# LEGISLATIVE AND REGULATORY DEVELOPMENTS IN 2015 OF INTEREST TO CHURCH-SPONSORED EMPLOYEE BENEFIT PLANS AND PROGRAMS

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# LEGISLATIVE AND REGULATORY DEVELOPMENTS IN 2015 OF INTEREST TO CHURCH-SPONSORED EMPLOYEE BENEFIT PLANS AND PROGRAMS

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## I. Legislative Guidance Affecting Retirement and Welfare Plans

### A. Church Alliance Legislative Initiatives - Church Plan Clarification Act of 2015

Over the last several years, the Church Alliance has been working with members of Congress on legislation that would address several issues of importance to church retirement plans. On November 19, 2015, Senator Ben Cardin (D-Md.) and Senator Rob Portman (R-Ohio) reintroduced the Church Plan Clarification Act of 2015 (S. 2308)[1] in the 114th Congress. Identical legislation was simultaneously introduced in the House as H.R. 4085 by Representatives Pat Tiberi (R-Ohio) and Richard Neal (D-Mass.).

S. 2308 and H.R. 4085 clarify the treatment of church pension plans on the following issues:

- Aggregation Under Controlled Group Rules. The final regulations under Code section 414(c) of the Internal Revenue Code of 1986, as amended (the "Code"), became effective January 1, 2009. These regulations include rules relating to the application of controlled group rules to tax-exempt entities, including nonqualified church controlled organizations ("non-QCCOs"). Under these rules, it appears that two or more non-QCCOs could be treated as being within the same "controlled group" if a denominational entity (such as a state convention) appoints 80% or more of the non-QCCO's trustees. This would mean that the plans maintained by these non-QCCOs would be aggregated for purposes of nondiscrimination and coverage testing. The legislation corrects this potential problem and also provides a general rule applicable to churches and QCCOs:

  (1) The general rule that is generally applicable to all churches and church-related organizations would provide that such entities will be considered within the same controlled group only if one entity provides 80% of another entity's operating funds and there is a degree of common management or supervision between the entities.

  (2) The legislation creates a special rule applicable to non-QCCOs that provides that two non-QCCOs will be treated as a single employer under the controlled group rules only if one non-QCCO has the direct or indirect

[1] The text of S. 2308 and H.R. 4085 is attached as Appendix A. (The official versions of the legislation were unavailable as of the date on which this report was completed.)

control over 80% of the directors of the other non-QCCO. However, direct or indirect control by a church or a QCCO over multiple non-QCCOs will not cause these non-QCCOs to be treated as a single employer.

(3) The legislation also provides that churches and QCCOs can be disaggregated from a non-QCCO even if the non-QCCO maintains its own separate plan and does not participate in a multiple employer denominational plan.

- Grandfathered Defined Benefit Plans. Generally, 403(b) plans must be defined contribution plans. However, church 403(b) defined benefit plans that were in effect on September 3, 1982, are permitted to continue to operate as defined benefit plans. Typically, these "grandfathered" 403(b) defined benefit plans are designed to comply with the benefit accrual limitations applicable to defined benefit plans under Code section 415(b), and not the contribution limitations applicable to defined contribution plans under Code section 415(c). However, the regulations under Code sections 403(b) and 415 provide that both the Code section 415(b) benefit limits and the Code section 415(c) contribution limits are applicable to grandfathered 403(b) defined benefit plans. The legislation fixes this problem by requiring grandfathered 403(b) defined benefit plans to comply only with the benefit limits applicable to defined benefit plans under Code section 415(b), and not the contribution limits applicable to defined contribution plans under Code section 415(c).

- Automatic Enrollment for Church Plans. The Pension Protection Act of 2006 ("PPA"), which became effective on August 17, 2006, included provisions designed to encourage the use of automatic enrollment arrangements. One of these provisions preempted the application of state wage withholding laws to automatic enrollment arrangements. However, this preemption provision was enacted as an amendment to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Church plans are, of course, not subject to ERISA and thus are not entitled to this state wage withholding law preemption, thereby hindering church plans from offering automatic enrollment features. S. 2308 and H.R. 4085 both would preempt the application of state wage withholding laws to church plans that include automatic enrollment arrangements.

- Transfers Between 403(b) and 401(a) Plans. The final regulations issued under Code section 403(b) authorized transfers between 403(b) plans. However, these regulations specifically prohibit transfers between a 403(b) plan and a 401(a) qualified plan. S. 2308and H.R. 4085 would amend Code section 414 to permit transfers between all types of 403(b) plans (including 403(b)(9) retirement income account plans) and 401(a) qualified plans that are maintained by the same church or convention or association of churches. In addition, the legislation would allow the merger of a 401(a) plan with a 403(b) retirement income account that are both maintained by the same church or convention or association of churches.

- 81-100 Trusts. Many financial institutions offer special tax-exempt investment vehicles that can only accept retirement plan investments. These investment vehicles (often referred to as "81-100 trusts")[2] operate under special securities law exemptions. Many church pension boards maintain investment pools in which their retirement plan assets are commingled with other assets devoted exclusively to church purposes. However, under current guidance issued by the Internal Revenue Service ("IRS"), these church pension boards cannot invest retirement plan assets in these 81-100 trusts because of the commingling with other non-retirement church assets. S. 2308 and H.R. 4085 include a provision that would authorize church plans and church pension boards to invest retirement plan assets in 81-100 trusts without any adverse tax consequences.

The Church Alliance is seeking out and pursuing every opportunity to secure passage of the Church Plan Clarification Act in 2015 before the 114th Congress concludes its First Session. The Church Alliance is working with the legislation's primary sponsors, the Senate Finance Committee, the House Ways and Means Committee, Senate leadership, and House leadership to this end.

## B. Trade Preferences Extension Act of 2015

On June 29, 2015, President Obama signed the Trade Preferences Extension Act of 2015 ("TPEA") into law.[3] In addition to numerous trade measures, the TPEA increases the penalties for failures to file correct information returns and to distribute required statements to taxpayers. The penalty increases apply to certain existing reporting requirements, including Forms W-2 and the Form 1099-series, and to the new reporting requirements imposed by the Patient Protection and Affordable Care Act under Code sections 6055 and 6056. The penalty increases are effective for information returns and taxpayer statements required to be filed or distributed on or after January 1, 2016.

Specifically, the TPEA increases the general penalty for failure to file a correct information return from $100 per return to $250 per return and increases the maximum annual penalty from $1.5 million to $3 million. The TPEA also increases the reduced penalties imposed on failures that are corrected within certain periods of time and on smaller employers with gross receipts of not more than $5 million. The amount of the reduced penalties under the new law range from $50 to $100 per return and the reduced maximum annual penalty ranges from $175,000 to $1.5 million. Further, the penalty associated with intentional failures increases from $250 to $500 per return, with no annual maximum penalty amount.

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[2] They are called 81-100 trusts because the IRS guidance first authorizing the use of these group trusts was Revenue Ruling 81-100, 1981-1 C.B. 326. The IRS modified Revenue Ruling 81-100 in Revenue Ruling 2011-1, 2011-2 I.R.B. 251. Therefore, occasionally, 81-100 trusts are now referred to as "2011-1 trusts."

[3] Pub. L. No. 114-27 (2015).

## **II.** Regulatory Initiatives and Other Guidance Relating to Retirement Plans

### A. Internal Revenue Service

#### 1. No Lump Sum Payments for Retirees Receiving Annuity Payments.

On June 9, 2015, the U. S. Department of the Treasury ("Treasury") and the IRS issued Notice 2015-49[4] to inform taxpayers that they intend to amend the required minimum distribution ("RMD") regulations under Code section 401(a)(9)[5] to address the use of lump sum payments to replace pensions being paid by a qualified defined benefit pension plan. Prior to the issuance of the Notice, a number of defined benefit plan sponsors had amended their defined benefit plans to provide a limited time period during which certain retirees and deferred vested former employees who were receiving joint and survivor, single life, or other life annuity payments from those plans, could elect to convert that annuity into a lump sum that was payable immediately. These programs are sometimes referred to as lump-sum risk transferring programs because they transfer longevity and investment risk to the retirees. Employers were offering these lump-sum risk transferring programs in an attempt to reduce pension plan liability, and to take advantage of recent changes to accounting and funding rules that allowed the calculation of lump sums using a basis more closely aligned with the funding and accounting measures of pension obligations instead of calculating lump sum amounts using 30-year Treasury rates.

The Notice states that the amended regulations will generally prohibit defined benefit plans from replacing any joint and survivor, single life, or other annuity currently being paid with a lump sum payment or other accelerated form of distribution effective as of July 9, 2015. Certain acceleration of annuity payments will be allowed if the acceleration is:

- in association with a plan amendment specifically providing for implementation of a lump sum risk-transferring program adopted prior to July 9, 2015;
- with respect to which a private letter ruling or determination letter was issued by the IRS prior to July 9, 2015; or

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[4] 2015-30 I.R.B. 79.

[5] Code section 401(a)(9) requires distribution of each employee's entire interest in the plan to begin by a certain required beginning date, which is generally April 1st of the calendar year following the later of the calendar year in which the employee attains age 70½ or retires. Absent an applicable exception, the regulations require distribution in the form of periodic annuity payments for the employee's or beneficiary's life or over a certain period specified in the regulations. The regulations also prohibit a change in the period or form of distribution once it has commenced, subject to certain exceptions.

- with respect to which a written communication to affected plan participants stating an explicit and definite intent to implement the lump sum risk-transferring program was received by those participants prior to July 9, 2015.

Any private letter ruling or determination letter issued by the IRS or the IRS Office of Chief Counsel involving a plan that provides for a lump sum risk-transferring program will generally include a caveat expressing no opinion as to the federal tax consequences of the lump sum risk-transferring program.

2. Safe Harbor Explanations – Eligible Rollover Distributions

On November 24, 2015, the IRS issued Notice 2014-74[6] to provide updated model notices that plan administrators of 401(a) qualified plans and 403(b) plans may provide to recipients of eligible rollover distributions to satisfy the provisions of Code section 402(f). The Notice updates the model notices issued by the IRS in Notice 2009-68 to reflect a number of changes in the eligible rollover distribution rules, including changes relating to the allocation of pre-tax and after-tax amounts, distributions in the form of in-plan Roth rollovers, and certain other changes made since September 28, 2009.

Notice 2014-74 includes two restated model notices. One of the model notices is for payments that are not made from a designated Roth account and the other model notice is for payments made from a designated Roth account. The IRS recommends providing two separate notices if the participant is eligible to receive eligible rollover distributions from both a non-Roth designated account and a Roth designated account. The model notices must be provided no less than 30 and no more than 180 days before the date on which the distribution is made. Copies of these restated model notices are attached to this report as Appendix B.

3. Determination Letter Program Revisions.

Section 401(b) of the Code provides a remedial amendment period during which a retirement plan may be amended retroactively to comply with certain Code requirements. Revenue Procedure 2007-44[7] sets forth procedures for submitting qualified plans to the IRS for determination letters and generally permits sponsors of individually-designed plans to apply for determination letters once every five years according to a schedule based upon the last digit of the plan sponsor's employer identification number ("EIN").

On July 21, 2015, the IRS issued Announcement 2015-19[8] stating that there will be significant changes to the employee plans determination letter program beginning in

[6] 2014-50 I.R.B. 937.

[7] 2007-28 I.R.B. 54.

[8] 2015-32 I.R.B. 157.

2017. Based on the stated need for the IRS to direct its limited resources in a more efficient manner, effective January 1, 2017, the staggered five-year remedial amendment cycles for individually-designed plans will be eliminated and the scope of the determination letter program will be limited for individually-designed plans to initial plan qualification, qualification upon plan termination and other circumstances identified by the IRS and Treasury in published guidance.

The Announcement also provides a transition rule with respect to the remedial amendment period for certain plans currently using the five-year cycle. Under the transition rule, sponsors of plans in the remedial amendment cycle known as "Cycle A" will continue to be permitted to submit determination letter applications during the period beginning February 1, 2016 and ending January 31, 2017. The Announcement also states that determination letter filings are no longer permitted to be made outside of the plan's remedial amendment cycle, except as specified above.[9]

4. IRS Changes to Employee Plans Compliance Resolution System.

On December 31, 2012, the IRS issued Revenue Procedure 2013-12[10] which updated and revised the Employee Plans Compliance Resolution System ("EPCRS"), the system used by retirement plans to correct plan errors. EPCRS consists of the following three correction programs:

- the Self-Correction Program ("SCP"), which permits plan sponsors with existing compliance practices and procedures to correct certain minor operational failures under a qualified plan or 403(b) plan. Plan sponsors who self-correct under SCP do not have to file a submission with the IRS or pay a compliance fee;

- the Voluntary Correction Program ("VCP"), which permits a plan sponsor to pay a compliance fee and receive the IRS's approval for correction of all qualification failures under a qualified plan, a 403(b) plan, SEP, or SIMPLE IRA at any time before an audit; and

- the Audit Closing Agreement Program ("Audit CAP"), which permits a plan sponsor to pay a sanction and correct any failures that were discovered during an audit.

Two Revenue Procedures were issued by the IRS in early 2015 that modify the current EPCRS Program described in Revenue Procedure 2013-12. These modifications are briefly summarized below:

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[9] Revenue Procedure 2007-44 currently refers to filings that are made outside of a plan's remedial amendment cycle as "off cycle" filings.

[10] 2013-4 I.R.B. 313.

*Revenue Procedure 2015-27*.

On March 27, 2015, the IRS released Revenue Procedure 2015-27,[11] which makes the following changes to the EPCRS Program:

- **Clarification of correction rules for overpayments made to plan participants.** Until this change, plan sponsors were required to take reasonable steps to recoup overpayments from affected participants and beneficiaries, and in many cases, were required to contribute the amount of the overpayment to the plan involved if the participant failed to repay the overpayment. However, plan sponsors have had difficulty in recouping overpayments. Under the new rules, more flexibility is granted. An employer or other party can repay the overpayment without attempting to first collect from the participant or the employer can amend the plan retroactively when using VCP to conform the plan to actual operations as long as the correction method is consistent with EPCRS correction principles and other EPCRS rules. For example, a retroactive amendment may be an appropriate correction method, provided the amendment complies with applicable Code requirements.

- **Modification of SCP for 415(c) failures.** Plan sponsors are permitted to use SCP to correct certain recurring excess annual additions under Code section 415(c) if the excess annual additions are distributed within a period of 9½ months after the end of the plan year in which the excess additions occurred. For 2015, the 415(c) limit is the lesser of $53,000 or 100% of compensation.

- **Lower compliance fees for certain submissions.** The guidance permits the following reduced VCP submission fees for required minimum distributions and plan loans:

  (1) Required minimum distributions ("RMDs"). A reduced compliance fee is available if a plan's sole failure is late payment of RMDs and 300 or fewer plan participants were affected. In the past, a $500 fee only covered up to 50 participants – now it covers up to 150 affected participants. The fee for 150 to 300 participants with RMD failures is now $1,500.

  (2) Plan loans. Reduced fees are available for plans which have participant loan failures. The reduced fees are listed in a table in the Revenue Procedure, and are based on the number of participants with loan issues instead of the total number of plan participants. Plans must meet specific conditions to qualify for the reduced fee.

[11] 2015-16 I.R.B. 914.

*Revenue Procedure 2015-28*.

On April 2, 2015, the IRS released Revenue Procedure 2015-28,[12] which makes the following additional changes to the EPCRS Program:

- **Automatic contribution and escalation errors – safe harbor correction method.** Prior to the issuance of Revenue Procedure 2015-28, plan sponsors of 401(k) and 403(b) plans with automatic contribution and contribution escalation features were required to make corrective contributions for missed or incorrectly calculated employee elective deferrals equal to 50% of the deemed amount the employee would have deferred, along with corrective matching contributions and lost earnings on both types of contributions. The revenue procedure eliminated the requirement for plan sponsors with automatic contribution features to make corrective contributions for missed elective deferrals if correct deferrals begin by the first payroll date after the earlier of: (a) if the plan sponsor was not notified of the failure by the affected employee, 9½ months after the end of the plan year in which the failure first occurred, or (b) if the plan sponsor was notified of the failure by the affected employee, the last day of the month after the month in which the affected employee first notified the plan sponsor of the error. No earnings are required to be contributed on missed or incorrect deferrals using this correction method. The plan sponsor must issue a written notice to affected employees within 45 days after the date correct deferrals begin. Although corrective deferrals are not required, the plan sponsor is required to make corrective matching contributions and associated earnings, if applicable.

- **Elective deferral errors for 401(k) and 403(b) plans without automatic contribution and escalation features corrected within three months of the error occurring – safe harbor correction method.** No corrective contributions (other than corrective matching contributions and earnings thereon) are required for missed employee elective deferrals in 401(k) and 403(b) plans if correct deferrals begin by the first payroll date after the earlier of: (a) three months after the failure first began for the affected employee, or (b) the last day of the month after the month the affected eligible employee first notified the plan sponsor of the failure. No earnings are required to be contributed on missed deferrals using this correction method. The plan sponsor must issue a written notice to affected employees within 45 days after the date correct deferrals begin and provide corrective matching contributions and associated earnings, if applicable.

- **Correction of elective deferral errors for 401(k) and 403(b) plans without automatic contribution and escalation features after three months but within the two-year EPCRS self-correction period – safe harbor correction method.** Corrective contributions in the amount of 25% (reduced from 50%) are required

[12] 2015-16 I.R.B. 920.

for missed employee elective deferral failures if the period of the failure exceeds three months but corrective deferrals begin by the first payroll date after the earlier of: (a) the last day of the second plan year after the plan year in which the failure first began for the affected employee, or (b) the last day of the month after the month the affected eligible employee first notified the plan sponsor of the failure. The plan sponsor must issue a written notice to affected employees within 45 days after the date correct deferrals begin and provide corrective matching contributions, if applicable. Earnings on all missed contributions and deferrals must also be made by the last day of the second plan year following the plan year for which the failure occurred.

- **Calculating earnings on elective deferral errors.** Earnings generally are calculated based on the participant's chosen investment alternatives. If the plan has automatic contribution features, earnings may be calculated using the plan's default investment alternative if the participant has not chosen an investment alternative. Cumulative losses do not reduce the corrective contributions. If the plan does not have an automatic contribution feature, earnings must be calculated pursuant to the provisions of Revenue Procedure 2013-12.

5. *My*RA.

Effective December 15, 2014, the Treasury began offering a new retirement savings program called *my*RA to increase retirement savings for more Americans. The new retirement account is targeted at employees who are not eligible to participate in an employer-sponsored retirement plan. This Roth IRA retirement account provides a principal-protected investment that earns interest at the same variable rate as investments in the government securities fund for federal employees. Similar to other Roth IRAs, *my*RA is generally available to anyone who earns an annual income of less than $131,000 a year for individuals and less than $193,000 for married couples filing jointly. The maximum contribution to *my*RA is $5,500 per year (or $6,500 per year for individuals 50 years of age or older at the end of the year).

Individuals can continue to participate in the program until their account balance reaches $15,000 or until they have participated in the program for 30 years, whichever occurs first. When either of those limits is reached, savings will be rolled over into a private-sector Roth IRA. Annual and lifetime contribution limits and annual earned income limits apply, as do conditions for tax-free withdrawal of interest.

On November 3, 2015, the *my*RA program was launched nationwide. The Treasury has not issued any formal guidance on the *my*RA product, but information for employers and individuals can be found on the *my*RA website at www.myra.gov.

6. Retirement Plan Limits for 2016.

The cost-of-living and required statutory limit adjustments applicable to retirement plans for 2016 are as follows:[13]

| | |
|---|---|
| Contribution limit for defined contribution plan under Code § 415(c) | **$53,000** (*no increase*) |
| Benefit limitation for defined benefit plan under Code § 415(b) | **$210,000** *(no increase)* |
| Elective deferral limit under Code § 402(g) | **$18,000** *(no increase)* |
| Age 50 catch-up contribution limit under Code § 414(v) | **$6,000** *(no increase)* |
| Age 50 catch-up contribution limit for SIMPLE plan | **$2,500** (*no increase*) |
| Contribution limit for a Code § 457(b) eligible deferred compensation plan | **$18,000** (*no increase*) |
| Annual compensation limit under Code § 401(a)(17) | **$265,000** (*no increase)* |
| HCE compensation definition dollar threshold | **$120,000** *(no increase)* |
| Dollar threshold limitation for key employee determination in top-heavy plan | **$170,000** (*no increase*) |
| Contribution limit for a SIMPLE retirement plan | **$12,500** *(no increase)* |
| Participant compensation eligibility amount under Code § 408(k)(2)(C) for simplified employee pension (SEP) employer contributions | **$600** *(no increase)* |

B. Department of Labor

1. Flexibility in Timing of Fee Disclosures.

Under Department of Labor ("DOL") regulations released in 2010, ERISA plan administrators are required to provide fee disclosure notices with fee and expense information to participants of participant-directed individual account plans at least annually after a participant can direct investments. The DOL defined the phrase "at least annually" in 2010 regulations as "at least once in any 12-month period, without regard to whether the plan operates on a calendar or fiscal year basis."

A final rule issued on March 18, 2015[14] amended the DOL's participant-level fee disclosure regulation by making a technical adjustment to a timing requirement in the 2010 regulation. The amendment provides plan administrators with flexibility as to when they must furnish annual disclosures to participants and beneficiaries by replacing the

[13] IR 2015-118 (Oct. 21, 2015).

[14] 80 Fed. Reg. 14,301 (Mar. 19, 2015).

words "12-month period" with "14-month period." The amendment is applicable to disclosures made on or after June 17, 2015.

Although the final rule does not apply to plans that are not subject to ERISA, such as non-electing church plans, it does provide useful guidance on disclosure of fee and expense information to participants in individual account plans.

2. Selection and Monitoring Under the Annuity Selection Safe Harbor for Defined Contribution Plans.

On October 7, 2008, the DOL published a final rule establishing a safe harbor for fiduciaries of ERISA individual account plans to select annuity providers for benefit distributions ("Safe Harbor Rule").[15] When an annuity provider is selected to offer annuities that participants may later choose as a distribution option, fiduciaries relying on the Safe Harbor Rule must periodically review the continuing appropriateness and financial ability of the annuity provider to make all future payments under the annuity contract, as well as the reasonableness of the cost of the contract in relation to the benefits and services to be provided. The final rule provides that the frequency of periodic reviews to comply with the Safe Harbor Rule depends on the facts and circumstances of a particular case.

Since 2008, employers have commented that they are unclear about the scope of their fiduciary obligations with respect to annuity selection under defined contribution plans and, in particular, are confused about how to reconcile the time of selection standard[16] in the Safe Harbor Rule with ERISA's duty to monitor and review certain fiduciary decisions. Accordingly, on July 13, 2015, the DOL released Field Assistance Bulletin ("FAB") 2015-02, which states that a defined contribution plan sponsor's fiduciary duty to monitor an annuity provider's financial strength ends when the plan no longer offers an annuity from that provider as a distribution option under the plan.

Several examples provided in this FAB clarify the Safe Harbor Rule by providing that the employer must periodically review and monitor the annuity provider, as long as the plan continues to offer participants the option to purchase an annuity at retirement from a particular annuity provider. However, the employer's obligation to periodically review an annuity provider ends when the employer stops offering annuities from that provider as a distribution option under the plan to participants or their beneficiaries.

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[15] 73 Fed. Reg. 58,447 (Oct. 7, 2008). According to the DOL, the 2008 final rule established a safe harbor but did not establish minimum requirements or the exclusive means by which a fiduciary may satisfy its responsibilities.

[16] The time of selection standard refers to the requirement that a plan fiduciary appropriately concludes at the time of selection of the annuity provider that the provider is financially able to make all future payments under the annuity contract and that the cost of the annuity contract is reasonable in relation to the benefits and services to be provided under the contract.

Although the guidance does not apply to plans that are not subject to ERISA, such as non-electing church plans, it does provide useful guidance on the prudent selection of annuity providers by fiduciaries of individual account plans.

3. Re-issued Proposed Fiduciary Regulations.

In October of 2010 the DOL proposed a rule[17] 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, which claimed that the added compliance costs and the increased legal liability for advisors would limit both general financial education and individual advice available to account holders with modest savings.

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."[18] The DOL also indicated its re-proposed rule would only impose fiduciary status on those advisors who provide individualized advice to plan clients, which would allow advisers to provide general education on retirement savings to plan participants without triggering fiduciary duties.

On April 14, 2015, the DOL issued the re-proposed rule defining who is a "fiduciary" of an employee benefit plan under ERISA as a result of giving investment advice to a plan or its participants or beneficiaries.[19] The proposed rule also applies to an IRA by way of Code section 4975. Moreover, the proposed rule would treat persons who provide investment advice or recommendations to an employee benefit plan, plan fiduciary, plan participant or beneficiary, IRA or IRA owner as fiduciaries under ERISA and/or the Code in a wider array of circumstances than under existing ERISA and Code regulations.[20]

If adopted, the proposed rule would provide that, for purposes of ERISA, a person is a fiduciary as a result of rendering certain types of investment advice described below with respect to moneys or other property of a plan or IRA if such person:

- provides, directly to an employee benefit plan, a plan fiduciary, participant or beneficiary, an IRA, or an IRA owner certain specific types of investment advice in exchange for a fee or other compensation, and

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[17] 75 Fed. Reg. 65,263 (Oct. 22, 2010).

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

[19] 80 Fed. Reg. 21,928 (Apr, 20, 2015).

[20] In addition to the proposed regulation, the DOL also proposed two administrative class exemptions from the prohibited transaction provisions of ERISA and also proposed amending several existing prohibited transaction class exemptions.

- represents or acknowledges the fiduciary nature of the advice, or renders the advice pursuant to an agreement, arrangement or understanding with the advice recipient that the advice is individualized to, or specifically directed to, the recipient for consideration in making investment or management decisions regarding plan assets.

The proposed rule contains the four following types of advice, which, when provided in exchange for a fee or other compensation, whether directly or indirectly, would be considered investment advice, unless one of the carve-outs set forth in the proposed rule applies:

- recommendations as to the advisability of acquiring, holding, disposing or exchanging securities or other property, including recommendations to take a distribution of benefits or a recommendation as to the investment of securities or other property to be rolled over or otherwise distributed from the plan or IRA;

- recommendations as to the management of securities or other property, including recommendations as to the management of securities or other property to be rolled over to or otherwise distributed from the plan or IRA;

- appraisals, fairness opinions or similar statements concerning the value of securities or other property if provided in connection with a specific transaction involving the plan or IRA; and

- recommendations of a person who is also going to receive a fee or other compensation to provide any of the types of advice listed in the three above bullets.

The proposed rule includes a number of specific carve-outs to the general definition of providing investment advice. The carve-outs include non-fiduciary investment education, advice rendered by employees of the plan sponsor, platform providers, arms-length sales and persons who offer or enter into swaps or security-based swaps with plans.

Although the proposed ERISA rule provides guidance for ERISA-covered retirement plans, and thus is not applicable to non-electing church plans, the proposed rule also interprets the fiduciary definition under Code section 4975. If a church benefit board employee provides advice on rolling over an IRA into a church retirement plan, and the employee directly or indirectly (such as through a performance based bonus) receives compensation for such advice, the proposed rule may be applicable. Church benefit boards providing incoming rollover advice to plan participants should therefore consider the applicability of the proposed rule.

4. Fiduciary Standard in Considering Economically Targeted Investments.

The DOL released Interpretive Bulletin 2015-01 in October of 2015, setting forth supplemental views with respect to a plan fiduciary's decision to invest plan assets in

"economically targeted investments" ("ETIs"). ETIs are generally defined as investments that are selected for the economic benefits they create in addition to the investment return to the employee benefit plan investor. In this Bulletin, the DOL withdraws Interpretive Bulletin 2008-01and reinstates the language of Interpretive Bulletin 94-01.

The DOL's objective in issuing Interpretive Bulletin 94-01 was to correct a popular misconception at the time that investments in ETIs are incompatible with ERISA's fiduciary obligations. ERISA does not prohibit fiduciaries from investing plan assets in an ETI if the ETI has an expected rate of return that is commensurate to the rates of return of alternative investments with similar risk characteristics that are available to the plan, and if the ETI is otherwise an appropriate investment for the plan in terms of such factors as diversification and the investment policy of the plan. The DOL states the focus of plan fiduciaries on the plan's financial returns and risk to beneficiaries must be paramount.

Interpretive Bulletin 2008-1 replaced Interpretive Bulletin 94-01 and clarified that fiduciary consideration of collateral, non-economic factors in selecting plan investments should be rare, and when considered, should be documented in a manner that demonstrates compliance with ERISA's rigorous fiduciary standards. The DOL is withdrawing 2008-01 and reinstating the language of Interpretive Bulletin 94-01 because it feels that Interpretive Bulletin 2008-01 has unduly discouraged fiduciaries from considering ETIs and environmental, social and governance factors.

Interpretive Bulletin 2015-01 clarifies that plan fiduciaries should appropriately consider factors that potentially affect risk and return. Environmental, social and governance issues may have a direct relationship to the economic value of the plan's investment. Plan fiduciaries may invest in ETIs based in part on their collateral benefits so long as the investment is economically equivalent, with respect to return and risk to beneficiaries in the appropriate time horizon, to investments without such collateral benefits.

Interpretive bulletins do not apply to non-electing church plans. However, they do provide useful guidance for determining fiduciary standards for social/economically targeted investing.

## **III.** Defense of Marriage Act

In 2013, the United States Supreme Court handed down a decision in *United States v. Windsor*, which struck down Section 3 of the Defense of Marriage Act ("DOMA"). Under Section 3, the definition of "marriage" and "spouse" for purposes of all federal laws and regulations, was limited to opposite sex couples.

The *Windsor* decision impacts employee benefit plans and many other programs maintained by employers. In 2013 and 2014, the IRS issued guidance interpreting the impact of this decision on employee benefit plans that provide benefits for spouses. In 2015, the U.S.

Supreme Court issued another decision in *Obergefell v. Hodges*[21] holding that every state is required to license a marriage between same-sex couples and to recognize same-sex marriages performed in other jurisdictions. In addition, the IRS issued proposed regulations implementing the U.S. Supreme Court's decisions in *Windsor* and *Obergefell*. The *Obergefell* decision and proposed regulations are further discussed below.

### A. *Obergefell v. Hodges*

In *Obergefell*, plaintiffs claimed the laws of Michigan, Kentucky, Ohio, and Tennessee that defined marriage as being a union between one man and one woman violated the Fourteenth Amendment. While the district courts ruled in the favor of the plaintiffs, the Sixth Circuit consolidated the cases and reversed. The Supreme Court reversed the Sixth Circuit's decision and held that such laws violate the Fourteenth Amendment and that "same-sex couples may exercise the fundamental right to marry in all States."[22]

Although historic, after the significant changes required by *Windsor*, this decision does not generally further impact retirement plans other than to eliminate the need for plan sponsors to determine whether a same-sex marriage occurred in a state that authorized the marriage celebration. The *Obergefell* decision does, however, impact other areas, such as the taxation of benefits, the design of welfare plans and potential employment law discrimination claims for failure to provide the same benefits to same-sex and opposite-sex spouses.

### B. IRS Proposed Regulations Implementing *Windsor* and *Obergefell*

On October 23, 2015, the IRS released proposed regulations defining terms related to marital status.[23] The proposed regulations reflect the holdings of *Obergefell*, *Windsor*, and Revenue Ruling 2013-17[24] and define terms in the Code describing the marital status of taxpayers.

Specifically, the proposed regulations define the terms spouse, husband, wife, and marriage throughout the Code for federal tax purposes so that marriages of couples of the same sex are treated the same as marriages of couples of the opposite sex. In addition, the proposed regulations state that a marriage of two individuals is recognized for federal tax purposes as long as that marriage is recognized by any state, possession or territory of the United States. The proposed regulations also clarify that the term marriage does not include registered domestic partnerships, civil unions, or other similar relationships recognized under state law that are not denominated as a marriage under the state's law.

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[21] *Obergefell v. Hodges*, 135 S.Ct. 2584 (2015).

[22] *Id*. at *28.

[23] 80 Fed. Reg. 64,378 (Oct. 23, 2015).

[24] 2013-38 I.R.B. 201.

## IV. Patient Protection and Affordable Care Act

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010. These two pieces of legislation (commonly referred to as the "ACA") impose sweeping changes on the delivery of health care in this country and have a major impact on all players in the health care market (including individuals, employers and insurers).

Since the ACA's enactment, the Department of Health and Human Services ("HHS"), the DOL, and the Treasury (collectively the "Agencies") have jointly issued final regulations and other guidance relating to different provisions in the ACA. Most of this guidance was issued in 2010 and 2011, but additional guidance was issued in later years. This report focuses on guidance that was issued in the last year.

### A. Church Alliance Efforts on Health Care Reform – Update on Church Health Plan Act of 2013

The ACA offers tax credits and cost-sharing subsidies for employees who purchase health insurance through a state Exchange. Generally, these tax credits and cost-sharing subsidies will not be available for employees who are covered under a denominational church plan. If these tax credits and subsidies are not available to participants in church health care plans, the Church Alliance is concerned that their availability through Exchanges will encourage church employers and their employees to forego their church health care plan participation. The departure of these employers and their employees could make self-insured church plans unsustainable if they lose the necessary economies of scale and stable risk pools. At the same time, coverage under the Exchanges will not provide clergy and church lay employees with the same portability, continuity and comprehensive coverage that is currently available under denominational plans.

The Church Alliance has continued to work with members of Congress to try to obtain legislative relief that would resolve this and other issues. In June 2013, Senators Mark Pryor (D-Ark.) and Chris Coons (D-Del.) introduced the Church Health Plan Act of 2013 (S. 1164).[25] This legislation would deem "qualified church plans" as being equivalent to health plans offered through the Exchanges so that eligible employees who are covered under a denominational church plan would qualify for the tax credits and cost-sharing subsidies.

Under the legislation, a "qualified health plan" is defined as a church plan, within the meaning of Code section 414(e), that:

- Is a welfare plan, provides health coverage for the employees of at least ten common law employers, and under which a majority of the covered employees are employees of churches or QCCOs;
- Provides an essential health benefit ("EHB") package;

[25] A copy of S. 1164 is attached as Appendix C.

- Complies with the following provisions of the ACA: guaranteed renewability of coverage, nondiscrimination in health care, prohibition on excessive waiting periods, coverage for individuals participating in clinical trials, certain disclosure requirements, prohibition on annual and lifetime limits, prohibition on rescissions, coverage of preventive health services, the extension of dependent coverage to age 26, the summary of benefits and coverage requirements, the provision of an internal claims appeal process and an external review process, and the provision of patient protections;

- Prohibits exclusions based on preexisting conditions or health status and prohibits discrimination against participants based on health status for purposes of enrollment; and

- Is treated as a "single" entity for the purposes of calculating a plan's medical loss ratio and calculates "earned premiums" for this purpose by including payments by, or on behalf of, employees of a church.

In addition to allowing employees covered under qualified church plans to qualify for the tax credits and cost-sharing subsidies, S. 1164 included the following:

- Provides guidance on the premiums that may be charged by qualified church plans.

- Allows eligible employers participating in church plans to qualify for the small employer tax credit in 2014 through 2016, which is currently only available to eligible employers offering coverage through a SHOP Exchange. The legislation accomplishes this by deeming an employer participating in a qualified church plan as an eligible small employer for purposes of the small employer tax credit.

- Confirms that a qualified church plan constitutes minimum essential coverage ("MEC") under an employer-sponsored plan and satisfies the individual responsibility requirements.

Although Senator Pryor did not win reelection, the Church Alliance has continued to work in the Senate to either reintroduce a similar bill in the new Congress or to include the basic tenets of the Church Health Plan bill within a larger bi-partisan bill amending certain provisions of the ACA.

B. Premium Reimbursement Arrangements.

1. Background – IRS Notice 2013-54.

In September 2013, the IRS issued Notice 2013-54,[26] which provides guidance on the application of the ACA market reform provisions to premium reimbursement

[26] 2013-40 I.R.B. 287.

arrangements. Under the Notice, employer health care arrangements, including employer premium reimbursement arrangements (referred to in the Notice as "employer payment plans" or "EPPs"), are considered group health plans that are subject to the market reform provisions of the ACA, including the prohibition on annual limits and the requirement to offer preventive care services with no cost sharing. A health care arrangement that is integrated with a group health plan that satisfies these requirements will not violate the market reform provisions of the ACA. However, an EPP cannot be integrated with an individual insurance policy. Accordingly, an EPP used to reimburse individuals for individual insurance premiums will violate the annual limit and preventive care requirements, resulting in an excise tax of $100 per day per violation for each employee participating in the EPP.

On November 6, 2014, the Agencies issued frequently asked questions ("FAQs") providing additional guidance on EPPs.[27] These FAQs indicate that an arrangement under which an employer provides cash reimbursement for the purchase of an individual insurance policy is considered a group health plan that is subject to the market reform provisions of the ACA, regardless of whether the reimbursement is made on a pre-tax or after-tax basis. Because the group health plan cannot be integrated with the individual insurance policy, the group health plan will fail to satisfy the market reform provisions of the ACA and will be subject to the significant excise taxes described above.

2. IRS Notice 2015-17.

On February 18, 2015, the IRS issued Notice 2015-17[28] (the "2015 Notice"), which provides excise tax transition relief for certain employers maintaining EPPs. The 2015 Notice also provides additional guidance on the one-employee health plan exception from the market reform provisions of the ACA, Medicare premium reimbursement arrangements, TRICARE-related health reimbursement arrangements, and increases in employee compensation to assist with individual insurance policy premiums.

Under the 2015 Notice, an excise tax will not be imposed for a violation of the ACA market reform provisions by EPPs that pay or reimburse employees for individual health policy premiums or Medicare Part B or Part D premiums (1) for 2014, for employers that are not applicable large employers ("ALEs") for 2014 under the ACA employer mandate; and (2) for January 1 through June 30, 2015, for employers that are not ALEs for 2015. The 2015 Notice makes it clear that employers eligible for the excise tax relief are not required to file Form 8928 with respect to 2014 ACA violations (or those that occur during the first half of 2015).

*One-Employee Health Plan Exception.*

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[27] *See* U.S. Dep't of Labor, FAQs about Affordable Care Act Implementation Part XXII (November 6, 2014) *available at* http://www.dol.gov/ebsa/faqs/faq-aca14.html.

[28] 2015-14 I.R.B. 845.

The 2015 Notice also confirms that an EPP with less than two participants who are current employees (a "one-employee health plan") is exempt from the ACA market reforms and, therefore, is not subject to the excise taxes imposed under the ACA.[29] The 2015 Notice also confirms that, pursuant to Revenue Ruling 61-146, premium reimbursement arrangements for non-employer sponsored hospital and medical insurance that are not subject to the ACA market reforms can be reimbursed on a pre-tax basis.

*Medicare Premium Reimbursement Arrangements.*

The 2015 Notice permits an employer to directly pay or reimburse employees for Medicare Part B or Part D premiums through an EPP that is "integrated" with another group health plan offered by the employer that complies with the ACA if the following requirements are satisfied:

- The employer offers a group health plan to the employee in addition to the EPP that does not consist solely of excepted benefits and that provides minimum value;
- The employee participating in the EPP is enrolled in Medicare Parts A and B;
- The EPP is available only to employees who are enrolled in Medicare Part A and Part B or Part D; and
- The EPP is limited to reimbursement of Medicare Part B or Part D premiums and excepted benefits, including Medigap premiums.

The 2015 Notice warns that these types of arrangements may be subject to restrictions under other laws, such as the Medicare secondary payer provisions.

*TRICARE-Related Health Reimbursement Arrangements.*

The 2015 Notice states that an arrangement under which an employer pays or reimburses medical expenses for employees covered by TRICARE would also be a group health plan subject to the ACA market reform requirements. The 2015 Notice refers to these arrangements as TRICARE-related HRAs. Although the actual text of the section of the 2015 Notice granting the excise tax relief does not extend that relief to TRICARE-related HRAs, the introductory paragraph of the 2015 Notice indicates that the excise tax relief is intended to apply to these types of arrangements.

[29] Although the 2015 Notice only addresses the one-participant health plan exception in connection with S corporation reimbursement arrangements, the IRS previously informally indicated that this rule would also apply for purposes of EPPs.

The 2015 Notice permits an employer to establish a TRICARE-related HRA that is "integrated" with another group health plan offered by the employer that complies with the ACA if the following requirements are satisfied:

- The employer offers a group health plan to the employee in addition to the HRA that does not consist solely of excepted benefits and that provides minimum value;
- The employee participating in the HRA is actually enrolled in TRICARE;
- The HRA is available only to employees who are enrolled in TRICARE; and
- The HRA is limited to reimbursement of cost sharing and excepted benefits, including TRICARE supplemental premiums.

The 2015 Notice warns that these types of arrangements may be subject to other laws that prohibit offering financial or other incentives for TRICARE-eligible employees to decline employer-provided group health coverage.

*Increases in Employee Compensation.*

The 2015 Notice confirms that an employer may increase an employee's compensation to assist with payments of individual insurance policy premiums and, as long as the payment of additional compensation is not conditioned on the purchase of health coverage, all ACA penalty issues are avoided.[30]

## C. Contraceptive Coverage

Under the ACA, all non-grandfathered plans must provide coverage for certain preventive care services and must cover such services without the imposition of any cost-sharing

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[30] On December 11, 2014, Representative Charles W. Boustany, Jr. (R-La.) and Representative Mike Thompson (D-Ca.) introduced the Small Business Healthcare Relief Act of 2014 (H.R. 5860) in the 113th Congress. This legislation "fixes" the problems created by Notice 2013-54 and the subsequent guidance by permitting small employers (i.e., employers that are not subject to the employer shared responsibility provisions of the ACA) to establish qualified health reimbursement arrangements. Under a qualified health reimbursement arrangement, an employer would be permitted to reimburse employees for premiums for a qualified health plan offered in a state exchange covering the employee, the employee's spouse and the employee's dependents and expenses incurred for medical care (as defined in Code section 213(d)) by the employee, the employee's spouse and the employee's dependents. The employer's total contributions to the qualified health reimbursement arrangement for a taxable year would not be permitted to exceed the health flexible spending account limit (which is $2,550 for 2015) or twice such limit in the case of family coverage. The legislation would also permit small employers to directly pay premiums for certain qualified health plans offered through an Exchange on behalf of an employee on a pre-tax basis. However, employees receiving such reimbursements would not also be able to claim premium tax credits for coverage provided through a state Exchange.

requirements (such as a copayment, coinsurance or deductible). These services include contraceptive coverage. Unless entitled to an exemption, non-grandfathered plans had to begin providing these services to women without cost-sharing for plan years beginning on or after August 1, 2011.

1. Regulatory Guidance.

In August 2011, the Agencies granted an exemption for group health plans established or maintained by "religious employers" (and health insurance coverage provided in connection with such plans) with respect to the requirement to cover contraceptive services. As originally drafted, the term "religious employer" was very narrowly defined. Subsequently, in February 2012, as a result of concerns expressed by a number of religious organizations, the Agencies committed to rulemaking to protect additional organizations from having to provide contraceptive coverage to which they object on religious grounds.

In June 2013, the Agencies issued final regulations that significantly broadened the definition of "religious employer."[31] The revised religious employer exemption would cover:

- churches;
- conventions and associations of churches; and
- integrated auxiliaries.[32]

*Accommodation for Other Religious Organizations*

The 2013 final regulations also provided for the "accommodation" of certain health care coverage provided by "eligible organizations." An employer eligible for the accommodation rules does not have to provide contraceptive coverage to its employees, but contraceptive coverage will be made available by either the health insurance issuer (in the case of fully-insured plans) or the third party administrator ("TPA") (in the case of self-insured plans). For purposes of the accommodation rules, an "eligible organization" is a non-profit entity that:

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[31] 78 Fed. Reg. 39,870 (July 2, 2013).

[32] An "integrated auxiliary" is defined in the applicable regulations as a tax-exempt (501(c)(3)) organization that is both affiliated with a church and internally supported. An organization is not "internally supported" if both of the following apply: (a) the organization offers goods, services or facilities for sale, other than on an incidental basis, to the general public; and (b) the organization normally receives more than 50% of its support from a combination of governmental sources, public solicitation of contributions, receipts from the sale of admissions or goods, the performance of services, or furnishing facilities in activities that are not unrelated trades or businesses.

- opposes coverage for some or all of the contraceptive services required to be covered;

- holds itself out as a religious organization; and

- maintains in its records a "self-certification" that indicates that it meets the above requirements and makes such self-certification available upon request by the first day of the first plan year for which the accommodation applies.[33]

As discussed above, an eligible organization will not have to contract, arrange, or pay for contraceptive coverage. However, women covered under the health care plans maintained by eligible organizations will still be entitled to contraceptive coverage paid for by either the health insurance issuer (in the case of fully-insured plans) or the TPA (in the case of self-insured plans).[34]

In the case of insured group health plans sponsored by eligible organizations, the coverage would be provided at no cost to the participant by the employer's health insurance issuer. In the case of self-insured health plans, the third-party administrator would assume the responsibility for arranging with a health insurance issuer to provide contraceptive coverage at no cost to participants. The Agencies state that the related costs incurred by both the issuer and the third-party administrator would be offset by adjustments in user fees that issuers pay on the state's "affordable insurance exchange" ("Exchange").

*2014 Regulatory Guidance*

In August 2014, following the Supreme Court's decision in the *Hobby Lobby* case, HHS issued interim regulations that provide a new method by which eligible non-profit religious organizations could provide notice of their religious objections to providing contraceptive coverage.[35] Under the interim rules, religious non-profits are still

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[33] The guidance does not elaborate on what it means for an organization to "hold itself out as a religious organization." However, this self-certification does not need to be submitted to any of the Agencies. Thus, it appears that the Agencies do not intend to review the self-certification to make their own determination as to whether the organization does or does not hold itself out as being religious.

[34] The final regulations require the issuer or TPA to provide direct payments for the contraceptive services.

[35] 79 Fed. Reg. 51,092 (Aug. 27, 2014). On October 27, 2014, the Church Alliance filed a comment letter on the interim final regulation. In that letter, the Church Alliance expressed its concern that the interim regulations fail to protect the religious rights of religious organizations that object to providing some or all contraceptive coverage through their employee benefit plans established for their employees and their dependents. The Church Alliance noted that the latest version of the accommodation still falls short of the needs of eligible organizations because they are still required to act contrary to their beliefs by maintaining a contractual relationship with third parties that facilitate delivery of the contraceptive

permitted to self-certify under the accommodation rules described above. However, in the alternative, such organizations may qualify for the accommodation by providing HHS with written notification of their objection to providing contraceptive coverage. HHS and DOL will then notify insurers and TPAs so that enrollees may receive separate coverage for such services.[36]

*2015 Regulatory Guidance*

In July 2015 the Agencies released regulations[37] that finalized provisions from interim final rules issued in July 2010 related to coverage of preventive services, interim final regulations issued in August 2014 related to the process an eligible organization uses to provide notice of its religious objection to the coverage of contraceptive services, and proposed regulations issued in August 2014 related to the definition of eligible organization which would expand the set of entities that may avail themselves of an accommodation with respect to the coverage of contraceptive services to include closely held for-profit entities.

These final regulations adopt the August 2014 interim final regulations establishing an alternative way for eligible organizations that have a religious objection to covering contraceptive services to seek an accommodation from contracting, providing, paying, or referring for such services. The rules allow eligible organizations to notify HHS in writing of their religious objection to providing contraception coverage, as an alternative to filling out EBSA Form 700 provided by the DOL to provide to their issuer or TPA. HHS and the DOL will then notify insurers and TPAs of the organization's objection so that enrollees in plans of such organizations receive separate payments for contraceptive services, with no additional cost to the enrollee or organization, and no involvement by the organization. The final regulations also describe the content requirements of the alternative notice and describe accommodations for closely-held for-profit entities.[38]

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coverage they oppose. The letter further argued that the regulations continue to violate the Establishment Clause.

[36] HHS also issued a proposed rule soliciting comments on how it might extend the same service to closely-held for-profit entities with religious objections to contraceptive coverage. This proposed rule is in response to the Supreme Court decision in *Hobby Lobby*.

[37] 80 Fed. Reg. 41,318 (July 14, 2015).

[38] The final rules define a "closely held for-profit entity" as an entity that is not publicly traded and that has an ownership structure under which more than 50 percent of the organization's ownership interest is owned by five or fewer individuals, or an entity with a substantially similar ownership structure. For purposes of this definition, all of the ownership interests held by members of a family are treated as being owned by a single individual. Based on available information, the Agencies believe that this definition includes all of the for-profit companies that have challenged the contraceptive-coverage requirement on religious grounds. The rules finalize standards concerning documentation and disclosure of a closely held for-profit entity's decision not to provide coverage for contraceptive services.

2. Legal Challenges to Contraceptive Coverage Requirements.

In September 2013, Christian Brothers Services ("Christian Brothers") and various religious organizations affiliated with the Catholic Church filed a class action lawsuit challenging the contraceptive coverage mandate. The plaintiffs claimed that complying with the contraceptive coverage mandate violates the Religious Freedom Restoration Act ("RFRA")[39] and the First and Fifth Amendments by requiring them to choose between violating their religious beliefs and incurring significant financial penalties. The plaintiffs requested that the court issue a preliminary and permanent injunction prohibiting the government from enforcing the mandate against the plaintiffs and from assessing penalties against them for failing to comply with the mandate.

In October, 2013, a similar class action lawsuit challenging the contraceptive coverage mandate was filed in the Western District of Oklahoma. This lawsuit was brought by GuideStone Financial Resources of the Southern Baptist Convention ("GuideStone") and two employers served by GuideStone. The causes of action asserted in the complaint are substantially the same as those asserted in the Christian Brothers complaint discussed above.

The District Courts issued conflicting decisions on these cases in December 2013. In the GuideStone case, the Court issued a preliminary injunction in favor of GuideStone and the other two plaintiffs.[40] In contrast, in the Christian Brothers Services case, the District Court denied the plaintiffs' request for a preliminary injunction on December 27, 2013,[41] and the next day, the Tenth Circuit denied a motion for an injunction pending appeal. Subsequently, on December 31, 2013, just before the mandate was scheduled to go into effect, Justice Sonia Sotomayor granted plaintiffs a temporary injunction pending appeal, a decision that was affirmed by the entire Supreme Court on January 24, 2014.[42]

The Tenth Circuit heard oral arguments in December of 2014 and, on July 14, 2015, the Tenth Circuit ruled against the religious organizations,[43] stating that they must comply with the mandate or face IRS penalties. A petition for *certiorari* was filed with the U.S. Supreme Court, asking the Court for relief due to the government's refusal to exempt them from a regulation that makes them choose between their faith—which

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[39] RFRA provides that the government cannot substantially burden a person's exercise of religion without a compelling governmental interest that cannot be satisfied by any less restrictive means.

[40] *Reaching Souls Int'l, Inc., et al. v. Sebelius*, No. CIV–13–1092–D, 2013 WL 6804259 (Dec. 20, 2013).

[41] *Little Sisters of the Poor Home for the Aged, et al. v. Sebelius*, 6 F.Supp.3d 1225 (D. Colo. 2013).

[42] *Little Sisters of the Poor Home for the Aged, et al. v. Sebelius*, 134 S. Ct. 1022 (2014).

[43] *Little Sisters of the Poor Home for the Aged, et al. v. Burwell*, 2015 WL 4232096 (July 14, 2015).

prohibits them from providing contraceptives—and continuing to pursue their religious missions. The Tenth Circuit ordered a stay until the Supreme Court rules on the case.

On November 6, 2015, the U.S. Supreme Court granted review of seven cases addressing the enforcement of the contraceptive coverage mandate cases, including the cases discussed above. In six of the appeals, the Courts of Appeal upheld the accommodation provided under the regulations as not violating the Religious Freedom Restoration Act. However, the Eighth Circuit ruled that it did. Oral arguments before the Supreme Court in the seven cases are expected to be held in mid to late March of 2016.

D. Reporting Requirements.

The ACA imposes two new reporting requirements on group health plans that are effective for the 2015 calendar year. The first reporting requirement under Code section 6055 requires entities that provide minimum essential coverage to individuals to report regarding such coverage. Reporting entities generally must file Form 1094-B (transmittal) and Form 1095-B to satisfy the Code section 6055 reporting requirement. The second reporting requirement is imposed under Code section 6056 and requires applicable large employers[44] to report regarding their compliance with the employer shared responsibility provisions. Applicable large employers must file Form 1094-C (transmittal) and Form 1095-C to satisfy the Code section 6056 reporting requirement. In addition, an applicable large employer that sponsors a self-insured plan may use the Form 1095-C (along with the transmittal) to satisfy both the Code section 6055 and 6056 reporting requirements by completing all sections of such form. Both types of reports are first required to be filed in early 2016.

On September 17, 2015, the IRS issued Notice 2015-68,[45] which provides guidance on the requirement to report minimum essential coverage under Code section 6055. Specifically, the notice states that the IRS will be issuing proposed regulations:

- Requiring health insurance issuers to report coverage in catastrophic plans offered through an Exchange on Forms 1095-B;[46]

- Permitting electronic delivery of statements for expatriate health plans unless the recipient expressly refuses to consent to electronic delivery or requests paper statements;[47]

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[44]An applicable large employer is an employer who employed an average of at least 50 full-time employees, including full-time equivalent employees, during the preceding calendar year.

[45] 2015-41 I.R.B. 547.

[46] The notice indicates that the regulations will apply to coverage provided in 2016 (statements filed in 2017). The notice also encourages health insurance issuers to report on coverage provided in 2015 (statements filed in 2016).

- Allowing health insurance issuers reporting on insured group health plans to use a truncated taxpayer identification number of the employer sponsoring the plan on the statement provided to taxpayers; and

- Providing rules for when a provider of minimum essential coverage is not required to report coverage of an individual who has other minimum essential coverage.[48]

The notice also requests comments on soliciting taxpayer identification numbers ("TINs") of covered individuals. Until additional guidance is issued, the notice states that reporting entities will not be subject to penalties for failing to report a TIN if (1) the reporting entity makes an initial solicitation for the TIN at an individual's first enrollment or, if the individual was already enrolled on September 17, 2015, by the next open enrollment period; (2) the reporting entity makes a second solicitation at a reasonable time thereafter; and (3) the reporting entity makes a third solicitation by December 31 of the year following the initial solicitation.

In conjunction with the notice, the IRS issued final forms and instructions that must be used to satisfy the Code section 6055 and 6056 reporting requirements.[49] The same penalties that apply for failure to furnish and failure to file certain information returns, including Form W-2 and the Form 1099-series, will apply to the section 6055 and section 6056 returns.[50] The IRS will not impose penalties on a reporting entity that makes good faith efforts to comply with the information reporting requirements but files incorrect or incomplete information on the returns furnished in 2016 to report offers of coverage made in 2015.

E. Cadillac Plan Tax.

1. IRS Notices.

Effective January 1, 2018, a 40% excise tax will be imposed on certain high-cost employer-sponsored health care plans (so-called "Cadillac" plans) to the extent that the

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[47] The notice permits reporting entities to apply these rules to expatriate health plans that are issued or renewed on or after July 1, 2015. See Section IV.H for additional guidance applicable to expatriate health plans.

[48] Importantly, if an employee is covered under an insured group health plan and HRA sponsored by the same employer, the notice indicates that the employer would not be required to report the employee's coverage under the HRA.

[49] The draft forms and instructions are available at: https://www.irs.gov/pub/irs-prior/i109495b--2015.pdf, https://www.irs.gov/pub/irs-prior/f1094b--2015.pdf, https://www.irs.gov/pub/irs-prior/f1095b--2015.pdf, https://www.irs.gov/pub/irs-prior/i109495c-2015.pdf, https://www.irs.gov/pub/irs-prior/f1094c--2015.pdf, https://www.irs.gov/pub/irs-prior/f1095c--2015.pdf.

[50] See Section I.B for a description of the penalties, which were increased by recent legislation.

annual cost for an employee exceeds a threshold amount.[51] The threshold amount is $10,200 for employee-only coverage and $27,500 for coverage other than employee-only. These thresholds will be adjusted for plans that carry a higher premium cost because of age and gender demographics of an employer's employees. The thresholds will also be increased for qualified retirees and employees in certain high-risk professions. In 2018, the threshold may also be adjusted if health care inflation exceeds that built into the ACA on date of enactment and, for years after 2018, adjustments will be made to the thresholds to reflect increases in the Consumer Price Index.

The IRS issued two notices describing potential approaches regarding a number of issues relating to the Cadillac plan tax – Notice 2015-16[52] and Notice 2015-52.[53] These Notices do not provide guidance on the Cadillac plan tax but, instead, request comments on potential approaches the IRS is considering including in future guidance. Specifically, the Notices request comment on potential approaches to:

- Defining applicable coverage subject to the excise tax;
- Determining the cost of applicable coverage;
- Applying the annual dollar limit to the cost of applicable coverage to determine if there is an excess benefit subject to the excise tax;
- Identifying the taxpayers liable for the excise tax;
- Application of the employer aggregation rules for employers in a controlled group;
- Allocation of the excise tax among the applicable taxpayers; and
- Payment of the applicable tax.

The Notices indicate that the Treasury and IRS will consider comments submitted and then issue proposed regulations followed by final regulations. The proposed regulations will provide further opportunity for comment.

2. Church Alliance Comment Letters.

The Church Alliance has filed two comment letters on the Cadillac plan tax in 2015 urging flexibility for all employers that maintain or participate in church plans. The Church Alliance filed the first comment letter with the IRS[54] on May 15, 2015, in

[51] There have been several pieces of legislation introduced in Congress to repeal the Cadillac plan tax.

[52] 2015-10 I.R.B. 732.

[53] 2015-35 I.R.B. 227.

[54] A copy of the first Church Alliance comment letter is attached as Appendix D.

response to Notice 2015-16. This letter urges the IRS to consider the unique difficulties for denominational health plans in determining cost of coverage for purposes of the Cadillac plan tax. In addition, the letter requests flexibility in the application and calculation of the Cadillac plan tax, flexibility in allocation of the excess benefit and the cost of applicable coverage, and adjustments to the applicable dollar limits for denominational health plans and church employers.

The Church Alliance filed its second comment letter with the IRS[55] on October 1, 2015, in response to Notice 2015-52. This letter also requests relief from the tax and flexibility to the extent relief is not granted. Further, the letter explains the difficulty in calculating the cost of coverage for a church employer and describes the challenges that would be involved in calculating and allocating any excess benefit in the time period suggested by the IRS.

F. Summary of Benefits and Coverage ("SBC") Final Regulations.

In June of 2015, the Agencies issued final regulations on the SBC requirement.[56] The final regulations would incorporate previous FAQ guidance about the SBC requirement and make certain additional changes, including the following:

- If the plan provides the SBC to a participant prior to applying for coverage, the plan is not required to automatically provide another SBC upon application if there is no change to the information included in the SBC. If there is a change, then the plan must provide an updated SBC as soon as practicable, but in no event later than seven business days following receipt of the application for coverage.

- If the plan sponsor is negotiating the terms of coverage after an application for coverage has been filed and the information included in the SBC changes, then the plan sponsor is not required to provide an updated SBC until the first day of coverage (unless requested sooner).

- If the entity responsible for providing the SBC enters into a binding agreement with another party to provide the SBC on its behalf, then the entity will be considered to have satisfied the requirement to provide the SBC if certain requirements set forth in the regulations are satisfied.

The final regulations are effective with respect to participants who enroll or re-enroll in group health plan coverage through an open enrollment period beginning on the first day of the first open enrollment period that begins on or after September 1, 2015. The final regulations are effective with respect to participants who enroll in group health coverage other than through an open enrollment period on the first day of the first plan year beginning on or after September 1, 2015.

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[55] A copy of the second Church Alliance comment letter is attached as Appendix E.

[56] 80 Fed. Reg. 34,292 (June 16, 2015).

In conjunction with the proposed SBC regulations issued on December 30, 2014, the Agencies issued a new proposed SBC template, instructions, an updated uniform glossary and other supporting documents. Importantly, the proposed revisions to these documents would:

- Decrease the length of the SBC from 4-double sided pages to 2½-double sided pages;
- Add a coverage example for a simple foot fracture with an emergency room visit; and
- Revise the template and glossary to reflect ACA market reforms (e.g., by removing references to annual limits and preexisting conditions).

The preamble to the final regulations issued in June states that the revised SBC template and associated documents will be finalized by January of 2016 and will apply to coverage that would renew or begin on the first day of the first plan year that begins on or after January 1, 2017 (including open season periods occurring in the fall of 2016 for coverage beginning on or after January 1, 2017). These documents are being finalized at a later date to allow the Agencies time to utilize consumer testing and to offer an opportunity for the public (including the National Association of Insurance Commissioners) to provide input.

G. Minimum Value Guidance.

Under the ACA, an employer-sponsored health plan provides minimum value if the plan's share of the total cost of benefits provided thereunder is at least 60 percent. The minimum value requirement is used for purposes of determining whether an applicable large employer is subject to an assessable excise tax under the employer-shared responsibility provisions and for purposes of determining whether an individual who is offered employer-sponsored coverage is eligible for a premium tax credit for coverage provided through an Exchange.

One method a plan is permitted to use to determine if it satisfies minimum value is the federal government's minimum value calculator. In 2014, the Agencies discovered that plans excluding substantial coverage for in-patient hospitalization or physician services were able to satisfy the minimum value requirement using the federal government's minimum value calculator. After discovering this defect, the IRS issued Notice 2014-69,[57] which informed employers of the intent to issue proposed regulations stating that plans that do not provide substantial coverage for in-patient hospitalization or physician services do not provide minimum value.

HHS issued final regulations on the minimum value requirements in February, and the IRS issued proposed regulations on the minimum value requirements in August.[58] Under both sets of regulations, an eligible employer-sponsored plan provides minimum value only if the

[57] 2014-48 I.R.B. 903.

[58] 80 Fed. Reg. 10,750 (Feb. 27, 2015); 80 Fed. Reg. 52,678 (Sept. 1, 2015).

plan's share of the total cost of benefits provided under the plan is at least 60% and the plan includes substantial coverage of inpatient hospitalization and physician services.

Under transition relief included in the Notice and regulations, the changes to the minimum value requirements will not apply before the end of the plan year beginning no later than March 1, 2015 for employers that, prior to November 4, 2014, had either entered into a binding written commitment to adopt, or begun enrolling employees in, a plan that does not provide substantial coverage for in-patient hospitalization or physician services. For purposes of the transition relief, the plan year is the plan year in effect under the terms of the plan on November 3, 2014. The Notice and regulations also state that an offer of coverage under a plan that does not provide substantial coverage for in-patient hospitalization or physician services does not preclude an eligible employee from obtaining a premium tax credit. The final HHS regulations are already in effect, and the IRS regulations are proposed to be effective for plan years beginning after November 3, 2014. [59]

## H. Expatriate Health Plans

There is no exception in the ACA's market reform requirements for expatriate coverage. This means that plans covering foreign missionaries must comply with all of the ACA's market reform requirements, including coverage for dependents up to age 26, limitations on lifetime and annual benefit limits, coverage of preventive care services, and the expanded claims procedures.

In 2013 and 2014, the Agencies issued two sets of FAQ guidance providing transition relief to certain types of insured expatriate health coverage.[60] The transition relief did not apply to self-insured expatriate health plans. Under the transition relief, the Agencies considered the requirements of the ACA's market reform provisions to be satisfied if the plan and issuer comply with legal requirements that applied before the ACA, including mental health parity provisions, HIPAA nondiscrimination provisions, ERISA claims procedures, and any ERISA reporting and disclosure obligations. The transition relief applies for plan years ending on or before December 31, 2016.

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[59] The Notice also imposes certain additional requirements on employers qualifying for the transition relief discussed below. If an employer qualifying for the transition relief set forth in the Notice previously stated or implied that the offer of coverage under the plan precludes an employee from obtaining a premium tax credit, then the employer is required to correct such statement in a timely manner. The employer is also prohibited from making any such disclosures in the future. An employer that offers both a plan that qualifies for the transition relief and another plan that provides coverage for in-patient hospitalization and physician services may advise employees that the offer of coverage under the plan that covers these services may preclude the employee from obtaining a premium tax credit.

[60] *See* U.S. Dep't of Labor, FAQs about Affordable Care Act Implementation Part XIII (March 8, 2013), http://www.dol.gov/ebsa/faqs/faq-aca13.html; *See* U.S. Dep't of Labor, FAQs about Affordable Care Act Implementation Part XVIII (Jan. 9, 2014), http://www.dol.gov/ebsa/faqs/faq-aca18.html.

1. Expatriate Health Coverage Clarification Act of 2014

On December 16, 2014, the Expatriate Health Coverage Clarification Act of 2014 (the "Expatriate Act") was enacted as part of the Consolidated and Further Continuing Appropriations Act 2015.[61] The Expatriate Act exempts from most of the ACA mandates both insured and self-insured expatriate health plans issued or renewed on or after July 1, 2015, the employers in their capacity as plan sponsors of such plans, and health insurance issuers with respect to coverage offered under such plans. To qualify for the exemption, an expatriate health plan must satisfy the following requirements:

- Substantially all of the primary enrollees[62] in the plan must be qualified expatriates;[63]
- Substantially all of the benefits provided under the plan are not considered excepted benefits;
- The plan provides coverage for inpatient hospital services, outpatient facility services, physician services, and emergency services;[64]
- The plan sponsor reasonably believes the plan provides minimum value;
- If the plan provides dependent coverage of children, then it must make such coverage available until the child turns age 26;[65]
- The plan must be issued by an expatriate health plan issuer or administered by an administrator that, together with any other person in the issuer or administrator's

[61] Pub. L. No. 113-235 (2014).

[62] The Expatriate Act states that an individual is not considered a primary enrollee if the individual is not a national of the United States and resides in the country of which the individual is a citizen.

[63] The Expatriate Act indicates that there are three categories of qualified expatriates: (1) individuals whose skills or job duties cause their employer to transfer them to the United States for a specific and temporary purpose, who are reasonably determined to require access to health insurance in multiple countries and who are offered other multi-national benefits on a periodic basis; (2) individuals who are working outside of the United States for at least 180 days in a consecutive 12-month period that overlaps with the plan year; and (3) individuals who are members of a group of similarly situated individuals formed for the purpose of traveling or relocating internationally for tax-exempt purposes other than the sale of health insurance and who the Agencies determine require access to health insurance in multiple countries (e.g., missionaries or students).

[64] The countries in which these services must be provided depend on the circumstances and location of the individuals covered under the plan.

[65] This requirement does not apply to children of child dependents who are eligible for coverage under the plan.

controlled group, has licenses to sell insurance in more than two countries[66] and offers reimbursements for items or services under such plan in the local currency in eight or more countries; and

- The plan satisfies certain pre-ACA requirements of the Public Health Service Act, ERISA and the Code, as applicable to such plan.

A plan that satisfies the above requirements is exempt from most of the ACA mandates with the exception of the new ACA reporting requirements imposed under Code sections 6055 and 6056,[67] the employer shared responsibility provisions and, under certain circumstances, the Cadillac plan tax.

2. Notice 2015-43.

On June 30, 2015, the IRS issued Notice 2015-43 to provide interim guidance on the application of certain provisions of the ACA to plans that qualify as expatriate health plans under the requirements of the Expatriate Act. Until the issuance of further guidance, taxpayers are permitted to apply the requirements of the Expatriate Act using a reasonable good faith interpretation. In addition, until further guidance is issued, an expatriate health plan that qualified for relief under the FAQs that were released prior to the Expatriate Act will be treated as satisfying the requirements of the Expatriate Act.

The notice also includes a special rule that may be applied when calculating the amount of the Patient Centered Outcome Research Institute or "PCORI" fee. The PCORI fee is imposed under the ACA on certain health insurance policies and plan sponsors of certain self-insured health plans to fund an institute to perform research on the clinical effectiveness of certain medical treatments, services, procedures, and drugs. Under the special rule and until the issuance of further guidance, plan sponsors and issuers are permitted to determine the PCORI fee by excluding the lives covered under an applicable self-insured health plan for plan years starting on or after July 1, 2015 or a specified health insurance policy that is issued or renewed on or after July 1, 2015, if the plan or policy was primarily designed to cover:

- employees who are working and residing outside of the United States;

- employees who are not United States citizens or residents but are assigned to work in the United States either for a specific and temporary purpose or for no more than six months of the plan or policy year; or

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[66] The plan or company must also maintain network provider agreements providing for direct claims payments in eight or more countries, maintain call centers in three or more countries and accept calls from customers in eight or more languages, process at least $1,000,000 in claims, make available global evacuation/repatriation coverage and maintain legal and compliance resources in three or more countries.

[67] The Expatriate Act permits expatriate plans to furnish required statements to individuals electronically unless the individual explicitly refuses to consent to the electronic receipt of such statements.

- individuals who are members of a group of similarly situated individuals[68] formed for the purpose of traveling or relocating internationally for tax-exempt purposes other than the sale of health insurance and who the Agencies determine require access to health insurance in multiple countries (e.g., missionaries or students).

The notice indicates that the Agencies intend to issue proposed regulations providing guidance on expatriate health plans in the future.

## I. Transitional Reinsurance Program.

The ACA established the Transitional Reinsurance Program ("TRP") as one of the means of attempting to stabilize health insurance premiums after the ACA became generally effective in 2014. The TRP provides funding for those insurers that incur high-cost claims in the individual market whether inside or outside the Exchanges.

Under the TRP, most self-insured plans and health insurance issuers are required to make payments that will be used to offset some of the costs of high-cost medical claims in the individual market for 2014, 2015 and 2016. The fee is calculated with respect to nearly all participants in group health plans providing major medical coverage, including dependents who participate.

On February 27, 2015, HHS issued final regulations including certain provisions applicable to the TRP.[69] Importantly, the final regulations:

- Establish the transitional reinsurance fee for 2016 as $27 per enrollee, which is a decrease from the 2015 fee of $44 per enrollee and the 2014 fee of $44 per enrollee;

- Exempt both insured and self-insured expatriate coverage from the reinsurance fee for 2015 and 2016;

- Exempt self-administered,[70] self-insured plans from the reinsurance fee for 2015 and 2016; and

- Provide clarification on the counting methods that may be used to calculate the reinsurance fee.

The final regulations also provide clarification on the contribution submission process. Under the final regulations, a contributing entity must submit enrollment counts to HHS no later

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[68] The notice also sets forth additional guidance for purposes of determining whether an individual is a member of a group of similarly situated individuals. Members of a group of similarly situated individuals are considered qualified expatriates under the Expatriate Act.

[69] 80 Fed. Reg. 10,750 (Feb. 27, 2015).

[70] A self-administered plan is a plan that does not use a TPA for claims processing, appeals or enrollment.

than November 15 of the 2014, 2015 or 2016 benefit year or, where November 15 is not a business day, the next business day. HHS will notify contributing entities of the amount of the fee when the annual enrollment count is entered on pay.gov and will not send a separate notification or invoice. The final regulations also clarify that a contributing entity is permitted to either pay the entire 2014, 2015 or 2016 benefit year contribution in one payment no later than January 15, 2015, 2016 or 2017, as applicable, or in two payments with the first payment due by January 15, 2015, 2016 or 2017 and the second payment due by November 15, 2015, 2016 or 2017. If January 15 or November 15 is not a business day, then the payment is due on the next business day.

J. Federally-Facilitated Marketplace Employer Notice Program.

The ACA and its implementing regulations require each Exchange (or Health Insurance Marketplace) to notify any employer whose employee was determined to be eligible for an advance premium tax credit or cost sharing reduction because the employee attested that he or she was not enrolled in employer-sponsored coverage and was not eligible for employer-sponsored coverage that provides minimum value and is affordable. On September 18, 2015, the Center for Medicare and Medicaid Services ("CMS") provided guidance on how federally-facilitated marketplaces ("FFM") will notify employers when employees obtain an advance premium tax credit during 2016.[71]

The guidance states that, beginning in 2016, the FFM will send notices to an employer when one of its employees receives an advance premium tax credit for at least one month in 2016 and the employee provided the marketplace with a complete address for the employer. The notice will identify the employee and state that the employee is enrolled in marketplace coverage with an advance premium tax credit. The FFM will not notify the employer when an employee receiving advance premium tax credits or cost sharing reductions terminates marketplace coverage. The FFM intends to send the notices out in additional batches throughout 2016;,employers can expect to start receiving notices in the spring of 2016.

The guidance also permits employers to appeal an employer notice and claim that the employee is not eligible for a premium tax credit either because the employee is enrolled in employer-sponsored coverage or was offered employer-sponsored coverage that provides minimum value and is affordable. The appeal must be made to the address set forth in the guidance within 90 days from the date of the notice that is received from the FFM. If the employer's appeal is successful, then the FFM will send a notice to the employee encouraging him or her to update the marketplace application because a failure to update such application could result in tax liability.

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[71] *See* Frequently Asked Questions Regarding The Federally-Facilitated Marketplace's (FFM) 2016 Employer Notice Program, *available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Employer-Notice-FAQ-9-18-15.pdf. An FFM is a marketplace managed by the federal government in states that chose not to establish their own exchanges. The guidance also provides state-based marketplaces with flexibility to phase in their employer notice process.

K. Proposed Regulations on Nondiscrimination in Health Programs and Activities.

On September 8, 2015, HHS proposed new rules to implement Section 1557 of the ACA,[72] which prohibits discrimination in health coverage and care based on race, color, national origin, age, disability, and sex. The proposed rule would apply certain existing civil rights statutes relating to discrimination to health care activities.[73]

According to an HHS fact sheet issued in conjunction with the proposed rule, "Section 1557 is the first federal civil rights law to prohibit discrimination on the basis of sex in health care." With respect to discrimination on the basis of sex, the proposed rule would prevent discrimination based on gender identity and includes specific protections for transgender individuals. Specifically, the proposed rule would prohibit a categorical exclusion of coverage for health services relating to gender transition. In addition, a covered entity would be prohibited from denying services based on an individual's self-identified gender.[74]

The proposed rule imposes liability on a "covered entity" that provides an employee health benefit program[75] to its employees and/or their dependents where:

1. The covered entity is principally engaged in providing or administering health services or health insurance coverage;

2. The covered entity receives Federal financial assistance, a primary objective of which is to fund the covered entity's employee health benefit program; or

3. The entity is <u>not</u> principally engaged in providing or administering health services or health insurance coverage <u>but</u> operates a health program or activity, which is <u>not</u> an employee health benefit program, that receives Federal financial assistance; except that the covered entity is liable under this part with regard to the provision or administration of employee health benefits only to the employees in that health program or activity.

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[72] 80 Fed. Reg. 54,172 (Sept. 8, 2015).

[73] This would include Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination and Employment Act of 1975 and Section 504 of the Rehabilitation Act of 1973.

[74] The example set forth in the proposed rule is that a covered entity may not deny an individual treatment for ovarian cancer based on the individual's identification as a transgender male if the individual could benefit medically from the treatment.

[75] The proposed rule defines "employee health benefit program" as including, among other things, health benefits coverage or heath insurance provided to employees and/or their dependents established, operated, sponsored, or administered by, or on behalf of one or more employers, whether provided or administered by entities including but not limited to an employer, group health plan (as defined in the Employee Retirement Security Act of 1974 (ERISA, at 29 U.S.C. 1191(a)), third party administrator or health insurance issuer."

Under the proposed rule, a covered entity would include any entity that operates a health program or activity,[76] any part of which receives federal financial assistance. The term "federal financial assistance" is broadly defined to include the receipt of funds from the federal government by "grant, loan, credit, subsidy, contract . . . or any other arrangement." The preamble to the proposed rule indicates that a self-insured health care plan's receipt of Medicare Part D payments (such as, in conjunction with an employer group waiver, or "EGWP," plan) could expose the plan to liability.

The proposed rule does not appear to apply to self-insured church health plans, a church headquarters organization, a church pension board or the participating employers for the following reasons. First, a self-insured church health plan is a "health program or activity" and not a covered entity. Second, it appears a church headquarters organization or church benefit board would not be described in paragraph (1) above because it is not primarily engaged in providing or administering health insurance coverage. Third, it appears that a church headquarters, a church pension board and participating employers would not be described in paragraph (2) above because none of them receive Medicare Part D subsidies – the plan does. Finally, although the church headquarters, the church benefit board or the participating employers could be viewed as operating a health program or activity (the plan), the plan is an employee health benefit program and these organizations would thus not be described in paragraph (3).

On November 9, 2015, the Church Alliance submitted a comment letter on the proposed rule.[77] In the comment letter, the Church Alliance requests that HHS exempt church self-insured health care plans from the proposed rule because the plans do not receive Federal financial assistance (other than certain retiree-only Medicare supplement plans), nor is such assistance received by all or substantially all of the employers participating in the plans. The Church Alliance stated that at a minimum, clarification should be provided that a retiree-only church health care plan is not a health program or activity within the meaning of the proposed rule. In addition, the Church Alliance submitted the proposed rule should contain a religious conscience exemption that will clearly protect the rights of religious organizations that object to providing coverage for certain health or medical services otherwise required under Code section 1557.

## L. Final Excepted Benefit Regulations for Limited Wraparound Coverage.

The Agencies issued final regulations in March 2015 including "limited wraparound coverage" as an excepted benefit.[78] The regulations indicate that this is a pilot program and that

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[76] The term "health program or activity" is defined as the provision or administration of health-related services or health-related insurance coverage, which may include a group health plan. If the entity is principally engaged in providing or administering health services or health insurance coverage, then all of the organization's operations are considered part of the health program or activity.

[77] A copy of the Church Alliance comment letter is attached as Appendix F.

[78] 80 Fed. Reg. 13,995 (Mar. 18, 2015).

the regulations will only apply to coverage first offered no earlier than January 1, 2016, and no later than December 31, 2018, and ending no later than three years after the date it was first offered.

The regulations require the wraparound coverage to be provided through a group health plan that wraps around eligible individual health insurance coverage or coverage provided through a Multi-State Plan on an Exchange. Eligible individual health insurance coverage is defined as individual health insurance coverage that does not qualify as a grandfathered plan, does not qualify as a transitional individual health insurance plan, and does not consist solely of excepted benefits.

To qualify as an excepted benefit, the wraparound coverage must satisfy the following five requirements:

1. Covers Additional Benefits. The coverage must provide meaningful benefits beyond coverage of cost sharing and may not only provide benefits under coordination of benefits provision or consist of account-based coverage.

2. Limited in Amount. The annual cost of coverage per employee may not exceed the greater of: (i) the limit for health flexible spending accounts ("FSAs"); or (ii) 15% of the cost of coverage under the primary plan.

3. Nondiscrimination Requirements. The coverage does not impose any preexisting condition exclusions, does not discriminate against individuals based on any health factor, and does not discriminate in favor of highly compensated individuals.

4. Reporting Requirements. The plan sponsor must satisfy certain reporting requirements.

5. Plan Eligibility Requirements. The wraparound participants may not also be enrolled in health FSA coverage that qualifies as an excepted benefit. In addition, the wraparound coverage must satisfy certain additional eligibility conditions that differ depending on whether the coverage wraps around eligible individual health insurance coverage or Multi-State Plan Coverage.

## M. Individual Mandate Final Regulations.

Beginning January 1, 2014, individuals whose income exceeds the applicable threshold[79] and who did not enroll for health care coverage were subject to a penalty.[80] The penalty increases over time:

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[79] In 2014, the filing threshold for purposes of this penalty was $10,150 for a single filer under age 65 and $20,300 for married individuals under age 65 filing jointly. In 2015, the filing thresholds are $10,300 for a single filer under age 65 and $20,600 for married individuals under age 65 filing jointly.

[80] Individuals who are members of a health sharing ministry are exempt from this requirement.

- 2014: The penalty was the greater of $95 or 1% of income.[81]
- 2015: The penalty is the greater of $325 or 2% of income.
- 2016: The penalty is the greater of $695 or 2.5% of income.[82]
- For a family, the penalty is capped at 300% of the individual tax.

To avoid the penalty, individuals must have acceptable health coverage from: (1) an employer-sponsored plan; (2) an individual policy purchased through a private insurer or through a state Exchange; (3) a government program (*e.g.*, Medicare, some types of Medicaid coverage, or CHIP); (4) a grandfathered plan; or (5) any other plan designated by HHS as acceptable health coverage for purposes of the individual mandate. A number of exemptions apply to the requirement to maintain acceptable health coverage. In 2013, the IRS and HHS both issued final regulations providing guidance on exemptions from the individual mandate and the process for applying for the exemptions. The HHS regulations also set forth additional types of coverage that are considered acceptable health coverage for purpose of the individual mandate.

In November of 2014, the IRS issued final regulations providing additional guidance to individual taxpayers who may be liable for shared responsibility.[83] Specifically, the final regulations provide guidance on:

- Whether certain categories of government programs qualify as acceptable coverage for purposes of the individual mandate;
- How employer contributions to cafeteria plans and health reimbursement arrangements are treated in determining whether an individual is eligible for the exemption from the individual mandate applicable to individuals who cannot afford coverage;
- How wellness incentives are taken into account in determining the affordability of employer-sponsored coverage;
- Claiming the hardship exemption; and
- Calculating the monthly penalty amounts.

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[81] For purposes of this penalty, "income" equals the amount by which the taxpayer's household income exceeds the threshold amount of income required for income tax return filing for that taxpayer.

[82] The tax will be adjusted for inflation after 2016.

[83] 79 Fed. Reg. 70,464 (Nov. 26, 2014).

N. Final Market Reform Regulations.

On November 13, 2015, the Agencies issued final regulations on the market reform provisions of the ACA.[84] Specifically, the final regulations provide guidance relating to the following provisions:

- Grandfathered plans;
- Preexisting condition exclusions;
- Lifetime and annual limits;
- Rescissions;
- Coverage of dependent children to age 26;
- Internal claims and appeals and external review procedures; and
- Patient Protections.

The regulations finalize the proposed and interim final regulations issued in 2010, as amended, and incorporate subregulatory guidance issued since 2010. The final regulations are substantially the same as the prior guidance but make some important clarifications. For example, the final regulations:

- Clarify that the preexisting condition exclusion rules do not prohibit plans from excluding all benefits for a particular condition as long as the exclusion applies regardless of when the condition arose;[85]
- Clarify that group health plans that are not required to provide coverage for "essential heath benefits" are permitted to define such term for purposes of the annual and lifetime limit prohibition by reference to any of the 51 benchmark plans identified by a state or the District of Columbia or one of the three largest Federal Employee Health Benefit Plans;[86]

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[84] 80 Fed. Reg. 72,192 (Nov. 18, 2015).

[85] The regulations note that other laws may prohibit plans from excluding all benefits for a condition, such as the requirement that certain plans cover essential health benefits (further discussed below).

[86] Certain group health plans (including self-insured plans) are not required to provide coverage for all of the "essential health benefits." However, these plans are prohibited from imposing annual and lifetime limits on essential health benefits. The following ten general categories of benefits are considered essential health benefits: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder benefits (including behavioral health treatment),

- Prohibit plans from excluding dependent children who do not reside in a particular service area (although this does not change the extent to which plans are required to cover out-of-network services);

- Permit plans to require participants to select in-network providers within a specific geographic limit as primary care providers;

- Clarify when balance billing is permitted for out-of-network emergency services and that emergency care is not required to be obtained within a specific timeframe, such as 24 hours; and

- Provide clarifications and new guidance on the integration requirements applicable to HRAs, including a clarification that a forfeiture of HRA amounts or waiver of HRA reimbursements will comply with the integration requirements even if the amounts can be reinstated at a future date, upon death or at the earlier of the two dates.

The regulations are effective as of the first day of the first plan year beginning on or after January 1, 2017.

O. Miscellaneous FAQ Guidance.

The Agencies issued a number of FAQs over the past year providing guidance on the application of certain provisions of the ACA. In addition to the FAQs discussed in previous sections of this report, the Agencies issued FAQs providing the following guidance.

1. Limitations on Cost Sharing.

For plan years beginning on or after January 1, 2015, the maximum out-of-pocket limit applicable to non-grandfathered group health plans (including self-insured plans) is $6,600 for self-only coverage and $13,200 for coverage other than self-only coverage. For plan or policy years beginning in 2016, the maximum limit is $6,850 for self-only coverage and $13,700 for other than self-only coverage. For later plan years, the annual limit for self-only coverage will be adjusted by an HHS premium adjustment percentage.

In final regulations issued in 2015 primarily applicable to Exchange plans, HHS clarified that the self-only maximum annual limit on cost-sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or coverage that is other than self-only. On May 26, 2015, the Agencies issued FAQ

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prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

guidance in response to questions about whether the clarification applies to self-funded and large group health plans.[87]

The FAQ guidance clarifies that the requirement applies to all non-grandfathered group health plans, including self-funded and large group plans. Accordingly, the self-only maximum ($6,850 for 2016) applies to all individuals enrolled in the plan, regardless of whether the individual is enrolled in self-only or other than self-only coverage. The FAQ also states that this clarification will apply for plan or policy years beginning in or after 2016.[88]

2. Supplemental Excepted Benefits Coverage.

Benefits are considered supplemental excepted benefits if they are provided under a separate policy, certificate or contract of insurance and are either:

- Medicare supplemental health insurance (Medigap);
- TRICARE supplemental programs; or
- Similar supplemental coverage provided under a group health plan that is designed to fill gaps in the primary coverage, such as coinsurance or deductibles.

In 2007 and 2008, the Agencies issued guidance describing the circumstances under which supplemental coverage would qualify as an excepted benefit for purposes of the ACA. Under the guidance, the Agencies will consider the following four criteria in determining whether supplemental coverage qualifies as an excepted benefit:

- The policy, certificate or contract of insurance must be issued by an entity that does not provide the primary coverage under the plan;
- The supplemental policy, certificate or contract of insurance must be specifically designed to fill gaps in primary coverage, such as deductible or copayments;

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[87] *See* U.S. Dep't of Labor, FAQs about Affordable Care Act Implementation Part XXVII (May 26, 2015) *available at* http://www.dol.gov/ebsa/faqs/faq-aca27.html.

[88] The FAQ includes an example under which a family of four individuals is enrolled in family coverage under a group health plan. The annual limit on cost sharing for 2016 for all four individuals is $13,000. Individual #1 incurs claims associated with $10,000 in cost sharing and individuals #2, #3 and #4 each incur claims associated with $3,000 in cost sharing. The self-only maximum cost sharing amount ($6,850 in 2016) applies to each individual. Accordingly, the cost sharing for individual #1 is limited to $6,850 and the plan is required to pay $3,150 (the difference between the $10,000 in cost sharing for individual #1 and the self-only maximum cost sharing amount of $6,850). The four individuals collectively incurred $15,850 in cost sharing ($6,850 + $3,000 + $3,000 + $3,000). The cost sharing for the four individuals collectively is limited to $13,000 under the plan. Accordingly, the plan must pay $2,850 (the difference between $15,850 and the $13,000 annual limitation).

- The cost of the supplemental coverage may not exceed 15% of the cost of the primary coverage; and

- Supplemental coverage sold in the group market must not differentiate among individuals in eligibility, benefits or premiums based on any health factor of the individual or dependents.

On February 13, 2015, the Agencies issued an FAQ because they became aware that health insurance issuers are selling supplemental products that provide a single benefit and characterizing such products as excepted benefits.[89] The FAQ states that the Agencies intend to propose regulations clarifying the circumstances under which supplemental insurance products that provide an additional benefit (instead of paying for cost-sharing amounts) are considered to be designed to fill in gaps in primary coverage. Specifically, the FAQ states that the Agencies intend to propose that the coverage of additional categories of benefits will be considered to be designed to fill in the gaps of primary coverage only if the benefits covered by the supplemental insurance product are not essential health benefits in the state where the product is being marketed.

The FAQ also provides an enforcement safe harbor pending the publication of proposed regulations. Under the enforcement safe harbor, the Agencies will not take any enforcement action if an issuer of group or individual health insurance coverage fails to comply with the Code, ERISA or the Public Health Service Act with respect to coverage that:

- Provides coverage of additional categories of benefits that are not considered essential health benefits in the applicable state (instead of filling in cost-sharing gaps);

- Complies with the applicable regulations and guidance on supplemental coverage; and

- Has been filed and approved with the state, as required under state law.

The FAQ also notes that the supplemental coverage will be designed to fill in gaps under the primary plan only if the benefits are not covered by the primary group health plan.

3. Other.

The Agencies have issued FAQs that provide guidance on the following:

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[89] *See* U.S. Dep't of Labor, FAQs about Affordable Care Act Implementation Part XXII (Feb. 13, 2015) *available at* http://www.dol.gov/ebsa/faqs/faq-aca22.html.

- Reference-based pricing structures, which are pricing structures under which the plan pays a fixed amount for a particular procedure which certain providers will accept as payment in full.[90]

- Wellness programs provided in connection with group health coverage.[91]

- The types of preventive services that must be covered by non-grandfathered health plans without the imposition of any cost sharing requirements.[92]

- The provider nondiscrimination requirements.[93]

- The requirements under the Mental Health Parity and Addiction Equity Act of 2008, including certain disclosure requirements.[94]

P. ACA Tax Credits.

Code section 36B(b)(2), which was enacted by the ACA, makes premium tax credits available to certain individuals who purchase coverage through an Exchange "established by the State under section 1311" of the ACA. The IRS issued a final rule defining "Exchange" for purposes of Code section 36B(b)(2) as including both an Exchange established by a State and a federally-facilitated Exchange established by HHS under Section 1321 of the ACA. On July 22, 2014, the D.C. Circuit Court of Appeals and the Fourth Circuit Court of Appeals issued conflicting decisions on the validity of the IRS's rule.

In *Halbig v. Burwell*,[95] the Court of Appeals for the D.C. Circuit ruled that the ACA unambiguously restricts premium tax credits to insurance purchased on Exchanges "established

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[90] *See* U.S. Dep't of Labor, FAQs about Affordable Care Act Implementation Part XXI (October 10, 2014) *available at* http://www.dol.gov/ebsa/faqs/faq-aca21.html.

[91] *See* U.S. Dep't of Labor, FAQs about Affordable Care Act Implementation Part XXV (April 16, 2015) *available at* http://www.dol.gov/ebsa/faqs/faq-aca25.html; *See* U.S. Dep't of Labor, FAQs about Affordable Care Act Implementation Part XXIX (October 23, 2015) *available at* http://www.dol.gov/ebsa/faqs/faq-aca29.html.

[92] *See* U.S. Dep't of Labor, FAQs about Affordable Care Act Implementation Part XXVI (May 11, 2015) *available at* http://www.dol.gov/ebsa/faqs/faq-aca26.html; *See* U.S. Dep't of Labor, FAQs about Affordable Care Act Implementation Part XXIX (October 23, 2015) *available at* http://www.dol.gov/ebsa/faqs/faq-aca29.html. The FAQs clarify that, if a plan provides coverage for dependents, then it is required to cover without cost sharing recommended women's preventive care services for dependent children (including recommended preventive services related to pregnancy) that are determined to be age and developmentally appropriate by the dependent's attending provider.

[93] *See* U.S. Dep't of Labor, FAQs about Affordable Care Act Implementation Part XXVII (May 26, 2015) *available at* http://www.dol.gov/ebsa/faqs/faq-aca27.html

[94] *See* U.S. Dep't of Labor, FAQs about Affordable Care Act Implementation Part XXIX (October 23, 2015) *available at* http://www.dol.gov/ebsa/faqs/faq-aca29.html.

by States." The Court found that the plain language of Code section 36B distinguishes between state-run and federally-facilitated Exchanges and only makes premium tax credits available to individuals purchasing insurance through state-run Exchanges. The Court also found that this interpretation does not create absurd results and that the legislative history does not show that this interpretation is "*demonstrably* at odds" with the intent of the ACA's drafters.

In contrast, the Fourth Circuit Court of Appeals determined in *King v. Burwell*[96] that the statutory language was ambiguous. The Court also determined that the IRS acted reasonably in interpreting the ambiguous provisions and that the IRS's rule making premium tax credits available to eligible individuals receiving coverage through either a state-run or federally-facilitated Exchange was a "permissible exercise of the agency's discretion." The plaintiffs in *King* filed a Petition for Certiorari with the U.S. Supreme Court, which was granted by the justices on November 7, 2014.[97]

On June 25, 2015, the U.S. Supreme Court decided in *King* that tax credits are available both for individuals who purchase insurance on state-run Exchanges and for individuals who purchase insurance on federally-facilitated Exchanges because the intent of the ACA was to provide coverage for all Americans.[98] While conceding that the statute's language was ambiguous, the Court looked to the broader text and structure of the ACA as a whole, holding that tax credits must be available to all qualifying citizens for insurance purchased on any Exchange created under the ACA, whether state-run or federally-facilitated. The Court explained that the plaintiffs' interpretation of the law "would destabilize the individual insurance market in any State with a Federal Exchange, and likely create the very 'death spirals' that Congress designed the [ACA] to avoid."[99]

Q. Future ACA Provisions of Importance.

1. Nondiscrimination Rules.

Currently, Code section 105(h) prohibits self-funded group health plans from discriminating in favor of highly compensated individuals in terms of eligibility and benefits. These Code section 105(h) rules apply to all self-funded group health plans, including church plans. The ACA imposed rules similar to these nondiscrimination

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[95] 758 F.3d 390 (D.C. Cir. 2014).

[96] 759 F.3d 358 (4th Cir. 2014), *cert. granted*, 135 S. Ct. 475 (2014).

[97] *Id.*

[98] 135 S.Ct. 2480 (2015).

[99] *Id.* at *15. After the U.S. Supreme Court's decision, the parties in the *Halbig* case filed a motion to voluntarily dismiss the appeal, which was granted by the Court of Appeals for the D.C. Circuit on July 9, 2015. 2015 WL 5209629, No. 14–5018 (July 9, 2015).

requirements to most fully insured health care plans, effective for plan years beginning on or after September 23, 2010.

As a result of comments raising concerns about compliance with the ACA nondiscrimination requirements in the absence of regulatory guidance, the IRS delayed the effective date of this provision until after it issues regulations or administrative guidance.[100] The issuance of any guidance on the insured plan nondiscrimination rules bears close watch because any such rules may also include revisions to the current nondiscrimination rules applicable to self-insured plans.

2. Automatic Enrollment

The Bipartisan Budget Act of 2015, which was enacted on November 2, 2015,[101] repealed the automatic enrollment provision included in the ACA. This provision would have required employers that have more than 200 full-time employees and that offer at least one health benefit plan to automatically enroll new employees in a health benefit plan. This provision had not gone into effect prior to its repeal.[102]

## V. Other Actions

### A. Litigation on Exclusion for Churches from Filing Forms 1023 and 990

In *Freedom From Religion Foundation v. Werfel*,[103] the Foundation claimed that the IRS was violating the Establishment and Equal Protection clauses of the U.S. Constitution by imposing different requirements on churches and other nonprofit organizations with respect to tax-exempt status. Specifically, the Foundation asserted that it was required to file a detailed Form 1023 application and pay a filing fee before obtaining tax exempt status and is required to annually file Form 990 information returns in order to maintain tax exempt status. Churches and their integrated auxiliaries are exempt from filing both of these forms. In September 2013, the District Court dismissed the claim relating to the Form 1023 filing requirement because it determined that the Foundation did not have standing to bring this claim. However, the Court denied the IRS's motion to dismiss with respect to the exemption for filing Forms 990. In

[100] IRS Notice 2011-01, 2011-2 I.R.B. 259 (Dec. 22, 2010).

[101] Pub. L. No. 114-74.

[102] Although this provision was technically effective on the date of the ACA's enactment (*i.e.*, March 23, 2010), the DOL indicated that it would not enforce this provision until after it issued regulations, and these regulations were never issued.

[103] *Freedom from Religion Found. v. Werfel*, No. 12-CV-946-BBC, 2013 WL 4501057 (W.D. Wis. Aug. 22, 2013).

September 2014, the IRS filed a motion for summary judgment in this case.[104] The case was dismissed for lack of standing to sue in December, 2014.[105]

B. Equal Employment Opportunity Commission.

1. Proposed Wellness Regulations.

The Americans with Disabilities Act ("ADA") generally prohibits employers from making disability-related inquiries and medical examinations unless the inquiry or exam is "voluntary" and part of an employee health program available at the employee's worksite. Prior to the issuance of the proposed rule, there was little guidance on how the ADA applies to wellness programs.

On April 20, 2015, the EEOC issued a proposed rule amending the regulations and interpretive guidance implementing Title I of the ADA as it relates to employer wellness programs.[106] The proposed rule explains that compliance with the proposed rule does not ensure compliance with all of the anti-discrimination laws the EEOC enforces.

The proposed rule clarifies that a wellness program may be a part of a group health plan, or may be offered outside of a group health plan (which includes both insured and self-insured group health plans). The proposed rules impose certain additional requirements on wellness programs offered as part of a group health plan.

Under the proposed rule, an employee health program, including any disability-related inquiries and medical examinations that are part of such a program, must be reasonably designed to promote health or prevent disease. The program must have a reasonable chance of improving the health of (or preventing disease in) participating employees and must not be overly burdensome, a subterfuge for violating the ADA or other laws prohibiting employment discrimination, or highly suspect in the method chosen to promote health or prevent disease.

The proposed rule clarifies that employers may offer limited incentives up to a maximum of 30% of the total cost of employee-only coverage (whether in the form of a reward or a penalty) to promote an employee's participation in a wellness program that includes disability-related inquiries or medical examinations as long as participation is voluntary. The proposed rule does not expressly address how this 30% limit applies to tobacco cessation programs. The proposed rule defines voluntary as meaning a covered entity:

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[104] Because Daniel Werfel, the IRS Commissioner who was the named defendant in the case, left the IRS and has been replaced by John Koskinen, the case is now named *Freedom From Religion Foundation v. Koskinen*.

[105] (W.D. Wis., Dec. 17, 2014).

[106] 80 Fed. Reg. 21,659 (Apr. 20, 2015).

- does not require employees to participate;

- does not deny coverage under any of its group health plans or particular benefits packages within a group health plan for non-participation or limit the extent of such coverage (except pursuant to allowed incentives); and

- does not take any adverse employment action or retaliate against, interfere with, coerce, intimidate or threaten employees within the meaning of section 503 of the ADA.

To ensure that participation in a wellness program that is part of a group health plan that includes disability-related inquiries and/or medical examinations is truly voluntary, an employer must provide a notice that clearly explains what medical information will be obtained, who will receive the medical information, how the medical information will be used, the restrictions on its disclosure, and the methods the covered entity will employ to prevent improper disclosure of the medical information. Finally, the proposed rule allows the disclosure of medical information obtained by wellness programs to employers only in aggregate form, except as needed to administer the health plan.

2. Genetic Information Nondiscrimination Act of 2008 Proposed Rule.

On October 30, 2015, the EEOC issued a proposed rule amending the regulations implementing Title II of the Genetic Nondiscrimination Act of 2008 as they relate to employer wellness programs.[107] The proposed rule addresses the extent to which an employer may offer an employee inducements for the employee's spouse to provide genetic information about the spouse's current or past health status as part of a health risk assessment administered in connection with an employer-sponsored wellness program in which the spouse participates.

The Genetic Information Nondiscrimination Act of 2008 ("GINA") restricts acquisition and disclosure of genetic information, and includes an absolute prohibition on the use of genetic information in making employment decisions. The EEOC issued implementing GINA regulations in 2010, which made it clear that one of the requirements of a voluntary wellness program that wanted to collect genetic information was that the wellness program could not condition inducements for employees on the provision of genetic information. Since 2010, the EEOC has received numerous inquiries about whether an employer will violate GINA by offering an employee an inducement if the employee's spouse completes a health risk assessment that seeks information about the spouse's current or past health status in connection with the spouse's receipt of health or genetic services as part of an employer-sponsored wellness program.

The proposed rule clarifies that GINA does not prohibit employers from offering limited inducements (whether in the form of rewards or penalties avoided) for the

[107] 80 Fed. Reg. 66,853 (Oct, 30, 2015).

provision by spouses covered by the employer's group health plan of information about their past or current health status as part of a health risk assessment, as long as certain requirements are met. Specifically, the provision of genetic information must be voluntary and the individual from whom the genetic information is being obtained must provide prior, knowing, voluntary and written authorization. In addition, the information being requested should be reasonably designed to promote health or prevent disease. The total inducement to the employee and spouse may not exceed 30 percent of the total annual cost of coverage for the plan in which the employee and any dependents are enrolled. The proposed rule prohibits inducements regarding an employee's children.

The proposed rule also provides the following guidance on the requirements imposed by GINA:

1. Employers may request, require or purchase genetic information as part of health or genetic services only when those services are reasonably designed to promote health or prevent disease.

2. The maximum share of the inducement attributable to the employee's participation in the employer wellness program must be equal to 30 percent of the cost of self-only coverage. The remainder of the inducement (equal to 30 percent of the total cost of coverage for the plan in which the employee and any dependents are enrolled, minus 30 percent of the total cost of self-only coverage) may be provided in exchange for the spouse providing information to an employer wellness program about his or her current or past health status.

3. A covered entity is prohibited from conditioning participation in a wellness program on an employee, spouse or other covered dependent agreeing to the sale of genetic information or waiving protections provided under GINA.

4. The employer is permitted to seek information about the current or past health status of an employee's spouse who is covered by the employer's group health plan and is completing a health risk assessment on a voluntary basis.

5. The term "financial" is being removed as a modifier of the type of inducements discussed in the regulation to make it clear that inducements include both financial and in-kind inducements, such as time off awards and prizes.

## C. Securities and Exchange Commission Issues No Comment Letter on Use of Certain Bank Collective Trusts.

On October 6, 2015, the Securities and Exchange Commission ("SEC") issued a letter to the North American Division of Seventh-day Adventists[108] stating it would not recommend enforcement action under Section 7 of the Investment Company Act of 1940 ("'40 Act") against a bank collective trust, or an insurance company separate account in which a bank collective trust

[108] North American Conference of the Seventh-day Adventists, SEC No-Action Letter (Oct. 6, 2015).

invests, if the insurance company separate account continues to rely on an exclusion from the definition of investment company in section 3(c)(11) of the '40 Act despite the fact that the bank collective trust contains church plan assets .

D. Challenges to Church Plan Status.

Twelve lawsuits have been filed in the last several years challenging the availability of the ERISA church plan exemption to defined benefit plans sponsored by a number of different religiously affiliated health care systems.[109] The focus in these cases is on defined benefit pension plans sponsored by these health care systems. The allegations in these lawsuits are substantially the same: plaintiffs in each lawsuit claim that (1) the defendant plans have violated ERISA requirements and engaged in prohibited transactions; (2) that the defendants have purposefully ignored ERISA requirements that are meant to protect participants by improperly claiming to be church plans, exempt from ERISA; and (3) that the plans are underfunded. All but one of the lawsuits also allege that the exemption of church plans from ERISA is unconstitutional. The principal argument in each case is that the IRS, DOL and courts have misinterpreted the church plan definition for over 30 years and that only plans established by churches can be church plans. According to plaintiffs' arguments, plans established by 501(c)(3) organizations that are controlled by or associated with a church cannot qualify as church plans.

Opinions have been handed down in six of these lawsuits to date. As discussed below, the judges authoring these opinions are not in agreement on how to interpret the church plan definition:

- The *Rollins* Decision: In December 2013, a decision was handed down in *Rollins v. Dignity Health*.[110] The District Court in California denied the defendant's motion to dismiss and ruled that a single employer cannot maintain a church plan. The court further concluded that a church plan must be established by a church or a convention or association of churches. The court's holding in this case specifically rejects the IRS's interpretation of the church plan definition which has been espoused by the IRS in numerous private letter rulings ("PLRs") for over 30 years.[111]

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[109] *Overall v. Ascension Health* (E.D. Mich.); *Chavies v. Catholic Health East* (E.D. Pa.); *Rollins v. Dignity Health* (N.D. Cal.); *Kaplan v. Saint Peter's Healthcare System* (D. N.J.); *Medina v. Catholic Health Initiatives* (D. Colo.); *Owens v. St. Anthony Medical Center* (N.D. Ill.); *Stapleton v. Advocate Health Care Network* (N.D. Ill.); *Lann v. Trinity Health* (D. Md.); *Morris v. Daughters of Charity Health System* (N.D. Cal.); *Griffith v. Providence Health Services* (W.D. Wash.); *Tucker v. Baptist Health System* (N.D. Ala.); and *Carver v. Presence Health Network* (N.D. Ill.).

[110] 2013 WL 6512682 (N.D. Cal. Dec 12, 2013).

[111] In February, 2015, the 9th Circuit Court of Appeals granted the defendants' request for an interlocutory appeal and briefs by all parties have been filed with the 9th Circuit.

- The *Kaplan* Decision: On March 31, 2014, a District Court in New Jersey issued an opinion in *Kaplan v. Saint Peter's Healthcare System.*[112] The court agreed with the ruling in the *Rollins* case, concluding that a church plan must be established by a church or a convention or association of churches. The court also ruled on another important issue—whether a PLR issued by the IRS on the church plan status of a particular employer's retirement plan is to be given deference in deciding how the church plan definition should be interpreted by a court. The employer had obtained a favorable PLR concluding that its defined benefit pension plan was a church plan; however, the court determined that this PLR issued to the employer should not be given deference.[113]

- The *Overall* Decision: On May 9, 2014, a decision was handed down in *Overall v. Ascension Health.*[114] A District Court in Michigan squarely rejected the *Rollins* and *Kaplan* courts' interpretation of the church plan definition. The court granted the defendants' motion to dismiss and ruled that a church plan does not need to be established by a church. In reaching its conclusion, the court also considered whether to give deference to PLRs and determined that such rulings were entitled to deference. The court ultimately held that the Ascension Health defined benefit pension plan is a church plan. The court also determined that the plaintiff did not have standing to pursue her claim that the church plan definition is unconstitutional.[115]

- The *Medina* Decision: In *Medina v. Catholic Health Initiatives*, decided on August 29, 2014, a District Court in Colorado also concluded that the church plan definition does not require that a church plan be established by a church.[116] The court did not grant the defendants' motion to dismiss, however. The court

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[112] 2014 WL 1284854 (D. N.J. March 31, 2014).

[113] In January, 2013, the 3rd Circuit Court of Appeals granted the defendants' request for an interlocutory appeal and oral arguments were heard on October 8, 2015.

[114] 2014 WL 2448492 (E. D. Mich. 2014).

[115] The case was appealed to the 6th Circuit Court of Appeals, but was settled prior to argument. The plan participants agreed to drop their claim that Ascension Health's plans are ineligible for ERISA's church plan exemption in exchange for an $8 million contribution to the Ascension plan as well as the inclusion of certain ERISA-like protections in its plan documents. *Overall v. Ascension Health*, No. 13-cv-11396-AC-LJM (E.D. Mich. May 11, 2015). This monetary contribution is well under the alleged $444 million funding shortfall claimed by the participants in a 2013 court filing, suggesting a significant victory for Ascension Health. The participants also agree to waive all future similar claims unless (1) the Roman Catholic Church disassociates itself from Ascension, (2) the IRS issues a private letter ruling stating that the plan is not a church plan, or (3) either a federal law is enacted or the U.S. Supreme Court rules that a church plan must be established by a church (or a convention or association of churches). An order and final judgment was entered in the District Court approving the settlement.

[116] 2014 WL 3408690 (D. Colo. July 9, 2014).

indicated that it still needs to determine whether the employer is controlled by or associated with a church and whether the plan is maintained by the type of organization required under the statute before that ruling can be made. The plaintiffs' interlocutory appeal motion was denied and the case continues at the trial court level with briefing on motions for summary judgment.

- The *Stapleton* Decision: In *Stapleton v. Advocate Health Care Network*, decided on December 31, 2014, a District Court in Illinois denied the defendant's motion to dismiss, agreeing with the analysis in *Rollins* and *Kaplan* by concluding that a church plan must be established by a church or a convention or association of churches.[117] As in *Kaplan*, the employer had obtained a favorable PLR concluding that its defined benefit pension plan was a church plan; however, the court determined that this PLR issued to the employer should not be given deference.[118]

- The *Lann* Decision: On February 24, 2015, a District Court in Maryland granted the employer's motion to dismiss in *Lann v. Trinity Health*.[119] The Court ruled that a church plan could be established by an organization that is "controlled by or associated with a church or convention or association of churches."

## E. HSA Limits for 2016

The IRS has announced the maximum contribution levels for HSAs and out-of-pocket spending limits for high deductible health plans ("HDHPs") that must be used in conjunction with HSAs for 2016.[120] The relevant amounts for 2016 are as follows:

| | |
|---|---|
| Annual HSA contribution limit | **$3,350**– individual coverage (*no change*)<br>**$6,650**–family coverage (*$100 increase*) |
| Catch-up contribution limit over age 55 | **$1,000** (*no change*) |
| Maximum HDHP out-of-pocket limit | **$6,550**– individual coverage (*$100 increase*)<br>**$13,100** – family coverage (*$200 increase*) |
| HDHP minimum deductible | **$1,300** – individual coverage (*no change*)<br>**$2,600** – family coverage (*no change*) |

[117] 2014 WL 1284854 (D.N.J. Mar. 31, 2014).

[118] The 7th Circuit Court of Appeals granted the defendants' request for an interlocutory appeal in February, 2015 and oral arguments were made in the case on September 18, 2015.

[119] (D. Md. Feb. 24, 2015).

[120] Rev. Proc. 2015-30.

## F. Social Security Cost of Living Adjustments

On October 15, 2015, the Social Security Administration announced the cost of living adjustments for 2016. The cost of living adjustments for 2016 are as follows:

| | |
|---|---|
| Increase in monthly benefits | 0% |
| Maximum earnings subject to Social Security taxes | $118,500 (*no change*) |
| Maximum earnings subject to Medicare taxes | Unlimited |
| Exempted earnings amount:[121]<br>• In year prior to year during which retiree reaches full retirement age (Note: Full retirement age is 66 for persons born between 1943 and 1954.)<br>• In year during which retiree reaches full retirement age (Note: This applies to persons turning 67 in 2016.) | <br>$15,720 *(no change)*<br><br>$41,880 *(no change)* |

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

# APPENDIX A – SENATE

## Text of the Church Plan Clarification Act of 2015

114TH CONGRESS
1ST SESSION

# S. _____

To amend the Internal Revenue Code of 1986 to clarify the treatment of church pension plans, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

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Mr. CARDIN (for himself, Mr. PORTMAN, and Ms. KLOBUCHAR) introduced the following bill; which was read twice and referred to the Committee on _____

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# A BILL

To amend the Internal Revenue Code of 1986 to clarify the treatment of church pension plans, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "Church Plan Clarification Act of 2015".

**SEC. 2. CHURCH PLAN CLARIFICATION.**

(a) APPLICATION OF CONTROLLED GROUP RULES TO CHURCH PLANS.—

(1) IN GENERAL.—Section 414(c) of the Internal Revenue Code of 1986 is amended—

(A) by striking "For purposes" and inserting the following:

"(1) IN GENERAL.—Except as provided in paragraph (2), for purposes", and

(B) by adding at the end the following new paragraph:

"(2) SPECIAL RULES RELATING TO CHURCH PLANS.—

"(A) GENERAL RULE.—Except as provided in subparagraphs (B) and (C), for purposes of this subsection and subsection (m), an organization that is otherwise eligible to participate in a church plan shall not be aggregated with another such organization and treated as a single employer with such other organization for a plan year beginning in a taxable year unless—

"(i) one such organization provides (directly or indirectly) at least 80 percent of the operating funds for the other organization during the preceding tax year of the recipient organization, and

"(ii) there is a degree of common management or supervision between the or-

ganizations such that the organization providing the operating funds is directly involved in the day-to-day operations of the other organization.

"(B) NONQUALIFIED CHURCH-CONTROLLED ORGANIZATIONS.—Notwithstanding subparagraph (A), for purposes of this subsection and subsection (m), an organization that is a nonqualified church-controlled organization shall be aggregated with 1 or more other nonqualified church-controlled organizations, or with an organization that is not exempt from tax under section 501, and treated as a single employer with such other organization, if at least 80 percent of the directors or trustees of such other organization are either representatives of, or directly or indirectly controlled by, such nonqualified church-controlled organization. For purposes of this subparagraph, the term 'nonqualified church-controlled organization' means a church-controlled tax-exempt organization described in section 501(c)(3) that is not a qualified church-controlled organization (as defined in section 3121(w)(3)(B)).

"(C) PERMISSIVE AGGREGATION AMONG CHURCH-RELATED ORGANIZATIONS.—The church or convention or association of churches with which an organization described in subparagraph (A) is associated (within the meaning of subsection (e)(3)(D)), or an organization designated by such church or convention or association of churches, may elect to treat such organizations as a single employer for a plan year. Such election, once made, shall apply to all succeeding plan years unless revoked with notice provided to the Secretary in such manner as the Secretary shall prescribe.

"(D) PERMISSIVE DISAGGREGATION OF CHURCH-RELATED ORGANIZATIONS.—For purposes of subparagraph (A), in the case of a church plan, an employer may elect to treat churches (as defined in section 403(b)(12)(B)) separately from entities that are not churches (as so defined), without regard to whether such entities maintain separate church plans. Such election, once made, shall apply to all succeeding plan years unless revoked with notice provided to the Secretary in such manner as the Secretary shall prescribe.".

(2) CLARIFICATION RELATING TO APPLICATION OF ANTI-ABUSE RULE.—The rule of 26 CFR 1.414(c)-5(f) shall continue to apply to each paragraph of section 414(c) of the Internal Revenue Code of 1986, as amended by paragraph (1).

(3) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to years beginning before, on, or after the date of the enactment of this Act.

(b) APPLICATION OF CONTRIBUTION AND FUNDING LIMITATIONS TO 403(b) GRANDFATHERED DEFINED BENEFIT PLANS.—

(1) IN GENERAL.—Section 251(e)(5) of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97–248), is amended—

(A) by striking "403(b)(2)" and inserting "403(b)", and

(B) by inserting before the period at the end the following: ", and shall be subject to the applicable limitations of section 415(b) of such Code as if it were a defined benefit plan under section 401(a) of such Code (and not to the limitations of section 415(c) of such Code).".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to years beginning be-

fore, on, or after the date of the enactment of this Act.

(c) AUTOMATIC ENROLLMENT BY CHURCH PLANS.—

(1) IN GENERAL.—This subsection shall supersede any law of a State that relates to wage, salary, or payroll payment, collection, deduction, garnishment, assignment, or withholding which would directly or indirectly prohibit or restrict the inclusion in any church plan (as defined in section 414(e) of the Internal Revenue Code of 1986) of an automatic contribution arrangement.

(2) DEFINITION OF AUTOMATIC CONTRIBUTION ARRANGEMENT.—For purposes of this subsection, the term "automatic contribution arrangement" means an arrangement—

(A) under which a participant may elect to have the plan sponsor or the employer make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor or the employer make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant

specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage), and

(C) under which the notice and election requirements of paragraph (3), and the investment requirements of paragraph (4), are satisfied.

(3) NOTICE REQUIREMENTS.—

(A) IN GENERAL.—The plan sponsor of, or plan administrator or employer maintaining, an automatic contribution arrangement shall, within a reasonable period before the first day of each plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which—

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) ELECTION REQUIREMENTS.—A notice shall not be treated as meeting the require-

ments of subparagraph (A) with respect to a participant unless—

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the explanation described in clause (i) and before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

(4) DEFAULT INVESTMENT.—If no affirmative investment election has been made with respect to any automatic contribution arrangement, contributions to such arrangement shall be invested in a default investment selected with the care, skill, prudence, and diligence that a prudent person selecting an investment option would use.

(5) EFFECTIVE DATE.—This subsection shall take effect on the date of the enactment of this Act.

(d) ALLOW CERTAIN PLAN TRANSFERS AND MERGERS.—

(1) IN GENERAL.—Section 414 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(z) CERTAIN PLAN TRANSFERS AND MERGERS.—

"(1) IN GENERAL.—Under rules prescribed by the Secretary, except as provided in paragraph (2), no amount shall be includible in gross income by reason of—

"(A) a transfer of all or a portion of the accrued benefit of a participant or beneficiary, whether or not vested, from a church plan that is a plan described in section 401(a) or an annuity contract described in section 403(b) to an annuity contract described in section 403(b), if such plan and annuity contract are both maintained by the same church or convention or association of churches,

"(B) a transfer of all or a portion of the accrued benefit of a participant or beneficiary from an annuity contract described in section 403(b) to a church plan that is a plan described

in section 401(a) or an annuity contract described in section 403(b), if such plan and annuity contract are both maintained by the same church or convention or association of churches, or

"(C) a merger of a church plan that is a plan described in section 401(a), or an annuity contract described in section 403(b) with an annuity contract described in section 403(b), if such plan and annuity contract are both maintained by the same church or convention or association of churches.

"(2) LIMITATION.—Paragraph (1) shall not apply to a transfer or merger unless the participant's or beneficiary's total accrued benefit immediately after the transfer or merger is equal to or greater than the participant's or beneficiary's total accrued benefit immediately before the transfer or merger, and such total accrued benefit is nonforfeitable after the transfer or merger.

"(3) QUALIFICATION.—A plan or annuity contract shall not fail to be considered to be described in sections 401(a) or 403(b) merely because such plan or annuity contract engages in a transfer or merger described in this subsection.

"(4) DEFINITIONS.—For purposes of this subsection:

"(A) CHURCH OR CONVENTION OR ASSOCIATION OF CHURCHES.—The term 'church or convention or association of churches' includes an organization described in subparagraph (A) or (B)(ii) of subsection (e)(3).

"(B) ANNUITY CONTRACT.—The term 'annuity contract' includes a custodial account described in section 403(b)(7) and a retirement income account described in section 403(b)(9).

"(C) ACCRUED BENEFIT.—The term 'accrued benefit' means—

"(i) in the case of a defined benefit plan, the employee's accrued benefit determined under the plan, and

"(ii) in the case of a plan other than a defined benefit plan, the balance of the employee's account under the plan.".

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to transfers or mergers occurring after the date of the enactment of this Act.

(e) INVESTMENTS BY CHURCH PLANS IN COLLECTIVE TRUSTS.—

(1) IN GENERAL.—In the case of—

(A) a church plan (as defined in section 414(e) of the Internal Revenue Code of 1986), including a plan described in section 401(a) of such Code and a retirement income account described in section 403(b)(9) of such Code, and

(B) an organization described in section 414(e)(3)(A) of such Code the principal purpose or function of which is the administration of such a plan or account,

the assets of such plan, account, or organization (including any assets otherwise permitted to be commingled for investment purposes with the assets of such a plan, account, or organization) may be invested in a group trust otherwise described in Internal Revenue Service Revenue Ruling 81–100 (as modified by Internal Revenue Service Revenue Rulings 2004–67, 2011–1, and 2014-24), or any subsequent revenue ruling that supersedes or modifies such revenue ruling, without adversely affecting the tax status of the group trust, such plan, account, or organization, or any other plan or trust that invests in the group trust.

(2) EFFECTIVE DATE.—This subsection shall apply to investments made after the date of the enactment of this Act.

# APPENDIX A – HOUSE

## Text of the Church Plan Clarification Act of 2015

.....

(Original Signature of Member)

114TH CONGRESS
1ST SESSION

# H. R. _____

To amend the Internal Revenue Code of 1986 to clarify the treatment of church pension plans, and for other purposes.

---

IN THE HOUSE OF REPRESENTATIVES

Mr. TIBERI introduced the following bill; which was referred to the Committee on _____

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# A BILL

To amend the Internal Revenue Code of 1986 to clarify the treatment of church pension plans, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Church Plan Clarification Act of 2015''.

**SEC. 2. CHURCH PLAN CLARIFICATION.**

(a) APPLICATION OF CONTROLLED GROUP RULES TO CHURCH PLANS.—

(1) IN GENERAL.—Section 414(c) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''For purposes'' and inserting the following:

''(1) IN GENERAL.—Except as provided in paragraph (2), for purposes'', and

(B) by adding at the end the following new paragraph:

''(2) SPECIAL RULES RELATING TO CHURCH PLANS.—

''(A) GENERAL RULE.—Except as provided in subparagraphs (B) and (C), for purposes of this subsection and subsection (m), an organization that is otherwise eligible to participate in a church plan shall not be aggregated with another such organization and treated as a single employer with such other organization for a plan year beginning in a taxable year unless—

''(i) one such organization provides (directly or indirectly) at least 80 percent of the operating funds for the other organization during the preceding tax year of the recipient organization, and

''(ii) there is a degree of common management or supervision between the or-

ganizations such that the organization providing the operating funds is directly involved in the day-to-day operations of the other organization.

''(B) NONQUALIFIED CHURCH-CONTROLLED ORGANIZATIONS.—Notwithstanding subparagraph (A), for purposes of this subsection and subsection (m), an organization that is a nonqualified church-controlled organization shall be aggregated with 1 or more other nonqualified church-controlled organizations, or with an organization that is not exempt from tax under section 501, and treated as a single employer with such other organization, if at least 80 percent of the directors or trustees of such other organization are either representatives of, or directly or indirectly controlled by, such nonqualified church-controlled organization. For purposes of this subparagraph, the term 'nonqualified church-controlled organization' means a church-controlled tax-exempt organization described in section 501(c)(3) that is not a qualified church-controlled organization (as defined in section 3121(w)(3)(B)).

''(C) PERMISSIVE AGGREGATION AMONG CHURCH-RELATED ORGANIZATIONS.—The church or convention or association of churches with which an organization described in subparagraph (A) is associated (within the meaning of subsection (e)(3)(D)), or an organization designated by such church or convention or association of churches, may elect to treat such organizations as a single employer for a plan year. Such election, once made, shall apply to all succeeding plan years unless revoked with notice provided to the Secretary in such manner as the Secretary shall prescribe.

''(D) PERMISSIVE DISAGGREGATION OF CHURCH-RELATED ORGANIZATIONS.—For purposes of subparagraph (A), in the case of a church plan, an employer may elect to treat churches (as defined in section 403(b)(12)(B)) separately from entities that are not churches (as so defined), without regard to whether such entities maintain separate church plans. Such election, once made, shall apply to all succeeding plan years unless revoked with notice provided to the Secretary in such manner as the Secretary shall prescribe.''.

(2) CLARIFICATION RELATING TO APPLICATION OF ANTI-ABUSE RULE.—The rule of 26 CFR 1.414(c)-5(f) shall continue to apply to each paragraph of section 414(c) of the Internal Revenue Code of 1986, as amended by paragraph (1).

(3) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to years beginning before, on, or after the date of the enactment of this Act.

(b) APPLICATION OF CONTRIBUTION AND FUNDING LIMITATIONS TO 403(b) GRANDFATHERED DEFINED BENEFIT PLANS.—

(1) IN GENERAL.—Section 251(e)(5) of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97–248), is amended—

(A) by striking ''403(b)(2)'' and inserting ''403(b)'', and

(B) by inserting before the period at the end the following: '', and shall be subject to the applicable limitations of section 415(b) of such Code as if it were a defined benefit plan under section 401(a) of such Code (and not to the limitations of section 415(c) of such Code).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to years beginning be-

fore, on, or after the date of the enactment of this Act.

(c) AUTOMATIC ENROLLMENT BY CHURCH PLANS.—

(1) IN GENERAL.—This subsection shall supersede any law of a State that relates to wage, salary, or payroll payment, collection, deduction, garnishment, assignment, or withholding which would directly or indirectly prohibit or restrict the inclusion in any church plan (as defined in section 414(e) of the Internal Revenue Code of 1986) of an automatic contribution arrangement.

(2) DEFINITION OF AUTOMATIC CONTRIBUTION ARRANGEMENT.—For purposes of this subsection, the term ''automatic contribution arrangement'' means an arrangement—

(A) under which a participant may elect to have the plan sponsor or the employer make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor or the employer make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant

specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage), and

(C) under which the notice and election requirements of paragraph (3), and the investment requirements of paragraph (4), are satisfied.

(3) NOTICE REQUIREMENTS.—

(A) IN GENERAL.—The plan sponsor of, or plan administrator or employer maintaining, an automatic contribution arrangement shall, within a reasonable period before the first day of each plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which—

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) ELECTION REQUIREMENTS.—A notice shall not be treated as meeting the require-

ments of subparagraph (A) with respect to a participant unless—

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the explanation described in clause (i) and before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

(4) DEFAULT INVESTMENT.—If no affirmative investment election has been made with respect to any automatic contribution arrangement, contributions to such arrangement shall be invested in a default investment selected with the care, skill, prudence, and diligence that a prudent person selecting an investment option would use.

(5) EFFECTIVE DATE.—This subsection shall take effect on the date of the enactment of this Act.

(d) ALLOW CERTAIN PLAN TRANSFERS AND MERGERS.—

(1) IN GENERAL.—Section 414 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(z) CERTAIN PLAN TRANSFERS AND MERGERS.—

''(1) IN GENERAL.—Under rules prescribed by the Secretary, except as provided in paragraph (2), no amount shall be includible in gross income by reason of—

''(A) a transfer of all or a portion of the accrued benefit of a participant or beneficiary, whether or not vested, from a church plan that is a plan described in section 401(a) or an annuity contract described in section 403(b) to an annuity contract described in section 403(b), if such plan and annuity contract are both maintained by the same church or convention or association of churches,

''(B) a transfer of all or a portion of the accrued benefit of a participant or beneficiary from an annuity contract described in section 403(b) to a church plan that is a plan described

in section 401(a) or an annuity contract described in section 403(b), if such plan and annuity contract are both maintained by the same church or convention or association of churches, or

''(C) a merger of a church plan that is a plan described in section 401(a), or an annuity contract described in section 403(b) with an annuity contract described in section 403(b), if such plan and annuity contract are both maintained by the same church or convention or association of churches.

''(2) LIMITATION.—Paragraph (1) shall not apply to a transfer or merger unless the participant's or beneficiary's total accrued benefit immediately after the transfer or merger is equal to or greater than the participant's or beneficiary's total accrued benefit immediately before the transfer or merger, and such total accrued benefit is nonforfeitable after the transfer or merger.

''(3) QUALIFICATION.—A plan or annuity contract shall not fail to be considered to be described in sections 401(a) or 403(b) merely because such plan or annuity contract engages in a transfer or merger described in this subsection.

''(4) DEFINITIONS.—For purposes of this subsection:

''(A) CHURCH OR CONVENTION OR ASSOCIATION OF CHURCHES.—The term 'church or convention or association of churches' includes an organization described in subparagraph (A) or (B)(ii) of subsection (e)(3).

''(B) ANNUITY CONTRACT.—The term 'annuity contract' includes a custodial account described in section 403(b)(7) and a retirement income account described in section 403(b)(9).

''(C) ACCRUED BENEFIT.—The term 'accrued benefit' means—

''(i) in the case of a defined benefit plan, the employee's accrued benefit determined under the plan, and

''(ii) in the case of a plan other than a defined benefit plan, the balance of the employee's account under the plan.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to transfers or mergers occurring after the date of the enactment of this Act.

(e) INVESTMENTS BY CHURCH PLANS IN COLLECTIVE TRUSTS.—

(1) IN GENERAL.—In the case of—

(A) a church plan (as defined in section 414(e) of the Internal Revenue Code of 1986), including a plan described in section 401(a) of such Code and a retirement income account described in section 403(b)(9) of such Code, and

(B) an organization described in section 414(e)(3)(A) of such Code the principal purpose or function of which is the administration of such a plan or account,

the assets of such plan, account, or organization (including any assets otherwise permitted to be commingled for investment purposes with the assets of such a plan, account, or organization) may be invested in a group trust otherwise described in Internal Revenue Service Revenue Ruling 81–100 (as modified by Internal Revenue Service Revenue Rulings 2004–67, 2011–1, and 2014-24), or any subsequent revenue ruling that supersedes or modifies such revenue ruling, without adversely affecting the tax status of the group trust, such plan, account, or organization, or any other plan or trust that invests in the group trust.

(2) EFFECTIVE DATE.—This subsection shall apply to investments made after the date of the enactment of this Act.

# APPENDIX B

## Sample 402(f) Notices

# Safe Harbor Explanations – Eligible Rollover Distributions

## Notice 2014-74

## I. PURPOSE

This notice amends the two safe harbor explanations in Notice 2009-68, 2009-2 C.B. 423, that can be used to satisfy the requirement under § 402(f) of the Internal Revenue Code ("Code") that certain information be provided to recipients of eligible rollover distributions. Amendments to the safe harbor explanations reflected in this notice relate to the allocation of pre-tax and after-tax amounts, distributions in the form of in-plan Roth rollovers, and certain other clarifications to the two safe harbor explanations. The amendments to the safe harbor explanations (and attached model notices) may be used for plans that apply the guidance in section III of Notice 2014-54, 2014-41 I.R.B. 670, with respect to the allocation of pretax and after-tax amounts.

## II. BACKGROUND

Section 402(f) requires the plan administrator of a plan qualified under § 401(a) to provide the written explanation described in § 402(f)(1) to any recipient of an eligible rollover distribution, as defined in § 402(c)(4). In addition, §§ 403(a)(4)(B) and 457(e)(16)(B) require the plan administrator of a § 403(a) plan, or an eligible § 457(b) plan maintained by a governmental employer described in § 457(e)(1)(A), to provide the written explanation to any recipient of an eligible rollover distribution. Further, § 403(b)(8)(B) requires a payor under a § 403(b) plan to provide the written explanation to the recipient of an eligible rollover distribution.

Notice 2009-68 contains two safe harbor explanations that reflect the relevant law as of September 28, 2009: one explanation is for payments not from a designated Roth account and the other explanation is for payments from a designated Roth account. These explanations include rules on the rollover of payments to Roth IRAs, including explanations of transition rules that only applied to distributions made before 2011. Notice 2009-68 provides that the safe harbor explanations can be used by plan administrators and payors to satisfy § 402(f) to the extent the explanations accurately reflect current law.

Section 402A(c)(4), which was added to the Code by the Small Business Jobs Act of 2010, P.L. 111-240, permits plans that include a qualified Roth contribution program to provide for rollovers to designated Roth accounts in the same plan ("in-plan Roth rollovers"). Notice 2010-84, 2010-51 I.R.B. 872, provides guidance on in-plan Roth rollovers under § 402A(c)(4). For a plan

offering in-plan Roth rollovers, Q&A-5 of Notice 2010-84 provides an amendment to the safe harbor explanation for payments not from a designated Roth account that can be used to satisfy § 402(f).

Section 402A(c)(4)(E), which was added to the Code by the American Taxpayer Relief Act of 2012, P.L. 112-240, permits the in-plan Roth rollover of amounts not otherwise distributable. Notice 2013-74, 2013-52 I.R.B. 819, provides additional guidance on in-plan Roth rollovers, including on in-plan Roth rollovers of amounts not otherwise distributable. Notice 2013-74 modifies Notice 2010-84, and also provides that a written explanation under § 402(f) is not required for a participant who makes an in-plan Roth rollover of an amount not otherwise distributable.

Proposed regulations that would modify § 1.402A-1, Q&A-5(a), were issued in conjunction with Notice 2014-54. The proposed regulations would limit the applicability of the requirement in § 1.402A-1, Q&A-5(a), applicable to distributions from designated Roth accounts, that "any amount paid in a direct rollover is treated as a separate distribution from any amount paid directly to the employee." Under the proposed regulations, this separate distribution requirement would not apply to distributions made on or after the applicability date of the Treasury decision finalizing the proposed regulations. Before the proposed regulations are finalized, taxpayers are permitted to apply the rules set out in section III of Notice 2014-54.

Section III of Notice 2014-54 provides new rules on the allocation of pretax and after-tax amounts among disbursements made from a plan to multiple destinations. Notice 2014-54 provides that the new allocation rules generally apply to distributions made on or after January 1, 2015 (or the applicability date of the Treasury decision that finalizes the proposed regulations under § 1.402A-1, in the case of distributions from a designated Roth account). However, transition rules permit the earlier application of the new allocation rules. The notice also provides that the IRS intends to revise the safe harbor explanations under § 402(f) to reflect the new allocation rules.

## III. AMENDMENTS TO THE SAFE HARBOR EXPLANATIONS

This section III contains amendments to update the safe harbor explanations in Notice 2009-68 for changes in the law occurring after September 28, 2009, and to make certain other clarifying changes. The amendments with respect to in-plan Roth rollovers apply to plans that offer in-plan Roth rollovers, including in-plan Roth rollovers of amounts not otherwise distributable, and the amendments with respect to the allocation of pretax and after-tax amounts apply to plans that apply the guidance in section III of Notice 2014-54. The updated safe harbor explanations provided in this notice can be used by plan administrators and payors to satisfy § 402(f). However, the updated safe harbor explanations will not satisfy § 402(f) to the extent the

explanations are no longer accurate because of a change in the relevant law occurring after December 8, 2014. The instructions in Notice 2009-68 on how to use the safe harbor explanations continue to apply.

Part A contains amendments to the safe harbor explanation for payments not from a designated Roth account and Part B contains amendments to the safe harbor explanation for payments from a designated Roth account. References throughout the safe harbor explanations to "IRS Publication 590, *Individual Retirement Arrangements (IRAs)*" should be replaced with "IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*, and Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*," as applicable, after Publications 590-A and 590-B are issued. Restated safe harbor explanations that include these amendments are at the end of this notice.

Part A – Amendments to the Safe Harbor Explanation for Payments not from a Designated Roth Account

1. Under the heading "How much may I roll over?," replace the eighth bullet with the following:

> Payments of certain automatic enrollment contributions requested to be withdrawn within 90 days of the first contribution

2. Under the heading "If I don't do a rollover, will I have to pay the 10% additional income tax on early distributions?," delete the ninth bullet (as it repeats the concept found in the last bullet), which reads:

> Contributions made under special automatic enrollment rules that are withdrawn pursuant to your request within 90 days of enrollment

3. Under the heading "If I do a rollover to an IRA, will the 10% additional income tax apply to early distributions from the IRA?," replace item (3) in the last bullet with the following:

> payments for health insurance premiums after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

4. Under the heading "If your payment includes after-tax contributions," replace the first and second paragraphs with the following:

> After-tax contributions included in a payment are not taxed. If a payment is only part of your benefit, an allocable portion of your after-tax contributions is included in the payment, so you cannot take a payment of only after-tax contributions. However, if you have pre-1987 after-tax

contributions maintained in a separate account, a special rule may apply to determine whether the after-tax contributions are included in a payment. In addition, special rules apply when you do a rollover, as described below.

You may roll over to an IRA a payment that includes after-tax contributions through either a direct rollover or a 60-day rollover. You must keep track of the aggregate amount of the after-tax contributions in all of your IRAs (in order to determine your taxable income for later payments from the IRAs). If you do a direct rollover of only a portion of the amount paid from the Plan and at the same time the rest is paid to you, the portion directly rolled over consists first of the amount that would be taxable if not rolled over. For example, assume you are receiving a distribution of $12,000, of which $2,000 is after-tax contributions. In this case, if you directly roll over $10,000 to an IRA that is not a Roth IRA, no amount is taxable because the $2,000 amount not directly rolled over is treated as being after-tax contributions. If you do a direct rollover of the entire amount paid from the Plan to two or more destinations at the same time, you can choose which destination receives the after-tax contributions.

If you do a 60-day rollover to an IRA of only a portion of a payment made to you, the after-tax contributions are treated as rolled over last. For example, assume you are receiving a distribution of $12,000, of which $2,000 is after-tax contributions, and no part of the distribution is directly rolled over. In this case, if you roll over $10,000 to an IRA that is not a Roth IRA in a 60-day rollover, no amount is taxable because the $2,000 amount not rolled over is treated as being after-tax contributions.

5. Under the heading "If you roll over your payment to a Roth IRA," delete the first paragraph, which reads:

You can roll over a payment from the Plan made before January 1, 2010 to a Roth IRA only if your modified adjusted gross income is not more than $100,000 for the year the payment is made to you and, if married, you file a joint return. These limitations do not apply to payments made to you from the Plan after 2009. If you wish to roll over the payment to a Roth IRA, but you are not eligible to do a rollover to a Roth IRA until after 2009, you can do a rollover to a traditional IRA and then, after 2009, elect to convert the traditional IRA into a Roth IRA.

6. Under the heading "If you roll over your payment to a Roth IRA," replace the second paragraph with the following:

If you roll over a payment from the Plan to a Roth IRA, a special rule applies under which the amount of the payment rolled over (reduced by any after-tax amounts) will be taxed. However, the 10% additional income

tax on early distributions will not apply (unless you take the amount rolled over out of the Roth IRA within 5 years, counting from January 1 of the year of the rollover).

7. Under the heading "If you roll over your payment to a Roth IRA," delete the fourth paragraph, which reads:

> You cannot roll over a payment from the Plan to a designated Roth account in an employer plan.

8. Following the section that is headed "If you roll over your payment to a Roth IRA," add a new section to read as follows:

> **If you do a rollover to a designated Roth account in the Plan**
>
> You cannot roll over a distribution to a designated Roth account in another employer's plan. However, you can roll the distribution over into a designated Roth account in the distributing Plan. If you roll over a payment from the Plan to a designated Roth account in the Plan, the amount of the payment rolled over (reduced by any after-tax amounts directly rolled over) will be taxed. However, the 10% additional tax on early distributions will not apply (unless you take the amount rolled over out of the designated Roth account within the 5-year period that begins on January 1 of the year of the rollover).
>
> If you roll over the payment to a designated Roth account in the Plan, later payments from the designated Roth account that are qualified distributions will not be taxed (including earnings after the rollover). A qualified distribution from a designated Roth account is a payment made both after you are age 59½ (or after your death or disability) and after you have had a designated Roth account in the Plan for at least 5 years. In applying this 5-year rule, you count from January 1 of the year your first contribution was made to the designated Roth account. However, if you made a direct rollover to a designated Roth account in the Plan from a designated Roth account in a plan of another employer, the 5-year period begins on January 1 of the year you made the first contribution to the designated Roth account in the Plan or, if earlier, to the designated Roth account in the plan of the other employer. Payments from the designated Roth account that are not qualified distributions will be taxed to the extent of earnings after the rollover, including the 10% additional income tax on early distributions (unless an exception applies).

<u>Part B – Amendments to the Safe Harbor Explanation for Payments from a Designated Roth Account</u>

1. Under the heading “How do I do a rollover?,” replace the next-to-last paragraph with the following:

> If you do a direct rollover of only a portion of the amount paid from the Plan and a portion is paid to you at the same time, the portion directly rolled over consists first of earnings.

2. Under the heading “How much may I roll over?,” replace the eighth bullet with the following:

> Payments of certain automatic enrollment contributions requested to be withdrawn within 90 days of the first contribution

3. Under the heading “If I don’t do a rollover, will I have to pay the 10% additional income tax on early distributions?,” delete the eighth bullet (as it repeats the concept found in the last bullet), which reads:

> Contributions made under special automatic enrollment rules that are withdrawn pursuant to your request within 90 days of enrollment

4. Under the heading “If I do a rollover to a Roth IRA, will the 10% additional income tax apply to early distributions from the IRA?,” replace item (3) in the last bullet with the following:

> payments for health insurance premiums after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

## IV. EFFECT ON OTHER DOCUMENTS

Notice 2009-68 is modified.

## DRAFTING INFORMATION

The principal author of this notice is Angelique Carrington of the Employee Plans, Tax Exempt and Government Entities Division. Questions regarding this notice may be sent via e-mail to RetirementPlanQuestions@irs.gov.

* * *

## YOUR ROLLOVER OPTIONS

You are receiving this notice because all or a portion of a payment you are receiving from the [INSERT NAME OF PLAN] (the "Plan") is eligible to be rolled over to an IRA or an employer plan. This notice is intended to help you decide whether to do such a rollover.

This notice describes the rollover rules that apply to payments from the Plan that are not from a designated Roth account (a type of account with special tax rules in some employer plans). If you also receive a payment from a designated Roth account in the Plan, you will be provided a different notice for that payment, and the Plan administrator or the payor will tell you the amount that is being paid from each account.

Rules that apply to most payments from a plan are described in the "General Information About Rollovers" section. Special rules that only apply in certain circumstances are described in the "Special Rules and Options" section.

## GENERAL INFORMATION ABOUT ROLLOVERS

### How can a rollover affect my taxes?

You will be taxed on a payment from the Plan if you do not roll it over. If you are under age 59½ and do not do a rollover, you will also have to pay a 10% additional income tax on early distributions (unless an exception applies). However, if you do a rollover, you will not have to pay tax until you receive payments later and the 10% additional income tax will not apply if those payments are made after you are age 59½ (or if an exception applies).

### Where may I roll over the payment?

You may roll over the payment to either an IRA (an individual retirement account or individual retirement annuity) or an employer plan (a tax-qualified plan, section 403(b) plan, or governmental section 457(b) plan) that will accept the rollover. The rules of the IRA or employer plan that holds the rollover will determine your investment options, fees, and rights to payment from the IRA or employer plan (for example, no spousal consent rules apply to IRAs and IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the IRA or employer plan.

### How do I do a rollover?

There are two ways to do a rollover. You can do either a direct rollover or a 60-day rollover.

If you do a direct rollover, the Plan will make the payment directly to your IRA or an employer plan. You should contact the IRA sponsor or the administrator of the employer plan for information on how to do a direct rollover.

If you do not do a direct rollover, you may still do a rollover by making a deposit into an IRA or eligible employer plan that will accept it. You will have 60 days after you receive the payment to make the deposit. If you do not do a direct rollover, the Plan is required to withhold 20% of the payment for federal income taxes (up to the amount of cash and property received other than employer stock). This means that, in order to roll over the entire payment in a 60-day rollover, you must use other funds to make up for the 20% withheld. If you do not roll over the entire amount of the payment, the portion not rolled over will be taxed and will be subject to the 10% additional income tax on early distributions if you are under age 59½ (unless an exception applies).

**How much may I roll over?**

If you wish to do a rollover, you may roll over all or part of the amount eligible for rollover. Any payment from the Plan is eligible for rollover, except:

- Certain payments spread over a period of at least 10 years or over your life or life expectancy (or the lives or joint life expectancy of you and your beneficiary)
- Required minimum distributions after age 70½ (or after death)
- Hardship distributions
- ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends)
- Cost of life insurance paid by the Plan
- Payments of certain automatic enrollment contributions requested to be withdrawn within 90 days of the first contribution
- Amounts treated as distributed because of a prohibited allocation of S corporation stock under an ESOP (also, there will generally be adverse tax consequences if you roll over a distribution of S corporation stock to an IRA).

The Plan administrator or the payor can tell you what portion of a payment is eligible for rollover.

**If I don't do a rollover, will I have to pay the 10% additional income tax on early distributions?**

If you are under age 59½, you will have to pay the 10% additional income tax on early distributions for any payment from the Plan (including amounts withheld for

income tax) that you do not roll over, unless one of the exceptions listed below applies. This tax is in addition to the regular income tax on the payment not rolled over.

The 10% additional income tax does not apply to the following payments from the Plan:

- Payments made after you separate from service if you will be at least age 55 in the year of the separation
- Payments that start after you separate from service if paid at least annually in equal or close to equal amounts over your life or life expectancy (or the lives or joint life expectancy of you and your beneficiary)
- Payments from a governmental defined benefit pension plan made after you separate from service if you are a public safety employee and you are at least age 50 in the year of the separation
- Payments made due to disability
- Payments after your death
- Payments of ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations
- Cost of life insurance paid by the Plan
- Payments made directly to the government to satisfy a federal tax levy
- Payments made under a qualified domestic relations order (QDRO)
- Payments up to the amount of your deductible medical expenses
- Certain payments made while you are on active duty if you were a member of a reserve component called to duty after September 11, 2001 for more than 179 days
- Payments of certain automatic enrollment contributions requested to be withdrawn within 90 days of the first contribution.

**If I do a rollover to an IRA, will the 10% additional income tax apply to early distributions from the IRA?**

If you receive a payment from an IRA when you are under age 59½, you will have to pay the 10% additional income tax on early distributions from the IRA, unless an exception applies. In general, the exceptions to the 10% additional income tax for early distributions from an IRA are the same as the exceptions listed above for early distributions from a plan. However, there are a few differences for payments from an IRA, including:

- There is no exception for payments after separation from service that are made after age 55.
- The exception for qualified domestic relations orders (QDROs) does not apply (although a special rule applies under which, as part of a divorce or separation agreement, a tax-free transfer may be made directly to an IRA of a spouse or former spouse).

- The exception for payments made at least annually in equal or close to equal amounts over a specified period applies without regard to whether you have had a separation from service.
- There are additional exceptions for (1) payments for qualified higher education expenses, (2) payments up to $10,000 used in a qualified first-time home purchase, and (3) payments for health insurance premiums after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

**Will I owe State income taxes?**

This notice does not describe any State or local income tax rules (including withholding rules).

## SPECIAL RULES AND OPTIONS

**If your payment includes after-tax contributions**

After-tax contributions included in a payment are not taxed. If a payment is only part of your benefit, an allocable portion of your after-tax contributions is included in the payment, so you cannot take a payment of only after-tax contributions. However, if you have pre-1987 after-tax contributions maintained in a separate account, a special rule may apply to determine whether the after-tax contributions are included in a payment. In addition, special rules apply when you do a rollover, as described below.

You may roll over to an IRA a payment that includes after-tax contributions through either a direct rollover or a 60-day rollover. You must keep track of the aggregate amount of the after-tax contributions in all of your IRAs (in order to determine your taxable income for later payments from the IRAs). If you do a direct rollover of only a portion of the amount paid from the Plan and at the same time the rest is paid to you, the portion directly rolled over consists first of the amount that would be taxable if not rolled over. For example, assume you are receiving a distribution of $12,000, of which $2,000 is after-tax contributions. In this case, if you directly roll over $10,000 to an IRA that is not a Roth IRA, no amount is taxable because the $2,000 amount not directly rolled over is treated as being after-tax contributions. If you do a direct rollover of the entire amount paid from the Plan to two or more destinations at the same time, you can choose which destination receives the after-tax contributions.

If you do a 60-day rollover to an IRA of only a portion of a payment made to you, the after-tax contributions are treated as rolled over last. For example, assume you are receiving a distribution of $12,000, of which $2,000 is after-tax contributions, and no part of the distribution is directly rolled over. In this case, if you roll over $10,000 to an IRA that is not a Roth IRA in a 60-day rollover, no

amount is taxable because the $2,000 amount not rolled over is treated as being after-tax contributions.

You may roll over to an employer plan all of a payment that includes after-tax contributions, but only through a direct rollover (and only if the receiving plan separately accounts for after-tax contributions and is not a governmental section 457(b) plan). You can do a 60-day rollover to an employer plan of part of a payment that includes after-tax contributions, but only up to the amount of the payment that would be taxable if not rolled over.

**If you miss the 60-day rollover deadline**

Generally, the 60-day rollover deadline cannot be extended. However, the IRS has the limited authority to waive the deadline under certain extraordinary circumstances, such as when external events prevented you from completing the rollover by the 60-day rollover deadline. To apply for a waiver, you must file a private letter ruling request with the IRS. Private letter ruling requests require the payment of a nonrefundable user fee. For more information, see IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*.

**If your payment includes employer stock that you do not roll over**

If you do not do a rollover, you can apply a special rule to payments of employer stock (or other employer securities) that are either attributable to after-tax contributions or paid in a lump sum after separation from service (or after age 59½, disability, or the participant's death). Under the special rule, the net unrealized appreciation on the stock will not be taxed when distributed from the Plan and will be taxed at capital gain rates when you sell the stock. Net unrealized appreciation is generally the increase in the value of employer stock after it was acquired by the Plan. If you do a rollover for a payment that includes employer stock (for example, by selling the stock and rolling over the proceeds within 60 days of the payment), the special rule relating to the distributed employer stock will not apply to any subsequent payments from the IRA or employer plan. The Plan administrator can tell you the amount of any net unrealized appreciation.

**If you have an outstanding loan that is being offset**

If you have an outstanding loan from the Plan, your Plan benefit may be offset by the amount of the loan, typically when your employment ends. The loan offset amount is treated as a distribution to you at the time of the offset and will be taxed (including the 10% additional income tax on early distributions, unless an exception applies) unless you do a 60-day rollover in the amount of the loan offset to an IRA or employer plan.

**If you were born on or before January 1, 1936**

If you were born on or before January 1, 1936 and receive a lump sum distribution that you do not roll over, special rules for calculating the amount of the tax on the payment might apply to you. For more information, see IRS Publication 575, *Pension and Annuity Income*.

**If your payment is from a governmental section 457(b) plan**

If the Plan is a governmental section 457(b) plan, the same rules described elsewhere in this notice generally apply, allowing you to roll over the payment to an IRA or an employer plan that accepts rollovers. One difference is that, if you do not do a rollover, you will not have to pay the 10% additional income tax on early distributions from the Plan even if you are under age 59½ (unless the payment is from a separate account holding rollover contributions that were made to the Plan from a tax-qualified plan, a section 403(b) plan, or an IRA). However, if you do a rollover to an IRA or to an employer plan that is not a governmental section 457(b) plan, a later distribution made before age 59½ will be subject to the 10% additional income tax on early distributions (unless an exception applies). Other differences are that you cannot do a rollover if the payment is due to an "unforeseeable emergency" and the special rules under "If your payment includes employer stock that you do not roll over" and "If you were born on or before January 1, 1936" do not apply.

**If you are an eligible retired public safety officer and your pension payment is used to pay for health coverage or qualified long-term care insurance**

If the Plan is a governmental plan, you retired as a public safety officer, and your retirement was by reason of disability or was after normal retirement age, you can exclude from your taxable income plan payments paid directly as premiums to an accident or health plan (or a qualified long-term care insurance contract) that your employer maintains for you, your spouse, or your dependents, up to a maximum of $3,000 annually. For this purpose, a public safety officer is a law enforcement officer, firefighter, chaplain, or member of a rescue squad or ambulance crew.

**If you roll over your payment to a Roth IRA**

If you roll over a payment from the Plan to a Roth IRA, a special rule applies under which the amount of the payment rolled over (reduced by any after-tax amounts) will be taxed. However, the 10% additional income tax on early distributions will not apply (unless you take the amount rolled over out of the Roth IRA within 5 years, counting from January 1 of the year of the rollover).

If you roll over the payment to a Roth IRA, later payments from the Roth IRA that are qualified distributions will not be taxed (including earnings after the rollover). A qualified distribution from a Roth IRA is a payment made after you are age

59½ (or after your death or disability, or as a qualified first-time homebuyer distribution of up to $10,000) and after you have had a Roth IRA for at least 5 years. In applying this 5-year rule, you count from January 1 of the year for which your first contribution was made to a Roth IRA. Payments from the Roth IRA that are not qualified distributions will be taxed to the extent of earnings after the rollover, including the 10% additional income tax on early distributions (unless an exception applies). You do not have to take required minimum distributions from a Roth IRA during your lifetime. For more information, see IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*, and IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*.

**If you do a rollover to a designated Roth account in the Plan**

You cannot roll over a distribution to a designated Roth account in another employer's plan. However, you can roll the distribution over into a designated Roth account in the distributing Plan. If you roll over a payment from the Plan to a designated Roth account in the Plan, the amount of the payment rolled over (reduced by any after-tax amounts directly rolled over) will be taxed. However, the 10% additional tax on early distributions will not apply (unless you take the amount rolled over out of the designated Roth account within the 5-year period that begins on January 1 of the year of the rollover).

If you roll over the payment to a designated Roth account in the Plan, later payments from the designated Roth account that are qualified distributions will not be taxed (including earnings after the rollover). A qualified distribution from a designated Roth account is a payment made both after you are age 59½ (or after your death or disability) and after you have had a designated Roth account in the Plan for at least 5 years. In applying this 5-year rule, you count from January 1 of the year your first contribution was made to the designated Roth account. However, if you made a direct rollover to a designated Roth account in the Plan from a designated Roth account in a plan of another employer, the 5-year period begins on January 1 of the year you made the first contribution to the designated Roth account in the Plan or, if earlier, to the designated Roth account in the plan of the other employer. Payments from the designated Roth account that are not qualified distributions will be taxed to the extent of earnings after the rollover, including the 10% additional income tax on early distributions (unless an exception applies).

**If you are not a plan participant**

Payments after death of the participant. If you receive a distribution after the participant's death that you do not roll over, the distribution will generally be taxed in the same manner described elsewhere in this notice. However, the 10% additional income tax on early distributions and the special rules for public safety officers do not apply, and the special rule described under the section "If you

were born on or before January 1, 1936" applies only if the participant was born on or before January 1, 1936.

**If you are a surviving spouse.** If you receive a payment from the Plan as the surviving spouse of a deceased participant, you have the same rollover options that the participant would have had, as described elsewhere in this notice. In addition, if you choose to do a rollover to an IRA, you may treat the IRA as your own or as an inherited IRA.

An IRA you treat as your own is treated like any other IRA of yours, so that payments made to you before you are age 59½ will be subject to the 10% additional income tax on early distributions (unless an exception applies) and required minimum distributions from your IRA do not have to start until after you are age 70½.

If you treat the IRA as an inherited IRA, payments from the IRA will not be subject to the 10% additional income tax on early distributions. However, if the participant had started taking required minimum distributions, you will have to receive required minimum distributions from the inherited IRA. If the participant had not started taking required minimum distributions from the Plan, you will not have to start receiving required minimum distributions from the inherited IRA until the year the participant would have been age 70½.

**If you are a surviving beneficiary other than a spouse**. If you receive a payment from the Plan because of the participant's death and you are a designated beneficiary other than a surviving spouse, the only rollover option you have is to do a direct rollover to an inherited IRA. Payments from the inherited IRA will not be subject to the 10% additional income tax on early distributions. You will have to receive required minimum distributions from the inherited IRA.

Payments under a qualified domestic relations order. If you are the spouse or former spouse of the participant who receives a payment from the Plan under a qualified domestic relations order (QDRO), you generally have the same options the participant would have (for example, you may roll over the payment to your own IRA or an eligible employer plan that will accept it). Payments under the QDRO will not be subject to the 10% additional income tax on early distributions.

**If you are a nonresident alien**

If you are a nonresident alien and you do not do a direct rollover to a U.S. IRA or U.S. employer plan, instead of withholding 20%, the Plan is generally required to withhold 30% of the payment for federal income taxes. If the amount withheld exceeds the amount of tax you owe (as may happen if you do a 60-day rollover), you may request an income tax refund by filing Form 1040NR and attaching your

Form 1042-S. See Form W-8BEN for claiming that you are entitled to a reduced rate of withholding under an income tax treaty. For more information, see also IRS Publication 519, *U.S. Tax Guide for Aliens*, and IRS Publication 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*.

**Other special rules**

If a payment is one in a series of payments for less than 10 years, your choice whether to make a direct rollover will apply to all later payments in the series (unless you make a different choice for later payments).

If your payments for the year are less than $200 (not including payments from a designated Roth account in the Plan), the Plan is not required to allow you to do a direct rollover and is not required to withhold for federal income taxes. However, you may do a 60-day rollover.

Unless you elect otherwise, a mandatory cashout of more than $1,000 (not including payments from a designated Roth account in the Plan) will be directly rolled over to an IRA chosen by the Plan administrator or the payor. A mandatory cashout is a payment from a plan to a participant made before age 62 (or normal retirement age, if later) and without consent, where the participant's benefit does not exceed $5,000 (not including any amounts held under the plan as a result of a prior rollover made to the plan).

You may have special rollover rights if you recently served in the U.S. Armed Forces. For more information, see IRS Publication 3, *Armed Forces' Tax Guide*.

## FOR MORE INFORMATION

You may wish to consult with the Plan administrator or payor, or a professional tax advisor, before taking a payment from the Plan. Also, you can find more detailed information on the federal tax treatment of payments from employer plans in: IRS Publication 575, *Pension and Annuity Income*; IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*; IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*; and IRS Publication 571, *Tax-Sheltered Annuity Plans (403(b) Plans)*. These publications are available from a local IRS office, on the web at www.irs.gov, or by calling 1-800-TAX-FORM.

## YOUR ROLLOVER OPTIONS

You are receiving this notice because all or a portion of a payment you are receiving from the [INSERT NAME OF PLAN] (the "Plan") is eligible to be rolled over to a Roth IRA or designated Roth account in an employer plan. This notice is intended to help you decide whether to do a rollover.

This notice describes the rollover rules that apply to payments from the Plan that are from a designated Roth account. If you also receive a payment from the Plan that is not from a designated Roth account, you will be provided a different notice for that payment, and the Plan administrator or the payor will tell you the amount that is being paid from each account.

Rules that apply to most payments from a designated Roth account are described in the "General Information About Rollovers" section. Special rules that only apply in certain circumstances are described in the "Special Rules and Options" section.

## GENERAL INFORMATION ABOUT ROLLOVERS

### How can a rollover affect my taxes?

After-tax contributions included in a payment from a designated Roth account are not taxed, but earnings might be taxed. The tax treatment of earnings included in the payment depends on whether the payment is a qualified distribution. If a payment is only part of your designated Roth account, the payment will include an allocable portion of the earnings in your designated Roth account.

If the payment from the Plan is not a qualified distribution and you do not do a rollover to a Roth IRA or a designated Roth account in an employer plan, you will be taxed on the earnings in the payment. If you are under age 59½, a 10% additional income tax on early distributions will also apply to the earnings (unless an exception applies). However, if you do a rollover, you will not have to pay taxes currently on the earnings and you will not have to pay taxes later on payments that are qualified distributions.

If the payment from the Plan is a qualified distribution, you will not be taxed on any part of the payment even if you do not do a rollover. If you do a rollover, you will not be taxed on the amount you roll over and any earnings on the amount you roll over will not be taxed if paid later in a qualified distribution.

A qualified distribution from a designated Roth account in the Plan is a payment made after you are age 59½ (or after your death or disability) and after you have

had a designated Roth account in the Plan for at least 5 years. In applying the 5-year rule, you count from January 1 of the year your first contribution was made to the designated Roth account. However, if you did a direct rollover to a designated Roth account in the Plan from a designated Roth account in another employer plan, your participation will count from January 1 of the year your first contribution was made to the designated Roth account in the Plan or, if earlier, to the designated Roth account in the other employer plan.

**Where may I roll over the payment?**

You may roll over the payment to either a Roth IRA (a Roth individual retirement account or Roth individual retirement annuity) or a designated Roth account in an employer plan (a tax-qualified plan or section 403(b) plan) that will accept the rollover. The rules of the Roth IRA or employer plan that holds the rollover will determine your investment options, fees, and rights to payment from the Roth IRA or employer plan (for example, no spousal consent rules apply to Roth IRAs and Roth IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the Roth IRA or the designated Roth account in the employer plan. In general, these tax rules are similar to those described elsewhere in this notice, but differences include:

- If you do a rollover to a Roth IRA, all of your Roth IRAs will be considered for purposes of determining whether you have satisfied the 5-year rule (counting from January 1 of the year for which your first contribution was made to any of your Roth IRAs).
- If you do a rollover to a Roth IRA, you will not be required to take a distribution from the Roth IRA during your lifetime and you must keep track of the aggregate amount of the after-tax contributions in all of your Roth IRAs (in order to determine your taxable income for later Roth IRA payments that are not qualified distributions).
- Eligible rollover distributions from a Roth IRA can only be rolled over to another Roth IRA.

**How do I do a rollover?**

There are two ways to do a rollover. You can either do a direct rollover or a 60-day rollover.

<u>If you do a direct rollover</u>, the Plan will make the payment directly to your Roth IRA or designated Roth account in an employer plan. You should contact the Roth IRA sponsor or the administrator of the employer plan for information on how to do a direct rollover.

<u>If you do not do a direct rollover</u>, you may still do a rollover by making a deposit within 60 days into a Roth IRA, whether the payment is a qualified or nonqualified distribution. In addition, you can do a rollover by making a deposit within 60 days

into a designated Roth account in an employer plan if the payment is a nonqualified distribution and the rollover does not exceed the amount of the earnings in the payment. You cannot do a 60-day rollover to an employer plan of any part of a qualified distribution. If you receive a distribution that is a nonqualified distribution and you do not roll over an amount at least equal to the earnings allocable to the distribution, you will be taxed on the amount of those earnings not rolled over, including the 10% additional income tax on early distributions if you are under age 59½ (unless an exception applies).

If you do a direct rollover of only a portion of the amount paid from the Plan and a portion is paid to you at the same time, the portion directly rolled over consists first of earnings.

If you do not do a direct rollover and the payment is not a qualified distribution, the Plan is required to withhold 20% of the earnings for federal income taxes (up to the amount of cash and property received other than employer stock). This means that, in order to roll over the entire payment in a 60-day rollover to a Roth IRA, you must use other funds to make up for the 20% withheld.

**How much may I roll over?**

If you wish to do a rollover, you may roll over all or part of the amount eligible for rollover. Any payment from the Plan is eligible for rollover, except:

- Certain payments spread over a period of at least 10 years or over your life or life expectancy (or the lives or joint life expectancy of you and your beneficiary)
- Required minimum distributions after age 70½ (or after death)
- Hardship distributions
- ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends)
- Cost of life insurance paid by the Plan
- Payments of certain automatic enrollment contributions requested to be withdrawn within 90 days of the first contribution
- Amounts treated as distributed because of a prohibited allocation of S corporation stock under an ESOP (also, there will generally be adverse tax consequences if S corporation stock is held by an IRA).

The Plan administrator or the payor can tell you what portion of a payment is eligible for rollover.

**If I don't do a rollover, will I have to pay the 10% additional income tax on early distributions?**

If a payment is not a qualified distribution and you are under age 59½, you will have to pay the 10% additional income tax on early distributions with respect to the earnings allocated to the payment that you do not roll over (including amounts withheld for income tax), unless one of the exceptions listed below applies. This tax is in addition to the regular income tax on the earnings not rolled over.

The 10% additional income tax does not apply to the following payments from the Plan:

- Payments made after you separate from service if you will be at least age 55 in the year of the separation
- Payments that start after you separate from service if paid at least annually in equal or close to equal amounts over your life or life expectancy (or the lives or joint life expectancy of you and your beneficiary)
- Payments made due to disability
- Payments after your death
- Payments of ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations
- Cost of life insurance paid by the Plan
- Payments made directly to the government to satisfy a federal tax levy
- Payments made under a qualified domestic relations order (QDRO)
- Payments up to the amount of your deductible medical expenses
- Certain payments made while you are on active duty if you were a member of a reserve component called to duty after September 11, 2001 for more than 179 days
- Payments of certain automatic enrollment contributions requested to be withdrawn within 90 days of the first contribution.

**If I do a rollover to a Roth IRA, will the 10% additional income tax apply to early distributions from the IRA?**

If you receive a payment from a Roth IRA when you are under age 59½, you will have to pay the 10% additional income tax on early distributions on the earnings paid from the Roth IRA, unless an exception applies or the payment is a qualified distribution. In general, the exceptions to the 10% additional income tax for early distributions from a Roth IRA listed above are the same as the exceptions for early distributions from a plan. However, there are a few differences for payments from a Roth IRA, including:

- There is no special exception for payments after separation from service.
- The exception for qualified domestic relations orders (QDROs) does not apply (although a special rule applies under which, as part of a divorce or separation agreement, a tax-free transfer may be made directly to a Roth IRA of a spouse or former spouse).

- The exception for payments made at least annually in equal or close to equal amounts over a specified period applies without regard to whether you have had a separation from service.
- There are additional exceptions for (1) payments for qualified higher education expenses, (2) payments up to $10,000 used in a qualified first-time home purchase, and (3) payments for health insurance premiums after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

**Will I owe State income taxes?**

This notice does not describe any State or local income tax rules (including withholding rules).

## SPECIAL RULES AND OPTIONS

**If you miss the 60-day rollover deadline**

Generally, the 60-day rollover deadline cannot be extended. However, the IRS has the limited authority to waive the deadline under certain extraordinary circumstances, such as when external events prevented you from completing the rollover by the 60-day rollover deadline. To apply for a waiver, you must file a private letter ruling request with the IRS. Private letter ruling requests require the payment of a nonrefundable user fee. For more information, see IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*.

**If your payment includes employer stock that you do not roll over**

If you receive a payment that is not a qualified distribution and you do not roll it over, you can apply a special rule to payments of employer stock (or other employer securities) that are paid in a lump sum after separation from service (or after age 59½, disability, or the participant's death). Under the special rule, the net unrealized appreciation on the stock included in the earnings in the payment will not be taxed when distributed to you from the Plan and will be taxed at capital gain rates when you sell the stock. If you do a rollover to a Roth IRA for a nonqualified distribution that includes employer stock (for example, by selling the stock and rolling over the proceeds within 60 days of the distribution), you will not have any taxable income and the special rule relating to the distributed employer stock will not apply to any subsequent payments from the Roth IRA or employer plan. Net unrealized appreciation is generally the increase in the value of the employer stock after it was acquired by the Plan. The Plan administrator can tell you the amount of any net unrealized appreciation.

If you receive a payment that is a qualified distribution that includes employer stock and you do not roll it over, your basis in the stock (used to determine gain

or loss when you later sell the stock) will equal the fair market value of the stock at the time of the payment from the Plan.

**If you have an outstanding loan that is being offset**

If you have an outstanding loan from the Plan, your Plan benefit may be offset by the amount of the loan, typically when your employment ends. The loan offset amount is treated as a distribution to you at the time of the offset and, if the distribution is a nonqualified distribution, the earnings in the loan offset will be taxed (including the 10% additional income tax on early distributions, unless an exception applies) unless you do a 60-day rollover in the amount of the earnings in the loan offset to a Roth IRA or designated Roth account in an employer plan.

**If you receive a nonqualified distribution and you were born on or before January 1, 1936**

If you were born on or before January 1, 1936, and receive a lump sum distribution that is not a qualified distribution and that you do not roll over, special rules for calculating the amount of the tax on the earnings in the payment might apply to you. For more information, see IRS Publication 575, Pension and Annuity Income.

**If you receive a nonqualified distribution, are an eligible retired public safety officer, and your pension payment is used to pay for health coverage or qualified long-term care insurance**

If the Plan is a governmental plan, you retired as a public safety officer, and your retirement was by reason of disability or was after normal retirement age, you can exclude from your taxable income nonqualified distributions paid directly as premiums to an accident or health plan (or a qualified long-term care insurance contract) that your employer maintains for you, your spouse, or your dependents, up to a maximum of $3,000 annually. For this purpose, a public safety officer is a law enforcement officer, firefighter, chaplain, or member of a rescue squad or ambulance crew.

**If you are not a plan participant**

Payments after death of the participant. If you receive a distribution after the participant's death that you do not roll over, the distribution will generally be taxed in the same manner described elsewhere in this notice. However, whether the payment is a qualified distribution generally depends on when the participant first made a contribution to the designated Roth account in the Plan. Also, the 10% additional income tax on early distributions and the special rules for public safety officers do not apply, and the special rule described under the section "If you receive a nonqualified distribution and you were born on or before

January 1, 1936" applies only if the participant was born on or before January 1, 1936.

**If you are a surviving spouse.** If you receive a payment from the Plan as the surviving spouse of a deceased participant, you have the same rollover options that the participant would have had, as described elsewhere in this notice. In addition, if you choose to do a rollover to a Roth IRA, you may treat the Roth IRA as your own or as an inherited Roth IRA.

A Roth IRA you treat as your own is treated like any other Roth IRA of yours, so that you will not have to receive any required minimum distributions during your lifetime and earnings paid to you in a nonqualified distribution before you are age 59½ will be subject to the 10% additional income tax on early distributions (unless an exception applies).

If you treat the Roth IRA as an inherited Roth IRA, payments from the Roth IRA will not be subject to the 10% additional income tax on early distributions. An inherited Roth IRA is subject to required minimum distributions. If the participant had started taking required minimum distributions from the Plan, you will have to receive required minimum distributions from the inherited Roth IRA. If the participant had not started taking required minimum distributions, you will not have to start receiving required minimum distributions from the inherited Roth IRA until the year the participant would have been age 70½.

**If you are a surviving beneficiary other than a spouse**. If you receive a payment from the Plan because of the participant's death and you are a designated beneficiary other than a surviving spouse, the only rollover option you have is to do a direct rollover to an inherited Roth IRA. Payments from the inherited Roth IRA, even if made in a nonqualified distribution, will not be subject to the 10% additional income tax on early distributions. You will have to receive required minimum distributions from the inherited Roth IRA.

Payments under a qualified domestic relations order. If you are the spouse or a former spouse of the participant who receives a payment from the Plan under a qualified domestic relations order (QDRO), you generally have the same options the participant would have (for example, you may roll over the payment as described in this notice).

**If you are a nonresident alien**

If you are a nonresident alien and you do not do a direct rollover to a U.S. IRA or U.S. employer plan, instead of withholding 20%, the Plan is generally required to withhold 30% of the payment for federal income taxes. If the amount withheld

exceeds the amount of tax you owe (as may happen if you do a 60-day rollover), you may request an income tax refund by filing Form 1040NR and attaching your Form 1042-S. See Form W-8BEN for claiming that you are entitled to a reduced rate of withholding under an income tax treaty. For more information, see also IRS Publication 519, *U.S. Tax Guide for Aliens*, and IRS Publication 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*.

**Other special rules**

If a payment is one in a series of payments for less than 10 years, your choice whether to make a direct rollover will apply to all later payments in the series (unless you make a different choice for later payments).

If your payments for the year (only including payments from the designated Roth account in the Plan) are less than $200, the Plan is not required to allow you to do a direct rollover and is not required to withhold for federal income taxes. However, you can do a 60-day rollover.

Unless you elect otherwise, a mandatory cashout from the designated Roth account in the Plan of more than $1,000 will be directly rolled over to a Roth IRA chosen by the Plan administrator or the payor. A mandatory cashout is a payment from a plan to a participant made before age 62 (or normal retirement age, if later) and without consent, where the participant's benefit does not exceed $5,000 (not including any amounts held under the plan as a result of a prior rollover made to the plan).

You may have special rollover rights if you recently served in the U.S. Armed Forces. For more information, see IRS Publication 3, *Armed Forces' Tax Guide*.

## FOR MORE INFORMATION

You may wish to consult with the Plan administrator or payor, or a professional tax advisor, before taking a payment from the Plan. Also, you can find more detailed information on the federal tax treatment of payments from employer plans in: IRS Publication 575*, Pension and Annuity Income*; IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*; IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*; and IRS Publication 571, *Tax-Sheltered Annuity Plans* (403(b) Plans). These publications are available from a local IRS office, on the web at www.irs.gov, or by calling 1-800-TAX-FORM.

# APPENDIX C

## Text of Church Health Plan Act of 2013 (S. 1164)

113TH CONGRESS
1ST SESSION

# S. 1164

To amend the Patient Protection and Affordable Care Act to clarify provisions with respect to church plans.

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IN THE SENATE OF THE UNITED STATES

JUNE 13, 2013

Mr. PRYOR (for himself and Mr. COONS) introduced the following bill; which was read twice and referred to the Committee on Finance

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# A BILL

To amend the Patient Protection and Affordable Care Act to clarify provisions with respect to church plans.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "Church Health Plan Act of 2013".

**SEC. 2. CHURCH PLANS AS QUALIFIED HEALTH PLANS.**

(a) IN GENERAL.—Section 1301(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)) is amended—

(1) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively; and

(2) by inserting after paragraph (2), the following:

"(3) INCLUSION OF QUALIFIED CHURCH PLANS.—

"(A) IN GENERAL.—Any reference in this title to a qualified health plan shall be deemed to include a qualified church plan, unless specifically provided for otherwise.

"(B) REQUIREMENTS OF QUALIFIED CHURCH PLANS.—A qualified church plan is a church plan, as defined in section 414(e) of the Internal Revenue Code of 1986, that—

"(i) is a welfare plan, as defined in section 2(c) of Public Law 106–244, and provides health care coverage for the employees of ten or more eligible common law employers, and if a majority of employees covered by the plan are employees of churches or qualified church-controlled organizations within the meaning of sections 3121(w)(3) (A) and (B) of the Internal Revenue Code of 1986, respectively;

"(ii) provides an essential health benefits package, as defined in section 1302(a);

"(iii) complies with the requirements under sections 2703, 2706, 2708, 2709, 2711, 2712, 2713, 2714, 2715, 2719, and 2719A of the Public Health Service Act;

"(iv) prohibits exclusions based on preexisting conditions or other health status, and prohibits discrimination against individual participants and beneficiaries based on health status for the purposes of enrollment, within the meaning of sections 2704 and 2705 of the Public Health Service Act, except as provided under subparagraph (C)(ii); and

"(v) limits, on average, the ratio of incurred losses plus loss adjustment expenses to earned premiums, within the meaning of section 2718 of the Public Health Service Act, as calculated across the entire church plan, except that, for purposes of this paragraph, earned premiums include payments by, or on behalf of, employees of a church, as defined in 414(e)(3)(B) of the Internal Revenue Code of 1986.

"(C) EXCLUSION OF QUALIFIED CHURCH PLANS FROM AMERICAN HEALTH BENEFIT EXCHANGES.—

"(i) IN GENERAL.—A qualified church plan may not participate in an American Health Benefit Exchange established by a State under section 1311(b) or by the Secretary of Health and Human Services (referred to in this paragraph as the 'Secretary') under 1321(c). The Secretary shall not assess a charge or make a payment to a qualified church plan to reflect actuarial risk pursuant to section 1343, and a qualified church plan shall be exempt from any other subsidies, payments, or requirements under this Act that apply to qualified health plans offered on American Health Benefit Exchanges, except as provided by this paragraph.

"(ii) PREMIUMS.—A qualified church plan may differentiate premiums using methods and criteria consistent with those that the Secretary uses to assess charges and payments to other qualified health plans based on the actuarial risks of enroll-

ees of such plans pursuant to section 1343 and those described in section 422.308 of title 42, Code of Federal Regulations. A qualified church plan may develop additional methods and criteria to define and account for the actuarial risk associated with the prohibition against qualified church plans enrolling a larger number and more diverse pool of enrollees as long as such additional methods and criteria are not inconsistent with the risk adjusters described in section 1343 and those described in section 422.308 of title 42, Code of Federal Regulations.

"(D) DEEMED STATUS OF QUALIFIED CHURCH PLANS.—A qualified church plan shall be deemed to be—

"(i) minimum essential coverage under an eligible employer-sponsored plan, as defined under section 5000A(f)(2) of the Internal Revenue Code of 1986; and

"(ii) for the purposes of subparagraph (F), equivalent to a health plan offered through an American Health Benefit Ex-

change, within the meaning of section 1311(b).

"(E) EMPLOYERS PARTICIPATING IN QUALIFIED CHURCH PLANS.—

"(i) ELIGIBLE SMALL EMPLOYERS.—An employer participating in a qualified church plan shall be deemed an eligible small employer under section 45R(d) of the Internal Revenue Code of 1986, if—

"(I) the employer has not more than 25 full-time equivalent employees, as defined under section 45R(d)(2) of the Internal Revenue Code of 1986, for the taxable year; and

"(II) the average annual wages of such full-time equivalent employees do exceed an amount equal to twice the dollar amount in effect under section 45R(d)(3)(B) of the Internal Revenue Code of 1986 for the taxable year, and if no employee of the employer who is enrolled in the qualified church plan receives premium tax

credits or reductions in cost-sharing under subparagraph (F).

"(ii) NO EXCLUSION FROM WAGES.—Any employer participating in a qualified church plan shall not exclude from wages and other compensation, for any individual receiving premium tax credits under section 1401, any employer contribution for minimum essential coverage under a qualified church plan under section 106 of the Internal Revenue Code of 1986.

"(iii) EMPLOYERS PARTICIPATING IN QUALIFIED CHURCH PLANS.—Any employer participating in a qualified church plan shall be deemed to be a 'religious employer' as defined in section 147.131 of title 45, Code of Federal Regulations.

"(F) PREMIUM TAX CREDITS, REDUCTIONS IN COST-SHARING, AND QUALIFIED CHURCH PLANS.—An individual receiving minimum essential coverage under a qualified church plan—

"(i) shall be deemed to satisfy the individual responsibility requirements under

section 5000A of the Internal Revenue Code of 1986;

"(ii) shall be deemed to qualify as an applicable taxpayer eligible to receive premium tax credits under section 1401, if the individual's household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved; and

"(iii) shall be deemed to qualify as an eligible insured eligible to receive reductions in cost-sharing under section 1402(b), if the individual's household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

"(G) REGULATIONS.—The Secretary and the Secretary of the Treasury shall promulgate regulations—

"(i) under subparagraph (E) to ensure that an eligible small employer offering a qualified church plan receives the same tax credit as any other eligible small

employer under section 45R of the Internal Revenue Code of 1986;

"(ii) under subparagraph (F)(ii) to ensure that an applicable taxpayer receiving minimum essential coverage under a qualified church plan receives the same premium tax credit as any other applicable taxpayer under section 1401;

"(iii) under subparagraph (F)(iii) to ensure that an eligible insured receiving minimum essential coverage under a qualified church plan receives the same reduction in cost-sharing as any other eligible insured under section 1402; and

"(iv) providing church plans sufficient opportunity to make appropriate transitions in order to meet the definition of qualified church plan under subparagraph (B).".

(b) EFFECTIVE DATE.—The amendments made by this Act shall take effect as if enacted as part of the Patient Protection and Affordable Care Act (Public Law 111–148).

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# APPENDIX D

## Church Alliance Comment Letter on Cadillac Plan Tax Guidance (Notice 2015-16)

**CHURCH ALLIANCE**
Acting on Behalf of Church Benefits Programs

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May 15, 2015

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Internal Revenue Service
CC:PA:LPD:PR (*Notice* 2015-16)
Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

**Re: Notice 2015-16**

*Comment to Notice 2015-16: Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage*

To Whom It May Concern:

## I. Introduction

The Church Alliance is submitting this letter as a public comment to *Notice 2015-16*: *Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage* (the "Notice") published by the United States ("U.S.") Department of the Treasury ("Treasury") and the Internal Revenue Service ("IRS") at 2015-10 I.R.B. 732 on February 23, 2015.

The Church Alliance is an organization composed of the chief executives of thirty-eight church benefit boards, covering mainline and evangelical Protestant denominations, two branches of Judaism, and Catholic schools and institutions. The church health benefit plans represented by the Church Alliance ("denominational health plans") provide health plan coverage to over one million participants (clergy and lay workers) serving over 155,000 churches, synagogues and affiliated organizations ("church employers"). For over 50 years, many denominational health plans, mostly nationwide self-funded plans, have allowed the families of clergy and lay church workers the comfort and security of career-long portable, comprehensive medical coverage, on an affordable basis through a plan that reflects their denomination's belief system.

The Church Alliance commends Treasury and the IRS for requesting comments about the excise tax on high cost employer-sponsored health coverage under Internal Revenue Code (the "Code") Section 4980I (the "Excise Tax"). We hope our comments will help Treasury and the IRS

establish reasonable methods for denominational health plans and church employers to comply with the Excise Tax requirements.

## II. Executive Summary

As explained in detail below, the Excise Tax is to be assessed on high cost employer-sponsored health coverage, but the determination of the cost of coverage under denominational health plans is difficult to determine, particularly since these plans have not been required to determine such cost for purposes of Code Section 4980B ("COBRA") because Code Section 4980B(d)(3) excludes them from the continuation coverage requirements of that Section. In addition, denominational health plans for decades have been functioning in a manner similar to the way Affordable Insurance Exchanges now are functioning, by covering employees, former employees and their dependents regardless of health risk and continuing to cover them after disablement or retirement, which increases aggregate health coverage costs for such plans. Denominational health plans, providing health coverage to lowly-paid clergy and other church workers, are not the type of lavish plans that the Excise Tax was intended to target.

For these reasons and others explained in this letter, the Church Alliance requests relief from the Excise Tax. Ideally this relief would be similar to the relief accorded in Q&A-21 of Notice 2012-9, which provides that the cost of coverage provided under a self-insured group health plan that is not subject to federal continuation coverage requirements is not required to be included in the cost of coverage reported on Form W-2. The Church Alliance also requests flexibility in the application of the Excise Tax, and adjustments to the applicable dollar limits that trigger the Excise Tax, as further described below.

## III. Church Structures and Denominational Health Plan Contributions

The application of the Excise Tax with respect to coverage under denominational health plans presents different challenges than it would for coverage under a typical single or multiemployer group health plan. Each denomination has a unique polity (governance structure) established to reflect its theological beliefs. The governance structures of the Church Alliance members range from purely hierarchical churches to independent churches or denominations that are congregational in nature. The governance structure of a denomination often determines how direct the relationship between each church, clergy member and the denominational plan is, and may affect the way employer and employee contributions for coverage are established or allocated. As a result, the true "cost of coverage" under a self-insured denominational health plan is not always readily evident to the employers and employees participating in such a plan.

The underlying polity of the denomination typically informs the identity of the plan sponsor and the control that it can exert on plan design and contribution limits. In some of the more hierarchical denominations, there is an independent civil corporation that serves as the plan sponsor and has the ability to mandate employer coverage and set contributions. In other denominations, often the more congregational in polity, the health plan can only control the plan design and administration, but participation remains optional for local church employers; in the latter setting, contributions may be more like a risk and experience-based premium. For those health plans, the plan sponsor may be the employer rather than the organization responsible for the health plan design and administration. In some denominations, the health plan charges an established contribution or premium to a regional sub-unit of the denomination, such as a diocese, presbytery or state convention. These intermediate bodies may then alter the method of sharing costs among participating churches. Because there is no centralized human resource or payroll function for any of the denominations, the organization responsible for the health plan design and administration may not actually know the level of contribution that the local unit requires of the employee.

Sometimes contributions set by the denominational health plan, e.g., single coverage rates and family rates, are blended by an intermediate church body or unit of church government in various ways. Rates may be blended to remove any perceived barriers to appointment/employment at a particular church due to a clergyperson's family size. For example, assume a state conference pays the denominational health plan $7,000 to cover single clergy and $13,000 to cover clergy with families. However, when the same state conference establishes charges to the church employers within its jurisdiction, it may blend the rates and charge each church $10,000 for each covered employee. The church employer then would not know the actual cost of coverage for its employees without obtaining additional information from the denominational health plan, at an additional cost to such plan.

Some denominations and intermediate church bodies may cross-subsidize churches through contribution structures. They may charge higher contribution rates to churches with larger memberships, greater revenue (giving), or more assets, and in turn charge a reduced contribution rate to smaller or rural churches or to churches serving economically poorer populations. This cross-subsidization reflects and serves the mission work of these denominations. In these cases, the cost of coverage to the denominational health plan may be substantially different than the cost of coverage charged to a local church for its employees.

Some denominational health plans require a contribution for coverage that is simply a fixed percentage of a clergyperson's, or an employee's, compensation. This percentage charge may not directly reflect the actual cost of coverage provided for its employees, but rather an amount that the denomination has determined is that church's fair share of the overall cost of coverage for all church workers in the plan. In other cases, the contribution under the health plan may be combined with the contribution to the church pension plan, to set one benefits coverage contribution for participating churches. In some cases an intermediate body may combine health plan contributions with other general church remittances for participating churches. These contributions may also be varied within a denomination, e.g., to subsidize poorer or smaller churches, to reflect mission needs and church values. Without some additional information from the denominational health plan or intermediate body, and an associated cost of providing that information, the employing church may not be able to easily determine the cost of coverage.

Though not subject to COBRA or most state continuation coverage requirements, most denominational health plans nonetheless offer continuation coverage of some sort and may offer the continued coverage for a longer duration than required by COBRA. These denominational health plans may require a contribution, i.e., may charge a continuation coverage contribution for such coverage, but this charge may reflect cross-subsidization, rather than actual costs. Also, in some cases these continuation coverage contributions are filtered through intermediate church bodies before reaching the former employee.

## IV. Challenges for Denominational Health Plans

### A. Excess Benefit

Denominational health plans face unique challenges with the application of the Excise Tax. For decades, denominational health plans have provided coverage in much the same way as the Affordable Insurance Exchanges, by including employees, former employees (including retirees and disabled former employees) and surviving spouses and dependent children, regardless of health condition. Even though providing coverage for such populations increased costs to denominational health plans, because of denominational beliefs, denominational mandates or just because "it was the right thing to do", those high cost individuals were covered, sometimes at little or no cost to the individuals. Denominational health

plans want to continue to cover these vulnerable (and high cost) populations, and request flexibility to adjust the calculation of the excess benefit or cost for such populations, including possibly excluding costs for such high cost populations when no contributions are being charged to those individuals or excluding those individuals from the definition of "employee" under Code Section 4980I(d)(3). Alternatively, perhaps the exception contained in Code Section 4980I(b)(3)(C)(iv), for qualified retirees and high-risk professions, could be applied with respect to such individuals.

**B. Applicable Coverage**

The requirement for each employer to aggregate the cost of applicable employer-sponsored coverage and the manner in which the employer is required to calculate and report each coverage provider's applicable share of any excess benefit under Code Sections 4980I(c)(3) and 4980I(c)(4) presents challenges for church employers and denominational health plans. As such, the Church Alliance respectfully requests that future guidance provide flexibility to denominational health plans to: 1) permit the plan sponsor to assign the entity responsible for the calculation, and 2) determine the manner in which any excess benefit is allocated to the coverage providers.

As noted above, the varied governance structures of the Church Alliance members often determine the way contributions for group health coverage are established. As a result, the cost of coverage under a self-insured denominational health plan is not always readily evident to individual employers.

The self-insured group health plans offered to employees of the church are often sponsored by a church board that, in accordance with rules established by the denomination, administers the health plans for participating church employers. In addition to sponsoring and administering the group health plans for active employees, the church board often directly provides pension benefits and retiree health benefits to retired clergy and lay employees and their beneficiaries.

An individual employer therefore cannot always easily ascertain the cost of group health coverage for their active and retired employees and their beneficiaries, and this information is of course necessary to fulfill its obligations under Code Sections 4980I(c)(3) and 4980I(c)(4). In addition, although the church board maintains the information necessary to determine the aggregate cost of group health coverage, the church board does not generally control nor have knowledge of other benefits offered by individual employers that are considered applicable employer-sponsored coverage, such as contributions to health flexible spending accounts ("health FSAs"), health savings accounts ("HSAs"), or health reimbursement arrangements ("HRAs"). Similarly, although the individual church employers will know the amount of their contributions to health FSAs, HSAs, or HRAs, they may not know the cost of denominational health plan coverage. Due to these unique challenges, the Church Alliance requests that future guidance provides flexibility to church employers and the sponsors of denominational health plans to designate the entity that is best suited to obtain the necessary information required by and handle the obligations under Code Sections 4980I(c)(3) and 4980I(c)(4).

The Church Alliance also requests flexibility in the calculation of the allocable share of any excess benefit to a coverage provider. Under Section 4980I(c)(3), the coverage provider that provides the highest cost coverage will be allocated the largest share of any excess benefit. Since church boards sponsor the denominational health plans provided to church employees, the plans may be allocated the largest share of any excess benefit, if the cost of the denominational health plans is larger than the cost of other benefits offered by individual employers that are considered applicable employer-sponsored coverage, such as contributions to health FSAs, HSAs, or HRAs. The Church Alliance understands that any excess benefit directly relating to the cost of a denominational health plan may be allocated to such plan, but requests

flexibility in the allocation of the excess benefit resulting from the cost of coverage provided by other coverage providers. Without this flexibility, the denominational health plans will unfairly bear a large percentage of the Excise Tax associated with excess benefits provided by other coverage providers, which could negatively impact the financial stability of denominational health plans. Therefore, the Church Alliance requests that Treasury and the IRS allow denominational health plans to apply a reasonable, good faith interpretation of the rules relating to the calculation and allocation of the excess benefit in order to provide the flexibility necessary to avoid unnecessary financial hardship on denominational health plans.

### C. Determination of Cost of Applicable Coverage

The cost of coverage under Code Section 4980I is to be determined under rules similar to the rules of COBRA for determining "applicable premiums." However, as previously noted, denominational health plans are not subject to COBRA and thus do not calculate "applicable premiums" under COBRA.

In fact, self-insured denominational health plans do not charge premiums at all. The Church Plan Parity and Entanglement Prevention Act, which clarifies the applicability of state insurance laws to church plans described in ERISA Section 3(33), provides that for purposes of determining the status of a church plan that is a welfare plan under provisions of state insurance law, a church plan is deemed to be a plan that reimburses costs from general church assets. Instead of charging premiums, denominational health plans obtain contributions to cover the aggregate amount needed to pay for the health coverage for all plan members.

The "applicable premium" under COBRA is to be determined by reasonably estimating the cost of providing coverage for "similarly situated beneficiaries." It is unclear how that would and should be applied in the case of the denominational health plans. Since, as explained previously, such plans do not determine contribution amounts based solely on cost, they do not divide plan members into various categories based on their similarities and assign cost on that basis.

Moreover, even when categories of "similarly situated" individuals may be determinable, denominational mandates or guidelines often reallocate health plan contribution rates based on principles, rather than cost. Subsidization of certain employee populations and other rate adjustments are made because of religious beliefs and as described earlier, contribution rates may be based on assets of the congregation or other factors, not on cost.

As a result, the Church Alliance requests that Treasury and the IRS establish a very flexible rule for church employers and denominational health plans to determine the cost of applicable health care coverage. The rule should allow such employers and plans to use any reasonable method to determine the cost of coverage. Ideally, the cost of coverage provided under a self-insured group health plan that is not subject to any federal continuation coverage requirements would not be required to be included in cost for purposes of computing the Excise Tax. This could eliminate the calculation and allocation issues described in Section "B", above, of this letter, as between the individual church employer and the denominational health plan. If such relief is not possible, where information on contributions for continuation coverage provided by the denominational health plan is available and appropriate, church employers should be allowed to use such information. Alternatively, such employers should be able to use a reasonable estimate of the "fair market value" or applicable "premium" – blended, cross-subsidized, or otherwise – extrapolated from the church contributions required of them.

In cases where such an estimate is not available, is not estimable without significant cost, and/or is impracticable to obtain, the Church Alliance suggests allowing denominational health plan employers to use either a reasonable good faith estimate of cost or the cost of similar coverage available elsewhere, such as through an Affordable Insurance Exchange or the applicable (based on state of residence, coverage type, etc.) state average premium for the small group market published by the U.S. Department of Health and Human Services as an estimate of the "cost of coverage".

### 1. Aggregation and Disaggregation

The Notice indicated that a possible approach to determining the cost of applicable coverage would be based on the application of the following aggregation and disaggregation rules:

- First, the initial group of similarly situated employees would be determined by aggregating "all employees ... covered by a particular benefit package provided by the employer."

- Second, the groups resulting from the application of the first step would be separated into two groups each, one for employees covered by employee-only coverage, and another for other than employee-only coverage ("family coverage").

- Third, an employer may aggregate all family coverage regardless of the number of individuals actually covered.

- Fourth, an employer may be able to disaggregate based on distinctions traditionally made in the group insurance market.

The Church Alliance offers the following two comments on the above approach with denominational health plans in mind.

#### a. Allow Plan-Based Individual Benefit Package Aggregation

The Church Alliance assumes that the grouping under the first step above would be based on the definition of "employer" in Code Section 4980H(f)(9), which provides that all employers treated as a single employer under Code Sections 414(b), (c), (m) or (o) will be treated as a single employer.

Employers in a denominational health plan should be permitted to rely on an individual benefit package based on an aggregation of all employers within the plan. This approach would be consistent with the calculation of the cost of COBRA coverage under Code Section 4980B(f)(4)(A), which defines "applicable premium" to mean, "with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred ...." (emphasis added).

A plan-based approach will have a number of advantages.

First, it will avoid saddling denominational health plans with the expense of calculating cost on an employer-by-employer basis, which few such self-insured plans currently do. The governance structure of a denomination often determines how direct the relationship between each church and the denominational health plan is, and, as noted above, may affect the way contributions for coverage are established. As a result, the "cost of coverage" under a self-insured denominational health plan is not always readily evident. As previously noted, in some denominations the plan charges an established

contribution to a regional sub-unit of the denomination, such as a diocese, presbytery or state convention. These intermediate bodies may alter the method of sharing costs among participating churches. A plan-based approach will save such plans from having to break out cost on an employer-by-employer basis, a task made more difficult by the absence of regulations applying Code section 414(c) to certain church entities. Treas. Reg. § 1.414(c)-5(e).

Second, a plan-based approach will reflect the basis on which some denominational health plans actually allocate cost. As previously noted, some denominations and intermediate church bodies may cross-subsidize churches through contribution structures. They may charge higher contribution rates to churches with larger memberships, greater revenue (giving), or more assets, and in turn charge a reduced contribution rate to smaller or rural churches or to churches serving economically poorer populations. Alternatively, some denominational health plans charge a contribution for coverage that is simply a fixed percentage of a clergyperson's, or an employee's, compensation, thus effectively subsidizing coverage for employers with lower compensated participants. This cross-subsidization may serve the mission work of these denominations.

**b. Allow Permissive Disaggregation To Be Based on Broad Standards**

Permissive disaggregation under the fourth step above should be permitted to be based on any standard traditionally used within the group insurance market while prohibiting the use of any criterion based on an individual's health. Such disaggregation would allow distinctions to be based on a church's polity and beliefs, such as disaggregation by diocese, presbytery or state convention, which could result in more accurate adjustments for geography and cost-sharing. Prohibiting the use of any criterion based on an individual's health status should allay any concerns about potential abuses.

**2. Self-Insured Plans' Methods**

The Notice indicates Treasury and the IRS are considering requiring a self-insured plan to use an actuarial basis method to compute the cost of applicable coverage unless the plan administrator elects to use the past cost method and the plan is eligible to use that method. The Church Alliance requests that Treasury and the IRS allow self-funded denominational health plans to compute cost using either method, while also allowing plan-based permissive aggregation as discussed in the section above. Denominational health plans need to be able to freely change between cost computation methods because such plans are often subject to the mandates of their denominations, which could cause the need to change from one method to the other before a set period of five or two years (for example, the plan may need to switch from the past cost method to the actuarial basis method if, due to a new denomination mandate, past costs are no longer likely to be accurate).

When using the actuarial basis method to compute the cost of applicable coverage, the Church Alliance supports a broad standard using an estimate of the actual cost the plan is expected to incur for a determination period, and not the minimum or maximum exposure the plan could have for that period. Using a minimum or maximum exposure could result in much higher or lower costs than the plan expects to experience. Denominational health plans should be able to perform actuarial estimates "in house". The use of outside accredited consultants should not be required because this could increase plan costs. In addition, the Church Alliance feels that specifying a list of factors to be utilized when making an actuarial determination of the cost of applicable coverage would further complicate an already-complicated set of rules.

The Church Alliance asks for flexibility in determining the measurement period used under the past cost method because, as stated above, denominational health plans are often subject to the mandates of their denominations, which could result in the need to change measurement periods before a specific period of time passes. In determining past cost, the Church Alliance would like self-insured denominational health plans to be able to use either the claims incurred or claims submitted measurement – whichever provides the most reasonable cost measure for the particular plan.

The Church Alliance suggests that additional guidance on what constitutes reasonable overhead expenses would not be beneficial and would instead prefer flexibility in allowing the plan to determine what is reasonable. An elective safe harbor allowing a self-administered, self-insured plan to assume that the amount of reasonable overhead expenses is equal to a defined percentage of claims may be of assistance to some self-insured plans.

### 3. Health Reimbursement Arrangements

Although HRAs meet the definition of applicable coverage under Section 4980I(d)(1)(A) of the Code and are not specifically excluded by another provision of 4980I, HRAs are excepted from the aggregate reportable cost of coverage reported on Form W-2 (under Notice 2012-09) and the Church Alliance asks that HRAs be similarly excepted from being included in the cost of coverage under Code Section 4980I. If HRAs are included in the cost of coverage for church employers, church workers will be harmed. Church budgets are typically strained, which is the reason church employers turned to the solution of HRAs to allow the limited financial resources of the church to be set aside for use when and if needed for health care costs. Requiring church employers' HRAs to be included in the cost of coverage will result in the elimination by church employers of HRAs, which will harm low-paid church workers. If HRAs are not excepted from the cost of applicable coverage, the Church Alliance recommends that HRA cost should only include claims for a particular period and should not be based on amounts made newly available or carried over from a prior year because this could over-value the HRA, if total contributions are not spent during the current period.

Moreover, the cost of applicable coverage should not include an HRA that can be used only to fund the employee contribution towards coverage because including that value would result in double counting. In addition, the cost of applicable coverage should not include an HRA that can fund a wide range of benefits, some of which would not be applicable coverage. Providing only one method to determine the cost of applicable coverage would decrease administrative complexity, but may not work for church employer HRAs that could be impacted by denominational mandates.

### 4. Form W-2 Reporting of Cost

The Church Alliance remains very grateful for the relief accorded for W-2 reporting of health care cost under Q&A-21 in Notice 2012-9. The Church Alliance respectfully requests similar relief under Code Section 4980I, specifically that the cost of coverage provided under a self-insured group health plan that is not subject to any federal continuation coverage requirements will not be required to be included in the cost of coverage under Code Section 4980I.

Alternatively, the Church Alliance requests Treasury and the IRS to grant employers providing coverage through a denominational health plan a lengthy transition period before the Excise Tax becomes applicable to them, similar to the transition relief that was accorded church health plans with respect to the Form W-2 reporting of cost requirements. Church employers and denominational health plans are making their best efforts to implement all of the requirements of the Affordable Care Act, but given the atypical

employment and polity structures of churches and denominations, longer time periods to implement these changes are necessary. As such, the Church Alliance suggests delaying making the Excise Tax mandatory for these employers and plans until at least after 2020.

### D. Applicable Dollar Limit

The Church Alliance appreciates the invitation from Treasury and the IRS to comment on adjustments to the baseline per-employee dollar limits. [1] We support the development of safe harbors that adjust dollar limit thresholds for employee populations, in particular those that recognize age characteristics that are different from those of the national workforce. Denominational health plans serving pastors provide health care coverage to the clerical workforce of many of the churches across our nation. The median age of pastors is 55, which, on average, is 15 years older than the U.S. labor force.[2] Because there is a direct correlation between an insured's age and the increased cost of health care,[3] the Excise Tax will result in denominational health plans paying an Excise Tax, per employee, that is higher than another employer whose workforce represents the median age of the labor force. An age-based safe-harbor can help mitigate the potential unfairness associated with the higher cost of health care provided to an older workforce by reducing or eliminating the Excise Tax attributable to older workers' health benefits. Accordingly, the Church Alliance suggests implementation of a safe harbor that recognizes and accommodates the increased expenses associated with employing an older workforce by establishing an inverse relationship to age and phasing out the Excise Tax for older employees.

The Church Alliance also supports an adjustment to the applicable dollar limit for denominational health plans and respectfully requests that the applicable annual limitation for denominational health plans, like multiemployer plans, equal the amount associated with other-than-self-only coverage. Denominational health plans (as defined in Code Section 414(e)) have a structure similar to multiemployer plans (as defined in Code Section 414(f)[4]) – both offer health plans to employees where more than one employer is required to contribute. In addition, health benefits are mandated by the church or its polity with some denominational health plans, in much the same way as benefits are mandated by collective bargaining agreements with multiemployer plans. Our request is also based on the reality that many pastors' wages

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[1] Two annual dollar limits are set out in Section 4980I(b)(3):
1) Employee only coverage, with the baseline per-employee dollar limit at $10,200 for 2018 (with the potential for adjustments).
2) Employee other-than-self-only coverage, with the baseline per-employee dollar limit at $27,500 for 2018 (with the potential for adjustments).

[2] In 2009, the average, median age of ordained senior/solo pastors was 55 years of age. See Associate Pastors, Research Services, A Ministry of the General Assembly Mission Council, Presbyterian Church (U.S.A.), September 2010, at www.uscongregations.org. Compare that to the median age of the U.S. labor force that same year of approximately 40 years of age. See Median Age of Labor Force; Employment Projections Program, U.S. Department of Labor, U.S. Bureaus of Labor Statistics, December 19, 2013.

[3] "[T]he use of medical care services by adults rises with age, and per capita expenditures on health care are relatively high among older age groups." See Global Health and Aging by National Institute of Aging/National Institutes of Health, U.S. Department of Health and Human Services and the World Health Organization, NIH Publication no. 11-7737, October 2011.

[4] Section 414(f)- Multiemployer plan: (1) Definition. For purposes of this part, the term "multiemployer plan" means a plan— (A) to which more than one employer is required to contribute, (B) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and (C) which satisfies such other requirements as the Secretary of Labor may prescribe by regulation.

are lower than the wages of their peers.[5] A number of the denominational plans started providing financial protection to ministers and their families for retirement and health costs as early as 1717 in recognition of the fact that pastors' wages were too low (or unreliable) to allow them to adequately save for unanticipated personal costs. The heritage of providing a comprehensive benefits program to supplement low wages continues as a covenant between the church and its workers. It is part and parcel of their call to serve. Unlike other employers, churches have been slow to shift the cost of coverage to the ministers or to reduce the benefits provided. Moreover, when a secular employer shifts more costs to employees to reduce plan costs, the employer still pays half of the FICA taxes on the increase in wages that may result from reduced health benefits. For clergy, however, who are statutorily self-employed for SECA tax purposes, such cost shifting results in a higher tax burden. As a result of this proud tradition of caring for its workers, the application of employee-only coverage as the applicable dollar limit will result in penalizing pastors and other church workers, who receive health benefits from denominational health plans, when those benefits are intended to care for those who spend their lives caring for others. To borrow a phrase common in the media, perhaps these health benefits can be categorized as something less than a Cadillac, but more than a Chevrolet. We don't believe the intent of the Excise Tax was to penalize pastors and church workers. Adjustment of the applicable dollar limit for denominational health plans to the amount associated with other-than-self-coverage will mitigate this consequence.

## V. Conclusion

Based on the foregoing, the Church Alliance respectfully requests relief from the Excise Tax, including transition relief and relief with respect to the cost of coverage provided under a self-insured group health plan that is not subject to federal continuation coverage requirements, flexibility in the application of the Excise Tax and adjustments to the applicable dollar limits, as further described above.

Thank you for your consideration of our views on this important issue to church employers and employees. If you have questions or wish to discuss this matter further, please feel free to contact the undersigned at (202) 661-3882 or stephen.cooper@klgates.com.

Sincerely,

Stephen H. Cooper
Government Affairs Counselor, K&L Gates
On Behalf of the Church Alliance

[5] The annual, median wage for clergy is $43,950, as compared to the annual, median wage for full-time salary workers with a professional degree, which is $85,228. See U.S. Bureau of Labor Statistics, Occupational Employment and Wages, 2011 Clergy, May 2014; and Employment Projections, Earnings and Unemployment Rates by Education Attainment, updated April 2, 2015.

# APPENDIX E

## Church Alliance Comment Letter on Cadillac Plan Tax Guidance (Notice 2015-52)

# CHURCH ALLIANCE

Acting on Behalf of Church Benefits Programs

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October 1, 2015

Electronically to Notice.comments@irscounsel.treas.gov

CC:PA:LPD:PR (*Notice* 2015-52)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

**Re: Notice 2015-52**

*Comment to Notice 2015-52: Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage*

To Whom It May Concern:

## I. Introduction

The Church Alliance is submitting this letter as a public comment to *Notice 2015-52*: *Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage* (the "Notice") published by the United States Department of the Treasury ("Treasury") and the Internal Revenue Service ("IRS") at 2015-35 I.R.B. 227 on July 30, 2015. To some extent this comment letter supplements a letter dated May 15, 2015, in which the Church Alliance commented on *Notice 2015-16* (the "Prior Comment"). A copy of the Prior Comment is attached.

The Church Alliance is an organization composed of the chief executives of thirty-seven church benefit boards, covering mainline and evangelical Protestant denominations, two branches of Judaism, and Catholic schools and institutions. The church health benefit plans represented by the Church Alliance ("denominational health plans") provide health plan coverage to over one million participants (clergy and lay workers) serving over 155,000 churches, synagogues and affiliated organizations ("church employers"). We hope our comments will help Treasury and the IRS apply the requirements with respect to the excise tax on high cost employer-sponsored health coverage under Internal Revenue Code (the "Code") section 4980I (the "Excise Tax") to denominational health plans and church employers.

## II. Executive Summary

As explained below, the Excise Tax is to be assessed on high cost employer-sponsored health coverage, but the determination of the cost of coverage under denominational health plans is challenging. Code section 4980I provides that cost is to be determined under rules similar to the rules for determining applicable premiums under Code section 4980B ("COBRA"). However, denominational health plans are excluded from COBRA. Moreover, the contributions paid by church employers for denominational health plan coverage are unlikely to have much correlation to the cost of coverage for the employees of that particular church employer, because of adjustments often made based on religious beliefs and principles. The processes expected to be involved in calculating and allocating any excess benefit in the time period necessary to complete these processes are particularly challenging for church employers in denominational health plans. As a result of these challenges, the Church Alliance continues to request relief from the Excise Tax for denominational health plans to the greatest extent possible, as well as flexibility in its application, to the extent relief is not granted.

## III. Challenges for Denominational Health Plans

### A. Persons Liable for the Section 4980I Excise Tax

Section 4980I(c)(2)(C) provides that the "coverage provider" liable for any applicable Excise Tax for "other applicable coverage" is "the person that administers the plan benefits". Treasury and the IRS have requested comments on two alternative approaches for determining the identity of the person that administers the plan benefits. For the reasons set forth below, the two approaches described in the Notice do not provide the level of certainty necessary to identify the coverage provider for other applicable coverage under denominational health plans.

Under the first approach described in the Notice, the person that administers the plan benefits would be the person responsible for performing the day-to-day functions that constitute the administration of plan benefits, which will generally be a third-party administrator for benefits that are self-insured. Many self-insured denominational health plans offer one or more benefit packages providing applicable coverage, but have separate third party administrators that perform the relevant day-to-day functions for separate categories of benefits under the plans: medical, mental health and prescription drug benefits. Therefore, this approach will not provide the level of certainty necessary to identify the third party administrator that is the coverage provider for other applicable coverage.

Under the second approach described in the Notice, the person that administers the plan benefits would be the person that has ultimate authority or responsibility under the plan with respect to the administration of plan benefits (including the final decisions on administrative matters), regardless of whether that person routinely exercises that authority or responsibility. The relevant administrative matters over which the person that administers the plan benefits would have ultimate authority or responsibility could include eligibility determinations, claims administration and arrangements with service providers. Given the unique structure of denominational health plans, in certain cases there may be different entities that have ultimate authority or responsibility for the different administrative matters with respect to the same benefit package. For example, a parish or synagogue may have ultimate responsibility over eligibility determinations, but the denominational board may have ultimate responsibility over claims administration. In addition, in a denominational health plan, an ecclesiastical authority may have ultimate

authority or responsibility with respect to plan benefit administration in certain circumstances. Therefore, this approach also fails to provide the level of certainty necessary to identify the entity that is the coverage provider for other applicable coverage.

Therefore, the Church Alliance respectfully requests that Treasury and the IRS consider an alternate approach that will provide flexibility and certainty to denominational health plans by allowing the designation of the coverage provider in the plan document for the applicable coverage. This approach would provide flexibility to denominational health plans to identify the entity best suited to comply with the obligations placed on the coverage provider and provide certainty to such health plans with respect to the identity of the coverage provider for other applicable coverage.

### B. Church Structures and Denominational Health Plans

Even after resolving the above question on the coverage provider, the application of the Excise Tax requirements to denominational health plans remains challenging. This is in part because each denomination has a unique governance structure that reflects its theological beliefs, which adds complexity to the application of the requirements. That governance structure often determines how direct the relationship between each church employer, clergy member and the denominational plan is, and may affect the way employer and employee contributions for coverage are established or allocated, which in turn impacts the determination of the "cost of coverage". The structure of the denomination also typically informs the identity of the plan sponsor and the control that it can exert on plan design and contribution limits. As a result, the true "cost of coverage" under a self-insured denominational health plan is not always readily evident. The organization responsible for the health plan design and administration may not actually know the level of contribution that the local unit requires of the employee, because there is no centralized human resource or payroll function for any of the denominations.

Sometimes contributions set by the denominational health plan, e.g., single coverage rates and family rates, are blended by an intermediate church body or unit of church government in various ways. Rates may be blended to remove any perceived barriers to appointment at a particular church employer due to a clergyperson's family size.

Some denominations and intermediate church bodies may cross-subsidize church employers through contribution structures. They may charge higher contribution rates to churches with larger memberships, greater revenue (giving), or more assets, and in turn charge a reduced contribution rate to smaller or rural churches or to churches serving economically poorer populations. This cross-subsidization reflects and serves the mission work of these denominations.

Some denominational health plans require a contribution for coverage that is simply a fixed percentage of a clergyperson's, or an employee's, compensation. This percentage charge may not directly reflect the actual cost of coverage provided for its employees, but rather an amount that the denomination has determined is that church employer's fair share of the overall cost of coverage for all church workers in the plan. In other cases, the contribution under the health plan may be combined with the contribution to the church pension plan, to set one benefits coverage contribution for participating church employers. These unique contribution arrangements based on church beliefs and structure present challenges for application of the Excise Tax requirements to denominational health plans.

### C. Employer Aggregation

#### 1. Identification of the applicable coverage taken into account as made available by an employer (Code § 4980I(d)(1)(A))

To lend some certainty to the challenging process of applying the Excise Tax requirements to denominational health plans, the Church Alliance recommends that each individual church employer generally be held responsible for determining the applicable coverage provided to its employees. An individual church employer may be the only entity to know all the coverage provided to its employees. In addition, individual church employers typically will be in a position to identify which coverage is excludable from each employee's gross income under Code section 106, as the individual church employer will be responsible for determining that in connection with the preparation of the Form W-2s. We suggest, though, due to the unique structures of denominations and church employers, flexibility in the application of this rule, which would allow individual church employers to rely on another party, perhaps another member of its controlled group under Code section 414(b) or (c) or the applicable denominational plan, for determining the applicable coverage, with the responsibility for the determination of applicable coverage to remain with the individual church employer, unless another responsible party is clearly designated.

#### 2. Identification of the employees taken into account for the age and gender adjustment (Code § 4980I(b)(3)(C)(iii))

We suggest that the identification of the employees taken into account for the age and gender adjustment be permitted to be done on a plan-wide basis in the case of a denominational health plan. As noted in our Prior Comment, a plan-based approach will reflect the basis on which many denominational health plans actually allocate costs. As described above, many denominations and intermediate church bodies cross-subsidize participating religious employers through their contribution structures. Alternatively, some denominational health plans charge contributions for coverage that are a fixed percentage of the clergyperson's or employee's compensation, thus effectively subsidizing coverage for employers with lower compensated participants.

A plan-wide approach will have the added advantage of saving plans the expense of calculating the age and gender adjustments on an employer-by-employer basis. As noted in our Prior Comment, few denominational plans calculate their costs on an employer-by-employer basis. Also, a denominational health plan may not know exactly which entities employ each of its participants. A diocese, for example, may contribute to a denominational benefit plan on behalf of all the employees employed by the parishes and other organizations within the diocese, without identifying exactly who is the common law employer of each participant.

#### 3. Identification of the taxpayer responsible for calculating and reporting the excess benefit (Code § 4980I(c)(4)(A))

Individual church employers generally should be responsible for calculating and reporting any excess benefit. As with the determination of applicable coverage, we suggest, though, flexibility in the application of this rule, which would allow individual church employers to rely on another party, perhaps another member of its controlled group under Code section 414(b) or (c) or the applicable denominational plan, to calculate and report excess benefits. This reliance may be necessary because the church employer

may not have the information necessary for it to ascertain the cost of coverage, or may not have the expertise to perform such calculation and reporting. However, any such delegation should not affect the individual employer's responsibility, unless another responsible party is clearly designated. This is similar to the way in which the calculation and reporting requirements are handled under Code section 6055 with respect to minimum essential coverage. The preamble to the final regulations under Code section 6055 provides:

> As stated in the preamble to the proposed regulations, one member of a controlled group may assist the other members by filing returns and furnishing statements on behalf of all members, thus providing administrative flexibility. However, each employer is treated as a plan sponsor separately liable for timely and correct reporting. Employers in controlled groups that are not applicable large employer members (determined after applying the aggregation rules under § 54.4980H–1(a)(16)), and reporting entities (such as issuers) that are not reporting as employers, may report under section 6055 as separate entities, or one entity may report for the group.

79 Fed. Reg. 13220, 13221 (Mar. 10, 2014).

The IRS and Treasury take a similar approach with respect to the information reporting by large employers under Code section 6056. *See* the preamble to the final regulations under Code section 6056, 79 Fed. Reg. 13231, 13246 (Mar. 10, 2014).

#### 4. Identification of the employer liable for any penalty for failure to properly calculate the tax imposed under § 4980I (Code § 4980I(e)(1)(B))

Code section 4980I(e)(1)(B) provides that the penalty for failure to properly calculate the excess benefit under Code section 4980I(c)(4) shall be imposed on the "employer or plan sponsor." Presumably, the penalty is imposed on the "plan sponsor" only in the case of a multiemployer plan. (See the last paragraph of Code section 4980I(c)(4).) That leaves the penalty to be imposed on the "employer" in all other cases. We suggest that individual church employers be responsible for any penalties for failure to properly calculate the tax under Code section 4980I. Church employers that rely on another party for calculations and reporting may be able to receive indemnity or other financial recompense from the other party for any such penalties, but this risk-shifting is best accomplished by agreement, rather than by regulation.

### D. Cost of Coverage

The Notice provides that "[t]o to calculate the amount of any excise tax that a coverage provider may owe under Section 4980I for a taxable period, an employer must determine the extent, if any, to which the cost of applicable coverage provided to an employee during any month of the taxable period exceeds the dollar limit" and that "[t]he the employer then must notify both the IRS and the coverage provider of the amount of the excess benefit...." These requirements are particularly challenging with respect to church employers in denominational health plans, many of which have volunteer treasurers, who do not have the knowledge, information or resources to make this determination, much less to make it soon after the end of the taxable year. The Notice cites to Section 4980(d)(2)(A) of the Code, which provides that the cost of coverage under Code section 4980I is to be determined under rules similar to the rules of COBRA for

determining "applicable premiums." However, as previously noted, denominational health plans are not subject to COBRA and thus do not calculate "applicable premiums" under COBRA. Instead of charging premiums, denominational health plans obtain contributions to cover the aggregate amount needed to pay for the health coverage for all plan members.

### 1. General

In the Notice, Treasury and the IRS stated that they "anticipate that the potential timing issues are likely to be different for insured plans and self-insured plans", and will also be different for Health Savings Accounts (HSAs), Archer Medical Savings Accounts (Archer MSAs), Health Flexible Spending Arrangements (FSAs), and Health Reimbursement Arrangements (HRAs). The Church Alliance agrees that such differences likely generally exist.

#### a. Self-Insured Plans

The Notice continues by stating that with self-insured plans, the information necessary to calculate and allocate any excess benefit "should be available to the employer relatively soon after the applicable calendar year ends." This will often not be the case for employers participating in a self-insured denominational health plan. The necessary information for this calculation likely will not be available to the church employer relatively soon after the close of the year, and may not be available at all, since the church employers may be separated from cost data by at least a couple of decision layers, based on church structure, mandates and guidance.

In many self-insured denominational health plans participating employers have no responsibility beyond the payment of their contributions. Such employers should be able to elect to use their contributions as their "cost", which would be available to each employer relatively soon after the applicable calendar year ends. However, since all church employers do not have such a contribution structure, the use of contributions as the measure of cost should not be mandatory for all church employers, and such employers should be allowed flexibility and additional time to obtain the information necessary to determine cost, to calculate a reasonable good faith estimate or to determine the cost of similar coverage available elsewhere (as a substitute for the calculation of cost).

#### b. HSAs, Archer MSAs, FSAs, and HRAs

In contrast to the difficulties described immediately above, church employers in denominational health plans should readily be able to determine the cost of applicable coverage for HSAs, Archer MSAs, FSAs, and HRAs, about which they should be able to obtain information soon after the close of the taxable period, if cost is based on amounts contributed. If, instead, cost would be based on amounts used from HSAs, Archer MSAs, FSAs, or HRAs, it would be much more difficult for church employers to determine cost soon after the close of the taxable year. In our Prior Comment the Church Alliance asked that HRAs be excluded from the cost of coverage under Code section 4980I. The Church Alliance continues to request such an exclusion, which would be consistent with the exclusion of HRAs from the aggregate reportable cost of coverage reported on Form W-2 (under *Notice 2012-09*). However, if that request cannot be granted, the Church Alliance would support the approach that the Treasury and IRS are considering under which contributions to account-based plans would be allocated on a pro-rata basis over the period to which the contribution relates, regardless of the timing of the contributions during the period.

A possible solution to the challenges of determining the cost of applicable coverage for church employers in denominational health plans would be to require those employers only to calculate, report and pay Excise Tax based on the cost of coverage under the plans about which they have knowledge: account-based plans. This also would be consistent with Section 4980I of the Code because, as described above and in the Notice, the cost of coverage under Code section 4980I is to be determined under rules similar to the rules of COBRA for determining "applicable premiums", but those rules are inapplicable to denominational health plans, so employers in such plans do not calculate such premiums. In addition, this would be consistent with the relief accorded for W-2 reporting of health care cost under *Notice 2012-9*.

Finally, the Church Alliance requests Treasury and the IRS to grant church employers providing coverage through a denominational health plan a lengthy transition period before the Excise Tax becomes applicable to them. Church employers and denominational health plans are making their best efforts to implement all the requirements of the Affordable Care Act (ACA), but given the atypical employment and structures of churches and denominations, longer time periods to implement these changes are necessary. This is especially so with respect to the Excise Tax, where the processes expected to be involved in calculating and allocating any excess benefit and the time period necessary to complete these processes is expected to be particularly lengthy and difficult, given the challenges described in this letter and in the attached Prior Comment.

### 2. Exclusion from Cost of Applicable Coverage of Amounts Attributable to the Excise Tax

The Notice indicates on the basis of Code section 4980(d)(2)(A) that any Excise Tax reimbursement to the coverage provider should be excluded from the cost of applicable coverage. We request that the IRS and Treasury make clear that in the case of a tax-exempt coverage provider that any Excise Tax reimbursements are not unrelated business income to the coverage provider. This is hinted at in footnote 5 of the Notice, but should be clarified.

The Notice indicates that the IRS and Treasury are considering whether some or all of the income tax reimbursement to the service provider be excluded from the cost of applicable coverage. We suggest that any income tax reimbursement be excluded from the cost of applicable coverage.

## E. Age and Gender Adjustment

The Church Alliance supports the potential adjustment to the baseline per employee dollar limits based on age and gender, as proposed in the Notice. It is critical to the Church Alliance that the calculation supporting the adjustment reflects the structure of denominational health plans, which is unique to each denomination and does not necessarily follow an employer/employee relationship, as described herein in Section III.B. Accordingly, the Current Population Survey as summarized in Table A-8a, as referenced in the Notice, provides an adequate basis on which to compare employed populations, but only if the population of those covered by the denominational health plans, excluding spousal and dependent coverage, are treated as one employee population (rather than being compared employer by employer). To do otherwise would result in potentially thousands of calculations per denominational health plan, sometimes with only one or two individuals per employer receiving health benefits.

The Church Alliance supports flexibility as to the timing of the date of measurement. From an administrative perspective, the first day of the plan year is often a time of the most benefit changes, following autumn annual enrollment. Providing the opportunity to select a day in the plan year, then consistently apply that date going forward, recognizes the transition of this time period, while preventing possible abuse.

### F. Notice and Payment

#### 1. Notice of calculation of applicable share of excess benefit and payment of tax

Many church employers participate in more than one group health plan. The church board that sponsors and administers a self-insured denominational health plan may not be aware of this other coverage (e.g., FSAs, HSAs and HRAs) provided by each of the thousands of church employers participating in the denominational health plan. If the church board doesn't know that multiple coverage providers exist or is unaware of all the coverage providers for each church employer, and is the entity designated to perform the excess benefit calculation, the amount of excess benefit will be incorrect, as will be the applicable share of the excess benefit assigned to each coverage provider. Church employers that offer insured group health plans will need to calculate the amount of excess benefit subject to the Excise Tax taking into account all other health coverage offered (e.g., FSAs, HSAs and HRAs). Church employers offering self-insured health plans also will need to perform this excess benefit calculation, if this duty is not delegated to another entity, such as the church board. The employer must also calculate and notify each coverage provider of its applicable share of the excess benefit. Many church employers rely on volunteers to carry out administrative duties and these individuals will not have in-depth knowledge of the Excise Tax, how it is calculated and how parties are notified.

Because of the complexity of a self-insured denominational health plan that does not have knowledge of individual church employers' other health plans, and the lack of sophistication of volunteer church workers required to calculate and notify parties of the Excise Tax, the Church Alliance expects many errors in these excess benefit calculations. The Church Alliance asks for a reasonable period of time for the church employer and/or church board to calculate the amount of the excess benefit subject to the tax and to notify the coverage providers of their applicable share. The process needs to allow time for coverage providers to review the calculation of their applicable share of the amount of the excess benefit subject to the tax, to question the applicable share if they think it is incorrect, and to resolve disputes before the IRS is notified. The Church Alliance believes a period of at least six months after the end of the plan year is required to calculate the Excise Tax and notify coverage providers and the IRS. After the coverage providers agree with their applicable share, they should be allowed an additional 60 days to remit the payment to the IRS.

#### 2. Correction of Errors

Because calculation errors can impact multiple coverage providers and multiple plan/coverage years, the Church Alliance also asks for flexibility in the method used for correction of errors. If the church employer and coverage providers do not detect and resolve a calculation error until after the IRS has been notified and the Excise Tax has been paid, any reallocation is bound to be complex and could cause years of angst for the IRS, employers and coverage providers alike. Coverage providers will need specific plan information from the church employers to substantiate the excess benefit calculation and to resolve the

error. If the amount of the Excise Tax is correct but the allocation of the applicable share among coverage providers is incorrect, the Church Alliance proposes that coverage providers that paid more than their applicable share obtain reimbursement directly from those coverage providers that paid less than their applicable share. The IRS can be notified of the reallocation, but would not be required to issue refunds or invoices for additional amounts due.

### G. Other Issues under Section 4980I

The Notice also invited comments on circumstances in which the interaction between the provisions of Code sections 4980H and 4980I may raise concerns and how these provisions might be coordinated, consistent with the statutory requirements of these provisions and in a manner that is administrable for employers and the IRS. The Church Alliance echoes the concerns raised in other comment letters submitted in response to *Notice 2015-16*, that health coverage that complies with the lowest possible minimum value requirement may soon exceed the applicable dollar limit under Code section 4980I, thereby exposing applicable large employers to 4980H assessable payments by merely complying with the law. Medical inflation has consistently outpaced increases in the consumer price index, which will make it increasingly more difficult, if not impossible, for employers to meet the minimum value standard to avoid the assessable payment under Code section 4980H, without exceeding the applicable dollar limits under Code section 4980I. Therefore, the Church Alliance requests flexibility or a delay in the application of Excise Tax and urges Treasury and the IRS to promulgate rules that would carry out the intention of the ACA to impose an excise tax on only excessively rich group health plans, not plans that meet the minimum requirements.

## IV. Conclusion

Based on the foregoing, the Church Alliance respectfully requests relief again from the Excise Tax, including transition relief and relief with respect to the cost of coverage provided under a self-insured group health plan that is not subject to federal continuation coverage requirements, such as denominational health plans. In addition, we request flexibility in the application of the Excise Tax, as above detailed.

Thank you for your consideration of our views on this important issue to church employers and employees. If you have questions or wish to discuss this matter further, please feel free to contact the undersigned at (202) 661-3882 or stephen.cooper@klgates.com.

Sincerely,

Stephen H. Cooper
Government Affairs Counselor, K&L Gates
On Behalf of the Church Alliance

# APPENDIX F

## Church Alliance Comment Letter on Proposed Rule on Nondiscrimination in Health Programs and Activities

CHURCH ALLIANCE
Acting on Behalf of Church Benefits Programs

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November 9, 2015

Electronically to http://www.regulations.gov.

U.S. Department of Health and Human Services, Office for Civil Rights
Attn: 1557 NPRM (RIN 0945-AA02)
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

**Re: Nondiscrimination in Health Programs and Activities; Proposed Rule**

To Whom It May Concern:

## I. Introduction

The Church Alliance is submitting this letter as a public comment to the Nondiscrimination in Health Programs and Activities; Proposed Rule ("Proposed Rule") published by the United States Department of Health and Human Services ("Department") at 80 Fed. Reg. 54172 on September 8, 2015.

The Church Alliance is an organization composed of the chief executives of thirty-seven church benefit boards, covering mainline and evangelical Protestant denominations, two branches of Judaism, and Catholic schools and institutions. The Church Alliance members provide employee benefit plans, including in many cases, health care coverage, to approximately one million participants (clergy and lay workers) serving over 155,000 churches, parishes, synagogues and church-associated organizations. These health care programs are defined as "church plans" under section 3(33) of the Employee Retirement Income Security Act of 1974 and section 414(e) of the Internal Revenue Code of 1986, as amended. All of the members of the Church Alliance share the common view that a church or an employer associated with a church should not have to face the choice of violating its religious tenets and beliefs or violating the law in order to maintain a health care plan for its workers. This is true even though some of the health care plans associated with the members of the Church Alliance do not impose restrictions on covered health or medical services falling within the ambit of the Proposed Rule.

## II. Executive Summary

The Church Alliance appreciates the Department's recognition of and sensitivity to religious conscience and liberty issues in promulgating regulations implementing the nondiscrimination requirements of section 1557 of the Affordable Care Act. For the reasons set forth below, the Church Alliance respectfully submits that church self-insured health care plans should be exempted from the Proposed Rule because the plans, other than certain retiree-only Medicare supplement plans, do not receive Federal financial assistance, nor is such assistance received by all, or substantially all, of the employers participating in the plans. At a minimum, clarification should be provided that a retiree-only church health care plan is not a

"health program or activity" within the meaning of the Proposed Rule. In addition, the Church Alliance submits that the Proposed Rule should include a religious conscience exemption that will clearly protect the rights of religious organizations that object to providing coverage for certain health or medical services otherwise required under section 1557.

## III. Definitional Issues for Multiple Employer, Church Health Care Plans

The Proposed Rule utilizes several key definitions that together determine its scope and reach. These key terms are "covered entity," "health program or activity," "Federal financial assistance," and "employer health benefit program." Before explaining the issues presented by these definitions for church self-insured health care plans, it is important to understand how these plans are structured.

### A. Description of Church Self-Insured Health Care Plans

Church self-insured health care plans are multiple employer in nature, with (in some cases) thousands of churches and other church-associated employers participating in the plans. In some cases, the plan is provided through or by a separately incorporated church benefits board. In other cases, the plan is provided directly by or through what might be called the church itself – in many cases this will be a separately incorporated, denominational "headquarters" organization. In almost all cases today, the typical church self-insured health care plan is administered by one or more third-party administrators ("TPAs") pursuant to administrative services contracts entered into by the TPAs and the church benefits board or church headquarters association.

As noted above, some of the larger church self-insured health care plans have literally thousands of participating employers. While most of these participating employers are churches, parishes or synagogues, church-associated organizations also participate in some of the plans. These church-associated organizations include colleges and universities, seminaries, K-12 parochial schools, Bible colleges, hospitals, nursing homes, children's homes, church camps and social service organizations. It is possible that some of these organizations could receive Federal financial assistance from HHS in connection with a health program or activity that is not an employee health benefit program—but the church plan sponsor will not know of this receipt. However, the Church Alliance believes that only a small number of participating employers in the typical church self-insured health care plan will receive such assistance--substantially all of them will not.

### B. Analysis of Key Proposed Rule Definitions

The Proposed Rule, in section 92.4, defines the term "covered entity" as including any entity that operates[1] a health program or activity, any part of which receives Federal financial assistance. For purposes of this definition, "*health program or activity* means the provision or administration of health-related services or health-related insurance coverage . . . ." The Proposed Rule goes on to provide, in the definition of "health program or activity," that if the entity is "principally engaged in providing or administering health services or health insurance coverage, all of its operations are considered part of the health program or activity" except as otherwise provided in the Proposed Rule. The "health program or activity" definition states that "such entities" (presumably those that are principally engaged in providing or administering health services or health insurance coverage) include, among other entities, a group health plan.

The preamble to the Proposed Regulations appears to make it clear (on p. 54191) that the Office of Civil Rights of the Department of Health and Human Services ("OCR") intends to apply the employer liability rules under Section 1557 of the Affordable Care Act "whether the employee health benefit program is self-insured or fully-insured by the employer." This portion of the preamble goes on to state that, if an employer "creates a separate legal entity to administer its employee health benefit plan, the employer continues to be liable for the nondiscriminatory provision

[1] The use of the word "operates" is itself unclear in the case of group health plans, where terms like "established or sponsored by," "administered by," or "maintained by" are commonly used to describe the relationship of a plan sponsor, plan administrator or employer to a particular health care plan.

of employee health benefits to its employees; the employer, as a recipient, may not, through contractual or other arrangements, discriminate on a prohibited basis against its employees."

The term "Federal financial assistance" is broadly defined to include the receipt of funds from the Federal government by grant, loan, credit, subsidy, contract… or any other arrangement." Footnote 94 on page 54191 of the preamble to the Proposed Regulations suggests that a self-insured health care plan's receipt of Medicare Part D payments (such as, in connection with an employer group waiver, or "EGWP," plan) could mean that section 1557 applies to a self-insured church Medicare supplemental plan, generally available only to retired clergy and church workers, and their spouses.

Finally, the Proposed Rule defines an "employee health benefit program" (a key definition for assessing employer liability under section 92.208 of the Proposed Regulations) as, among other things, "health benefits coverage or health insurance provided to employees and/or their dependents established, operated, sponsored, or administered by, or on behalf of one or more employers, whether provided or administered by entities including but not limited to an employer, group health plan (as defined in the Employee Retirement Security Act of 1974 (ERISA, at 29 U.S.C. 1191(a)), third party administrator or health insurance issuer."

Section 92.2 of the Proposed Rule sets out its scope, and the preamble explaining this section indicates that it applies to any "health program or activity" (which appears to include a group health plan) any part of which receives Federal financial assistance from any Federal agency.[2] The Proposed Rule therefore appears to be very broad in application and, with its focus on the term "health program or activity" would seem to reach an employer's group health plan.

However, when assessing an employer's[3] liability for a Section 1557 violation, the focus of the Proposed Rule shifts to determining what is a "covered entity" because section 92.208 of the Proposed Rule appears to impose this liability only on a "covered entity" that provides an "employee health benefit program" to <u>its employees</u> and/or their dependents, and then only if one of the following three conditions is met:

1. The covered entity is principally engaged in providing or administering health services or health insurance coverage (Section 92.208(a));

2. The covered entity receives Federal financial assistance, a primary objective of which is to fund the covered entity's employee health benefit program (Section 92.208(b)); or

3. The entity is <u>not</u> principally engaged in providing or administering health services or health insurance coverage <u>but</u> operates a health program or activity, which is not an employee health benefit program, that receives Federal financial assistance; except that the covered entity is liable under this part with regard to the provision or administration of employee health benefits only to the employees in that health program or activity. (Section 92.208(d) (emphasis supplied))

A church self-insured health care plan would not itself appear to be a covered entity for purposes of section 92.208 liability because it is the "employee health benefit program" a church or church benefits board provides. A church or church benefits board would not appear to satisfy any of the three conditions (described above) for section 92.208 liability to be imposed on it.[4]

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[2] The Proposed Rule later makes it clear that it only covers Federal financial assistance from HHS, although it encourages other agencies to adopt its standards for purposes of their enforcement of section 1557. <u>See</u> footnote 2 in the preamble of the Proposed Rule, on page 54173.

[3] We say "employer's liability" here because the title of section 92.208 is "<u>Employer</u> liability for discrimination in employer health benefit programs." (emphasis supplied)

[4] The church or typical church benefit board would not satisfy the "principal engagement" requirement under section 92.208(a), would not itself receive Federal financial assistance to fund the employee health benefit program it provides (92.208(b), and would not operate a health program or activity other than an employee health benefit program (92.208(c)).

As noted above, however, it is possible for an employer participating in a church self-insured health care plan to receive Federal financial assistance for a health program or activity that is not an employee health benefit program, and the employer therefore would appear to be a covered entity described in section 92.208(c). The Church Alliance believes that there would only be a small number of participating employers (if any) fitting this description in a church self-insured health care plan—but the sponsor of the plan (the church or church benefit board) will not know whether any participating employers are covered entities. As a practical matter, in order to avoid an inadvertent section 1557 violation, the plan sponsor will be faced with the Hobson's choice of complying with the section 1557 requirements for all participating employers (the vast majority of which are not covered entities subject to the Proposed Rule) or exclude employers described in section 92.208(c) from plan participation—and the latter option would not be an administratively viable or realistic one. The first option would impose a requirement that otherwise would not apply to most employers in the plan, and could create First Amendment issues—for example, if the church has established an existing dispute resolution process that conflicts with the grievance procedures required by section 1557.

C. Medicare Supplemental Plans

As noted above, it appears that a Medicare supplemental plan available only to retired clergy and church workers, and their spouses, may be a health program or activity for purposes of the Proposed Rule. It also appears that such a plan's receipt of Federal financial assistance in the form of Medicare Part D subsidies could be considered as not having been received for the purpose of funding an employee health benefit program, depending on the manner in which the retiree-only plan is structured.[5]

The Affordable Care Act and the Health Insurance Portability and Accountability Act both contain broad exemptions for retiree-only health care plans. The Church Alliance submits that a retiree-only church Medicare supplemental plan, like that described above, should be exempt from the Proposed Rule, if an exemption for church self-insured health care plans is not provided in the final regulations.

In light of the above analysis, the Church Alliance requests that the final regulations either:

1. Provide an exemption from the Proposed Rule for a church self-insured health care plan, or
2. Clarify that a retiree-only church Medicare supplemental plan is not a "health program or activity" for purposes of the Proposed Rule.

## IV. Religious Conscience Exemption

The Church Alliance also wants to respond to the Department's request for comment on whether the final section 1557 regulations should include a specific exemption for health care plans or other covered entities with respect the proposed requirements of the rule related to sex discrimination, including the requirements that are discussed in the proposed rule. In the preamble, OCR states: "For example, HHS wants to ensure that the rule has the proper scope and adequately protects sincerely held religious beliefs to the extent those beliefs conflict with the provisions of the regulations."

If the final regulations will not provide an exemption for church self-insured health care plans, the Church Alliance submits that a religious conscience exemption like that mentioned in the preamble is vital, and hereby requests that the final regulations provide such an exemption. The Proposed Rule, if finalized in its current form, appears to prohibit excluding transgender-focused health care benefits from coverage under a self-insured group health plan. Some church health care plans represented through the Church Alliance do not have a religious or theological objection to providing such benefits. Some do, however, and it is in part for this reason that the Church Alliance

[5] For example, if the Medicare supplemental plan is sponsored by the church or church benefit board for retired clergy and church workers but paid for by the retirees themselves who decide to enroll in it, with no employer involvement or funding, the retiree-only plan may not be an employee health benefit program within the meaning of the Proposed Rule.

requests a religious conscience exemption be included in the final regulations. We say "in part" because the Church Alliance's concern goes beyond the transgender benefits issue and extends to other types of health care benefits that could, in the future, be mandated under section 1557, but to the provision of which, a church health care plan sponsor has religious objections. For both of the reasons noted above, the Church Alliance believes a religious conscience objection provision should be included in the final Section 1557 regulations.[6]

A possible exception for church self-insured health care plans could read as follows:

> A church health care plan described in section 414(e) of the Internal Revenue Code of 1986, as amended, shall not be required to include or arrange for coverage for any health care benefit required under section 1557 if the provision of such benefit would violate the religious beliefs of a church or a convention or association of churches that maintains, sponsors or participates in such a plan.

## V. Conclusion

For the reasons given above, the Church Alliance requests that church self-insured health care plans be exempted from the Proposed Rule because all or substantially all of their participating employers do not receive Federal financial assistance, or, at a minimum, that it be clarified that retiree-only church health care plans receiving Medicare Part D subsidies are not "health programs or activities" for purposes of the Proposed Rule. If an exemption for church self-insured health care plans is not provided, the Church Alliance requests that a religious conscience exemption like that described above be included in the final regulations. If HHS representatives would like to discuss the Church Alliance's concerns about the Proposed Rule before the final regulations are issued, Church Alliance representatives will be glad to meet and discuss them.

Please contact the undersigned at 202-661-3882 if you have any questions or wish to discuss this matter further.

Sincerely,

Stephen H. Cooper
Government Affairs Counselor, K&L Gates
On Behalf of the Church Alliance

[6] The preamble to the Proposed Rule also requested comments on whether "certain protections" that already exist would mean that an explicit religious conscience exemption is not needed in the final regulations. The Church Alliance is concerned that, without an explicit exemption, it will be necessary to litigate with private litigants over whether coverage for certain health care plan benefits is required under Section 1557, despite strongly and sincerely held religious beliefs objecting to the provision of these benefits. An explicit exemption will avoid the necessity of this litigation.