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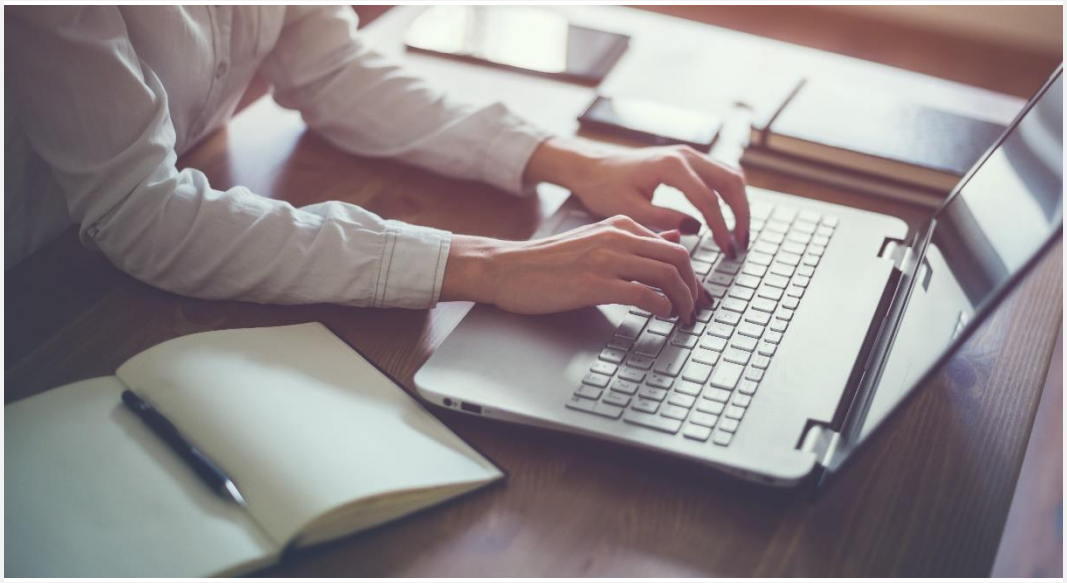

In this Issue:

IRS Releases Long-Awaited Final RMD Regulations

Following the publication of proposed regulations updating the rules governing required minimum

distributions (RMDs) in February 2022, the Internal Revenue Service (IRS) released the final version of the RMD regulations in July. The amended regulations generally reflect the amendments to the RMD rules that Congress enacted as part of the SECURE Act of 2019 (SECURE 1.0), as well as some provisions from the SECURE 2.0 Act of 2022 (SECURE 2.0).

Background

The Internal Revenue Code (Code) and the corresponding regulations issued by the IRS provide rules that determine the minimum amount that must be distributed from a retirement plan account or IRA once the account owner reaches a certain age, called the "required beginning date." The RMD rules were modified significantly by SECURE 1.0 and SECURE 2.0. For example, SECURE 1.0 increased the required beginning date and created the so-called "10-year rule," under which generally, upon the participant's death, the participant's beneficiary is required to withdraw the entire interest from the account within 10 years. SECURE 1.0 also created special, more favorable rules for eligible designated beneficiaries (EDBs), such as surviving spouses and minor children. SECURE 2.0 once again increased the required beginning date, made changes to the annuitization rules in the RMD regulations, and reduced the penalty for failures to take an RMD, among other changes.

In February 2022, the IRS published proposed regulations to reflect SECURE 1.0's changes to the RMD rules. During the period in which the IRS was working on finalizing the regulations, Congress enacted the additional RMD changes in SECURE 2.0. IRS officials have indicated in comments that the final RMD regulations would incorporate some of the more straightforward RMD rule changes in SECURE 2.0, but that other SECURE 2.0 changes would need to be issued as a new set of proposed regulations.

Final Regulations

On July 18, 2024, the IRS released the highly anticipated final RMD regulations. The lengthy and complicated final regulations generally reflect amendments to the RMD rules that were made by SECURE 1.0, as well as some provisions from SECURE 2.0. The final regulations will apply beginning on January 1, 2025.

High-level takeaways from the final regulations include:

- Required beginning date. The final regulations reflect SECURE 2.0's increased required beginning date to age 75.
- 10-year rule interpretation. The final regulations retain a controversial interpretation of the 10-year rule that was a part of the 2022 proposal. Essentially, the proposed regulations explained that, if the 10-year rule applies, distributions from the account must continue *throughout* the 10-year period in certain situations. This interpretation surprised many stakeholders who had interpreted the 10-year rule as permitting a single lump sum distribution at the *end* of the 10-year period. (A more detailed discussion of the 10-year rule interpretation and the temporary relief that was provided by the IRS is available in Rewards Policy Insider 2024-10.)
- Applicability to 457(b) plans. The final regulations provide that the 10-year rule applies to 457(b) plans of both governments and tax-exempt employers. This was not clear from the proposed regulations, so many commenters had asked for clarification on this point.

- **EDBs.** The proposed regulations contained an unnecessarily complicated rule that would have applied when a plan participant died after they had begun taking RMDs from their account and their EDB was older than the participant. The final regulations eliminate this rule.

New Proposed Regulations

In line with IRS officials' prior comments that they would need to release a second set of proposed regulations to incorporate some changes from SECURE 2.0 that require stakeholder input, the regulatory package released on July 18th also contains new proposed regulations that would further modify the RMD regulations. The proposed regulations address, among other things, provisions in SECURE 2.0 that changed the rules for qualifying longevity annuity contracts, addressed the annuity rules under the RMD regulations, and reduced the penalty for failures to take an RMD. Comments on the proposed regulations are due by September 17, 2024.

Federal and State Policymakers Continue to Focus on PBMs

Both the Federal Trade Commission (FTC) and a Congressional committee have recently released reports claiming that Pharmacy Benefit Managers (PBMs) are driving prescription drug costs higher for consumers. And even though the wait for Federal PBM reform legislation continues, states continue to push ahead, with Pennsylvania being the latest to enact new PBM reforms. In the meantime, the Supreme Court is considering whether to hear a case that potentially could curtail the ability of states to implement PBM reforms for self-insured plans subject to ERISA.

FTC and Congressional Committee Reports

The FTC report ("Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies") is based on information provided to FTC by a group of large PBMs in response to an FTC order. The report indicates that its findings are preliminary because the PBMs have so far failed to fully comply with the order.

According to the FTC report, due to horizontal consolidation of PBMs the top 3 PBMs now process almost 80% of all prescriptions dispensed by U.S. pharmacies, and the top 6 process almost 90%. Furthermore, the largest PBMs are vertically integrated – generally meaning they own (or are in the same control group as) certain pharmacies, health plans, and health care providers.

The report highlights a number of issues resulting from this horizontal and vertical integration of PBMs, including the following:

- Leading PBMs exercise significant power over Americans' access to drugs and the prices they pay;
- Vertically integrated PBMs may have the ability and incentive to prefer their own affiliated businesses, which can disadvantage independent pharmacies and lead to higher prescription drug costs; and
- PBMs and brand drug manufacturers sometimes negotiate rebates that are specifically conditioned on limiting access to lower cost generic alternatives.

The report by the House Committee on Oversight and Accountability staff ("The Role of Pharmacy Benefit Managers in Prescription Drug Markets") follows similar themes, but also notes that some of the cost management techniques routinely employed by PBMs – including prior authorization, fail first policies, and "formulary manipulations" – are having "significant detrimental impacts on Americans' health outcomes."

The House Committee report also notes that, in response to state regulation and possible Congressional action, PBMs are already moving certain functions overseas in order to avoid transparency and other proposed reforms.

Speaking of Reform …

There is still a chance that Congress will enact a package of PBM reforms before the 118th Congress adjourns late this year or early next year. In the meantime, individual states continue to act.

One of the most recent examples is Pennsylvania, where Gov. Josh Shapiro signed a new set of PBM reforms into law on July 17th. Among other things, the new Pennsylvania law:

- prohibits certain "steering" practices, such as requiring a policyholder to purchase drugs exclusively through a mail order pharmacy or at a pharmacy owned or controlled by the PBM.
- prohibits a pharmacy from charging a price that is more than the consumer would pay if they walked in off the street and paid in cash or that is more than the pharmacy would receive from the insurer or PBM.
- contains robust network adequacy requirements that require a PBM to establish a network that meets or exceeds federal Medicare access standards.

These and other requirements will be applicable to health insurance policies approved and pharmacy contracts issued, renewed, or amended after November 14, 2024. Certain other provisions of the new law, including new PBM transparency requirements, will be implemented in 2026.

What about the Supreme Court?

Late last year, the 10th Circuit Court of Appeals ruled that certain key elements of Oklahoma's PBM reform law were preempted by ERISA – and thus could not be enforced with respect to self-insured group health plans subject to ERISA. Some have argued that the 10th Circuit's decision is at odds with an earlier Supreme Court holding that a Vermont PBM reform law, which regulated PBM reimbursements, was not preempted by ERISA.

Oklahoma has petitioned the Supreme Court to review the 10th Circuit's decision, and that request is being supported by a number of other stakeholders – including a group of states.

If the Supreme Court decides to grant Oklahoma's petition, its ultimate decision could potentially alter, in a significant way, the ability of states to regulate PBMs.

A decision by the Supreme Court to grant or deny Oklahoma's petition is expected sometime this fall. If the petition is granted, a final ruling likely would be issued in early summer of 2025.

Final Mental Health Parity Regulations Coming Soon

Long-anticipated final regulations under the Mental Health Parity and Addiction Equity Act are now under review by the White House's Office of Management and Budget (OMB), and likely will be published in the Federal Register sometime in August or September.

Background

In general, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans that offer mental health and substance use (MH/SU) disorder benefits to provide such benefits on no less favorable terms than they provide medical and surgical (MS) benefits. These parity requirements apply both with respect to a plan's quantifiable treatment limitations – e.g., cost-sharing requirements – and its non-quantifiable treatment limitations (NQTL's), such as prior authorization requirements and provider network composition. The Affordable Care Act of 2010 extended the mental health parity rules to the individual health insurance market, among other things.

The Consolidated Appropriations Act, 2021 (CAA, 2021) amended the MHPAEA to expressly require group health plans to prepare comparative analyses of the design and application of any NQTL's, and to share these comparative analyses with appropriate Federal and state regulators upon request. Additionally, CAA, 2021 requires the agencies to submit an annual report on their NQTL comparative analyses reviews to Congress.

Most recently, the Consolidated Appropriations Act, 2023 (CAA, 2023) eliminated the ability of self-funded, non-Federal governmental plan sponsors to opt-out of the MHPAEA's requirements.

Overview of Proposed Regulations

According to the preamble to the proposed regulations, the proposals would:

- Make clear that MHPAEA requires that individuals can access their MH/SU benefits in parity with MS benefits;
- Provide specific examples that make clear:
    - that plans and issuers cannot use more restrictive prior authorization and other medical management techniques for MU/SU benefits
    - standards related to network composition for MH/SU benefits

    - factors to determine out-of-network reimbursement rates for MH/SU providers;
- Require plans and issuers to collect and evaluate outcomes data and take action to address material differences in access to MH/SU benefits as compared to MS benefits, with a specific focus on ensuring that there are not any material differences in access as a result of the application of their network composition standards;
- Codify the comparative analyses requirement, including evaluating standards related to network composition, out-of-network reimbursement rates, and prior authorization NQTLs; and
- Implement the sunset provision for self-funded, non-Federal governmental plan elections to opt-out of MHPAEA.

Approximately 9,500 public comments on the proposed regulations were submitted during the extended comment period, which ended on October 17, 2023.

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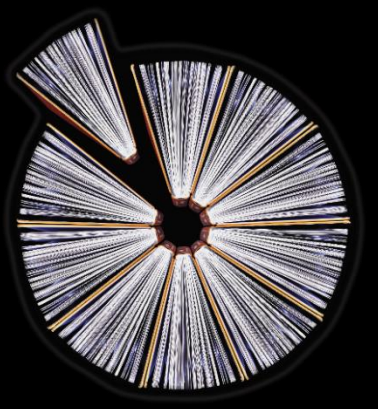

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