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GRS INSIGHT

IN THIS ISSUE

IRS Guidance on Self-Correction under SECURE 2.0

The Internal Revenue Service (IRS) guidance under the SECURE 2.0 Act of 2022 (SECURE 2.0) began with the issuance of Notice 2023-43[1] addressing the changes to the self-correction program under the Employee Plans Compliance Resolution System (EPCRS). The Notice provides guidance on the eligibility for the self-correction program, the expansion of the types of failures that are eligible for the program, and the required timing for correction.

Under SECURE 2.0, the IRS is also directed to issue a restated Revenue Procedure within two years, which would reflect the new statutory changes. In the meantime, the Notice provides initial guidance regarding the plan failures that can now be self-corrected by plans, including governmental qualified plans and 403(b) plans.[2]

Background

Prior to SECURE 2.0, the self-correction program under EPCRS was largely limited to the correction of: 1) "insignificant" operational failures; or 2) "significant" operational failures that were promptly corrected (generally within three years). Meanwhile, some failures were generally not eligible for self-correction, including certain plan document errors, certain loan failures, employer eligibility failures, and demographic failures.

To correct eligible failures under the self-correction program, the following requirements must have been met:

- A plan sponsor must have had established practices and procedures designed to "promote and facilitate" compliance with the Internal Revenue Code (Code);
- The correction must have followed the general principles set forth in EPCRS; and
- Qualified plans and 403(b) plans must have had a favorable letter (e.g., determination or opinion letter) in order to self-correct a significant failure.

SECURE 2.0 Expansion of Self-Correction

Under SECURE 2.0 section 305, the self-correction program was expanded to allow any "eligible inadvertent failure" to comply with applicable Code requirements to be self-corrected, if: 1) the failure is not first identified by the IRS (i.e., the plan is not under audit) prior to demonstration of a "specific commitment" to self-correct such failure; and 2) the self-correction is completed within a reasonable time of discovering the failure.

Generally, SECURE 2.0 defines eligible inadvertent failures as those that occur

[1] https://www.irs.gov/pub/irs-drop/n-23-43.pdf

[2] While the Notice addresses qualified plans, 403(b) plans, SEPs, and SIMPLE IRAs, this article focuses on qualified plans and 403(b) plans.

notwithstanding established practices and procedures supporting Code compliance. However, in no event does such definition include failures that are egregious or relate to the diversion or misuse of plan assets or an abusive tax avoidance transaction.

Notice 2023-43

The Notice provides guidance on the timing for completing a correction under the relief, including whether a correction has been completed within a reasonable period after it is identified. Such determination will generally be based on a "facts and circumstances" test, but the IRS did provide that a self-correction process that is completed by the last day of the 18th month following identification of the failure will be treated as having been completed within a reasonable period. However, there is an exception to that safe harbor for employer eligibility failures (generally affecting 403(b) plans), for which the outside window to cease contributions to the plan is the last day of the sixth month following identification of the failure.

The Notice also includes guidance on the IRS' determination of a plan sponsor's demonstration of a "specific commitment" to implement self-correction. Again, this determination is based on the facts and circumstances, but the plan sponsor must demonstrate that it was actively pursuing correction of the specific failure.

The guidance allows for the self-correction of these eligible inadvertent failures prior to the issuance of an updated EPCRS, but the self-correction requirements under existing EPCRS guidance must generally be satisfied. That said, the expanded self-correction remains available for qualified plans and 403(b) plans even if some of the requirements under existing EPCRS guidance are not met. For example, the expanded program may be used even if the plan does not have a favorable determination or opinion letter, or the failure is a demographic or employer eligibility failure, or for a loan failure that was not previously eligible for self-correction. It may also be used for the correction of a significant failure that is not completed within the three-year period. However, the correction method used must not be prohibited by existing EPCRS guidance. Notably, failures that occurred prior to the enactment of SECURE 2.0 may still be corrected in accordance with these new guidelines.

While the relief does provide a greatly expanded program, certain specific failures and/or corrections remain ineligible for self-correction before EPCRS is updated, including: the failure to initially adopt a 401(a) plan or 403(b) plan and correction of an operational failure by retroactive amendment to conform plan terms to operations if such amendment would result in a cutback (i.e., plan terms that are less favorable to members).

Notwithstanding the availability of this expanded program, a plan sponsor may still choose to submit a voluntary correction program application to the IRS (e.g., where an excise tax applies to the failure since self-correction does not automatically waive the tax). In addition, prior to the issuance of an updated EPCRS, plan sponsors retain the ability to self-correct an insignificant failure (including an eligible inadvertent failure) while the plan is under audit, even if the failure is discovered during an audit.

Reliance

Plan sponsors may rely on the guidance in the Notice immediately. However, such reliance will end upon the issuance of an updated EPCRS.

SECURE 2.0 Provides Flexibility in Overpayment Recovery

A common issue faced by plans is the required correction in the event of a plan overpayment, which occurs when a payment to a member or beneficiary exceeds: 1) the amount payable under the terms of the plan; or 2) a limitation provided in the Internal Revenue Code (Code) or Treasury Regulations.

As noted in the May 2023 issue of *GRS Insight*, the SECURE 2.0 Act of 2022 (SECURE 2.0) section 301 provides increased flexibility in the rules for the recoupment of overpayments by governmental plans, specifically with respect to "inadvertent benefit overpayments." SECURE 2.0 provides that an eligible plan, including a governmental 401(a) plan or 403(b) plan (but not a governmental 457(b) plan), does not lose its tax-favored status merely because the plan fails to recover (or even seek to recover) an inadvertent benefit overpayment or is otherwise amended to permit the increased benefit.[3]

[3] Consideration should be given to whether state fiduciary standards may require additional action.

Inadvertent Benefit Overpayment

"Inadvertent benefit overpayment" is not defined in the statute, nor is there any indication of its scope in the legislative history. However, the legislative history does indicate that overpayment is defined under the Employee Plans Compliance Resolution System (EPCRS), (currently, Revenue Procedure 2021-30) and references payments "mistakenly" received. Further, the statute provides that to the extent the limits under Code sections 401(a)(17) or 415 are implicated by the overpayment (i.e., to the extent the overpayment occurs because the applicable limit is exceeded), it is a separate failure to follow the Code. In such case, the overpayment falls outside the definition of inadvertent benefit overpayment and should be corrected in accordance with the general overpayment recoupment rules (e.g., recoupment should be sought).

Relief

The relief for governmental plans under the Code provides that a plan sponsor is not required to seek recovery of prior overpayments. However, going forward, the governmental plan can either correct any future payments or amend the plan to reflect the benefit actually paid.

Governmental plans are not subject to the new, somewhat stringent, restrictions on recovery from members and beneficiaries that are imposed on ERISA plans. However, if collection efforts are undertaken with respect to an overpayment, a governmental plan could decide to follow some or all of the following ERISA imposed restrictions:

- No interest or other fee can be sought with the overpayment;
- For a non-decreasing annuity, reductions of future payments are capped at 10% of the overpayment each calendar year, and not more than a 10% reduction in the periodic payment is permitted;
- Generally, no threat of litigation or use of a collection agency is permitted;
- Use of a collection agency is only permitted if the participant or beneficiary ignores or rejects efforts to recoup the overpayment following either a final judgment in Federal or State court or a settlement between the participant or beneficiary and the plan authorizing recoupment;
- Collection of a participant's overpayment may not be sought from a beneficiary of the participant;
- Generally, no collection is permitted for any overpayments if the first overpayment is made more than three years before written notice is provided of the error;
- The plan's claims procedures are available to contest the recoupment process; and
- Hardship of the recoupment may be considered in determining the amount to recover.

Generally, overpayments are not eligible for favorable tax treatment, including eligibility for rollover. However, in certain cases, inadvertent benefit overpayments may be treated as any other eligible rollover distribution (if otherwise eligible for rollover). For example, if the full amount of an inadvertent benefit overpayment is rolled over, the portion of such overpayment with respect to which recoupment *is not sought* is treated as an eligible rollover distribution (if such amount would have been an eligible rollover distribution, but for being an overpayment (e.g., a lump sum, not a lifetime benefit)). The portion of such overpayment with respect to which recoupment *is sought* will be treated as an eligible rollover distribution to the distributing plan (to the extent repayment is made).

Conclusion

Where an overpayment qualifies as an inadvertent benefit overpayment, there is no *Federal* requirement for governmental plans to attempt to recoup the overpayment. Therefore, in the absence of State requirements to the contrary, it may be reasonable to forego some or all collection efforts in such cases. Alternatively, as noted above, a governmental plan could decide to follow the ERISA imposed restrictions if collection efforts are taken. In any event, plans may consider taking a "wait and see" approach and continuing to follow their pre-SECURE 2.0 overpayment procedures, pending future guidance. However, it is important to recognize that repeated overpayment failures without updated plan procedures may fall outside of these relaxed rules.

Tri-Agencies Propose Sweeping Changes to Mental Health Parity Rules

On August 3, 2023, the Departments of Health and Human Services (HHS), Labor (DOL) and Treasury (collectively, the Tri-Agencies) published a Proposed Rule which significantly alters group health plans' and health insurance issuers' responsibilities under the Mental

Health Parity and Addiction Equity Act (MHPAEA). The Tri-Agencies also released a Technical Release and the 2023 MHPAEA Report to Congress. The Proposed Rule primarily makes changes to the Nonquantitative Treatment Limitation (NQTL) requirements. Additionally, HHS proposes to amend its regulations to align with the Consolidated Appropriations Act, 2023 (CAA, 23), specifically the sunset of the MHPAEA opt-out election for sponsors of self-funded non-Federal governmental plans.

Stakeholders must submit their comments on the Proposed Rule and Technical Release by October 17, 2023. The Proposed Rule, if finalized, would apply beginning the first day of the first plan year beginning on or after January 1, 2025.

The Proposed Rule, Technical Release, and Report to Congress

The Proposed Rule

The Proposed Rule significantly diverges from the Tri-Agencies' existing regulations and guidance related to NQTLs. Below are key provisions in the Proposed Rule.

The most significant change that the Tri-Agencies propose is a new "three-part" test to determine whether an NQTL is permissible under MHPAEA.

- First, plans and issuers must apply the "substantially all/predominant" test to NQTLs (same test used for cost sharing and visit limits).
- Second, plans and issuers would not be permitted to implement an NQTL, unless, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in "designing and applying" the NQTL to Mental Health or Substance Use Disorder (MH/SUD) benefits in the classification are comparable to, and are applied no more stringently than to the Medical and Surgical (M/S) benefits in the same classification (comparable to current NQTL rule).
- Third, a plan or issuer must collect and evaluate relevant outcomes data to assess the impact of the NQTL on access to MH/SUD and M/S benefits. Notably, "material differences" in the data will be viewed as a strong indicator of noncompliance to the extent that outcomes data for MH/SUD benefits are more stringent than outcomes data for M/S benefits. However, for the network composition NQTL, the Tri-Agencies specify an *enhanced* standard providing that a "material difference" in outcomes data will be considered noncompliance. The agencies do not define "material."

The Tri-Agencies propose a new requirement to provide a "meaningful benefit" for MH/SUD conditions in each classification, which would be determined in comparison to benefits provided for M/S conditions in the same classification. The agencies also do not define "meaningful."

The Proposed Rule specifies the elements that must, at a minimum, be included in the NQTL comparative analysis. Many of these elements were already included in the Tri-Agencies' guidance; however, the Proposed Rule provides more detail on the content.

The Tri-Agencies clarify that the comparative analysis is considered:

- An instrument under which a plan is established and operated and must be disclosed to a participant or beneficiary under ERISA, upon request; and
- A document, record, and other information relevant to the claimant's claim for benefits under an adverse benefit determination and must be provided to a participant or beneficiary and provider, upon request.

Finally, HHS specifies that a sponsor of a self-funded, non-Federal governmental plan may not *elect* to exempt its plan from any of the MHPAEA requirements on or after December 29, 2022 (i.e., no new elections), and a MHPAEA opt-out election that expires on or after June 27, 2023 may not be renewed (i.e., no renewals). HHS also specifies that for a self-funded non-Federal governmental plan that is subject to multiple collective bargaining agreements of varying lengths, the plan may extend the opt-out election until the date on which the term of the last applicable collective bargaining agreement expires.

Technical Release

The DOL issued a Technical Release that delineates a data-driven approach for determining whether the NQTLs related to network composition comply with the new data requirements (third element of the new NQTL test).

The Tri-Agencies are also considering requiring the collection and evaluation of various data points, including out-of-network utilization, percentage of in-network providers that actively submit claims, time and distance standards, and reimbursement rates.

The Tri-Agencies intend to define standards for this data and, potentially, craft a safe harbor for covered entities that satisfy certain standards for NQTLs related to network composition for a specified period of time.

The 2023 MHPAEA Report to Congress

The Tri-Agencies published their 2023 report to Congress that surveyed their enforcement actions related to the CAA's mandated NQTL comparative analyses. The Tri-Agencies also included a list of common deficiencies in NQTL comparative analyses, with examples of how these issues have been resolved. This report identifies the plans and issuers by name that received a final determination of noncompliance by the DOL or HHS, which totaled eight plans/issuers. The report also explained the enforcement priorities for the DOL and HHS.

Hospital and Fixed Indemnity Proposed Rule

On July 7, 2023, the Departments of Health and Human Services, Labor and Treasury (Tri-Agencies) published a proposed rule (Proposed Rule) that, among other things, proposed changes to the excepted benefit requirements and "clarified" the tax treatment of benefit payments from employer-provided accident or health insurance under Internal Revenue Code (Code) section 105(b).

Excepted Benefits

The Proposed Rule includes several changes to hospital indemnity and other fixed indemnity excepted benefits, at least in part because the Tri-Agencies are concerned that consumers are being misled to believe that the coverage constitutes comprehensive coverage. The Proposed Rule also seeks to align the individual and group market rules.

In the group market, the Proposed Rule retains the requirement that the policy must pay a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, $100/day) regardless of the actual or estimated amount of expenses incurred. The Proposed Rule added that the policy also cannot pay based on:

- Services or items received;
- Severity of illness or injury experienced by a covered participant or beneficiary;
- Other characteristics particular to a course of treatment received by a covered participant or beneficiary; or
- Any other basis (such as on a per-item or per-service basis).

The Proposed Rule also added a new notice requirement that the plan or issuer would be required to display prominently on the first page of any marketing, application, and enrollment materials.

Tax Exclusion

Where premiums are paid on a pre-tax basis, Code section 105(b) excludes from a participant's gross income benefit payments under accident or health plans that are paid to reimburse the participant for Code section 213(d) medical expenses. This rule is reflected in the current section 105(b) regulations, which provide that section 105(b):

> "does not apply to amounts which the taxpayer would be entitled to receive irrespective of whether or not he incurs expenses for medical care . . . If the amounts are paid to the taxpayer solely to reimburse him for expenses which he incurred for the prescribed medical care, section 105(b) is applicable even though such amounts are paid without proof of the amount of the actual expenses incurred by the taxpayer, but section 105(b) is not applicable to the extent that such amounts exceed the amount of the actual expenses for such medical care."

The Proposed Rule revises the regulatory language to provide that the section 105(b) exclusion does not apply if the plan pays benefits without regard to the actual amount of incurred, unreimbursed, and substantiated Code section 213(d) medical expenses. The Proposed Rule specifically states that the section 105(b) exclusion not apply to amounts received under a fixed indemnity hospital or other fixed indemnity or specified disease or illness policy that is an excepted benefit (since those policies are required to pay without regard to the amount of medical expense incurred).

Interestingly, the preamble notes this is merely a "clarification" to the current rule, and not a change. However, if finalized, the Proposed Rule would significantly change how entities currently tax these benefits, which is to only tax amounts in excess of the unreimbursed medical expenses.

IRS Issues Guidance on COVID-19 Testing and Preventive Care for High Deductible Health Plans

On June 23, 2023, the Internal Revenue Service (IRS) issued Notice 2023-37[4] (2023 Notice), which addressed the pre-deductible coverage under a high deductible health plan (HDHP) of expenses related to treatment and testing for COVID-19 and the preventive care safe harbor. The IRS issued the notice in response to the end of the COVID-19 National Emergency (NE) and Public Health Emergency (PHE) and to modify and clarify its prior guidance.

High Deductible Health Plan Requirements

An individual is eligible to contribute to a health savings account (HSA) if he or she is covered under an HSA-compatible HDHP and has no other disqualifying coverage. To be an HSA-compatible HDHP, the plan must not provide any benefits before the deductible is satisfied. However, the Internal Revenue Code provides a "safe harbor" under which an HDHP may provide pre-deductible preventive care benefits.

COVID-19 Testing and Treatment

In 2020, the IRS issued Notice 2020-15[5] (2020 Notice), which allowed an HDHP to cover COVID-19 testing and treatment on a pre-deductible basis. The 2023 Notice states that the IRS has determined that this relief is no longer needed now that the PHE and NE have ended. Therefore, the relief in the 2020 Notice applies only with respect to plan years that end on or before December 31, 2024.

The 2023 Notice also states that the preventive care safe harbor in Notice 2004-23[6] for certain infectious disease screening services does not apply to common and episodic illnesses, such as the flu and COVID-19. This leaves open the question of whether the IRS would ever treat COVID-19 testing as preventive care.

Task Force Recommendations

On April 13, 2023, following the *Braidwood* decision,[7] the Departments of Health and Human Services, Labor, and the Treasury (Tri-Agencies) issued FAQs that provide initial guidance on how the decision affects the requirement to cover preventive services without cost-sharing under the Affordable Care Act. The FAQs state that, until further guidance is issued, items and services recommended with an "A" or "B" rating by the U.S. Preventive Services Task Force (USPSTF) on or after March 23, 2010 will be treated as preventive care for purposes of the HSA preventive care safe harbor. The 2023 Notice reiterates this point.

[4] https://www.irs.gov/pub/irs-drop/n-23-37.pdf
[5] https://www.irs.gov/pub/irs-drop/n-20-15.pdf
[6] https://www.irs.gov/pub/irs-drop/n-04-23.pdf
[7] *Braidwood Mgmt., Inc. v. Becerra*, No. 4:20-CV-00283-O, 2022 WL 4091215 (N.D. Tex. Sept. 7, 2022) and 2023 WL 2703229 (N.D. Tex. Mar. 30, 2023), *appeal docketed*, No. 23-10326 (5th Cir. Apr. 3, 2023).