LEGISLATIVE AND REGULATORY DEVELOPMENTS IN 2022 OF INTEREST TO CHURCH-SPONSORED EMPLOYEE BENEFIT PLANS AND PROGRAMS

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I. LEGISLATION AND LEGISLATIVE INITIATIVES

A. Consolidated Appropriations Act, 2022

On March 15, 2022, President Biden signed the Consolidated Appropriations Act of 2022 ("CAA 2022") into law. The CAA 2022 includes a temporary extension to treat telehealth and other remote care services as disregarded coverage under section 223 of the Internal Revenue Code of 1986, as amended (the "Code") from April 1, 2022 through December 31, 2022. Therefore, a high deductible health plan ("HDHP") participant's health savings account ("HSA") eligibility and the status of HDHP coverage will not be impacted by covering telehealth and other remote care services without applying an HDHP deductible from April 1, 2022 through December 31, 2022. In contrast, the coverage of telehealth and other remote care services without applying an HDHP deductible during the period from January 1, 2022 through March 31, 2022 would cause a loss of HDHP status.

Plans may, but are not required to, provide telehealth services without the HDHP deductible from April 1, 2022 through December 31, 2022. There may be administrative considerations about whether to provide this relief since it is only available for part of 2022.

B. Inflation Reduction Act

President Biden signed the Inflation Reduction Act into law on August 16, 2022. The Inflation Reduction Act includes the following provisions aimed at reducing the costs of prescription drugs:

- Government to negotiate maximum prices for brand name drugs that do not have generic competition. Negotiated prices not available to commercial purchasers.
- Drug manufacturers must pay a rebate to the government if the price of a brand name drug rises faster than inflation, but prices paid by the commercial market are not included in calculating the rebate.
- Three-year extension of enhanced subsidies for coverage purchased through an Affordable Care Act ("ACA") exchange.
- $35 monthly copayment cap for insulin for Medicare beneficiaries. The cap does not apply to employer plans.
- HDHPs are not required to have a deductible for insulin.

Following the enactment of the Inflation Reduction Act, President Biden signed an Executive Order directing the Department of Health and Human Services ("HHS") to consider testing new health care payment and delivery models that would lower drug costs and promote access to innovative drug therapies for Medicare and Medicaid enrollees.[1]

[1] *See* https://www.whitehouse.gov/briefing-room/presidential-actions/2022/10/14/executive-order-on-lowering-prescription-drug-costs-for-americans/.

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 Church Alliance has been in communication with Senator Amy Klobuchar (D-MN) regarding reintroducing the standalone CPO clarification legislation. To do so, the Church Alliance has been exploring potential new Republican co-leads for the legislation following Senator David Perdue's (R-GA) 2020 election loss. The Church Alliance continues to work with key staff on the committees of jurisdiction on the status of potential Commodity Futures Trading Commission ("CFTC") reauthorization legislation or to find another potential legislative vehicle for the clarification.

2. Retirement Reform

The Church Alliance has been working on retirement reform 2.0 for several years. The retirement reform legislation is summarized below in Section I.D of this report. As noted below, two provisions in the House Ways and Means Committee-passed legislation have church plan exemptions – automatic enrollment and the expansion of multiple employer plans to 403(b) plans. Additionally, the Church Alliance has been working to communicate its preferences with respect to provisions that differ slightly between the various versions of the legislation.

Finally, the Church Alliance supports inclusion of section 503 of the Retirement Security & Savings Act (S. 1770), which is also included in the Enhancing American Retirement Now Act (S. 4808) (the "EARN Act"). This provision would allow surviving spouses to use the same methodology for calculating their required minimum distributions ("RMDs") if they elect to remain in their deceased spouses' employer plans rather than rolling over those plan assets to an IRA.

D. Proposed Legislation

1. Retirement – SECURE 2.0

The following three comprehensive retirement bills are pending in Congress:[2]

- Securing a Strong Retirement Act (H.R. 2954), which was passed by the House on March 29, 2022 ("Secure 2.0").
- Retirement Improvement and Savings Enhancement to Support Healthy Investments for the Nest Egg Act (S. 4353), which was reported out of the Senate HELP Committee on June 14, 2022 ("Rise and Shine Act").
- The EARN Act, which was reported out of the Senate Finance Committee on June 22, 2022.[3]

Below is a summary of some – but not all – of the potential changes. Most of these changes are included in at least two of the pending bills.

- RMD age increased incrementally to age 75 by 2033. (EARN Act increases RMD to 75 in 2032 with no phase-in).
- RMD excise tax reduced from 50% to 25%. If the RMD failure is corrected in a timely manner, then the excise tax is reduced from 25% to 10%.
- Catch-up contributions increased to $10,000 at age 62, 63, and 64 (Ages 60-63 in the EARN Act).
- All catch-up contributions to be made as Roth contributions (possible income threshold).
- Plan participants may be given the option to receive matching contributions on a Roth basis. (EARN Act also permits this for nonelective contributions).
- Employers permitted to offer *de minimis* financial incentives to boost participation in retirement plans (applicable to 401(k) and 403(b) plans).
- Student loan payments can be treated as elective deferrals for purposes of matching contributions (applicable to 401(k), 403(b), and governmental 457(b) plans).

[2] Some of the provisions from the Retirement Improvement and Savings Enhancement Act (H.R. 5891) and the Retirement Security & Savings Act (S. 1770) have been incorporated into one or more of these retirement bills, including provisions from other retirement plan legislation.

- Cash-out limit increased from $5,000 to $7,000 (not applicable to church plans).

- Employers may rely on employee certification that a hardship distribution is on account of a deemed hardship event and that such amount is not in excess of the need.

- Repayment of birth or adoption withdrawals limited to three years (to confirm availability of refund).

- Distributions to domestic abuse victims (subject to limits) permitted without 10% penalty. Amounts may be repaid within three years.

- Discretionary amendments that increase benefits accrued may be adopted by the due date of the employer's tax return for the applicable year.

- Expansion of self-correction for inadvertent failures and for loan errors; Employee Plans Correction Resolution System ("EPCRS") available for certain IRA failures.

- Department of Labor ("DOL") to establish rules for target date fund benchmarks (for plans subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA")).

- Plan may choose not to obtain repayment of an inadvertent benefit overpayment or may amend the plan to increase benefit payments to adjust for the overpayment.

- Relief for automatic enrollment failures (though correction method to be determined through guidance).

- Modification of disclosure rules with respect to unenrolled participants. (ERISA and Code amended; not clear how this would apply to church plans.)

- Creation of "Retirement Lost and Found" registry – national online searchable lost and found database. This provision appears only to apply to ERISA plans; not clear whether it would be available to church plans.

- Long-term part-time worker rule modified to reduce three-year requirement to two-years (only applicable to 401(k) plans).

- Separate top-heavy testing (not applicable to 403(b) plans) for plans covering excludible employees.

- Modification to RMD restrictions on life annuities relating to commercial annuities (e.g., guaranteed annual increases and return of premium death benefits to be permitted.)

- For qualified longevity annuity contracts ("QLACs"): (i) 25% of account balance limit eliminated; (ii) dollar limit revised to $200,000; (iii) clarify that a divorce after purchase would not affect permissibility of joint and survivor benefits; and (iv) 90-day free look period permitted.

- Earnings, qualified nonelective contributions ("QNECs"), and qualified matching contributions ("QMACs") can be withdrawn from 403(b) plans as part of hardship distributions (conforming to 401(k) plan rules).

- 403(b) plans can be multiple employer plans. There is an express exception for church plans and a statement that no inference regarding application of 403(b) to a multiple employer church plan is to be made from such exception.

- 403(b) plans permitted to invest in Rev. Rul. 81-100 group trusts (collective investment trusts) and insurance company separate accounts.

- Elimination of "first day of the month" requirement for governmental 457(b) plans (but not for other tax-exempt employers).

- Automatic enrollment required for new plans, but express exception for church plans.

- If a participant separates from service with a nonforfeitable accrued benefit of $1,000 or less and does not claim it within 6 months of the plan administrator notifying them of the benefit or attempting to pay it, then the plan administrator must transfer the benefit to a government-run Office of Retirement Savings Lost and Found and provide certain information and certifications. If the plan administrator later "discovers information that may assist" the Office in locating the participant, it must notify and provide such information to the Office.

2. Mental Health Legislation

There have been several bills introduced this year focusing on expanding access to mental health care services. The House of Representatives passed both the Restoring Hope for Mental Health and Well-Being Act of 2022 (H.R. 7666) and the Mental Health Matters Act (H.R. 7780) this year. Both of these bills include provisions that would impact employer-provided health care plans. The Restoring Hope for Mental Health and Well-Being Act of 2022 includes a provision that would increase the transparency of pharmacy benefit managers ("PBMs") by requiring PBMs to provide group health plan sponsors with reports on the costs, fees, and rebate information under PBM contracts. Among other provisions, the Mental Health Matters Act would:

- Expand the ability of the DOL and plan participants to file civil litigation under ERISA against health plans, fiduciaries, and administrative service providers for mental health parity violations.

- Deem forced arbitration clauses, class action waivers, representation waivers, and discretionary clauses unenforceable for ERISA section 502 claims or common law claims involving a plan or plan benefit.

The Senate Finance Committee's Mental Health Workforce has also released three bipartisan discussion drafts of legislation aimed at expanding mental health care. One of the discussion drafts focuses on expanding the availability of telehealth for mental health care services.[4]

II. REGULATORY GUIDANCE AND OTHER INITIATIVES IMPACTING RETIREMENT PLANS

A. Internal Revenue Service

1. 403(b) Determination Letter Program

On November 7, 2022, the Internal Revenue Service ("IRS") issued Revenue Procedure 2022-40, which permits plan sponsors of 403(b) retirement plans to apply for individual determination letters using the same procedures that currently apply to qualified retirement plans. Beginning June 1, 2023, the revenue procedure permits plan sponsors of individually-designed 403(b) plans to submit a determination letter application for an initial plan determination, after a plan has been merged, upon plan termination, and in certain other circumstances identified by the IRS in guidance published in the Internal Revenue Bulletin.

An application for an initial determination letter and a determination letter for a merged plan must be submitted on Form 5300, Application for Determination for Employee Benefit Plan. The revenue procedure provides guidance on the qualification and 403(b) requirements that will be considered in determining whether a plan will receive a favorable determination letter and modifies the definition of a "form defect." The first date on which a Form 5300 application may be submitted for an initial determination is staggered over three dates based on the employer identification number ("EIN") of the plan sponsor, as follows:

- If the EIN of the plan sponsor ends in a 1, 2, or 3, then a determination letter application may be submitted beginning on June 1, 2023, or any later date.

- If the EIN of the plan sponsor ends in a 4, 5, 6, or 7, then a determination letter application may be submitted beginning June 1, 2024, or any later date.

- If the EIN of the plan sponsor ends in an 8, 9, or 0, then a determination letter application may be submitted beginning on June 1, 2025, or any later date.

[4] *See* https://www.finance.senate.gov/chairmans-news/wyden-crapo-stabenow-daines-unveil-mental-health-workforce-enhancement-discussion-draft, https://www.finance.senate.gov/chairmans-news/wyden-crapo-carper-cassidy-unveil-youth-mental-health-discussion-draft, and https://www.finance.senate.gov/chairmans-news/wyden-crapo-cardin-thune-release-telehealth-policies-for-mental-health-care-initiative.

The revenue procedure also provides guidance on when a plan is eligible to be submitted for an initial determination. According to the revenue procedure, a determination letter issued to a pre-approved plan adopter using Form 5307 is not considered in determining whether the plan sponsor is eligible to submit the plan for an initial determination letter.

The revenue procedure also permits retirement plan sponsors to request a determination letter upon termination of a 403(b) plan using Form 5310, Application for Determination for Terminating Plan, on or after June 1, 2023, regardless of the sponsor's EIN. An application for a determination letter for a terminating plan must be filed no later than the later of (1) one year from the effective date of the termination, or (2) one year from the date on which the action terminating the plan is taken. In no event, however, may the application be filed later than 12 months from the date substantially all the plan assets are distributed in connection with the termination.

The IRS requests comments on additional circumstances under which the IRS should accept 403(b) determination letter applications. Comments are due February 28, 2023.

The IRS also indicated that it will issue another revenue procedure in the near future that will contain additional guidance on plan submissions, including a requirement to submit determination letter requests electronically.[5]

2. 2022 Cumulative List of Changes for 403(b) Plans

In 2013, the IRS began accepting applications for approval of the form of 403(b) prototype and volume submitter plans. The IRS issued opinion and advisory letter for these plans in 2017. Eligible employers were required to adopt the pre-approved documents by June 30, 2020, which is the end of the initial Remedial Amendment Period ("RAP") provided for under the IRS revenue procedure instituting the 403(b) pre-approved plan program. In 2019, the Setting Every Community Up for Retirement Enhancing Act of 2019 ("SECURE Act") clarified that both qualified church-controlled organizations ("QCCOs") and non-QCCOs can participate in section 403(b)(9) plans.

In 2021, the IRS issued Revenue Procedure 2021-37, which sets forth the IRS's procedures for issuing opinion letters to 403(b) pre-approved plans in Cycle 2 of the program. The filing period for 403(b) pre-approved plans for Cycle 2 began May 2, 2022 and will end May 1, 2023. The revenue procedure also announced the IRS's intention to publish a cumulative list of changes in the section 403(b) requirements for each remedial amendment cycle.

In Notice 2022-08, the IRS released the 2022 cumulative list of changes in section 403(b) requirements for section 403(b) pre-approved plans. The notice identifies changes in the requirements of Code section 403(b) that will be taken into account by the IRS in the Cycle 2 review and that were not taken into account during the Cycle 1 review. The notice does not extend the deadline by which a section 403(b) plan is required to be

[5] IR-2022-196 (Nov. 7, 2022).

amended to comply with the requirements listed therein. The 2022 cumulative list sets forth changes that were enacted or issued after October 1, 2012. If a plan was not reviewed during Cycle 1, then the IRS will review the plan for compliance with the 2022 cumulative list and the requirements that were reviewed during Cycle 1.

3. PATH Act Church Plan Clarifications

The Protecting Americans from Tax Hikes Act of 2015[6] ("PATH Act") was signed into law in 2015. One of the provisions included in the PATH Act allows the permissive aggregation and disaggregation of certain church-related organizations. The PATH Act also allows church-related organizations to revoke the election to aggregate or disaggregate by providing notice to the IRS. In 2018, the IRS issued guidance clarifying that church-related organizations only need to provide the statutorily-required notice to revoke an election to aggregate or disaggregate to the IRS upon request.

In March, the IRS requested comments on whether this guidance is appropriate or should be changed. The Church Alliance submitted a comment letter stating that the current guidance is appropriate and should not be changed. The comment letter also requests that the IRS consider updating Revenue Procedure 2011-1 to reflect the changes made by the PATH Act and to clarify that assets that can be permissibly commingled with church plan assets need not be subject to the exclusive benefit requirement that was applicable to group trusts under Revenue Ruling 2011-1.

4. Comment Letter on Church Plan Definition

In Notice 2022-21, the IRS requested recommendations for items to be included in the 2022-23 Priority Guidance Plan ("PGP"). In response to the notice, the Church Alliance submitted a comment letter noting that the Department of Treasury's PGP has not included updates to the definition of a church plan under Code section 414(e) in several years. The comment letter references the comment letter that the Church Alliance had previously submitted in 2018 in response to the Treasury's regulatory agenda, which had indicated that it was working on proposed regulations to update the definition of a church plan under Code section 414(e). The comment letter also points out that the current regulations on church plans were issued in 1980, which was over 40 years ago and prior to the enactment of the Multiemployer Pension Plan Amendments Act of 1980, which expanded the church plan definition. The comment letter requests that the IRS publish regulations as soon as possible updating the definition of a church plan under Code section 414(e).

The 2018 comment letter asked that several issues be addressed in the church plan regulations, including:

- The type of organizations that qualify as principal purpose organizations.

[6] Pub. L. No. 114-113 (2015).

- That the "controlled by" requirement that must be satisfied for a church-affiliated employer's employees to be deemed church employees can be satisfied by canonical or ecclesiastical control.

- That the "associated with" test be broadly construed.

- That multiple churches be permitted to participate in a church plan without the necessity of demonstrating that they share common religious bonds and convictions.

5. 2022-2023 Priority Guidance Plan

On November 4, 2022, the Department of Treasury and the IRS released its 2022-2023 PGP.[7] A list of the items the Church Alliance has flagged to generally monitor in the 2022-2023 iteration of the PGP is below. The italicized items in this list are new when compared to the Church Alliance's last submission on the 2021-2022 fourth quarter PGP.

The main item the Church Alliance will be watching is the church plan definition rulemaking, which was added back onto the PGP this year after the Church Alliance filed a comment letter requesting that the IRS include it. The Church Alliance is also continuing to watch SECURE Act-related rulemakings. If retirement reform 2.0 passes this year, there will be a new round of rulemakings to implement the legislation. Finally, the Church Alliance is monitoring final regulations under Code sections 4980H and 105(h) related to health reimbursement arrangements ("HRAs").

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 EPCRS. *Notices 2022-33 and 2022-45 were released on August 3, 2022 and September 26, 2022, respectively* (these notices are further discussed below in Section II.A.6 of this report).

- Regulations updating electronic delivery rules and other guidance for providing applicable notices and making participant elections.

- *Final regulations relating to SECURE Act modifications to §401(a)(9) and addressing other issues under §401(a)(9). Proposed regulations were published on February 24, 2022* (the proposed regulations are further discussed below in Section II.A.10 of this report).

- *Regulations relating to SECURE Act modifications to certain rules governing §401(k) plans.*

[7] *See* https://www.irs.gov/pub/irs-utl/2022-2023-pgp-initial.pdf.

- 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.*

- 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).*

- 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.

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).

6. Extension of Certain Plan Amendment Deadlines

Most plans were originally required to be amended by December 31, 2022 for certain provisions of the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), SECURE Act, Bipartisan American Miners Act, and Taxpayer Certainty and Disaster Tax Relief Act of 2020. In Notices 2022-33 and 2022-45, the IRS delayed the

amendment deadlines for qualified retirement plans and 403(b) plans until December 31, 2025 for the following provisions:[8]

- All provisions of the SECURE Act.
- The CARES Act provisions that suspended 2020 RMDs from defined contribution plans and allowed plans to offer certain penalty-free coronavirus-related distributions and plan loan relief to participants.
- The provision of the Bipartisan American Miners Act of 2019 that lowered the permissible age for in-service distributions to 59½.
- The provision of the Taxpayer Certainty and Disaster Tax Relief Act of 2020 allowing penalty-free distributions to participants affected by certain disasters.

Plans are required to be administered in conformity with these requirements even though the amendment deadline is delayed.

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.[9]

The amendments listed on the 2020 required amendment list must be adopted by December 31, 2022 (i.e., the end of the second calendar year following the year the required amendments list is published). The 2020 required amendments list included in Notice 2020-83 listed no changes that would require an amendment.[10]

The IRS also provides an "Operational Compliance List"[11] on its website. The Operational Compliance List is updated periodically and identifies changes in qualification

[8] A different deadline applies for governmental plans.

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

[10] The required amendments list also includes a section listing changes in requirements that the Treasury Department and IRS anticipate will not require an amendment but could require one if a plan includes an unusual provision. This section lists the following two changes in requirements that may require an amendment by the end of 2022: difficulty of care payments treated as compensation for retirement contribution limitations under the SECURE Act and the application of cooperative and small employer charity pension plan rules to certain charitable employers under the CARES Act. It appears that the recent guidance in Notices 2022-33 and 2022-45 extended the deadline until December 31, 2025 for the SECURE Act amendment but not the CARES Act amendment described in this footnote. Accordingly, plans would still need to be amended by December 31, 2022 for the CARES Act amendment described in this footnote, if applicable.

[11] 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.

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 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 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 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.[12]

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.[13]

9. Proposed Regulations on Multiple Employer Plans and the "One Bad Apple" Rule

In 2019, the IRS issued proposed regulations[14] relating to the unified plan rule, which is also known as the "one bad apple rule." Under this rule, if one employer in a multiple employer plan violates a Code qualification requirement, then the entire plan can lose its qualified status. The proposed regulations provide an exception to the one bad apple rule if certain requirements are satisfied, including a requirement to spin off the plan assets held on behalf of employees of the non-compliant employer. The Church Alliance filed a comment letter on the 2019 proposed regulations under which it requested that the IRS clarify that section 413(c) and its implementing regulations, including the unified plan rule, do not apply to 403(b) plans. Alternatively, the comment letter requested that relief be granted to 403(b) church plans so that they are not required to spinoff the assets of noncompliant employers.

In 2019, the SECURE Act added section 413(e) to the Code, which generally eliminates the one bad apple rule for multiple employer plans ("MEPs") that (i) are maintained by employers that have a common interest other than having adopted the plan, or (ii) have a pooled plan provider.

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

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

[14] 84 Fed. Reg. 31,777 (July 3, 2019).

In March, the IRS issued proposed rules[15] withdrawing the 2019 proposed regulations and implementing Code section 413(e). According to the preamble to the proposed regulations,

> A MEP is eligible for the exception to the unified plan rule if it is a section 413(c) defined contribution plan described in section 401(a) or consists of individual retirement accounts described in section 408 (including by reason of section 408(c)), provided that the MEP either is maintained by employers that have a "common interest" or has a "pooled plan provider."[16]

As part of this statement, the proposed regulations include a footnote stating:

> Although section 403(b) plans are defined contribution plans, they are not plans described in section 401(a) or 408. Therefore, section 413(e)(1) does not apply to section 403(b) plans.

The Church Alliance submitted a comment letter requesting that the IRS clarify that, in addition to Code section 413(e)(1), Code section 413(c) does not apply to 403(b) church plans. The comment letter points out that this clarification would be consistent with the language included in SECURE 2.0, which exempts 403(b) church plans from the provisions related to 403(b) multiple employer plans. As an alternative, the comment letter requests relief for 403(b) plans from the unified plan rule.

10. Required Minimum Distribution Guidance

Under the SECURE Act, the age at which RMDs are required to begin increased from 70½ to 72. This change applies to distributions required to be made after 2019, with respect to individuals who attain age 70½ after 2019. This change does not apply to qualified charitable distributions from IRAs, nor does it apply for purposes of required actuarial increases in a defined benefit plan for active service after reaching age 70½.

Effective for distributions with respect to employees who die after 2019, IRAs and defined contribution plans are subject to RMD rules for distributions to designated beneficiaries after the death of the IRA owner/participant. The SECURE Act requires, with important exceptions, that these distributions be completed by the end of the 10th calendar year following the IRA owner's/participant's year of death. Exceptions apply if the designated beneficiary is a surviving spouse, disabled under Code section 72(m)(7), chronically ill, not more than ten years younger than the IRA owner/participant, or a minor child of the IRA owner/participant (upon age of majority, the 10-year rule applies). The new rule also does not apply to certain commercial annuities in effect on December 20, 2019.

[15] 87 Fed. Reg. 17,225 (March 28, 2022).

[16] *Id*. at 17,226 (footnotes excluded).

The new rule eliminates the common planning technique referred to as the "stretch IRA." If there is no "designated beneficiary" (e.g., an estate), then the current 5-year rule continues to apply. The change does not apply to certain commercial annuities in effect December 20, 2019, if the participant had made an irrevocable election regarding distributions prior to December 20, 2019. The following special rules apply regarding the death of the beneficiary:

- When the eligible designated beneficiary dies, the 10-year rule applies to his or her beneficiary.

- If an employee dies before January 1, 2020 and the designated beneficiary dies after December 31, 2019, the new rule applies to any beneficiary of the designated beneficiary.[17]

On February 24, 2022, the IRS issued proposed regulations restating the regulations applicable to RMDs under Code section 401(a)(9). The proposed regulations would be applicable for determining RMDs for 2022 and after.

The proposed regulations would provide that Code section 401(a)(9) requires actuarial increases for employees who retire in a year after the year in which the employee attains age 70½. There is an exception for governmental plans and church plans. For this purpose, a church is defined as a church or a QCCO.[18] This creates difficulties for plans that cover non-QCCOs along with churches and QCCOs.

The SECURE Act beneficiary changes included an exception for commercial annuities in effect on December 20, 2019. This exception has been extended to Code section 403(b)(9) retirement income accounts even if a commercial annuity is not used, provided that the other requirements for the qualified annuity exception are satisfied. Under the exceptions, payments must have started before December 20, 2019 or the employee must have made an irrevocable election before December 20, 2019 as to the method and amount of the annuity payments.

The proposed regulations also include the following additional clarifications:

- If a participant dies after their required beginning date, 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.

[17] For example, John Doe dies on November 1, 2019. The participant's designated beneficiary, Jane Doe, names a new beneficiary and then dies. The 10-year rule will apply to Jane Doe's beneficiary.

[18] According to the preamble to the proposed regulations, "a plan for the employees of a tax-exempt organization that is not a church or a qualified church-controlled organization must provide an actuarial increase…"

- If the beneficiary is an eligible designated beneficiary who is receiving stretch payments, a similar rule would apply upon the death of the eligible designated beneficiary.

- QLACs are permitted to have a cash surrender value prior to the participant's required beginning date.

- A plan must specify which RMD method applies (i.e., 10-year rule or life expectancy rule) for an eligible designated beneficiary who does not make (or is not permitted to make) an election.

- The age of majority is 21 for eligible designated beneficiary purposes.

- Details for determination of disabled and chronically ill.

- With respect to multiple beneficiaries,

  - The oldest beneficiary will generally determine RMD calculations and whether 10-year rule applies.

  - If one beneficiary is not an eligible designated beneficiary, then eligible designated beneficiary treatment is not permitted for any beneficiary.

  - It is unclear whether separate accounting can avoid these rules.

The IRS requested comments on the RMD rules for 403(b) plans. The Church Alliance submitted a comment letter that focused on issues of interest to church plans. The comment letter requests that the final regulations:

- Clarify that if a plan is maintained by a church or QCCO for employees of a church or QCCO, inclusion of non-QCCO employees does not cause loss of the church plan exemption or require the church plan to make actuarial adjustments for the non-QCCO employees.

- Omit Proposed Regulation section 1.409(a)(9)-6(g)(3)(iii), which was added by the proposed regulations and states: "The determination of whether an employee is a church employee is made without regard to section 414(e)(3)(B)."

- Not change the RMD rules for 403(b) plans in a manner that would decrease flexibility with the allocation of distributions.

In October, the IRS issued Notice 2022-53, which provides 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. 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.

The notice also states that final regulations will not apply earlier than the 2023 distribution calendar year.

11. 90-Day Pre-Audit Compliance Program

In the Employee Plans newsletter issued on June 3, 2022, the IRS announced a new 90-day pre-audit compliance pilot program.[19] As part of this program, the IRS sent letters to 100 employers in June. The letters give plan sponsors 90 days to review their plan documents and operations to identify and correct any mistakes. If the review reveals mistakes, then the letter states that the plan sponsor may be able to correct the mistakes using EPCRS's self-correction program. If self-correction is not available, then the letter permits the plan sponsor to request a closing agreement using the fee structure that is available under EPCRS's voluntary compliance program. The IRS will review the plan sponsor's documentation and determine if it agrees with the plan sponsor's conclusions and corrections. The IRS will then issue a closing letter or conduct an examination. A sample letter indicates that the primary issue the IRS plans to review is compliance with the annual contribution limitation under Code section 415.

The purpose of this pilot program is to reduce the amount of time spent on retirement plan examinations. At the end of the pilot, the IRS will review the effectiveness of the program and determine if it should become part of its overall compliance strategy.

12. Extension of In-Person Notarization Requirements

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 and 2021-40, the IRS extended the physical presence requirement relief to June 30, 2022. Provided the applicable requirements set forth in the notices are satisfied, the temporary relief from the physical presence requirement applies to participant elections that are witnessed by either: (i) a plan representative; or (2) a notary public of a state that permits remote electronic notarization. In Notice 2022-27, the IRS further extended the relief from the physical presence requirement until December 31, 2022.

13. Determination of Substantially Equal Periodic Payments

In 2020, the IRS issued final regulations updating the life expectancy and distribution period tables used to calculate RMDs from retirement plans and individual retirement accounts to take into account longer life expectancies. In the preamble to those regulations, the IRS stated that it would issue future guidance on applying the updated life expectancy, distribution period, and mortality tables for purposes of determining "substantially equal periodic payments" under Code section 72(t).

[19] *See* https://www.irs.gov/retirement-plans/employee-plans-news.

The IRS issued this additional guidance in Notice 2022-6. The guidance in the notice applies for any series of substantially equal periodic payments commencing on or after January 1, 2023. For payments commencing in 2022, the notice permits taxpayers to use either the old tables or the new tables. In the case of a series of payments commenced prior to 2023 using the RMD method of calculating the payments, the notice permits a one-time change to the updated tables.

14. Retirement Plan Limits for 2023

The cost-of-living and required statutory limit adjustments applicable to retirement plans for 2023 are as follows:[20]

Contribution limit for defined contribution plan under Code § 415(c)	**$66,000** (*$5,000 increase*)
Benefit limitation for defined benefit plan under Code § 415(b)	**$265,000** *($20,000 increase)*
Elective deferral limit under Code § 402(g)	**$22,500** *($2,000 increase)*
Age 50 catch-up contribution limit under Code § 414(v)	**$7,500** *($1,000 increase)*
Age 50 catch-up contribution limit for SIMPLE plan	**$3,500** (*$500 increase*)
Contribution limit for a Code § 457(b) eligible deferred compensation plan	**$22,500** (*$2,000 increase)*
Annual compensation limit under Code § 401(a)(17)	**$330,000** (*$25,000 increase)*
HCE compensation definition dollar threshold[21]	**$150,000**[22] *($15,000 increase)*
Dollar threshold limitation for key employee determination in top-heavy plan	**$215,000** *($15,000 increase*)
Contribution limit for a SIMPLE retirement plan	**$15,500** *($1,500 increase)*
Participant compensation eligibility amount under Code § 408(k)(2)(C) for simplified employee pension (SEP) employer contributions	**$750** *($100 increase)*

B. Department of Labor

This section of the report focuses on DOL guidance issued over the last year under ERISA. The guidance in this section 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.

[20] Notice 2022-55.

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

[22] For the 2023 plan year, an employee who earns more than $150,000 in 2022 is an HCE.

1. Final ESG Investment Rules

In 2020, under the Trump administration, the DOL issued a final rule[23] amending the "investment duties" regulation under 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.[24] Following this announcement, the Biden administration issued an Executive Order[25] 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.

Later in 2021, the DOL issued proposed rules[26] to amend the 2020 rules governing the selection of retirement plan investments. In early 2022, the DOL issued a request for information on possible actions it could take under ERISA and other relevant laws to protect retirement savings from the threats of climate-related financial risk.[27]

On November 22, 2022, the DOL finalized the proposed rules.[28] The final rules are substantially the same as the proposed rules but make certain clarifications and changes in response to public comments. Like the proposed rules, 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.[29]

2. 401(k) Plan Investments in Cryptocurrencies

The DOL issued Compliance Assistance Release 2022-01 on March 10, 2022 in which it cautioned 401(k) plan fiduciaries about allowing investments in cryptocurrencies.

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[23] 85 Fed. Reg. 72,846 (Nov. 13, 2020).

[24] *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.

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

[26] 86 Fed. Reg. 57,272 (Oct. 14, 2021).

[27] 87 Fed. Reg. 8,289 (Fed. 14, 2022).

[28] *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.

[29] 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.

Cryptocurrencies include digital assets such as those marketed as tokens, coins, crypto assets, and derivatives of the same.

In the Compliance Assistance Release, 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" including risks for fraud, theft, and loss from:

- The speculative and volatile nature of such investments.
- Lack of expertise to make informed decisions related to such investments.
- Custodial and recordkeeping concerns.
- Valuation concerns related to reliability, accuracy, and the complexity of valuing such investments.
- The evolving regulatory environment and possibility that the sale of some cryptocurrencies could be an unlawful transaction.

The DOL's Employee Benefits Security Administration ("EBSA") has indicated it will conduct an investigative program targeting plans that offer participants investment in cryptocurrencies and related products either through an investment option or a brokerage window. Plan fiduciaries should "expect to be questioned" about how they have satisfied their duties of prudence and loyalty if they offer such investments as an investment option or allow investment in the plan through a self-directed brokerage account.

The DOL's comments have been criticized due to the absence of a notice and comment process and indication that brokerage window investment of cryptocurrency would be scrutinized. On May 5, 2022, Senator Tommy Tuberville (R-AL) introduced legislation that would prohibit government restrictions on specific types of investments.[30] A lawsuit was also filed on June 2, 2022 by a 401(k) provider, ForUsAll Inc., alleging a violation of the required regulatory administrative process.[31]

3. Proposed Amendments to the Voluntary Fiduciary Correction Program

On November 18, 2022, the DOL issued proposed amendments to the DOL's Voluntary Fiduciary Correction Program ("VFCP").[32] The proposed amendments add a self-correction component to VFCP that would allow retirement plan sponsors to notify EBSA electronically that they have self-corrected certain late participant contributions and loan repayments. A plan may only use the new self-correction program if:

[30] The Financial Freedom Act (S. 4147).

[31] *ForUsAll, Inc. v. Dept. of Labor et al.*, No. 1:22-cv-01551 (D.D.C. filed June 2, 2002).

[32] 87 Fed. Reg. 71,164 (Nov. 21, 2022).

- Participant contributions or loan repayments are remitted to the plan no more than 180 calendar days from the date of withholding or receipt.

- Lost earnings do not exceed $1,000 when calculated from the date of withholding or receipt.

- The plan is not under investigation.

- The plan uses the program's online calculator to calculate lost earnings and an online web tool to file the self-correction notice.

- The plan completes and retains the self-correction retention record checklist.

The proposed amendments would also expand the types of transactions eligible for relief, simplify the administrative requirements that must be satisfied to receive the relief, and amend the associated prohibited transaction exemption 2002-51.

4. DOL Statement of Private Equity in Defined Contribution Plan Designated Investment Alternatives

On December 21, 2021, the DOL issued a statement supplementing its Information Letter issued in 2020 on the use of private equity investments in designated investment alternatives made available to participants in individual account plans subject to ERISA.[33] The 2020 Information Letter stated that a plan fiduciary would not violate the fiduciary duties set out in sections 403 or 404 of ERISA solely by reason of offering a professionally managed asset allocation fund with a private equity component as a designated investment alternative. However, the fiduciary must determine that the investment is prudent and made solely in the interests of participants. The letter did not endorse or recommend such investments and noted that private equity investments tend to be more complicated than other more traditional investments and that plan fiduciaries are responsible for obtaining sufficient information to understand the investment and its risks. The letter also stated that fiduciaries should compare the fund with funds that do not include private equity and included a list of factors plan fiduciaries should consider in determining whether to include an investment with a private equity component.

The DOL received questions and reactions from stakeholders about the 2020 Information Letter. Shortly after the DOL released the 2020 Information Letter, the Securities and Exchange Commission ("SEC") issued a "Risk Alert" highlighting compliance issues in examinations of registered investment advisors that manage private equity funds or hedge funds.

In light of the input from stakeholders and the SEC Risk Alert, the DOL decided it should issue a statement supplementing the 2020 Information Letter to ensure plan fiduciaries do not misread the 2020 Information Letter as stating that private equity "is

[33] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/information-letters/06-03-2020-supplemental-statement.

generally appropriate for a typical 401(k) plan." The statement makes two clarifications. First, the DOL states that the representations in the 2020 Information Letter were not balanced with counter-arguments and research data about the risks of private equity investments and includes some of these counter-arguments. Second, the letter clarifies that plan fiduciaries may not have the knowledge necessary to determine whether it is prudent to select private equity as a component of a designated investment alternative and may need to seek assistance from a qualified investment manager or other investment professional in making this determination.

C. Other Retirement Plan Guidance

1. SEC Proposed Rule on ESG Investment Practices

On May 25, 2022, the SEC held a meeting on environmental, social, and governance ("ESG") disclosures. A few months after the meeting, the SEC proposed a rule requiring investment advisors and companies to provide enhanced disclosures about ESG investment practices.[34] Among other changes, the proposed rules would require:

- Investment advisors to provide more specific disclosures in fund prospectuses, annual reports, and advisor brochures based on the ESG strategies they are pursuing.
- Funds focused on ESG strategies to disclose greenhouse gas emissions related to their investments.
- Funds trying to achieve an ESG impact to disclose such impact and their progress in achieving it.
- Funds using proxy voting to achieve their ESG strategy to disclose information about their proxy voting on ESG-related matters.

The proposed rule would also require investment funds and advisors to provide certain ESG reporting on forms that are filed with the SEC.

2. GAO Studies of Interest to Church Plans

The Government Accountability Office ("GAO") completed one study and is in the process of conducting two additional studies of interest to church plans. The three studies are on 403(b) plans, church pension plans, and the use of target-date funds in 401(k) and similar defined contribution plans.

In March, the GAO released its report on 403(b) investment options, fees, and other features.[35] The study concluded that total assets held in 403(b) plans in 2020 was more than $1.1 trillion. Only about half of these assets are held in 403(b) plans covered by

[34] 87 Fed. Reg. 36,654 (June 17, 2022).

[35] *See* https://www.gao.gov/products/gao-22-104439.

ERISA. From 2010 to 2019, assets in ERISA 403(b) plans grew while the number of plans declined, which is likely due to the consolidation of firms in the health care sector since this sector represents a large portion of plan assets. About 93% of ERISA 403(b) plans are the sole or primary retirement plan offered by the employer. Of the 21 plan sponsors of non-ERISA 403(b) plans that responded to the GAO survey, the majority stated that their plans were supplemental to another retirement plan offered by the employer.

The study also found that the number of investment options offered by 403(b) plans were generally higher than the number offered by 401(k) plans. In addition, record keeping and administrative fees for 403(b) plans surveyed varied widely from 0.0008% to 2.01% of plan assets and investment fees ranged from 0.01% to 2.37%. The data also showed that large 403(b) plans had lower administrative fees than smaller ones. According to the data, 403(b) plans sponsored by universities, states, and plan sponsors with $1 billion or more in assets took steps to reduce fees while other sponsors stated that they did not have the information necessary to help them monitor fees.

The GAO is in the process of reviewing church pension plans. 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. The focus of this GAO study is not, however, limited to this narrow category of church plans—rather, it will also involve church plans sponsored by all types of eligible church plan sponsors, including churches and denominational benefit boards.

Representatives of the Church Alliance, along with representatives of a number of denominational benefit boards which are Church Alliance members, were interviewed by the GAO in connection with its study. Several church plan attorneys were also interviewed. However, the GAO interviews also included organizations and individuals who have expressed concerns about the ERISA church plan exemption in the past. It is impossible at this point to predict what the GAO will conclude in its church pension plan study as well as what recommendations it might make to Congress for changes in the law applicable to such plans. The Church Alliance will be closely monitoring the study and will keep Church Alliance members informed of issues related to it. The study has not yet been released.

The GAO is also in the process of studying the use of target-date funds ("TDFs") in 401(k) and similar defined contribution plans. In 2021, Senator Patty Murray (D-WA), the Chair of the Senate Committee on Health, Education, Labor, and Pensions, and Representative Robert Scott (D-VA), the Chair of the House Committee on Education and Labor, requested this study.[36] According to the request:

> The employer-provided retirement system must effectively serve its participants and retirees, and we are concerned certain aspects of TDFs may be placing them at risk. TDFs are often billed as "set it and forget it" investments, yet expenses and risk allocations vary considerably among funds. The millions of families who trust their financial futures to target-

[36] *See* https://www.napa-net.org/sites/napa-net.org/files/GAO%20Target%20Date%20Fund%20Request%20FINAL_050621.pdf.

date funds, need to know these programs are working as advertised and providing the retirement security promised.

The request includes several questions for the GAO to address in its report. The report has not yet been issued.

III. REGULATORY AND OTHER INITIATIVES IMPACTING HEALTH AND WELFARE PLANS

A. Internal Revenue Service

1. Final Regulations on Affordability of Employer Coverage and Cafeteria Plan Change in Election Rules

An individual is ineligible to receive subsidized coverage through a health care Exchange if the individual receives an offer of affordable employer-sponsored coverage. Under the regulations that are currently in effect, the affordability of employer-sponsored coverage for a family member is determined based on the affordability of self-only coverage rather than the affordability of family coverage. This has become known as the "family glitch" and has resulted in family members being ineligible for subsidized coverage through the Exchange if family coverage is unaffordable but self-only coverage is affordable.

In 2021, President Biden issued Executive Order 14009, directing the Secretary of Treasury to reconsider previous regulations that limit the affordability of coverage. As a result of the Executive Order, the IRS issued final regulations in October to fix the family glitch.[37] Under the final regulations, the affordability of employer-sponsored coverage for a family member will be based on the cost of family coverage rather than self-only coverage. The regulations are effective for taxable years beginning after December 31, 2022.

An employer generally cannot allow employees to change their election for family coverage in the middle of a plan year unless the employee has experienced a permitted election change event under the cafeteria plan rules. The IRS issued Notice 2022-41 on the same day that it issued the final regulations. Under the notice, employers with non-calendar year plans can permit employees to drop family coverage mid-year if:

- One or more family members are eligible for a special enrollment period for Exchange coverage or want to enroll in Exchange coverage during the Exchange's annual open enrollment period; and

- The revocation of coverage corresponds with the enrollment of the family member in Exchange coverage that is effective no later than the day immediately following the last day of coverage under the employer plan.

[37] 87 Fed. Reg. 61,979 (Oct. 13, 2022).

An employer that decides to adopt this provision must amend its cafeteria plan on or before the last day of the plan year in which the election change is allowed. The amendment may be retroactively effective as of the first day of that plan year, as long as the plan is operated in accordance with the notice and participants are informed of the amendment. For the 2023 plan year, the notice permits an employer to amend its cafeteria plan at any time on or before the last day of the 2024 plan year. Employers are not permitted to allow an election to revoke coverage on a retroactive basis.

2. 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 2023.[38] The relevant amounts for 2023 are as follows:

Annual HSA contribution limit	**$3,850 –** individual coverage *($200 increase)* **$7,750 –** family coverage *($450 increase)*
Catch-up contribution limit over age 55	**$1,000** *(no change)*
Maximum HDHP out-of-pocket limit	**$7,500 –** individual coverage (*$450 increase*) **$15,000 –** family coverage (*$900 increase*)
HDHP minimum deductible	**$1,500 –** individual coverage (*$100 increase*) **$3,000 –** family coverage (*$200 increase*)

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

The IRS has announced several inflation-adjusted items for 2023 under various provisions of the Code.[39] The relevant amounts for 2023 are as follows:

Annual contribution limit for Health Care Flexible Spending Account ("FSA")	**$3,050** *($200 increase)*
Maximum cafeteria plan carryover amount (if permitted)	**$610** (*$40 increase*)
Annual contribution limit for Dependent Care FSA	**$5,000**[40] *(unchanged)*

[38] Rev. Proc. 2022-24.

[39] Rev. Procs. 2022-38.

[40] 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	**$5,850 –** individual coverage (*$400 increase*) **$11,800 –** family coverage (*$750 increase*)
Monthly contribution fringe benefit exclusion limit for Qualified Mass Transportation and Qualified Parking under Code sections 132(f)(2)(A) and (B)	**$300** *($20 increase)*
Employer Mandate Affordability Percentage[41]	**9.12%** *(0.49% decrease)*

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

- $2.79 (a $0.13 increase from the previous year) for plan or policy years ending on or after October 1, 2021, and before October 1, 2022.[42]

- $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.[43]

B. Department of Health and Human Services

1. Proposed Regulations Under Section 1557 of the Affordable Care Act

The HHS Office for Civil Rights ("OCR") released proposed regulations under section 1557 of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in certain health programs and activities.[44] The proposed regulations largely restore the Obama Administration's section 1557 regulations (which the Trump Administration had scaled back). The proposed regulations do not apply directly to self-insured plans, but they do apply to insurers and TPAs that administer self-insured plans, if they receive direct or indirect Federal financial assistance ("FFA").

The proposed regulations would:

- Prohibit benefit designs that impermissibly limit coverage based on a person's sex at birth, gender identification, or gender otherwise recorded.

- Provide that "discrimination on the basis of sex" includes discrimination based on sex stereotypes, sex characteristics, pregnancy or related conditions, or

[41] 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 9.12% applies to plan years beginning in 2023. Rev. Proc. 2022-34.

[42] Notice 2022-4.

[43] Notice 2022-59.

[44] 87 Fed. Reg. 47,824 (Aug. 4, 2022).

sexual orientation and gender identity (a follow up to the Supreme Court's 2020 decision in *Bostock v. Clayton County*).

- Reinstate and expand notice requirements and require covered entities to put in place new policies and procedures, including grievance procedures, on section 1557 and to train employees.

- Provide a means for covered entities to notify HHS that the entity believes it is exempt from the proposed regulations because of federal conscience or religious freedom laws, including the Religious Freedom Restoration Act ("RFRA").

- Interpret the phrase "health program or activity" broadly to include providing or administering health-related services. However, the proposed rule clarifies that it does not apply to a covered entity in its capacity as an employer with respect to employment practices, including the provision of employee health benefits.

Third-party administrators ("TPAs") that develop plan or policy documents or terms that are adopted by a plan sponsor may be held responsible for section 1557 violations. HHS may refer or transfer matters to other federal agencies (such as the Equal Employment Opportunity Commission ("EEOC")) if a discriminatory feature originated with a self-insured plan.

On October 2, 2022, the Church Alliance submitted a comment letter on the proposed regulations. The comment letter requests that HHS clarify the inapplicability of the proposed regulations to employers with respect to employment practices, including employee health benefits. The comment letter also requests that HHS provide further clarification on the process that will apply in assessing notifications of views on exemption due to religious freedom laws.

2. Health Plan Cost-Sharing Limits

HHS has announced the maximum annual limits on cost-sharing that apply to non-grandfathered plans for 2023.[45] The relevant amounts for 2023 are as follows:

Self-Only Coverage	**$9,100** *($400 increase)*
Other than Self-Only Coverage	**$18,200** *($800 increase)*

[45] *See* https://www.cms.gov/files/document/2023-papi-parameters-guidance-v4-final-12-27-21-508.pdf.

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

1. No Surprises Act Final Regulations and FAQ Guidance

The No Surprises Act ("NSA") was adopted as part of the Consolidated Appropriations Act, 2021 ("CAA 2021") and is effective for plan years beginning on or after January 1, 2022. The NSA is applicable to:

- Emergency services performed by nonparticipating providers/facilities at a participating or nonparticipating facility.
- Non-emergency services performed by nonparticipating providers at participating facilities (absent the patient's informed consent, where permitted by the NSA).
- Air ambulance services.

The NSA prescribes how a health plan must calculate a participant's cost-sharing amount for these services. Cost-sharing payments for these services must be applied to the participant's in-network deductible and maximum out-of-pocket limit. In addition, out-of-network providers and facilities may not "balance bill" patients for any amounts in excess of the cost-sharing amounts unless the patient has provided informed consent.

During 2021, the IRS, DOL, and HHS (collectively, the "Agencies") and the Office of Personnel Management ("OPM") issued two sets of interim final rules providing guidance on the requirements of the NSA. On August 19, 2022, the Agencies issued a final rule providing guidance on certain aspects of the NSA and the balance billing restrictions.[46] At the same time, the Departments also issued guidance in the form of frequently asked questions ("FAQs") related to the NSA protections.[47]

The final rules include additional clarifications about the independent dispute resolution ("IDR") process. Under the NSA, 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 IDR process.

According to the final rules, the IDR entity must consider the qualifying payment amount ("QPA") and then must consider all additional permissible information submitted by each party to determine which offer best reflects the appropriate out-of-network rate. The IDR entity is required to explain its payment determination and underlying rationale in a written decision to be submitted to the parties and the Agencies. The written decision

[46] 87 Fed. Reg. 52,618 (Aug. 26, 2022).

[47] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf.

must include an explanation of the information that the IDR entity determined demonstrated that the selected offer best represents the value of the item or service, including the weight given to the QPA and any additional credible information regarding the relevant factors. If the IDR entity relied on additional information or circumstances when selecting an offer, the final rules state that the written decision must include an explanation of why the IDR entity concluded the information was not already reflected in the QPA. The final rules removed the requirement (that had been in the interim rules, but had been vacated through legal action)[48] for the IDR entity to give deference to the QPA.

The final rules and FAQs also include new plan requirements related to the initial offer or payment denial if a plan downcodes a billed claim. The final rules provide a downcode definition[49] and require that, if the QPA is based on a downcoded service code or modifier, the initial payment or denial must include a statement that explains that the service code or modifier billed was downcoded along with an explanation of why and a description of which services codes or modifiers were altered, added, or removed as well as the amount that would have been the QPA if the service code or modifier had not been downcoded.

The FAQs also provide guidance on the following:

- The application of these rules to a plan that does not have a network and uses reference-based pricing.

- For a plan that does not provide out-of-network coverage, the NSA applies if emergency services, air ambulance services, and non-emergency services furnished by a nonparticipating provider with respect to a visit to a participating facility are otherwise covered under the plan.

- If non-emergency air ambulance services are not covered under the terms of the plan or coverage, then the NSA does not require such coverage or limit the amount that a participant may be charged for such services. This is a different approach than that used for the rules for emergency services.

- The NSA protections apply to air ambulance services furnished by a nonparticipating provider even when the pickup point is outside of the U.S.[50]

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[48] See Section IV.B.1 of this report for additional information about the court decision.

[49] According to the final rules, "Downcode" means:

> the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower qualifying payment amount than the service code or modifier billed by the provider, facility, or provider of air ambulance services.

[50] The guidance states future rulemaking will provide more information on the geographic region to be used to calculate the QPA for air ambulance services when the point of pickup is outside of the U.S. However, an example is provided for what a reasonable method would be to calculate this (e.g., if the pickup is in the Bahamas with an air ambulance that was dispatched from Florida with transport back through the Miami-Fort Lauderdale-West Palm

- To the extent that services provided in response to a behavioral health crisis are "emergency services" then, if the services are provided with respect to a facility that meets the definition of an "emergency department of a hospital" or an "independent freestanding emergency department," the services are subject to the NSA protections.

- If a group health plan does not have its own website (even if the plan sponsor does) for the public posting of the NSA notice, the plan's TPA may instead post on its public website on behalf of the plan, provided certain requirements are satisfied.

- Plans and issuers are not required to provide information in the NSA notice on state balance billing laws, unless they are applicable (such as where a self-insured plan voluntarily opted into a state law).

- The requirements to calculate the median contracted rate separately for each provider specialty.

- Self-insured health plans with multiple benefit packages offered by different TPAs may allow each TPA to calculate the median contracted rate separately for those benefit package options administered by the TPA.

- A provider, facility, or air ambulance service may not initiate open negotiations prior to receiving an initial payment or notice of denial of payment for items or services protected by the NSA, but if a plan or issuer fails to send an initial payment or notice of denial within the 30 calendar days after receiving the clean claim, the 30 business day time period to initiate open negotiations will not begin until an initial payment or notice of denial is made.

- The initial payment should be the amount the plan or issuer reasonably intends to be the payment in full based upon the relevant facts and circumstances and as required under the terms of the plan or coverage. The initial payment is not required to be equal to the QPA (or the QPA less the individual's cost sharing amount). But the QPA amount for each applicable item or service must be included with initial payment or notice of denial along with a statement certifying that the QPA applies for purposes of the recognized amount and any other required information. This FAQ also details the difference between a notice of denial and an adverse benefits determination.

- It is not sufficient for a plan to provide an explanation of benefits ("EOB") that merely includes a statement that the claim was processed according to the applicable state or federal law and directs the provider to the website for more information.

Beach metropolitan statistical area ("MSA"), the QPA could be calculated using the geographic region that corresponds to the U.S. border point of entry, the MSA in Florida).

- If the plan or issuer has failed to disclose the information it is required to provide when making an initial payment or sending a notice of denial, a provider, facility, or air ambulance service may initiate an open negotiation period and proceed to IDR or they may request an extension to initiate IDR. The failure of a party to supply required information may lead to a finding by the IDR entity that did not consider the missing information or may lead to the IDR entity drawing an inference about the absent information that is adverse to the party not providing such information.

- A plan or issuer could possibly establish an online portal for nonparticipating providers, facilities, and air ambulance services to submit information to initiate the open negotiation period, but its use may not be required.

The Agencies also issued a new version of the Surprise Billing model notice that plans and issuers must use in 2022 and beyond.[51] The disclosures addressed in the model notice are required to be made publicly available, posted on the health plan's public website, and included as part of the EOBs for any item or service to which the NSA protections apply.

Finally, the Agencies updated the amount of the administrative fee and the certified IDR entity fee for 2023. Both parties are required to pay the administrative fee, and the losing party is responsible for the certified IDR entity fee for using the IDR process. The administrative fee for 2023 will remain $50. Unless otherwise approved by the Agencies, the IDR entity fees for a single determination may range from $200 to $700 (batched determinations may range from $268 to $938).[52]

2. Request for Information on Advanced Explanation of Benefits and Good Faith Estimates

The NSA includes a provision requiring health care providers to provide good-faith estimates of expected charges when an individual schedules items or services or upon request. If the individual is enrolled in a health plan, then the provider must provide the good-faith estimate to the health plan. Upon receipt of the good-faith estimate, the health plan must send the individual an Advanced Explanation of Benefits notification that includes certain information. This provision was originally effective January 1, 2022, but the Agencies deferred enforcement of this requirement until after they establish standards for the transfer of data from providers and facilities to plans and issuers and to give plans, issuers, providers, and facilities enough time to build the necessary infrastructure to support the data transfers.

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[51] *See* https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf for the model notice. The initial version may continue to be used for good faith compliance for the remainder of the 2022 plan year, but only the new version may be used for good faith compliance for plan or policy years beginning on or after January 1, 2023.

[52] *See* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CY2023-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf.

In September, the Agencies issued a request for information on the requirement to provide an Advanced Explanation of Benefits and good faith estimate for covered individuals.[53] In particular, the Agencies are requesting information on how providers and facilities would transfer good faith estimates to plans, issuers, and carriers and how to ensure that providers and facilities transfer the necessary data for plans, issuers, and carriers to prepare accurate Advanced Explanations of Benefits.

3. FAQ Guidance on Coverage of COVID-19 Diagnostic Testing

On January 10, 2022 and February 4, 2022, the Agencies released FAQ guidance focusing on the requirement to cover over-the-counter ("OTC") COVID-19 testing without provider involvement.[54] Effective January 15, 2022 and during the public health emergency, plans must provide coverage for OTC COVID-19 testing[55] in accordance with the following:

- Plans must cover OTC COVID-19 tests that do not involve a health care provider without imposing cost-sharing, prior authorization, or other medical management requirements.

- Plans do not have to provide direct reimbursement to sellers of the tests, but are encouraged to do so. Plans can require participants to submit a claim for reimbursement.

- Plans do not have to provide this coverage when it is for purposes not primarily intended for individualized diagnosis or treatment of COVID-19. Specifically, plans are not required to provide coverage of testing that is for employment purposes.

- Except for the safe harbor structure below, plans cannot limit coverage only to tests that are provided through preferred pharmacies or other retailers.

- The FAQs provide a safe harbor under which the Agencies will not take enforcement action related to coverage of OTC COVID-19 tests against a plan that provides direct coverage[56] for OTC COVID-19 tests by ensuring participants have adequate access to these tests with no upfront out-of-pocket expenses. Whether a plan provides adequate access depends on the facts and

[53] 87 Fed. Reg. 56,905 (Sept. 16, 2022).

[54] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-51.pdf and https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-52.

[55] The FAQ guidance does not apply to COVID-19 tests that use a self-collected sample but are processed in a laboratory or by a health care provider (e.g., a home-collection PCR test that consumers can directly purchase).

[56] "Direct coverage" means the plan pays the seller directly, thus the participant does not have to seek post-purchase reimbursement. Direct coverage may be provided in a number of ways, including, but not limited to, a direct-to-consumer shipping program that allows orders to be placed online or by telephone, the plan's pharmacy network, other non-pharmacy retailers, and alternative OTC COVID-19 test distribution sites established by the plan. Plans must ensure participants are made aware of information needed to access the testing

circumstances but generally requires that OTC COVID-19 tests are available through one direct-to-consumer shipping mechanism[57] and one in-person mechanism.[58] The safe harbor also requires plans to limit the reimbursement of OTC COVID-19 tests from nonpreferred pharmacies or other retailers to no less than the actual price, or $12 per test (whichever is lower). Plans can be more generous on the reimbursement amount.

- The Agencies will not take enforcement action against a plan that is temporarily unable to provide direct coverage for OTC COVID-19 tests due to a supply shortage.

- Plans can limit participants to eight individual OTC COVID-19 tests per 30-day period (or calendar month). This restriction can apply only to OTC tests that are administered without a provider's involvement.

- Plans and issuers may act to prevent, detect, and address fraud and abuse, such as by requiring an attestation that the OTC COVID-19 test was purchased by the participant, beneficiary, or enrollee for personal use, not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale. Plans may also establish a policy that limits coverage of OTC COVID-19 tests to tests purchased from established retailers that would be expected to sell these tests and disallows reimbursement for tests purchased from a private individual or from a seller that uses an online auction or resale marketplace. However, plans cannot implement programs that require an individual to submit multiple documents or involve numerous steps that unduly delay reimbursement.

- A plan may require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of an OTC COVID-19 test (such as the UPC code for the OTC COVID-19 and/or a receipt from the seller) documenting the date of purchase and the price.

- The FAQs also provide guidance on how plans can facilitate access to, effective use of, and prompt payment for OTC COVID-19 tests.

- An individual cannot be reimbursed more than once for the same medical expense. Therefore, the cost of OTC COVID-19 tests that are paid or

[57] A "direct-to-consumer shipping mechanism" is a program that provides direct coverage of OTC COVID-19 tests for participants without requiring the individual to obtain the test at an in-person location.

[58] A plan must ensure participants have access to OTC COVID-19 tests through an adequate number of locations (which may include pharmacies, other retailers, and independent distribution sites set up by the plan). Whether there is adequate access is based on all of the facts and circumstances, including the locality of the participants, current utilization of the plan's pharmacy network by its participants (when making coverage available through the pharmacy network), and how the plan notifies participants of the retail locations, distribution sites, or other mechanisms for distributing the tests. The plan must also inform participants of the tests available under the direct coverage program. The Agencies also stated that they may request information from plans to ensure participants have adequate access to OTC COVID-19 tests.

reimbursed by a plan cannot also be reimbursed by a health FSA or HRA. The FAQs state that plans may want to notify participants of this rule.

4. FAQ Guidance on Preventive Services

On January 10, 2022 and July 28, 2022, the Agencies released FAQ guidance about preventive service requirements relating to colonoscopies and contraceptives.[59]

Colonoscopies

Effective for plan years beginning on or after May 31, 2022, plans must cover without cost-sharing a follow-up colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization screening test for colorectal cancer.

Contraceptives

According to the January 10th FAQs, the government has received complaints of the following practices that are potentially in violation of the contraceptive coverage requirement for plans that are not exempt from that requirement:

- Denying coverage for all or particular brand name contraceptives, even after the provider determinates that a particular contraceptive procedure is medically necessary.

- Requiring participants to fail first using other services before approving coverage for the service or product that the provider determines is medically appropriate for the individual.

- Failing to provide an accessible exception process (e.g., requiring use of the appeal process to obtain an exception).

The Agencies are actively investigating these reports and may take enforcement or other corrective action. The Agencies are also considering whether changes to existing regulations or guidance are necessary.

The July 28th FAQs state that the Agencies are issuing additional FAQs on the contraceptive coverage provisions in response to reports that individuals are still experiencing difficulty in obtaining contraceptive coverage without cost sharing. These FAQs also provide guidance on the application of the contraceptive coverage requirements to fertility awareness-based methods and emergency contraceptives and on federal preemption of state law.

[59] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-51.pdf and https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-54.pdf.

5. FAQ Guidance on Transparency in Coverage Machine-Readable Files

In 2020, the Agencies issued final regulations on transparency in coverage ("TiC") requirements applicable to certain group health plans.[60] In 2021, President Trump signed the CAA 2021 into law, which also included transparency in coverage requirements for group health plans. The TiC final rules include a statement in the preamble that they do not apply to "Denominational Health Plans" because the rules were issued under the Public Health Service Act ("PHSA"), which does not apply to denominational church plans.[61] The preamble does not include a definition of the term "Denominational Health Plan."[62]

The TiC final rules require group health 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. The machine-readable file requirements for in-network rates, out-of-network allowed amounts, and billed charges are effective for plan years beginning on or after July 1, 2022. These files must be posted in the first month of a plan year.

The Agencies issued FAQ guidance on the TiC machine-readable files rules on April 19, 2022[63] and August 19, 2022.[64] The FAQs provide 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. The FAQs also include the following guidance:

- If a plan does not have a public website (even if the employer plan sponsor does have a public website), the plan can enter into a written agreement with its service provider to provide the TiC machine readable files on the service provider's public website. However, if the service provider fails to properly post the machine-readable files on its public website on behalf of the plan, the plan will be in violation of the TiC disclosure rules. If a plan has a public website, it may still satisfy the rules through written agreement for its service provider to publicly post. However, in this instance, the plan must also post a link to the file hosted by the service provider on the plan's public website.

[60] 85 Fed. Reg. 72,158 (Nov. 12, 2020).

[61] The CAA 2021 also includes transparency in coverage requirements for group health plans, many of which are applicable to church plans. There is some overlap between the transparency in coverage provisions included in the TiC final rules and those included in the CAA 2021.

[62] We understand that some church plans are choosing to comply with the machine-readable file requirement included in the TiC final rules.

[63] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-53.

[64] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf.

- The list of codes for the 500 items and services required in the self-service tool for plan years beginning on or after January 1, 2023 will be updated quarterly when an item or service code is no longer valid.[65]

6. Transparency Deadline Reminders

The current deadlines for the transparency requirements included in the TiC final rules and the CAA 2021 are set forth below:

- Machine Readable Files for network rates and out-of-network amounts – to be posted on public websites by July 1, 2022.
    - Posting requirement for prescription drug prices currently delayed.
    - This requirement does not apply to "Denominational Health Plans."
- Prescription drug and health care spending reporting - reporting for 2020 and 2021 due by December 27, 2022, and by June 1 thereafter.
- Air ambulance services – reporting due for 2022 by March 31, 2023 and for 2023 by March 30, 2024.
- Advanced explanation of benefits – pending future guidance.
- Attestation of prohibition of gag clauses – no guidance yet, though effective for 2022.
- Price comparison tool:
    - The CAA 2021 provisions are effective January 1, 2023.
    - The provisions of the TiC final rules are effective January 1, 2023 for 500 specific items and services and January 1, 2024 for all covered items and services.
- Already effective:
    - Cost-sharing information required on ID cards.
    - Continuity of care requirements.
    - Provider directory requirements – must be updated at least quarterly.
    - Service provider disclosure requirements.

[65] The list of codes can be found at: http://www.cms.gov/healthplan-price-transparency/resources/500-items-services.

7. Outbreak Period Reminders

The IRS and DOL published joint relief May 4, 2020 regarding the extension of certain benefit plan deadlines. Effective March 1, 2020, the relief requires benefit plans to disregard the "Outbreak Period" when determining if certain participant deadlines and time periods have been satisfied. In 2021, the DOL issued a notice extending the relief issued in 2020 and providing guidance on how to apply the "Outbreak Period."[66] Under the 2021 notice, the deadline extension applies on a person-by-person basis until the earlier of 60 days after the announced end of the COVID-19 national emergency, or one year from when the person was first eligible for the relief.

The relief applies to:

- HIPAA[67] special enrollment.
- COBRA elections.
- COBRA qualifying event and disability notices.
- Initial and monthly COBRA payments.
- Claim and appeal deadlines.
- External review deadlines.

The presidentially-declared "national emergency" regarding COVID-19 is ongoing. On March 13, 2020, President Trump declared a "national emergency" with respect to COVID-19 effective as of March 1, 2020. President Biden continued the "national emergency" through a declaration on February 24, 2021. On February 18, 2022, President Biden announced that he was continuing the "national emergency" declaration beyond March 1, 2022.[68]

D. Other Health and Welfare Plan Guidance

1. Church Alliance Comment Letter on Prescription Drug Reporting Requirements

The CAA 2021 requires group health plans to report annually to the Agencies the following information related to prescription drugs and benefits:

- Number of enrollees.

[66] The Treasury, IRS, and HHS concurred with the guidance.

[67] "HIPAA" stands for the "Health Insurance Portability and Accountability Act of 1996."

[68] *See* https://www.whitehouse.gov/briefing-room/presidential-actions/2022/02/18/notice-on-the-continuation-of-the-national-emergency-concerning-the-coronavirus-disease-2019-covid-19-pandemic-2/.

- States of coverage.
- 50 most frequently dispensed drugs.
- 50 most costly prescription drugs and total amount spent.
- 50 prescription drugs with greatest increase in plan spending from the previous year.
- Total spending broken down by:
    - Type of costs
    - Primary and specialty care costs.
    - Prescription drug costs.
    - Other medical costs (including wellness services).
    - Spending on prescription drugs by plan and enrollees.
    - Average monthly premium paid by employer and enrollees.
    - Impact of rebates and other drug manufacturer payments.

The CAA 2021 requires plans to submit this information to the Agencies by December 27, 2021, and by June 1 of each year thereafter. The FAQs delay enforcement of this provision so that plans have until December 27, 2022, to submit the required information for 2020 and 2021.

In June, the Agencies and OPM issued a request for information[69] on the prescription drug reporting requirements included in the CAA 2021. The CAA 2021 added parallel provisions on the reporting requirements to the PHSA, ERISA, and the Code. The PHSA provision provides an express exemption for church plans whereas the Code provision does not. On July 23, 2021, the Church Alliance filed a comment letter requesting that the Agencies add the same exemption for church plans to the Code. The comment letter also describes several challenges that church plans would face if they are required to comply with this provision.

On November 17, 2021, the Agencies and the OPM issued interim final rules[70] on the reporting requirements. The preamble to the interim final rule clarifies that church plans are required to comply with the reporting requirements.

On January 22, 2022, the Church Alliance filed a second comment letter seeking an exemption or temporary non-enforcement for church plans. The comment letter

[69] 86 Fed. Reg. 32,813 (June 23, 2021).

[70] 86 Fed. Reg. 66,495 (Nov. 23, 2021).

explains the Church Alliance's view that Congress intended to exempt all church plans from the reporting requirements. The comment letter also explains that denominational church plan sponsors do not have access to some of the information required to comply with the reporting requirements and obtaining such information would be unduly burdensome. If an exemption is not provided, then the comment letter requests that the Agencies issue a temporary non-enforcement and/or limited scope exemption for church plans until additional guidance is issued on satisfying the reporting requirements.

2. Mental Health Parity Report to Congress on Nonquantitative Treatment Limitation Violations

Group health plans and insurers must provide to federal and state agencies – upon request – a comparative analysis of nonquantitative treatment limitations ("NQTLs") related to mental health and substance abuse disorder benefits ("MH/SUD"). Generally stated, NQTLs are a limitation on the scope or duration of benefits for treatment that is not expressed by number. The Agencies are required to request at least 20 comparative analyses per year. The analysis must include specific findings and conclusions of compliance.

On April 2, 2021, the Agencies issued FAQs[71] on the mental health parity NQTL provision of the CAA 2021. The FAQs provide that a general statement of compliance and conclusory references are not sufficient. In addition, the large production of documents without clear descriptions and relevant analysis is not sufficient. If a plan carefully applies the guidance in the Self-Compliance Tool, then the FAQs state that the plan is in a "strong position" for compliance. The FAQs state that EBSA will issue an updated Self-Compliance Tool in 2022.

The Agencies have broad discretion to request NQTL comparative analyses in any situation. For example, the Agencies may request a comparative analysis from a plan if they receive a complaint of a prior authorization requirement for prescriptions to treat opioid use disorders.

State regulators may request NQTL comparative analyses. Plans and issuers must, upon request, provide NQTL comparative analyses to participants, beneficiaries or enrollees, or their authorized representative including providers.[72] Claimants (or their authorized representative) may also request, free of charge, upon appeal of a denied claim or a final internal adverse decision, the NQTLs comparative analyses, if the information is relevant to the claim.

On January 25, 2022, the Agencies issued their first annual mental health parity report to Congress after the imposition of the new comparative analyses requirements.[73]

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[71] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.

[72] This requirement may only apply to ERISA plans.

[73] *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. As of result of the statistics cited in the Report to Congress, a coalition of trade associations for employers and other entities (including the American Benefits Council) sent a letter to the Secretary of the DOL requesting a meeting to discuss ways to ensure that

EBSA began requesting comparative analyses April 10, 2021 (two months after the new comparative analyses requirements took effect). EBSA issued 156 letters to plans and issuers for comparative analyses and none of the comparative analyses reviewed contained sufficient information. The 156 requests covered 216 unique NQTLs across 86 investigations. If each NQTLs is counted separately by benefit classification, plan, and product, then EBSA has requested comparative analyses for 1,112 NQTLs. EBSA issued 80 insufficiency letters requesting additional information related to 170 NQTLs.

In 2021, EBSA also closed investigations with 74 health plans that involved mental health parity issues (41 self-insured plans, 17 fully-insured plans, and 16 plans that offered both fully-insured and self-insured options). EBSA reported 14 mental health parity violations in 12 of such investigations.

According to the report, common deficiencies in comparative analyses included:

- Failure to document comparative analyses before designing and applying NQTLs.
- Conclusory assertions lacking specific supporting evidence or detailed explanations.
- Lack of meaningful comparisons or meaningful analysis.
- Many comparative analyses used a table format with separate columns for MH/SUD and medical/surgical benefits. The same general text was in both columns with conclusory statements rather than detailed meaningful comparisons or explanations.
- Generically prepared by a service provider and not properly addressing the applicable plan or coverage.
- Medical policies produced with no explanation of how applied in practice.
- Failure to properly classify services (e.g., inpatient v. outpatient; mental health v. medical).
- Failure to identify methodologies used within benefit classifications or by third party pricing entities for out-of-network reimbursement rates.
- Use of generic terms such as "cost containment" or "high-cost services" without precise definitions.

employers, health plans, and issuers better understand the DOL's compliance expectations and the enforcement process under the mental health parity law.

- Failure to provide detail about how factors were considered in designing or applying a NQTL.

- Failure to demonstrate compliance of a NQTL as applied (e.g., failure to provide evidence that preauthorization or network admission standards were actually applied in parity).

EBSA has issued 30 initial determination letters to plans and issuers finding 48 NQTLs (36 unique NQTLs) related to MH/SUD benefits lacked compliant parity. Some plans and issuers decided to remove a NQTL after receiving an initial request, insufficiency letter, or follow-up request from EBSA, even when EBSA had not issued an initial determination of non-compliance. Twenty-six plans and issuers have agreed to make prospective changes to their plans.

The following are examples of changes to MH/SUD benefits in response to EBSA review:

- Removal of applied behavioral analysis ("ABA") therapy exclusions or restrictions.

- Service provider notified clients it would not apply ABA exclusion prospectively and would require plans take corrective action regarding prior denied claims.

- Removal of exclusion of medication-assisted treatment for opioid use disorder.

- Removal of exclusion for anorexia nervosa, bulimia nervosa, and binge-eating disorder.

- New internal procedures for handling claims for urine drug testing (stopped automatic denial).

- Removal of blanket precertification requirement for all outpatient MH/SUD services.

- Removal of impermissible separate treatment limitations.

The following are examples of general corrective actions in response to EBSA review:

- Retroactive change in plan terms to remove a limitation, reduce a limitation's scope, or add benefits previously excluded.

- Notice to participants and beneficiaries of an opportunity to submit claims as a result of retroactive plan term changes.

- Re-adjudication of improperly denied claims.

- Amendment of medical policies, claims processing policies and procedures, or other practices.

- Training for claims processing staff.

The following are the most common NQTLs for which EBSA requested comparative analyses (in order of frequency):

- Provider qualifications or billing restrictions.

- Limitations on residential care or partial hospitalization programs.

- Nutritional counseling limitations.

- Speech therapy restrictions.

- Exclusions based on chronicity or treatability of condition, likelihood of improvement, or functional progress.

- Virtual or telephonic visit restrictions.

- Fail-first or step therapy requirements.

The following are NQTLs that lacked parity (in order of frequency):

- Limitation or exclusion of ABA therapy or other services to treat autism spectrum disorder.

- Billing requirements – licensed MH/SUD providers can bill the plan only through specific types of other providers.

- Limitation or exclusion of medication-assisted treatment for opioid use disorder.

- Preauthorization or precertification requirements.

- Limitation or exclusion of nutritional counseling for MH/SUD conditions.

- Provider experience requirement beyond licensure.

- Care manager or specific supervision requirement for MH/SUD.

- Exclusion or limitation on residential care or partial hospitalization to treat MH/SUD conditions.

- "Effective treatment" requirement applicable only to substance-use disorder benefits.

- Treatment plan requirement.
- Employee assistance program referral requirement.
- Exclusion of care for chronic MH/SUD conditions.
- Exclusion of speech therapy to treat MH/SUD conditions.
- Concurrent care and discharge planning requirements.
- Retrospective review.
- Maximum allowable charge and reference-based pricing.
- Other exclusion specifically targeting MH/SUD benefits.
- Age, scope, or duration limits.
- Formulary design.
- Limit on telehealth for MH/SUD.
- Restriction on lab testing for MH/SUD.

EBSA working groups are focused on in-network and out-of-network provider reimbursement rates – using claims data to identify networks with reimbursement parity "red flags." The working groups are also focused on NQTLs relating to the autism spectrum disorder. The following are examples of complaints EBSA benefit advisors referred to an EBSA investigator for potential violations:

- Difficulty locating a mental health network provider and inaccurate provider list.
- Substance-use disorder residential treatment facility contacted EBSA regarding reimbursement issues.
- Participant complaint for failure to cover ABA therapy beyond 25th day/year without meeting certain medical necessity criteria.
- Participant complaint regarding an out-of-network anesthesia bill brought to light separate potential mental health parity violations related to co-pays for outpatient mental health visits.
- COBRA[74] participant's complaints regarding continued access to employee assistance program benefits brought to light an additional possible mental

[74] "COBRA" means the "Consolidated Omnibus Budget Reconciliation Act."

health parity violation in the plan's summary of benefits and coverage ("SBC") related to preauthorization requirements.

3. Universal Health Coverage

On March 29, 2022, the House Committee on Oversight and Reform held a hearing on "Examining Pathways to Universal Health Coverage." The purpose of the meeting was described as follows:

> This hearing will assess how uninsurance and underinsurance negatively impacts health outcomes and examine how moving toward universal coverage could advance health equity in the United States. The hearing will also evaluate reforms that would expand access to affordable health care and move our nation toward universal coverage, including the Medicare for All Act.

IV. LITIGATION

A. Litigation Impacting Retirement Plans

1. Fee 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 2021, the U.S. Supreme Court considered fee litigation involving two 403(b) plans sponsored by Northwestern University. In *Hughes v. Northwestern University*,[75] the plaintiffs alleged violations of ERISA's fiduciary duty of prudence with respect to:

- Monitoring and controlling 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.

In this case, the district court granted defendants' motion to dismiss the case and the Seventh Circuit affirmed, citing the plan's array of investment choices that included the types of funds plaintiffs wanted (e.g., low-cost index funds). In the Seventh Circuit's view, these offerings "eliminat[ed] any claim that plan participants were forced to stomach

[75] 142 S. Ct. 737 (2022).

an unappetizing menu."[76] In addition, the Seventh Circuit stated that "plan participants had options to keep the expense ratios (and, therefore, recordkeeping expenses) low."[77]

The Supreme Court 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. According to the Court, "At times, the circumstances facing an ERISA fiduciary will implicate difficult tradeoffs, and courts must give due regard to the range of reasonable judgments a fiduciary may make based on her experience and expertise."[78]

2. 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, the St. Joseph Health Services of Rhode Island Retirement Plan was placed into receivership as insolvent after a merger involving the plan sponsor hospital. The receiver and various beneficiaries sued the hospitals and their corporate parents, claiming they fraudulently concealed that the plan was grossly underfunded and then completed a reorganization that left the plan with a corporate entity that had no assets. As a result, the plaintiffs claim the defendants, among other things, violated ERISA. The plaintiffs moved for summary judgment claiming the plan lost its church plan status during 2013 at the latest and, therefore, became subject to ERISA at that time.

On September 13, 2022, the District Court for Rhode Island determined that ERISA applied to the plan no later than 2013 because the plan sponsor had amended and restated the plan to state that the employer was the plan administrator instead of a principal purpose organization.[79] A plan that is not established and maintained directly by a church must be maintained by a principal purpose organization[80] to qualify as a church plan under ERISA.

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[76] *Divane v. Northwestern Univ.*, 953 F. 3d 980, 991 (7th Cir. 2020).

[77] *Id.* at 991 n.10.

[78] *Hughes*, at 742.

[79] *Del Sesto v. Prospect Chartercare, LLC, et al.,* No. 18-328 WES, 2022 WL 4182374 (D.R.I. Sept. 13, 2022).

[80] A principal purpose organization is:

> an organization ... 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 [or employees of church-affiliates], if such organization is controlled by or associated with a church or a convention or association of churches.

ERISA section 3(33).

Accordingly, the court granted the plaintiffs motion for summary judgment, determining that the plan was subject to ERISA since at least 2013.

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

3. 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. On December 23, 2021, the Supreme Court of New York denied the defendants' motions to dismiss.[81]

In May, 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.[82] 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.

4. African Methodist Episcopal Church Litigation

During 2022, several class action lawsuits were filed against the African Methodist Episcopal Church Ministerial Retirement Annuity Fund alleging that the defendants breached their fiduciary duties by permitting a single individual to exercise unsupervised control in managing the plan assets.[83] 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 in assets or about 75% of its assets.

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

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

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

[83] *In re AME Church Employee Retirement Fund Litigation*, No. 1:22-md-03035-STA-jay (W.D. Tenn. amended complaint filed Aug. 19, 2022).

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. If the defendants provide proof that the plan is an ERISA plan or the court determines that the plan is an ERISA plan, then plaintiffs asserted claims under ERISA in the alternative to the state law claims.

5. Target Date Fund Litigation

Several large 401(k) retirement plan sponsors have been sued for selecting certain BlackRock target date funds.[84] 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.

6. Managed Account Service Litigation

There have been a recent series of lawsuits focused on passively managed (indexed) target date funds.[85] The lawsuits allege a breach of fiduciary duty relating to managed account services. Specifically, the lawsuits argue that the fees are unreasonable and the service is duplicative of available target date fund strategies.

B. Litigation Impacting Health and Welfare Plans

1. Surprise Medical Billing Lawsuits

On February 23, 2022, the U.S. District Court for the Eastern District of Texas vacated the provisions of the NSA 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.[86] In the court's view, the "rebuttable presumption" requirement:

- Improperly "places its thumb on the scale for the QPA."[87]
- Conflicts with the unambiguous text of the NSA that does not require such presumption.
- Impermissibly bypassed procedural requirements by imposing such a presumption.

[84] *See, e.g., Beldock et al. v. Microsoft Corp. et al.*, No. 2:22-CV-01082 (W.D. Wash. filed Aug. 2, 2022) and *Tullgren v. Booz Allen Hamilton Inc. et al.*, No. 1:22-cv-00856 (E.D. Va. filed Aug. 1, 2022).

[85] *See, e.g., Gosse v. Dover Corp. et al.*, No. 1:22-cv-04254 (N.D. Ill. filed Aug. 11, 2022).

[86] *Texas Med. Ass'n v. DHHS*, 587 F.Supp.3d 528 (E.D. Tex. 2022).

[87] *Id.* at 542.

The DOL issued a memorandum on February 28, 2022 stating it will be withdrawing guidance on the invalidated portions of rule.[88]

A few months later, in *LifeNet, Inc. v. DHHS*,[89] the same court vacated portions of IDR provisions related to air ambulance services, on similar grounds.

After the final rules were issued in August of 2022, Texas Medical Association and LifeNet, Inc. both filed another lawsuit challenging the arbitration provisions of the final rules relating to disagreements between out-of-network providers and health insurers. In October, a district court judge for the Eastern District of Texas decided to consolidate the two lawsuits because they involve common questions of law or fact.[90]

2. Section 1557 Litigation

Section 1557 of the ACA prohibits discrimination under any health program or activity that received Federal financial assistance on any grounds prohibited by Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination and Employment Act of 1975, and section 504 of the Rehabilitation Act of 1973. The prohibited grounds for discrimination under these laws include race, color, national origin, age, disability, and sex.

In 2016, the DOL issued final regulations implementing section 1557.[91] Later that year, plaintiffs filed a lawsuit against HHS, arguing that it exceeded its authority in interpreting sex discrimination as including gender identity and termination of pregnancy. The district court agreed and vacated the portion of the regulations relating to gender identity and termination of pregnancy. The trial court later determined that the RFRA had been violated and permanently enjoined HHS from requiring the plaintiff health care providers to perform or provide health insurance coverage for gender transition procedures or abortions. HHS appealed.

On August 26, 2022, the Fifth Circuit Court of Appeals upheld the district court's vacatur of the 2016 rules and permanent injunction.[92] The court cited recent HHS actions as evidence of HHS's intent to continue enforcing section 1557 using an approach similar

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[88] *See* https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act/memorandum-regarding-continuing-surprise-billing-protections-for-consumers.

[89] 2022 WL 2959715 (E.D. Tex. 2022) (July, 26, 2022).

[90] *Texas Medical Ass'n et al., v. DHHS*, Case No. 6:22-cv-00372-JDK (E.D. Tex. Oct. 4, 2022).

[91] 81 Fed. Reg. 31,376 (May 18, 2016).

[92] *Franciscan Alliance, Inc. v. Becerra*, 47 F. 4th 368 (5th Cir. 2022). Several actions happened between the issuance of the 2016 regulations and the Fifth Circuit decision with respect to section 1557. In 2020, the DOL issued regulations that substantially narrowed portions of the 2016 regulations, including the removal of the prohibition on discrimination based on gender identity and sex stereotyping. In addition, the U.S. Supreme Court ruled in *Bostock v. Clayton Cnty.* that sex discrimination under Title VII includes discrimination based on sexual orientation and gender identity.

to the 2016 regulations. The recent HHS actions included the August 2022 proposed regulations and a March 2022 notice on gender affirming care.[93]

3. PrEP Litigation

The *Braidwood Management Inc. v. Becerra*[94] decision relates to a religious challenge to the ACA's preventive services coverage requirement that non-grandfathered health plans (beginning with the 2021 plan year) must cover the PrEP (pre-exposure prophylaxis) HIV prevention medication without cost sharing for HIV-negative adults at high risk for getting HIV through sex or injection drug use. The PrEP mandate requirement also applies to the associated ancillary services, such as the office visits and monitoring tests needed for the use of the PrEP medication.

The Plaintiffs in this case include six individuals and two businesses that challenged and objected to the legality of the preventive-care mandates under the U.S. Constitution and the RFRA. The objections were based on both religious and economic reasons. The named Plaintiff, Braidwood Management Inc. ("Braidwood"), is a for-profit corporation that provides health insurance to its employees through a self-insured health plan. The owner of Braidwood desires to provide his employees with health benefits, but due to religious objections, wants to exclude coverage for certain preventive care such as PrEP. Braidwood sought declaratory and injunctive relief to prevent the government from enforcing the preventive-care mandates against it.

RFRA generally prohibits the government from imposing a substantial burden on a person's exercise of religion even if the burden results from a rule of general applicability. To receive protection under RFRA, a person must be able to show: (1) that the relevant religious exercise is grounded in sincerely held religious belief, and (2) that the government's action or policy substantially burdens that exercise by forcing the person to engage in conduct that seriously violates its religious beliefs. Once this is shown, then the government may only substantially burden the person's exercise of religion if it can demonstrate that the application of the burden to the person is: (1) in furtherance of a compelling governmental interest, and (2) that it is the least restrictive means of furthering that compelling governmental interest.

In this case, the Court held that Braidwood showed that the PrEP mandate substantially burdened its religious exercise, but the defendants, as required by RFRA, did not show that the PrEP mandate would further a compelling governmental interest. Even if the government had satisfied the compelling-interest requirement, the Court held that it did not show that the PrEP mandate was the least restrictive means for the government to further that interest.

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[93] *See* https://www.hhs.gov/sites/default/files/hhs-ocr-notice-and-guidance-gender-affirming-care.pdf.

[94] *Braidwood Mgmt. Inc. v. Becerra, et al*., No. 4:20-cv-00283-O, 2022 WL 4091215 (N.D. Tex. Sept. 7, 2022).

Therefore, the Court in this case found that the PrEP mandate violates Braidwood's rights under RFRA, and granted Braidwood's summary judgement motion. However, the Court reserved its ruling on this claim for the remaining Plaintiffs and also reserved its ruling on the appropriate remedy.

Even though the Court decision held that the PrEP mandate violates RFRA with respect to Braidwood, the Court asked for additional briefs to be filed on the scope of relief and for a joint status report to be filed to outline remaining issues to be decided and to propose a schedule for the remaining briefings. Therefore, at this point it is unclear how broadly the ruling will apply and if the decision will extend beyond Braidwood.

The government is expected to appeal the district court's decision.

4. Yale Wellness Plan Settlement

The Americans with Disabilities Act ("ADA") and Genetic Information Nondiscrimination Act ("GINA") generally prohibit employers from requiring medical exams or inquiries unless it is part of a "voluntary wellness program." The 2016 ADA and GINA regulations provided a safe harbor for incentives or penalties that could be applied under a "voluntary" wellness program. Following litigation initiated by AARP, the EEOC withdrew the incentive/penalty percentage safe harbor portions of the 2016 regulations at the end of 2018.

The EEOC issued proposed wellness regulations under ADA and GINA in 2021, which were later withdrawn. The proposed regulations would have:

- Limited participatory wellness programs (that involve disclosure health information) to "de minimis" incentives (e.g., a water bottle or a modest gift card).

- Subjected health contingent programs offered through a health plan to the HIPAA incentive limits (i.e., 30% or 50% for tobacco).

The Yale University wellness program included a $25 per week ($1,300 annual) surcharge for employees who opted out of the wellness program or did not complete required screenings. The surcharge also applied if a spouse failed to complete screenings.

Yale employees (with AARP assistance) filed a class action lawsuit in 2019 alleging a violation of ADA and GINA due to the required involuntary disclosure of health information. On March 4, 2022, the parties requested approval of a settlement with the following terms:

- Yale to pay $1.29 million to certain impacted employees and for attorneys' fees.

- Yale to cease collecting the surcharge fees for a period of 4 years, or until the law expressly allows wellness plans to apply such incentives/penalties.

- An employee will be required to provide a HIPAA consent before data is transferred to health coaches, and certain data previously collected will be purged.

On July 13, 2022, the court issued an order granting the preliminary approval of the proposed class action settlement.[95] A hearing is set for November 22, 2022 for final approval of the settlement.

5. Supreme Court Medicare Secondary Payer Litigation

In *Marietta Memorial Hospital v. DaVita*, DaVita, a provider of dialysis, challenged the Marietta Memorial Hospital Employer Heath Benefit Plan as violating the Medicare Secondary Payer Act by limiting payment for dialysis. The Medicare Secondary Payer Act prohibits health plans from treating individuals with end-stage renal disease ("ESRD") differently in eligibility or access to benefits. On June 21, 2022, the U.S. Supreme Court found in favor of the health plan holding that because the plan's terms uniformly covered all individuals for ESRD benefits, it did not "differentiate" in the benefits it provided to individuals with ESRD and it also did not impermissibly "take into account" whether an individual was entitled to or eligible for Medicare.[96] The court also rejected a disparate impact theory and a proxy theory in its holding.[97]

6. COVID-19 Vaccine Mandate Litigation

On November 4, 2021, the Occupational Safety and Health Administration issued an Emergency Temporary Standard ("ETS") under which employers with 100 or more employees must require all employees either to be fully vaccinated for COVID-19 or to produce a negative COVID-19 test on a weekly basis and wear a face covering at work (subject to certain exceptions). On November 5, 2021, the Centers for Medicare and Medicaid released an interim final rule requiring most health care employers that receive Medicare or Medicaid reimbursement to ensure their staff is fully vaccinated. In January, the U.S. Supreme Court blocked the COVID-19 vaccine rules for employers with 100 or more employees but let them proceed for health-care employers that receive Medicare or Medicaid reimbursement.[98]

[95] Order Granting Preliminary Approval of Proposed Class Action Settlement, *Kwesell v. Yale Univ.*, No. 3:19-cv-01098 (KAD) (D. Conn. June 13, 2022).

[96] *Marietta Mem'l Hosp. Employee Benefit Plan, et al., v. DaVita Inc., et al*., 142 S. Ct. 1968 (2022).

[97] Legislation has been introduced in both the House and Senate attempting to overturn the *Marietta* decision. The legislation would prohibit private health insurers from limiting, restricting, or conditioning the benefits they provide for renal dialysis services as compared to the benefits the plan provides for other medical conditions under the Medicare secondary payer rules. *See* the Restore Protections for Dialysis Patients Act (H.R. 8594 and S. 4750).

[98] *Nat'l Fed'n of Indep. Bus. et al. v. Dep't of Labor*, 142 S. Ct. 661 (2022); Biden v. Beccera, 142 S. Ct. 647 (2022).

V. 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). The 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.[99] On health care, the Church Alliance has been monitoring legislative proposals relating to mandated benefits, surprise billing, price transparency, drug pricing/PBMs, and public option/single payer. With regard to the latter, the Church Alliance closely followed California's proposed Guaranteed Health Care for All legislation (AB 1400), which would provide single-payer health care coverage. The Church Alliance also followed other legislative proposals that could impact church plans, including Colorado's Health-care Sharing Plan Reporting Act (HB22-1269), which is further discussed below in Section V.E of this report.

In the retirement plan area, the Church Alliance has been monitoring proposals that would establish state multiple employer plans or automatic enrollment IRA plans, including the Hawaii Retirement Savings Act (SB 3289) and Delaware Expanding Access for Retirement and Necessary Saving Act (HB 205). The automatic enrollment IRA plan laws are further discussed below in Section V.C of this report. Also in the retirement plan area, the Church Alliance has been following state fiduciary laws and developments, including most recently a proposed fiduciary duty regulation reissued in Nevada.

Finally, the Church Alliance has started to monitor comprehensive privacy legislation at the state level, including Connecticut's recently enacted Concerning Data Privacy and Online Monitoring (SB 6).

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.[100] 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.

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

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

California recently passed legislation establishing the California Reproductive Health Equity Program within the Department of Health Access and Information to ensure abortion and contraception services are affordable and accessible to all patients.[101] The legislation requires a "health care service plan" and a health insurer that provides health coverage to employees of a religious employer that does not include coverage and benefits for abortion and contraception to provide an enrollee or insured with written information on the abortion and contraception benefits or services that may be available at no cost through the California Reproductive Health Equity Program. This is to be provided upon initial enrollment and then annually upon renewal.

Following the U.S. Supreme Court's decision to overturn *Roe v. Wade*, President Biden signed two Executive Orders relating to protecting access to reproductive healthcare services.[102] The directives in the Executive Orders are intended to:

- Protect access to reproductive health care services.
- Protect patients' privacy and access to accurate information.
- Ensure the safety and security of patients, providers, clinics, pharmacies, and other entities.
- Protect people seeking reproductive healthcare services from fraudulent or deceptive practices.
- Coordinate the implementation of the efforts to protect access to reproductive healthcare services among federal agencies.
- Promote compliance with non-discrimination laws by healthcare providers that receive federal financial assistance.
- Evaluate the adequacy of research in accurately measuring the effect of access to reproductive healthcare on maternal health outcomes and take actions to improve those efforts.

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.[103] States with implemented programs include California, Connecticut, Illinois, Maryland, and Oregon.

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[101][101] Assembly Bill No. 2134.

[102] *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-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)..

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

States and cities with enacted but not implemented laws include Colorado, Delaware, Hawaii, Maine, New Jersey, New York, Virginia, and New York City. 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.[104] Generally, various penalties for non-compliance apply under the programs.

D. 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 New York, Connecticut, New Jersey, Washington, Rhode Island, Massachusetts, and California) 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. Effective January 1, 2023, Oregon and Colorado adopted laws requiring employers to collect and remit premiums for the state paid leave program. Employers with a private plan that provides equal or greater benefits than those provided under the state leave program can apply for a private plan exemption from the requirement to contribute to the state

[104] 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).

leave program. Maryland and Delaware will be establishing similar programs beginning October 1, 2023 for Maryland and January 1, 2025 for Delaware.

E. Colorado Health Care Sharing Ministry Law

A new Colorado law creates reporting requirements for health care sharing ministries (and other entities described therein). Beginning October 1, 2022 and by the 1st of every March thereafter, the law requires any person that is not authorized to engage in the business of insurance in the State of Colorado but that offers or intends to offer a plan or arrangement to facilitate the payment or reimbursement of health-care costs or services for residents of Colorado to submit certain specified information annually to the commissioner of insurance. The new law also imposes a fine on persons that fail to comply with these requirements.

The Church Alliance Core Lawyers Working Group has reviewed the new Colorado law and does not believe it is applicable to church welfare plans.

VI. OTHER

A. Social Security Cost of Living Adjustments

On October 13, 2022, the Social Security Administration announced the cost-of-living adjustments for 2023.[105] The cost-of-living adjustments for 2023 are as follows:

Increase in monthly benefits	8.7%
Maximum earnings subject to Social Security taxes	$160,200 (*$13,200 increase*)
Maximum earnings subject to Medicare taxes	Unlimited
Exempted earnings amount:[106] • In year prior to year during which retiree reaches full retirement age • In year during which retiree reaches full retirement age	 $21,240 *($1,680 increase)* $56,520 *($4,560 increase)*

[105] Social Security Press Release, October 13, 2022, https://www.ssa.gov/news/press/releases/2022/#10-2022-2.

[106] 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.