starts.

What Happens When the IRS First Comes Onsite

After the opening letter and the first round of IDRs arrive, the IRS agent assigned to the audit – and possibly other IRS representatives in the cases of complex or large plan audits – will set up an initial meeting. At this meeting, the IRS will often discuss: the audit process; the right to be represented by counsel and other advisors; taxpayer rights; the initial scope of the audit; and any items a plan may want to self-identify (such as a correction already being completed) for the IRS. In many cases, the IRS will also begin reviewing documents available on site and even begin asking questions. It is important to prepare documents, onsite space for the IRS review, and potential individuals for interview before the meeting.

The Middle Period

From this point, an IRS audit can proceed in many ways. In the simplest situation, one onsite meeting and one review of documents onsite (if any) is sufficient. There may be some more back and forth with IDRs and questions, but if all goes well, the audit may simply get closed with a closing letter. Realistically, and more commonly for larger, more complex governmental plans, there are likely to be multiple rounds of IDRs, more interviews and questions, and discussions about potential operational – or plan document – defects or mistakes.

Getting to Resolution

Eventually, after a few (or potentially many) rounds of back and forth with the IRS, the audit will start to enter its final lap. At this point, there are three common ways the audit proceeds:

- First, if nothing is found by the IRS, a simple closing letter will be issued.
- Second, the IRS may find minor issues of note, but the agent may conclude that there is no need for corrective action, and will simply include some notes in the closing letter and/or ask for some minor clarifications to the plan or plan processes, but without any sanction.
- Third, the IRS may assert that failures have occurred and need to be corrected or even sanctions paid. A closing agreement under the EPCRS Audit Closing Agreement Program ("Audit CAP") is generally part of a three part process: 1) the agreement; 2) correction is made prior to entering into the closing agreement; and 3) a sanction is paid to the IRS.

Alternatively, a governmental plan may decide to appeal the IRS audit decision. Litigation with the IRS may also be an option.

Mental Health Parity Guidance

On April 24, 2018, the Departments of Labor, Health and Human Services, and the Treasury (Departments) issued multiple pieces of guidance regarding implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Included in this guidance were:

1) a new set of proposed Frequently Asked Questions (FAQs);

2) a Self-Compliance Toolkit; and

3) an updated model MHPAEA Disclosure Request Form.

This guidance resulted, in large part, from the 21st Century Cures Act (Cures Act). The Cures Act was enacted in December 2016 and required the Departments to take certain steps to promote understanding of and compliance with MHPAEA. These steps include:

i) Providing additional guidance regarding disclosure requirements and nonquantitative treatment limitations (NQTLs);

ii) Providing stakeholders the opportunity to provide input;

iii) Soliciting feedback on how disclosure processes can be improved;

iv) Issuing a compliance program guidance document; and

v) Providing increased transparency through annual reports to Congress summarizing closed Department of Labor MHPAEA-related investigations and enforcement actions.

Proposed FAQs

The proposed FAQs, in large part, address compliance with MHPAEA's NQTL rule. MHPAEA's NQTL rule provides that a group health plan or health insurance issuer may not impose a NQTL with respect to mental health/substance use disorder (MH/SUD) benefits in any benefit classification unless any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the same classification. Notably, the Departments reaffirm their commitment to encouraging voluntary compliance, as well as address certain disclosure requirements under MHPAEA with regard to provider directories.

The FAQs focus largely on reconfirming the application of the regulatory rules in specific contexts, and do not address the more difficult questions that frequently arise in evaluating MHPAEA compliance, like how plans should justify medical management techniques and provider reimbursement for MH/SUD benefits.

The Departments' examples represent fairly straightforward NQTL compliance issues. For example, in one of the FAQs, a plan excludes coverage for residential treatment of substance use disorders, but does not exclude similar levels of coverage for medical/surgical conditions. However, this is an existing example in MHPAEA's Final Rule, which already makes clear that such exclusion is impermissible. Thus, the FAQ does not address important questions about how plans can manage care in residential treatment facilities, which are issues that are frequently discussed in the press in the context of the opioid crisis.

Importantly, these FAQs were released in proposed form only, and were subject to a comment period that closed on June 22, 2018. Comments submitted on the FAQs focus on reframing the FAQs as supportive of reaching compliance with the existing statutory and regulatory rules under MHPAEA, not creating additional requirements with which plans must comply. Importantly, several comments focus on the fact that the results of a compliant NQTL process can result in different limitations on MH/SUD benefits as compared with medical/surgical benefits – a point of clarification needed as some of the more simplistic applications of the NQTL rule described in the FAQs create a sense that parity is measured on results alone.

Self-Compliance Toolkit

The Self-Compliance Toolkit is a comprehensive guide on the evaluation of a plan for MHPAEA compliance. While the FAQs focus on possibly overly-simplified applications of the NQTL rule to different plan designs, the Self-Compliance Toolkit appears to require a significant degree of detail in the underlying NQTL analysis. By imposing this level of granularity in the analysis, the Departments could create both significant administrative burdens at the plan level and significant levels of confusion by consumers in evaluating whether and to what extent their plan offers MH/SUD benefits in parity.

Updated Model Disclosure Request Form

Finally, the Departments issued a revised Model Disclosure Request Form that had already been subject to public comment. The form is designed to provide a straightforward means for enrollees to request information on parity compliance from their plan and issuer. Under MHPAEA, group health plans and health insurance issuers are required to disclose certain information. Importantly, the form is not required to be used by enrollees.

While some improvements had been made since the initial publication, the form still contains very technical information that may be misleading or confusing to individuals not familiar with the intricacies of MHPAEA and plan design.

Conclusion

While this set of MHPAEA guidance represents a good start in helping group health plans and health insurance issuers meet the requirements of MHPAEA, particularly the often subjective requirements of the NQTL rule, plans and issuers should watch for the final versions of the FAQs and Model Disclosure Request Form, as they could materially impact how plans and issuers assess and ensure MHPAEA compliance.

Update on Recent Health Litigation

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

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

Texas claims that that the individual mandate, as amended by the Tax Cuts and Jobs Act of 2017, is unconstitutional because, in *NFIB v. Sebelius*, the Supreme Court upheld the individual mandate as a tax and, starting January 1, 2019, the individual mandate will no longer be a tax because it will not raise any revenue. Since both Congress and the Supreme Court viewed the mandate as "essential" to the operation of the ACA, Texas argues that the district court should find that the ACA is unlawful and enjoin its operation.

On April 9, 2018, California and 16 other states filed a motion to intervene to defend the ACA, which the district court granted on May 16, 2018. Furthermore, on April 23, 2018, Texas filed a motion for a preliminary injunction, asking the district court to immediately enjoin enforcement of the ACA in its entirety.

On June 7, 2018, the Department of Justice (DOJ) filed a brief announcing that it agreed with Texas that the individual mandate would be unconstitutional as of January 1, 2019, and that the DOJ would, therefore, decline to defend it. Instead, the DOJ requested that the court find the individual mandate unconstitutional and the guaranteed issue and community rating provisions of the ACA invalid as inseverable. However, the DOJ did not request that the court invalidate the remainder of the ACA.

The DOJ's unconventional decision to decline to defend the law sparked great interest in the legal community. While many commentators have argued that Texas and the DOJ's arguments are legally dubious, there remains the chance they could be successful, at least in the

district court, leading to great disruptions in the national health insurance market.

Most recently, on July 5, 2018, Texas filed its reply brief. While Texas maintains its request for a nationwide preliminary injunction enjoining the enforcement and implementation of the entire ACA, the brief contains an intriguing alternative request: that the district court order an injunction limited to the individual mandate, guaranteed issue, and community rating provisions, applicable only to Texas and the other plaintiff-states. If the district court grants this request, it could greatly disrupt the ACA markets in several large states, including both Texas and Florida, while litigation continues.

Reacting to the stakes of the dispute, many interested parties have filed amicus briefs arguing for the ACA's ongoing viability and importance. These parties include America's Health Insurance Plans (a health insurance trade association), the AARP, prominent economic and legal scholars, and the American Hospital Association.

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