Rewards Policy Insider
2023-01

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"SECURE 2.0" Retirement Legislation Signed Into Law

In the waning days of the 117th Congress, the retirement legislation known as "SECURE 2.0" was signed into law on December 29, 2022 as part of the year-end omnibus bill.

The law expands coverage of retirement plans, makes changes to plan administration and compliance, and is intended to bolster Americans' retirement savings.

Consolidated Appropriations Act, 2023

On December 22nd and December 23rd, respectively, the House of Representatives and the Senate passed the Consolidated Appropriations Act, 2023 ("CAA") (H.R. 2617), a massive $1.7 trillion spending bill. President Biden signed the bill into law the following week, on December 29th. The CAA includes funding for the federal government through the end of Fiscal Year 2023, assistance to Ukraine, and electoral reforms. It also includes the comprehensive retirement legislation package entitled the SECURE 2.0 Act of 2022 ("SECURE 2.0"). SECURE 2.0 is the final product of extensive bipartisan negotiations and – with the exception of one new provision permitting rollovers from 529 college savings accounts under certain circumstances – is largely a combination of three separate bills that originated earlier this year in the Senate Finance Committee, Senate Health, Education, Labor, and Pensions ("HELP") Committee, and the House.

Highlights from SECURE 2.0

The final Rewards Policy Insider of 2022 discussed a range of provisions that could possibly be included in a SECURE 2.0 package. Now that a SECURE 2.0 package has been enacted, below is a discussion of those same provisions as they appear in the final law.

- Required Minimum Distributions. The law increases (in phases) the age by which an individual must start taking required minimum distributions ("RMDs") from a retirement plan or IRA from age 72 to age 73 (starting in 2023) and age 75 (starting in 2033). More specifically, age 73 will apply to anyone who turns age 72 after 2022 and 73 before 2033. Age 75 will apply to anyone who attains 74 after 2032. Note that the RMD rules specify when plan distributions to a participant must begin, but do not prohibit plans from requiring participants to start taking distributions earlier.
- Catch-up Contributions. The law increases the catch-up contribution limitations for individuals who are between the ages of 60 and 63. Generally, the new catch-up contribution limit for 401(k), 403(b), and governmental 457(b) plans for individuals ages 60-63 is the greater of $10,000 (indexed) or 150% of the regular catch-up contribution limit for those plans. (For example, for 2023, the catch-up contribution limit for 401(k), 403(b), and 457(b) plans is $7,500. 150% of $7,500 is $11,250.) For SIMPLE IRAs and SIMPLE 401(k)s, the new catch-up contribution limit for individuals ages 60-63 is the greater of $5,000 (indexed) or 150% of the regular catch-up contribution limit for those IRAs/plans. (For example, for 2023, the catch-up contribution limit for SIMPLE IRAs and SIMPLE 401(k)s is $3,500. 150% of $3,500 is $5,250.) This provision is effective starting in 2025.
- Lump Sum Windows. The law contains a provision that implements enhanced disclosure requirements with respect to defined benefit plans that offer participants a "lump sum window," during which participants can elect to receive their benefit immediately as a lump sum or in another form. The provision generally is not effective until regulations implementing these new requirements are published.
- Recovery of Overpayments. The law allows retirement plan fiduciaries to decide not to recoup certain accidental overpayments to plan

participants. This provision is generally effective on the date of enactment (i.e., December 29, 2022) but contains certain retroactive relief for plans, fiduciaries, employers, and plan sponsors.

- Part-Time Workers. Under current law, employers maintaining a 401(k) plan must generally allow certain long-term, part-time workers to participate in the plan if they complete three years of employment. The law reduces the three-year requirement to two years. This requirement will be effective for plan years beginning after December 31, 2024.
- Mandatory Cash-Outs. Under current law, a plan can "cash out" a participant who terminates their employment if the value of the employee's benefit does not exceed $5,000. The law increases the mandatory cash-out limit to $7,000. The provision is effective for distributions made after December 31, 2023.

Omnibus Bill Includes Health & Welfare Provisions, Too

Passage of "SECURE 2.0" – a package of comprehensive retirement reforms – as part of the Consolidated Appropriations Act, 2023 (CAA 2023) grabbed most of the employee benefits headlines. But two provisions relating to group health plans are noteworthy as well.

One provision extends for 2 more years the special rule permitting health savings account (HSA) compatible high-deductible health plans (HDHPs) to provide below-the-deductible coverage for telehealth services. The second eliminates the option for self-funded state and local government plans to opt-out of federal mental health parity laws.

HDHP Exception for Telehealth Services

As noted, CAA 2023 includes a provision to extend the special telehealth exception to the general rule that HSA-compatible high-deductible health plans may not cover expenses below the minimum required deductible to plan years beginning before January 1, 2025. The exception had been scheduled to expire at the end of 2022.

Pursuant to Code Section 223, only "eligible individuals" may contribute to an HSA. In order to be an "eligible individual," a person generally must be covered by an HDHP and no other coverage that is not an HDHP (i.e., "disqualifying coverage"). An HDHP is a health plan that satisfies certain minimum deductible (in 2023 $1,500 self-only and $3,000 family) and maximum out-of-pocket limit (in 2023 $7,500 self-only and $15,000 family) requirements, and that does not provide coverage below the minimum deductible except for "preventive services."

The Coronavirus Aid, Relief, and Economic Security (CARES) Act amended Code Section 223 to specifically allow HDHPs to provide first-dollar coverage for telehealth and other remote care services, and to provide such coverage is not “disqualifying coverage” if provided by another plan – such as an HSA-compatible health reimbursement arrangement (HRA). These changes were effective with respect to telehealth and other remote care services provided on or after January 1, 2020, with respect to plan years beginning on or before December 31, 2021. The Consolidated Appropriations Act, 2022 (“CAA 2022”), temporarily reinstated these rules for months beginning after March 31, 2022, and before January 1, 2023.

The CAA 2023 provision extends the special telehealth exception to plan years beginning after December 31, 2022 and before January 1, 2025. For calendar year plans, this means the extension will apply to the 2023 and 2024 plan years.

For non-calendar year plans, it’s a bit more complicated. Before this latest extension was enacted, the special exception applied to months beginning before January 1, 2023; therefore, in the case of a 2024 plan year that started on October 1, 2022, the special telehealth exception will not be available from January through September of 2023. It will become available again for the full plan year beginning on October 1, 2023. It will also be available for the full plan year beginning on October 1, 2024, even though that plan year will not end until September 30, 2025.

The CAA 2023 provision also extends the special designation of telehealth and other remote services as “disregarded coverage.” Certain coverage – e.g., dental, vision, and accident-only insurance – is specifically disregarded for purposes of determining if someone has “disqualifying coverage.” As a result of this extension, HSA-compatible HRAs and Health FSAs can continue to reimburse participants for telehealth and other remote care services incurred during plan years beginning before January 1, 2025 without affecting the individual’s ability to fund an HSA. However, an HRA or health FSA cannot reimburse a participant for these services to the extent they are also covered by the HDHP.

Note that the special telehealth exception and the special designation of telehealth as “disregarded coverage” are optional provisions that plans are not required to implement. Plans that have not previously taken advantage of these special rules may want to reconsider now that they know they will be available for at least the next two years.

Option for Certain State and Local Governmental Plans to Opt-out of Mental Health Parity Eliminated

Historically, self-funded non-governmental group health plans have been able to opt-out of mental health parity and certain other group health plan mandates included in the Public Health Service Act. More than 200 self-funded state and local government plans have exercised this option with respect to the mental health parity rules.

CAA 2023 includes a provision that eliminates the opt-out option with respect to mental health parity effective as of the date of the bill’s enactment – December 29, 2022. Note that the CAA 2023 provision does not change the opt-out rules relating to benefits for mothers and newborns, required coverage for reconstructive surgeries following mastectomies, or coverage of dependent students on medically necessary leaves of absence.

Rewards Policy Insider will provide updates on regulatory guidance implementing these provisions as it is issued.

Agencies Extend Prescription Drug Data Collection Deadline

On December 23, 2022, the Departments of Health and Human Services, Labor, and Treasury (Agencies) announced a grace period until January 31, 2023 for group health plans and health insurance issuers to file required prescription drug and health care spending reports for 2020 and 2021.

Background

The Consolidated Appropriations Act, 2021 (CAA, 2021) added a provision to ERISA, the Internal Revenue Code, and the Public Health Service Act to require group health plans and health insurance issuers to annually file a report disclosing certain information about prescription drug and other health care expenditures. The statutory deadline for the initial report was December 27, 2021, with annual reporting beginning on June 1, 2022. However, interim final regulations issued in November 2021 delayed the deadline for the initial report until December 27, 2022 and moved the deadline for the first annual report to June 1, 2023.

The information that must be reported includes, among other things:

- general information regarding the plan or coverage;
- the 50 most frequently dispensed brand prescription drugs;
- the 50 most costly prescription drugs by total annual spending;
- the 50 prescription drugs with the greatest increase in plan expenditures over the preceding plan year;
- total spending by the plan or coverage broken down by the type of costs; and
- the average monthly premiums paid by participants, beneficiaries, and enrollees and paid by employers.

Additionally, plans and issuers must report the impact on premiums of rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators or service providers.

Submission Grace Period

Recognizing the “significant operational challenges” group health plans and issuers have encountered trying to comply with the new requirement, the Agencies on December 23 announced in a set of Frequently Asked Questions (FAQs) that they will not consider a plan or issuer out of compliance with the reporting requirements so long as they make a good faith submission of the required information for 2020 and 2021 no later than January 31, 2023.

Note that this special grace period, and the accompanying “good faith” relief, applies only with respect to the required reporting of data for 2020 and 2021. The FAQs do not provide any special relief with respect to the data reporting for 2022, which as of now is still due by June 1, 2023.

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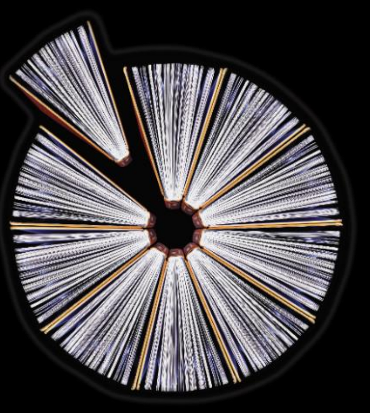

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