JANUARY 2020

GRS INSIGHT

Pension Plans Legislative Update

IN THIS ISSUE

On December 20, 2019, President Trump signed into law two spending bills to fund the government through September 30, 2020, one of which (the *Further Consolidated Appropriations Act, 2020* (H.R. 1865)) contains the provisions from the *Setting Every Community Up for Retirement Enhancement Act of 2019* (the SECURE Act, H.R. 1994) that has been discussed in prior *GRS Insights*. The SECURE Act includes provisions which substantially affect retirement plans, including governmental retirement plans.

The most significant changes for governmental plans relate to plan distribution rules, including required minimum distributions, in-service distributions, and distributions on account of a disaster.

For required minimum distributions, the SECURE Act delays the age for determining a member's required beginning date from age 70½ to age 72 (effective for members turning age 70½ after December 31, 2019) and limits the ability of certain beneficiaries to stretch payments over their lifetimes after a member's death (effective for member deaths after December 31, 2021). More detailed information is provided in the following article, "What's New With Required Minimum Distributions?"

In addition, governmental plans are given more flexibility regarding in-service distributions, including: 1) defined benefit and 457(b) plans may now permit in-service distributions at age 59½ (effective for plan years beginning after December 31, 2019); and 2) defined benefit and defined contribution plans may take advantage of expanded disaster relief (for disasters occurring from January 1, 2018 through 60 days after enactment of the SECURE Act).

While some of these changes are optional, and a few provisions have delayed effective dates for governmental plans, others are required and/or are effective immediately. For those which have a later effective date, consideration should still be given to whether any adopted changes will affect system programming or member decisions prior to the provision's effective date. Additional guidance is expected from the IRS, which, when issued, will help with the implementation of many of these provisions.

What's New With Required Minimum Distributions?

Recent legislation and proposed regulations provide important updates to the rules for required minimum distributions (RMDs).

The *Setting Every Community Up for Retirement Enhancement Act of 2019* (the SECURE Act) was passed by Congress and

signed into law on December 20, 2019, as part of the fiscal year 2020 funding legislation, the *Further Consolidated Appropriations Act, 2020* (H.R. 1865). The SECURE Act is the most comprehensive retirement legislation enacted by Congress since the Pension Protection Act of 2006. Among other provisions, the SECURE Act makes changes to the RMD rules that apply to employer-sponsored retirement plans, including governmental plans. While governmental retirement plans are deemed to comply with the RMD rules if they are operated under a "reasonable and good faith interpretation" of Internal Revenue Code Section 401(a)(9), the conservative approach would be to comply with these changes.

First, the SECURE Act increases the age for a member's "required beginning date" (i.e., the date that determines when members must start receiving RMDs) from age 70½ to age 72. The new age applies to members who turn age 70½ after December 31, 2019.

Second, the SECURE Act curtails how long some beneficiaries may receive distributions after a member's death. Previously, designated beneficiaries could generally elect to have payments made over the beneficiary's lifetime. Unless the designated beneficiary meets the definition of "eligible beneficiary," the SECURE Act limits this distribution period by requiring that all remaining distributions after the member's death be made within ten years of a member's death. There is some relief for eligible beneficiaries, which the SECURE Act defines as a beneficiary who is a surviving spouse, disabled, chronically ill, not more than ten years younger than the member, or a child of the member who has not reached majority, who are not subject to the ten-year limitation and may still receive lifetime payments. For governmental plans, this change is effective for deaths after December 31, 2021.

The Internal Revenue Service (IRS) also proposed new RMD regulations on November 8, 2019, which would update the life expectancy tables used by most defined contribution plans to determine the amount of an RMD. The updated figures generally reflect increased expected lifetimes and, as a result, lower required annual distributions. The proposed regulations are slated to be effective January 1, 2021, for distributions made in that year and after, but would provide some transition relief for members who were deceased before January 1, 2020.

If eventually enacted, the proposed regulations should work along with the SECURE Act to allow members to keep more money in their retirement accounts for a longer time period. Meanwhile, the new ten-year rule for designated beneficiaries would prevent lifetime payments to certain beneficiaries under the plan.

Frequently Asked Questions (FAQs) About Required Minimum Distributions

What is a required minimum distribution ("RMD")?

Under Internal Revenue Code Section 401(a)(9), beginning with a member's required beginning date, a member must receive at least a minimum portion of his or her benefit each year. This minimum amount is known as a "required minimum distribution."

What types of retirement plans are required to comply with the required minimum distribution rules?

All employer-sponsored retirement plans, including defined benefit and defined contribution plans under Code Section 401(a), along with Code Section 403(b) and 457(b) plans, must adopt RMD rules. Governmental retirement plans are deemed to comply with the RMD requirements if they satisfy a reasonable and good faith interpretation of the requirements (although the IRS has not provided an explanation of what such interpretation entails).

When are required minimum distributions required to be made?

A member's first RMD must be paid by the member's required beginning date ("RBD"). Pursuant to the SECURE Act, the RBD for members who turn age 70½ after December 31, 2019 is changed to April 1 of the calendar year following the later of the calendar year during which the member reaches age 72 or retires. For members who turned age 70½ prior to January 1, 2020, the RBD remains April 1 of the calendar year following the later of the calendar year during which the member

reaches age 70½ or retires.[1] After the first RMD, the member must take subsequent RMDs by December 31st of each calendar year.

How do plans calculate the amount of a required minimum distribution?

Defined benefit plans generally meet the RMD requirements by making annuity payments over the life of the member (and the member's designated beneficiary) or over a period certain that is shorter than such life expectancy(ies). The first RMD (due by the member's required beginning date) is equal to one monthly payment. Continued payment of the annuity satisfies the RMD requirements for future years. For a lump sum payment from a defined benefit plan, the defined contribution plan rules are often applied by treating the lump sum as the member's account balance as of the end of the relevant calendar year (see below). Alternatively, the annuity rules may be applied to the lump sum.

For a defined contribution plan, the amount of a required minimum distribution is generally calculated by applying the applicable life expectancy table to the member's account balance (i.e., dividing the account balance as of the end of the immediately preceding calendar year by the applicable distribution period under the table).

How must payments be made to beneficiaries after a member's death to comply with the required minimum distribution rules?

If the member has a designated beneficiary who is an eligible beneficiary (generally, a surviving spouse, disabled, chronically ill, not more than ten years younger than the member, or a child of the member who has not reached majority), amounts may be distributed over the life expectancy of the beneficiary provided that distributions begin by the end of the calendar year following the calendar year of the member's death. If the designated beneficiary is not an eligible beneficiary, any amounts owed to the beneficiary must be distributed within ten years of the member's death.

How do the required minimum distribution rules apply if an individual participates in multiple retirement plans?

RMDs from a Code Section 401(a) or 457(b) plan must be made separately from each plan. For Code Section 403 (b) plans, while the plan must determine the amount of the RMD separately for each plan, the total RMD may be taken from one or more of the applicable 403(b) plans.

How are required minimum distributions taxed?

RMDs are taxed at the member's federal income tax rate as ordinary income (with the exception of any amounts a member contributes on a post-tax basis, which are not subject to income tax on a distribution). Further, as RMDs are not eligible for rollover, such amounts are subject to 10% voluntary withholding.

Are there any special required minimum distribution rules that specifically do not apply to governmental plans?

The following RMD rules do not apply to governmental plans: 1) the more restrictive required beginning date rules for an employee who is a 5-percent owner; and 2) the actuarial adjustment for members who retire in a calendar year after the year in which they turn age 72.

What happens if an employer sponsored retirement plan fails to comply with the rules for required minimum distributions?

A failure to comply with the RMD rules could raise plan qualification concerns. In addition, members that do not timely receive an RMD are subject to a 50% excise tax on unpaid amounts. This excise tax may be waived by the IRS (see below).

What steps can be taken if a required minimum distribution is not made in a timely manner?

A member can request a waiver of the excise tax by filing Form 5329, *Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts*. The request should include a letter explaining the reason for

[1] Effective December 31, 2019. A more detailed discussion on recent required minimum distribution changes is provided in "What's New With Required Minimum Distributions?" on pages 1 and 2.

the failure to take the RMD and that reasonable steps are being taken to remedy the failure. Additionally, the plan can correct the potential qualification issue through the Self Correction Program or the Voluntary Correction Program ("VCP") under the Employee Plans Compliance Resolution System ("EPCRS") contained in Revenue Procedure 2019-19. A VCP filing could also include a request to the IRS for a waiver of the excise tax assessed against individual members.

IRS Provides for Expanded 403(b) Plan Remedial Amendment Period

As discussed in the July edition of *GRS Insight*, the initial remedial amendment period for 403(b) plans ends March 31, 2020. (*See* Revenue Procedure 2017-18.) To provide additional relief for 403(b) plans, the Internal Revenue Service (IRS) issued Revenue Procedure 2019-39 to establish a recurring remedial amendment period, while also extending the initial remedial amendment period beyond March 31, 2020 for certain form defects.[2]

Once the initial remedial amendment period ends on March 31, 2020, the recurring remedial amendment period for individually designed 403(b) plans provides additional opportunities for the retroactive self-correction of defects in the form of a 403(b) plan (form defects). For these form defects, the remedial amendment period generally begins on: 1) for a new 403(b) plan, the date the plan is effective; 2) for an amendment to an existing 403(b) plan, the earlier of the date the amendment is adopted or put into effect; 3) for changes to a 403(b) plan requirement, the date such change is effective; and 4) for an amendment integral to changes to a 403(b) plan requirement, the date on which the plan was operated in accordance with the change.

For governmental 403(b) plans, the recurring remedial amendment period for form defects generally ends on the later of: 1) the second plan year following the calendar year in which the failure occurred; or 2) 90 days after the close of the third regular legislative session of the legislative body with the authority to amend the plan that begins after the end of the calendar year in which the failure occurred. Revenue Procedure 2019-39 also generally extends the initial March 31, 2020 remedial amendment period for a form defect first occurring prior to the end of the initial remedial amendment period to the later of: 1) March 31, 2020; or 2) the end of the applicable recurring remedial amendment period noted above. For discretionary amendments to a governmental 403(b) plan (unless otherwise provided in IRS guidance), the amendment deadline is the later of: 1) the end of the plan year in which the amendment is operationally put into effect; or 2) 90 days after the close of the second regular legislative session of the legislative body with the authority to amend the plan that begins on or after the date the amendment is operationally put into effect.

The annual required amendments list issued by the IRS will also include changes to the Code Section 403(b) requirements that are effective during the plan year in which the list is published (as has been done over the last few years for 401(a) plans). Further, changes to the Code Section 403(b) requirements that are effective during a calendar year will be included in updates to the operational compliance list maintained by the IRS.

"Bona Fide" Terminations

An important issue facing retirement plans, including governmental defined benefit plans, is related to bona fide terminations. To avoid potential challenges to a plan's tax-qualified status, retirement plans should consider their processes for addressing situations where an employee who terminates employment is rehired soon thereafter.

Unfortunately, there is very limited guidance from the Internal Revenue Service (IRS) addressing bona fide terminations. The most comprehensive guidance is contained in a Private Letter Ruling (PLR 201147038) issued by the IRS on April 20, 2010, which provides that "if both the employer and employee know at the time of 'retirement' that the employee will, with reasonabl[e] certainty, continue to perform services for the employer, a termination of employment has not occurred upon 'retirement' and the employee has not legitimately

[2] This article discusses individually designed 403(b) plans. Different rules apply in some cases for pre-approved plans.

retired." Further, "employees who 'retire' on one day in order to qualify for a benefit under the Plan, with the explicit understanding between the employee and employer that they are not separating from service with the employer, are not legitimately retired."

This concept is the overriding principle to be taken from the ruling and applied to a defined benefit plan to avoid "sham" terminations. In other words, when determining if a member has had a severance from employment which would permit receipt of a distribution from the plan, it is important to determine whether there is an understanding between the employee and employer at the time of "retirement" that the employee will return to service with the employer. To protect the plan, this answer should often be "no." Otherwise, there is a potential risk that the IRS could find plan qualification issues due to an impermissible in-service distribution (presuming in-service distributions are not permitted, as with many governmental defined benefit plans).

Some governmental defined benefits plans have set a time period under the plan after which an employee who is receiving retirement benefits may return to service. Importantly, the IRS has not issued guidance endorsing a specific severance period that would constitute a sufficient length of time to automatically constitute a bona fide termination. Therefore, while including such a severance period under the plan may be a supporting factor that there was no understanding between the employee and the employer that the employee would return to service with the employer, it does not guarantee a finding of a "bona fide termination" on its own.

Health Legislation Update

For health care legislation, 2019 was another busy year in Congress since a variety of bills were introduced that were designed to address surprise balance billing, prescription drug costs, and the ACA's Cadillac Tax, among many others. Although surprise balance billing and drug pricing legislation remain top legislative priorities on both sides of the aisle, it remains unclear whether any proposals will pass through Congress before the end of 2020, particularly given the political realities of a presidential election year.

Surprise Balance Billing Update

In December, both the Senate Committee on Health, Education, Labor, and Pensions and the House Committee on Energy and Commerce reached a compromise legislative proposal over "surprise balance bills"—that is, medical charges that arise when a patient unexpectedly receives care from an out-of-network provider (e.g., when a patient receives emergency care, or when a patient receives treatment from an out-of-network provider at an in-network facility). Over the past year, legislators have introduced legislation seeking to end surprise balance billing. However, such efforts have largely stalled in recent months over the reimbursement methodology for out-of-network providers, including whether arbitration should be used to determine reimbursement.

Similar to earlier legislation, the compromise proposal—which is contained within the *Lower Health Care Costs Act* (S. 1895), a larger package addressing medical spending—would hold patients harmless against surprise balance bills by requiring them to pay only the in-network cost-sharing amount in certain situations that generate surprise balance bills. The balance would then be resolved by requiring insurers to pay the provider an amount equal to the median contracted rate for the service in the geographic area where the service was delivered.

Where the compromise proposal differs from more recent proposals is in its inclusion of an arbitration provision. Specifically, if the median in-network rate payment is above $750, the provider or insurer may elect to proceed to binding arbitration to determine reimbursement. Under this process, an arbitrator would consider information brought by the parties related to the training, education, and experience of the provider, the market share of the parties, and other extenuating factors such as patient acuity and the complexity of furnishing the item or service. In allowing for arbitration for payments above $750, the proposal attempts to find a compromise between those who favor a benchmark payment methodology and those who favor arbitration to resolve payment disputes.

Committee leaders had hoped that the compromise proposal would make its way into the government funding legislation that Congress passed at the end of 2019, but it was ultimately omitted. Thus, the proposal

will have to pass on its own or, more likely, as part of a larger health care package in 2020. However, with 2020 being a presidential election year, it may be an uphill climb. Since addressing surprise balance billing remains a top Congressional priority on both sides of the aisle, passing legislation in 2020 is not out of the question.

Drug Pricing Update

In December, House Democrats passed the *Lower Drug Costs Now Act* (H.R. 3), Speaker Nancy Pelosi's drug pricing bill that would allow the Secretary of Health and Human Services to negotiate the prices of up to 250 brand-name drugs in Medicare that lack competitors. Once negotiated, the new prices would apply to all prescription drug buyers, not just for those enrolled in Medicare. The Act, which was widely expected to pass the Democratic-controlled House, places a $2,000 annual cap on out-of-pocket costs for Medicare beneficiaries. Additionally, to the extent drug manufacturers have raised their prices above inflation since 2016, with respect to Medicare Part B and D, the Act requires them either to lower their prices or, otherwise, refund the excess portion back to the U.S. Treasury. Notably, group health plans would be permitted to take advantage of the government-negotiated rate for brand-name drugs under H.R. 3.

Although the White House had previously indicated a willingness to work with Speaker Pelosi on passing bipartisan drug pricing legislation, the Act is regarded as having little chance for success in the Senate, where Senate Majority Leader Mitch McConnell has expressed little interest in taking up the bill.

As an alternative, in December, House Republicans unveiled their own package, the *Lower Costs, More Cures Act* (H.R. 19). Rather than regulating the prices of new drugs directly through mandatory governmental negotiation, the Republicans' bill would place a cap on price increases at the rate of inflation. The bill would also place a higher cap on out-of-pocket spending for Medicare Part D—$3,100 versus the $2,000 cap in the Democrats' bill. Significantly, the bill would require insurance companies to make Medicare drug pricing information available in real time at physicians' offices, aiming to facilitate drug cost transparency before a prescription is written.

Although that bill has little chance for success in the Democratic-controlled House, some of its provisions could ultimately work their way into the *Prescription Drug Pricing Reduction Act* (S. 2543)—bipartisan legislation in the Senate co-sponsored by Senators Chuck Grassley (R-IA) and Ron Wyden (D-OR). Like the House Republicans' bill, the bipartisan Senate bill would implement an out-of-pocket maximum for Medicare beneficiaries and cap drug price increases at inflation, among other proposals. The Senate bill is regarded as more moderate than the House Democrats' proposal and has the support of the White House. However, Senate Majority Leader McConnell has declined thus far to advance the legislation to the floor for a vote.

Overall, drug pricing remains a high priority in Congress, as a number of different proposals continue to percolate on Capitol Hill. Yet, it remains to be seen whether any measure can gain enough political steam to pass through both chambers, particularly in a presidential election year.

Cadillac Tax

In December, as part of a government spending package, Congress permanently repealed the Affordable Care Act's so-called "Cadillac Tax" on high-cost health plans. Stakeholder groups for many years had urged lawmakers to repeal the tax, which had been delayed several times by Congress—most recently until 2022.

The Cadillac Tax would have imposed a 40% excise tax on employer-sponsored coverage that was considered too expensive, and would have applied to both employers' and employees' share of the cost of health coverage, as well as to contributions to health saving accounts, health reimbursement arrangements, and medical flexible spending accounts. The tax was one of the few provisions in the ACA intended primarily to "bend the cost curve" and reduce overall health care spending, and the Obama Administration defended it vigorously. However, the tax remained unpopular in both parties and was delayed time and again.

Opposition groups criticized the Cadillac Tax for its projected impact on working Americans. While the tax was designed to affect only Americans with "gold-plated" plans, critics alleged that much more modest plans covering low- and moderate-income employees would trigger the tax. They also viewed the tax as disproportionately penalizing small businesses.

The Joint Committee on Taxation estimates that the repeal of the Cadillac Tax will cost almost $197 billion over ten years. The repeal is effective for taxable years beginning after 2019.

Tri-Agency Publishes Proposed Rule on Disclosure of Cost-Sharing Information

On November 15, 2019, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) published a proposed rule requiring the disclosure of certain cost-sharing information (Proposed Rule). The Proposed Rule imposes two significant disclosure requirements on group health plans and insurers: 1) a requirement to provide certain estimated cost-sharing information to participants and beneficiaries upon request; and 2) a requirement to publish pricing information on a public website.

Comments on the Proposed Rule were originally due January 14, 2020, but the Departments extended the deadline to January 29, 2020 to allow more time for public feedback. The Proposed Rule would be applicable one year after the effective date of the final rule.

Disclosure of Cost-Sharing Information to Participants and Beneficiaries

The Proposed Rule first requires group health plans and health insurers to disclose to plan participants and beneficiaries upon their request certain real-time cost-sharing information, including in-network negotiated rates with providers and out-of-network allowed amounts. The disclosures must be facilitated using an internet-based self-service tool that allows individuals to input search terms and sort through the results based on various criteria.

In promulgating the Proposed Rule, the Departments state that they are seeking to rectify some of the issues associated with today's more consumer-driven approach to health care spending, including rising out-of-pocket costs and more opaque cost-sharing models. By requiring disclosure of cost-sharing information upon request, the Departments believe that consumers will be better able to make cost-conscious decisions, fostering competition among providers to "narrow price differences for the same services in the same health care markets." Over time, the Departments believe that more informed, price-conscious consumers could lower overall health care costs.

Under the Proposed Rule, when an individual makes a disclosure request, the plan or insurer must disclose the following cost-sharing elements:

- An estimate of the cost-sharing liability for furnishing a covered item or service by a particular provider;
- An individual's accumulated amounts incurred to date (such as with respect to a deductible or an out-of-pocket maximum);
- The negotiated rate, reflected as a dollar amount, for an in-network provider for a requested covered item or service;
- The out-of-network allowed amount for the requested covered item or service (if the individual requests cost-sharing information for an item or service furnished by an out-of-network provider);
- If the individual requests cost-sharing information for an item or service that is subject to a bundled arrangement, a list of those covered items and services included in the bundled arrangement; and
- If applicable, notification that coverage of a specific item or service is subject to a prerequisite (such as preauthorization).

When disclosing these cost-sharing elements, the plan must make other "plain language" disclosures, such as: 1) out-of-network providers may balance bill the individual for amounts over the allowed amount, and that the cost-sharing estimate does not account for those potential amounts; 2) actual charges may be different from the estimated cost-sharing amounts; and 3) providing a cost-sharing estimate does not guarantee coverage for the particular item or service.

The self-service tool must allow individuals to conduct searches for covered items or services from both specific in-network providers and from all in-network providers, with results sortable by both geographic proximity and the amount of estimated cost-sharing.

Public Disclosure of In-Network Negotiated Rates and Out-of-Network Allowed Amounts

The Proposed Rule also requires group health plans and insurers to publish on a public website certain information regarding negotiated rates for in-network providers and historical allowed amounts for out-of-network providers. Individuals would need to be able to access the information free of charge and without establishing any login credentials, and the information would need to be updated at least monthly. The negotiated rate and allowed amount information would need to include specific billing codes used by the plan to adjudicate claims for covered items or services, as well as a plain language description of each billing code and the associated negotiated rate or out-of-network allowed amount.

In proposing the public disclosure requirement, the Departments state that they are seeking to enable plans to gather more information about what other plans actually pay for particular items and services. In so doing, the Departments believe that plans will be better able to evaluate offers from third-party administrators and insurers with respect to network pricing, which could ultimately drive down prices.

Special Rules to Prevent Unnecessary Duplication

Significantly, the Proposed Rule specifies that if a plan is insured, the plan may satisfy the disclosure requirements by executing a written agreement with the plan's insurer requiring the insurer to provide the information. In that case, the insurer would be liable in the event that it failed to disclose the required information.

For self-funded plans, the Proposed Rule would also allow the plan to satisfy the public disclosure requirement by contracting with a third party (such as a third-party administrator). However, in that case, the plan would remain liable in the event the third party failed to disclose the required information.

About GRS

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

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