LEGISLATIVE AND REGULATORY DEVELOPMENTS IN 2023 OF INTEREST TO CHURCH-SPONSORED EMPLOYEE BENEFIT PLANS AND PROGRAMS

Presented to the Church Benefits Association
Indianapolis, Indiana
November 28, 2023 – November 30, 2023

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I. LEGISLATION AND LEGISLATIVE INITIATIVES

A. Consolidated Appropriations Act, 2023

At the end of 2022, President Biden signed into law the Consolidated Appropriations Act, 2023 (the "CAA 2023"). The CAA 2023 incorporates provisions impacting retirement and health plans, including retirement plan legislation commonly known as SECURE 2.0 and provisions extending the ability of high deductible health plans ("HDHPs") to cover telehealth and other remote care services prior to a participant's satisfaction of the HDHP deductible.

1. SECURE 2.0

The Church Alliance prepared a chart with a summary of the SECURE 2.0 provisions of interest to church plans. A copy of the chart is attached to this report as Appendix A.

On May 23, 2023, congressional leaders sent a letter to Department of Treasury and Internal Revenue Service ("IRS") officials clarifying the intent of several provisions of SECURE 2.0 and stating that Congress intends to issue technical corrections to correct errors in the statutory language.[1] Specifically, the technical corrections would fix the provision that could be read as eliminating all catch-up contributions beginning in 2024 and clarify that the applicable age for RMDs increases from 73 to 75 for individuals who turn 73 (not 74) after December 31, 2032.

2. Telehealth – Pre-HDHP Deductible and HSAs

CAA 2023 temporarily extends the flexibility for HDHPs to cover telehealth and other remote care services prior to a participant's satisfaction of the HDHP deductible. This optional design is allowed without jeopardizing an HDHP participant's eligibility to contribute to a health savings account ("HSA").

This design option was first allowed under Coronavirus Aid, Relief, and Economic Stability Act "(CARES Act") in 2020 through December 31, 2021. It was again available from April 1, 2022 through December 31, 2022. There was a gap during which the option was not available from January 1, 2022 through March 31, 2022.

Under CAA 2023, the relief is allowed for plan years beginning after December 31, 2022 and before January 1, 2025. This relief is optional. For calendar year plans, this relief covers the 2023 and 2024 plan years. For non-calendar year plans, this option would not apply until the beginning of the first plan year that begins after December 31, 2022. The IRS has not provided any relief for the first gap period (January 1, 2022 through March 31, 2022) or the second gap period (applicable to non-calendar year plans from January 1, 2023 until the start of the 2023 plan year).

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[1] *See* https://si-interactive.s3.amazonaws.com/prod/planadviser-com/wp-content/uploads/2023/05/24163248/2023_Letter-from-Congress-to-Treasury_SECURE-2.0-technical-corrections_052323.pdf.

Employers that would like to offer pre-deductible telehealth and other remote care services to HDHP participants will need to consider participant communications and whether a plan amendment is needed. A mid-year material modification to the Summary of Benefits and Coverage ("SBC") requires 60-days advance notice. It is not clear if this change would be considered a material modification.

B. ESG Resolution Vetoed

In 2020, under the Trump administration, the Department of Labor ("DOL") issued a final rule[2] amending the "investment duties" regulation under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") to require plan fiduciaries to select investments and investment courses of action based solely on "pecuniary" factors. When choosing investments, the rules only allow plan fiduciaries to use "non-pecuniary" factors if the fiduciary is unable to decide on an investment using pecuniary factors alone. Examples of "nonpecuniary" factors include environmental, social, and governance ("ESG") factors.

In 2021, the DOL announced that it will not enforce the final rule.[3] Following this announcement, the Biden administration issued an Executive Order[4] that directed the Secretary of Labor to consider publishing a proposed rule "to suspend, revise, or rescind" the rules finalized in 2020 by the previous administration. The Executive Order also directed the DOL to identify actions it could take under ERISA and certain other laws to protect retirement savings from climate-related financial risk.

On November 22, 2022, the DOL issued final rules amending the 2020 rules governing the selection of retirement plan investments.[5] The final rules require fiduciaries to use a risk-return analysis in selecting investments instead of considering "pecuniary" factors. When selecting investments, the rules permit fiduciaries to consider any factor that is material to the risk-return analysis, including climate change-related factors and other ESG factors.[6]

In March, Congress passed a resolution[7] nullifying the final ESG rules. President Biden vetoed the resolution so that the final rules remain in effect.

As discussed further in Section V.A.5 of this report, there is also a lawsuit pending in the Fifth Circuit involving these rules.

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[2] 85 Fed. Reg. 72,846 (Nov. 13, 2020).

[3] *See* https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/erisa/statement-on-enforcement-of-final-rules-on-esg-investments-and-proxy-voting.pdf.

[4] *See* https://www.whitehouse.gov/briefing-room/presidential-actions/2021/05/20/executive-order-on-climate-related-financial-risk/.

[5] *See* https://www.dol.gov/sites/dolgov/files/ebsa/temporary-postings/prudence-and-loyalty-in-selecting-plan-investments-and-exercising-shareholder-rights-final-rule.pdf.

[6] In October, Representative Greg Murphy (R-NC) introduced legislation (H.R. 9198) that would amend ERISA to limit fiduciary consideration of non-pecuniary factors in making investment decisions.

[7] H.J.Res.30.

C. Church Alliance Legislative Initiatives

1. Commodity Pool Operator Fix

The Dodd-Frank Act amended the Commodity Exchange Act's definition of "commodity pool operator" ("CPO"), expanding the universe of entities that must register as such. Under the applicable regulations, church plans are generally excluded from the "pool" definition in 17 CFR §4.10(d)(1). However, there is some concern that if an entity (e.g., a church benefits board), commingles plan assets with non-plan assets for investment purposes, then it could qualify as a "pool" if it trades in qualifying commodity interests and, therefore, would be required to register as a CPO. Trading in qualifying commodity interests includes investing or retaining investment managers that invest in such interests.

There is congressional interest in continuing to pursue legislation to enact a CPO fix. The issue is finding a legislative vehicle in which the desired clarification can be provided. The Farm Bill expires at the end of 2023, so one option may be to include potential Commodity Futures Trading Commission ("CFTC") reauthorization legislation in the reauthorized Farm Bill. The Church Alliance continues to work with key staff on the committees of jurisdiction on the status of potential CFTC reauthorization legislation or to find another potential legislative vehicle for the needed clarification.

D. Proposed Legislation

1. Retirement Plans

The following legislative proposals impacting retirement plans have been issued over the past year:

- 403(b) Plan Investments in Collective Trusts: SECURE 2.0 included a provision that amended the Internal Revenue Code (the "Code") to permit 403(b)(7) retirement plans to invest their assets in so-called "collective investment trusts," or CITs. Prior to this change, 403(b)(7) retirement plan assets could only be invested in registered mutual funds. (Church 403(b)(9) plans were not subject to this limitation, however, and have always been able to invest their assets in CITs.) The SECURE 2.0 legislation, as originally conceived, would also have made a number of changes to the federal securities laws which were critical to this tax law change. However, due to a jurisdictional squabble, the securities law portion of the legislation was not included in SECURE 2.0.

  The Retirement Fairness for Charities and Educational Institutions Act of 2023 (H.R. 3063) contains the needed securities law provisions. This bill was passed by the House Financial Services Committee in May of this year but has not been considered by the full House, nor has a companion bill been introduced in the Senate.

  Church retirement plans (including church 403(b) plans) already enjoy a wide array of federal and state securities law exemptions, so it initially appeared that the Church Alliance did not need to participate in the legislative process regarding H.R.

3063. However, there is one provision included in H.R. 3063 that could, if not clarified, raise a question about how the church plan securities law rules and exemptions work in the case of assets invested in an insurance company separate account. The Church Alliance is therefore working with Congressional staff and others who support H.R. 3063 to obtain the desired clarification.

- Automatic Reenrollment: The bipartisan Auto Reenroll Act of 2023, which was introduced in both the House (H.R. 4924) and Senate (S. 2517), would permit employers sponsoring defined contribution plans with certain types of automatic enrollment features to automatically reenroll noncontributing employees once every three years.

2. Health and Welfare Plans

Over the past year, there have been several legislative proposals that would impact health and welfare plans. Proposed legislation has been issued in the following areas:

- HSAs. The HSA Improvement Act of 2023 (H.R. 5688) and the HSA Modernization Act of 2023 (H.R. 5687) would expand the ability of individuals to contribute to HSAs and the services that can be paid for using HSAs. Both of these bills were approved by the House Ways and Means Committee on September 28, 2023.

- Health Care Price Transparency and Competition: The Lower Costs, More Transparency Act (H.R. 5378) would make hospital prices clear and understandable to patients by requiring hospitals and related facilities to publicly list the prices they charge patients. The Church Alliance is closely following this legislation. The Health Care Price Transparency Act (H.R. 4822) and the PATIENT Act (H.R. 3561) include similar requirements.

- Telehealth: Several bills have been issued over the past year proposing to expand the availability of telehealth services, including the Telehealth Expansion Act of 2023 (H.R. 1843), the Telehealth Benefit Expansion for Workers Act (H.R. 824), and the CONNECT for Health Act (S. 2016).

- Drug Pricing: There have been several bills introduced over the past year focusing on lowering prescription drug costs by:

    - Increasing oversight and regulation of pharmacy benefit managers ("PBMs"), including prohibiting PBMs from charging health plans more for prescription drugs than what they reimburse to pharmacies (this is also

known as "spread pricing"), requiring PBMs to pass the full amount of rebates to health plans, and imposing reporting requirements on PBMs.[8]

- Improving access to lower-cost generic drugs.[9]

- Extending Medicare's lower negotiated prices on prescription drugs to individuals covered by private health insurance plans and penalizing drug companies that raise prices faster than the rate of inflation.[10]

- Health Care Sharing Ministries: Representative Mike Kelly (R-PA) introduced H.R. 3426 in May to expand access to health care sharing ministries by allowing membership expenses to qualify for the deduction for medical expenses.

- Contraception and Abortion: There have been several bills issued over the past year in the wake of the *Dodd* decision relating to contraception and abortion, which include the following:

  - The Right to Contraception Act (S. 1999), which would codify a right to contraception.

  - The Freedom to Travel for Health Care Act (S. 2053), which would ensure women can travel for reproductive care.

  - The Upholding Protections for Health and Online Location Data Privacy Act (S. 631), which would protect online health and location data so it cannot be used against people seeking reproductive health care services.

  - The Let Doctors Provide Reproductive Health Care Act (S. 1297), which would ensure doctors may provide patients from other states with abortion services without liability.

  - The Women's Health Protection Act (S. 701), which would provide a statutory right to provide and access abortion care, free from medically unnecessary restrictions and bans.

3. Clergy Act

On October 26, 2023, Representative Kevin McCarthy (R-CA) introduced the Clergy Act (H.R. 6068), which would establish a one-time enrollment period during which

[8] *See, e.g.,* Pharmacy Benefit Manager Reform Act (S. 1339), Pharmacy Benefit Manager Transparency Act of 2023 (S. 127), Modernizing and Ensuring PBM Accountability (MEPA) Act (S. 2973), and Patients before Middlemen (PBM) Act (S. 1967).

[9] *See, e.g.,* Ensuring Timely Access to Generics Act of 2023 (S. 1067) and Expanding Access to Low-Cost Generics Act of 2023 (S. 1114).

[10] *See* Lower Drug Costs for American Families Act (H.R. 4895).

members of the clergy who previously opted out of Social Security could opt back in. The bill was referred to the House Committee on Ways and Means.

On November 1, 2023, the Chair of the Church Alliance submitted a letter to the House Committee on Ways and Means, expressing the Church Alliance's support of the Clergy Act. The letter also requests that a provision be included requiring the Commissioner of the IRS, in consultation with the Commissioner of Social Security, to create a plan to inform clergy who previously opted out of Social Security about the ability to opt back in.

4. Do Not Harm Act

In April, Rep. Robert C. Scott (D-VA) introduced the Do Not Harm Act (H.R. 2725). According to a Fact Sheet on this legislation, the Act "restores the original purpose of the *Religious Freedom Restoration Act* [("RFRA")] to provide protections for religious exercise while ensuring that RFRA is not used to erode civil rights under the guise of religious freedom."[11] The Fact Sheet also states that several court rulings have "escalated the potential misapplication of RFRA," including the *Hobby Lobby* ruling permitting corporations to rely on RFRA to deny certain preventive health services to employees and the *Braidwood Management* ruling providing that the Affordable Care Act ("ACA") requirement to cover HIV prevention medication, known as PreEP, violates RFRA.

The legislation would provide that RFRA does not apply in circumstances where a religious exemption could cause harm to others, including nondiscrimination laws, employment laws governing wages, and access to health care. The legislation would also clarify that RFRA could only be used where the government is a party to the litigation.

II. REGULATORY GUIDANCE AND OTHER INITIATIVES IMPACTING RETIREMENT PLANS

A. Internal Revenue Service

1. SECURE 2.0 RMD Relief

SECURE 2.0 included a provision increasing the required beginning age for required minimum distributions ("RMDs") to 73 in 2023 and 75 in 2033. Following the enactment of SECURE 2.0, plan administrators and other payors expressed concern that it would take time to update payment systems to reflect this change and that distributions received in 2023 by participants who would have been required to receive an RMD but for the SECURE 2.0 change would be mischaracterized as RMDs. Accordingly, the IRS issued Notice 2023-54 to provide the following transition relief:

[11] *See* https://democrats-edworkforce.house.gov/imo/media/doc/do_no_harm_fact_sheet.pdf.

- A plan administrator does not fail to satisfy the 402(f) notice requirement, the rollover rules, or the withholding rules merely because of a failure to treat the following as eligible rollover distributions:
    - A distribution made between January 1, 2023 and July 31, 2023,
    - To a participant born in 1951 (or that participant's surviving spouse), and
    - The distribution would have been an RMD but for the SECURE 2.0 change in the required beginning date.
- The 60-day rollover period for any such distribution was extended to September 30, 2023.[12] The notice also provides similar relief for IRA distributions (with special provisions related to the one rollover per year rule).

If a participant dies after the required beginning date, proposed regulations issued in 2022 clarify that the "at-least-as-rapidly" rule would require payments to continue and the 10-year rule (for a non-eligible designated beneficiary) would require an annual payment to be made over a 10- year period. Many commentators indicated that they had interpreted the 10-year rule in a different manner than the IRS interpreted it in the proposed regulations, which likely resulted in many taxpayers not taking RMDs in 2021 and 2022. In 2022, the IRS provided relief from failures in 2021 and 2022 to comply with the IRS's interpretation of the 10-year rule for RMDs, as set forth in the proposed regulations. Notice 2023-54 provides similar relief for failures in 2023, provided certain requirements are satisfied.

2. Relief from RMD Reporting for IRAs

For an IRA owner who attains age 72 after December 31, 2022, and age 73 before January 1, 2033, the date by which RMDs must begin is April 1 of the calendar year following the calendar year in which the individual attains age 73 (rather than 72). If an RMD is due for a year, then the financial institution that is the trustee, custodian, or issuer maintaining the IRA has until January 31st of that year to provide a statement to the IRA owner that includes the date by which the RMD must be distributed.

In March, the IRS issued Notice 2023-23 to provide guidance to financial institutions on reporting RMDs for 2023 after changes that were made by SECURE 2.0. Because of the changes made by SECURE 2.0, Notice 2023-23 states that the RMD statement should not be sent to IRA owners who will attain age 72 in 2023. However, recognizing the short period of time between when SECURE 2.0 was enacted and the IRA statements were due, the IRS stated that it will not consider an RMD statement provided to an IRA owner who will turn 72 in 2023 to have been provided incorrectly as long as the owner was notified no later than April 28, 2023 that an RMD is not required for 2023.

[12] For example, if a participant who was born in 1951 received a single-sum distribution in January 2023, part of which was treated as ineligible for rollover because it was mischaracterized as an RMD, that participant had until September 30, 2023 to roll over the mischaracterized part of the distribution.

3. Delayed Effective Date of SECURE 2.0 Roth Catch-Up Contribution Provisions

SECURE 2.0 includes a provision requiring all catch-up contributions to be designated as Roth contributions for employees making over $145,000 in FICA wages per year, as adjusted. This provision was originally effective for tax years beginning after December 31, 2023. This provision is not applicable to clergy because clergy wages are subject to taxation under the Self-Employed Contributions Act, or SECA, not FICA.

In August, the IRS issued Notice 2023-62 delaying the effective date of this provision for two years so that it is now effective for taxable years beginning after December 31, 2025. During the period prior to the new effective date, the notice clarifies that catch-up contributions may continue to be made on either a pre-tax or Roth basis and that a plan is not required to allow catch-up contributions to be made on a Roth basis. The notice also states that the IRS intends to issue additional guidance on the new Roth catch-up contribution rules, which is expected to include the following:

- The new rule would not apply to participants without any FICA wages during the preceding year.

- For participants subject to the new rule, an employer would be permitted to treat an election for pre-tax catch-up contributions as an election to make Roth catch-up contributions.

- For plans maintained by more than one employer, a participant's wages from one participating employer during the preceding year would not be aggregated with wages from another participating employer for purposes of determining whether the participant is subject to the new Roth catch-up contribution rule.

The Church Alliance filed a comment letter on October 24. The comment letter thanked the IRS for the transition relief and clarification provided in the notice. The comment letter also points out that many retirement plans do not require participants to affirmatively elect to make catch-up contributions because the plan deems any amount contributed in excess of the section 402(g) limit under the Code as a catch-up contribution. The Church Alliance requested that a plan administrator and employer be permitted to treat such amount as an election by the participant to make a catch-up contribution on a Roth basis.

4. Expanded Use of Self-Correction

SECURE 2.0 expanded the use of self-correction under the IRS's Employee Plans Compliance Resolution System ("EPCRS") for eligible inadvertent failures and requires the IRS to update the current EPCRS guidance (i.e., Revenue Procedure 2021-30) within two-years of the date of enactment of SECURE 2.0. An eligible inadvertent failure is a failure that occurs despite the existence of practices and procedures that satisfy the standards set forth in Section 4.04 of Revenue Procedure 2021-30 (or similar standards for IRAs), is not egregious, does not relate to the diversion or misuse of plan assets, and is not related to an abusive tax avoidance transaction.

In May, the IRS issued Notice 2023-43 providing interim guidance on the EPCRS provisions included in SECURE 2.0 in advance of the comprehensive update that will be issued within the required two-year period. The notice provides guidance on the types of eligible inadvertent failures that may be self-corrected before Revenue Procedure 2021-30 is updated (provided certain requirements are satisfied) and the types of eligible inadvertent failures that may not be self-corrected before Revenue Procedure 2021-30 is updated.[13] The notice also provides interim interpretive guidance on the correction of eligible inadvertent failures.

5. Proposed Regulations on the Use of Forfeitures in Qualified Retirement Plans

In February, the IRS issued proposed regulations[14] on the use of forfeitures in qualified retirement plans, including both defined benefit and defined contribution plans. For defined benefit plans, the proposed regulations would update the rules on the use of forfeitures to reflect the enactment of the new minimum funding requirements.

For defined contribution plans, the regulations would require that forfeitures be used for one of the following three purposes:

- To pay administrative expenses of the plan,
- To reduce employer contributions under the plan, or
- To increase benefits in the accounts of other participants in accordance with the terms of the plan.

The proposed regulations would also require defined contribution plan forfeitures to be used no later than 12 months following the end of the plan year in the forfeiture was incurred. The regulations also include a transition rule under which forfeitures incurred during any plan year beginning before January 1, 2024 would be treated as having been incurred during the first plan year beginning on or after such date.[15]

6. Proposed Regulations Permanently Allowing Retirement Plans to Accept Remote Participant Elections and Spousal Consents

In response to the COVID-19 public health emergency, the IRS provided temporary relief from the physical presence requirement in Treasury regulation section 1.401(a)-21(d)(6) for certain participant elections, including spousal consent required under Code section 417. In Notices 2021-3, 2021-40, and 2022-27 the IRS extended the physical

[13] The notice states that an IRA custodian may not correct an eligible inadvertent failure under EPCRS before Revenue Procedure 2021-30 is updated.

[14] 88 Fed. Reg. 12,282 (Feb. 27, 2023).

[15] Recently, several lawsuits have been filed challenging the use of forfeitures by 401(k) plan fiduciaries. The plaintiffs allege that the plan fiduciaries violated ERISA by using the forfeitures to reduce future employer contributions rather than to benefit plan participants, such as by paying plan expenses that are otherwise charged to participant accounts. *See, e.g., Rodriguez v. Intuit, Inc.*, No. 5:23-CV-05053 (N.D. Cal. filed Oct. 2, 2023).

presence requirement relief to December 31, 2022. In December, the IRS issued proposed regulations[16] making the relief permanent.

Under the proposed regulations, plans are permitted to accept spousal consents that are witnessed remotely by either a plan representative or a notary public, provided certain requirements are satisfied. The requirements differ depending on whether the spousal consent is being remotely witnessed by a plan representative or a notary public. The proposed regulations may be relied upon until the effective date of any final regulations.

7. Required Amendments List and Operational Compliance List

The IRS publishes a required amendments list annually now that the 5-year remedial amendment cycle for individually-designed plans has been discontinued. Plan sponsors will generally be required to adopt an item on the required amendment list by the end of the second calendar year following the year the required amendments list is published. The IRS has a webpage that provides links to required amendment lists from previous years and the amendment deadlines set forth therein.[17]

The amendments listed on the 2021 required amendments list must be adopted by December 31, 2023 (i.e., the end of the second calendar year following the year the required amendments list is published). The 2021 required amendments list included in Notice 2021-64 lists one change that only applies to multiemployer plans.

At the end of 2022, the IRS issued Notice 2022-62, which provides the 2022 required amendment list. The amendments listed on the 2022 required amendment list must be adopted by December 31, 2024. The 2022 required amendments list includes no required amendments.

The IRS also provides an "Operational Compliance List"[18] on its website. The Operational Compliance List is updated periodically and identifies changes in qualification requirements and Code section 403(b) requirements effective during a calendar year. This list is helpful for plan sponsors to achieve operational compliance even before required amendments are adopted by plans. It may also be a helpful tool to identify mandatory and discretionary plan amendments as well as other significant guidance that impacts daily plan operation.

8. Postponement of Certain Tax Deadlines After Federally-Declared Disasters

The IRS will postpone certain retirement plan and IRA deadlines for affected taxpayers in the event of a presidentially-declared disaster, which often includes severe storms (e.g., tornados and hurricanes), wildfires, floods, or earthquakes. An affected

[16] 87 Fed. Reg. 80,501 (Dec. 30, 2022).

[17] *See* https://www.irs.gov/retirement-plans/required-amendments-list.

[18] The Operational Compliance List is available at the following website only and will not be published in an Internal Revenue Bulletin: https://www.irs.gov/retirement-plans/operational-compliance-list.

taxpayer is generally a person who lives in or has a business in an area impacted by the disaster.

After a disaster is declared, the IRS will issue a news release describing the type of relief, the eligible taxpayers, and the relief period. Section 8 of Revenue Procedure 2018-58 lists the retirement plan and IRA deadlines that the IRS may postpone. If the news release for a disaster does not limit the relief, then all of the deadlines listed in the revenue procedure will be postponed.[19]

The IRS issued several news releases over the past year providing tax relief for certain disasters. The news releases are listed on the IRS's website.[20]

9. Retirement Plan Limits for 2024

The cost-of-living and required statutory limit adjustments applicable to retirement plans for 2024 are as follows:[21]

Contribution limit for defined contribution plan under Code § 415(c)	**$69,000** (*$3,000 increase*)
Benefit limitation for defined benefit plan under Code § 415(b)	**$275,000** *($10,000 increase)*
Elective deferral limit under Code § 402(g)	**$23,000** *($500 increase)*
Age 50 catch-up contribution limit under Code § 414(v)	**$7,500** *($0 increase)*
Age 50 catch-up contribution limit for SIMPLE plan	**$3,500** (*$0 increase*)
Contribution limit for a Code § 457(b) eligible deferred compensation plan	**$23,000** (*$500 increase)*
Annual compensation limit under Code § 401(a)(17)	**$345,000** (*$15,000 increase)*
HCE compensation definition dollar threshold[22]	**$155,000**[23] *($5,000 increase)*
Dollar threshold limitation for key employee determination in top-heavy plan	**$220,000** *($5,000 increase*)
Contribution limit for a SIMPLE retirement plan	**$16,000** *($500 increase)*
Participant compensation eligibility amount under Code § 408(k)(2)(C) for simplified employee pension (SEP) employer contributions	**$750** *($0 increase)*

[19] *See* https://www.irs.gov/retirement-plans/disaster-relief-for-retirement-plans-and-iras.

[20] *See* https://www.irs.gov/newsroom/tax-relief-in-disaster-situations.

[21] Notice 2023-75.

[22] The definition of highly compensated employee, or HCE, is also used in several welfare plan nondiscrimination tests.

[23] For the 2024 plan year, an employee who earns more than $155,000 in 2023 is an HCE.

B. Department of Labor

1. Proposed Rule on Investment Advice Fiduciaries

In October of 2010, the DOL proposed a rule[24] to update and expand the 35-year old regulation containing the definition of the term "fiduciary" under ERISA to more broadly cover those who provide retirement investment advice. That proposal encountered strong resistance from the financial services industry. Subsequently, in September 2011, the DOL announced that it would withdraw and re-propose the fiduciary rule to "protect consumers while avoiding unjustified costs and burdens."[25]

The DOL issued the re-proposed rule in 2015[26] and finalized it in 2016.[27] The United States Court of Appeals for the Fifth Circuit struck down the DOL's fiduciary rule in 2018, finding that the DOL exceeded its authority in promulgating the rule.[28] In 2020, the DOL issued a final rule[29] implementing the Fifth Circuit's vacatur of the 2016 rule by reinstating the regulations in effect prior to the 2016 regulations.

In October, the DOL issued another proposed rule defining an investment advice fiduciary under ERISA.[30] Comments on the proposed rule must be submitted on or before January 2, 2024. At the same time, the DOL proposed amendments to several prohibited transaction exemptions that provide investment advice fiduciaries with relief from certain prohibited transactions.[31]

The most recent proposed rule states that a person would be an investment advice fiduciary under ERISA if the person:

- makes a recommendation of a securities or investment transaction to a plan, plan fiduciary, IRA, IRA owner or beneficiary, or IRA fiduciary (a "retirement investor"),
- provides the advice for a fee or other direct or indirect compensation, and the person either:

[24] 75 Fed. Reg. 65,263 (Oct. 22, 2010).

[25] EBSA News Release (Sept. 19, 2011).

[26] 80 Fed. Reg. 21,928 (Apr. 20, 2015).

[27] 81 Fed. Reg. 20,946 (Apr. 8, 2016).

[28] *Chamber of Commerce v. U.S. Dep't of Labor*, 885 F. 3d 360 (5th Cir. 2018).

[29] 85 Fed. Reg. 40,589 (July 7, 2020).

[30] 88 Fed Reg. 75,890 (Nov. 3, 2023). The proposed rule has also been met with widespread resistance within the financial services industry and will no doubt be the subject of future litigation.

[31] 88 Fed. Reg. 75,979 (Nov. 3, 2023), 88 Fed. Reg. 76,004 (Nov. 3, 2023), and 88 Fed. Reg. 76,032 (Nov. 3, 2023).

- Has discretionary authority or control with respect to purchasing or selling securities or other investment property for the retirement investor,

- Makes investment recommendations on a regular basis as part of their business and the circumstances indicate that the recommendation is based on the retirement investor's individual needs or circumstances and may be relied upon in making investment decisions that are in the retirement investor's best interests, or

- Represents or warrants that they are acting as a fiduciary when making such recommendations.

The investment advice fiduciary rule does not apply to plans that are not subject to ERISA, such as non-electing church plans, but may provide useful information to and suggest "best practices" for such plans.

C. Other Retirement Plan Guidance

1. GAO Church Plan Study

The Government Accountability Office ("GAO") is an independent, non-partisan agency that provides Congress and federal agencies with research to help the government save money and work more efficiently. At the request of the then-Chairman of the House Education and Labor Committee, Rep. Robert C. Scott (D-VA), the GAO began a study on church pension plans in 2021. The church pension plan study appears to have been undertaken at the request of organizations that have supported litigation challenging the church plan status of church-affiliated hospital defined benefit plans, even though the focus of the GAO study was not limited to this narrow category of church plans. Church Alliance representatives, denominational benefit board representatives, and church plan attorneys were interviewed by the GAO in connection with its study, along with the representatives of the organizations that requested Rep. Scott to pursue the study.

On October 27, 2023, the GAO released its report on church pension plans, titled "Improved Communication Needed on Church Plan Eligibility for Federal Insurance Coverage."[32] The report addresses three areas – (1) data available on church plans and a general background on church plan administration, (2) the roles of federal and state governments with respect to church plans, and (3) how expected outcomes in legal cases involving church plans affect participants' benefits. The report provides an overview of church plans generally, a discussion of practices identified by the church plans interviewed by the GAO, and an examination of several bankruptcy cases and settlement agreements. The report also discusses state laws and practices with respect to church plans in California, New York, New Jersey, Rhode Island, and Illinois. Those states were selected because those are states where plans have become insolvent or filed for bankruptcy

[32] *See* https://www.gao.gov/products/gao-23-105080?utm_campaign=usgao_email&utm_content=topic_retirementsecurity&utm_medium=email&utm_source=govdelivery.

or have some established statutory requirements for plans. Finally, the report devotes significant attention to the GAO's methodology for collecting and analyzing church plan data obtained from various sources, including the IRS, DOL and Pension Benefit Guarantee Corporation ("PBGC").

The main focus of the report is the PBGC and defined benefit plans. The report's central finding relates to concerns that non-electing church plans (i.e., plans that have not made a 410(d) election)[33] are contributing premiums to the PBGC while unaware that they are not eligible for PBGC coverage in the event of a plan termination. The GAO makes several recommendations on ways the PBGC could improve its communications with these plans to inform them they may not be covered. The PBGC responded that they are working through the recommendations and will be reaching out to potential church plans that are paying PBGC premiums.

2. GAO Recommendation to DOL to Improve 403(b) Plan Educational Materials

In June, several members of the House of Representatives asked the GAO to research (1) the extent of 403(b) retirement plan oversight by the federal agencies, (2) state actions that could improve 403(b) participant outcomes, and (3) options identified by stakeholders and experts that could improve retirement outcomes for 403(b) participants. The GAO report[34] addresses three areas:

- 403(b) Oversight by Federal Agencies: The GAO determined that the DOL's website does not contain targeted educational materials explaining 403(b) fees to participants and recommended that the DOL update educational materials to include this information.

- State Actions Improving Outcomes: The GAO reviewed how five states worked to improve participant outcomes, which included consolidating the number of service providers offering investment options to reduce required oversight of these providers and providing participants with additional information about plan investment options and fees or making such information available.

- Stakeholder and Expert Recommendations: Stakeholders and experts suggested the following actions to improve 403(b) participant outcomes: (1) establishing fiduciary duties for non-ERISA plans in states that are not subject to these protections, (2) requiring distribution of standardized information on investment returns and fees for participants in non-ERISA plans, and (3) permitting 403(b) plans to use certain other investment vehicles, such as collective investment trusts and real estate investment trusts.

[33] Code section 410(d) permits a church plan to forego its exemption from ERISA and the special exemptions and rules in the Code that are available to church plans.

[34] *See* https://www.gao.gov/assets/830/827172.pdf.

3. GAO Report on Disparities in Retirement Plan Participation

Earlier this year, senators asked the GAO to research retirement account disparities in income and race. On July 27, 2023, the GAO issued a report[35] indicating that retirement account disparities in income have increased and disparities in race have persisted over time. Specifically, the report finds that:

- Disparities between the retirement accounts of low-income and high-income workers between ages 51 and 64 were greater in 2019 than 2007.
- One in ten low-income households had a retirement account balance in 2019, whereas one in five had a balance in 2007.
- Nine in ten high-income households had a retirement account balance between 2007 and 2019.
- More white households had a retirement account balance than households of other races.

The GAO conducted this study because of concern that retirement plan tax incentives are mostly going to higher-income workers and are not helping lower income workers save for retirement.

4. Congressional Research Service Reports on 403(b) Plans and Church Tax Benefits

In October, the Congressional Research Service issued two reports of interest to church benefit boards – one on 403(b) plans[36] and one on church tax benefits.[37] The report on 403(b) plans provides an overview of the laws and regulations applicable to 403(b) plans and recent legislative developments impacting 403(b) plans.

The report on church tax benefits concludes that, when drafting legislation providing church tax preferences, Congress should consider organizations that seek classification as a church primarily as a tax avoidance device or to hide other prohibited activity. The report also states that Congress should balance the rights of legitimate churches with the government's ability to eliminate tax avoidance schemes and ensure the integrity of the tax system. Finally, the report suggests that Congress consider drafting church tax preference legislation to avoid challenges under the Establishment Clause of the First Amendment.

[35] *See* https://www.gao.gov/products/gao-23-105342.

[36] *See* https://crsreports.congress.gov/product/pdf/IF/IF12518.

[37] *See* https://www.everycrsreport.com/files/2023-10-16_IF12509_02eedf320a1d72e8ae243f690055e1e489cf9368.pdf.

5. SEC Charges Church and Investment Management Company for Disclosure Failures and Misstated Filings

In Press Release 2023-35,[38] the Securities and Exchange Commission ("SEC") announced charges against The Church of Jesus Christ of Latter-day Saints and its non-profit investment management company, Ensign Peak Advisors, Inc. The SEC alleges that Ensign Peak, with the Church's knowledge, had several shell corporations file Forms 13F (the form used by investment managers to disclose the value of the securities they manage) instead of Ensign Peak, which "obscured the Church's portfolio and misstated Ensign Peak's control over the Church's investment decisions." Ensign Peak agreed to pay a $4 million penalty and the Church agreed to pay a $1 million penalty to settle these charges.

III. REGULATORY AND OTHER INITIATIVES IMPACTING HEALTH AND WELFARE PLANS

A. Internal Revenue Service

1. Final Regulations Making Permanent ACA Reporting Deadline Extension

At the end of 2022, the IRS issued final regulations[39] providing guidance on the ACA information reporting of health coverage requirements under Code sections 6055 and 6056. Code section 6055 requires providers of minimum essential coverage to file and furnish statements about such coverage while Code section 6056 requires applicable large employers to file and furnish statements about the health insurance offered to full-time employees. The reporting is required to be made using Form 1095-B or 1095-C, as applicable, and must be filed with the IRS and furnished to individuals by certain deadlines. The deadline to furnish statements to individuals is currently January 31 of the year following the calendar year to which the statement relates although the IRS has issued notices extending this deadline for the past several years.

The final regulations provide a permanent 30-day extension of time for both providers of minimum essential coverage and applicable large employers to furnish the required statements about health insurance coverage to individuals.[40] The final regulations also provide an alternative method for reporting entities to furnish individual statements as long as the individual mandate penalty remains zero.

Under the alternative method, a reporting entity must provide a clear and conspicuous notice on its website that is reasonably accessible to all responsible individuals, contains certain information, states that individuals may receive a copy of their statement upon request, is posted by the due date for furnishing individual statements, and remains on the website through October 15 of the year following the calendar year to which the statements relate (or the next business day if October 15th falls on a weekend or

[38] *See* https://www.sec.gov/news/press-release/2023-35.

[39] 87 Fed. Reg. 76,569 (Dec. 15, 2022).

[40] The final regulations do not extend the deadline to file the forms with the IRS.

holiday). If an individual requests a statement, then the reporting entity must distribute the statement to the individual within 30 days of the date the request was received.

With respect to applicable large employers that offer self-insured coverage to their employees, the relief does not apply to statements for full-time employees but would apply to statements for employees who are not full-time or individuals who are not employees (e.g., COBRA participants). The reason the relief does not apply to the distribution of statements to full-time employees is because the required reporting form (i.e., Form 1095-C) includes certain information relating to the employer mandate.

2. Guidance on COVID-19 Relief and Preventive Care for HDHPs

During the COVID-19 public health emergency, the IRS issued Notice 2020-15, permitting HDHPs to cover the testing and treatment of COVID-19 prior to the application of the deductible. In response to the end of the COVID-19 public health emergency, the IRS issued Notice 2023-37. This notice states that the relief set forth in Notice 2020-15 only applies to plan years ending on or before December 31, 2024. Accordingly, an HDHP will not be able to cover the testing and treatment of COVID-19 prior to the application of the deductible effective for the first plan year beginning on or after January 1, 2025.[41]

The notice clarifies that items or services recommended with an "A" or "B" rating by the United States Preventive Services Task Force ("USPSTF") on after March 23, 2010 are treated as preventive care for purposes of the HDHP safe harbor under Code section 223(c)(2)(C), regardless of whether these services are required to be covered without cost sharing. This means that an HDHP would be permitted to cover COVID-19 testing before the application of the deductible if COVID-19 testing was to be recommended with an "A" or "B" rating by the USPSTF.

3. FAQs on FSA and HSA Reimbursable Expenses

The IRS issued FAQs[42] regarding the eligibility of certain expenses for health care flexible spending account ("FSA") or HSA reimbursements. The following are generally reimbursable medical expenses:

- Physicals, dental exams, and eye exams.
- Drug or alcohol use disorder treatment programs.

[41] The notice also clarifies that the preventive care safe harbor does not include screening (i.e., testing) for COVID-19, effective as of June 23, 2023. This means that the preventive care safe harbor does not permit an HDHP to cover COVID-19 testing before the HDHP deductible is satisfied. Although this clarification is effective June 23, 2023, HDHPs can continue to cover COVID-19 testing before the deductible is met for plan years ending on or before December 31, 2024 under the relief set forth in Notice 2020-15.

[42] *See* https://www.irs.gov/individuals/frequently-asked-questions-about-medical-expenses-related-to-nutrition-wellness-and-general-health.

- Smoking cessation programs.

The following are potentially reimbursable:

- Therapy, if treatment for a disease (such as a diagnosed mental illness).

- Nutritional counseling or weight loss programs, but only if treating a specific disease diagnosed by a physician.

- Gym membership, but only if purchased for the sole purpose of affecting a structure or function of the body (such as a prescribed plan for physical therapy to treat an injury) or the sole purpose of treating a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease).

- Food or beverages purchased for weight loss or other health reasons, but only if: (1) the food or beverage does not satisfy normal nutritional needs, (2) the food or beverage alleviates or treats an illness, and (3) the need for the food or beverage is substantiated by a physician. The reimbursable amount would be limited to the amount by which the cost of the food or beverage exceeds the cost of a product that satisfies normal nutritional needs.

- Nutritional supplements, but only if the supplements are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician.

Over-the-counter drugs and medicines can be reimbursed by an FSA or HSA. The cost of exercise for the improvement of general health, such as swimming or dancing lessons, is not a medical expense, even if recommended by a doctor.

4. Fixed Indemnity Wellness Policies

In June, the IRS issued Chief Counsel Memorandum 202323006.[43] The employer described in the memorandum provides employees with an optional fixed-indemnity health insurance policy (separate from comprehensive coverage). Employees pay $1,200 monthly premiums through a Code section 125 cafeteria plan, and there is no employer contribution.

The benefits under the fixed-indemnity health insurance policy include a $1,000 payment per month if the employee participates in certain health or wellness activities that are already covered under the comprehensive health plan (e.g., preventive care or vaccinations).[44] The memorandum concludes that the $1,000 payments, along with the premium that is paid through the cafeteria plan, are includible in the employee's gross income because the $1,000 is paid without regard to whether medical expenses are incurred. The memorandum also concludes that the $1,000 per month payment is treated

[43] *See* https://irs.gov/pub/irs-wd/202323006.pdf.

[44] The policy also provides wellness counseling, nutrition counseling, telehealth at no additional cost, and a per-day hospitalization benefit.

as wages for employment tax purposes because the exclusion from wages for medical expenses would not apply.

In July, the IRS issued proposed regulations[45] clarifying that amounts received under a plan that pays regardless of the amount of medical care expenses actually incurred are not payments for medical care under Code section 105(b) and are included in the employee's gross income under Code section 105(a). The proposed regulations also address the requirements for fixed indemnity insurance to be an excepted benefit for ACA purposes.

5. Health Savings Account Limits

The IRS has announced the maximum contribution levels for HSAs and out-of-pocket spending limits for HDHPs that must be used in conjunction with HSAs for 2024.[46] The relevant amounts for 2024 are as follows:

Annual HSA contribution limit	**$4,150 –** individual coverage *($300 increase)* **$8,300 –** family coverage *($550 increase)*
Catch-up contribution limit over age 55	**$1,000** *(no change)*
Maximum HDHP out-of-pocket limit	**$8,050 –** individual coverage (*$550 increase*) **$16,100 –** family coverage (*$1,100 increase*)
HDHP minimum deductible	**$1,600 –** individual coverage (*$100 increase*) **$3,200 –** family coverage (*$200 increase*)

6. Flexible Spending Account, Qualified Transportation Fringe Benefit Limits, PCORI Fee, and Employer Mandate Affordability Percentage

The IRS has announced several inflation-adjusted items for 2024 under various provisions of the Code.[47] The relevant amounts for 2024 are as follows:

Annual contribution limit for Health Care FSA	**$3,200** *($150 increase)*
Maximum cafeteria plan carryover amount (if permitted)	**$640** (*$30 increase*)
Annual contribution limit for Dependent Care FSA	**$5,000**[48] *(unchanged)*

[45] 88 Fed. Reg. 44,596 (July 12, 2023).

[46] Rev. Proc. 2023-23.

[47] Rev. Proc. 2023-34.

[48] The annual contribution limit for a dependent care FSA is $5,000 (or $2,500 for married taxpayers filing separately). This number is not indexed for inflation.

Qualified Small Employer HRA ("QSEHRA") Payment and Reimbursement Limit	**$6,150 –** individual coverage (*$300 increase*) **$12,450 –** family coverage (*$650 increase*)
Monthly contribution fringe benefit exclusion limit for Qualified Mass Transportation and Qualified Parking under Code sections 132(f)(2)(A) and (B)	**$315** *($15 increase)*
Employer Mandate Affordability Percentage[49]	**8.39%** *(0.73% decrease)*

The IRS also announced the applicable dollar amount that is used in calculating the Patient Centered Outcome Research Institute ("PCORI") fee as follows:

- $3.00 (a $0.21 increase from the previous year) for plan or policy years ending on or after October 1, 2022, and before October 1, 2023.[50]

- $3.22 (a $0.22 increase from the previous year) for plan or policy years ending on or after October 1, 2023, and before October 1, 2024.[51]

B. Department of Health and Human Services

1. No Surprises Act – Independent Dispute Resolution Update

On April 27, 2023, the Center for Medicare & Medicaid Services ("CMS") released its Status Update on the Federal independent dispute resolution ("IDR") process developed under the No Surprises Act.[52] The IDR process is further described in Sections III.C.3, III.C.4, III.C.5, and V.B.1 of this report. According to the Status Update, between April 15, 2022 and March 31, 2023:

- 334,248 disputes were initiated, which is 14 times more than estimated.

- 39,890 disputes were determined to be ineligible for IDR.

- 42,158 payment determinations were made. The initiating party prevailed in 71% of disputes and the non-initiating party prevailed in 29% of disputes.

[49] The affordability percentage is the percentage used to determine whether employer-sponsored health coverage is affordable for purposes of the employer shared responsibility (or employer mandate) provisions. The adjusted affordability percentage of 8.39% applies to plan years beginning in 2024. Rev. Proc. 2023-29.

[50] Notice 2022-59.

[51] Notice 2023-70.

[52] *See* https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf.

2. Proposed Amendments to HIPAA Privacy Rule to Support Reproductive Health Care Privacy

In April, the Department of Health and Humans Services ("HHS") issued proposed rules[53] modifying the HIPAA privacy rule to limit the uses and disclosures of protected health information ("PHI") about reproductive health care that is provided under lawful circumstances. Specifically, the proposed rules would prohibit uses and disclosures of PHI for criminal, civil, or administrative investigations or proceedings against individuals, covered entities (or their business associates), and other persons for seeking, obtaining, providing or facilitating reproductive health care that is provided under lawful circumstances.

3. Proposed Rule on Conscience and Religious Nondiscrimination

Federal law includes several provisions known as "conscience provisions," which prohibit recipients of federal funds from forcing individuals and entities in the health care field to participate in actions they find objectionable on a religious or moral basis. At the end of 2022, HHS issued a proposed rule[54] aimed at safeguarding protections for health care workers with conscience-based objections to providing care while protecting access to necessary medical services.

4. Request for Information on Essential Health Benefits

The ACA requires non-grandfathered plans in the small group market to cover all required essential health benefits. Although self-insured plans and fully-insured plans in the large group market are not subject to the requirement to cover essential health benefits, the prohibition on annual and lifetime limits and the maximum out-of-pocket limits apply to the essential health benefits that are covered under the plan.

At the end of 2022, HHS issued a request for information[55] related to essential health benefits under the ACA. HHS has not updated the guidance on essential health benefits since 2014 and is requesting comments on whether certain aspects of this guidance should be updated to reflect changes that have occurred since 2014.

5. Health Plan Cost-Sharing Limits

HHS has announced the maximum annual limits on cost-sharing that apply to non-grandfathered plans for 2024.[56] The relevant amounts for 2024 are as follows:

[53] 88 Fed. Reg. 23,506 (April 17, 2023).

[54] 88 Fed. Reg. 820 (Jan. 5, 2023).

[55] 87 Fed. Reg. 74,097 (Dec. 2, 2022).

[56] *See* https://www.cms.gov/files/document/2024-papi-parameters-guidance-2022-12-12.pdf.

Self-Only Coverage	**$9,450** *($350 increase)*
Other than Self-Only Coverage	**$18,900** *($700 increase)*

C. Internal Revenue Service, Department of Labor, and Health and Human Services Joint Guidance

1. Gag Clause Attestation

Plans and insurers may not enter into contracts with providers, networks, third party administrators ("TPAs") or other service providers offering network access that would restrict the plan or insurer from:

- Providing provider-specific cost or quality of care information or data through a consumer tool (or otherwise) to referring providers, plan sponsor, enrollees, or individual eligible to enroll.
- Electronically accessing de-identified claims and encounter information or data.
- Sharing such info with HIPAA business associates.

Plans and insurers must annually attest to the government regarding compliance. The requirements were effective for plan contracts entered into (or renewed) on or after December 27, 2020.

On February 23, 2023, the following guidance was issued relating to the gag clause attestation:

- FAQs[57]
- A website for plans and issuers to use to submit attestations[58]
- A User Manual and Instructions on how to submit attestation through the HIOS Gag Clause Prohibition Compliance Attestation ("GCPCA") module.[59]
- A template for use when submitting an attestation on behalf of multiple plans.[60]

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[57] *See* https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-57.pdf.

[58] *See* https://hios.cms.gov/HIOS-GCPCA-UI.

[59] *See* https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance.

[60] *Id.*

The initial deadline to submit the GCPCA is December 31, 2023, and thereafter annually by December 31. The first attestation covers the period from December 27, 2020 to the date of attestation. Each annual attestation covers the period from the last attestation. The penalty for failure to comply is $100 per day per affected individual.

The GCPCA requirements apply to:

- Fully-insured and self-insured group health plans (church plans subject to the Code and ERISA plans) including grandfathered and grandmothered plans.

- Health insurance issuers offering group health insurance coverage.

- Health insurance issuers offering individual health insurance coverage (including student health insurance coverage and individual health insurance coverage issued through an association).

Plans offering only excepted benefits, HRAs, and other account-based plans do not need to submit a GCPCA.

The FAQs issued by the IRS, DOL, and HHS (collectively, the "Agencies") on February 23, 2023 provide the following guidance on the gag clause attestation requirements:

- A self-insured plan may contract with a service provider (TPA, PBM, managed behavioral health organization) to attest on behalf of the plan. If the provider does not properly or timely attest on behalf of the self-insured plan, the compliance issue remains with the plan.

- Fully-insured group health plans and their issuers must both submit a GCPCA annually. However, if an issuer submits on its own behalf and also on behalf of the fully-insured plan, it is sufficient to meet the attestation requirement.

- An issuer or TPA may submit a single attestation on behalf of itself, its insured policy holders, and its self-insured plan clients.

- Plans, issuers, and TPAs can individually determine and authorize the appropriate person within the organization to make the attestation.

- Attestation submissions for a plan can be made separately for different provider agreements (e.g., medical, PBM, and behavioral health).

- Example of a gag clause: The TPA contract provides the plan sponsor's access to provider-specific cost and quality care information is only at the discretion of the TPA (though the TPA may place reasonable restrictions on public disclosure).

- To the extent a term in a contract either directly or indirectly prevents a plan or issuer from providing, accessing or sharing the information or data, then it violates the gag clause prohibition.

- Plans that do not timely submit attestations may be subject to enforcement actions.

2. Mental Health Parity Guidance

The Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (the "Mental Health Parity Act") was signed into law in 2008 to prohibit group health plans that provide mental health benefits from imposing greater limitations on such benefits than are imposed on medical/surgical benefits. To satisfy the parity requirements, any "financial requirements" (*e.g.*, deductibles, copayments, coinsurances, and out-of-pocket expenses) or "treatment limitations" imposed on the mental health/substance use disorder benefits cannot be more restrictive than the "predominant" financial requirements or treatment limitations imposed on "substantially all" of the medical/surgical benefits.

"Treatment limitations" include both quantitative treatment limitations, which are expressed numerically (e.g., 50 outpatient visits per year), and nonquantitative treatment limitations ("NQTLs"), which otherwise limit the scope or duration of benefits for treatments under the plan, such as medical management standards limiting or excluding benefits based on medical necessity. The regulations define "predominant" to mean generally more than one-half and "substantially all" to mean generally at least two-thirds.

The Consolidated Appropriations Act, 2021 ("CAA 2021") amended the Mental Health Parity Act to require group health plans and insurers to provide to federal and state agencies – upon request – a comparative analysis of NQTLs related to mental health and substance abuse disorder benefits. In 2022, the Agencies issued their first annual mental health parity report to Congress after the imposition of the new comparative analysis requirement, which stated that all of the NQTL comparative analyses that were submitted contained insufficient information to show compliance with the mental health parity requirements.[61]

On July 25, 2023, the Agencies issued the following guidance relating to the mental health parity requirements:

- Proposed regulations.[62]

- Technical release regarding data collection related to network composition.[63]

- 2023 Comparative Analysis Report to Congress.[64]

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[61] *See* https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.

[62] 88 Fed. Reg. 51,552 (Aug. 3, 2023).

[63] *See* https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/23-01.

[64] *See* https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.

The proposed regulations include the following proposed changes to the current mental health parity rules:

- Adds a new purposes section stating that the substantially all/predominant level tests that currently apply to quantitative treatment limitations would also apply to NQTLs (e.g., if an NQTL does not apply to two-thirds of benefits in a medical/surgical classification, it could not be applied to mental health/substance abuse benefits in that classification).

- Processes and factors used in designing an NQTL for mental health/substance abuse must be comparable to and applied no more stringently than medical/surgical.

- Plans must collect data necessary to assess the impact of an NQTL on access to benefits, such as the percentage of claim denials and network composition information.

- Material differences in access to mental health benefits will be considered a strong indicator of noncompliance.

- Plans may not apply a separate treatment limitation only to mental health and not medical/surgical in the same benefit classification.

- Plans must provide meaningful benefits for treatment of a particular condition in each benefit classification. For example, a plan cannot cover the full range of medical/surgical benefits in a classification but then only cover one type of benefit for autism spectrum disorder ("ASD") in the same classification and exclude all other benefits for ASD (including applied behavioral analysis).

- ASD is considered a mental health condition for purposes of the Mental Health Parity Act.

- Specific content required for comparative analyses.

- Plan fiduciary must certify that comparative analysis complies with content requirements.

- Specific deadlines for submission of comparative analysis (initial deadline of 10 business days following request).

- Required participant notification of a determination of noncompliance.

Technical Release 2023-01P addresses the data that plans and insurers would be required to collect and evaluate as part of their comparative analyses regarding network composition, including:

- Out-of-network utilization,

- Percentage of in-network providers actively submitting claims,
- Network adequacy time and distance standards, and
- Reimbursement rate information.

The 2023 Comparative Analysis Report to Congress shows similar deficiencies to the 2022 report with respect to comparative analyses – primarily lack of meaningful analysis regarding factors considered in design and application of NQTLs.

3. Technical Guidance on No Surprises Act

Under the No Surprises Act, health plans must make an initial payment or deny claims of out-of-network providers and facilities that are subject to the surprise billing provisions within 30 days of receiving the claim. If the provider does not agree with the payment amount, a dispute resolution process begins with a 30-day negotiation. If the parties cannot reach a successful resolution during negotiation, the parties have four days to initiate the independent dispute resolution ("IDR") process.

In September, the Agencies issued proposed rules[65] relating to the fees for the Federal IDR process. Under the proposed rules, the administrative fee charged by the Agencies to use the Federal IDR process and the ranges for certified IDR entity fees for single and batched determinations will be set by the Agencies through notice and comment rulemaking rather than in guidance published annually. The rules also propose the amount of the administrative fee and certified IDR entity fee ranges for disputes initiated on or after the later of the effective date of the rules or January 1, 2024 and explain the methodology and considerations used to calculate these fees.

One month later, the Agencies issued another proposed rule[66] relating to the Federal IDR process, which would require plans to include new information with the initial payment or notice of payment denial, including claim adjustment reason codes and remittance advice remark codes under certain circumstances. The proposed rules would also amend certain requirements relating to the Federal IDR process, including the open negotiation period, initiation, eligibility review, the payment and collection of administrative fees and certified IDR entity fees, bundled payment arrangements, requirements relating to batched items and services, and the rules for extensions of time due to extenuating circumstances. The rules also propose to require plans to register in the Federal IDR portal. Comments on the proposed rule must be submitted by January 2, 2024.

Both sets of proposed rules were at least partially issued because of the litigation discussed in Section V.B.1 of this report.

[65] 88 Fed. Reg. 65,888 (Sept. 26, 2023).

[66] 88 Fed. Reg. 75,744 (Nov. 3, 2023).

4. FAQ Guidance Implementing Certain Provisions of the No Surprises Act After Texas Medical Association Decision

During the IDR process imposed by the No Surprises Act, the IDR entity must consider the qualifying payment amount ("QPA") for items and services subject to the No Suprises Act. The QPA for an item or service is generally the median of the contracted rates recognized by the plan on January 31, 2019 for the same or a similar item or service provided by a provider in the same or similar specialty or facility of the same or similar facility type in the same geographic area, as adjusted for inflation.

There have been a series of cases challenging the implementation of the IDR process, which are further described in Section V.B.1 of this report. In one of the cases, the court vacated certain provisions of the 2021 interim final rule governing how payers should calculate the QPA for items and services.

In October, the Agencies issued FAQ guidance[67] as a result of this decision. Among other guidance, the FAQs state that plans should calculate QPAs using a "good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect after the . . . decision." The FAQs also state that the Agencies will "exercise their enforcement discretion" for plans that continue to rely on QPAs calculated in accordance with the 2021 interim final rules for items and services furnished before May 24, 2024.

5. IDR Administrative Fees

In December 2022, the Agencies increased the IDR administrative fee from $50 to $350 for disputes initiated during 2023 due to large volume and associated costs.[68] As further discussed in Section V.B.1 of this report, a Texas district court vacated the increased fee in August 2023.

Following the decision, the Agencies issued FAQs[69] explaining how the Agencies will handle the administrative fee in accordance with the court order. The FAQs state that the administrative fee will revert to the $50 per party per dispute amount in effect prior to the increase. In addition, the FAQs clarify that the court order does not require a refund of the $350 administrative fee to be issued for fees paid before the date of the decision.

6. Request for Information on Coverage of Over-the-Counter Preventive Drugs Under the ACA Preventive Coverage Requirement

Since the U.S. Supreme Court overturned *Roe v. Wade*, President Biden has issued several Executive Orders relating to improving access to contraception. The most recent Executive Order, which was issued in 2023, directs the Secretaries to consider issuing

[67] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-62.

[68] *See* https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf.

[69] *See* https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/no-surprises-act-independent-dispute-resolution-administrative-fee-frequently-asked-questions.pdf.

guidance to improve access to contraception without out-of-pocket expenses and to promote increased access to over-the-counter contraception. In July, the Food and Drug Administration ("FDA") approved an over-the-counter progestin-only birth control pill. This is the first daily oral contraceptive available for use without a prescription.

In light of the Executive Orders and the FDA approval of the first over-the-counter daily contraceptive pill, the Agencies issued a request for information[70] on the application of the ACA preventive coverage requirement to over-the-counter preventive items and services that are available without a prescription. Specifically, the Agencies requested comments on the potential benefits and costs of requiring non-grandfathered health plans to cover over-the-counter preventive items and services without cost sharing or a prescription, any challenges with providing this coverage, how providing this coverage would benefit consumers, and any potential burdens on plans if required to provide this coverage. Comments must be submitted by December 4, 2023.

7. Proposed Regulations on Contraceptive Coverage Requirements

In February, the Agencies issued proposed regulations[71] on the contraceptive coverage rules. The proposed rules would change the framework for moral and religious objections. The current final rules provide exemptions from the contraceptive coverage requirement for group health plans, institutions of higher education that arrange student health insurance coverage, health insurance issuers, and individuals with sincerely held religious or moral objections.

The proposed rules maintain the religious exemption, and they also do not modify the optional accommodation that religious entities may elect to use. The Agencies state that they elected to retain the religious exemption due to RFRA and the large number of religious entities with religious objections to contraceptive coverage. However, the proposed rules eliminate the moral convictions exemption since few entities used the moral exemption, RFRA does not apply to the moral exemption, and no other law protects the moral exemption.

The proposed rules establish a new pathway for individuals to use when contraceptive coverage is not provided for religious reasons (and the optional accommodation is not provided). The proposed "individual contraceptive arrangement" pathway would not require any involvement or action (i.e., no communications or forms, etc.) on the part of the entity objecting for religious reasons.

Through the new proposed pathway, a "willing provider" is required to furnish contraceptive services (including items and services that are integral to the furnishing of the contraceptives) to the "eligible individual" without imposing a fee or charge of any kind, directly or indirectly, on the individual or any other entity (including the objecting religious entity) for the cost of such items and services. Like the current process for TPA adjustments under the optional accommodation, the willing provider would seek

[70] 88 Fed. Reg. 68,519 (Oct. 4, 2023).

[71] 88 Fed. Reg. 7,236 (Feb. 2, 2023).

reimbursement through an adjustment to its user fees from a participating qualified health plan issuer in the Federally Facilitated Exchange or a State Based Exchange on the Federal platform.

8. FAQ Guidance on Transparency in Coverage Provisions

In 2020, the Agencies jointly issued final regulations[72] requiring most group health plans to make disclosures to participants, beneficiaries, enrollees, and, under certain circumstances, the public. The preamble to the final regulations also states that the final regulations do not apply to "Denominational Health Plans."[73]

Specifically, the regulations require group health plans to make advance disclosures of the cost-sharing information specified in the regulations to participants, beneficiaries, and enrollees through an internet-based self-service tool on an internet website and in paper form upon request. This disclosure requirement is effective for plan years beginning on or after January 1, 2023 for an initial list of 500 items and services and for plan years beginning on or after January 1, 2024 for all items and services required to be disclosed.

The final regulations also require plans to make price transparency information available to the public on an internet website through three machine-readable files that are updated monthly. The three files include disclosure of payment rates negotiated between plans and providers for all covered services, the allowed amount and billed charges for services provided by out-of-network providers, and pricing information for prescription drugs.

In 2021, the Agencies issued FAQs deferring enforcement of certain requirements of the final regulations, pending further consideration by the Agencies. The enforcement of these requirements was delayed after enactment of the CAA 2021 because that law included potentially duplicative and overlapping reporting requirements for prescription drugs.

In 2022, the Agencies issued FAQs providing an enforcement safe harbor for plans that use certain types of alternative reimbursement arrangements, such as an arrangement under which it is not possible to determine specific dollar amounts for items or services before the item or service is provided.

In September, the Agencies issued FAQs[74] stating that the Agencies do not intend to issue further guidance in the near future on the prescription drug machine-readable file requirements of the transparency in coverage final rules. The Agencies have determined

[72] 85 Fed. Reg. 72,158 (Nov. 12, 2020).

[73] The Church Alliance submitted a comment letter on the proposed regulations. In the comment letter, the Church Alliance specifically requested that denominational health plans be exempt from these requirements. The Agencies discussed this request in the preamble to the final regulations and included language stating that the requirements do not apply to "Denominational Health Plans." *See* https://church-alliance.org/comment-letters/comment-proposed-health-care-transparency-coverage-regulations-january-29-2020.

[74] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-61.

that there is not a conflict between the transparency in coverage final regulations and the CAA 2021 because they require disclosure of different information. Accordingly, the Agencies rescinded question 1 of the 2021 FAQs, which deferred enforcement of the prescription drug machine readable file requirement of the transparency in coverage final rules.

The FAQs also rescinded the enforcement safe harbor provided in the 2022 FAQs for plans that use certain types of alternative reimbursement arrangements. Instead of having a safe harbor, the Agencies will exercise enforcement discretion on a case-by-case basis and are unlikely to pursue enforcement action if a plan can show that compliance would have been "extremely difficult or impossible."

The Agencies also issued an FAQ[75] stating that "facility fees" are included in the definition of items and services for purposes of the transparency in coverage final rules. Accordingly, plans must make price comparison information for covered facility fees available to participants through the internet-based self-service tool and in paper form, upon request.

The FAQ also states that the Agencies anticipate issuing future proposed rules that would address facility fees with respect to the good faith estimate and advanced explanation of benefit provisions of the No Surprises Act (which was included in CCA 2021). When an individual schedules items or services or upon request, providers and facilities must provide a notification of the good faith estimate of the expected charges for those items or services to the plan (if the individual is covered under a plan). Upon receiving a good faith estimate, plans must send participants an advanced explanation of benefits that includes certain required information.

9. FAQ Guidance on Cost-Sharing

The ACA requires non-grandfathered plans to ensure that any annual cost sharing under the plan does not exceed the out-of-pocket maximum provided for under the ACA. The No Surprises Act provides protections against surprise medical bills for emergency services, including services performed by "nonparticipating" providers.

In July, the Agencies issued FAQs[76] confirming that cost-sharing for services furnished by a "nonparticipating" provider for purposes of the No Surprises Act is not subject to the ACA out-of-pocket limit. In addition, a direct or indirect contractual relationship with a provider will cause the provider to be "participating" for purposes of the No Surprises Act and "in-network" for purposes of the ACA out-of-pocket limit.

10. FAQ Guidance on *Braidwood Management* Decision

The ACA preventive services coverage mandate requires non-grandfathered health plans to cover the USPSTF recommended preventive services rated "A" or "B," along with

[75] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-60.

[76] *Id.*

certain other preventive services. On March 30, 2023, a district court judge in *Braidwood Management Inc. v. Becerra*[77] enjoined enforcement of the requirement to cover USPSTF preventive services with "A" or "B" ratings issued on or after March 23, 2010. The *Braidwood* decision is discussed in further detail in Section V.B.2 of this report.

On April 13, 2023, the Agencies issued FAQ guidance[78] providing as follows:

- Plans and issuers are not prevented from continuing to provide coverage for preventive items and services recommended with an "A" or "B" USPSTF rating on or after March 23, 2010 and the Agencies "strongly encourage" plans to continue such coverage.

- The decision does not impact USPSTF recommended preventive services with "A" or "B" ratings before March 23, 2010 and the Agencies anticipate providing additional guidance regarding what those recommendations were.

- To the extent there is overlap with (1) the USPSTF "A" or "B" ratings on or after March 23, 2010, and (2) the Advisory Committee on Immunization Practices ("ACIP") or Health Resources and Service Administration ("HRSA") guidelines, plans or issuers must continue to provide preventive coverage without cost sharing for such ACIP overlapping items and services.

- The *Braidwood Management* decision does not impact the COVID-19 vaccine requirements. The current COVID-19 vaccine requirements stem from immunization recommendations from the ACIP.

- With respect to HDHPs and HSAs, until further guidance is issued, items and services recommended with an "A" or "B" rating by the USPSTF on or after March 23, 2010 will be treated as preventive care for purposes of the HDHP safe harbor under Code section 223(c)(2)(C), regardless of whether the ACA requires such preventive care without cost sharing.

- The *Braidwood Management* decision does not impact the application of applicable state laws.

- The Agencies remind plans and issuers to consider other applicable federal and state laws when determining whether to make any mid-year plan or policy changes, such as notice requirements (including the advance SBC notice), applicable state laws, or other contractual obligations. Plans subject to ERISA would also need to consider a summary of material modifications ("SMM") related to any mid-year changes.

[77] No. 4:20-cv-00283-O, 2023 WL 2703229 (N.D. Tex. Mar. 30, 2023).

[78] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-59.

11. FAQ Guidance on Prescription Drug and Health Care Spending Reporting

The CAA 2021 included a provision requiring group health plans to report annually to the Agencies certain information relating to prescription drug and other health care expenditures. In 2021, the Agencies issued interim final rules stating that the Agencies would not initiate enforcement action against a plan that does not report the required information by the first or second statutory deadlines for reporting (i.e., December 27, 2021 or June 1, 2022) and instead submits reports for 2020 and 2021 by December 27, 2022.

On December 23, 2022, the Agencies issued FAQ guidance[79] stating that they would not take enforcement action against plans that used a good faith, reasonable interpretation of the applicable regulations and reporting instructions when submitting the report. The FAQs also provided a grace period permitting reports to be submitted by January 31, 2023, and included additional guidance on the requirements for reports that include data for the 2020 and 2021 reference years.

D. Other Health and Welfare Plan Guidance

1. GAO Information on Farm Bureau Health Plans, Health Care Sharing Ministries, and Fixed Indemnity Plans

In July, the GAO issued a report[80] with information on the following three alternatives to traditional health insurance:

- Health plans sold to members of state Farm Bureaus.
- Health care sharing ministry memberships in organizations whose members share similar beliefs and contribute monthly to pay for the medical costs of members.
- Fixed indemnity plans that pay a fixed dollar amount on a per-period or per-incident basis.

The GAO found that the benefits and features of these plans varied. State insurance officials stated that these plans tend to contain few consumer protections. These plans generally are not required to comply with the requirements and protections of the ACA. The GAO also found that sellers of these plans used a variety of marketing practices, some of which have been misleading. The market practices include focusing on affordability, suitability, choices, and values.

[79] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-56.pdf.

[80] *See* https://www.gao.gov/products/gao-23-106034.

IV. REGULATORY GUIDANCE IMPACTING BOTH RETIREMENT AND HEALTH CARE PLANS

A. Internal Revenue Service

1. IRS Priority Guidance Plan 2023-2024

On September 29, 2023, the Department of Treasury and the IRS released its 2023-2024 Priority Guidance Plan ("PGP").[81] A list of the items the Church Alliance has flagged to generally monitor in the 2023-2024 iteration of the PGP appears below. The italicized items in this list are new when compared to last year's PGP list.

The main item the Church Alliance will be watching is the church plan definition rulemaking, which was added back into the PGP last year after the Church Alliance filed a comment letter requesting that the IRS include it. On June 8, 2023, the Church Alliance filed a comment letter on this year's PGP, requesting that the IRS publish regulations on the church plan definition as soon as possible. The Church Alliance also requested additional guidance and transition relief on the Roth catch-up contribution provision of SECURE 2.0.[82]

Employee Benefits – Retirement Benefits

- Guidance relating to certain IRS, Tax Exempt and Government Entities, Employee Plans programs, including the Pre-approved Plan Program, the Determination Letter Program, and the Employee Plans Compliance Resolution System (EPCRS).

- *Guidance implementing changes made by Division T of the Consolidated Appropriations Act, 2023, known as the SECURE 2.0 Act of 2022 (SECURE 2.0 Act), including guidance providing questions and answers on certain issues under the SECURE 2.0 Act.*

    - *PUBLISHED 09/11/23 in IRB 2023-37 as NOT. 2023-62 (RELEASED on 08/25/23).*

- *Final regulations relating to the timing of the use or allocation of forfeitures in qualified retirement plans. Proposed regulations were published on February 27, 2023.*

- *Final regulations updating electronic delivery rules and other guidance for providing applicable notices and making participant elections. Proposed regulations were published on December 30, 2022.*

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[81] *See* https://www.irs.gov/pub/irs-utl/2023-2024-priority-guidance-plan-initial-version.pdf.

[82] After this comment letter was submitted, the IRS issued Notice 2023-62 providing transition relief on the Roth catch-up contribution provision included in SECURE 2.0. The notice is further discussed in Section II.A.3 of this report.

- *Final regulations and other guidance relating to modifications to §401(a)(9) made by the Division O of the Further Consolidated Appropriations Act, 2020, Setting Every Community Up for Retirement Enhancement Act of 2019 (SECURE Act), and the SECURE 2.0 Act and addressing other issues under §401(a)(9). Proposed regulations were published on February 24, 2022.*

    - *PUBLISHED 07/31/23 in IRB 2023-31 as NOT. 2023-54 (RELEASED on 07/14/23).*

- Regulations *and other guidance* relating to modifications to certain rules governing §401(k) plans *made by the SECURE Act and the SECURE 2.0 Act.*

- Guidance on student loan payments and qualified retirement plans and §403(b) plans.

- Regulations and related guidance on closed defined benefit plans and related matters. Proposed regulations were published on January 29, 2016.

- Guidance on missing participants, including guidance on uncashed checks.

- Final Regulations and related guidance on the exception to the unified plan rule for §413(e) multiple employer plans. Proposed regulations under §413(c) were published on March 28, 2022.

- Regulations on the definition of church plan under §414(e).

- *Final regulations under §417(e) that update the minimum present value requirements for defined benefit plans. Proposed regulations were published on November 25, 2016.*

- Regulations relating to the reporting requirements under §6057. Proposed regulations were published on June 21, 2012.

Executive Comp, Health Care/Other Benefits, and Employment Taxes

- Regulations under §457(f) and related guidance on ineligible plans. Proposed regulations were published on June 22, 2016.

- Guidance on contributions to and benefits from paid family and medical leave programs.

- Final regulations under §§4980H and 105(h) related to HRAs. Proposed regulations were published on September 30, 2019.

- *Guidance regarding assessment and collection of §4980H employer-shared responsibility payment.*

Exempt Organizations

- Guidance revising Rev. Proc. 80-27 regarding group exemption letters. Notice 2020-36 was published on May 18, 2020.

- Final regulations on §509(a)(3) supporting organizations. Proposed regulations were published on February 19, 2016.

- Regulations under §512 regarding the allocation of expenses in computing unrelated business taxable income and addressing how changes made to §172 net operating losses by section 2303(b) of the CARES Act apply for purposes of §512(a)(6).

- *Guidance addressing the SECURE 2.0 Act changes relating to §529.*

- *Regulations designating an appropriate high-level Treasury official under §7611. Proposed regulations were published on August 5, 2009.*

2. Electronic Filing Requirements

Prior to 2024, certain IRS filings were permitted to be made on paper if the organization filed less than 250 returns. In February, the IRS issued final regulations[83] reducing the 250-return threshold to ten, so an organization with ten or more returns must file those electronically beginning with 2024 filings (which will reflect information for the 2023 tax year). This applies to many types of returns, but employers need to be particularly aware of the impact on Forms W-2, 1095-C, and 1099.

B. Department of Labor

1. Recommendations on Cybersecurity Issues for Employee Benefit Plans

In December, the DOL's ERISA Advisory Council issued two reports with recommendations to the Secretary of Labor on (1) cybersecurity insurance and employee benefit plans, and (2) cybersecurity issues affecting health benefit plans. In the report on cybersecurity insurance and employee benefit plans, the ERISA Advisory Council made the following two recommendations to the DOL:[84]

- The DOL should continue to study the issue of cybersecurity insurance (or other risk-mitigation strategies) and employee benefit plans.

[83] 88 Fed. Reg. 11,754 (Feb. 23, 2023).

[84] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/about-us/erisa-advisory-council/2022-cybersecurity-insurance-and-employee-benefit-plans.pdf.

- After further study, the DOL should consider developing education for plan fiduciaries and others about the types of insurance coverages that are available to protect against cyber incident losses.

In the report on cybersecurity issues affecting health plans, the ERISA Advisory Council made the following six recommendations to the DOL:[85]

- The DOL should make explicit that acting prudently with respect to cybersecurity risks is the responsibility of fiduciaries of all employee benefit plans, not just pension plans.

- The DOL should make clear that the fiduciary duty to act prudently includes the duty of health plan fiduciaries to make sure that their service providers have practices and procedures to deal with these risks.

- The DOL should clarify that prior guidance called, Cybersecurity Program Best Practices and Tips for Hiring a Service Provider with Strong Cybersecurity Practices ("Best Practices and Tips"), also applies to health plans.

- The DOL should clarify the extent to which compliance with HIPAA and HITECH satisfies the recommended practices in Best Practices and Tips.

- The DOL should regularly review and update the Best Practices and Tips to reflect changes in the practices resulting from the evolving nature of cybersecurity threats.

- The DOL should provide education and materials to health plan sponsors and fiduciaries to help them understand and carry out their duties relating to cybersecurity.

C. Internal Revenue Service, Department of Labor, and Health and Human Services Joint Guidance

1. FAQ Guidance on End of "Outbreak Period" Relief

The "Outbreak Period" is the period of time from March 1, 2020 until 60 days after the announced end of the COVID-19 national emergency. As indicated in Notice 2021-21, the "Outbreak Period" is determined on a *person by person* (*event by event*) basis and continues until the earlier of:

- 60-days after the announced end of the COVID-19 national emergency, or

- One year from when the person is first eligible for relief.

[85] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/about-us/erisa-advisory-council/2022-cybersecurity-issues-affecting-health-benefit-plans.pdf.

The "Outbreak Period" relief extended certain benefit plan deadlines during the COVID-19 national emergency, including HIPAA special enrollment, COBRA elections and premium payments, and claim and appeal submissions.

The Biden administration originally announced that it planned to end the national emergency on May 11, 2023. Based on this date, the Agencies issued FAQ guidance[86] stating they anticipate that the tolling relief would end July 10, 2023 (or, if earlier, one year from when the person was first eligible for relief). The FAQs also provide guidance on how the COVID-19 coverage and payment requirements under the Families First Coronavirus Response Act ("FFCRA") and the CARES Act will change when the public health emergency ends, including the following:

- The FFCRA and CARES Act will no longer require plans to provide coverage for COVID-19 diagnostic testing that is furnished after the end of the public health emergency. If plans do provide such coverage, they are permitted to impose cost-sharing requirements, prior authorization, or other medical management requirements, subject to other applicable legal requirements.

- Plans are required to continue to cover, without cost sharing, qualifying coronavirus preventive services, including COVID-19 vaccines. However, plans with a network of providers are not required to cover coronavirus preventive services furnished by an out-of-network provider unless the plan does not have an in-network provider who can provide these services.

On April 10, 2023, President Biden signed into law H.J.Res. 7, which immediately terminated the national emergency related to the COVID-19 pandemic. The DOL informally indicated that the early termination of the national emergency did not impact the July 10, 2023 end of the "Outbreak Period."

V. LITIGATION

A. Litigation Impacting Retirement Plans

1. African Methodist Episcopal Church Litigation Update

During 2022, several class action lawsuits were filed against the African Methodist Episcopal Church, church officials, third-party service providers, and certain others alleging that the defendants breached their fiduciary duties by permitting a single individual to exercise unsupervised control in managing the plan assets of the African Methodist Episcopal Church Ministerial Retirement Annuity Fund. This individual made illegal and risky investments involving self-dealing with no oversight from the church or its ministers. As a result, the plan lost more than $90 million or about 75% of its assets.

The plaintiffs brought numerous ERISA and state law claims. In this case, the plaintiffs did not assert that the plan is an ERISA plan. Instead, the plaintiffs allege that

[86] *See* https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-58.pdf.

the defendants agreed in numerous written plan documents provided to plaintiffs to govern the plan in accordance with ERISA. As a result, the plaintiffs allege the defendants should be held to ERISA standards in their management of the plan assets. The plaintiffs claim they are entitled to remedies under ERISA in addition to remedies under state law.

On Mach 17, 2023, the court ruled on several Motions to Dismiss filed by the Defendants.[87] On the ERISA claims, the court determined that ERISA does not govern the plan and dismissed these claims. The court made this determination based on the plain language of the plan (which states that it is a non-electing church plan), the fact that the amended complaint states that the church had not formally elected to be governed by ERISA, and certain concessions made by the parties at the motion hearing. The court also granted in part and dismissed in part several of the state law claims.

2. Litigation Alleging State Law Breach of Contract and Fiduciary Duty Claims

The Roman Catholic Diocese of Albany, New York cofounded St. Claire's Corporation to operate a hospital. The corporation established the St. Clare's Hospital Retirement Income Plan to provide a pension benefit to retired hospital workers. The plan was determined to be a church plan by the IRS in 1992. Thereafter, the corporation made inadequate contributions to the plan. In 2018, the corporation terminated the plan and informed participants that their benefits would either be reduced or ended in 2019. The corporation's board then filed a petition for judicial dissolution in which they stated that the corporation owed more than $50 million to the plan and had no assets to make the plan whole.

Former employees sued the corporation for breach of contract and breach of fiduciary duty. In 2021, the Supreme Court of New York denied the defendants' motions to dismiss.[88]

In 2022, the New York Attorney General filed another lawsuit against the Roman Catholic Diocese of Albany relating to the alleged mismanagement of the St. Clare's Hospital Retirement Income Plan.[89] The New York Attorney General claims the defendants violated their fiduciary duties under New York law by making the decision to remove the plan from the protections of ERISA by applying for church plan status and then failing to adequately fund the plan. The Attorney General is seeking full restitution from the defendants for their actions. This action has been consolidated with the action filed by former employees.[90]

[87] *In re AME Church Employee Retirement Fund Litigation*, No. 1:22-md-03035-STA-jay (W.D. Tenn. March 17, 2023).

[88] *Hartshorne et al. v. Roman Catholic Diocese of Albany, N.Y. et al.*, 200 A.D.3d 1427 (N.Y. App. Div. 2021).

[89] *State of New York v, Roman Catholic Diocese of Albany, NY, et al*., No. 0000830 (S. Ct. NY filed May 24, 2022).

[90] The consolidated action is proceeding in the Schenectady County Supreme Court under Index No. 2022-830.

In March, the Diocese filed Chapter 11 bankruptcy proceedings,[91] which automatically stayed all lawsuits filed against the Diocese. In May, the Official Committee of Unsecured Creditors submitted a motion requesting a termination of the automatic stay so the state pension case could move forward. The Diocese did not oppose the motion. In June, the court granted relief from the automatic stay so the state pension action could proceed in state court.[92]

3. Fiduciary Litigation

New cases continue to be filed alleging that retirement plan sponsors and committees are breaching their ERISA fiduciary duties to retirement plans and plan participants by paying excessive and unreasonable fees to retirement plan recordkeepers, administrative service providers, and investment providers. These cases have been filed against large, for-profit companies sponsoring 401(k) plans, and college and university 403(b) plans.

In *Hughes v. Northwestern University*, the plaintiffs alleged that Northwestern University violated ERISA's fiduciary duty of prudence with respect to two 403(b) plans that it sponsored by:

- Failing to monitor and control recordkeeping fees.
- Offering "retail" share classes of mutual funds and annuities with higher fees than identical "institutional" share classes of the same investments.
- Offering too many investment options (over 400) that resulted in participant confusion and poor investment decisions.

The district court granted defendants' motion to dismiss the case and the Seventh Circuit[93] affirmed, citing the plan's array of investment choices that included the types of funds plaintiffs wanted (e.g., low-cost index funds). The U.S. Supreme Court[94] disagreed with the Seventh Circuit's rationale, concluding in January of 2022 that the Seventh Circuit's focus on investor choice ignored plan fiduciaries' obligation to conduct their own independent evaluation to determine the prudence of investment options. The case was remanded for the Seventh Circuit to consider whether the plaintiffs plausibly alleged a violation of the duty of prudence using the pleading standard articulated in *Tibble v. Edison Int'l* under which a fiduciary normally has a continuing duty of some kind to monitor investments and remove imprudent ones.

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[91] *In re: The Roman Catholic Diocese of Albany, NY*, No. 23-10244-1-rel (Bankr. N.D.N.Y. Mar. 15, 2023).

[92] *Id., First Periodic Update Regarding Consolidated State Court St. Clare's Pension Litigation for August 2023* (filed Aug. 9, 2023).

[93] *Divane v. Northwestern Univ.*, 953 F. 3d 980 (7th Cir. 2020).

[94] 142 S. Ct. 737 (2022).

On remand, the Seventh Circuit[95] refused to dismiss claims related to unreasonable recordkeeping fees and imprudent fund retention due to high cost and poor performance (particularly the use of retail share classes instead of institutional). The court rejected Northwestern's argument that the heightened pleading standard applicable to employee stock ownership plans should also apply to 401(k) plans. The court also determined that a plaintiff must plausibly allege fiduciary decisions are outside a range of reasonableness, which will depend on the circumstances at the time the fiduciary acts. If there is an obvious explanation for a fiduciary's conduct that the plaintiffs cannot overcome, a motion to dismiss will likely be granted. If there are multiple reasonable explanations for the conduct, the motion to dismiss should fail.

The Seventh Circuit dismissed claims that Northwestern plan fiduciaries were imprudent by offering multiple duplicative funds. According to the court, "Unspecific allegations that a fiduciary provided too many funds, without more, do not state a claim for breach of the duty of prudence."

4. Target Date Fund Litigation

Several large 401(k) retirement plan sponsors have been sued for selecting certain BlackRock target date funds. The complaints in these cases are different because they do not allege any deficiency in the plan sponsor's selection process when choosing the BlackRock target date funds and do not focus on the cost of the funds. Instead, the complaints allege that the plan sponsors violated their fiduciary duties under ERISA solely based on the performance of BlackRock target date funds when compared to four of its largest competitors.

Several of these cases have been dismissed due to the plaintiffs' failure to allege facts regarding the selection process for the target date funds.[96] Plaintiffs instead relied on alleged underperformance as evidence of breach of fiduciary duty.

5. ESG Litigation

As discussed in Section I.B of this report, the DOL issued final rules[97] in 2022 amending rules that were issued in 2020 under the Trump administration relating to whether fiduciaries may consider ESG factors when selecting retirement plan investments.[98] The final rules permit fiduciaries to consider any factor that is material to

[95] *Hughes v. Northwestern Univ.*, 63 F.4th 615 (7th Cir. 2023).

[96] *See, e.g.*, *Tullgren v. Booz Allen Hamilton*, No. 1:22-cv-00856-MSN-IDD, 2023 WL 2307615 (E.D. Va. Mar. 1, 2023) and *Beldock v. Microsoft Corp.* No. C22-1082JLR, 2023 WL 3058016 (W.D. Wash. April 24, 2023).

[97] *See* https://www.dol.gov/sites/dolgov/files/ebsa/temporary-postings/prudence-and-loyalty-in-selecting-plan-investments-and-exercising-shareholder-rights-final-rule.pdf.

[98] *See* https://www.dol.gov/sites/dolgov/files/ebsa/temporary-postings/prudence-and-loyalty-in-selecting-plan-investments-and-exercising-shareholder-rights-final-rule.pdf.

the risk-return analysis, including climate change-related factors and other ESG factors. Congress passed a resolution[99] nullifying the final ESG rules that President Biden vetoed.

In January, Republican attorneys general from several states filed a lawsuit[100] against the Secretary of Labor claiming the rule violates ERISA and is arbitrary and capricious. The district court judge denied the plaintiffs' claims and granted the DOL's motion for summary judgment. The Republican attorneys general appealed the district court decision to the Fifth Circuit Court of Appeals.

6. Fiduciary Litigation on Failure to Consider Float Income

A new type of claim in excess fee litigation is that plan sponsors have breached their fiduciary duty by failing to monitor or control excessive compensation paid for recordkeeping fees, which includes the amount of float income earned by the plan's recordkeeper. According to the complaint filed in *Barner v. McLane Company, Inc.*,[101] "McLane has not tracked, monitored, or negotiated the amount of compensation Merrill Lynch receives from float compensation. McLane never disclosed this compensation to Plan participants either."[102]

7. Cryptocurrency Investment Litigation

The DOL issued Compliance Assistance Release ("CAR") 2022-01 on March 10, 2022 in which it cautioned 401(k) plan fiduciaries about allowing investments in cryptocurrencies. Cryptocurrencies include digital assets, such as those marketed as tokens, coins, crypto assets, and derivatives of the same.

In the CAR, the DOL stated that it "has serious concerns about the prudence of a fiduciary's decision to expose a 401(k) plan's participants to direct investments in cryptocurrencies, or other products whose value is tied to cryptocurrencies." According to the DOL, these sorts of investments involve "significant risks and challenges to participants' retirement accounts."

In 2022, a lawsuit was filed by ForUsAll Inc., a 401(k) provider that offered cryptocurrency investment options to retirement plans, to invalidate the CAR as violating the required regulatory administrative process. The court dismissed the case in August[103] for the following reasons:

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[99] H.J.Res.30.

[100] *State of Utah, et al. v. Walsh*, No. 2:23-CV-016-Z, 2023 WL 6205926 (N.D. Tex. Sept. 21, 2023).

[101] No. 6:23-00301 (W.D. Tex filed April 24, 2023).

[102] The DOL issued guidance on fiduciary obligations relating to float income in Field Assistance Bulletin 2022-03. *See* https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2002-03.

[103] *ForUsAll, Inc. v. Dept. of Labor et al.*, No. 22-cv-01551, 2023 WL 5559682 (D.D.C. Aug. 29, 2023).

- The 401(k) provider did not have standing to bring the case because the court determined that invalidating the CAR would not cure the alleged injury by restoring negotiations with plans that decided not to use the 401(k) provider's services.

- The CAR is not a final or binding agency action that can be challenged in court.

The court also determined that the CAR did not impose "crypto-specific fiduciary obligations that are above and beyond the ordinary duty of prudence" required under ERISA. Instead, the CAR's directive to exercise "extreme care" when allowing investments in cryptocurrency was a reference to the requirement under ERISA that fiduciaries act prudently under the circumstances. The court also stated that the CAR does not extend fiduciary obligations to brokerage windows that did not already exist.

8. Church Plan Litigation Update

Numerous lawsuits have been filed in the last ten years challenging the availability of the ERISA church plan exemption to defined benefit plans sponsored by several different religiously affiliated health care systems. In one such case, plaintiffs brought an action alleging the health care system's retirement plan did not qualify for the church plan exemption under ERISA. The district court determined that the plan did not qualify as a church plan because it had not been established by a church. The Third Circuit affirmed the district court ruling. The U.S. Supreme Court reversed the Third Circuit's ruling, concluding that church plans can include plans that are established by church-affiliated entities.

On remand, the district court agreed with the Supreme Court and determined that the plan qualified as a church plan because it satisfies the statutory definition of a church plan under section 3(33) of ERISA. Section 3(33)(C)(i) of ERISA states that a church plan includes "a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches."[104] These organizations are often referred to as "principal-purpose organizations."

The Church Alliance continues to monitor the progress of church plan status cases.

B. Litigation Impacting Health and Welfare Plans

1. Surprise Medical Billing Litigation

As described in additional detail in Sections III.C.3, III.C.4, and III.C.5 of this report, the No Surprises Act requires health plans to make an initial payment or deny claims of out-of-network providers and facilities that are subject to the surprise billing provisions

[104] *Kaplan v. St. Peter's Healthcare System et al.*, No. 13-2941 (MAS) (TJB), 2023 WL 2071725 (D.N.J. Fed. 17, 2023).

within a certain period of time. If the provider does not agree with the payment amount and the parties cannot come to an agreement after a dispute resolution process, the parties can initiate the IDR process. During the IDR process, the IDR entity must consider the QPA amount for items and services subject to the IDR process.

There have been a series of cases challenging the implementation of the IDR process that have been filed in the Eastern District of Texas under the name *Texas Medical Association, et al. v. HHS ("TMA").* These cases resulted in the following rulings:

- *TMA I*: On February 23, 2022, the court vacated the provisions of the No Surprises Act interim final rule issued in 2021 that effectively required a rebuttable presumption for the IDR entity to select the offer closest to the QPA under the arbitration process.[105]

- *TMA II*: After TMA I, the Agencies issued a final rule in August 2022 removing the provisions identified by the court in *TMA I*. Instead of requiring the IDR entity to presume the QPR is the appropriate payment amount, the final rule required IDR entities to consider the QPA first and then consider additional information submitted by the parties. In *TMA II*, the court struck down the revised provision in the final rule, stating that the No Surprises Act requires the IDR entity to consider the QPA in addition to certain other information submitted by providers without favoring any factor.[106] HHS has appealed this decision to the Fifth Circuit.[107]

- *TMA III*: In August, the court vacated certain provisions of the 2021 interim final rule governing how payers should calculate the QPA for items and services.[108] Following this decision, the Agencies issued FAQ guidance[109] on how to calculate the QPA and stating that they intend to appeal the decision. The FAQ guidance is further described in III.C.4 of this report.

- *TMA IV*: During the same month, the court vacated an increase to the IDR administrative fee and the IDR procedures on "batching" related claims in a single IDR proceeding because these changes were made without notice and comment and were arbitrary and capricious.[110]

[105] 587 F.Supp.3d 528 (E.D. Tex. 2022).

[106] No. 6:22-cv-372-JDK, 2023 WL 1781801 (E.D. Tex. Fed. 6, 2023).

[107] *Id., appeal docketed* No. 23-40217 (5th Cir. April 11, 2023).

[108] No. 6:22-cv-450-JDK, 2023 WL 5489028 (E.D. Tex. Aug. 24, 2023).

[109] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-62.

[110] No. 6:23-cv-59-JDK, 2023 WL 4977746 (E.D. Tex. Aug. 3, 2023).

As a result of the decisions, the Agencies temporarily suspended the IDR process.[111] Since the suspension was first instituted, the IDR process has been reopened for certain types of disputes.

2. Preventive Coverage Litigation

The ACA preventive services coverage mandate requires non-grandfathered health plans to cover the following preventive services without cost sharing, when provided in-network:

- The USPSTF recommended preventive services rated "A" or "B."
- CDC and ACIP recommended immunizations.
- Any additional preventive care and screenings for women not recommended by the USPSTF but provided for in the HRSA guidelines.
- Preventive screenings and care for infants, children, and adolescents that are provided for in the HSRA guidelines.

In *Braidwood Management Inc. v. Becerra,*[112] Braidwood Management, Inc., a Christian-owned business, and six individuals brought an action in 2022 asserting that (1) providing the USPSTF with authority to establish certain preventive services requirements under the ACA was unconstitutional; and (2) the ACA preventive services requirement to cover the PrEP (pre-exposure prophylaxis) HIV prevention medication violates the plaintiff's rights under RFRA. The district court determined that the USPSTF was improperly allocated authority to establish preventive services requirements and the PrEP mandate violates Braidwood Management's rights under RFRA.

On March 30, 2023,[113] the same judge enjoined enforcement of the ACA requirement to cover USPSTF preventive services with "A" or "B" ratings issued on or after March 23, 2010. This ruling does not impact the requirement to cover USPSTF preventive services that were recommended before that date or the requirement to cover the other categories of preventive services.

The government appealed,[114] and the Fifth Circuit stayed enforcement of the order enjoining the ACA requirement to cover USPSTF preventive services with "A" or "B" ratings while the appeal is decided.[115]

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[111] *See* https://www.cms.gov/nosurprises/help-resolve-payment-disputes/payment-disputes-between-providers-and-health-plans and https://nsa-idr.cms.gov/paymentdisputes/s/.

[112] *Braidwood Mgmt. Inc. v. Becerra, et al*., 627 F.Supp.3d 624 (N.D. Tex. Sept. 7, 2022).

[113] No. 4:20-cv-00283-O, 2023 WL 2703229 (N.D. Tex. Mar. 30, 2023).

[114] *Id., appeal docketed* No. 23-10326 (5th Cir. April 3, 2023).

[115] *Id., Unpublished Order*, (5th Cir. June 13, 2023).

The Agencies issued FAQs relating to the April 13, 2023 decision, which are further discussed in Section III.C.10 of this report.

3. Pharmacy Benefit Manager Litigation

An Oklahoma PBM law was originally passed in 2019 and was amended in 2022. It potentially impacts common prescription plan designs, such as the required use of mail-order pharmacies for specialty drugs.

In 2022, a federal district court held that ERISA does not preempt its application to self-funded benefit plans. The trade group that brought the lawsuit appealed. The Oklahoma Insurance Department indicated that it was prepared to enforce the law[116] and negotiated a $4.8 million settlement with CVS regarding the collection of transaction fees from pharmacies for Medicare Part D and ERISA plan claims.[117]

On August 15, 2023, the Tenth Circuit Court of Appeals held that:

- ERISA preempts the access standards, discount prohibition, any willing provider provision, and provider probation prohibition as applied to ERISA plans; and
- Medicare Part D preempts the any willing provider provision as applied to Medicare Part D plans.

4. Abortion Drug Litigation

Over the past year, there have been several cases involving mifepristone, a drug used to induce abortion. Two of the cases resulted in conflicting decisions, which could result in the U.S. Supreme Court hearing the cases.

Mifepristone is an FDA-approved drug. As a condition of its approval, the FDA requires compliance with certain controls pursuant to a risk evaluation and mitigation strategy or "REMS." The mifepristone REMS have changed over time.

In *Alliance for Hippocratic Medicine v. FDA*,[118] physicians and physician associations filed a case in a Texas district court challenging the FDA's approval of mifepristone. On April 7, the district court blocked the FDA's approval of mifepristone. On August 16, the Fifth Circuit[119] ruled to allow mifepristone to remain available but to reinstate the FDA's more burdensome pre-2016 REMS for obtaining the drug. The Department of Justice filed a writ of certiorari with the U.S. Supreme Court on September

[116] *See* https://www.oid.ok.gov/release_040522/.

[117] *See* https://www.oid.ok.gov/release_012022/.

[118] No. 2:22-CV-223-Z, 2023 WL 2825871 (N.D. Tex. April 7, 2023).

[119] *Alliance for Hippocratic Medicine v. FDA*, 78 F.4th 210 (5th Cir. 2023).

8. The Fifth Circuit decision has been stayed and mifepristone will remain available under the FDA's current REMS while the case proceeds.[120]

In contrast, attorneys general of seventeen states and the District of Columbia filed suit in *State of Washington v. FDA*,[121] arguing that the 2023 mifepristone REMS improperly constrain access to the drug. On April 7, 2023, a Washington district court issued a preliminary injunction barring the FDA from altering the current REMS in the plaintiff states. After this ruling, a group of seven other states asked to intervene in the litigation in an attempt to maintain abortion restrictions in those states. On April 21, 2023, the court rejected this request,[122] and the seven states appealed this decision to the Seventh Circuit.[123]

VI. STATE LAWS

ERISA preemption does not apply to self-insured church plans, thus state laws are potentially applicable. Under the Church Plan Parity and Entanglement Prevention Act of 1999, a church plan is deemed to be a single employer plan for purposes of state laws that require a church plan to be licensed or relate solely to the solvency or insolvency of a church plan (including participation in state guaranty funds and associations). RFRA states that the government may substantially burden a person's exercise of religion only if it demonstrates that application of the burden to the person is in furtherance of a compelling governmental interest and is the least restrictive means of furthering that compelling governmental interest. Some state laws may include an exception for church plans or denomination plans. Below is a description of certain types of state laws issued during the past year of interest to church plans.

A. State Law Initiatives Being Monitored by the Church Alliance

The Church Alliance continues to monitor state legislative proposals that could impact church plans.[124] This year, the Church Alliance has focused on state health care legislation since the American Benefits Council is closely following retirement bills. On health care, the Church Alliance has been monitoring legislative proposals relating to privacy measures and their impact on church plans, Medicare benefits, the regulation of PBMs, and public option/single payer bills.

B. State Abortion Laws

In June, the U.S. Supreme Court reversed its 1973 ruling in *Roe v. Wade*, overturning the constitutional right to an abortion.[125] As a result, the decision about whether to allow abortions is now up to the states. In some states, the Supreme Court decision "triggered" certain pro-life legislation to come into effect. Other states passed abortion legislation after the Supreme Court decision. A battle over abortion access is still taking place in many other states. Both the Church

[120] *Danco Labs., LLC v. Alliance for Hippocratic Medicine, et al.*, 143 S. Ct. 1075 (2023).

[121] No. 1:23-CV-3026-TOR, 2023 WL 2825861 (E.D. Wash. April 7, 2023).

[122] *Id.,* 2023 WL 3035380 (E.D. Wash. April 21, 2023).

[123] *State of Washington, et al. v. FDA*, *appeal docketed* No. 23-35294 (9th Cir. May 1, 2023).

[124] The Church Alliance has prepared a chart that summarizes relevant state legislative proposals.

[125] *Dobbs v. Jackson Women's Health Org*., 142 S. Ct. 2228 (2022).

Alliance and the American Benefits Council have prepared charts summarizing current and prospective state abortion laws.[126]

C. State Auto-Enrollment Programs

Several states and some cities have enacted laws establishing automatic payroll deduction IRA savings programs that require employers to automatically enroll eligible employees.[127] States with implemented programs include California, Colorado, Connecticut, Illinois, Maryland, Oregon and Virginia. States with enacted but not implemented laws include Delaware, Hawaii, Maine, Minnesota, Nevada, New Jersey, New York, and Vermont. Other states have active legislation being considered or have adopted optional state-run automatic payroll deduction IRA savings programs.

Most programs do not provide specific exemptions for churches or church plans. However, for the California and Connecticut programs, covered employment does not include:

- Certain services for a church, convention or association of churches, or for an organization operated primarily for religious purposes that is operated, supervised, controlled or principally supported by a church or convention or association of churches.

- Certain services that are for religious purposes by a duly ordained, commissioned, or licensed minister of a church in the exercise of his or her ministry or by a member of a religious order.

Some of the state-run automatic payroll savings programs have small employer exceptions that include various maximum employee thresholds.

Generally, the programs include exceptions if the employer maintains a retirement plan, such as a 403(b) or 401(k) program that meets certain criteria (such as offering the plan for a certain number of years). In many instances, it is unclear if an employer must offer its retirement plan to all employees (such as certain part-time employees) for the employer to be fully exempt from the state-run program. Under some of the programs, employers may be required to take action to file, report, or certify their exemption from the program.[128] Generally, various penalties for non-compliance apply under the programs.

D. Texas Health Plan Bills

Over the past year, a number of bills were introduced in Texas that included language covering church plans. One theory as to why these bills included the language covering church plans is that a template with this language was being used as a starting point for the legislation.

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[126] *See* https://www.americanbenefitscouncil.org/pub/B4C9391B-1866-DAAC-99FB-76EDD2B1CDDA.

[127] The Church Alliance has prepared a chart that summarizes state auto-IRA enrollment legislation that has been enacted or is being considered to date.

[128] For example, registration of an employer's exemption is required in Illinois (Illinois Secure Choice Savings Program Act), Oregon (OregonSaves), and Connecticut (Connecticut Retirement Security Program).

GuideStone Financial Resources took the lead on having this language removed and was successful in having it removed from all but one bill.

E. State Paid Family Leave

Currently, the federal Family and Medical Leave Act ("FMLA") requires employers with at least 50 employees to permit employees to take up to 12 weeks of unpaid leave for certain reasons, including the birth or adoption of a child, to care for a sick family member, or as a result of a medical condition of the employee. Many states also have laws that permit employees to take a leave of absence for family or medical reasons, and several states have expanded the amount of leave or the reasons for the leave.

A few states (including California, Colorado, Connecticut, Maryland, Massachusetts, New Jersey, New York, Oregon, Rhode Island, and Washington) along with the District of Columbia have programs under which employers and/or employees pay premiums to the state family leave program to fund paid leave under certain circumstances. Employers with a private plan that provides equal or greater benefits than those provided under the state leave program can generally apply for a private plan exemption from the requirement to contribute to the state leave program. Delaware and Minnesota will establish similar programs beginning January 1, 2025 for Delaware and January 1, 2026 for Minnesota.

New Hampshire and Vermont recently created voluntary paid family and medical leave programs under which employers and/or workers may opt into the programs. New Hampshire's program went into effect January 1, 2023, and Vermont's will become effective July 1, 2024.

VII. OTHER

A. Senate HELP Committee Request for Information on Health Care Workforce Shortage

In March, members of the Senate Health, Education, Labor, and Pensions ("HELP") Committee requested input from healthcare stakeholders on the reasons for health care workforce shortages and potential solutions to this problem. The Church Alliance submitted a comment letter in response to the request for input from the HELP Committee. One suggestion included in the comment letter is to expand telehealth, which increases the number of providers available to individuals in cities and rural areas with healthcare shortages. The comment letter also urges Congress to make permanent the CARES Act provision that allowed employer-sponsored health plans the ability to cover telehealth services pre-deductible without impacting eligibility for an HSA.

B. Executive Orders on Contraception and Reproductive Health Care

Following the U.S. Supreme Court's decision to overturn *Roe v. Wade*, President Biden signed two Executive Orders in 2022 relating to protecting access to reproductive healthcare services.[129] Among other things, the directives in the Executive Orders are intended to protect

[129] *See* https://www.whitehouse.gov/briefing-room/presidential-actions/2022/07/08/executive-order-on-protecting-access-to-reproductive-healthcare-services/ and https://www.whitehouse.gov/briefing-room/presidential-

access to reproductive health care services, protect patients' privacy and access to accurate information, and ensure the safety and security of patients, providers, clinics, pharmacies, and other entities.

On June 23, 2023, President Biden issued another Executive Order[130] called "Strengthening Access to Affordable, High-Quality Contraception and Family Planning Services." This Executive Order builds on the orders issued in 2022 by:

- Requiring the Agencies to consider issuing guidance to further improve access to contraception under the ACA without out-of-pocket expenses, which ensures coverage of all types of contraception approved by the FDA and streamlines the process for patients and providers to request coverage of medically necessary contraception.

- Requiring HHS, through the Administrator of CMS, to consider taking steps to expand access to affordable family planning services and supplies through Medicaid.

- Promoting access to contraception through other Federal programs.

As a result of the above Executive Orders, several proposed rules have been issued during the past year, including the following:

- Proposed rules to strengthen privacy protections under HIPAA for reproductive health care, which is further discussed in Section III.B.2 of this report.

- Proposed rules requiring coverage of over-the-counter preventive services without cost-sharing, including the first over-the-counter oral contraceptive pill, which is further discussed in Section III.C.6 of this report.

- Proposed rules providing women with a new way to access contraceptives when their private health insurance is exempt from covering this benefit, which is further discussed in Section III.C.7 of this report.

C. Medicaid Changes May Result in Increased Enrollment in Employer-Sponsored Plans

During the COVID-19 pandemic, state Medicaid agencies were not permitted to terminate the coverage of Medicaid or CHIP beneficiaries. This rule ended March 31, 2023. HHS estimates that more than 4 million people may move to employer-sponsored coverage as a result of this rule ending.

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actions/2022/08/03/executive-order-on-securing-access-to-reproductive-and-other-healthcare-services/#:~:text=On%20July%208%2C%202022%2C%20following,Access%20to%20Reproductive%20Healthcare%20Services)..

[130] *See* https://www.whitehouse.gov/briefing-room/presidential-actions/2023/06/23/executive-order-on-strengthening-access-to-affordable-high-quality-contraception-and-family-planning-services/.

D. Social Security Cost of Living Adjustments

On October 12, 2023, the Social Security Administration announced the cost-of-living adjustments for 2024.[131] The cost-of-living adjustments for 2024 are as follows:

Increase in monthly benefits	3.2%
Maximum earnings subject to Social Security taxes	$168,600 (*$8,400 increase*)
Maximum earnings subject to Medicare taxes	Unlimited
Exempted earnings amount:[132] • In year prior to year during which retiree reaches full retirement age • In year during which retiree reaches full retirement age	 $22,320 *($1,080 increase)* $59,520 *($3,000 increase)*

[131] Social Security Press Release, October 12, 2023, https://www.ssa.gov/news/press/releases/2023/#10-2023-2.

[132] The "exempted earnings amount" is the amount of annual earnings a retiree who is under full retirement age can earn without a reduction in Social Security benefits. There is no reduction for a retiree who has attained full retirement age.

APPENDIX A

SECURE 2.0
PROVISIONS OF INTEREST TO CHURCH PLANS

Please note that this chart is not intended to be legal advice and is based on information available just weeks after enactment. Further clarification of this new law will be forthcoming and technical and other corrections remain possible in the future.

Topic	Summary	Effective Date[1]	Mandatory or Optional	Citation[2]	CLWG Comments
RMD Age	Required Minimum Distribution (RMD) age increased to 73 in 2023 and 75 in 2033.	Initial RMDs required to be made for 2023 or later	Mandatory	Sec. 107 (p. 831)	This will require operational changes immediately for defined contribution and defined benefit plans and plan amendments by last day of first plan year beginning on or after 2025[3] (i.e., for those who turn age 72 in 2023, their first RMD is not required until 4/1/2025, although it could be paid by 12/31/2024). This means that participants will only be subject to an initial RMD for calendar year 2023 if they reached age 72 before 2023 and they retire in 2023. Participants whose initial RMD is for calendar year 2022 will be required to receive that RMD no later than April 1, 2023.
Contribution Incentives	De minimis incentives permitted but cannot come from plan assets.	Plan years beginning 1/1/2023	Optional	Sec 113 (p. 837)	Applies to 403(b) and 401(k) plans.

[1] This chart is roughly in order of the effective date of the provision.
[2] All section references are to Division T of Appropriations Act, 2023 (also titled SECURE 2.0 Act of 2022). Page references are to Government Publishing Office publication.
[3] This is the date for plan amendments for SECURE 2.0, SECURE, and CARES as provided in Section 501.

Topic	Summary	Effective Date[1]	Mandatory or Optional	Citation[2]	CLWG Comments
CITs for 403(b)(7) Plans	403(b)(7) plans may now invest in collective investment trusts (CITs).	Amounts invested after 12/29/2022	Optional	Sec. 128 (p. 872)	Securities laws pose limitations on the ability of 403(b) plans to be permitted to invest in CITs, but those limitations do not apply to church plans.
Roth Treatment for Employer Matching and Other Non-Elective Contributions	Plans may allow an employee to elect to have employer contributions treated as Roth contributions.	Contributions after 12/29/2022	Optional	Sec. 604 (p. 934)	Roth employer contributions must vest immediately. Permitted in a 401(k) or 403(b) plan.
Recovery of Retirement Plan Overpayments	Plan fiduciaries may opt not to collect an over payment. For ERISA plans, collections are subject to severe limitations.	12/29/2022	Optional	Sec. 301 (p. 877)	Provides an option not to pursue overpayment and preserves the tax status of rollovers of overpayments. Plan is not precluded from pursuing overpayments, but ERISA plans are limited in doing so.
403(b) MEPs	403(b) Multiple Employer Plans (MEPs) and Pooled Employer Plans (PEPs) are permitted.	Effective 1/1/2023	Optional	Sec. 106 (p. 828)	This provision does not apply to church plans. Church MEPs are already permitted and are not subject to the "one bad apple" rule.
Commercial Annuities/RMDs	Permits flexibility in the design of commercial annuities purchased under plans.	Calendar years ending after 12/29/2022	Optional	Sec. 201 (p. 872)	Allows increasing annuities within limits, such as annual increases up to 5%. Applies to commercial annuities, not "in-plan" annuities.

Topic	Summary	Effective Date[1]	Mandatory or Optional	Citation[2]	CLWG Comments
QLACs (Deferred annuity, e.g., starting at age 80)	Up to $200,000 of a plan account balance can be used to buy a Qualified Longevity Annuity Contract (QLAC). (25% of account limit repealed).	12/29/2022	Optional	Sec. 202 (p. 873)	New provisions also facilitate the retention of survivor benefits, if directed by Qualified Domestic Relations Order (QDRO) (in cases where QLAC is to be paid over joint lifetimes at the time of purchase, but divorce occurs after purchase and before commencement).
Aggregation of Accounts for RMDs	If a plan account is only partially annuitized, a participant can elect to calculate RMD remaining after subtracting annuity payments during year.	12/29/2022	Optional	Sec. 204 (p. 876)	Applies to only defined contribution plans that permit a portion of account balance to be used to purchase an annuity.
Reduction in Excise Tax for Failed RMD	Excise tax reduced from 50% to 25% and further to 10% if corrected within a 2-year window.	12/29/2022 (plus retroactive period)	Mandatory	Sec. 302 (p. 881)	Does not directly affect plan operation. Impacts recipients of late RMDs.
Birth or Adoption Distributions (QBADs)	New time limit of 3 years applies to pay back of this type of distribution.	12/29/2022	Optional	Sec. 311 (p. 889)	QBADs were already permitted under SECURE; only time limit for repayment is new.
Exemption from Penalty Tax for Distribution to Terminally Ill Employee	Exempts this type of early distribution from 10% penalty tax.	Distributions after 12/29/2022	Optional	Sec. 326 (p. 901)	Creates an opportunity for a plan to permit a new type of distribution. Distribution can be made after the date the employee is certified by a physician as having a terminal illness. Proof must be provided to plan administrator.

Topic	Summary	Effective Date[1]	Mandatory or Optional	Citation[2]	CLWG Comments
Hardship Withdrawals	Participants can self-certify that they qualify for hardship distribution from 401(k) and 403(b).	Plan years commencing after 12/29/2022	Optional	Sec. 312 (p. 889)	Plan administrator may rely on participant certification.
Disaster Distributions	Disaster distributions for federally declared disasters automatically allowed, may be accounted for as income over 3 years and may be repaid to plan within 3 years. Also allows loan design flexibility.	Disasters after 1/26/2021	Optional	Sec. 331 (p. 903)	Creates an opportunity for a plan to permit a new type of distribution. May be recontributed to a retirement plan that accepts rollover contributions within three years, treated as a 60-day rollover.
Interest Crediting for Cash Balance Plans	Interest rate credit limited to 6% to prevent backloading.	Plan years beginning after 12/29/2022	Mandatory	Sec. 348 (p. 927)	Even though on its face this may not apply to church plans, there are Age Discrimination in Employment Act (ADEA) provisions that may make this applicable to any retirement plan subject to ADEA requirements.

Topic	Summary	Effective Date[1]	Mandatory or Optional	Citation[2]	CLWG Comments
Enhancing Retiree Health Benefits in Pension Plans	Extends sunset date to the end of 2032 for rules permitting the use of overfunded pension plan assets to pay retiree health and life insurance benefits; transfers permitted if the transfer is no more than 1.75% of plan assets and the plan is at least 110% funded.	Transfers made on or after 12/29/2022	Optional	Sec. 606 (p. 938)	Church plans may determine their funded status differently than ERISA plans but arguably can rely on this provision based on how they determine their own funded status.
Matching Student Loan Payments	403(b) and other retirement plans may offer matching contributions on qualified student loan payments made by employee.	Effective for plan years beginning after 12/31/2023	Optional	Sec. 110 (p. 832)	Participants may self-certify their student loan repayments, simplifying administration.
Penalty Tax Exemption for $1,000 Withdrawals for Emergency Expenses	A plan may allow one emergency withdrawal per calendar year up to $1,000. Withdrawal not subject to penalty tax and may be repaid within 3 years.	Distributions after 12/31/2023	Optional	Sec. 115 (p. 838)	Creates an opportunity for a plan to permit a new type of distribution. Follows QBAD rules for repayment. Can be repaid within 3 years to a plan that accepts rollover contributions.

Topic	Summary	Effective Date[1]	Mandatory or Optional	Citation[2]	CLWG Comments
Mandatory Cash-Outs	Mandatory cash-out limitation increased to $7,000.	Distributions after 12/31/2023	Optional	Sec. 304 (p. 883)	Plans are not required to increase their limits on forced cash-outs. Applies to both defined benefit and defined contribution plans.
Automatic Transfer of Rollover Made to "Forced" IRA	These distributions can be automatically rolled into new employer's plan and providers may receive fees (to be disclosed) for transaction unless participant opts out.	Transactions on or after 12/29/2023	Optional	Sec. 120 (p. 845)	Statute amends IRC 4975(d) (prohibited transaction exemption rules) and allows the vendor to receive fees for these burdensome transactions.
529 Balance Rollover	529 account beneficiaries can make penalty-free rollovers to Roth IRA.	Distributions after 12/31/2023	Optional	Sec. 126 (p. 858)	Doesn't seem to affect church plan providers.
Emergency Savings Accounts (a/k/a "Sidecar" Accounts)	Plans may offer non-highly compensated employees an emergency savings account in the plan. Balance limit is $2,500 (indexed).	Plan years beginning after 12/31/2023	Optional	Sec. 127 (p. 859)	This will require TPA willingness and capability. This applies to ERISA plans only.
403(b) Hardship Rules	401(k) and 403(b) hardships withdrawal rules made parallel.	Plan years beginning after 12/31/2023	Optional	Sec. 602 (p. 933)	Will require plan amendments if more liberal rules are adopted by the 403(b) plan. Allows more fund sources for 403(b) withdrawals.

Topic	Summary	Effective Date[1]	Mandatory or Optional	Citation[2]	CLWG Comments
Withdrawals Permitted for Victims of Domestic Violence	Plan can permit withdrawals up to $10,000 (indexed) or 50% of account balance on employee certification. Not subject to 10% penalty tax.	Distributions after 12/31/2023	Optional	Sec. 314 (p. 891)	Creates an opportunity for a plan to permit a new type of distribution. Does not apply to defined benefit plans or plans subject to the qualified joint and survivor rules (such as non-electing money purchase pension plans). Follows QBAD rules for repayment – may be repaid within 3 years to a plan that accepts rollover contributions.
Retirement Savings Lost and Found	Establishes online national searchable database for lost retirement plan assets.	To be created within 2 years of enactment (12/29/2024)	N/A	Sec. 303 (p. 881)	Applies only to plans to which vesting standards of ERISA Sec. 203 apply, so most church plans will not participate.
EPCRS Expansion	Allows self-correction of more plan administrative errors.	Effective 12/29/2022. Guidance to be issued within 2 years	Optional	Sec. 305 (p. 883)	
Top-Heavy Test	Flexibility to exclude certain employees in testing.	Plan years beginning after 12/31/2023	Optional	Sec. 310 (p. 888)	
Asset Benchmarks	Department Of Labor (DOL) to issue regulations for benchmarks for allocated funds (like target date funds).	2 years after enactment (12/29/2024)		Sec. 318 (p. 895)	While DOL regulations won't apply directly to church plans, these financial benchmarks may become universal.

Topic	Summary	Effective Date[1]	Mandatory or Optional	Citation[2]	CLWG Comments
Auto Enrollment & Escalation Errors	May correct reasonable errors within 9½ months after plan year end.	Plan years beginning after 12/31/2023	Optional	Sec. 350 (p. 928)	Makes current correction safe-harbor under the IRS correction program permanent.
RMDs for Roth Accounts	Pre-death RMDs no longer required. Follows existing IRA rules.	Plan years beginning after 12/31/2023	Mandatory	Sec. 325 (p. 901)	Will require plan amendments along with other RMD amendments. May generate new interest in Roth accounts, in-plan conversions, and ability to elect employer contributions as Roth.
Surviving Spouse Treated as Employee for RMD Rules	A surviving spouse may elect to be treated as the deceased employee for purposes of RMD rules. Applies the uniform life table to determine the distribution period.	Plan years beginning after 12/31/2023	Mandatory	Sec. 327 (p. 901)	Will require plan amendments along with other RMD amendments. This change will give surviving spouses the same flexibility they would have in an IRA, reducing the incentive to roll over to an IRA for more favorable RMD rules. Surviving spouses who are older than the deceased participant may need help understanding trade offs of choice (earlier commencement of RMDs, but payable over joint lifetimes).
Catch-Up Contributions must be on Roth Basis	For employees with FICA wages exceeding $145,000 (indexed) in prior calendar year, catch-up contributions must go to Roth account.	Plan years beginning after 12/31/2023	Mandatory if plan offers catch-up for participants in general	Sec. 603 (p. 933)	This will require significant operational and document changes. Not applicable to 403(b) 15-year catch-up provision. Plans cannot exclude highly-compensated participants from catch-up contributions to avoid compliance. We do not believe this applies to clergy as it refers to FICA wages, although it is possible this may be changed in the future.

Topic	Summary	Effective Date[1]	Mandatory or Optional	Citation[2]	CLWG Comments
Rollover Notices	Secretary of Treasury to issue simplified sample rollover forms.	Transfers, rollovers, exchanges after 12/31/2024	Optional	Sec. 324 (p. 900)	
Auto Enrollment Mandatory for New Plans	New 401(k) and 403(b) plans must incorporate mandatory auto-enrollment provisions.	Plan years beginning after 12/31/2024	Mandatory	Sec. 101 (p. 817)	Church plans are specifically exempt from mandatory auto enrollment.
Catch-up Limit Increase	For people attaining age 60, 61, 62, and 63 during the tax year, catch-up contributions increase to $10,000 (indexed) or 50% more than the regular catch-up amount in 2025.	Plan years beginning after 12/31/2024	Mandatory	Sec. 109 (p. 832)	This will require plan amendments.
Required Coverage for Part-Time Workers	Reduces 3-year eligibility rule to 2 years. Expands the rule to 403(b) plans.	Plan years beginning after 12/31/2024	Mandatory	Sec. 125 (p. 856)	Non-electing church 403(b) plans exempt. 401(k) plans are affected.

Topic	Summary	Effective Date[1]	Mandatory or Optional	Citation[2]	CLWG Comments
Long-Term Care Contracts Purchased with Plan Distributions	Permits a qualified plan to distribute up to $2,500 per year (indexed) for a participant's payment of premiums for long-term care contract. Also exempts distribution from penalty tax.	Distributions after 12/29/2025	Optional	Sec 334 (p. 910)	This appears to be difficult to administer because proof of contract details must be filed with the plan.
Paper Plan Statements	Requires paper statements once per year for DC plans and once every three years for DB plans.	Plan years beginning after 12/31/2025	Mandatory	Sec. 338 (p. 915)	Amends ERISA only; won't apply to church plans.
Saver's Match Revamp	Current tax credit discontinued and replaced by Treasury deposit to saver's qualified plan account. Credit is 50% of IRA or retirement plan contribution up to $2,000 per individual.	Plan years beginning after 12/31/2026	Optional	Sec. 103 (p. 821)	Implementation to be determined. Retirement plans are not required to accept Saver's match contributions from Treasury.