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

Prepared for the Church Alliance
Covers the Period Beginning November 28, 2023 and Ending October 31, 2024
(Red Text Designates Guidance Issued During the Period beginning August 1, 2024 and Ending October 31, 2024)

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This report provides summaries of legislative and regulatory developments of interest to church-sponsored employee benefit plans and programs for the period beginning November 28, 2023 and ending October 31, 2024. Red text designates guidance issued during the period beginning August 1, 2024 and ending October 31, 2024. The Executive Summary highlights issues that are discussed more fully in the report. If you click on the section reference in the Executive Summary of a legislative or regulatory issue, you will be taken to the section of the report where the issue is more fully discussed. Section I of the report provides summaries of retirement plan guidance, and Section II of the report provides summaries of welfare plan guidance. Both of these sections are divided into legislative guidance, regulatory guidance, litigation, state laws, and other guidance of interest to church-sponsored retirement and welfare plans. Section III of the report includes summaries of other guidance of interest to church-sponsored employee benefit plans and programs. In certain sections of the report, we have indicated in italics when a provision does or does not apply to church plans.

EXECUTIVE SUMMARY

The following chart highlights guidance issued and other developments during the period beginning August 1, 2024 and ending October 31, 2024, all of which are discussed more fully in the report. This Executive Summary contains a short description of a particular issue and a link to the section of the report where the issue is more fully discussed. See the Executive Summary of the prior report for a summary of guidance issued during the period beginning November 28, 2023 and ending July 1, 2023.

Legislative or Regulatory Issue	Current Status Report
Employee Plans Compliance Resolution System (EPCRS) Guidance (provides interim guidance on the impact that Code sections 414(aa) and 402(c)(12), which were added by SECURE 2.0, have on the correction of inadvertent benefit overpayments under the current EPCRS program).	Subject to certain exceptions, the guidance states that plan sponsors generally are not required to seek recovery of inadvertent benefit overpayments from participants or make corrective contributions to the plan because of the changes made by SECURE 2.0. The guidance also discusses the tax treatment of inadvertent benefit overpayments that are rolled over to eligible retirement plans. See Section I.B.1.h.
Student Loan Payment Matching Contributions (provides guidance on the SECURE 2.0 provision permitting employers to make matching contributions on employees' qualified student loan payments under section 401(k) plans, section 403(b) plans, SIMPLE IRAs, and governmental section 457(b) plans)	The notice applies for plan years beginning after December 31, 2024. For plan years beginning before January 1, 2025, the notice permits a plan sponsor to rely on a good faith, reasonable interpretation of the SECURE 2.0 provision. See Section I.B.1.i.
Request for Comments on Saver's Match (requests comments on the SECURE 2.0 provision permitting the Secretary of the	Comments must be submitted by November 4, 2024. See Section I.B.1.j. The Church Alliance has requested the American Benefits Council

Treasury to provide matching contributions to certain types of retirement plans (including 401(k) and 403(b) plans) on behalf of eligible individuals who make qualified retirement savings contributions (including elective deferrals and after-tax contributions)).	to add a comment to the ABC comment letter requesting clarification that no reporting related to the Saver's Match is required by church plans.
AME Church Plan Litigation (breach of fiduciary duty litigation for allowing a single individual to invest the assets of a church plan with no oversight where the individual made illegal and risky investments resulting in the loss of more than $90 million)	In August, the AME church and the plaintiffs entered into a contingent settlement agreement that is subject to court approval. Litigation continues against the remaining defendants. See Section I.C.2.a.
Notice 2024-75 (expands the types of preventive care expenses permitted to be covered under a high deductible health plan and clarifies certain items that are treated as preventive care under Code section 223(c)(2)(C)).	Among other items, a high deductible health plan is now permitted to cover, as preventive care, over-the-counter oral contraceptives for a covered individual potentially capable of becoming pregnant, including over-the-counter birth control pills and emergency contraceptives, regardless of whether the individual has a prescription. See Section II.B.1.b.
2025 Inflation-Adjusted Amounts for Health Plans (the inflation-adjusted amounts include adjusted amounts for the employer mandate affordability percentage, flexible spending accounts, QSEHRAs, and qualified transportation fringe benefits).	See Sections II.B.1.e and II.B.1.f.
Mental Health Parity Final Rule (provides guidance on the mental health parity requirements, specifically nonquantitative treatment limitations and the comparative analysis requirement).	For group health plans, the final rules are generally effective for plan years beginning on or after January 1, 2025, with a one-year delayed effective date for certain provisions. See Section II.B.4.a.
Proposed Rule on Contraceptive Coverage (expands the types of contraceptive coverage that health plans are required to cover without cost sharing).	Among other changes, the proposed rule would remove the prescription requirement so that health plans would be required to cover over-the-counter emergency contraception and the FDA-approved oral contraceptive that is available for use without a prescription and without cost sharing. Currently, a health plan is required to cover over-the-counter contraceptive items only if such items are prescribed by a physician. The proposed rules

	would not modify the current federal conscience protections or religious and moral exemptions from the contraceptive coverage requirements. See Section II.B.4.i.
FAQ Guidance on Preventive Care Services and Women's Health and Cancer Rights Act (provides guidance on the changes plans must make to comply with the 2023 recommendations of the United States Preventive Services Task Force for Pre-Exposure Prophylasis (PreP), an HIV prevention medication, and makes certain clarifications regarding the Women's Health and Cancer Rights Act).	The changes to comply with the recommendations for PreP must be made for plan years beginning on or after August 31, 2024. See Section II.B.4.j.
Ways and Means Republican Tax Teams Request for Information on Tax Reform	The Church Alliance responded to the request for information. See Section III.C.

I. RETIREMENT PLAN GUIDANCE

A. Legislation and Legislative Updates Impacting Retirement Plans

1. SECURE 2.0 Technical Corrections Discussion Draft

The SECURE 2.0 Act of 2022 ("SECURE 2.0") was enacted at the end of 2022 as part of the 2023 appropriations bill. On December 6, 2023, the House and Senate jointly released a discussion draft of the SECURE 2.0 technical correction bill. Key updates include:

- Confirming that early distributions for terminally ill individuals are permitted distribution events (contrary to IRS Notice 2024-2).
- Fixing the inadvertent elimination of all catch-up contributions beginning in 2024.
- Clarifying the required minimum distribution ("RMD") age change from 73 to 75 in 2033 for individuals who reach 73 after 2032.
- Clarifying that the 2025 catch-up limit (as indexed) is used for determining increased catch-up contributions for participants age 60 to 63 (SECURE 2.0 had incorrectly referenced the 2024 catch-up limit).
- Confirming that the catch-up contribution increase applies for qualified student loan payments.

- Revising mandatory automatic enrollment rules (*those rules are not applicable to church plans*).

- Clarifying that the lost and found database will include IRA and deferred annuity contract issuers (*this provision does not apply to church plans because it only applies to plans to which the vesting standards of ERISA Section 203 apply*).

2. Church Alliance Legislative Initiatives

(a) 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 House and Senate Agriculture Committees have largely focused on the Farm Bill for the past two years. The Church Alliance understands there is interest in doing a Commodity Futures Trading Commission ("CFTC") reauthorization bill, which is the most likely vehicle for this fix. The House Agriculture Subcommittee on Commodity Markets recently held a hearing on this topic, which could refresh momentum on a CFTC reauthorization bill down the road. The Church Alliance continues to be engaged on this issue.

(b) 403(b) Collective Investment Trust Expansion Legislation

The Senate recently introduced its companion bill (S. 4917) to the House-passed legislation that would allow 403(b) plans to invest in collective investment trusts. The Church Alliance has been engaged on this legislation to ensure it does not inadvertently negatively impact existing securities law exemptions for church plans.

3. Proposed Legislation

(a) Automatic IRA Act of 2024

On February 7, 2024, Representative Richard E. Neal (D-MA) introduced the Automatic IRA Act of 2024 (H.R. 7293), which has been referred to the House Committee on Ways and Means. Subject to certain exemptions, the bill would require employers with more than 10 employees that do not already sponsor a retirement plan to automatically enroll their employees in an IRA or another

automatic contribution plan, such as a 401(k) plan. The bill includes exemptions for employers that have been in existence for less than two full years and employers with church or governmental plans.

(b) Tax Relief for American Families and Workers Act of 2024

On January 17, 2024, Representative Jason Smith (R-MO) introduced the Tax Relief for American Families and Workers Act of 2024 (H.R. 7024). The bill includes disaster relief provisions that would extend the relief provided in the Taxpayer Certainty and Disaster Tax Relief Act, which was enacted at the end of 2019 as part of the Further Consolidated Appropriations Act, 2020. The disaster relief provisions include:

- Forgiveness of the 10% early-withdrawal penalty for "qualified disaster distributions."
- Permitting certain hardship distributions taken for the purchase or construction of a primary residence that were not used to be recontributed to the plan.
- An increase in the amount of loans permitted from qualified plans.

The bill would extend the relief to any federally declared disaster that occurs during the period beginning January 1, 2020 and ending 60 days after the date of enactment. The bill passed the House and has been read twice by the Senate and placed on the calendar.

(c) Small Nonprofit Retirement Security Act of 2024

On August 1, 2024, Senators James Lankford (R-Okla.) and Catherine Cortez Masto (D-Nev.) introduced the Small Nonprofit Retirement Security Act of 2024 (S. 4965). This Act would provide qualifying nonprofit organizations with the same incentives to adopt a retirement plan as for-profit organizations through a tax credit for retirement plan startup costs and an additional tax credit for including auto-enrollment features. Since nonprofits generally do not pay income tax, the credit would be applied against the nonprofit organization's payroll tax liability.

B. Regulatory Guidance and Other Initiatives Impacting Retirement Plans

1. Internal Revenue Service

(a) Proposed Regulations and Other Guidance on Long-Term Part-Time Employees

Under the Setting Every Community Up for Retirement Enhancement Act (the "SECURE Act"), which was enacted in 2019, 401(k) plans (*including church 401(k) plans*) are required to permit elective deferrals for employees who complete at least 500 hours of service in three consecutive 12-month periods. Only years

after 2020 must be counted for the three-year requirement, so January 1, 2024 is the first time that eligibility is required under this rule. Matching and nonelective contributions are not required. Under SECURE 2.0, for plan years beginning after December 31, 2024, employees who complete at least 500 hours of service in two consecutive 12-month periods must be eligible for deferrals.

SECURE 2.0 also added the long-term part-time ("LTPT") rules to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), which means that 403(b) plans covered by ERISA are subject to the rule as described in SECURE 2.0. *However, church 403(b) plans are not subject to this rule because they are not subject to ERISA*. Only service on or after January 1, 2021 must be counted for purposes of counting vesting service under a 401(k) plan. (For these employees, vesting service must be counted for employees who work 500 hours in a 12-month period.)

Since the Annual Report was finalized in November 2023, the IRS has issued proposed LTPT regulations and Notice 2024-73 which provides guidance on ERISA-covered 403(b) plans covering LTPT employees, both of which are further discussed below.

Proposed Regulations

On November 24, 2023, the Internal Revenue Service ("IRS") released proposed regulations on LTPT employees.[1] The proposed regulations apply to plan years beginning on or after January 1, 2024 and can be relied on prior to publication of final rules. The proposed regulations do not include a good faith interpretation standard.

Under the proposed regulations, the 12-month period for determining years with 500 hours begins on the date first credited with an hour of service; following the completion of the 12-month period, a plan can elect to switch to a plan year for the hours-of-service determination. The switch to a plan year determination can accelerate eligibility. A plan can use the Department of Labor ("DOL") hours equivalencies for LTPT equivalencies. A plan can apply the same entry dates as for other employees.

There are no break-in-service rules for LTPT employees, so immediate participation upon rehire and prior years with 500 hours of service will need to be considered upon rehire. Plans can use a regular vesting computation period (e.g., anniversary of employment year or plan year) for LTPT vesting years. *Although church and governmental plans are generally exempt from section 411 of the Internal Revenue Code of 1986, as amended (the "Code"), the proposed regulations apply certain vesting rules of Code section 411 to these plans, thus*

[1] 88 Fed. Reg. 82,796 (Nov. 27, 2023).

requiring a year of service for each year in which an LTPT employee works at least 500 hours.

An employer can exclude LTPT employees from coverage and nondiscrimination testing, but this election must apply to all of the testing. LTPT employees can be excluded from safe harbor contributions, but this exclusion must be set forth in the plan document. An employer can exclude LTPT employees from top-heavy vesting and benefit requirements, but cannot exclude them for purposes of determining whether a plan is top-heavy.

Plans can still exclude employees based on reasonable classifications that are not based on or a proxy for age or service. However, if an employee is excluded from participation because of any such classification but would be eligible to participate as a LTPT employee in the absence of the exclusion, then the employee must be included in nondiscrimination, coverage, and top-heavy testing. Employees who become eligible under any other plan service requirement cease to be LTPT employees – and thus cease to be eligible for the testing exclusion for LTPT employees. LTPT employee rules generally do not apply to plans that use elapsed time, and testing relief for LTPT employees is not available for those plans.

In January, the Church Alliance submitted a comment letter on the proposed regulations. The comment letter states that the Church Alliance does not object to granting LTPT employees vesting service credit if certain requirements are satisfied "but not at the expense of making church plans subject to all of Code Section 411." The comment letter also states that the Church Alliance's understanding is that aggregation of an employee's service in a denominational plan is not required under the proposed regulations, as long as the separate employers are not members of a controlled group.

Notice 2024-73

On October 3, 2024, the IRS issued Notice 2024-73, which provides guidance on the eligibility rules for LTPT employees participating in 403(b) plans subject to ERISA, including how the new rules relate to Code section 403(b)'s universal availability requirement. The notice confirms that SECURE 2.0's LTPT employee requirements do not apply to 403(b) church plans that are exempt from ERISA. The notice also requests comments and states that the IRS intends to issue proposed regulations on the eligibility rules for LTPT employees in ERISA-covered 403(b) plans.

The notice also states that the final regulations on LTPT employees participating in 401(k) plans will apply no earlier than plan years beginning on or after January 1, 2026. The proposed regulations on LTPT employees under 401(k) plans are discussed above.

(b) Miscellaneous SECURE 2.0 Guidance

On December 20, 2023, the IRS issued Notice 2024-2, which includes miscellaneous guidance on SECURE 2.0 in the form of questions and answers. Among other provisions, the notice provides guidance on mandatory automatic enrollment, financial incentives for plan contributions, early distributions for terminally ill individuals, corrections of elective deferrals, plan amendment deadlines, and Roth employer contributions.[2]

Mandatory Automatic Enrollment

The mandatory automatic enrollment provisions are effective for plan years beginning after December 31, 2024. *Church plans are exempt from these requirements.*

Under these rules, 401(k) and 403(b) plans established after December 29, 2022 must provide for:

- Automatic enrollment of at least 3% and no more than 10%.
- Automatic escalation of one percentage point each year, up to at least 10%.

A new qualified cash or deferred arrangement ("CODA") is established on the date adopted – not the date effective.[3]

There are exceptions for new businesses (less than 3 years) and small businesses (less than 10 employees). An exception also applies for CODAs established before December 29, 2022. A 403(b) plan is treated as a pre-enactment CODA if it was established before December 29, 2022, without regard to the date of adoption of plan terms that provide for salary reduction.

The notice includes detailed rules for plan mergers and plan spinoffs – including rules for multiple employer plans. Mandatory automatic enrollment rules apply to starter 401(k) deferral-only arrangements and 403(b) safe harbor deferral-only plans, unless an exception applies (*again, an exception applies for church plans generally*).

[2] The Notice also includes the following items generally applicable to employers with 100 or fewer employees: start-up credit enhancement, the military spouse retirement plan eligibility credit, increased contribution limits for SIMPLE IRAs and SIMPLE 401(k) plans, mid-year termination and rollover changes for SIMPLE IRAs, and SIMPLE and SEP Roth IRAs.

[3] For example, an employer adopts a CODA on October 3, 2022, with an effective date of January 1, 2023. For this purpose, it was "established" on October 2, 2022.

Financial Incentives for Plan Contributions

A *de minimis* financial incentive for employees who elect to make contributions does not violate the contingent benefit rule applicable to 401(k) plans or the universal availability rule applicable to 403(b) plans. A $250 maximum incentive is permitted. An incentive can only be offered to employees for whom no salary deferral election is already in place. An incentive can be provided in installments that are contingent on continuing to defer, still subject to a total limit of $250. A matching contribution cannot be an incentive for this purpose.

An incentive is taxable to the recipient and is subject to applicable employment tax withholding and reporting requirements – unless otherwise excluded under another Code provision.[4] The guidance also applies to 403(b) plans subject to the universal availability rule.

In February, the Church Alliance submitted a comment letter on the financial incentive provision. The Church Alliance requests that the IRS allow parties other than an employer to provide a *de minimis* financial incentive to encourage participation in retirement plans, such as a church, synagogue, denominational benefit organization, or individual donor.

Terminally Ill Individuals

Distributions to "terminally ill individuals" are not subject to the 10% additional tax for early withdrawals and are eligible for repayment to the plan. "Terminally ill" is defined as an individual who has been certified by a physician as having an illness or physical condition that can reasonably be expected to result in death in 84 months or less after the date of the certification. A physician is defined as a doctor of medicine or osteopathy who is legally authorized to practice medicine and surgery by the State in which the doctor performs such function or action.

A distribution must be made on or after the date on which the employee has been certified by a physician as having a terminal illness. An employee must furnish the physician's certification to the plan administrator. An employee must retain certification and underlying documentation. The certification must include specific information regarding the participant and physician. The plan administrator cannot rely on employee self-certification. There is no dollar limit on the amount.

Currently, terminally ill distributions do not meet the distribution restrictions applicable to 401(k) and 403(b) plans. This means that, currently, elective deferrals cannot be distributed solely because of terminal illness. The discussion draft of a SECURE 2.0 technical corrections bill discussed in Section

[4] For example, a $200 gift card is not excludable because it is a cash equivalent.

I.A.1 of this report would permit the distribution of elective deferrals due to terminal illness.

Qualified plans are not required to permit terminally ill distributions. Even if the plan does not permit these distributions, individuals can treat an otherwise permissible in-service distribution as a terminally ill individual distribution on an individual's tax return. The notice did not include any guidance on Form 1099-R reporting of terminally ill distributions.

Correction of Elective Deferral Failures

SECURE 2.0 codified an alternative method of correcting an elective deferral failure in an automatic enrollment plan. No correction for the missed deferral is required if correct deferrals commence within certain periods of time and timely notice is provided to the participant.

Corrective matching contributions are always required. Matching contributions must be deposited within a reasonable period. The last day of the sixth month following the month in which the correct elective deferrals begin is treated as reasonable. An alternative method may be used for terminated employees as well. The notice can be modified to remove information about current and future deferrals.

Plan Amendment Deadlines

The Notice extends the plan amendment deadline for required and discretionary amendments under the SECURE Act, SECURE 2.0, and certain provisions of other laws to December 31, 2026 for 403(b) plans and qualified plans.[5] Amendments made after the deadline are not eligible for anti-cutback relief.

Roth Employer Contributions

Plans are not required to offer this option and may choose to offer it for matching or nonelective contributions. A designation as a Roth contribution must be made no later than the time the contribution is allocated to the account and must be irrevocable. Separate accounting is required.

If an employee election is permitted, the employee must have an effective opportunity to make or change the designation at least once per plan year. The contribution is includible in income for the taxable year in which it is allocated to the individual's account – even if the contribution is deemed to have been made on the last day of the prior taxable year.

[5] Different deadlines apply to 403(b) plans maintained by public schools, governmental qualified plans, and collectively bargained plans.

The participant must be fully vested in the type of contribution (matching or nonelective). This restriction will not violate Code section 401(a)(4).

For 401(k) and 403(b) plans, designated Roth matching and nonelective contributions:

- Are not wages for income tax withholding purposes (i.e., they are excluded from wages under Code § 3401(a)), and

- Are not wages for FICA or FUTA purposes (i.e., they are excluded from wages under Code §§ 3121(a) and 3306(b)).

The contributions must be reported using Form 1099-R for the year in which they are allocated to the individual's account. The total amount of designated Roth matching and nonelective contributions that are allocated in that year are reported in boxes 1 and 2a of Form 1099-R, and code "G" is used in box 7.

The contributions are not included in the wage withholding and Form W-2 safe harbor definitions of compensation.

(c) Guidance on Certain SECURE 2.0 Early Distribution Provisions

In June, the IRS issued Notice 2024-55, providing guidance on the exceptions from the 10% additional tax under Code section 72(t)(1) for emergency personal expense distributions and distributions for victims of domestic abuse. Both types of distributions were added by SECURE 2.0 and became effective on January 1, 2024.

An emergency personal expense distribution is a distribution from an applicable retirement plan to an individual for unforeseeable or immediate financial needs relating to necessary personal or family emergency expenses. The notice provides the following guidance on emergency personal expense distributions:

- The relevant facts and circumstances to be considered in determining whether an individual has an unforeseeable or immediate financial need relating to necessary personal or family emergency expenses include, but are not limited to, whether the individual has expenses relating to medical care, accident or loss of property due to casualty, imminent foreclosure or eviction from a primary residence, the need to pay for burial or funeral expenses, auto repairs, or any other necessary emergency personal expenses.

- The types of plans that are eligible to permit emergency personal expense distributions include 401(a) plans, 403(a) plans, 403(b) plans, 457(b) plans, or IRAs.

- An individual is permitted to treat one distribution per calendar year as an emergency personal expense distribution.

- The amount that may be treated as an emergency personal expense distribution in a calendar year may not exceed the lesser of $1,000 or the excess of the individual's total nonforfeitable accrued benefit under the plan on the date of distribution over $1,000.

- If an individual receives an emergency personal expense distribution, the individual generally cannot receive another emergency personal expense distribution for the immediately following three calendar years unless the distribution is fully repaid to the plan or the individual's elective deferrals and employee contributions to the plan after the distribution are at least equal to the amount of the distribution that has not been repaid.

- An individual may repay an emergency personal expense distribution, and a plan is required to permit repayment if certain requirements are satisfied. A repayment is treated as a direct rollover.

A domestic abuse victim distribution is a distribution from an applicable retirement plan to a domestic abuse victim if made within one-year of any date on which the individual is a victim of domestic abuse[6] by a spouse or domestic partner. The notice provides the following guidance on domestic abuse victim distributions:

- The types of plans that are eligible to permit domestic abuse victim distributions are eligible retirement plans described in Code section 402(c)(8)(B),[7] other than a defined benefit plan or a plan to which the spousal consent requirements of Code section 401(a)(11) or 417 apply.

- The amount that an individual may treat as a domestic abuse victim distribution cannot exceed the lesser of $10,000 (indexed for inflation) or 50% of the vested accrued benefit of the employee under the plan.

- An individual may repay a domestic abuse victim distribution within three years provided certain requirements are satisfied. A repayment is treated as a direct rollover.

The notice provides the following guidance applicable to both types of distributions:

- An applicable eligible retirement plan is permitted, but not required, to allow these distributions.

[6] "Domestic abuse" is defined as "physical, psychological, sexual, emotional, or economic abuse, including efforts to control, isolate, humiliate, or intimidate the victim, or to undermine the victim's ability to reason independently, including by means of abuse of the victim's child or another family member living in the household."

[7] A retirement plan described in Code section 402(c)(8)(b) includes an individual retirement account or annuity described in Code section 408(a) or (b), a 401(a) plan, a 403(a) plan, a 403(b) plan, or a governmental 457(b) plan.

- A plan administrator is permitted to rely on an employee's written certification that the employee is eligible for one of these types of distributions.

- These distributions are not treated as eligible rollover distributions for purposes of the direct rollover rules, notice requirement, or mandatory withholding rules.

- If an eligible retirement plan does not permit one of these distributions but an individual receives a permissible distribution that satisfies the applicable requirements, the individual may treat the distribution as an emergency personal expense distribution or a domestic abuse victim distribution (as applicable) on the individual's federal tax return.

The notice also states that the IRS anticipates issuing regulations on the 10% additional tax and requests comments on all matters discussed in the notice. Comments must be submitted by October 7, 2024.

(d) SECURE 2.0 RMD Guidance and Final Regulations

The RMD rules under Code section 401(a)(9) require that distributions to a participant begin no later than the participant's required beginning date, which is generally April 1 following the later of the calendar year in which the participant attains the applicable age or the calendar year in which the participant retires. The SECURE Act and SECURE 2.0 both increased the age at which RMDs must commence.

Code section 401(a)(9) also identifies the period over which the employee's entire interest in the plan must be distributed, which varies based on several factors. 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 for "eligible designated beneficiaries," which include a designated beneficiary who 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).

In 2022, the IRS issued proposed regulations restating the regulations applicable to RMDs under Code section 401(a)(9). Among other guidance, the proposed regulations clarify that, if a participant dies after the required beginning date, the 10-year rule (for a non-eligible designated beneficiary) would require an annual payment to be made over a 10-year period. Many commentators indicated that they had interpreted the 10-year rule in a different manner than the IRS

interpreted it in the proposed regulations, which likely resulted in many taxpayers not taking RMDs in 2021 and 2022.

As a result of these concerns, the IRS issued Notices 2022-53 and 2023-54 to provide relief from failures in 2021, 2022, and 2023 to comply with the IRS's interpretation of the 10-year rule for RMDs, as set forth in the proposed regulations. In April, the IRS issued Notice 2024-35 extending the relief provided in Notices 2022-53 and 2023-54 through 2024.

In July, the IRS finalized the 2022 proposed regulations, with a few changes made in response to comments.[8] The final regulations apply for purposes of determining RMDs for calendar years beginning on or after January 1, 2025. The final regulations include the following guidance and clarifications:

- Clarifies that the "applicable age" is:
  - age 70½ for employees born before July 1, 1949,
  - age 72 for employees born on or after July 1, 1949 but before January 1, 1951,
  - age 73 for employees born on or after January 1, 1951 but before January 1, 1959,
  - age 75 for employees born on or after January 1, 1960.
- Code section 401(a)(9) requires actuarial increases for employees in defined benefit plans and annuity contracts (including those purchased under defined contribution plans) who retire in a year after the year in which the employee attains age 70½. There is an exception for governmental and church plans, but "church plan" is defined as a plan maintained by a church for church employees, and a church is defined as a church or a qualified church-controlled organization ("QCCO"). For purposes of this rule, the final regulations allow:
  - a licensed minister who is self-employed but treated as an employee of a church under Code section 414(e)(3)(B)(i) to be considered an employee of a church under Code section 401(a)(9)(C)(iv).
  - a church plan to be excepted from the actuarial increase requirement only if at least 85% of the individuals covered by the plan are employees of a church or QCCO. This rule allows certain plans to

[8] 89 Fed. Reg. 58,886 (July 19, 2024).

cover some employees of non-QCCOs without becoming subject to the actuarial increase rule.[9]

- If a participant dies after the 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.

- Qualified longevity annuity contracts ("QLACs") are permitted to have a cash surrender value prior to the participant's required beginning date and may also include a right to rescind the contract within a period of up to 90 days from the date of purchase.

- If the plan is intended to be operated using a default that is different than the default that would apply under the final regulations, then 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. A plan may also provide that a particular distribution method will apply to certain categories of eligible designated beneficiaries or an election is only available to certain categories of eligible designated beneficiaries.

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

The final regulations also include details on the determination of when an individual is "disabled" and "chronically ill" and guidance on how RMDs are distributed where the participant has multiple beneficiaries.

On the same day the final regulations were released, the IRS released proposed regulations providing guidance on certain RMD changes made by SECURE 2.0, including the determination of applicable age for employees born in 1959, purchases of an annuity contract with a portion of an employee's individual account, distributions from designated Roth accounts, corrective distributions resulting in a reduction or waiver of the Section 4974 excise tax, spousal elections, divorce after purchasing a QLAC, and distribution to a trust beneficiary.[10] Comments on the proposed regulations must be submitted by September 17, 2024, and a public hearing on the proposed regulations is scheduled for September 25, 2024.

[9] The Church Alliance submitted a comment letter in 2022 requesting that the final regulations clarify that the actuarial increase rule only apply when a plan only covers non-QCCOs.

[10] 89 Fed. Reg. 58,644 (July 19, 2024).

(e) SECURE 2.0 Fact Sheets

In May, the IRS issued two fact sheets providing guidance on SECURE 2.0 provisions.[11] In FS-2024-18, the IRS provides guidance to businesses on changes to the amounts that need to be reported on 2023 Forms W-2 (which are filed in 2024) as a result of the following changes made by SECURE 2.0:

- *De minimis* financial incentives to participate in a retirement plan.
- Roth SIMPLE and Roth SEP IRAs.
- Designated Roth nonelective contributions and matching contributions.[12]

In FS-2024-19, the IRS provides FAQ guidance on the SECURE 2.0 provisions providing special rules for distributions from retirement plans and IRAs and loans from retirement plans for individuals impacted by federally declared disasters.

(f) Pension-Linked Emergency Savings Account Guidance

SECURE 2.0 included a provision permitting defined contribution plans to establish an optional pension-linked emergency savings account ("PLESA") within the plan that is available only to non-highly compensated employees. The account is subject to a $2,500 limit, and automatic enrollment is permitted up to 3% of compensation. The amounts in the accounts are treated as Roth contributions. The provision is effective for plan years beginning after December 31, 2023. The provision appears to be limited to ERISA-covered defined contribution plans and is different from another SECURE 2.0 provision authorizing emergency personal expense distributions.

If a plan permits these accounts, the plan must permit at least monthly withdrawals, and the first four withdrawals must not be subject to an administrative fee. There does not appear to be any restrictions on the reason for the withdrawal. The accounts must be separately record-kept. The amounts must be invested in an interest-bearing cash account or an investment product designed to preserve principal.

PLESA contributions must be treated as elective deferrals for purposes of matching contributions and contribution limits. Matching contributions are treated

[11] *See* https://www.irs.gov/newsroom/secure-2-point-0-act-changes-affect-how-businesses-complete-forms-w-2 and https://www.irs.gov/newsroom/disaster-relief-frequent-asked-questions-retirement-plans-and-iras-under-the-secure-20-act-of-2022.

[12] If a business has already filed 2023 Forms W-2 without following the new guidelines, then the fact sheet states that they may need to file Form W-2c to correct any errors. The General Instruction for Forms W-2 and W-3 provide guidance on when and how to file Form W-2c.

first as being made on non-PLESA contributions and cannot exceed the maximum account balance ($2,500) for the plan year.

On January 12, 2024, the IRS issued Notice 2024-22, providing initial guidance on "anti-abuse" rules intended to prevent manipulation of the rules to cause matching contributions to exceed the intended amounts or frequency. Plan sponsors are not required to impose additional rules beyond those provided in the statute. Thus, it is not abusive for a participant to make a $2,500 contribution in one year, receive the matching contribution and then take $2,500 in distributions that year and repeat that pattern in subsequent years.

The following procedures are deemed to be unreasonable (and thus not permitted as part of a PLESA design). A plan may not:

- Provide that matching contributions already made on account of PLESA contributions will be forfeited by reason of a participant's withdrawal from a PLESA.
- Suspend a participant's ability to contribute to the participant's PLESA on account of a withdrawal.
- Suspend matching contributions made on account of participant elective deferrals to the underlying defined contribution plan.

The DOL, in consultation with the IRS, released additional PLESA guidance in the form of frequently asked questions ("FAQs") on January 17, 2024.[13] The FAQs appear to contemplate that the employer can have more generous eligibility requirements for a PLESA than general plan participation. While automatic enrollment is permitted, mandatory contributions are not permitted.

A plan cannot:

- Require a minimum amount for opening or keeping a PLESA.
- Require a minimum balance.
- Impose a penalty for falling below a specified amount.
- Require a minimum contribution per pay period.

A plan can require contributions in whole dollar amounts or whole percentages of not less than 1%. A plan is also permitted to either include or exclude earnings on a participant's contributions as long as the portion of the account attributable to participant contributions does not exceed the $2,500 account

[13] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/pension-linked-emergency-savings-accounts.

limit. Plans cannot impose a limit on contributions in addition to the $2,500 limit. The same ERISA timing requirements apply for employer remittance of participant contributions as for deferrals and loan payments.

PLESA amounts can be held in a segregated omnibus account provided the separate accounting and separate recordkeeping requirements are satisfied.

A participant is not required to demonstrate the existence of an emergency or other need to obtain a PLESA distribution. Withdrawal fees (for withdrawals after the first four) must be reasonable and can be charged against the PLESA or against the participant's plan account. There are no restrictions on the method of distribution at this time (e.g., check, debit card, or electronic transfer).

The statute requires investment of PLESA accounts in cash, interest-bearing deposit accounts, or other products designed to preserve principal and provide a reasonable rate of return. The FAQ guidance provides that the objective is "capital preservation and liquidity consistent with immediate access to savings to respond to unexpected financial needs." Surrender changes are incompatible with that objective (which is a potential issue for stable value funds). The investment option used for PLESA assets cannot be the plan's qualified default investment arrangement ("QDIA") as that would not satisfy this objective.

There are no model notices at this time, but they are under consideration by the DOL and IRS. Pension benefit statements and fee disclosures are not required to include PLESA information. The DOL is working on Form 5500 updates on how to reflect PLESAs.

The notice did not include guidance on the following:

- Form 1099-R or other reporting requirements.
- Clarification of application to non-ERISA plans, like church plans.
- Interaction with mandatory cash-out rules.
- Correction for inadvertent inclusion of a highly compensated employee ("HCE").

(g) Recommendations Request on the 2024-25 Priority Guidance Plan

In Notice 2024-28, the IRS requested comments on items to be included on the 2024-2025 Priority Guidance Plan. The Treasury Department and IRS use the Priority Guidance Plan each year to identify and prioritize the tax issues that should be addressed through regulations or other administrative guidance.

In May, the Church Alliance issued a letter in response to the notice requesting that the IRS publish proposed regulations updating the definition of church plan under Code section 414(e) as soon as possible. The letter also states

that the Church Alliance submitted extensive comments on the church plan regulations in 2018 in response to the Treasury's regulatory agenda.

(h) Employee Plans Compliance Resolution System Guidance

The Employee Plans Compliance Resolution System ("EPCRS") is the IRS correction system for retirement plans and includes guidance on the correction of overpayments from plans. The current EPCRS program is described in Revenue Procedure 2021-30.

SECURE 2.0 added sections 414(aa) and 402(c)(12) to the Code providing rules on inadvertent benefit overpayments from employer-sponsored retirement plans. Code section 414(aa) includes special rules applicable to benefit overpayments, while Code section 402(c)(12) addresses when an overpayment is eligible to be treated as an eligible rollover distribution.

In October, the IRS issued Notice 2024-77, providing interim guidance on the impact that Code sections 414(aa) and 402(c)(12) have on the correction of inadvertent benefit overpayments under the current EPCRS program. The notice generally defines an "inadvertent benefit overpayment" as a payment that (i) exceeds the amount payable under the plan or a limit provided in the Code or (ii) is paid before it is eligible to be paid under the Code or the terms of the plan. An "inadvertent benefit overpayment" does not include overpayments made to disqualified persons (defined in Code section 4975(e)(2)) or overpayments made to correct a different qualification failure under the current EPCRS guidance.

Subject to certain exceptions, the guidance states that plan sponsors generally are not required to seek recovery of inadvertent benefit overpayments from participants or make corrective contributions to the plan because of the changes made by SECURE 2.0. The notice also states that a plan is permitted to seek recoupment, even if it is not required, using the rules set forth in EPCRS.

SECURE 2.0 provides that an inadvertent benefit overpayment that is rolled over may retain its tax-favored status if the plan sponsor does not seek recovery of the overpayment and the payment would have been an eligible rollover distribution had it not been an overpayment. If the plan sponsor seeks recovery and it does not occur, then the notice clarifies that the inadvertent benefit overpayment may not be treated as an eligible rollover distribution. In this case, the plan sponsor is required to notify the participant that the unreturned portion of the inadvertent benefit overpayment is not eligible to be treated as a tax-free rollover, which can be included in the request for recoupment.

If an inadvertent benefit overpayment exceeds the Code section 401(a)(17) or 415 limits, a corrective payment must be made to the plan in accordance with EPCRS by either the individual, the plan sponsor, or another person. If the recipient does not repay the inadvertent overpayment, then the plan sponsor must notify the

recipient that any unreturned portion may not be treated as an eligible rollover distribution.

The notice is effective October 15, 2024. For periods before such date, a taxpayer may rely on a good faith, reasonable interpretation of Code sections 414(aa) and 402(c)(12). The notice also requests comments on the guidance included in the notice by December 16, 2024.

(i) Student Loan Payment Matching Contributions

SECURE 2.0 included a provision permitting employers to make matching contributions on employees' qualified student loan payments ("QSLPs") under section 401(k) plans, section 403(b) plans, SIMPLE IRAs, and governmental section 457(b) plans. This provision applies to contributions made for plan years beginning after December 31, 2023.

A QSLP is a payment made by an employee in repayment of a qualified education loan, as defined in Code section 221(d)(1), incurred by the employee to pay qualified higher education expenses. The amount of a QSLP cannot exceed the lesser of the Code section 402(g) limit or the employee's compensation under Code section 415(c)(3) for the year, reduced by the employee's elective deferrals for the year. The employee making the payment must certify annually to the employer making the matching contribution that a payment has been made on the loan.

QSLP matches are treated as matching contributions if (i) a plan provides matching contributions on account of elective deferrals at the same rate as QSLP matches, (ii) the plan provides QSLP matches only on behalf of employees eligible to receive elective deferral matches, (iii) all employees who are eligible to receive elective deferral matches under the plan are eligible to receive QSLP matches, and (iv) the plan provides that QSLP matches and elective deferral matches vest in the same manner.

In August, the IRS issued Notice 2024-63 in question-and-answer format to provide additional guidance on QSLPs, including the following:

- Limitations: A plan may not include a provision limiting QSLP matches to only certain education loans (such as qualified education loans for an employee's own education, for a certain degree, or for attending a certain school) because QSLP matches must be available to all employees eligible for elective deferrals.

- Same Plan Year: An employee's qualified education loan payments that were made during a plan year are only eligible to be counted for an employee's QSLP match for the same plan year.

- Legal Obligation: A qualified education loan is only treated as incurred by an employee if the employee who makes the loan payment has a legal obligation to do so under the terms of the loan.

- Employee Certification:

  - A plan can permit either a separate certification for each qualified education loan payment or an annual certification for all qualified education loan payments intended to qualify as QSLPs for a year.

  - A plan must receive the following information to satisfy the certification requirement: (i) the amount of the loan payment, (ii) the date of the loan payment, (iii) that the employee made the payment, (iv) that the loan being repaid is a qualified education loan used to pay qualified higher education expenses of the employee, the employee's spouse, or the employee's dependent, and (v) that the loan was incurred by the employee. The required information may be satisfied through affirmative certification by the employee. The notice also provides guidance on alternative certification methods for certain required information and how often the certification is required.

- Reasonable Procedures: A plan may establish any reasonable administrative procedures to implement a QSLP match. A plan may establish either a single QSLP match claim deadline for a plan year or multiple deadlines, provided each deadline is reasonable. An annual deadline that is three months after the end of a plan year is considered reasonable.

- ADP Testing: A plan with a QSLP match feature may apply a single ADP test for all employees or a separate ADP test for employees who receive QSLP matches and employees who do not receive QSLP matches. The notice provides two methods for plans that choose to apply separate ADP tests.

- Miscellaneous Guidance:

  - A plan may provide for QSLP matches to be contributed at a different frequency than elective deferral matches.

  - A match based on an employee's certification of a QSLP that is determined to be incorrect does not need to be corrected. If it is corrected, however, all QSLPs made under similar circumstances must be corrected.

The notice applies for plan years beginning after December 31, 2024. For plan years beginning before January 1, 2025, the notice permits a plan sponsor to

rely on a good faith, reasonable interpretation of the SECURE 2.0 provision. The notice also states that the Treasury Department and IRS anticipate issuing proposed regulations on QSLPs and request comments on the QSLP provision and guidance included in the notice.

(j) Request for Comments on Saver's Match

SECURE 2.0 included a provision permitting the Secretary of the Treasury to provide matching contributions to certain types of retirement plans (including 401(k) and 403(b) plans) on behalf of eligible individuals who make qualified retirement savings contributions (including elective deferrals and after-tax contributions). This is known as the Saver's Match.

Effective for taxable years beginning after December 31, 2026, an individual who makes contributions to an applicable retirement plan of up to $2,000 can receive a Saver's Match contribution of up to $1,000. The amount of the Saver's Match depends on the individual's income or joint income and phases out for higher earning individuals.

On September 5, 2024, the IRS issued Notice 2024-65 requesting comments on various aspects of the Saver's Match. Comments are due by November 4, 2024. The Church Alliance has requested the American Benefits Council to add a comment to its comment letter on the Saver's Match requesting clarification that no reporting related to the Saver's Match is required by church plans.

(k) 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 amendments 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.[14]

At the end of 2023, the IRS issued Notice 2023-79, which provides the 2023 required amendment list. The amendments listed on the 2023 required amendment list must be adopted by December 31, 2025. The 2023 required amendments list includes no required amendments.

The IRS also provides an "Operational Compliance List"[15] on its website. The Operational Compliance List is updated periodically and identifies changes in qualification requirements and Code section 403(b) requirements effective during

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

[15] 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.

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.

(l) Postponement of Certain Tax Deadlines After Federally Declared Disasters

The IRS will postpone certain retirement plan and IRA deadlines for affected taxpayers in the event of a presidentially-declared disaster, which often includes severe storms (e.g., tornados and hurricanes), wildfires, floods, or earthquakes. An affected taxpayer is generally a person who lives in or has a business in an area impacted by the disaster.

After a disaster is declared, the IRS will issue a news release describing the type of relief, the eligible taxpayers, and the relief period. Section 8 of Revenue Procedure 2018-58 lists the retirement plan and IRA deadlines that the IRS may postpone. If the news release for a disaster does not limit the relief, then all of the deadlines listed in the revenue procedure will be postponed.[16]

The IRS issued several news releases since the Annual Report was prepared providing tax relief for certain disasters. The news releases are listed on the IRS's website.[17]

2. Department of Labor

(a) Investment Advice Fiduciary Final Rules

In October of 2010, the DOL proposed a rule[18] to update and expand the 35-year-old regulation containing the definition of the term "fiduciary" under ERISA to more broadly cover those who provide retirement investment advice. That proposal encountered strong resistance from the financial services industry. Subsequently, in September 2011, the DOL announced that it would withdraw and re-propose the fiduciary rule to "protect consumers while avoiding unjustified costs and burdens."[19]

The DOL issued the re-proposed rule in 2015[20] and finalized it in 2016.[21] The United States Court of Appeals for the Fifth Circuit struck down the DOL's fiduciary rule in 2018, finding that the DOL exceeded its authority in promulgating

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

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

[18] 75 Fed. Reg. 65,263 (Oct. 22, 2010).

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

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

[21] 81 Fed. Reg. 20,946 (Apr. 8, 2016).

the rule.[22] In 2020, the DOL issued a final rule[23] implementing the Fifth Circuit's vacatur of the 2016 rule by reinstating the regulations in effect prior to the 2016 regulations.

In 2023, the DOL issued a new proposed rule defining an investment advice fiduciary under ERISA. The DOL finalized the rule in April with certain changes based on public comments and testimony at public hearings.[24] At the same time, the DOL finalized amendments to several prohibited transaction exemptions that provide investment advice fiduciaries with relief from certain prohibited transactions.[25]

Under the final rule, a person is an investment advice fiduciary under ERISA if the person:

- makes a "recommendation of any securities transaction or other investment transaction," which includes recommendations as to:
    - how property should be invested after being rolled over from a plan or IRA,
    - investment policies or strategies, portfolio composition, selection of other persons to provide investment advice or investment management services, selection of investment account arrangements (e.g., account types such as brokerage versus advisory) or voting of proxies, and
    - rolling over, transferring, or distributing assets from a plan or IRA, including recommendations as to whether to engage in the transaction, the amount, the form, and the destination of such a rollover, transfer, or distribution.
- makes the recommendation with respect to moneys or other property of a plan or IRA to a plan, plan participant or beneficiary, plan fiduciary, IRA, IRA owner or beneficiary, plan fiduciary, or IRA fiduciary (a "retirement investor"),
- provides the advice for a fee or other direct or indirect compensation, and

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

[23] 85 Fed. Reg. 40,589 (July 7, 2020).

[24] 89 Fed. Reg. 32,122 (April 25, 2024).

[25] 89 Fed. Reg. 32,260 (April 25, 2024), 89 Fed. Reg. 32,302 (April 25, 2024), and 89 Fed. Reg. 32,346 (April 25, 2024).

- either:
    - Directly or indirectly makes professional investment recommendations on a regular basis as part of their business, and the circumstances would indicate to a reasonable investor that the recommendation is based on review of the retirement investor's particular needs or individual circumstances, reflects the application of professional or expert judgment to such needs or circumstances, and may be relied upon in advancing the retirement investor's best interests, or
    - Represents or acknowledges that they are acting as a fiduciary when making such recommendations.
        - A person does not provide investment advice if the person makes a recommendation but neither of the above two requirements is satisfied. For example, the provision of investment information or education without an investment recommendation does not qualify as advice for purposes of the final rule. A written statement disclaiming status as a fiduciary or stating one of the above conditions exists is not controlling if it is inconsistent with the person's oral or written communications, marketing materials, applicable law, or other interactions with a retirement investor.

Two district courts in Texas have separately stayed the final rule's September 23, 2024 effective date until further order. One order cites the Supreme Court's recent *Loper Bright* ruling, stating that the court is no longer required to provide deference to the DOL's interpretation of ERISA in writing the final rule. See Section C.4 for additional information about the Supreme Court's *Loper Bright* ruling.

The investment advice fiduciary rule does not apply to plans that are not subject to ERISA, such as non-electing church plans, but may provide useful information to and suggest "best practices" for such plans.[26]

[26] The Church Alliance submitted a comment letter on the proposed investment advice fiduciary regulations issued in 2023. The comment letter requested that the regulations clarify that they do not apply to plans exempted from ERISA or to participant transactions involving such plans. If the final regulations do not include this clarification, then the comment letter requests that the regulation state that set salary or other fixed compensation paid to individuals working directly for church benefit organizations or church plans does not constitute fees or other compensation for rendering investment advice and that the provision of information about rollovers, distribution options, and plan terms is investment education and not advice, provided the information does not include recommendations on specific fund investments. The final rule includes a provision stating that the provision of investment information or education without an investment recommendation does not qualify as advice for purposes of the final rule.

(b) Automatic Portability Transaction Regulations

SECURE 2.0 included a provision amending the Code to add a prohibited transaction exemption for fees and compensation received by a provider for services provided in connection with an automatic portability transaction. When an employee terminates employment with retirement benefits of $7,000 or less, the plan administrator can automatically roll over the benefits to a default IRA if permitted by the plan document and if certain requirements are satisfied. An automatic portability transaction is a transfer of assets from a default IRA to an active account in a defined contribution plan sponsored by the employee's new employer. The participant must be given notice of the transfer and not opt out.

The DOL issued proposed regulations on January 18, 2024.[27] The regulations focus on requirements for automatic portability providers.

(c) Information Collection Request on SECURE 2.0 Provision Establishing a Lost and Found Searchable Database

SECURE 2.0 added a provision to ERISA requiring the DOL to establish an online national searchable database that would reunite individuals with lost retirement plan assets. The DOL is required to establish the database by December 29, 2024.

In April, the DOL issued a notice proposing to request that ERISA plan administrators voluntarily provide certain information to the DOL that is needed to establish the database.[28] The DOL also proposes that this information would be submitted as an attachment to the 2023 Form 5500. The DOL requested comments on this proposal.

In response to comments, the DOL issued a revised proposal decreasing the amount of information that it will request ERISA plan administrators to voluntarily provide to create the database.[29] The DOL requested comments on the revised proposal, which was issued in September.

The lost and found searchable database provision does not apply to church plans because it only applies to plans to which the vesting standards of ERISA Section 203 apply. Although church plans are not subject to this provision, it is unclear whether church plans are permitted to access and contribute data to the database.

[27] 89 Fed. Reg. 5624 (Jan. 29, 2024).

[28] 89 Fed. Reg. 26,932 (April 16, 2024).

[29] 89 Fed. Reg. 74,291 (Sept. 12, 2024).

(d) Applications for Prohibited Transaction Administrative Exemptions

In January, the DOL issued a final rule on the procedures governing the filing and processing of applications for administrative exemptions from the prohibited transaction provisions of ERISA and the Code.[30] In the preamble, the DOL "notes, for clarity, that the term employee benefit plan also refers to governmental and church plans."

3. Joint-Agency Guidance

(a) Request for Information on Retirement Plan Reporting and Disclosure Requirements

SECURE 2.0 includes provisions requiring the Department of Treasury, DOL, and Pension Benefit Guaranty Corporation ("PBGC") to review the existing reporting and disclosure requirements for certain retirement plans under ERISA and the Code. These agencies are required to provide a report of their findings to Congress by December 29, 2025. In January, these agencies issued a request for information on the effectiveness of the reporting and disclosure requirements.[31] The information collected will assist these agencies in preparing the report to Congress.

C. Litigation Impacting Retirement Plans

1. ESG Litigation

In *Spence v. American Airlines, Inc*.,[32] an American Airlines pilot alleged that plan fiduciaries breached the duties of prudence and loyalty by investing in funds managed by BlackRock and others who engaged in conduct that pursues environmental, social, and governance ("ESG") objectives to the detriment of plan participants. The plaintiff cited consistent underperformance of ESG-focused investment managers compared to similarly situated funds due to investment managers casting proxy votes for ESG measures, among other reasons. The court rejected the defendants' motion to dismiss.

2. Church Plan Litigation

(a) AME Church Retirement Plan Litigation

During 2022, several class action lawsuits were filed against the African Methodist Episcopal Church, church officials, third-party service providers, and certain others alleging that the defendants breached their fiduciary duties by permitting a single individual to exercise unsupervised control in managing the plan assets of the African Methodist Episcopal Church Ministerial Retirement Annuity

[30] 89 Fed. Reg. 4678 (Jan. 24, 2024).

[31] 89 Fed. Reg. 4215 (Jan. 23, 2024).

[32] 2024 WL 733640 (N.D. Tex. Feb. 21, 2024).

Fund. This individual made illegal and risky investments involving self-dealing with what is alleged to be no oversight from the church or its ministers. As a result, the plan lost more than $90 million or about 75% of its assets.

The plaintiffs brought numerous ERISA and state law claims. In this case, the plaintiffs did not assert that the plan is an ERISA plan. Instead, the plaintiffs allege that the defendants agreed in numerous written plan documents provided to plaintiffs to govern the plan in accordance with ERISA. As a result, the plaintiffs allege the defendants should be held to ERISA standards in their management of the plan assets. The plaintiffs claim they are entitled to remedies under ERISA in addition to remedies under state law.

In 2023, the court ruled on several Motions to Dismiss filed by the Defendants.[33] On the ERISA claims, the court determined that ERISA does not govern the plan and dismissed these claims. The court made this determination based on the plain language of the plan (which states that it is a non-electing church plan), the fact that the amended complaint states that the church had not formally elected to be governed by ERISA, and certain concessions made by the parties at the motion hearing. The court also granted in part and dismissed in part several of the state law claims.

As would be expected in a case of this nature, everyone is suing everybody. The plan participants have sued, among others, the alleged perpetrator of the embezzlement, the Church and its leadership, the plan's recordkeeper (The Newport Group), the plan's auditor (Rodney Brown and Company), and the insurance company from whom $49 million in annuities were purchased by the perpetrator. Cross-actions have been filed by the Church against Symetra Life, the Newport Group, and Rodney Brown and Company, and those three cross-defendants have in turn sued the Church and each other.

A number of motions and cross-motions to dismiss were resolved by the Court, and the litigation is now proceeding to discovery, with a number of depositions having been scheduled. The next status hearing is set for December 2024.

In August, the African Methodist Episcopal Church and the plaintiffs entered into a contingent settlement agreement that is subject to court approval. Litigation continues against the remaining defendants.

(b) Diocese of Albany Litigation

The Roman Catholic Diocese of Albany, New York co-founded 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

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

workers. The plan was determined to be a church plan by the IRS in 1992. Thereafter, the corporation allegedly made inadequate contributions to the plan. In 2018, the corporation terminated the plan and informed participants that their benefits would either be reduced or ended in 2019. The corporation's board then filed a petition for judicial dissolution in which they stated that the corporation owed more than $50 million to the plan and had no assets to make the plan whole.

Former employees sued the corporation for breach of contract and breach of fiduciary duty. In 2021, the Supreme Court of New York denied the defendants' motions to dismiss.[34]

In 2022, the New York Attorney General filed another lawsuit against the Roman Catholic Diocese of Albany relating to the alleged mismanagement of the St. Clare's Hospital Retirement Income Plan.[35] The New York Attorney General claims the defendants violated their fiduciary duties under New York trust and exempt organizations laws by making the decision to remove the plan from the protections of ERISA by applying for church plan status and then failing to adequately fund the plan. The Attorney General is seeking full restitution from the defendants for their actions. This action has been consolidated with the action filed by former employees.[36]

In 2023, the Diocese filed Chapter 11 bankruptcy proceedings,[37] which automatically stayed all lawsuits filed against the Diocese. The Official Committee of Unsecured Creditors submitted a motion requesting a termination of the automatic stay so the state pension case could move forward. The Diocese did not oppose the motion. The court granted relief from the automatic stay so the state pension action could proceed in state court.[38]

The trial judge recently held a week-long mediation session in which he attempted to settle the non-bankruptcy case. The Diocese of Albany made a settlement proposal, but the creditor group representing sexual abuse victims in the Diocese's bankruptcy proceeding objected to the proposed settlement with the pension creditor group, and the proposed settlement fell through.

The next step in the case likely will be a hearing on motions for summary judgment that have been filed. However, the trial judge indicated during the recent mediation that he believes there are significant issues of fact before the court.

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

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

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

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

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

The bankruptcy judge has appointed two co-mediators to consider the settlement of all claims in the bankruptcy proceeding, and it is likely that they will also attempt to resolve the pension issue through settlement.

(c) Roberts v. Life Insurance Co. of N.A.

In *Roberts v. Life Insurance Co. of N.A.*,[39] the plaintiff brought a state law action against her former employer, Madonna Manor, and insurance carrier, Life Insurance Company of North America, for failing to pay benefits under a plan. The defendants removed the matter to federal court, arguing that the claims are preempted by ERISA. The plaintiff claimed that the case should be remanded to state court because the plan is a "church plan" that is exempt from ERISA.

The plaintiff argued that all plans maintained by church-affiliated organizations qualify as church plans that are exempt from ERISA. The court disagreed with the plaintiff's argument, determining that two types of plans are exempt from ERISA – plans established by a church or a convention or association of churches and plans maintained by principal-purpose organizations.

The plaintiff also argued that an organization can qualify as a principal purpose organization if one of its functions is administration of the plan, even if the administration of a plan is not the principal purpose of the organization. The court disagreed based on the plain language in the Code defining the term "principal purpose" organization and precedent analyzing whether the "principal purpose" of the organization is the administration or funding of an employee benefit plan. Accordingly, the court determined that the plan did not qualify as a church plan and dismissed the case without prejudice to allow the plaintiff the ability to file a new action asserting claims under ERISA.

3. Fiduciary Litigation

(a) Managed Accounts

Managed accounts provide a more personalized investment strategy to participants by considering additional information, such as current savings, risk tolerance, and expected retirement date. Because these accounts are more personalized, they generally charge a higher fee.

There have been several lawsuits filed in the past few years relating to managed accounts. Recently, one such lawsuit was filed against Bechtel Global Corporation alleging participants were harmed when they were defaulted into managed account services because they did not elect to use the managed account service or pay the higher fee.[40] In October, the district court dismissed this suit because the plaintiffs (i) failed to "plausibly allege a 'meaningful benchmark'" that

[39] *Roberts v. Life Ins. Comp. of N.A.,* et al., No. 2:23-129-DCR (E.D. Ky. Dec. 20, 2023).

[40] *Hanigan v. Bechtel Global Corp.*, No. 1:24-cv-00875 (E.D. Va. *filed* May 24, 2024).

shows the managed account fees are excessive when compared to the services provided and (ii) compared the "administrative costs" of the managed account plan (which includes both an administrative fee and a managed account fee) against just the administrative fee charged by five target date fund plans without indicating whether these plans charge additional account fees.[41] The court granted the plaintiff's motion for leave to file an amended complaint.

(b) Forfeitures

Several lawsuits have been filed in California challenging the use of forfeitures by 401(k) plan fiduciaries. Despite the fact that the IRS has determined otherwise, the plaintiffs allege that the plan fiduciaries violated ERISA by using the forfeitures to reduce future employer contributions rather than to benefit plan participants, such as by paying plan expenses that are otherwise charged to participant accounts. Motions to dismiss have been filed in multiple cases with at least one court denying the motion to dismiss and one court granting it with leave to amend.[42] The plaintiffs have refiled in the case where the motion to dismiss was granted.

4. U.S. Supreme Court Overturns 1984 Decision Requiring Courts to Defer to Agency Interpretations of Statutory Ambiguities

On June 28, 2024, the U.S. Supreme Court overturned its 1984 decision in *Chevron USA Inc. v. National Resources Defense Council, Inc.*[43] Under *Chevron*, a court was required to use a two-step framework when interpreting a statute administered by a federal agency. Under the first step, the court had to determine whether congressional intent is clear and, if it is, then the inquiry is over. Under the second step, if the court determines that the "statute is silent or ambiguous with respect to the specific issue," then the court must defer to an agency's interpretation of a statute as long as it "is based on a permissible construction of the statute." This became known as the *Chevron* doctrine.

In companion cases, *Loper Bright Enterprises v. Raimondo* and *Relentless, Inc. v. Dept. of Commerce*, the Court overturned the *Chevron* doctrine and 40-years of precedent, holding that the Administrative Procedure Act does not allow courts to defer to an agency interpretation of a statutory ambiguity.[44] Instead, courts must exercise their own independent judgment in deciding whether an agency acted within its statutory authority in interpreting the statute. This decision will have implications for statutes governing retirement and welfare plan issues.

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[41] *Id.* 2024 WL 4528909 (E.D. Vir. Oct. 18, 2024).

[42] *Perez-Cruet v. Qualcomm Inc.*, No. 23-cv-1890-BEN (MMP), 2024 WL 2702207 (S.D. Cal. May 24, 2024); *Hutchins v. HP Inc.*, 23-cv-05875-BLF, 2024 WL 3049456 (N.D. Cal. June 17, 2024).

[43] 467 U.S. 837 (1984).

[44] 144 S.Ct. 2244 (2024).

D. State Laws Impacting Retirement Plans

1. Church Alliance Initiatives

The Church Alliance has continued to monitor legislation at the state level impacting church retirement plans,[45] including ESG legislative proposals and state laws establishing automatic payroll deduction IRA savings programs. The state auto-enrollment programs are further discussed below in Section I.D.2 of this report.

2. 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.[46] States with implemented programs include California, Colorado, Connecticut, Illinois, Maryland, Oregon Virginia, and Maine. States with enacted but not implemented laws include Delaware, Hawaii, Minnesota, Nevada, New Jersey, New York, Vermont, Washington, and Rhode Island. Other states have similar legislation pending 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.*

The Virginia program also includes an FAQ on the website stating that "religious organizations" are exempt from the mandate. Some of the state-run automatic payroll savings programs also 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,

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

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

employers may be required to take action to file, report, or certify their exemption from the program. Generally, various penalties for non-compliance apply under the programs.

E. Other Guidance Impacting Retirement Plans

1. GAO Reports Impacting Retirement Plans

The U.S. Government Accountability Office ("GAO") has issued two reports in 2024 impacting retirement plans. In February, the GAO issued a report titled "Additional Federal Actions Would Help Participants Track and Consolidate Their Retirement Savings."[47] In April, the GAO issued a report titled "Department of Labor Should Update Guidance on Target Date Funds."[48]

In the February report, the GAO recommends that Congress grant authority to a federal agency to establish:

- A pension dashboard that allows plan participants to view information about all of their employer-sponsored retirement plans in one place.
- An electronic plan-to-plan rollover system that automatically transfers savings when an individual changes jobs, provided certain requirements are satisfied.[49]

The GAO also made four recommendations to federal agencies in the February report to assist 401(k) participants by improving the information they receive about options for retirement plan savings and the process that is required to consolidate their retirement savings after changing jobs.

In the April report, the GAO found that funds closer to the target date varied more in investment performance and risk when compared to funds farther from such date. Accordingly, the GAO recommends that the DOL update the guidance on target date funds that was issued more than a decade ago with more recent information so plan sponsors and participants can better understand the target date fund disclosures and risks.

2. American Academy of Actuaries Issue Brief on ERISA-Exempt Church-Sponsored Retirement Plans

In January, the American Academy of Actuaries published an Issue Brief titled "Church-Sponsored Retirement Plans – Overview and Considerations."[50] The brief discusses the impact of participating in a church plan that is not subject to the protections of ERISA, governance and fiduciary responsibilities, benefit funding, and how bankruptcy or termination of an underfunded church plan can expose participants to more harm since the plan is not covered by the PBGC. While ERISA exemption gives church plan sponsors

[47] *See* https://www.gao.gov/products/gao-24-103577.

[48] *See* https://www.gao.gov/products/gao-24-105364#summary_recommend.

[49] See Section I.B.2.b of this report.

[50] *See* https://www.actuary.org/sites/default/files/2024-01/pension-brief-church-plans.pdf.

more flexibility in funding and plan design, the brief states that it can also create potential drawbacks for participants in the areas of transparency and benefit security. By following the actuarial standards of practice ("ASOP"), the brief also states that actuaries can assist church plan sponsors in understanding "the current and future financial status of their plans and the impact of various decisions with regard to benefit levels, actuarial assumptions and contribution policies and amounts."

The Church Alliance is working with the American Academy of Actuaries so future reports and testimony by the Academy more accurately reflect church plan rules.

II. WELFARE PLAN GUIDANCE

A. Legislation and Legislative Updates Impacting Welfare Plans

Since the Annual Report was finalized, there have been several legislative proposals that would impact health and welfare plans. Proposed legislation has been issued in the following areas:

- Health Care Price Transparency: In December, the bipartisan Lower Costs, More Transparency Act (H.R. 5378) passed the House, and the bipartisan Health Care PRICE Transparency Act 2.0 (S. 3548) was introduced in the Senate. The bills are similar but not identical. Both of these bills include provisions making health care costs more transparent by requiring health care providers and insurers to disclose certain information about costs. While the Church Alliance generally supports the intent behind the bills and efforts to further transparency for plan participants, the Church Alliance is advocating for technical clarifications on how some provisions in the bill may intersect with church plans.

- PBM Reform: The Lower Costs, More Transparency Act (H.R. 5378) would require pharmacy benefit managers ("PBMs") to provide reports to health plan sponsors on spending, rebate, and fee information on covered drugs. The bill would also require PBM contracts to allow health plan fiduciaries to audit certain claims and cost information with no undue restrictions.

- Lower Health Care Costs: The Health Care Affordability Act of 2024 (H.R. 9774), which was introduced in the House in September, would lower the cost of health care premiums by increasing the tax credits that are available for Marketplace plans.

- Telehealth: In May, the House Energy and Commerce Subcommittee on Health passed the Telehealth Modernization Act of 2024 (H.R. 7623), and the House Committee on Ways and Means prepared a mark-up of the Preserving Telehealth, Hospital, and Ambulance Access Act (H.R. 8261). Both of these bills would extend through 2026 certain telehealth flexibilities for Medicare beneficiaries that were originally authorized during the COVID-19 pandemic. In September, the House Education and Workforce Committee also voted in favor of the Transparency Telehealth Bills Act (H.R. 9457) and the Healthy Competition for Better Care Act (H.R. 3120). The Transparency Telehealth Bill Act limits telehealth billing, and the Healthy Competition for Better

Care Act bans anticompetitive terms in facility and insurance contracts that limit access for lower cost and higher quality care.

- Health Care Sharing Ministries: In June, Representative Mike Kelly (R-PA) introduced the Health Care Sharing Ministry Tax Parity Act (H.R. 8776) to expand access to health care sharing ministries by allowing membership expenses to qualify for the deduction for medical expenses.

- American Privacy Rights Act (H.R. 8818): The American Privacy Rights Act would create a comprehensive federal consumer privacy network.

B. Regulatory Guidance and Other Initiatives Impacting Welfare Plans

1. Internal Revenue Service

(a) Expenses Treated as Medical Care

Amounts treated as medical care expenses under Code section 213(d) may be paid or reimbursed under a health flexible spending account ("FSA"), Archer medical savings account ("Archer MSA"), health reimbursement arrangement ("HRA"), or health savings account ("HSA"). Medical care expenses that are not paid or reimbursed under a health FSA, Archer MSA, HRA, or HSA may be included as an itemized deduction on a taxpayer's income tax return, provided certain requirements are satisfied.

On October 17, 2024, the IRS issued Notice 2024-71, which provides a safe harbor under which condoms will be treated as amounts paid for medical care under Code section 213. Accordingly, amounts paid for condoms are eligible to be reimbursed under a health FSA, Archer MSA, HRA, or HSA. In the alternative, amounts paid for condoms may be treated as deductible medical expenses under Code section 213, provided certain requirements are satisfied.

(b) HDHP Pre-Deductible Preventive Care Expenses

An individual is permitted to establish a tax-favored HSA under Code section 223, provided the individual is covered under a high deductible health plan ("HDHP") and has no disqualifying health coverage. Until the deductible is satisfied for a year, an HDHP is only permitted to provide benefits for preventive care services under Code section 223(c)(2)(C).

The IRS issued Notice 2024-75, expanding the types of preventive care expenses permitted to be covered under an HDHP. Effective December 30, 2022, the notice expands preventive care to include:

- All over-the-counter oral contraceptives for a covered individual potentially capable of becoming pregnant, including over-the-counter birth control pills and emergency contraceptives, regardless of whether the individual has a prescription.

- Male condoms, regardless of the gender of the individual covered under the HDHP who purchases them and regardless of whether they are purchased with a prescription.

The notice also clarifies that the following items are treated as preventive care under Code section 223(c)(2)(C):

- All types of breast cancer screening for individuals who have been diagnosed with breast cancer, including MRIs, ultrasounds, and similar screening services in addition to mammograms, and

- Continuous glucose monitors for individuals diagnosed with diabetes, if they measure glucose using a similar detection method as other glucometers (i.e., piercing the skin) and do not provide additional functions that are not preventive care.

Effective for plan years beginning after December 31, 2022, the notice also clarifies that the Code section 223(c)(2)(G) safe harbor for "selected insulin products" applies "without regard to whether the insulin product is prescribed to treat an individual diagnosed with diabetes or prescribed for the purpose of preventing the exacerbation of diabetes or the development of a secondary condition."

(c) Private Letter Ruling Permitting Employee Choice Among Various Pre-Tax Benefits

On May 20, 2024, the IRS issued Private Letter Ruling 202434006 approving a new benefit design under which employees are allowed to allocate an employer contribution among a 401(k) plan, retiree health reimbursement arrangement, health savings account, or educational assistance program. Although a private letter ruling may only be relied upon by the taxpayer who requested it, the ruling suggests that the IRS is open to approving programs providing employees with a choice of different benefits. The private letter ruling also does not address all aspects of the arrangement, including certain tax consequences and whether the program satisfies the applicable nondiscrimination requirements.

(d) Health Savings Account

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 2025.[51] The relevant amounts for 2025 are as follows:

Annual HSA contribution limit	**$4,300** – individual coverage *($150 increase)* **$8,550 –** family coverage *($250 increase)*

[51] Rev. Proc. 2024-25.

Catch-up contribution limit over age 55	**$1,000** *(no change)*
Maximum HDHP out-of-pocket limit	**$8,300** – individual coverage (*$250 increase*) **$16,600** – family coverage (*$500 increase*)
HDHP minimum deductible	**$1,650** – individual coverage (*$50 increase*) **$3,300** – family coverage (*$100 increase*)

(e) Employer Shared Responsibility Penalties and Affordability Percentage

On February 12, 2024, the IRS issued Revenue Procedure 2024-14, announcing the 2025 inflation amounts used to calculate the employer shared responsibility penalties established by the Patient Protection and Affordable Care Act ("ACA"). The 2025 penalty amounts are as follows:

Code § 4980H(a) penalty[52]	**$2,900 per full-time employees (less 30)** *($70 decrease)*
Code § 4980H(b) penalty[53]	**$4,350 per full-time employee receiving subsidized coverage from an exchange** *($110 decrease)*

The IRS also issued the adjusted employer mandate affordability percentage in Revenue Procedure 2024-35. 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 9.02% applies to plan years beginning in 2025 (which is increased from 8.39% for plan years beginning in 2024).

(f) Flexible Spending Account, QSEHRA, and Qualified Transportation Fringe Benefit Limits

The IRS has announced several inflation-adjusted items for 2025 under various provisions of the Code.[54] The relevant amounts for 2025 are as follows:

Annual contribution limit for Health Care FSA	**$3,300** *($100 increase)*

[52] The "(a)" penalty applies if an employer fails to offer minimum essential coverage to 95% of full-time employees (and their dependents), if a full-time employee receives subsidized coverage from an Exchange.

[53] The "(b)" penalty applies if an employer offers coverage that is not affordable or does not satisfy the minimum value regulations to full-time employees (and their dependents), if a full-time employee receives subsidized coverage from an Exchange.

[54] Rev. Proc. 2024-40.

Maximum cafeteria plan carryover amount (if permitted)	**$660** (*$20 increase*)
Annual contribution limit for Dependent Care FSA	**$5,000**[55] *(unchanged)*
Qualified Small Employer HRA ("QSEHRA") Payment and Reimbursement Limit	**$6,350** – individual coverage (*$200 increase*) **$12,800** – family coverage (*$350 increase*)
Monthly contribution fringe benefit exclusion limit for Qualified Mass Transportation and Qualified Parking under Code sections 132(f)(2)(A) and (B)	**$325** *($10 increase)*

2. Department of Labor

(a) Final Rule Rescinding Association Health Plan Rule

In 2018, the DOL issued final rules on association health plans, expanding the definition of "employer" under ERISA for purposes of providing health care benefits.[56] The change would have expanded the use of association health plans.

In March of 2019, a federal district judge struck down a key part of the rules, stating that they are an "end run" around the ACA and ignore the language and purpose of ERISA and the ACA.[57] The DOL issued a statement regarding the district court ruling on April 29, 2019.[58] In the statement, the DOL stated that it will not pursue enforcement actions for violations stemming from good faith actions taken before the district court's decision in reliance on the final rules, provided that plans pay health benefit claims as promised. In addition, the statement provides that the DOL will not take action against existing association health plans for continuing to provide benefits to members who enrolled in good faith prior to the district court decision through the end of the plan year or contract term that was in effect at the time of such decision.

In April, the DOL issued a final rule formally rescinding the rule issued in 2018.[59] Because of the DOL statement issued after the 2019 district court ruling,

[55] 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.

[56] 83 Fed. Reg. 28,912 (June 21, 2018). *These regulations do not apply to plans that are not subject to ERISA, such as non-electing church plans*. However, we mention this because of their similarity to the multiple employer nature of church health care plans.

[57] *New York v. United States Department of Labor*, 363 F. Supp.3d 109 (D.D.C. 2019).

[58] *See* https://www.dol.gov/newsroom/releases/ebsa/ebsa20190429.

[59] 89 Fed. Reg. 34,124 (April 30, 2024).

the DOL states that it is not aware of any association health plans that exist today in reliance on the 2018 rule. Accordingly, the rescission of the 2018 rule should have limited impact.

(b) DOL Updates Cybersecurity Guidance

On September 6, 2024, the DOL issued Compliance Assistance Release No. 2024-01, updating the cybersecurity guidance it issued in April 2021.[60] The updated guidance confirms that the 2021 guidance applies to all ERISA-covered employee benefit plans, including health and welfare plans.

3. Department of Health and Human Services

(a) Section 1557 Final Rules

In May, the Department of Health and Human Services ("HHS") released a final rule 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.[61] The final rule largely restores the Obama Administration's section 1557 regulations (which the Trump Administration had scaled back). The final rule does not apply directly to self-insured plans, but they do apply to insurers and third-party administrators ("TPAs") that administer self-insured plans, if they receive direct or indirect Federal financial assistance. The final rule was generally effective July 5, 2024, with delayed effective dates for certain provisions. The provisions relating to nondiscrimination in health coverage are effective the first day of the first plan year beginning on or after January 1, 2025.

The final rule:

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

- Provides that "discrimination on the basis of sex" includes discrimination based on sex stereotypes, sex characteristics, pregnancy or related conditions, sexual orientation, and gender identity (a follow up to the Supreme Court's 2020 decision in *Bostock v. Clayton County*).

- Reinstates and expands notice requirements and requires covered entities to put in place new policies and procedures, including grievance procedures, on section 1557 and to train employees. The final rule also

[60] *See* https://www.dol.gov/agencies/ebsa/key-topics/retirement-benefits/cybersecurity/compliance-assistance-release-2024-01.

[61] 89 Fed. Reg. 37,522 (May 6, 2024). HHS also issued FAQs on the final rule, which are located here: https://www.hhs.gov/civil-rights/for-individuals/section-1557/faqs/index.html.

requires covered entities to review and revise the policies and procedures, as necessary, to ensure they comply with section 1557 and the final rules.

- Clarifies "nothing in section 1557 shall be construed to have any effect on Federal laws regarding conscience protection; willingness or refusal to provide abortion; and discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion."

- Provides a means for covered entities to notify HHS that the entity believes it is exempt from the final rule because of federal conscience or religious freedom laws, including the Religious Freedom Restoration Act ("RFRA"). The final rule also strengthens this process.

- Interprets the phrase "health program or activity" broadly to include providing or administering health-related services. However, the final 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.[62]

- Applies the nondiscrimination protections to the use of telehealth and patient care decision support tools.

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 originates with a self-insured plan.

Three district courts have issued preliminary injunctions prohibiting enforcement of the final rule as follows:

- A Florida district court issued an injunction for Florida that applies only to the portions of the rule that extend sex discrimination to include gender identity.[63] In August, HHS appealed the injunction to the Eleventh Circuit.

[62] In 2023, the Church Alliance submitted a comment letter on the proposed rule. 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. Both of these requests were addressed in the final rule.

[63] *State of Florida v. HHS*, No. 8:24-cv-1080-WFJ-TGW (M.D. Fla. July 30, 2024).

- A Texas district court issued an injunction for Texas and Montana delaying the effective date of the entire final rule.[64]

- A Tennessee district court issued a nationwide injunction only for the portions of the final rule that extend sex discrimination to include gender identity.[65] In August, HHS appealed the injunction to the Fifth Circuit.

In March 2024, a federal district court in North Dakota also issued a permanent injunction blocking HHS and the EEOC from enforcing certain agency interpretations of ACA Section 1557 and Title VII of the Civil Rights Act against a Christian employer organization. This decision is further discussed in Section II.D.2 of this report.

(b) Final Amendments to HIPAA Privacy Rule to Support Reproductive Health Care Privacy

In April, HHS issued final rules[66] modifying the Health Insurance Portability and Accountability Act ("HIPAA") privacy rule to limit the uses and disclosures of protected health information ("PHI") about reproductive health care that is provided under lawful circumstances. Specifically, the final rules prohibit covered health care providers, health plans, or health care clearinghouses (or their business associates) from using or disclosing PHI for any of the following purposes:

- To conduct a criminal, civil, or administrative investigation into or impose criminal, civil, or administrative liability on any person for seeking, obtaining, providing, or facilitating reproductive health care that is provided under lawful circumstances.

- To identify any person for the purpose of conducting the investigation or imposing liability.

A covered entity or business associate must obtain a valid attestation before disclosing PHI "potentially related" to reproductive health care when the request for PHI is for health oversight activities, judicial and administrative proceedings, law enforcement purposes, and disclosures to coroners and medical examiners. The attestation must be written, signed, and satisfy the other conditions explained in the final rule. HHS plans to issue model attestation language.

PHI may be disclosed without an individual's authorization only where the use or disclosure is expressly permitted or required by the privacy rule, such as certain disclosures for law enforcement purposes. These disclosures are only

[64] *State of Texas and State of Montana v. Becerra*, No. 6:24-cv-211-JDK (E.D. Tex. July 3, 2024).

[65] *State of Tennessee v. Becerra*, No. 1:24cv161-LG-BWR (S.D. Miss. July 3, 2024).

[66] 89 Fed. Reg. 32,976 (April 26, 2024).

permitted where the disclosure is not subject to the prohibition, the disclosure is required by law, and the disclosure satisfies all requirements of the privacy rule.

The final rule also requires changes to the content of the HIPAA Notice of Privacy Practices that covered entities must provide to individuals and post on their website and at physical locations. The Notice must be updated by February 16, 2026.

The final rule is effective June 25, 2024, but covered entities have until December 23, 2024 to comply with the final rule (with the exception of changes to the HIPAA Notice of Privacy Practices as discussed above).

(c) Final Rule on Conscience and Religious Nondiscrimination

Federal law includes several provisions known as "conscience provisions," which prohibit recipients of federal funds from forcing individuals and entities in the health care field to participate in actions they find objectionable on a religious or moral basis. In January, HHS issued a final rule[67] aimed at safeguarding protections for health care workers with conscience-based objections to providing care while protecting access to necessary medical services.

(d) Health Plan Cost-Sharing Limits for 2025

HHS has announced the maximum annual limits on cost-sharing that apply to non-grandfathered plans for 2025.[68] The relevant amounts for 2025 are as follows:

Self-Only Coverage	**$9,200** *($250 decrease)*
Other than Self-Only Coverage	**$18,400** *($500 decrease)*

4. Joint-Agency Guidance

(a) Final Mental Health Parity Rules

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

[67] 89 Fed. Reg. 2078 (Jan. 11, 2024).

[68] *See* https://www.cms.gov/files/document/2025-papi-parameters-guidance-2023-11-15.pdf.

requirements or treatment limitations imposed on substantially all of the medical/surgical benefits in the same classification.

For this purpose, there are six benefit classifications – (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. In addition, "treatment limitations" include both quantitative treatment limitations, which are expressed numerically (e.g., 50 outpatient visits per year), and nonquantitative treatment limitations ("NQTLs"), which otherwise limit the scope or duration of benefits for treatments under the plan, such as medical management standards limiting or excluding benefits based on medical necessity.

The Consolidated Appropriations Act, 2021 ("CAA 2021") amended the Mental Health Parity Act to require group health plans and insurers to provide to federal and state agencies – upon request – a comparative analysis of NQTLs related to mental health and substance abuse disorder benefits. The IRS, DOL, and HHS (the "Agencies") issued mental health parity reports to Congress in 2022 and 2023, both of which stated that all of the NQTL comparative analyses that were submitted contained insufficient information to show compliance with the mental health parity requirements.

In September, the Agencies issued final rules relating to the Mental Health Parity Act. Among other clarifications and revisions, the final rules:[69]

- Add a new purposes section stating plans may not design or apply financial requirements or treatment limitations that impose a greater burden on access to mental health or substance use disorder benefits than they impose on medical/surgical benefits in the same classification of benefits.

- Require the terms of the plan to define a mental health condition or substance use disorder in a manner that is consistent with generally recognized independent standards of current medical practice and to include all mental health conditions or substance use disorders covered under the plan that are listed in the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders.[70]

- Clarify that autism spectrum disorder ("ASD"), anorexia nervosa, bulimia nervosa, and binge-eating disorder are considered mental health conditions.

[69] 89 Fed. Reg. 77,586 (Sept. 23, 2024).

[70] If generally recognized independent standards of current medical practice do not address whether a condition is a mental health condition or substance use disorder, plans may define the condition or disorder in accordance with applicable federal or state law.

- Provide that a plan may not impose any NQTL on mental health or substance use benefits in any classification that is more restrictive (as written or in operation) than the predominant NQTL that applies to substantially all the medical/surgical benefits in the same classification. A plan does this by satisfying two requirements:[71]

    - Design and application requirement: Processes, strategies, evidentiary standards, and factors (as defined in the final rule) used in designing and applying an NQTL to mental health and substance use disorder benefits in a classification must be comparable to and applied no more stringently than those used in applying the NQTL to medical/surgical benefits in the same classification. Plans are also prohibited from relying on discriminatory factors or evidentiary standards that are "biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits."

    - Relevant data evaluation requirement: Plans must collect data necessary to assess the impact of an NQTL on access to benefits, such as the percentage of claim denials and network composition information.[72] The final rule also includes guidance on how to comply with this requirement if a plan imposes an NQTL for which no data exists or imposes a new NQTL for which it does not yet have the required data.

- Include an illustrative, non-exhaustive list of NQTLs.

- Clarify that material differences in access to mental health benefits in a classification will be considered a strong indicator of noncompliance and, if the relevant data suggests material differences, requires the plan take reasonable action to address the material differences to ensure compliance in operation and to document such actions.

- Provide that plans may not apply a separate treatment limitation only to mental health or substance use disorder benefits and not to medical/surgical benefits in the same classification.

- Require plans that provide benefits for mental health condition or substance use disorder in any benefits classification to provide

[71] The final regulations remove the proposed mathematical "substantially all" and "predominant" tests for NQTLs and replace them with the design and application requirements and the relevant data evaluation requirements.

[72] The preamble indicates that the Agencies intend to issue additional guidance on this requirement in the future. Until additional guidance is issued, the Agencies expect a plan with a typical design to collect and evaluate data that is relevant for most NQTLs.

meaningful benefits for that condition or disorder in every classification in which meaningful medical/surgical benefits are provided.[73]

The final rules also provide guidance on the requirement that health plans conduct comparative analyses of the design and application of each NQTL. Specifically, the final rules specify the content required for the comparative analysis, the steps the Agencies will take to request a comparative analysis, and the review process and required timeframes. Plans are also required to make a copy of the comparative analysis available when requested by any applicable state authority, a participant, beneficiary, or enrollee who receives an adverse benefit determination, and participants and beneficiaries in ERISA-covered plans at any time. The final rules include a provision requiring a plan fiduciary to certify that the fiduciary engaged in a prudent process to select one or more qualified service providers to perform and document a comparative analysis and monitored those service providers.

The final rules are generally effective for group health plans on the first day of the first plan year beginning on or after January 1, 2025, except for the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the related requirements in the provisions governing comparative analyses. The latter requirements are effective on the first day of the first plan year beginning on or after January 1, 2026.

(b) Final Rule on Essential Health Benefits

HHS and the Department of Treasury finalized a regulation on essential health benefits ("EHBs") on April 2, 2024 that will likely have implications for certain drug manufacturers' assistance programs.[74] The new rule provides that prescription drugs covered under a plan in excess of those covered by a State's EHB-benchmark plan must be considered EHBs.

Because they are EHBs, benefits for those prescription drugs would be subject to EHB protections, including the annual limitation on cost sharing and the prohibition on lifetime and annual limits (with certain exceptions). This new EHB rule only applies to individual and small group market plans. However, in the preamble to the regulation and in an FAQ released on the same date,[75] the government states that it intends to address large group and self-funded plans in separate rule-making that would align the standards applicable to large group

[73] Mental health and substance use disorder benefits are "meaningful" if they cover a core treatment for a condition or disorder in each classification in which the plan provides benefits for a core treatment for medical/surgical procedures.

[74] 89 Fed. Reg. 26,218 (April 15, 2024). The preamble to the regulation also indicates that a new proposed regulation will specifically address "copay assistance programs."

[75] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-66.

market health plans and self-insured group health plans with those applicable to individual and small group market plans.

(c) No Surprises Act – IDR Update

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

There were several cases filed in the Eastern District of Texas challenging the implementation of the IDR process under the name *Texas Medical Association, et al. v. HHS ("TMA").* The court in one decision vacated an increase to the IDR administrative fee and the IDR procedures on "batching" related claims in a single IDR proceeding because these changes were made without notice and comment and were arbitrary and capricious.[76] As a result of the decisions, the Agencies temporarily suspended the IDR process.[77] The IDR process was fully reopened in December 2023.

In December, the Agencies issued final rules providing guidance on the fees for the IDR process, which:

- State that the administrative fee charged by the Agencies to use the Federal IDR process and the ranges for certified IDR entity fees for single and batched determinations will be set by the Agencies through notice and comment rulemaking rather than in guidance published annually.

- Provide for an administrative fee to participate in the IDR process of $115 per party ($50 previously).

- Determine the certified entity IDR fees range for single determinations ($200 to $840) and batched determinations ($268 to $1,173).[78]

In November 2023, the Agencies issued FAQ guidance on how the batching requirements apply to qualified IDR items and services for disputes eligible for IDR after the August 3, 2023 (i.e., the date of the court order vacating these

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

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

[78] 88 Fed. Reg. 88,494 (Dec. 21, 2023). Technical corrections to the final rules was published in the Federal Register in January. 89 Fed. Reg. 4547 (Jan. 24, 2024).

requirements).[79] Until additional guidance is issued, disputes eligible for IDR should be submitted in a manner consistent with the statutes and regulations that remain in effect after the *Texas Medical Association* cases. The statute states that items and services may be batched and considered jointly only if they are "related to the treatment of a similar condition." In addition, air ambulance services for a single transport may, but are not required to be, submitted as a batched dispute.

The Agencies also issued a notice in January reopening the comment period for the proposed rule that appeared in the November 3, 2023 issue of the Federal Register.[80] The proposed rule would require plans to include new information with the initial payment or notice of payment denial, including claim adjustment reason codes and remittance advice remark codes under certain circumstances.[81] The proposed rules would also amend certain requirements relating to the Federal IDR process, including the open negotiation period, initiation, eligibility review, the payment and collection of administrative fees and certified IDR entity fees, bundled payment arrangements, requirements relating to batched items and services, and the rules for extensions of time due to extenuating circumstances. The rules also propose to require plans to register in the Federal IDR portal.

(d) No Surprises Act – Update on the Qualifying Payment Amount

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

In one of the *Texas Medical Association, et al. v. HHS* cases challenging the implementation of the IDR process, the court vacated certain provisions of the 2021 interim final rule governing how payers should calculate the QPA for items and services.[82] In October 2023, the Agencies issued FAQ guidance[83] as a result of these cases. Among other guidance, the FAQs state that plans should calculate QPAs using a "good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect after the . . . decision." The FAQs also state that the Agencies will "exercise their enforcement discretion" for plans that continue to rely on QPAs calculated in accordance with the 2021 interim final rules for items and services furnished before May 24, 2024. On May 1, 2024, the Agencies issued

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

[80] 89 Fed. Reg. 3896 (Jan. 22, 2024).

[81] 88 Fed. Reg. 75,744 (Nov. 3, 2023).

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

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

FAQ guidance extending the May 24, 2024 date to November 1, 2024.[84] The FAQ guidance states that the Agencies do not expect to extend further this enforcement relief.

(e) Final Regulations on Fixed Indemnity Coverage

The Agencies issued a final rule impacting employer-provided fixed indemnity coverage. Fixed indemnity insurance (such as hospital indemnity coverage) pays a set cash amount following a health event.[85] Structured properly, it can qualify as independent, non-coordinated coverage that is an excepted benefit and, as such, not subject to most group health plan mandates.

The final rule adds a new consumer notice requirement for employer-provided fixed indemnity plans to highlight that the product does not constitute comprehensive coverage. Plans and issuers must prominently display the notice in marketing, application, and enrollment (and reenrollment) materials. The final rule did not address the following topics that were in the proposed rule:

- Amendments to the payment standards and the non-coordination requirements necessary for maintaining excepted benefit status.

- Clarifications regarding the taxable status of payments from employer-provided fixed indemnity plans and related substantiation requirements.

(f) Guidance on County Data for Culturally and Linguistically Appropriate Services

The ACA requires non-grandfathered group health plans (*including non-grandfathered church plans*) to provide certain notices relating to claims and appeals in a culturally and linguistically appropriate manner. Group health plans (*including church plans*) must also provide the summary of benefits and coverage and uniform glossary ("SBC") in a culturally and linguistically appropriate manner. Specifically, plans subject to these requirements must provide (1) oral language services (e.g., a telephone assistance hotline) including answering questions and providing assistance with filing claims and appeals in any applicable non-English language, (2) notices or SBCs in any applicable non-English language upon request, and (3) a statement in English versions of the notice or SBC that is prominently displayed in any applicable non-English language explaining how to access the plan's language services.

A language qualifies as an applicable non-English language if 10% or more of the population residing in the county to which the notice or document is sent is literate only in the same non-English language, based on census data. At the end of 2023, the Agencies issued updated guidance on the counties that exceed the 10%

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

[85] 89 Fed. Reg. 23,338 (April 3, 2024).

threshold. Effective for plan years beginning on or after January 1, 2025, plans are required to begin providing notices and SBCs in accordance with the updated guidance.[86] The Agencies also intend to update the following documents:

- SBC template and sample SBCs in English with updated taglines in applicable non-English languages,
- Additional translated versions of the SBC and uniform glossary, and
- Model notices for internal claims and appeals and external review with updated taglines in applicable non-English languages.

(g) FAQ Guidance on Coverage of Preventive Services

Subject to any available exemption or accommodation, non-grandfathered group health plans and issuers that are subject to the preventive services mandate must provide specified contraceptive coverage without cost-sharing. In addition to meeting prior guidance compliance standards, FAQ guidance issued on January 22, 2024 clarifies that plans and issuers can ensure compliance with contraceptive coverage requirements by using a "therapeutic equivalent approach."[87]

For example, a plan covers several oral contraceptives approved by the U.S. Food and Drug Administration ("FDA") without cost sharing. At the same time, the plan may exclude coverage for certain oral contraceptives where there is a therapeutic equivalent that is covered without cost sharing. This allows the plan to exclude certain brand-name drugs as long as a therapeutically equivalent drug, such as a generic, is covered without cost sharing. Plans and issuers utilizing a "therapeutic equivalent approach" must also make available an "exceptions" process, which is distinct from the appeals process.

The Agencies have issued a letter warning health plan sponsors and insurers to make sure their plans comply with the contraceptive coverage mandate and outlining steps plan sponsors and insurers can follow to ensure compliance and avoid future enforcement actions.

(h) FAQ Guidance on the Transparency in Coverage Final Rules

In 2020, the Agencies jointly issued final regulations[88] requiring most group health plans to make disclosures to participants, beneficiaries, enrollees, and, under

[86] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-63 and https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/clas-county-data-2023.pdf.

[87] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-64.

[88] 85 Fed. Reg. 72,158 (Nov. 12, 2020).

certain circumstances, the public. The preamble to the final regulations also states that the final regulations do not apply to "Denominational Health Plans."

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

The final regulations permit the cost-sharing disclosure for an item or service on the internet-based self-service tool to be accurate at the time the request is made. The cost-sharing estimate is usually based on contracted rates, but plans are permitted to use "advanced analytics such as past claims data to provide more accurate cost estimates." If a rate is not negotiated as a prospective dollar rate (e.g., percentage-of-billed-charges arrangements), cost estimates must be based only on past claims data.

In February, the Agencies issued FAQ guidance on compliance with the cost-sharing disclosure requirement for items and services with extremely low utilization where the cost estimate is based on claims data (rather than prospective rates).[89] In this case, the Agencies will likely exercise their discretion not to bring enforcement actions against plans that fail to include a cost estimate for items and services for which a cost estimate would need to be based on past claims data and for which there have been fewer than 20 claims over the past three years. The self-service tool should indicate that the item or service is covered but that a specific cost estimate is not available because of insufficient data and that the participant should contact the plan for more information.

(i) Proposed Regulations on Preventive Service Benefits, Including Contraceptive Coverage

In October, the Agencies issued a proposed rule expanding the types of contraceptive coverage that health plans are required to cover without cost sharing. Currently, a health plan is required to cover over-the-counter contraceptive items only if such items are prescribed by a physician. The proposed rule would remove the prescription requirement so that health plans would be required to cover over-the-counter emergency contraception and the FDA-approved oral contraceptive that is available for use without a prescription and without cost sharing. The rule would also require plans to cover all FDA-approved contraceptive drugs or drug-led combination products without cost sharing, other than those items for which the plan covers at least one therapeutic equivalent without cost sharing. The proposed

[89] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-65.

rules would not modify the current federal conscience protections or religious and moral exemptions from the contraceptive coverage requirements.

Under the proposed rule, plans would be required to add a disclosure to the results of any search on a transparency in coverage self-service tool.[90] The disclosure would explain that over-the-counter contraceptive items are covered without a prescription or cost sharing and include a phone number and internet link to additional information about the plan's contraceptive benefits.

The proposed rule would also provide that a plan's medical management technique is not reasonable unless it provides an easily accessible, transparent, and sufficiently expedient exceptions process. The exceptions process must allow an individual to receive coverage without cost sharing for a medically necessary preventive service, as determined by the provider, even if that service is not generally covered under the plan.

(j) FAQ Guidance on the Preventive Care Services and the Women's Health and Cancer Rights Act

On October 21, 2024, the Agencies issued FAQ guidance on the coverage of preventive care services under the ACA and the Women's Health and Cancer Rights Act.[91] The FAQs provide guidance on:

- The changes plans must make to comply with the 2023 recommendations of the United States Preventive Services Task Force for Pre-Exposure Prophylasis (PreP), an HIV prevention medication. The changes must be made for plan years beginning on or after August 31, 2024. See Section II.D.3 of the report for information about litigation impacting this preventive service requirement.

- Coding for recommended preventive items and services to ensure individuals receive the required preventive service items without cost sharing. The FAQ guidance also includes examples to illustrate the guidance it includes on proper coding for preventive care items and services.

- The Women's Health and Cancer Rights Act, including that breast reconstructive services covered under the plan in connection with a mastectomy must include "coverage for chest wall reconstruction with aesthetic flat closure, if elected by the patient in consultation with the attending physician."

[90] The preamble to the final regulations on the transparency in coverage requirements states that the final regulations do not apply to "Denominational Health Plans." 85 Fed. Reg. 72,158 (Nov. 12, 2020).

[91] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-68.pdf.

C. Other Welfare Plan Guidance

1. House Education and Workforce RFI on ERISA Health Plans

On January 22, 2024, the House Committee on Education and the Workforce issued a request for information to members of the employee health benefits community in light of the 50th anniversary of ERISA's enactment.[92] According to the letter, "the Committee is seeking feedback on ways to build upon and strengthen ERISA, the foundation of employer-sponsored health care." Specifically, the letter requests information in the areas of preemption, fiduciary requirements, reporting requirements, prohibited transactions, data sharing, cybersecurity, direct and indirect compensation, expanding the role of the ERISA Advisory Council, the medical loss ratio, COBRA and portability, and specialty drug coverage.

D. Litigation Impacting Welfare Plans

1. Fee Litigation

Recent group health plan fiduciary litigation has centered around service provider fees and health care costs, including fees charged by PBMs. These cases follow years of litigation in the retirement plan area in which the plaintiffs have alleged 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.

Group health plan fee litigation now has the attention of the plaintiffs' bar, including plaintiffs' class action firms. There are several distinctions between retirement plan fees and group health plan fees. Retirement plan fees have far greater transparency than group health plan fees. There are also fewer distinct benefits in a retirement plan. Group health plans include many more types of fees and costs (and service providers). The source of fees (direct versus indirect) is also important.

In February, a proposed class action lawsuit was filed against Johnson & Johnson and its Benefits Committee alleging that the employer and fiduciaries breached their ERISA fiduciary duty by overpaying its PBM for prescription drugs, which resulted in higher premiums and out-of-pocket costs for employees.[93] Motions to dismiss have been filed.

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[92] *See* https://edworkforce.house.gov/uploadedfiles/1.22.24_erisa_rfi_final_1.22.2024.pdf.

[93] *Lewandowski v. Johnson & Johnson, et al.*, No. 3:24-cv-00671 (D.N.J. *filed* Feb. 5, 2024).

The *Navarro v. Wells Fargo, et al*.[94] case was filed on June 30, 2024. The complaint closely tracks that of the Johnson & Johnson lawsuit and focuses mostly on prescription drug costs and related fees.[95]

The same class action law firm is behind both lawsuits, and both lawsuits involve the same PBM and consultant. Neither the PBM nor consultant is named as a defendant.

2. Section 1557 Litigation

In March of 2024, a federal district court in North Dakota issued a permanent injunction blocking HHS and the EEOC from enforcing certain agency interpretations of ACA Section 1557 and Title VII of the Civil Rights Act against a Christian employer organization.[96]

Title VII bans employers with 15 or more employees from engaging in sex discrimination. Section 1557 prohibits sex discrimination in "any health program or activity." The EEOC has long interpreted Title VII to protect against gender identity discrimination, a position supported by the U.S. Supreme Court's *Bostock* decision.[97]

Section 1557 regulations issued in 2020 repealed significant portions of earlier regulations, including protections based on gender identity and termination of pregnancy. However, the EEOC issued guidance granting employment protections based on sexual orientation or gender identity, and HHS announced that it would continue to interpret Section 1557 as applying to discrimination based on sexual orientation and gender identity.

Christian Employers Alliance sued EEOC to challenge these interpretations. In 2022, the court issued a preliminary injunction that enjoined HHS from interpreting or enforcing Section 1557 and its regulations against the organization, its health plans, insurers, or TPAs. The EEOC was also enjoined from interpreting or enforcing Title VII against the organization, its plans, insurers, or TPAs. The court has now issued a permanent injunction, concluding, among other things, that the organization has shown that these agencies have substantially burdened a sincere religious exercise or belief.

HHS also issued final regulations in 2024 that are further discussed in Section II.B.3.a of this report.

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[94] No. 0:2024cv03043 (D. Minn. *filed* July 30, 2024).

[95] Unlike the Johnson & Johnson lawsuit, the Wells Fargo complaint alleges that the plan's fiduciaries engaged in a prohibited transaction for failure to satisfy ERISA's new group health plan covered service provider compensation disclosure requirements (effective for contracts entered into, extended, or renewed after December 27, 2021). See ERISA Section 408(b)(2)(B).

[96] *Christian Employers Alliance v. EEOC*, No. 1:21-cv-195, 2024 WL 935591 (D.N.D. March 4, 2024).

[97] *Bostock v. Clayton Cnty., Ga.*, 140 S. Ct. 1731 (2020).

3. ACA Preventive Services Litigation

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

- The United States Preventive Services Taskforce ("USPSTF") recommended preventive services rated "A" or "B."
- Immunizations recommended by the Centers for Disease Control ("CDC") and Advisory Committee on Immunization Practices ("ACIP").
- Any additional preventive care and screenings for women not recommended by the USPSTF but provided for in the HRSA guidelines.
- Preventive screenings and care for infants, children, and adolescents that are provided for in the Health Resources and Service Administration ("HSRA") guidelines.

In *Braidwood Management Inc. v. Becerra,*[98] Braidwood Management, Inc., a Christian-owned business, and six individuals brought an action in 2022 asserting that (1) providing the USPSTF with authority to establish certain preventive services requirements under the ACA was unconstitutional; and (2) the ACA preventive services requirement to cover the PrEP (pre-exposure prophylaxis) HIV prevention medication violates the plaintiff's rights under RFRA. The district court determined that the USPSTF was improperly allocated authority to establish preventive service requirements and the PrEP mandate violates Braidwood Management's rights under RFRA.

On March 30, 2023,[99] the same judge enjoined enforcement of the ACA requirement to cover USPSTF preventive services with "A" or "B" ratings issued on or after March 23, 2010. This ruling does not impact the requirement to cover USPSTF preventive services that were recommended before that date or the requirement to cover the other categories of preventive services.

The government appealed,[100] and the Fifth Circuit stayed enforcement of the order enjoining the ACA requirement to cover USPSTF preventive services with "A" or "B" ratings while the appeal is decided.[101]

In June, the Fifth Circuit affirmed the district court's decision that providing the USPSTF with authority to establish certain preventive services requirements under the

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

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

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

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

ACA was unconstitutional.[102] However, the Fifth Circuit did not agree with enjoining the requirements nationwide and determined that the government could enforce the requirement only as to the plaintiffs in the case. The Fifth Circuit also remanded the plaintiffs' cross appeal that the ACIP and HRSA preventive care recommendations are unconstitutional because these arguments were presented for the first time on appeal.

The government filed a Petition for Writ of Certiorari with the U.S. Supreme Court on September 19, 2024.[103] The district court entered a stay pending Supreme Court proceedings.[104]

4. U.S. Supreme Court Decision on Abortion Drug Litigation

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

In *Alliance for Hippocratic Medicine v. FDA*,[105] physicians and physician associations filed a case in a Texas district court challenging the FDA's approval of mifepristone. In 2023, the district court blocked the FDA's approval of mifepristone. On appeal, the Fifth Circuit[106] ruled to allow mifepristone to remain available but to reinstate the FDA's more burdensome pre-2016 REMS for obtaining the drug. The Department of Justice filed a writ of certiorari with the U.S. Supreme Court. The Fifth Circuit decision was stayed and mifepristone remained available under the FDA's current REMS while the U.S. Supreme Court case proceeded.[107]

In June, the U.S. Supreme Court determined that the plaintiffs did not have standing to sue.[108] According to the Court,

> The plaintiffs have sincere legal, moral, ideological, and policy objections to elective abortion and to FDA's relaxed regulation of mifepristone. But under Article III of the Constitution, those kinds of objections alone do not establish a justiciable case or controversy in federal court. Here, the plaintiffs have failed to demonstrate that FDA's relaxed regulatory requirements likely would cause them to suffer an injury in fact.

Accordingly, the Court reversed the Fifth Circuit's decision.

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[102] *Id.*, 104 F.4th 930 (5th Cir. June 21, 2024).

[103] *Id.*, *petition for cert. filed*, *Becerra, et. al v. Braidwood Mgmt., Inc*. (U.S. Sept. 19, 2024).

[104] Case No. 4:20-cv-00283-O (N.D. Tex. Aug. 29, 2024).

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

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

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

[108] *FDA v. Alliance for Hippocratic Medicine*, 144 S. Ct. 1540 (2024).

5. Roman Catholic Diocese of Albany v. Vullo

The New York Department of Financial Services has a regulation requiring employer health insurance policies providing hospital, surgical or medical expense coverage to include coverage for medically necessary abortions. The Roman Catholic Diocese of Albany filed a case challenging the regulation's exemption for "religious employers" as being too narrow and violating the First Amendment rights of certain types of religiously affiliated employers that do not satisfy the definition.[109] In 2024, a New York Court of Appeals determined that neither the abortion regulation nor the "religious employer" exemption violate the Free Exercise clause. In September, the Roman Catholic Diocese of Albany filed a Petition for Writ of Certiorari with the U.S. Supreme Court.[110]

6. U.S. Supreme Court Overturns 1984 Decision Requiring Courts to Defer to Agency Interpretations of Statutory Ambiguities

This decision impacts both retirement and welfare plans and was summarized in the Retirement Plan Guidance section of this Mid-Year Report. See Section I.C.4 for a summary of this decision.

7. Litigation on Copay Accumulators

In 2023, a district court set aside key parts of a 2021 rule permitting plans to exclude prescription drug manufacturer copay assistance from a participant's out-of-pocket maximum.[111] This practice is sometimes referred to as a copay accumulator program. The case reinstated the 2020 version of the rule, which allows plans to exclude prescription drug manufacturer copay assistance from a participant's out-of-pocket maximum only for brand name drugs that have a medically-appropriate generic available.

HHS initially appealed the decision and indicated that, until it issues further guidance, it does not intend to initiate enforcement action against group health plans that continue to follow the 2021 rule. In January, HHS withdrew its appeal.

8. Litigation on Excluding Coverage for Gender-Affirming Care

As further discussed in Sections II.B.3.a and II.D.2 of this report, section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in certain health programs and activities. Section 1557 applies to insurers and TPAs that administer self-insured plans, if they receive direct or indirect Federal financial assistance.

A district court held that the categorical exclusion of gender affirming medical care by Blue Cross Blue Shield of Illinois violated Section 1557 of the ACA as discrimination

[109] *Roman Catholic Diocese of Albany v. Vullo*, No. 45, 2024 WL 2278222 (N.Y. Ct. App. May 21, 2024).

[110] *Id., petition for cert. filed, Roman Catholic Diocese of Albany v. Harris* (U.S. Sept. 20, 2024).

[111] *HIV & Hepatitis Policy Institute et al. v. U.S. Dep't of Health & Human Services et al.*, No. 1:22-cv-02604 (D.D.C. Sept. 29, 2023).

on the basis of sex. The district court enjoined Blue Cross from administering or enforcing these exclusions but stayed enforcement of the order pending an appeal to the Ninth Circuit.[112]

9. Litigation on Nicotine Surcharges

Several lawsuits have been filed alleging that nicotine surcharges violate ERISA by discriminating against employees based on a health-status factor.[113] Employers are permitted to impose nicotine surcharges under wellness programs if they provide participants with an alternative to paying the fee, such as participating in a smoking cessation program. Plaintiffs in the recent lawsuits claim they either were not provided with access to or were not notified of an alternative.

10. No Surprises Act Litigation on the Qualifying Payment Amount

The No Surprises Act requires health plans to make an initial payment or deny claims of out-of-network providers and facilities that are subject to the surprise billing provisions within a certain period of time. If the provider does not agree with the payment amount and the parties cannot come to an agreement after a dispute resolution process, the parties can initiate the independent dispute resolution ("IDR") process.

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

There have been a series of cases challenging the implementation of the IDR process that have been filed in the Eastern District of Texas under the name *Texas Medical Association, et al. v. HHS ("TMA").* In one of the cases, the court vacated certain provisions of the 2021 interim final rule governing how payers should calculate the QPA for items and services. In October, the Fifth Circuit reversed the district court's decision as to the QPA calculation (and made a few other rulings relating to the No Surprises Act).[114]

E. State Laws Impacting Welfare Plans

ERISA preemption of state laws does not apply to self-insured church plans, making state laws potentially applicable to church plans. 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 MEWA laws. Church welfare plans are also exempt from state laws that would require them to be licensed or relate solely to the solvency or insolvency of a church plan (including participation

[112] *Pritchard et al. v. Blue Cross Blue Shield of Illinois*, Case No. 3:20-cv-06145, 2023 WL 8777349 (W.D. Wash. Dec. 19, 2023) and 2024 WL 532400 (W.D. Wash. Jan. 22, 2024), *appeal filed* No. 23-4331 (9th Cir. Dec. 22, 2023).

[113] *See, e.g., Krista Noel v. Pepsico Inc. et. al,* No. 7:24-cv-07516 (S.D. NY filed Oct. 3, 2024).

[114] *Texas Medical Ass'n v. HHS*, No. 23-40605 (5th Cir. Oct. 20, 2024).

in state guaranty funds and associations). RFRA states that the government may substantially burden a person's exercise of religion only if it demonstrates that application of the burden to the person is in furtherance of a compelling governmental interest and is the least restrictive means of furthering that compelling governmental interest. Some state laws may include an exception for church plans or denomination plans. Below is a description of certain types of state laws issued during the past year of interest to church plans.

1. State Law Initiatives Being Monitored by the Church Alliance

The Church Alliance has continued to monitor legislation at the state level impacting church welfare plans,[115] focusing on health care and privacy. Within health care, the Church Alliance has focused on identifying legislation that would mandate health care benefits, regulate PBMs, and create or study a public option or other health care reform system. The Church Alliance has seen in particular an increasing number of legislative proposals that would mandate health care benefits and regulate in some form PBMs. The Church Alliance continues to assess their potential impact on church plans.

2. State Abortion Laws

In June 2022, the U.S. Supreme Court reversed its 1973 ruling in *Roe v. Wade*, overturning the constitutional right to an abortion.[116] 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 pro-life and pro-choice legislation after the Supreme Court decision. A battle over abortion access is still taking place in many other states. Both the Church Alliance and the American Benefits Council have prepared charts summarizing current and prospective state abortion laws.[117]

3. State PBM Legislation

In addition to federal legislative and regulatory efforts, states are passing laws imposing additional rules on PBMs. PBM laws have recently been enacted or become effective in New York, Florida, Kentucky, and Oregon.

F. Other Guidance Impacting Welfare Plans

1. Federal Trade Commission Report on PBMs

In July, the Federal Trade Commission ("FTC") recently issued an interim report that is part of an ongoing study of PBMs and their impact on access to and affordability of prescription drugs.[118] The report is critical of PBMs and provides the following key insights:

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

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

[117] *See* americanbenefitscouncil.org/pub/?ID=38EDDBEE-DF50-5614-48F1-62FE090D1A1F.

[118] *See* https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf.

- The market for PBM services is highly concentrated, and the largest PBMs are vertically integrated with the largest health insurers and specialty and retail pharmacies.

- As a result, the leading PBMs exercise significant power over the access to and cost of drugs.

- Vertically integrated PBMs may give preference to affiliated businesses to the disadvantage of unaffiliated pharmacies, which could increase prescription drug prices.

- Increased concentration may allow PBMs to enter into contractual relationships that disadvantage smaller, unaffiliated pharmacies and their patients.

- PBMs and drug manufacturers sometimes negotiate rebates that are expressly conditioned on limiting access to lower cost generic drugs.

In 2022, the FTC issued requests for documents and data from six large PBMs along with a solicitation for public comments. The FTC reviewed the submissions it has received thus far from the PBMs along with more than 1,200 public comments. The FTC indicated this is an interim report because it has not yet received all the information it requested from PBMs.

2. Change Healthcare Ransomware Attack

In February 2024, Change Healthcare was the subject of a massive ransomware cyberattack impacting healthcare plans and their billing information systems throughout the country. Change Healthcare, an administrative point solution, is a subsidiary of United Healthcare Group that serves as a HIPAA business associate for health plans and providers nationwide.

On March 13, 2024, OCR announced its investigation into the incident.[119] The investigation is to determine whether a breach of PHI has occurred and will focus on Change Healthcare's (and United's compliance with) HIPAA's privacy, security, and breach notification rules.

OCR urges covered entities to review cybersecurity measures "with urgency" and includes links to several resources intended to assist health care entities in protecting records systems and patients from cyberattacks.

[119] OCR's letter is available at: https://www.hhs.gov/sites/default/files/cyberattack-change-healthcare.pdf.

III. OTHER GUIDANCE OF INTEREST

A. Clergy Act

In 2023, Representative Kevin McCarthy (R-CA) introduced the Clergy Act (H.R. 6068), which was referred to the House Committee on Ways and Means. In April 2024, U.S. Senators Maggie Hassan (D-N.H.) and Katie Britt (R-Ala.) introduced the Senate companion to the House bill (S. 4126). These bills would establish a one-time enrollment period during which members of the clergy who previously opted out of Social Security could opt back in.

B. State Unemployment Compensation Opt Out for Religious Employers

Under Wisconsin law, organizations "operated primarily for religious purposes" are exempt from making contributions to Wisconsin's unemployment insurance system. The Wisconsin Supreme Court was asked to determine whether Catholic Charities Bureau and certain related organizations were exempt from making contributions to Wisconsin's unemployment insurance system because they are "operated primarily for religious purposes." The Court determined that the motivations and activities of the organizations must be considered in making this determination.[120] After reviewing the motivations and activities, the Court decided that while the organizations have a religious motivation, the organizations are not "operated primarily for religious purposes" because their activities are primarily charitable and secular. The Court also determined that application of the applicable statute to the petitioners does not violate the First Amendment.

C. Ways and Means Republican Tax Teams Request for Information on Tax Reform

On May 21, 2024, the Ways and Means Republican Tax Teams issued a request for comments on tax reform. The Church Alliance submitted a response to the request for comment on October 15, 2024. The Church Alliance letter requests:

- The preservation and addition of incentives that encourage individuals to join and/or contribute to retirement plans and employers to offer retirement plans, including allowing tax-exempt organizations to qualify for certain tax credits that are currently only available to for-profit employers.
- Restoring the ability to exclude from income employer-provided qualified moving expense reimbursements.
- The passage of the Clergy Act, which is further discussed above in Section III.A of this report.
- An expansion or clarification of the church plan exemption to the actuarial adjustment requirement in Code section 401(a)(9)(C) so that it applies to all denominational plans and not just those that meet the safe harbor definition under the regulations.

[120] *Catholic Charities Bureau, Inc. v. State of Wisconsin Labor and Industry Review Commission*, No. 2020AP207, 411 Wis.2d 1 (S. Ct. Wis. March 14, 2024).

- Clarification on chaplain and self-employed minister participation in denominational plans other than 403(b)(9) plans.