Deloitte.

United States | Human Capital | 22 September 2023

Rewards Policy Insider
2023-19

In this Issue:

1. IRS Delays SECURE 2.0 Roth Catch-Up Contribution Requirement
2. 10th Circuit Rules Administrator Improperly Denied Claim for Residential Treatment Services
3. Compliance Reminder: Group Health Plans Must Provide Part D Creditable Coverage Notice Before October 15

IRS Delays SECURE 2.0 Roth Catch-Up Contribution Requirement

In guidance released at the end of August, the Internal Revenue Service ("IRS") delayed the effective date of the SECURE 2.0 Act of 2022 ("SECURE 2.0") provision that requires catch-up contributions made by high-earning employees to be made on a Roth basis. In addition to the delay, the guidance addresses some technical issues regarding the new catch-up contribution provision and provides a window into possible future guidance on the requirement.

Background

Under section 603 of SECURE 2.0, a 401(k), 403(b), or governmental 457(b) plan that permits catch-up contributions (i.e., additional retirement plan contributions available to individuals age 50 or older) must require those contributions to be designated as Roth contributions, but only in the case of individuals whose wages are in excess of $145,000 (adjusted annually for inflation beginning in 2025) for the prior year. The statute provides that the provision applies beginning in 2024. However, in the wake of SECURE 2.0's enactment, it quickly became clear that it would be difficult, if not impossible, for many plans to implement this change because of the time and resources it will take for plans to update their systems to account for the new requirement. Many trade associations and retirement plan companies petitioned the IRS to delay the effective date of the Roth catch-up requirement.

IRS Notice 2023-62

On August 25, 2023, the IRS released Notice 2023-62, which grants a highly-requested two-year delay – called an "administrative transition period" in the guidance – of the effective date of section 603. Thus, for the 2024 and 2025 tax years, catch-up contributions made by individuals with wages over $145,000 (or the inflation-adjusted threshold in 2025) will be automatically treated as satisfying the Roth catch-up requirement, regardless of whether they were actually made on a Roth basis. In addition, a plan that does not allow for Roth contributions at all will not be treated in violation of SECURE 2.0 during this time period. Unless the IRS releases further relief in the future, plans must be prepared to implement section 603's requirement starting in 2026.

In addition to the two-year delay, the Notice addresses some technical issues in section 603. For example, the language of section 603 could be interpreted to prohibit *all* catch-up contributions in 2024 and later years for 401(k) and 403(b) plans, and as requiring *all* employees participating in governmental 457(b) plans to make age-based catch-up contributions on a Roth basis (not just those with wages over $145,000). The IRS clarifies in the Notice that a plan may continue to allow for catch-up contributions in 2024 and later years, and for plan participants that make less than $145,000, catch-up contributions are not required to be designated as Roth.

Lastly, the Notice provides a preview of future guidance regarding section 603 and requests public comments on the guidance. For example, the Notice states that future guidance is expected to provide that the Roth catch-up requirement would not apply to a plan participant who does not have "wages," as defined in Code section 3121(a), in the prior calendar year from the employer sponsoring the plan; therefore, a partner or self-employed individual would not be subject to section 603. The Notice also requests public comments specifically on whether a plan should be allowed to prohibit participants who are above the

inflation-adjusted $145,000 wage threshold from making catch-up contributions at all, while allowing eligible participants under the threshold to make catch-up contributions. Comments are due October 24, 2023.

Tenth Circuit Rules Administrator Improperly Denied Claim for Residential Treatment Services

In a case involving a minor beneficiary under a group health plan whose father sought coverage for her stay in residential treatment facilities for mental health and substance abuse issues, the U.S. Court of Appeals for the Tenth Circuit held that the claims administrator improperly denied the claim because it did not follow ERISA's claims processing requirements. The court emphasized that an administrator must engage in "meaningful dialogue" with claimants when deciding their benefits claims.

Facts of the Case

ERISA requires a plan that denies a claim for benefits to provide adequate notice in writing to the participant or beneficiary, setting forth the specific reasons for the denial. The plan must also afford a reasonable opportunity for the individual to receive a full and fair review by the plan's fiduciary.

Plaintiff "David P." was enrolled in his employer's ERISA-covered group health plan, which covered mental health and substance abuse services that are "medically necessary" (as defined by the plan). David P.'s teenage daughter suffered from significant mental health and substance abuse-related issues, and, at the recommendation of her physicians, received back-to-back treatments at two separate residential treatment centers over the course of about a year. A third-party behavioral health administrator had discretionary authority to interpret the plan's provisions and make decisions regarding benefits claims. The administrator's own guidelines allowed coverage for mental health/substance abuse treatment such as intensive outpatient care, inpatient hospital care, and residential treatment in certain types of centers.

Following David P.'s submission of claims to cover his daughter's treatment, the administrator denied coverage for all of the daughter's time at one facility and nearly all of her stay at the second facility. Generally, the administrator stated that it denied coverage because there was no clinical information indicating that the daughter required the 24-hour monitoring that two treatment centers provided, and she could have been treated in a less intensive setting because it was documented that she did not want to hurt herself or others.

After exhausting the lengthy claims and appeals process with the administrator, David P. sued the administrator (and the employer) seeking to recover benefits from the entirety of the stays at the two treatment centers, claiming that the administrator had improperly denied the claims. In 2021, a Utah district court

concluded that the administrator violated ERISA by improperly denying the plaintiff's claims.

Tenth Circuit Decision

On appeal, the Tenth Circuit affirmed the district court's ruling, holding that that the administrator abused its discretion in denying benefits because the manner in which it denied the claims violated ERISA's claims processing requirements. Specifically, it "deprived [the plaintiff] of the meaningful dialogue ERISA requires between claimants and the plan administrator deciding their benefits claims." Thus, in the court's opinion, it is not sufficient for an administrator to merely document the reasons for a denial in its internal notes, as the administrator did with respect to the claims – instead, the administrator should have communicated those reasons to the plaintiff. Similarly, the court found that if the administrator disagreed with the treatment recommendations – such as the need to stay in a residential center – that were made by the daughter's health care providers, it should have stated this point in the denial letters and explained why, instead of disregarding their opinions without providing an explanation.

The court expressed multiple additional concerns with the administrator's claims processing, such as the fact that the denials were inconsistent because it had denied coverage for all of the daughter's stay at one facility but covered a week (but no more) at another. In addition, the court believed that the denials had contradicted the administrator's own guidelines for coverage, which provide that residential treatment can be warranted even if the patient is not a current risk to herself or others. The Tenth Circuit also expressed concern over the fact that the administrator did not consider the daughter's treatment for substance abuse as independent grounds for coverage, despite David P. raising this in the appeals process. The administrator also failed to explain in its denial letters why the daughter's care was not "medically necessary."

This case serves as a reminder that claims administrators must be sure to fulfill ERISA's requirement of, in the words of the Tenth Circuit, having a "meaningful dialogue" with claimants about claims denials. Within the Tenth Circuit, this may require the inclusion of significant details and explanations in denial letters, not just in internal notes taken by the administrator.

Compliance Reminder: Group Health Plans Must Provide Part D Creditable Coverage Notice before October 15

Each year, before October 15, group health plans that provide prescription drug benefits must notify all Medicare-eligible participants if the plan's prescription drug coverage is "creditable coverage."

The written notice must go to all Medicare-eligible participants and their dependents, regardless of whether they are covered as active employees, COBRA beneficiaries, or retirees. This would include those who are age 65 and older, as well as those who are Medicare-eligible due to disability or end-stage

renal diseases. Some group health plans merely provide the notice to all participants in order to avoid inadvertently overlooking someone who should have received it.

In addition to the annual creditable coverage notice, the notice also must be provided at certain other times – such as when a Medicare-eligible individual first joins the group health plan.

The notice is important because individuals who do not enroll in Medicare Part D when they first become eligible will be subject to a late enrollment penalty unless they maintain other creditable coverage.

What Coverage is Creditable?

In order for a group health plan's prescription drug coverage to be "creditable," its actuarial value must equal or exceed the actuarial value of standard prescription drug coverage under Medicare Part D. In general, the actuarial equivalence test measures whether the expected amount of paid claims under the group health plan's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Part D benefit.

In addition to the creditable coverage notice to participants, group health plans also must report its creditable coverage status to CMS each year using the Online Disclosure to CMS Form. This annual disclosure is generally required no more than 60 days before the beginning of each plan year, as well as within 30 days of any change in a plan's creditable coverage status.

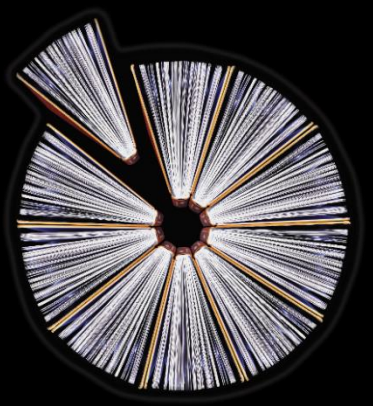
For additional information on these requirements, including links to official model notices of creditable coverage, see the CMS website.

Visit the Archive

All previous issues of the Rewards Policy Insider are archived on Deloitte.com and can be accessed here.

Don't forget to bookmark the page for quick and easy reference!

Upcoming editions will continue to be sent via email and will be added to the site on a regular basis.



Get in touch

Subscribe/Unsubscribe

should consult a qualified professional adviser. Deloitte shall not be responsible for any loss sustained by any person who relies on this publication.