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GRS INSIGHT

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Required Minimum Distributions After the SECURE Act and SECURE 2.0

As noted in the July 2018 issue of *GRS Insight,*[1] the primary purpose of pension plans is to provide employees with a savings vehicle for retirement. However, the ability to defer the distribution of amounts from such plans does not continue indefinitely. Section 401(a)(9) of the Internal Revenue Code of 1986, as amended (the Code), provides a number of rules regarding Required Minimum Distributions (RMDs) from a pension plan.

The *Setting Every Community Up for Retirement Enhancement Act* (SECURE Act), and later, the *SECURE Act of 2022* (SECURE 2.0), made a number of changes to the requirements under Code Section 401(a)(9). These changes are reflected in the final regulations (89 Fed. Reg. 58886)[2] and proposed regulations (89 Fed. Reg. 58644)[3] issued on July 19, 2024. However, it is important to note that many of the changes will not apply to defined benefit plans. The key rules applicable to governmental defined benefit plans are outlined below.

Timing

Code Section 401(a)(9) provides that the RMDs are required to begin by April 1 of the calendar year following the later of the calendar year in which a member attains "RMD age" or retires. This is the member's "required beginning date."[4] Therefore, during a member's lifetime, benefits under the plan must, no later than the member's "required beginning date": 1) be distributed in full; or 2) begin to be distributed over the life of the member or the joint lives of the member and designated beneficiary (i.e., as an annuity).

After the SECURE Act and SECURE 2.0, a member's RMD age for purposes of determining the required beginning date depends on the member's date of birth, as follows:

- If the member was born before July 1, 1949, the member's RMD age is 70½.
- If the member was born after June 30, 1949 and before January 1, 1951, the member's RMD age is 72.
- If the member was born after December 31, 1950 and before January 1, 1960, the member's RMD age is 73.
- If the member was born after December 31, 1959, the member's RMD age is 75.

[1] *See* https://www.grsconsulting.com/wp-content/uploads/2019/07/GRS-Insight-July-2018.pdf

[2] *See* https://www.federalregister.gov/documents/2024/07/19/2024-14542/required-minimum-distributions

[3] *See* https://www.federalregister.gov/documents/2024/07/19/2024-14543/required-minimum-distributions

[4] Alternatively, a plan may track the rule for 5% owners (which is not otherwise applicable to governmental plans) and require a member to begin receiving distributions by April 1 of the calendar year after the member reaches RMD age, even if the member has not retired.

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After a member's required beginning date, the deadline for taking subsequent RMDs is December 31 of each year, including the year of the member's required beginning date. This means that a member that delays the first RMD to the member's required beginning date will receive two RMDs in that year.

Amount

A member's RMD is the amount that must be paid each year to satisfy these rules, which is based on the member's life expectancy (or the member's and the beneficiary's joint life expectancies). For most defined benefit plans, this amount is actuarially increased for a member that retires after age 70½. However, this requirement does not apply to governmental plans.

Defined benefit plans generally meet the RMD requirements by making annuity payments over the life of the member (or the life of the member and the 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, and 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 immediately preceding calendar year and dividing the lump sum amount by the applicable distribution period under the Uniform Lifetime Table (or the Joint and Last Survivor Table where the member's beneficiary is the member's spouse that is at least ten years younger). Alternatively, the lump sum amount may be expressed as an annuity, with the portion of the lump sum payment that is an RMD to be equal to one year of annuity payments.

Payment of RMDs After the Member's Death

After the member's death, RMDs must continue to be paid to the member's beneficiary. The required timing for such distributions depends on whether the member died: 1) before; or 2) on or after the required beginning date.

If the member dies on or after the required beginning date, any remaining amounts must be distributed to the beneficiary at least as rapidly as they were paid to the member prior to death. (If a member dies after commencing distributions as an annuity, the member will generally be treated as dying after the required beginning date, even if the member had not otherwise reached the required beginning date.)

If the member dies prior to the required beginning date, the entire interest of the member generally must be distributed within five years of the member's death. However, if the member has a designated beneficiary, and such form of payment is permitted under the plan, amounts may instead be distributed over the life expectancy of the beneficiary, if distributions begin by the end of the calendar year following the calendar year of the member's death. Special rules also apply if the designated beneficiary is the member's spouse.

Taxation and Withholding

RMDs are taxed as ordinary income at the member's (or beneficiary's) federal income tax rate (unless any portion represents a return of after-tax basis). Further, since RMDs are not eligible rollover distributions, 10% voluntary withholding will apply to any amount distributed as an RMD.

Failure to Take/Pay an RMD

If a member or beneficiary fails to withdraw the full amount of an RMD for any year, any portion of the required amount not timely withdrawn is subject to an excise tax. Generally, that tax will be 25% of the amount by which the RMD exceeds the actual amount distributed during the calendar year.[5] For example, if the member fails to take an RMD of $10,000, the member will owe an additional tax of $2,500.

The Internal Revenue Service (IRS) is authorized to waive the applicable excise tax. To seek such a waiver on a case-by-case basis, the member or beneficiary can file Form 5329, *Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts*, for each year in which there is a shortfall, along with the federal tax return for the year in which the full amount

[5] The excise tax may be reduced to 10% if the deficiency is resolved within a limited correction window (generally within two years). Further, for deficiencies applicable to taxable years prior to 2023, the excise tax is 50% of the shortfall.

of the RMD was not taken. The waiver request should also include a letter of explanation providing that the shortfall in distributions was due to reasonable error and that reasonable steps are being (or have been) taken to remedy the shortfall.

In addition, the failure to timely pay all or a portion of an RMD is an operational failure for the plan. While there is no excise tax applicable to the plan, paying the RMD (with an interest adjustment for the late payment) is necessary to correct the failure and maintain the tax-qualified status of the plan. This correction can be completed through either the Self-Correction Program or the Voluntary Correction Program under Revenue Procedure 2021-30[6] (EPCRS). A VCP filing could also include a request to waive any excise taxes assessed against all impacted members and beneficiaries. If this is the case, the members and beneficiaries would not need to file an individual Form 5329 to request a waiver.

Governmental Plans

The RMD requirements affect all tax-qualified governmental retirement plans established by federal, state and local government agencies. However, such plans are subject to an overriding *reasonable and good faith* interpretation of the requirements when determining if the plan complies with Code Section 401(a)(9).

While this is helpful in theory, unfortunately, the IRS has not provided further explanation, in either the Code or related guidance, as to what a reasonable and good faith interpretation entails. Therefore, in most cases, governmental pension plans seek to satisfy the general rules for defined benefit plans in the payment of RMDs (to the extent governmental plans are not specifically exempted from a requirement (e.g., the actuarial increase requirement noted above)).

Missing Members

The IRS provides guidelines regarding missing members in the context of paying RMDs. In certain cases where a plan is unable to make an RMD to a member (or beneficiary) due to the plan's inability to locate the member, the IRS will not find an operational failure if the plan has taken the following steps:

- Searched plan and related plan, sponsor, and publicly-available records or directories for alternative contact information;
- Used a commercial locator service, a credit reporting agency, or a proprietary internet search tool to locate individuals; and
- Sent a letter via U.S. Postal Service certified mail to the last known mailing address and other known addresses.

If a pension plan has not completed the steps above in connection with the failure to timely pay an RMD, the IRS may assert that the plan has violated the RMD standards under the Code. In such case, the plan could be subject to disqualification, unless the failures are corrected with the IRS in accordance with EPCRS.

Conclusion

While governmental defined benefit plans are not subject to many of the increasingly complex rules under the SECURE Act and SECURE 2.0, the defined benefit plan rules retain many pitfalls where errors can occur. Therefore, it is advisable to consult with qualified legal counsel to ensure that plan provisions and operations comply with the applicable laws and regulations, including the reasonable and good faith standard.

SECURE 2.0: What Should Defined Benefit Plans Be Doing Now?

The enactment of the SECURE 2.0 Act of 2022 (SECURE 2.0) in late December 2022 brought about many changes for retirement plans, including governmental defined benefit plans. At this point, many of these SECURE 2.0 provisions are effective and require operational compliance. Similar to our January 2024 issue of *GRS Insight*[7], the chart on pages 4 and 5 outlines those key provisions that are effective now, along with related considerations, both for required changes and those optional provisions that may be offered to plan members.

[6] *See* https://www.irs.gov/pub/irs-drop/rp-21-30.pdf

[7] *See* https://www.grsconsulting.com/wp-content/uploads/2024/01/GRS-Insight-January-2024-Final.pdf

SECURE 2.0 Operational Compliance

Bill Section	SECURE 2.0 Change	Operational Considerations
Required Changes		
Increase in Required Minimum Distribution (RMD) age (Section 107)	The RMD age is increased to: i) age 73 for a member who was born after December 31, 1950 and before January 1, 1960; and ii) age 75 for a member who was born after December 31, 1959 (per the 2024 proposed RMD regulations).	A plan amendment will be needed to reflect the change. Applying the correct age is key to ensuring the proper calculation and treatment of RMDs (e.g., for withholding and rollover purposes). The 402(f) notice will need to be updated to reflect the new age requirement.[8]
Reduction in excess accumulation excise tax (Section 302)	Reduces the excise tax for failure to take RMDs from 50% of the deficiency to 25%. The excise tax is reduced further, to 10%, if the deficiency is corrected quickly (generally, within a two-year correction window).	This tax is imposed on the individual who did not take the RMD (though the failure to pay the full RMD is a qualification issue for the plan). Voluntary Correction Program (VCP) filings and excise tax returns remain available to request abatement of the excise tax.
Substantially equal periodic payment clarification (Section 323)	The exception to the 10% early withdrawal penalty for substantially equal periodic payments continues to apply after certain rollovers and for certain annuities.	For rollovers, a plan may rely on an employee's self-certification that the substantially equal periodic payment requirements are met (absent actual knowledge to the contrary), such that no additional taxes need to be reported. For annuities, the plan needs to ensure these payments comply with the required minimum distribution rules.
Section 72(t) exception for individuals with a terminal illness (Section 326)	Creates a new exception to the 10% early withdrawal penalty for distributions to individuals with an illness or condition that is reasonably expected to result in death in 84 months or less.	The employee must be otherwise eligible for a distribution, as no separate in-service distribution right was created under SECURE 2.0 (though a proposed technical corrections bill would create such right). A self-certification of such illness is not sufficient. The member's physician must provide a certification of terminal illness. Notice 2024-2[9] provides the required contents of the certification. The withdrawal may be repaid within three years from the day after the date of distribution. The 402(f) notice will need to be updated to reflect this Section 72(t) exception.
Section 72(t) exception for Qualified Public Safety Employees (QPSEs) for 25 years of service (Section 329)	Creates a new exception to the 10% early withdrawal penalty for distribution to those qualified public safety employees who have separated from service and have completed 25 years of service.	The plan must confirm the service requirement is met. The 402(f) notice will need to be updated to reflect this Section 72(t) exception.
Section 72(t) exception expansion of QPSE definition (Section 330)	Expands the definition of qualified public safety employee for purposes of the 10% early withdrawal penalty to include certain corrections officers and forensic security employees.	Members in these categories are now eligible for the age 50 and 25 years of service exceptions to the 10% early withdrawal penalty. The plan must confirm the member is in an eligible job classification (though the IRS has not provided guidance relating to these classifications).

[8] The IRS has not yet updated its model notice to reflect the new changes, but many plans have made changes to reflect provisions applicable to their plan.

[9] *See* https://www.irs.gov/pub/irs-drop/n-24-02.pdf

SECURE 2.0 Operational Compliance

Bill Section	SECURE 2.0 Changes	Operational Considerations
Optional Changes		
Plan overpayment corrections (Section 301)	A governmental defined benefit plan will not jeopardize its tax-favored status solely due to a determination not to recover an "inadvertent benefit overpayment" or otherwise to amend the plan to permit the increased benefit.	If an overpayment falls within the definition of "inadvertent benefit overpayment," there is no collection required and, therefore, it is reasonable to forego any/all collection efforts. In some cases, the overpayment may also be eligible for rollover. To the extent that Code Section 401(a)(17) or 415 is implicated by the overpayment, the overpayment generally falls outside this exception. State fiduciary standards should be considered since they may limit a plan's ability to forego recoupment. If current plan terms require recoupment, a plan amendment will be needed to follow this relief.
Expansion of Employee Plans Compliance Resolution System (EPCRS) (Section 305)	Eligible inadvertent failures may now be self-corrected under EPCRS at any time unless: i) the IRS identified the failure before self-corrective measures commenced; or ii) the self-correction was not completed in a reasonable period after the failure was identified.	Plans have additional rights and flexibility in self-correcting a number of failures. The updated EPCRS, which should add preapproved correction methods and general principles of correction has not been issued. In the meantime, however, reliance on Notice 2023-43[10] is available until the updated Revenue Procedure is issued.
Surviving spouse treatment as employee (Section 327)	Allows a spouse beneficiary that is the member's sole designated beneficiary to elect treatment as the employee for RMD purposes.	If the member dies prior to his required beginning date, the "election" is automatic. If elected/defaulted, the applicable distribution period after the member's year of death is now determined under the uniform life table. The 2024 final and proposed RMD regulations provide additional clarification regarding this election.
Expansion of exclusion from gross income for health and long-term care insurance distributions from governmental plans (Section 328)	The plan may now distribute funds to a member to pay for qualified health and long-term care insurance premiums (rather than as a direct payment to the insurer).	A plan amendment will be needed, if implemented. If payments are made to the member, the member must include a self-certification with their tax return that such funds did not exceed the amount paid for premiums in the year of the distribution to be eligible for the exclusion from gross income. The 402(f) notice will need to be updated to reflect this flexibility (if implemented).
Increased distribution and loan rights due to qualified federally declared disasters (Section 331)	Provides permanent special rules governing plan distributions, along with a new exception to the 10% early withdrawal penalty, and loans in cases of qualified federally declared disasters.	This distribution right provides some immediate relief without needing to wait for specific IRS relief for each disaster. The plan should consider procedures to confirm eligibility (e.g., the member's primary residence is in a federally declared disaster area). The withdrawal may be repaid within three years from the day after the date of distribution. The amount may be included in gross income over a three-year period. The 402(f) notice will need to be updated to reflect this Section 72(t) exception (if implemented). The IRS issued FAQs (FS-2024-19)[11] to provide additional clarification on these distributions.

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

[11] *See* https://www.irs.gov/newsroom/disaster-relief-frequent-asked-questions-retirement-plans-and-iras-under-the-secure-20-act-of-2022

Plan Amendments

For governmental plans, SECURE 2.0 plan amendments are not due until December 31, 2029. However, such amendments will apply retroactively to each provision's effective date (or the date implemented, if an optional provision) and plans must maintain operational compliance as if the amendment were in effect for the entire period. Though the IRS has yet to update its Listing of Required Modifications ("LRMs," which contain model language) for defined benefit plans, the LRMs for defined contribution plans and cash or deferred arrangements have been updated and include language to address some of the above changes.[12]

Tri-Agencies Finalize Sweeping Changes to Mental Health Parity Requirements

On September 9, 2024, the Departments of Labor, Health and Human Services, and Treasury (collectively, the Tri-Agencies) released the Mental Health Parity and Addiction Equity Act (MHPAEA) Final Rule.[13] The Final Rule establishes new mental health parity obligations and implements existing compliance requirements under the *Consolidated Appropriations Act, 2021* (CAA). Group health plans have until the first day of the first plan year beginning on or after January 1, 2025 to come into compliance with most of the new parity requirements. However, plans have until the first day of the first plan year beginning on or after January 1, 2026 to comply with some of the more challenging compliance reforms.

Mental Health Parity Background

MHPAEA was enacted in 2008 and significantly expanded the mental health parity requirements established in 1996. MHPAEA requires plans to ensure that both "financial requirements" (e.g., copays, coinsurance) and "treatment limits" (e.g., visit limits) are only applied to mental health/substance abuse disorder (MH/SUD) benefits if they are also applied to substantially all of the medical/surgical (M/S) benefits in an amount no more restrictive than the predominant level of the financial requirement or treatment limit.

The 2010 MHPAEA regulations provided that Non-Quantitative Treatment Limits (NQTLs) are limits on the scope or duration of benefits that are not numeric, and specified that NQTLs (e.g., prior authorization, concurrent review, provider admission to a network) applied to MH/SUD benefits must be comparable to, and no more stringent than, the NQTLs applied to M/S benefits in the same benefit classification (e.g., inpatient, outpatient). Congress codified this requirement in 2016.

In 2021, Congress enacted the CAA that requires the Tri-Agencies to audit at least 20 group health plans and issuers annually for NQTL compliance. Plans and issuers must provide their NQTL documentation to their applicable State regulator or the Department of Labor (DOL) or the Department of Health and Human Services (HHS) upon request. The CAA also established a Corrective Action Plan (CAP) process if a plan or issuer cannot demonstrate their NQTLs are compliant. The DOL and HHS are required to identify by name the plans and issuers found noncompliant in an annual report to Congress.

On July 25, 2023, the Tri-Agencies released the MHPAEA Proposed Rule, a technical release with proposed data requirements (and safe harbor), and the 2023 MHPAEA Comparative Analysis Report to Congress.[14]

The Final Rule's Implications for Plans

Plans only have a few more months to come into compliance with the Final Rule's requirements effective for plan years beginning in 2025. Plan sponsors should

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[12] *See* https://www.irs.gov/pub/irs-tege/dc-lrm0124.pdf and https://www.irs.gov/pub/irs-tege/coda-lrm0124.pdf

[13] Requirements Related to the Mental Health Parity and Addiction Equity Act, 89 Fed. Reg. 77586 (Sept. 23, 2024) (codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pts. 146 & 147).

[14] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552 (Aug. 3, 2023) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pts. 146 & 147); Department of Labor, Technical Release 2023-01P (July 25, 2023) (available at: https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/23-01); Department of Labor, MHPAEA Comparative Analysis Report to Congress, July 2023 (July 25, 2023) (available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis).

review their group health plans for parity compliance and should also have NQTLs prepared in the event a State regulator, DOL, or HHS requests such information.

The Final Rule revised and established new definitions for key parity terms, finalized new comparative analyses content requirements, clarified the effect and ensuing obligations for a plan if the DOL or HHS Secretary determines the plan is noncompliant with MHPAEA, and imposed new disclosure obligations, among other changes.

Key provisions of the Final Rule are summarized below:

- **New NQTL Compliance Test.** A plan must satisfy a new two-part test for NQTL compliance: 1) the design and application requirement; and 2) the relevant data evaluation requirement. Beginning in 2025, a plan cannot impose an NQTL, unless (as written and in operation) the processes, strategies, evidentiary standards, or other factors used in "designing and applying" the NQTL to MH/SUD benefits in the classification are comparable to and are applied no more stringently than M/S benefits. Beginning in 2026, plans are prohibited from relying upon any factor or evidentiary standard if its underlying sources, standards, or information discriminates against MH/SUD benefits when compared to M/S benefits. Such discrimination will be found if the underlying data or standards are biased or unobjective in a manner that results in less favorable treatment for MH/SUD benefits in light of all the relevant facts and circumstances. Independent professional medical or clinical standards and fraud and abuse standards are not considered discriminatory if impartially applied. Beginning in 2026, a plan must also collect and evaluate "relevant data" in a manner reasonably designed to assess the impact of a particular NQTL on relevant outcomes related to access to MH/SUD and M/S benefits. The Tri-Agencies noted that more guidance is forthcoming on this data requirement.

- **A Material Difference in Outcomes Data is a "Strong Indicator" of Noncompliance.** Effective in 2026, if the relevant data evaluated suggests that the NQTL contributes to "material differences" in access to MH/SUD benefits, as compared to M/S benefits, such differences will be considered a "strong indicator" that the plan violates MHPAEA. A plan must take reasonable action, as necessary, to address such material differences in access where the relevant data suggests that an NQTL contributes to the difference. The "reasonableness" of a plan's remedial actions is a facts and circumstances determination.

- **Meaningful Benefits Standard.** Effective in 2026, plans must provide "meaningful benefits" (i.e., benefits for a "core treatment") for the treatment of a particular MH/SUD benefit in each classification, which is determined in comparison to the benefits provided for M/S conditions in the same classification. A "core treatment" is a standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of current medical practice.

- **NQTL Content Requirements.** The NQTL comparative analyses of plans must adhere to the new content requirements, which include six particular categories of information. For Employee Retirement Income Security Act of 1974 (ERISA) plans, the comparative analysis must also include a certification from a named fiduciary.

- **Compliance Opt-Out for Self-funded, Non-Federal Governmental Plans Eliminated.** In conformance with the *Consolidated Appropriations Act, 2023* (CAA, 2023), the Final Rule implemented the sunset provision for self-funded, non-Federal governmental plan elections to opt out of compliance with MHPAEA. HHS confirmed that MHPAEA opt-out elections expiring on or after June 27, 2023 may not be renewed.

Mental Health Parity Compliance Resources

- The Final Rule is available on the Federal Register at: https://www.federalregister.gov/documents/2024/09/23/2024-20612/requirements-related-to-the-mental-health-parity-and-addiction-equity-act

- The DOL released a condensed Fact Sheet on the Final Rule as well as one-page guidance document for plans and issuers, which are available respectively at: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/final-rules-under-the-mental-health-parity-and-addiction-equity-act-mhpaea and https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/new-mhpaea-rules-what-they-mean-for-plans-and-issuers.pdf

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