LEGISLATIVE AND REGULATORY DEVELOPMENTS IN 2016 OF INTEREST TO CHURCH-SPONSORED EMPLOYEE BENEFIT PLANS AND PROGRAMS

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Table of Contents

Page

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I. Church Alliance Legislative Initiatives

A. Church Plan Clarification Act of 2015 (enacted as part of the *Protecting Americans from Tax Hikes Act of 2015*)

On December 18, 2015, President Obama signed the *Protecting Americans from Tax Hikes Act of 2015*[1] ("PATH Act") into law. Section 336 of the PATH Act contains important provisions applicable to church retirement and welfare benefit plans. The language in section 336 is identical to that of the Church Plan Clarification Act of 2015 introduced in the United States Senate (S. 2308) and House of Representatives (H.R. 4085) in November of 2015. Section 336 of the PATH Act addresses the following issues:

1. Controlled Group Rules.

Section 336(a) of the PATH Act clarifies the application of controlled group rules to church plans. The new controlled group rules are effective for all years beginning before, on or after the date of enactment of the PATH Act.

a. Controlled group rules for church plans**.** Section 414(c)(2) of the Internal Revenue Code of 1986, as amended ("Code") states that an organization that is otherwise eligible to participate in a church plan[2] will only be aggregated with another church, QCCO or non-QCCO and treated as a single employer with such other organization if:

(1) such organization provides (directly or indirectly) at least 80% of the operating funds for the other organization during the preceding taxable year of the recipient organization, and

(2) there is a degree of common management or supervision between the organizations such that the organization providing the operating funds is directly involved in the day-to-day operations of the other organization.

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

[2] These organizations include churches, qualified church-controlled organizations ("QCCOs") and non-QCCOs.

b. Controlled group rules for non-QCCOs. The new language also provides (in Code section 414(c)(2)(B)) that a non-QCCO will be aggregated with one or more other non-QCCOs, or with an organization not exempt from tax under Code section 501, and treated as a single employer with such organization, if at least 80% of the directors or trustees of such other organization are either representatives of, or indirectly or directly controlled by, such non-QCCO. This means that non-QCCOs only are aggregated with other non-QCCOs under the "governance control" test – control of a non-QCCO by a church or QCCO will not result in a controlled group unless financial control and common management or supervision are also present.[3]

c. Permissive Aggregation and Disaggregation**.** Code section 414(c)(2)(C) allows a church or a convention or association of churches to elect to treat its church-related organizations as a single employer for a plan year. Such election, once made, will apply to all succeeding plan years unless revoked with notice provided to the Secretary in such manner as the Secretary prescribes. An employer may also elect under Code section 414(c)(2)(D) to "permissively disaggregate" and treat churches and QCCOs separately from non-QCCOs 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 prescribes.[4]

d. Anti-Abuse Provision. Section 336(a) of the PATH Act contains a statement that the anti-abuse provision contained in Treasury Regulations section 1.414(c)-(5)(f) continues to apply to these church plan controlled group rules. This means the IRS can treat an entity as under common control with an exempt organization in certain cases, including any case in which the IRS determines the structure of one or more exempt organizations (which may include an exempt organization and a taxable entity) or the positions taken by the organizations have the effect of avoiding or evading any requirements for tax-favored retirement plans (or any other employee benefit requirements to which the common control rules apply).[5]

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[3] However, if a non-QCCO financially controls a QCCO, and there is common management or supervision between them, the non-QCCO and the QCCO will be in a controlled group under the "financial control" test.

[4] It appears there will be few instances where permissive disaggregation is needed under the new controlled group rules. Permissive disaggregation would only be needed if a church or QCCO and a non-QCCO are in the same controlled group, and that can only happen if the church or QCCO provides 80% or more of the organization's operating support – and if the organization is in fact a non-QCCO, the church will not be providing that level of support. Permissive disaggregation may also be useful in the situation where a non-QCCO financially controls and manages or supervises a QCCO.

[5] The anti-abuse rule appears to apply even if there is a demonstrable business purpose for the structure of a group of organizations, if the IRS finds the structure has the effect of evading or avoiding any of the employee benefit provisions to which Code section 414(c) applies.

2. Automatic Enrollment.

Section 336(c) of the PATH Act preempts any state law directly or indirectly prohibiting or restricting the inclusion of an automatic contribution arrangement in any church plan, effective as of the date of enactment of the PATH Act.

a. Definition of Automatic Contribution Arrangement. An automatic contribution arrangement is defined under Section 336(c) as an arrangement:

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

(2) under which a participant is treated as having elected to have the plan sponsor or employer make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant specifically elects to have such contributions made at a different percentage or stopped; and

(3) under which certain notice, election and investment requirements are satisfied.

b. Notice Requirements. The plan sponsor of (or plan administrator or employer maintaining) an automatic contribution arrangement must, within a reasonable period of time before the first day of each plan year, provide a notice of a participant's rights and obligations under the arrangement to each participant to whom the arrangement applies.[6] The notice must be sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and must be written in a manner calculated to be understood by the average participant to whom the arrangement applies. The notice must:

(1) include 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);

[6] The annual notice requirement will not prevent an employer from adopting, for the first time, an automatic contribution arrangement mid-year. This conclusion is supported by IRS FAQs regarding automatic contribution arrangements (*see* FAQ #4 – "Can an employer add an automatic contribution arrangement to its existing retirement plan?"https://www.irs.gov/Retirement-Plans/Retirement-Plans-FAQs-Regarding-Automatic-Contribution-Arrangements-Automatic-Enrollment-Arrangements).

(2) ensure that the participant has a reasonable period of time, after receipt of such explanation and before the first elective contribution is made, to make such election; and

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

c. Default Investment. If no affirmative investment election has been made by a participant with respect to an automatic contribution arrangement, contributions to such arrangement must be invested in a default investment option selected with the care, skill, prudence and diligence that a prudent person selecting an investment option would use. Information describing the default investment fund must be included in the notice.

d. Auto Enrollment Guidance**.** There is no current regulatory or other agency guidance addressing the new church plan automatic enrollment provisions. However, the IRS has issued guidance governing automatic contribution arrangements, including regulations describing the requirements for "eligible automatic contribution arrangements," or "EACAs," and "qualified automatic contribution arrangements," or "QACAs." If a church plan's automatic contribution arrangement is an EACA or QACA, the rules that apply to it are clear – including provisions requiring an initial notice to plan participants who become eligible to participate in an EACA or QACA, annual EACA and QACA participant notice requirements, and rules governing a participant's ability to withdraw contributions made under an EACA (or a QACA qualifying as an EACA.) These rules will presumably only continue to apply to a church plan automatic contribution arrangement that is intended to qualify as an EACA or QACA.[7]

3. Church Plan Transfers and Mergers.

Section 336(d) of the PATH Act adds a new Code section 414(z), effective for transfers or mergers occurring after the date of enactment of the PATH Act, which provides that the following transactions will not be treated as distributions includable in gross income:

[7] The new church plan automatic contribution arrangement rules contain a "uniformity" requirement. EACAs and QACAs are also subject to a uniformity requirement, and the EACA and QACA regulations clearly spell out the uniformity rules that apply to such arrangements. However, these regulations do not apply to automatic contribution arrangements that are not EACAs or QACAs, and they therefore should not apply to a church automatic contribution arrangement that is not an EACA or QACA.

(1) a transfer of all or a portion of the accrued benefit of a participant or beneficiary (whether or not vested) from a church 401(a) plan or 403(b) annuity contract[8] to a 403(b) annuity contract;

(2) a transfer of all or a portion of the accrued benefit of a participant or beneficiary (whether or not vested) from a 403(b) annuity contract to a church 401(a) plan; or

(3) a merger of a church 401(a) plan or 403(b) annuity contract with a 403(b) annuity contract.

These transfers and mergers may occur only if the plan and annuity contracts are both maintained by the same church or convention or association of churches.[9] In addition, the participant's or beneficiary's total accrued benefit immediately after the transfer or merger must be 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 must be nonforfeitable after the transfer or merger.

This ability to transfer and merge plans will provide church employers with a better alternative to terminating or having to maintain separate "legacy" plans, and should decrease complexity and administrative costs for church employers, as well as decreasing confusion for employees who are covered by more than one plan of the employer. This statutory language will also allow churches with frozen 401(a) plans to move the frozen assets into 403(b)(9) church retirement income account plans.

4. Investment In Group Trusts.

Section 336(e) of the PATH Act provides that, for investments made after its date of enactment, the investment of assets of a: (1) church plan (as defined in Code section 414(e), including a 401(a) plan and a 403(b)(9) retirement income account), and (2) a Code section 414(e)(3(A) organization whose principal purpose or function is the administration of such plan or account (including any assets otherwise permitted to be commingled for investment purposes with the assets of such plan, account or organization) may be invested in a group trust described in Revenue Ruling 2011-1 without adversely affecting the tax status of the group trust, the plan, account or organization, or any other plan or trust that invests in the group trust. This new statutory language thus makes it clear that these amounts can be invested in 2011-1 group trusts, even though some of the assets being invested are from other church assets (such as church endowment funds) and not only church retirement plan assets.

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[8] The term "annuity contract" also includes a Code section 403(b)(7) custodial account and a Code section 403(b)(9) church retirement income account.

[9] For this purpose, a "church or convention or association of churches" includes a church benefit board or an employer controlled by or associated with a church.

5. Grandfathered Defined Benefit Plans.

Section 336(b) of the PATH Act amends section 251(e)(5) of the Tax Equity and Fiscal Responsibility Act of 1982, for years beginning before, on or after the date of enactment of the PATH Act, to provide that any grandfathered defined benefit plan is subject only to the applicable limitations of Code section 415(b). These arrangements are thus no longer also subject to the limitations of Code section 415(c) applicable to defined contribution plans.

The Church Alliance submitted a letter to the IRS and Treasury on August 3, 2016, regarding consideration of certain points if PATH Act guidance is issued.[10] Specifically, the letter recommended that:

- Direct or indirect control (for purpose of the controlled group rules) be based on objective indications of actual participation in the management of an organization, and not the mere right to participate in an organization's management.

- Any guidance regarding the right to permissively aggregate or disaggregate clarify that an election can be made in any reasonable manner, and that revocation of an election can be made by submitting a notice to the Treasury Secretary.

- Code section 415 regulations be updated to reflect the PATH Act provision regarding 403(b) defined benefit plans being subject only to the defined benefit plan limitations.

- Guidance clarify that a church plan offering an automatic contribution arrangement which satisfies the requirements of Section 414(w)(3) of the Code can elect to treat the automatic contribution arrangement as a eligible automatic contribution arrangement under the rules that currently apply to ERISA plans, and may allow permissible withdrawals in accordance with section 1.414(w)-1 of the Treasury Regulations.

- Guidance indicate that a church plan that satisfies the qualified automatic contribution arrangement requirements of section 401(k)(13) of the Code will be deemed to satisfy the automatic contribution arrangements of subsection 336(c) of the PATH Act, other than the default investment requirement of subsection (c)(4).

- Guidance indicate that any failures to satisfy the automatic contribution arrangement notice requirement will not result in a loss of preemption, provided the failure is corrected within a reasonable time after discovery.

- Guidance clarify that the merger and transfer section of the PATH Act does not require the issuance of regulations under Code section 414(z) to be effective.

[10] A copy of the August 3, 2016 Church Alliance letter is attached as Appendix A.

- Guidance specify how to determine the accrued benefit for certain mergers and transfers from a defined benefit plan to an individual account balance plan.

- The IRS update Revenue Ruling 2011-1 to reflect the PATH Act section 336(e) provisions and confirm that no changes are necessary to Treasury Regulations section 1.403(b)-9(a)(6) to permit the commingling authorized under section 336(e) of the PATH Act.

B. Commodity Pool Operator Legislation

The Church Alliance continues to engage with staff of congressional leadership, appropriations, authorizers, champions, and key opinion leaders in order to advocate for the inclusion of a church plan commodity pool operator ("CPO") clarification if there is a year-end legislative package that moves through Congress. The authorizers (the House and Senate agriculture committees) and certain Senators and Representatives have been helpful in working with leadership and appropriators to encourage incorporation of the Church Alliance's CPO language into legislation. Although the prospects and scope of a potential year-end package continue to be uncertain, the CPO fix appears well-positioned for consideration if legislation advances.

II. Regulatory Initiatives and Other Guidance

A. Internal Revenue Service

1. 403(b) Pre-Approved Plan Program and Non-QCCO Guidance.

The IRS has indicated that it plans to issue advisory and opinion letters on pre-approved 403(b) plans by the end of first quarter of 2017. During the review of volume submitter church plan documents, the IRS informed submitter that QCCOs were not eligible to participate in pre-approved 403(b)(9) plans because QCCOs could become non-QCCOs at some point, and non-QCCOs are not eligible to participate in 403(b)(9) plans, at all. This development came as something of a shock to the entire 403(b) community, because non-QCCOs have been participating in 403(b)(9) retirement income account plans since the addition of section 403(b)(9) to the Code in 1982.

The IRS had previously issued guidance that indicated non-QCCOs can participate in 403(b)(9) plans. Because the IRS refused to change its position on the non-QCCO issue despite its prior guidance and even after meeting with Church Alliance representatives, the Church Alliance is seeking a legislative clarification of this problem.[11] Language clarifying that non-QCCOs can participate in 403(b)(9) retirement income account plans has been included in S. 3471, the Retirement Enhancement and Savings Act of 2016, which was introduced by Senate Finance Committee Chairman

[11] The Church Alliance provided two letters to the IRS explaining the non-QCCO issue. These two letters are attached as Appendices B and C.

Orrin Hatch (R-Utah) on November 16, 2016. There is a possibility that this legislation could move through Congress by year-end. However, the pre-approved 403(b) plan program is an IRS administrative program, so even if there is legislative clarification that non-QCCOs can participate in 403(b)(9) plans, the IRS can still prohibit QCCOs and non-QCCOS from participating in pre-approved 403(b)(9) volume submitter plans.

2. Guidance on Mid-Year Changes to Safe Harbor 401(k) Plans.

Until Notice 2016-16[12] was issued on January 29, 2016, the IRS took the position that employers could make only very limited mid-year changes to their safe harbor plans due to Treasury regulations adopted by the IRS which required most provisions to not only be adopted before the beginning of a plan year, but also to remain in effect for the entire plan year. Under Notice 2016-16, the IRS significantly expanded the amendments permitted during a plan year for safe harbor plans. The Notice is effective for mid-year changes made on and after January 29, 2016, and allows plan sponsors to make various mid-year changes as long as updated and timely employee notices and election requirements are followed. The Notice provides examples of acceptable and unacceptable mid-year changes, and specifically prohibits the following mid-year changes to safe harbor plans:

- Increasing the years of service (vesting) requirement for a qualified automatic contribution arrangement type of safe harbor plan;
- Reducing the number (or otherwise narrowing the group) of employees eligible to receive safe harbor contributions;
- Changing the type of safe harbor plan;
- Modifying or adding a formula used to determine matching contributions or the definition of compensation used to calculate matching contributions, if the change increases the amount of matching contributions; and
- Adding discretionary matching contributions.

3. Final Rules on After-Tax Rollovers to Roth Individual Retirement Accounts.

Final regulations[13] issued by the IRS remove the allocation rule for disbursements from designated Roth accounts to multiple destinations, allowing retirement plan participants to more easily transfer after-tax retirement plan money to Roth individual retirement accounts ("IRAs"). The final regulations eliminate the previous requirement that each disbursement from a designated Roth account which is directly rolled over to an eligible retirement plan must be treated as a separate distribution from any amount paid directly to the employee. The regulations generally apply to distributions on or after January 1, 2016.

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[12] 2016-7 I.R.B. 318.

[13] 81 Fed. Reg. 31,165 (May 18, 2016).

As a result of this change, if disbursements are made from a taxpayer's designated Roth account both to the taxpayer and to the taxpayer's Roth IRA or designated Roth account in a direct rollover, then pre-tax amounts will be allocated first to the direct rollover, rather than being allocated *prorata* to each destination. In addition, a taxpayer is now able to direct the allocation of pre-tax and after-tax amounts that are included in disbursements from a designated Roth account that are directly rolled over to multiple destinations, applying the same allocation rules to distributions from designated Roth accounts that apply to distributions from other types of accounts.

4. Same-Sex Marriage Guidance.

a. Final Regulations Defining Spouse for Federal Tax Purposes. On September 2, 2016, the IRS issued final regulations[14] that define terms in the Code describing the marital status of taxpayers for federal tax purposes and reflect the holdings of *Obergefell v. Hodges* and *Windsor v. United States*, as well as guidance provided by Revenue Ruling 2013-17. Specifically, the 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 regulations state that a marriage of two individuals is recognized for federal tax purposes if the marriage is recognized by any state, possession or territory of the United States in which the marriage is entered into, regardless of domicile. The regulations 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. Finally, the regulations provide that two individuals who enter into a relationship denominated as marriage under the laws of a foreign jurisdiction are recognized as married for federal tax purposes if the relationship would be recognized as marriage under the laws of at least one state, possession or territory of the United States, regardless of domicile.

b. Guidance on Application of *Obergefell*. In Notice 2015-86,[15] the IRS provided guidance in a question and answer format on the application of the decision in *Obergefell v. Hodges* to retirement plans qualified under Code section 401(a) and to health and welfare plans, including cafeteria plans under Code section 125. The guidance relates solely to the application of federal tax law with respect to same-sex spouses. It clarified that a qualified retirement plan sponsor was not required to make additional plan changes because of *Obergefell*, but could amend a plan to provide new rights or benefits with respect to participants with same-sex spouses to make up for benefits or benefit options that had not previously been available to those participants, such as qualified joint and survivor annuity distribution rights. The Notice states that a plan must recognize the same-sex spouse of a participant on or after June 26, 2013 but could have

[14] 81 Fed. Reg. 60,609 (Sept. 2, 2016).

[15] 2015-42 I.R.B. 887.

done so prior to June 26, 2013. Because these amendments are discretionary amendments, the deadline to adopt the amendments was the end of the plan year in which the amendment was operationally effective.

The guidance also clarified that, because federal tax law generally does not require health and welfare plans to offer any specific rights or benefits to spouses, no changes to the terms of a health or welfare plan are required because of *Obergefell*. If health or welfare plans offer benefits to a participant's spouse, *Obergefell* could require changes to the operation of the plan to the extent that the decision results in a change in the group of spouses eligible for coverage under the terms of the plan. Assuming the terms of a cafeteria plan allow a participant to make coverage changes due to a significant improvement in coverage, then a participant may revoke an existing election and make a new election to add same-sex spousal coverage. A plan could also be amended to permit participants to make a change in election due to a significant improvement in coverage. Such an amendment must be adopted no later than the last day of the plan year including the later of the date same-sex spouses first became eligible for coverage under the plan or December 9, 2015. The amendment may be retroactive to the date same-sex spouses first became eligible for coverage under the plan.

5. Waiver of 60 Day Rollover Requirement.

Generally, if a participant wants to roll money from a 401(a) qualified plan, 403(a) annuity plan, 403(b) tax-sheltered annuity plan, or IRA to another eligible retirement plan or IRA on a tax-free basis, the rollover must be contributed to the receiving plan either directly by the trustee of the distributing plan or by the participant within 60 days of the participant's receipt of the distribution. If certain circumstances beyond the reasonable control of the taxpayer prevent the rollover from meeting the 60-day deadline, individual taxpayers are permitted to request the IRS to grant a waiver of the 60-day limit.

On August 24, 2016, the IRS issued Revenue Procedure 2016-47,[16] which allows a taxpayer to self-certify that the 60-day rollover deadline was missed due to specific reasons the IRS now considers reasonable, including:

- an error committed by the financial institution making the distribution or receiving the contribution;
- a distribution check was misplaced and never cashed;
- a taxpayer deposited the distribution into an account, but the taxpayer mistakenly thought such account was an IRA or retirement plan;
- a taxpayer's principal residence incurs severe damage;
- a taxpayer's family member has a serious illness or dies;
- a taxpayer is incarcerated;

[16] 2016-37 I.R.B. 346.

- a postal error occurs;
- a distribution was made on account of an IRS levy and the levy proceeds were returned;
- the party making the distribution delayed providing information that the receiving plan or IRA required to complete the rollover; or
- restrictions were imposed on the distribution by a foreign country.

If the reason for missing the 60-day rollover deadline is one listed above, and if the taxpayer makes the rollover contribution as soon as practicable after the applicable reason above no longer prevents the contribution from being made, then a plan administrator or IRA trustee can rely on the taxpayer's self-certification and accept the rollover after the 60-day deadline (unless it has actual information that is contrary to that self-certified by the taxpayer). The IRS has provided a model certification rollover letter that a participant can use to provide the self-certification to the plan administrator or IRA trustee, in the appendix of the revenue procedure.

Although a self-certification is not a waiver by the IRS of the 60-day rollover requirement, a taxpayer that meets the self-certification requirements can report the contribution as a valid rollover unless otherwise informed by the IRS. If the IRS later determines there was a material misstatement in the self-certification, it can impose penalties on the taxpayer. Revenue Procedure 2016-47 was effective August 24, 2016.

6. Guidance on Changes to Determination Letter Program.

The IRS previously announced significant changes to its qualified retirement plan determination letter program, including its intent to eliminate the 5-year remedial amendment cycles for individually-designed plans effective January 1, 2017. The IRS also previously provided transition relief permitting sponsors of plans in the remedial amendment cycle known as "Cycle A" to submit determination letter applications during the period beginning February 1, 2016 and ending January 31, 2017.

In 2016, the IRS issued two sets of guidance on the changes to the determination letter program. These changes are briefly summarized below:

a. Notice 2016-03. In Notice 2016-03,[17] the IRS issued guidance on the determination letter program relating to Cycle A elections, determination letter expiration dates, and extensions of deadlines for certain defined contribution pre-approved plans in anticipation of the elimination of the 5-year remedial amendment cycle system for individually-designed plans. Specifically, the Notice provides that:

- controlled groups and affiliated service groups that maintain more than one plan are permitted to submit determination letter

[17] 2016-3 I.R.B. 278.

applications during the Cycle A submission period that begins on February 1, 2016 and ends on January 31, 2017, provided that a prior Cycle A election with respect to the controlled group or affiliated service group had been made by January 31, 2012 (the last day of the previous Cycle A submission period), and

- expiration dates included in determination letters issued prior to January 4, 2016 are no longer operative, and future guidance will clarify the extent to which an employer may rely on a determination letter after a subsequent change in law or plan amendment.

The Notice also extends the deadline for an employer to adopt a current defined contribution pre-approved plan and apply for a determination letter, if otherwise permissible, from April 30, 2016 to April 30, 2017 with respect to any defined contribution pre-approved plan adopted on or after January 1, 2016, other than a plan that is adopted as a modification and restatement of a defined contribution pre-approved plan that has been maintained by the employer prior to January 1, 2016. This extension will facilitate a plan sponsor's ability to convert an existing individually-designed plan to a current defined contribution pre-approved plan.

b. Revenue Procedure 2016-37. Revenue Procedure 2016-37,[18] which was issued by the IRS on June 29, 2016, officially eliminates the 5-year remedial amendment cycle for individually-designed plans as of January 1, 2017 with the exception of the January 31, 2017 deadline for Cycle A determination letter applications. The Revenue Procedure also limits the circumstances under which a sponsor of an individually-designed plan will be permitted to submit a determination letter application for initial plan qualification, qualification upon plan termination, and certain other limited circumstances permitted by the IRS.

In addition, the Revenue Procedure extends the remedial amendment period for individually-designed plans. Such remedial amendment period generally will be based on a Required Amendment List ("RA List"), unless otherwise provided in legislation or other guidance. The RA List will be an annual list of the amendments required for an individually-designed plan to maintain its qualified status and will be published after October 1 of each year. Plan sponsors will generally be required to adopt an item placed on the RA List by the end of the second calendar year following the year in which the RA List is published. Discretionary amendments are still required to be adopted by the end of the plan year in which the change is effective.

[18] 2016-29 I.R.B. 136.

The IRS also intends to provide an annual Operational Compliance List to identify changes in qualification requirements that are effective during a calendar year. Although the extended remedial amendment period described above permits plans to be amended retroactively to comply with qualification requirements, all plans are also required to operate in compliance with changes in the qualification requirements as of their effective date. The Operational Compliance List will assist plan sponsors in operating their plans in compliance with any changes in qualification requirements as of the date they become effective.

Finally, the revenue procedure also makes changes to the 6-year remedial amendment cycle system for pre-approved qualified plans and delays until August 1, 2017, the beginning of the 12-month submission period for master and prototype plan sponsors and volume submitter practitioners to submit pre-approved defined contribution plans for opinion or advisory letters.

7. Proposed Deferred Compensation Regulations for Tax-Exempt and Governmental Entities.

On June 22, 2016, the IRS issued proposed regulations[19] describing the taxation of nonqualified deferred compensation programs of tax-exempt and governmental entities under Code section 457(f). The proposed rules include guidance on determining when amounts deferred are includible in income, the amounts that are includible in income, and the types of plans that are subject to the rules.

Under Code section 457(f), compensation deferred under a deferred compensation arrangement is includible in a participant's gross income on the later of the date on which the participant has a legally binding right to the compensation or the date on which a substantial risk of forfeiture lapses. The proposed regulations discuss the types of plans that are not treated as providing for a deferral of compensation under Code section 457, including bona fide severance pay plans, bona fide death benefit plans, bona fide disability pay plans, and bona fide sick leave and vacation leave plans. The regulations also discuss the conditions that constitute a substantial risk of forfeiture, and state that a substantial risk of forfeiture exists only if entitlement to an amount is conditioned on the future performance of substantial services, or upon the occurrence of a condition that is related to the purpose of the compensation, if the possibility of forfeiture is substantial.

The regulations allow for the limited use of non-compete agreements to create a substantial risk of forfeiture as long as certain conditions are met. These conditions include a written, enforceable agreement under which an employer makes reasonable efforts to verify compliance, an employer with a bona fide interest in preventing the employee from performing the prohibited services and an employee with a bona fide interest in engaging (and an ability to engage) in the prohibited services. The regulations allow a rolling risk of forfeiture in certain circumstances.

[19] 81 Fed. Reg. 40,548 (June 22, 2016).

Further, the proposed regulations provide (i) general rules on determining the present value of compensation deferred under an ineligible plan, (ii) a short term deferral exception for 457(f) plans, and (iii) a discussion of the treatment of recurring, part-year compensation. Finally, the proposed regulations also include guidance on the interaction of Code sections 409A and 457(f) and clarify that Code section 457(f) applies separately and in addition to any requirements under Code section 409A.

The proposed regulations will not apply until finalized, but taxpayers are generally permitted to rely on them before such date.

8. Proposed Regulations on Application of 409A to Nonqualified Deferred Compensation Plans.

The IRS released proposed regulations[20] on June 21, 2016, clarifying and modifying certain provisions of the final Code section 409A regulations which were issued in 2007. The proposed regulations cover a wide variety of topics, and include provisions that:

- Clarify that the rules under Code section 409A apply to nonqualified deferred compensation plans separately and in addition to the rules under Code section 457A;
- Modify the short-term deferral rule to permit a delay in payments to avoid violating Federal securities laws or other applicable law;
- Clarify various provisions of equity based plans, including a stock purchase, stock rights and the definition of recipient stock;
- Provide that a plan under which a service provider has a right to payment or reimbursement of reasonable attorneys' fees and other expenses incurred to pursue a bona fide legal claim against the service recipient with respect to the service relationship does not provide for a deferral of compensation;
- Modify the rules regarding recurring part-year compensation;
- Provide a rule that is generally applicable to determine when a "payment" has been made for purposes of Code section 409A;
- Modify the rules applicable to amounts payable following death;
- Provide that the addition of the death, disability, or unforeseeable emergency of a beneficiary who has become entitled to a payment due to a service provider's death as a potentially earlier or intervening payment event will not violate the 409A prohibition on the acceleration of payments;
- Modify the conflict of interest exception to the prohibition on the acceleration of payments to permit the payment of all types of deferred compensation to comply with bona fide foreign ethics or conflicts of interest laws;

[20] 81 Fed. Reg. 40,569 (June 22, 2016).

- Clarify the provisions permitting payments upon the termination and liquidation of a plan in connection with bankruptcy;
- Provide that a plan may accelerate the time of payment to comply with Federal debt collection laws;
- Clarify and modify the proposed income inclusion regulations (Treasury Regulations section 1.409A-4(a)(1)(ii)(B)) regarding the treatment of deferred amounts subject to a substantial risk of forfeiture for purposes of calculating the amount includible in income under Code section 409A(a)(1). This change limits the ability of a service recipient to make a change to the time or form of payment with respect to unvested deferred amounts without incurring a penalty; and
- Attempt to clarify when an employee has a separation from service. Under the existing final regulations, the separation happens when the employee and employer reasonably expect the employee's services to permanently decrease to 20% or less than the average level of bona fide services performed over the preceding 36 month period (the "20% Test"). Thus, if the employee enters into a consulting agreement in connection with a termination of employment, the 20% Test will prevent a separation from service in some cases. Assuming that there is no separation at the time the consulting agreement is entered into, the proposed regulations provide that the separation is delayed until the entire contractual relationship under the consulting agreement ends.

The proposed regulations will not apply until finalized, but taxpayers are generally permitted to rely on the proposed regulations before such date.

9. Updated Employee Plans Compliance Resolution System("EPCRS") Program.

Revenue Procedure 2016-51[21] was released by the IRS on September 29, 2016 and is effective for correcting plan errors on or after January 1, 2017. This Revenue Procedure updates and replaces Revenue Procedure 2013-12. The new Revenue Procedure incorporates guidance from Revenue Procedures 2015-27 and 2015-28, eliminates references to the Social Security letter forwarding program for missing participants, addresses changes to the determination letter program and removes the user fee schedule (the user fee schedule will be separately published, annually). Sanctions under audit CAP will no longer be negotiated using a percent of the maximum payment amount but will instead be based on a list of factors, including what the plan sponsor did to identify and correct failures prior to audit. The updated EPCRS document also changes certain fees and clarifies that the IRS can impose sanctions above the user fee for egregious VCP failures.

[21] 2016-42 I.R.B. 466.

10. Health FSA Carryover Provisions.

In Section V of Notice 2015-87,[22] the IRS clarified several health flexible spending account (FSA) carryover provisions. A cafeteria plan may allow a carryover of up to $500 of unused amounts remaining at the end of a plan year in a health FSA. The IRS stated that a health FSA may limit the availability of the carryover of unused amounts (subject to the $500 limit) to individuals who have elected to participate in the health FSA in the next year, even if the ability to participate in the next year requires a minimum salary reduction election to the health FSA for that next year. The IRS also said that a health FSA may limit the ability to carry over unused amounts to a maximum period (subject to the $500 limit). For example, a health FSA can limit the ability to carry over unused amounts to one year. Thus, if an individual carried over $30 and did not elect any additional amounts for the next year, the health FSA may require forfeiture of any amount remaining at the end of that next year.

11. Hurricane Matthew Relief.

In Announcement 2016-39,[23] the IRS provided relief for retirement plan participants who want to use retirement assets held in qualified employer plans (401(a), 401(k), 403(b)) to alleviate hardships caused by Hurricane Matthew. The Announcement also provides relief from certain verification procedures that may be required under retirement plans with respect to loans and hardship distributions. Plans may make loans and hardship distributions for a need arising from Hurricane Matthew, to an employee or former employee whose principal residence on October 4, 2016 (October 3, 2016 for Florida) was located in one of the counties identified for individual assistance by the Federal Emergency Management Association because of the devastation caused by Hurricane Matthew, or whose place of employment was located in one of these counties on the applicable date, or whose lineal ascendant or descendant, dependent or spouse had a principal residence or place of employment in one of these counties on the applicable date. Plan administrators may rely on representations from the employee or former employee as to the need for and the amount of a hardship distribution, unless the plan administrator has actual knowledge to the contrary, and the distribution will be treated as a hardship distribution for all purposes under the Code and regulations.

To make a loan or hardship distribution pursuant to the relief contained in the Announcement, a qualified employer plan that does not provide for loans or hardships must be amended to provide for them no later than the end of the first plan year beginning after December 31, 2016. To qualify for the relief under the Announcement, a hardship distribution must be made on account of a hardship resulting from Hurricane Matthew and be made on or after October 4, 2016 (October 3, 2016 for Florida) and no later than March 15, 2017. In addition, a retirement plan will not be treated as failing to follow procedural requirements for plan loans or distributions imposed by the terms of

[22] 2015-52 I.R.B. 889.

[23] 2016-45 I.R.B. 720.

the plan merely because those requirements are disregarded for any period beginning on or after October 4, 2016 (October 3, 2016 for Florida), and continuing through March 15, 2017, provided the plan administrator makes a good-faith diligent effort under the circumstances to comply with those requirements. As soon as practicable, the plan administrator must make a reasonable attempt to assemble any foregone documentation.

12. State IRAs.

Five states[24] have enacted state-run IRAs in the last two years, and many other states are considering these types of savings vehicles. The state IRA legislation generally requires certain employers that do not provide employer-sponsored retirement plans to offer payroll deduction IRAs to their employees, and in some cases, requires employers to automatically enroll employees in the IRA unless employees have elected to opt out from participation. The definition of which employers are subject to the law varies from state to state. For example, in California, all employers that do not provide an employer-sponsored retirement plan and that have 5 or more employees will be required to offer an IRA program. In Illinois, employers are required to participate if they employ 25 or more employees and have not offered a qualified retirement plan in the preceding two years. Churches and other organizations should be aware of state-run IRA laws in their states because churches and other tax-exempt organizations are generally not exempt from these laws.

13. Retirement Plan Limits for 2017.

The cost-of-living and required statutory limit adjustments applicable to retirement plans for 2017 are as follows:[25]

Contribution limit for defined contribution plan under Code § 415(c)	**$54,000** (*$1,000 increase*)
Benefit limitation for defined benefit plan under Code § 415(b)	**$215,000** *($5,000 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)	**$270,000** (*$5,000 increase)*

[24] California, Connecticut, Illinois, Maryland and Oregon have enacted state-run IRA legislation in 2015 and 2016.

[25] IR 2016-141 (Oct. 27, 2016).

HCE compensation definition dollar threshold	**$120,000** *(no increase)*
Dollar threshold limitation for key employee determination in top-heavy plan	**$175,000** (*$5,000 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 - Final Regulations Defining Fiduciary

In October of 2010 the Department of Labor (DOL) proposed a rule[26] 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."[27] 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.[28] The proposed rule also applied to an IRA by way of Code section 4975. The proposed rule treated 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.

[26] 75 Fed. Reg. 65,263 (Oct. 22, 2010).

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

[28] 80 Fed. Reg. 21,928 (Apr. 20, 2015).

On April 6, 2016, the DOL issued the final fiduciary rule.[29] The rule provides 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, to a plan, plan fiduciary, plan participant or beneficiary, IRA, or IRA owner certain specific types of investment advice for a fee or other compensation, direct or indirect; and

- represents or acknowledges the fiduciary nature of the advice, or renders the advice pursuant to a verbal or written agreement, arrangement or understanding that the advice is based on the particular investment needs of the advice recipient, or directs the advice to a specific advice recipient regarding the advisability of a particular investment or management decision with respect to securities or other investment property of the plan or IRA.

The final rule provides that the following types of advice, when provided in exchange for a fee or other compensation, whether directly or indirectly, are considered investment advice, unless one of the carve-outs set forth in the final rule applies:

- recommendations as to the advisability of acquiring, holding, disposing of, or exchanging, securities or other investment property, or a recommendation as to how securities or other investment property should be invested after the securities or other investment property are rolled over, transferred, or distributed from the plan or IRA.

- recommendations as to the management of securities or other investment property, including, among other things, recommendations on investment policies or strategies, portfolio compensation, selection of other persons to provide investment advice or investment management services, selection of investment account arrangements, or recommendations with respect to rollovers, transfers or distributions from a plan or IRA, including whether, in what amount, in what form, and to what destination such a rollover, transfer or distribution should be made.

The final rule includes a number of specific carve-outs to the general definition of providing investment advice. The carve-outs include platform providers, furnishing non-fiduciary investment education or general communications, transactions with independent fiduciaries with financial expertise, swap and security-based swap transactions, and advice rendered by employees of the plan sponsor.

Although the ERISA fiduciary rule provides guidance for ERISA-covered retirement plans, and thus is not applicable to non-electing church plans, the final 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

[29] 81 Fed. Reg. 20,946 (April 8, 2016). In addition to the final regulation, the DOL also issued two administrative class exemptions from the prohibited transaction provisions of ERISA and amended several existing prohibited transaction class exemptions.

indirectly (such as through a performance based bonus) receives compensation for such advice, the final rule may be applicable. Church benefit boards providing incoming rollover advice to plan participants should therefore consider the applicability of the final rule. The final rule is applicable on April 10, 2017.

There is some indication that the Trump administration will take action to attempt to repeal the final fiduciary definition rule. However, for several reasons, it is not clear that this can be done, and it is also not clear that it can be done by April 10, 2017, when the final rule becomes initially applicable. Financial service organizations are therefore working towards compliance with the final rule – particularly because the final rule's primary enforcement tool is not governmental fines or penalties, but the right of private individuals to sue for violations of the rule.

III. 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. This report focuses on guidance that was issued in the last year.

A. Church Alliance Efforts Related to the ACA – Update on Church Health Plan Act of 2013

Following the enactment of the ACA, the Church Alliance began an effort to obtain premium tax credits and cost-sharing subsidies for participants in church health care plans. In June of 2013, the Church Health Plan Act was introduced in the Senate by Senators Mark Pryor (D–Ark.) and Chris Coons (D–Del.). This legislation provided that church health care plans that met certain requirements would be treated as health care plans provided through the ACA state exchanges, so that employees eligible to participate in a church health plan would be entitled to the desired tax credits and cost-sharing.

The Church Alliance has continued its efforts to secure passage of the Church Health Plan Act, though in different form. However, with the election of Donald Trump to the Presidency, and in light of the vow of President-elect Trump and Republican leadership in Congress to repeal and replace the ACA, Church Alliance representatives are currently assessing the prospects for that occurring, along with what a Republican replacement for the ACA will look like. That assessment will in all likelihood not be completed until the Republican ACA replacement alternative is unveiled after President-elect Trump's inauguration.

B. Premium **Reimbursement Arrangements**

1. Background.

In September 2013, the IRS issued Notice 2013-54,[30] which provides guidance on the application of the ACA market reform provisions to premium reimbursement 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.[31] 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 (i.e. the premium reimbursement arrangement) 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.

On February 18, 2015, the IRS issued Notice 2015-17[32] (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,[33] TRICARE-related health reimbursement arrangements,

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[30] 2013-40 I.R.B. 287.

[31] *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.

[32] 2015-14 I.R.B. 845.

[33] The notice states that, to the extent a Medicare reimbursement arrangement is available to active employees, it may be subject to restrictions under other laws, such as the Medicare secondary payer provisions. The Medicare secondary payer provisions prohibit an employer from offering a Medicare-eligible individual a financial or other incentive not to enroll in a group health plan that would pay primary to Medicare. There is an exception to the Medicare secondary payer provisions for certain small employers. If the small employer exception does not apply, then it appears that the reimbursement of Medicare premiums likely would be considered an impermissible financial incentive that violates the

and increases in employee compensation to assist with individual insurance policy premiums.

2. Notice 2015-87.

On December 16, 2015, the Agencies issued Notice 2015-87,[34] which includes lengthy guidance on the application of the ACA market reform provisions to employer-provided coverage and on certain other ACA provisions. The provisions of the Notice applicable to premium reimbursement arrangements are discussed below, while the remaining provisions are discussed in section II.A.10 of this report.

- A health reimbursement arrangement ("HRA") that covers fewer than two participants who are current employees is exempt from the market reforms. Accordingly, an HRA covering fewer than two participants who are current employees may be used to purchase individual market coverage after an employee covered by the HRA ceases to be covered by other integrated group health plan coverage. In contrast, an HRA covering two or more participants who are current employees may not be used for this purpose.

- An HRA is permitted to be integrated with an employer's other group health plan only with respect to the individuals covered under both the HRA and the other group health plan. Accordingly, an HRA that reimburses the expenses of a spouse or dependent who is not covered under the employer's other group health plan will fail to satisfy the ACA market reform provisions. The notice provides transition relief for certain HRAs that fail to satisfy this requirement.

- An HRA or EPP that may be used only for individual market coverage consisting solely of excepted benefits does not fail to satisfy the ACA market reform provisions.

- An EPP that reimburses the cost of individual coverage through a cafeteria plan fails to satisfy the ACA market reform provisions.

The guidance provided in the notice applies for plan years beginning on and after December 16, 2015, except as otherwise provided in the notice.

3. Other IRS Guidance.

During the past year, the IRS has issued additional guidance on premium reimbursement arrangements in the form of an Office of Chief Counsel Memorandum[35]

Medicare secondary payer provisions even if the reimbursement arrangement complies with the requirements set forth in the notice.

[34] 2015-52 I.R.B. 889.

[35] Office of Chief Counsel Memo. No. 201547006.

and four information letters.[36] The information letters are from the IRS Office of Chief Counsel and respond to inquiries raised by a governmental employer and members of Congress.

The Office of Chief Counsel Memorandum clarifies that an employer may exclude premiums for group health plan coverage provided by a spouse's employer from an employee's gross income only to the extent the spouse paid for the coverage on an after-tax basis and not through salary reduction under a section 125 cafeteria plan.[37] The memorandum states that the same rule applies to payments made to an HRA that are used to reimburse an employee for the cost of a spouse's group health plan premiums. If the spouse paid for the premiums on a pre-tax basis, then the HRA will fail to qualify as a health plan, and no amounts paid to any participant would be excluded from gross income.

The information letters primarily reiterate the IRS's previously-established position on premium reimbursement arrangements as set forth in prior guidance. In one of the information letters, the IRS notes that vendors have developed premium reimbursement products that they claim do not impose an annual limit on essential health benefits. Based on the information presented, the IRS Office of Chief Counsel believes these products do impose an annual limit on essential health benefits and, therefore, fail to satisfy the ACA market reforms.

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[36] Info. Ltr. Nos. 2016-0005, 2016-0019, 2016-0021 and 2016-0023. In addition to the four information letters relating to premium reimbursement arrangements, the IRS Office of Chief Counsel issued an information letter providing guidance on health care sharing ministries, which is further discussed above in Section III.Q of this report. Info. Ltr. No. 2016-0051. The information letter primarily provides guidance on the taxability of payments made to a health care sharing ministry but also has some ACA implications. Specifically, the information letter indicates that coverage provided by a health care sharing ministry is not a group health plan. The information letter does not, however, state whether an arrangement under which an employer reimburses an employee for the cost of membership in a health care sharing ministry would be considered a group health plan. If such a reimbursement arrangement is not considered a group health plan, then it would not be subject to the ACA market reform provisions, including the annual limit and preventive care requirements.

The Agencies also issued an FAQ applicable to student health insurance coverage. Until further guidance is issued, the Agencies will not assert that a premium reduction arrangement fails to satisfy the annual limit prohibition or preventive care requirements if the arrangement is offered in connection with other insured or self-insured student health coverage.

[37] Importantly, the memorandum does not discuss the ACA implications of reimbursing employees directly for the cost of a spouse's group health plan premiums. Based on previous guidance applicable to premium reimbursement arrangements, we believe an employer may only reimburse an employee for the cost of a spouse's group health plan premiums that were paid by the spouse on an after-tax basis through an HRA (or other account-based plan) that is properly integrated with a group health plan.

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 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.

Exemption for Religious Employers

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."[38] The revised religious employer exemption would cover:

- churches;
- conventions and associations of churches; and
- integrated auxiliaries.[39]

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,

[38] 78 Fed. Reg. 39,870 (July 2, 2013).

[39] 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.

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:

- 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.[40]

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).[41]

In the case of insured group health plans sponsored by eligible organizations, the coverage would thus 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").

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.[42] Under the interim rules, religious non-profits are still

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[40] 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.

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

[42] 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

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.[43]

In July 2015, the Agencies finalized the interim final regulations issued in August 2014.[44] The final regulations also describe the content requirements of the alternative notice and describe accommodations for closely-held for-profit entities.[45]

2. U.S. Supreme Court Decision.

On November 6, 2015, the U.S. Supreme Court granted review of seven cases addressing the enforcement of the contraceptive coverage mandate cases. Oral arguments before the Supreme Court in the seven cases were held in March of 2016. After hearing the oral arguments, the Supreme Court requested supplemental briefing from the parties addressing the alternative approaches that could be used to provide contraceptive coverage to the organization's employees without requiring the organization to provide notice to insurers, TPAs or HHS. The supplemental brief for the religious organizations indicated that their religious exercise is not infringed if they are required to do nothing more than contract for a plan that does not provide coverage for some or all forms of contraception, even if their employees receive such coverage from the same insurance company. The supplemental brief for the government indicated that the accommodation could be modified in this way for insured plans, but notes that this approach would not work for self-insured plans.

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

[43] 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*.

[44] 80 Fed. Reg. 41,318 (July 14, 2015).

[45] 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.

In light of the "substantial clarification and refinement in the positions of the parties" raised in the supplemental briefs, the Court remanded the seven cases back to the appellate courts in May of 2016 and anticipates that those courts will "allow the parties sufficient time to resolve any outstanding issues between them."[46] The Court also states that it expresses no view on the merits of the case.

In June 2016, the Court remanded six additional cases involving the religious employer accommodation back to the appellate courts. The Court stated again that it was not ruling on the merits of the cases.

As a result of the Court's decision to remand these cases to the appellate courts, the Agencies issued a request for information in July 2016.[47] The request for information asks for comments on whether there are alternative ways to structure the accommodation for religious organizations while ensuring women enrolled in their plans receive the full range of contraceptive coverage without cost sharing. In particular, the Agencies requested information regarding alternative approaches that would work for insured plans as well as self-insured plans.

The Church Alliance filed a comment letter on September 20, 2016 in response to the request for information.[48] In the comment letter, the Church Alliance again requested that the Agencies expand the types of church-affiliated employers that are exempt from the contraceptive coverage mandate to include any objecting employer that provides health coverage through a church plan. If the Agencies decide not to expand the exemption, then the Church Alliance requested that the Agencies adjust the notification required to qualify for the accommodation as follows:

- Allow objecting employers to inform their insurer or TPA of their religious objections to the contraceptive coverage mandate, without further obligation on such objecting employers;

- Allow a multiple-employer church plan sponsor or church-affiliated administrator to inform the plan's insurer or TPA of the religious objection on behalf of all participating employers, or otherwise allow an employer to communicate its objection through another entity;

- Clarify that notifying the insurer or TPA as to such religious objection would exempt the employer from any obligation to provide contraceptive services, and any contraceptive services would be provided through a separate policy without any connection or cost to the employer; and

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[46] *Zubik v. Burwell*, 136 S. Ct. 1557 (2016).

[47] 81 Fed. Reg. 47,741 (July 22, 2016). Comments were required to be received on or before September 20, 2016.

[48] A copy of the comment letter is attached as Appendix D.

- Ensure that any contraceptive coverage is truly separate and does not involve the plan, meaning that it does not require the employer to issue new plan documents or use the plan or the plan's infrastructure or information.

D. Final **Market Reform Regulations**

On November 13, 2015, the Agencies issued final regulations on the market reform provisions of the ACA.[49] 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 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 selected by a state or the District of Columbia or one of the three largest Federal Employee Health Benefit Plans;
- 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);
- Clarify the types of arrangements that can be integrated with other group health plan coverage to include HRAs, medical reimbursement plans and health flexible spending arrangements and referring to such arrangements as "account-based plans";
- Provide guidance on the integration requirements applicable to HRAs and other account-based plans, including a clarification that forfeited or waived amounts may be reinstated at a future date, upon death or at the earlier of the two dates as long as the reinstated amounts may not be used to reimburse or pay medical expenses incurred during the period after the forfeiture and prior to the reinstatement;
- Permit integration with Medicare for HRAs or other account-based plans of certain employers with less than 20 employees that are not required to offer group

[49] 80 Fed. Reg. 72,192 (Nov. 18, 2015).

health plan coverage to Medicare-eligible employees, provided that certain requirements are satisfied;

- Clarify that non-grandfathered group health plans are not permitted to impose a time limit (e.g., 24 hours) during which a participant must seek emergency services; and
- Provide additional guidance on claims and appeals procedures and external review.

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

E. Cadillac **Plan Tax**

On December 18, 2015, President Obama signed into law the Consolidated Appropriations Act, 2016.[50] This Act delays the effective date of the Cadillac tax by two years until 2020 (i.e., tax years beginning after 2019) and permits the deductibility of the Cadillac tax.

The Cadillac tax is a 40% excise tax that will be imposed on certain high-cost employer-sponsored health care plans (so-called "Cadillac" plans) to the extent that the annual cost for an employee exceeds a threshold amount. The threshold amount is $10,200 for employee-only coverage and $27,500 for coverage other than employee-only and will be indexed annually. These thresholds also will be adjusted for plans that carry a higher premium cost because of age and gender demographics of an employer's employees and for qualified retirees and employees in certain high-risk professions.

Efforts continue by a broad-based employer coalition to repeal the Cadillac tax. It may also be repealed in connection with the "repeal and replace" alternative being developed by the Trump administration and Congress.

F. Summary **of Benefits and Coverage**

The ACA requires health plans and issuers to provide participants with a summary of benefits and coverage ("SBC"), which briefly describes what the plan covers and the cost sharing responsibility of participants. On April 6, 2016, the Agencies issued a revised SBC template, instructions, an updated uniform glossary and other supporting documents.[51]

The new SBC template provides additional information about deductibles and out-of-pocket limits, including a requirement that plans disclose both the individual and overall out-of-pocket limits. The revised SBC template also includes an additional coverage example for a simple foot fracture with an emergency room visit so a participant understands what a plan covers in an emergency situation. Health plans are required to begin using the revised SBC

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

[51] *See* https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits.

template beginning on the first day of the first open enrollment period that begins on or after April 1, 2017.

G. Guidance **on Application of Market Reform Provisions to Employer-Sponsored Health Coverage**

In addition to the premium reimbursement guidance discussed above, Notice 2015-87 provides other guidance on the application of the market reform provisions to employer-sponsored health coverage, including the following:[52]

- An employer contribution to an HRA and employer health flex contributions[53] to a cafeteria plan that may be used to pay the employee share of premiums under the employer's major medical plan generally reduce the employee's required contribution for coverage under such plan for purposes of the employer shared responsibility provisions, if certain requirements are satisfied. For this purpose, these contributions are treated as made ratably for each month of the period for which they are made. The Notice also provides transition relief for employer flex contributions made on or before December 16, 2015 that do not qualify as health flex contributions.
- An employee's required contribution for health coverage is increased by the amount of any "opt out" payment that is conditioned solely on the employee declining coverage under the employer's health plan. The Notice provides transition relief for certain opt out payments made on or before December 16, 2015.[54]
- The IRS intends to amend the employer-shared responsibility regulations so that the 9.5% standard used in the affordability safe harbors will be adjusted in the same manner as the 9.5% standard used to determine affordability for purposes of the premium tax credit (i.e., 9.66% for plan years beginning in 2016).
- An hour of service does not include certain hours for which employees are paid but do not perform services, as further explained in the notice.
- For applicable large employer reporting under Code section 6056, the IRS will not impose penalties on employers that can show they have made a good faith effort to comply with the reporting requirements for returns and statements filed and furnished in 2016 to report offers of coverage in 2015. The relief does not apply to employers that fail to timely file a return or furnish a statement.

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[52] The Notice also includes guidance on unused amounts in health flexible spending accounts that are permitted to be carried over to the following year. This guidance is further discussed in section II.A.10.

[53] The Notice provides that an amount is a health flex contribution if (1) the employee may not opt to receive the amount as a taxable benefit; (2) the employee may use the amount to pay for minimum essential coverage; and (3) the employee may use the amount exclusively to pay for medical care (as defined in Code section 213).

[54] The IRS issued proposed regulations on opt out payments on July 6, 2016, which are further discussed in section III.L.

The guidance provided in the Notice applies for plan years beginning on and after December 16, 2015, except as otherwise provided in the notice.

H. Reporting **Requirements**

The ACA imposes two reporting requirements on group health plans that were effective in 2015. 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 Forms 1094-B (transmittal) and 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[55] to report regarding their compliance with the employer shared responsibility provisions. Applicable large employers must file Forms 1094-C (transmittal) and 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 forms.

The IRS recently issued updated forms and instructions for 2016, which include minor revisions to the forms, changes to certain reporting codes and clarifications to the instructions, including revisions to the transition relief provisions that were only available for 2015 or part of 2016. The IRS also issued a notice extending the due date for furnishing required returns to individuals and providing good-faith transition relief for 2016 reporting along with proposed regulations applicable to the Code section 6055 reporting requirement. The notice and proposed regulations are further discussed below.

1. Due Date Extension and Transition Relief.

On November 18, 2016, the IRS issued Notice 2016-70 to extend the due date for furnishing Forms 1095-B and 1095-C to individuals from January 31, 2017 to March 2, 2017.[56] The notice also provides transition relief from penalties to reporting entities that have made good-faith efforts to comply with the reporting requirements for 2016 but report incorrect or incomplete information on the returns. The transition relief does not apply to entities that fail to timely file or furnish required returns.

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[55] 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.

[56] The notice does not extend the due date for filing the 2016 forms with the IRS. Accordingly, the required forms must be filed with the IRS by February 28, 2017 (or March 31, 2017 if filing electronically).

2. Proposed Regulations on Section 6055 Reporting.

The IRS also issued proposed regulations on August 2, 2016 that provide guidance on the requirement to report minimum essential coverage under Code section 6055.[57] Specifically, the proposed regulations:

- Truncated employer identification numbers. Permit health insurance issuers reporting on insured group health plans to use a truncated employer identification number ("EIN") of the employer sponsoring the plan on the statement provided to taxpayers;

- Coverage for which reporting is not required. Provide the following rules for when a provider of minimum essential coverage is not required to report coverage of an individual who has other minimum essential coverage:

    - If an individual is covered by more than one plan providing minimum essential coverage that is offered by the same reporting entity, reporting is required for only one of the plans;[58] and

    - If an individual is covered by eligible employer-sponsored coverage for which section 6055 reporting is required and is also eligible for certain supplemental coverage offered by the same employer (as determined after application of the controlled group rules), then reporting is not required for the supplemental coverage.[59]

- Taxpayer identification number solicitation. Under current law, the penalty that would be imposed on a failure to include a correct taxpayer identification number ("TIN") is waived if the reporting entity acts in a "responsible manner" in soliciting a TIN. A reporting entity is treated as acting in a responsible manner if it makes (1) an initial solicitation when an account is opened or a relationship is established; (2) a first annual solicitation by December 31 of the year the account

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[57] 81 Fed. Reg. 50,671 (Aug. 2, 2016).

[58] According to the example provided in the proposed regulations, if an individual is enrolled in a self-insured group health plan provided by an employer and is also enrolled in a self-insured HRA provided by the same employer, then the employer is only required to report one type of coverage for that individual. If the employee later drops coverage under the non-HRA but remains covered under the HRA, then the employer is required to report coverage under the HRA for the months after the employee drops the non-HRA coverage.

[59] If an individual is eligible for an employer's HRA only if he or she is enrolled in the insured group health plan offered by the same employer, then the example provided in the proposed regulations states that an employer is not required to report the HRA coverage of such individual. If, however, an employee is enrolled in his or her employer's HRA and in a spouse's non-HRA group health plan coverage, then the employer is required to report the coverage under the HRA and the spouse's employer is required to report the coverage under the group health plan.

is opened (or January 31 of the following year if the account is opened in December); and (3) a second annual solicitation by December 31 of the year following the year in which the account is opened. The IRS previously issued transition relief on the solicitation of TINs in Notice 2015-68, and the proposed regulations permit taxpayers to continue to rely on the transition relief set forth in such notice until final regulations are issued.[60]

Under the proposed regulations, an account is considered "opened" on the date the filer received a substantially completed application for new coverage or to add an individual to existing coverage. Accordingly, the initial solicitation may be made as part of the application process. The first annual solicitation must then be made no later than 75 days after the date on which the account is opened or, if the coverage is retroactive, no later than the 75th day after the determination of retroactive coverage is made. The deadline for the second annual solicitation remains December 31 of the year following the year in which the account is opened.

The proposed regulations provide additional relief for individuals who were enrolled in coverage on any day before July 29, 2016 by treating an account of these individuals as opened on July 29, 2016. Accordingly, the initial solicitation requirement is satisfied as long as TINs were requested prior to July 29, 2016. The relief also provides additional time for the first and second annual solicitations since the deadline for such solicitations is measured from the date the account is "opened" (i.e., July 29, 2016).

The regulations are generally proposed to apply for taxable years ending after December 31, 2015, and may be relied upon for calendar years ending after December 31, 2013.

I. Minimum **Value and Affordability**

On December 16, 2015, the IRS issued final regulations providing guidance on various issues relating to the health insurance premium tax credit.[61] Some of the provisions included in the final regulations provide guidance on how wellness program incentives and employer contributions to HRAs are taken into account for purposes of determining whether an employer-sponsored plan satisfies the affordability and minimum value requirements.

1. Wellness Programs.

Reduced cost-sharing in wellness programs generally does not count toward minimum value ("MV"). The one exception is with respect to wellness programs related to prevention or reduction of tobacco use. The final regulations provide that MV may be

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[60] 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.

[61] 80 Fed. Reg. 78,971 (Dec. 18, 2015).

calculated assuming that every individual satisfies the terms of a nondiscriminatory program aimed at the prevention or reduction of tobacco use.

Wellness incentives that reduce health care plan premiums generally will not be considered as increasing affordability. However, the affordability of plans for tobacco users will be determined based on the premiums charged to tobacco users who complete a nondiscriminatory wellness program related to tobacco use (such as attending smoking cessation classes). Thus, the health care plan premium that applies to non-tobacco users is used for testing affordability for all employees, including those who are tobacco users.

2. HRA Contributions.

The final regulations provide that amounts newly made available under an HRA that is integrated with an employer health care plan for the current plan year count for purposes of minimum value if the amounts may only be used for cost-sharing and not for premiums. The final regulations also provide that amounts made newly available under an HRA that is integrated with an employer health care plan are taken into account in determining affordability if the employee may use the amounts only for premium payment or may choose to use the amounts for either premiums or cost-sharing reduction.

The final regulations also clarify that HRA contributions are only taken into account in determining affordability and minimum value if the same employer offers both the HRA and primary employer-sponsored coverage. In addition, HRA contributions are only taken into account to the extent the amount of the annual contribution is required under the terms of the plan or is determinable within a reasonable time before the employee must decide whether to enroll.

3. Employer (Flex) Contributions to Cafeteria Plans.

The final regulations include guidance on how employer contributions to cafeteria plans are taken into account for purposes of determining whether coverage is affordable. Under the final regulations, an employee's required contribution for coverage is reduced by employer contributions to a cafeteria plan that (1) may not be taken as a taxable benefit; (2) may be used to pay for minimum essential coverage; and (3) may be used only to pay for medical care within the meaning of Code section 213.

J. Patient-Centered Outcome Research Institute Adjusted Fee

The ACA includes a provision imposing a fee 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 (the Patient-Centered Outcome Research Institute or "PCORI"). The fee is generally imposed on health insurance issuers and plan sponsors of self-insured health plans for each plan or policy year ending after September 30, 2012, and before October 1, 2019. The fee, which initially was $1 times the average number of covered lives in the first plan year ending after September 30, 2012, and $2 for each covered life in the second plan year ending after September 30, 2012, is subject to indexing. On November 4, 2016, the IRS issued Notice 2016-64, increasing the amount used

to calculate the fee to $2.26 for plan and policy years ending on or after October 1, 2016, and before October 1, 2017.

K. Proposed **Expatriate Plan Regulations**

In June of 2016, the Agencies issued proposed regulations implementing the provisions of the Expatriate Health Coverage Clarification Act of 2014 (the "Expatriate Act").[62] The proposed regulations may be relied upon until final regulations become applicable.

The Expatriate Act was enacted on December 16, 2014 as part of the Consolidated and Further Continuing Appropriations Act 2015.[63] The Expatriate Act exempts from most of the ACA mandates: (1) both insured and self-insured expatriate health plans issued or renewed on or after July 1, 2015, (2) the employers in their capacity as plan sponsors of such plans, and (3) health insurance issuers with respect to coverage offered under such plans. To qualify for the exemption for plan or policy years ending after January 1, 2017, an expatriate health plan must satisfy the following requirements:

- Substantially all of the primary enrollees[64] in the plan must be qualified expatriates;[65]
- 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;[66]

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[62] The proposed regulations also provide guidance on short-term, limited duration insurance, certain types of excepted benefits (including supplemental health insurance coverage, travel insurance, hospital indemnity and other fixed indemnity insurance and specified disease coverage) and annual and lifetime limits. This guidance (with the exception of the provisions relating to hospital indemnity and other fixed indemnity insurance) were finalized in the final excepted benefit regulations discussed in section III.N of this report.

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

[64] 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.

[65] The proposed regulations provide that there are three categories of qualified expatriates: (1) individuals (other than nationals of the United States) whose skills, qualifications, job duties or expertise cause their employer to transfer them to the United States for a specific and temporary purpose or assignment that is tied to the individual's employment, 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 or across two consecutive plan years; 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 who satisfy certain requirements and who the Agencies determine require access to health insurance in multiple countries (e.g., missionaries or students).

- The plan sponsor reasonably believes the plan provides minimum value;[67]
- If the plan provides dependent coverage of children, then it must make such coverage available until the child turns age 26;[68]
- The plan or coverage must be a group health plan issued by an expatriate health plan issuer[69] or administered by an expatriate health plan administrator that, together with any other person in the issuer or administrator's controlled group, has licenses to sell insurance in more than two countries[70];
- The plan or coverage offers reimbursements for items or services in 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.[71]

A plan that satisfies the above requirements is exempt from most of the ACA mandates with the exception of the employer shared responsibility provisions, the Cadillac plan tax (under certain circumstances) and the ACA reporting requirements imposed under Code sections 6055 and 6056, subject to the modifications described below.

For purposes of Code section 6055 and 6056 reporting, an expatriate health plan is permitted to furnish required statements to individuals electronically unless the individual explicitly refuses to consent to the electronic receipt of such statements in the form of either an electronic or paper document. A request for a paper statement is treated as an explicit refusal to receive an electronic statement. For a recipient to be treated as having consented to an electronic

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

[67] For purposes of this requirement, a plan sponsor is permitted to rely on the reasonable representations of the insurer or administrator as to whether the coverage provides minimum value unless the plan sponsor knows or has reason to know that the coverage fails to satisfy the minimum value requirements.

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

[69] An expatriate plan covering qualified expatriates who are members of a group of similarly situated individuals formed for the purpose of traveling or relocating internationally for tax-exempt purposes may only be issued by an expatriate health insurance issuer.

[70] 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. The proposed regulations also clarify that a group health plan will not fail to be an expatriate health plan merely because any portion of the coverage is provided through a self-insured arrangement.

[71] The proposed regulations state that the plan is not required to issue certifications of creditable coverage but, to the extent the plan imposes a pre-existing condition exclusion, the plan must ensure that enrollees with prior creditable coverage have an opportunity to demonstrate that they had creditable coverage.

statement, the furnisher must provide a notice to the recipient at least 30 days prior to the due date for furnishing the first electronic statement to the recipient. The notice must inform the recipient that the statement will be provided electronically unless the recipient refuses to consent to an electronic statement.

The proposed regulations also provide guidance on the application of the PCORI fee. The existing regulations on the PCORI fee exclude expatriate health plans from the fee only if the plan is designed to cover primarily employees who are working and residing outside of the United States. The proposed regulations would expand the exclusion from the PCORI fee to expatriate health plans regardless of whether the plan provides coverage for qualified expatriates residing or working in or outside of the United States.

L. **IRS Proposed Regulation on Opt-Out Payments**

On July 6, 2016, the IRS issued proposed regulations on whether offering cash payments to employees who opt out of employer-sponsored health coverage would be taken into account in determining whether such coverage is affordable for certain purposes, including the employer shared responsibility provisions.[72] The proposed regulations confirm that the amount of an opt out payment increases the employee's monthly premium for health coverage under an employer-sponsored health plan, regardless of whether the employee enrolls or declines to enroll in such plan. In addition, the increased premium amount is required to be reported on Form 1095-C (the IRS form used to satisfy the ACA reporting requirements under Code section 6056).

The proposed regulations include an exception for eligible opt-out arrangements under which an employee's right to receive an opt-out payment is conditioned on the employee providing evidence that he or she has obtained minimum essential coverage from another source. An opt-out arrangement must satisfy certain requirements set forth in the proposed regulations for the exception to apply.

The regulations are proposed to apply for taxable years beginning on or after January 1, 2017. For the period prior to such date, the transition relief provided in Notice 2015-87 continues to apply. Notice 2015-87 includes transition relief for employers with opt-out arrangements in effect prior to December 16, 2015 that satisfy certain requirements.

M. Final **Rule on Nondiscrimination in Health Programs and Activities**

On May 13, 2016, HHS issued a final rule implementing section 1557 of the ACA. Section 1557 of the ACA prohibits discrimination under any health program or activity that received Federal financial assistance on any grounds prohibited by Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination and Employment Act of 1975 and section 504 of the Rehabilitation Act of 1973.[73] The prohibited

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[72] 81 Fed. Reg. 44,557 (July 8, 2016).

[73] 81 Fed. Reg. 31,376 (May 18, 2016).

grounds for discrimination under these laws include race, color, national origin, age, disability, and sex.

The scope of section 1557 is broader than the scope of the final rule. The final rule only applies to health programs and activities that receive federal financial assistance through HHS or that are administered by HHS. This would include federal and state Exchanges, the insurers participating in such Exchanges, the employee health benefit plans of employers principally engaged in health care that receive federal financial assistance (e.g., hospitals) and possibly group health plans that receive funds from HHS (e.g., the retiree drug subsidy or EGWP payments). The final rule would also apply to any services that insurers subject to the rule offer outside the Exchanges, including third party administration services.

The final regulations clarify that an employer does not become covered by the rule as a result of its third-party administrator ("TPA") being covered. HHS also adopted a procedure to govern complaints alleging discrimination in plans administered by a TPA subject to the final rule. When it receives a complaint, HHS will determine whether the TPA or employer is responsible for the discriminatory action. If the alleged discrimination is related to the TPA's administration of the plan, then HHS will process the complaint against the TPA. If the alleged discrimination relates to the design of a self-insured health plan, HHS will process the complaint against the employer if it has jurisdiction or refer the matter to the EEOC if it does not have jurisdiction.

Section 1557 is the first federal civil rights law to prohibit discrimination on the basis of sex in federally funded health care programs. With respect to discrimination on the basis of sex, the final rule would prevent discrimination based on gender identity and prohibit a covered entity from denying services based on an individual's self-identified gender. In addition, the rule would prohibit a categorical exclusion of coverage for health services relating to gender transition.

The final regulations do not include a religious exemption. However, the final regulations include a provision stating that the regulations will not apply if the application of any requirement would violate "applicable Federal statutory protections for religious freedom and conscience."

The final regulations were generally effective July 18, 2016, except that any provisions affecting the design of health insurance plans will not become effective until the first day of the first plan year beginning on or after January 1, 2017.

N. Final **Regulations on Short-Term, Limited-Duration Insurance, Excepted Benefits and Lifetime and Annual Limits**

On October 28, 2016, the Agencies issued final regulations on short-term, limited-duration insurance, excepted benefits coverage for supplemental health insurance and travel insurance and lifetime and annual limits.[74] The regulations apply to group health plans and

[74] 81 Fed. Reg. 75,316 (Oct. 31, 2016).

health insurance issuers beginning on the first day of the first plan year beginning on or after January 1, 2017.

1. Short-Term, Limited Duration Insurance.

Short-term, limited-duration insurance is a type of insurance designed to fill temporary gaps in coverage when an individual is moving to a different plan or coverage. Although short-term, limited-duration insurance is not an excepted benefit, it is exempt from the ACA market reform provisions because it is not considered individual insurance coverage. Under prior regulations, the maximum term of coverage was limited to 12 months. The Agencies became aware that some issuers were providing renewals of coverage that extended the duration beyond the 12-month limit.

To ensure that short-term, limited duration insurance is not being sold as a type of primary coverage, the final regulations state that the duration of short-term, limited duration insurance must be less than three months, including the period for which the policy may be renewed. In addition, the final regulations include a notice that must be prominently displayed in the contract and any application materials provided in connection with enrollment. The notice states that the coverage is not minimum essential coverage that satisfies the requirements of the ACA and that an individual without minimum essential coverage may owe a penalty.[75]

2. Similar Supplemental Coverage.

Similar supplemental coverage qualifies as an excepted benefit if it is provided under a separate policy, certificate or contract of insurance and supplements coverage provided under a group health plan. 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;
- 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.

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[75] The final regulations also include transition relief for certain products sold before April 1, 2017 where the coverage period is three-months or more, provided that the coverage ends on or before December 31, 2017 and otherwise complies with the regulations. States may also elect not to take enforcement action against issuers with respect to such coverage.

The final regulations provide guidance on what it means to be designed to fill gaps in primary coverage. Specifically, the final regulations clarify that coverage supplements and fills gaps in group health coverage if the coverage is designed to:

- fill gaps in cost sharing in primary coverage (e.g., coinsurance or deductibles);
- provide benefits for items and services that are not covered by the primary coverage and are not essential health benefits in the state where the coverage is issued; or
- both fill gaps in cost sharing and cover the benefits described in the second bullet.

The final regulations also state that similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination of benefits provision.

3. Travel Insurance.

The final regulations also recognize travel insurance as a new type of excepted benefit. Travel insurance is defined as insurance coverage for personal risks incident to planned travel, such as trip interruption or cancellation, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability or death occurring during travel, provided that health benefits are offered on a standalone basis and are incidental to other coverage. Travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting six months or longer, such as expatriates or deployed military personnel.

4. Lifetime and Annual Limits.

Certain plans (including self-insured plans) are not required to provide coverage for essential health benefits ("EHBs") but, if they do provide coverage, then they are prohibited from imposing annual and lifetime limits on any benefits that qualify as EHBs. The final regulations clarify that such plans must define EHBs in a manner that is consistent with an EHB-benchmark plan in any state (including any additional state-required benefits that are considered EHBs) or one of the three largest Federal Employees Health Benefit Program plans (including any additional benefits necessary to satisfy the EHB requirements).

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, including, but not limited to, SBCs, preventive services, rescissions, out-of-network emergency services, coverage for individuals participating in approved clinical trials, cost-sharing limits and premium reimbursement arrangements for student health plan coverage. The FAQs also include guidance on the Mental Health Parity and Addiction Equity Act of 2008, the Women's Health and Cancer Rights Act, and the extent to which the COBRA continuation notice may include information about enrollment in the Exchanges. The FAQs issued this year include Parts 30 through 34 and can be found at:

https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs.

P. Future ACA Provisions of Importance – 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 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.[76] 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.

Q. Health Care Sharing Ministries

The Department of the Treasury recently released a June 22, 2016 letter to Representative Joseph Donnelly (D. Ind.), addressing a constituent's question as to whether an employer can contribute to the premiums of employees who decline coverage in an employer group health plan and instead participate in a health care sharing ministry. The letter said that employers can contribute, but any amounts contributed would be considered additional wages to the employee.

The letter confirmed that members of a health care sharing ministry are exempt from the Affordable Care Act's requirement to have minimum essential coverage. However, the IRS letter points out that coverage under a health care sharing ministry is not minimum essential coverage, membership in a health care sharing ministry is not health insurance, and payments for participating in a health care sharing ministry are not considered to be deductible medical care.

Because participation in a health care sharing ministry is not employer-provided coverage under an accident or health plan, the IRS also said that any employer payments for the cost of employee participation will be taxable income (additional wages) to the employee.

R. Small Business Health Care Relief Act

The Small Business Health Care Relief Act of 2016, H.R. 5447, was introduced on June 10, 2016 by Rep. Charles Boustany (R-La.), and was referred to the House Committee on Ways and Means, in addition to the Committees on Education and the Workforce, and Energy and Commerce. The Committee on Ways and Means ordered the bill reported, as amended, by voice vote on June 15, 2016.

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

H.R. 5447 would create a safe harbor for employer payment arrangements through an HRA by amending the Code to define a qualified small employer health reimbursement arrangement (QSEHRA) as an arrangement under which an employer pays directly for or reimburses individual health coverage of an employee and his or her dependents on a pre-tax basis. In order to be eligible for this arrangement, an employer must generally have had fewer than 50 full-time employees during the prior year. An employee must provide proof of having minimum essential health insurance coverage, as defined for purposes of the individual mandate, and reimbursement payments to an employee would be capped at $5,130 ($10,260, if an HRA also provides for reimbursements for an employee's family members), indexed for inflation. Under this proposal, employees would be prohibited from receiving a double benefit from qualifying HRAs and marketplace premium tax credits. H.R. 5447 also establishes a number of notice and reporting requirements. The legislation mandates that employers provide eligible employees with a written notice containing the amount of the employee's permitted benefit and also requires employers to report contributions to a reimbursement arrangement on their employees' W-2 form. An employer that offered a QSEHRA would not be subject to penalties under the Internal Revenue Code, the Employee Retirement Income Security Act of 1974, or the Public Health Service Act that typically apply to group health plans that fail to meet certain ACA requirements.

IV. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

A. Final 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 in 2015, there was little guidance on how the ADA applies to wellness programs.

On May 16, 2016, the Equal Employment Opportunity Commission ("EEOC") finalized the 2015 proposed rule on employer wellness programs.[77] The final rule applies to all wellness programs that require employees to respond to disability-related inquiries or undergo medical examinations, including programs that are offered as part of a group health plan and programs that are offered outside of a group health plan.

Under the final 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. A wellness program is considered "reasonably designed" to promote health or prevent disease if it has a reasonable chance of improving the health of (or preventing disease in) participating employees and is not 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 program must also be "voluntary" meaning that the covered entity does not (i) require employees to participate, (ii) deny coverage under any of its group health plans or particular benefits packages within a group

[77] 81 Fed. Reg. 31,126 (May 17, 2016).

health plan for non-participation or limit the extent of such coverage (except pursuant to allowed incentives), or (iii) take any adverse employment action or retaliate against, interfere with, coerce, intimidate or threaten employees who do not participate in the program.

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. The EEOC has also published a sample notice that employers may use to comply with the notice requirements of the final rule, along with guidance in the form of questions and answers about the sample notice.[78]

The final rule also restricts the maximum inducement (financial or in-kind) for participation in a wellness program, whether in the form of a reward or penalty, to:

- 30% of the total cost of self-only coverage under the group health plan in which the employee is enrolled, if participation in the wellness program is conditioned on enrollment in the plan;

- 30% of the total cost of self-only coverage under the group health plan offered by the employer where the employer only offers one group health plan and participation in the wellness program is not conditioned on enrollment in the plan;

- 30% of the lowest cost self-only coverage offered by the employer where the employer offers more than one group health plan and participation in the wellness program is not conditioned on enrollment in the plan; and

- 30% of the cost of self-only coverage available to a non-smoker who is 40 years old under the second lowest cost Silver Plan available through an Exchange in the location of the employer's principal place of business, if the employer has no group health plan.

The 30% limit also applies to tobacco cessation programs that require employees to be tested for nicotine or tobacco use.

The incentive limits under the final rule do not align with ACA guidance on wellness programs, which permits a maximum incentive of 30% of the cost of coverage in which the employee is enrolled (including family coverage). In addition, the ACA guidance permits incentives of up to 50% for tobacco cessation programs regardless of whether they require employees to be tested for nicotine or tobacco use.

The final 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.

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[78] *See* https://www.eeoc.gov/laws/regulations/ada-wellness-notice.cfm; and https://www.eeoc.gov/laws/regulations/qanda-ada-wellness-notice.cfm.

The final rule also prohibits a covered entity from requiring an employee to agree to the sale, exchange, sharing, transfer or other disclosure of medical information (except to the extent required to administer the wellness program) or to waive any confidentiality protections as a condition for participating in the wellness program or receiving an incentive. Finally, the final rule clarifies that the ADA bona fide benefit plan safe harbor does not apply to wellness programs that include disability-related inquiries or medical examinations.

The new provisions of the final rule relating to the notice requirement and incentives apply to wellness programs as of the first day of the first plan year beginning on or after January 1, 2017. According to the EEOC, the remaining provisions of the final rule, which simply clarify existing requirements, apply now.

B. Genetic Information Nondiscrimination Act of 2008 Final Rule

On the same day the ADA final rule on wellness programs was issued, the EEOC issued a final rule amending the regulations implementing Title II of the Genetic Nondiscrimination Act of 2008 ("GINA") as they relate to employer wellness programs.[79] Title II of GINA includes an absolute prohibition on the use of genetic information in making employment decisions and restricts employers and other covered entities from requesting, requiring or purchasing genetic information.

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. The final rule generally defines "reasonably designed" in the same manner as the ADA wellness program final rule discussed above. A covered entity is also prohibited from conditioning participation in a wellness program on an employee, spouse or other covered dependent agreeing to the sale, exchange, transfer or other distribution of genetic information or waiving protections provided under GINA.

Employers are permitted to collect genetic information as part of a voluntary wellness program as long as the wellness program does not condition inducements for employees on the provision of genetic information. The final rule clarifies that GINA does not prohibit employers from offering limited inducements to employees for the 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 the same requirements that would apply to the employee (including certain authorization requirements) also apply to the spouse and any information obtained is not used to discriminate against the employee. While the final rule permits employers to provide inducements in exchange for information about a spouse's health status, it does not permit an employer to provide inducements in exchange for genetic information about a spouse or genetic or health information about an employee's children. However, an employer is permitted to allow children to participate in a wellness program as long as they do not offer inducements in exchange for health information about the child.

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[79] 80 Fed. Reg. 66,853 (Oct. 30, 2015).

The final rule also restricts the maximum inducement for participation in a wellness program to 30% of the total cost of employee-only coverage. The incentive generally will be calculated using the same methods that are used under the ADA wellness program final rules discussed above. If both an employee and spouse are eligible to participate in the wellness program, then they may each receive an inducement up to the maximum permissible amount. Accordingly, the total amount that may be received by both an employee and a spouse equals two times the 30% of employee-only coverage limit.

The new provisions of the final rule relating to incentives apply to wellness programs as of the first day of the first plan year beginning on or after January 1, 2017.

V. Litigation

A. Challenges to Church Plan Status

Over 30 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. The allegations in these lawsuits are substantially the same: plaintiffs in each lawsuit claim, among other things, that (1) the defined benefit plans maintained by the respective defendant health care systems do not comply with ERISA and have engaged in prohibited transactions; (2) 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) the plans are underfunded. Almost all of the lawsuits also allege that the ERISA church plan exemption 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 the plaintiffs' argument, plans established by 501(c)(3) organizations that are controlled by or associated with a church cannot qualify as church plans.

The Third,[80] Seventh,[81] and Ninth[82] Circuit Courts of Appeals have all ruled in favor of the plaintiffs and held that the defined benefit plans maintained by the respective health care systems were not church plans. In *Medina vs. Catholic Health Initiatives*,[83] the trial court rules in favor of the defendant health care system, and that case is now on appeal to the Tenth Circuit Court of Appeals. St. Peter's Healthcare System, Advocate Health Care Network and Dignity Health have all filed petitions for writs of certiorari with the U.S. Supreme Court, asking the Court to determine whether their pension plans are "church plans" under ERISA. The certiorari petitions will be considered by the U.S. Supreme Court in late November. The Church Alliance joined GuideStone Financial Resources and the Pension Boards, United Church of Christ, Inc. in filing amicus briefs in the *Rollins* and *Medina* cases. The Church Alliance also filed an amicus

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[80] *Kaplan v. St. Peter's Healthcare System*, 2015 WL 9487719 (Dec. 29, 2015).

[81] *Stapleton v. Advocate Health Care Network*, 817 F.3d 517 (Mar. 17, 2016).

[82] *Rollins v. Dignity Health*, 2016 WL 3997259 (July 26, 2016).

[83] *Medina v. Catholic Health Initiatives*, 2014 WL 3408690 (July 9, 2014).

brief in support of the certiorari petitions filed with the U.S. Supreme Court in *Kaplan*, *Stapleton*, and *Rollins*.

B. Fee Litigation

New cases continue to be filed alleging that retirement plan sponsors and committees are breaching their ERISA fiduciary duties to the plan and plan participants by paying excessive and unreasonable fees to retirement plan recordkeepers, administrative service providers, and investment providers. Until this year, most of these cases have been filed against large, for-profit companies sponsoring 401(k) plans. In August, 2016, a number of cases were filed against college and university 403(b) plans.

Portico Benefit Services was also served with a complaint last year, alleging that it breached its fiduciary duty under Minnesota state law by charging plan participants excessive plan administration fees. The district court for the Fourth District of Minnesota dismissed the case due to a lack of subject matter jurisdiction. The plaintiffs appealed this decision, and the Minnesota Court of Appeals reversed the trial court's decision, determining that subject matter jurisdiction is present. Portico appealed to the Minnesota Supreme Court, and the Church Alliance filed an *amicus curiae* brief in support of Portico's appeal. Unfortunately, the Minnesota Supreme Court did not accept the appeal. We understand that Portico is considering filing a petition for certiorari with the U.S. Supreme Court, asking the Court to decide the subject matter jurisdiction issue.

C. Housing Allowance Litigation Update

In *Freedom From Religion Foundation v. Lew*,[84] the Freedom from Religion Foundation ("Foundation") challenged (on Constitutional grounds) the exclusion of housing allowance from the gross income of a minister. The trial court decided that the Foundation had standing to sue because the individual co-presidents of the Foundation (also plaintiffs in the case) were excluded from an income tax exemption granted to others. The court then held that the housing allowance for ministers violated the Establishment Clause of the First Amendment of the United States Constitution, reasoning that the exemption provided a benefit only to religious persons, and that the exception was not necessary to alleviate a special burden on religious exercise.

The federal government appealed the trial court's decision to the Court of Appeals for the Seventh Circuit. On April 9, 2014, the Church Alliance filed an *amicus curiae* brief in support of the government's position on appeal. On November 13, 2014, the Seventh Circuit vacated the District Court's decision in this case[85] and remanded it back to the lower court with instructions to dismiss the complaint for lack of standing. However, the Seventh Circuit provided a roadmap for how the Foundation and its co-presidents could have standing to pursue their claim. The Seventh Circuit's opinion indicated that, if the Foundation's employees to whom housing

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[84] 983 F. Supp. 2d 1051 (W.D. Wis. 2013). The Freedom From Religion Foundation had filed an identical lawsuit in California prior to filing the complaint in this action.

[85] 773 F.3d 815 (7th Cir. 2014).

allowance was granted filed a tax return claiming that their housing allowance was excludible from income taxation, and the IRS denied the claimed exclusion, these employees would then have standing to pursue their claim that Code section 107 is unconstitutional.

The Foundation followed the guidance offered by the Seventh Circuit on the standing issue, and on April 6, 2016, filed another complaint[86] in the Western District of Wisconsin. The government conceded that the plaintiffs now have standing to pursue the claim that Code section 107 is unconstitutional in the case of a housing allowance exclusion, but argued that the plaintiffs did not have standing to pursue a claim of unconstitutionality with respect to "in kind" housing provided to clergy.

This case is before the same judge, Judge Barbara Crabb, who held that Code section 107 was unconstitutional in 2013, before the Seventh Circuit vacated her decision. On October 24, 2016, Judge Crabb dismissed for lack of standing the portion of the Foundation's complaint that Code section 107(1) housing (the in-kind housing exclusion) is unconstitutional, but granted standing with respect to clergy housing allowance excludable under Code section 107(2). The case will now move forward at the trial court level on the substantive issue of whether the housing allowance provision of Code section 107(2) is constitutional.

VI. Other

A. SEC Comment Letter on Incentive-Based Compensation Arrangements

Section 956 of the Dodd-Frank Act requires that the banking regulators, the U. S. Securities and Exchange Commission and other regulatory agencies, prohibit certain incentive-based compensation arrangements that they determine encourage too much risk-taking by a covered financial institution, including investment advisers as defined in Section 202(a)(11) of the Investment Advisers Act of 1940. The Church Alliance was concerned that entities typically exempt from the investment adviser definition like church plans – could end up being subject to Section 956 of the Dodd-Frank Act.

The financial regulators issued proposed regulations[87] under Section 956 of the Dodd-Frank Act on May 6, 2016. The proposed regulations apply to advisers who hold average total consolidated assets of at least $1 billion, not including any non-proprietary assets, but did not specifically exempt advisors to church plans who are exempted from the obligation to register as investment advisers pursuant to Section 203(b)(5) of the Investment Advisers Act of 1940. Compensation that tax-exempt organizations can pay to their employees and other service providers is of course already restricted by the requirements imposed on Code section 501(c)(3) organizations. The Church Alliance decided to submit a comment letter urging an express exemption for church plans in the final rule. The letter was submitted on July 22, 2016 to the Securities and Exchange Commission, and a copy of the letter is attached as Appendix E.

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[86] *Gaylor v. Lew*, 3:16-cv-00215 (W.D. Wis. 2016).

[87] 81 Fed. Reg. 37,670 (June 10, 2016).

B. Corporate Integration Proposal

Senator Orrin Hatch (R-Utah), Chair of the Senate Finance Committee, is expected to introduce proposed legislation that would eliminate or reduce additional taxes on corporate equity investments that arise because corporate income is generally taxed both at the corporate level and as dividends at the individual level. The Hatch proposal would tax shareholders on dividends paid at a 35% rate, while corporations would be given a dividends-paid deduction against their corporate income. This corporate integration plan is troubling to many tax-exempt entities, foreign shareholders and retirement plans because it would cause them to pay taxes on income that is now exempt from tax. In the case of retirement plans, these dividends would be taxed again when participants make withdrawals from their retirement plans. At Senate Finance Committee hearings in May, 2016, Senator Hatch heard from retirement plans and tax-exempt entities about their concerns. A Finance Committee staff member has stated that many of these concerns have been addressed in the pending draft bill, which has not yet been released to the public.

C. DOL Updates Employer's Guide to the Family and Medical Leave Act

In May, 2016, the DOL published an updated "Employer's Guide to the Family and Medical Leave Act (FMLA)." The guide contains helpful information for employers to use when administering common FMLA situations. The updated guide can be found on the DOL website.[88] The DOL also published an updated FMLA notice that informs employees of their rights under the FMLA. Covered employers must post this notice in a place where employees and job applicants can see it.[89]

D. HSA Limits for 2017

The IRS has announced the maximum contribution levels for health savings accounts (HSAs) and out-of-pocket spending limits for high deductible health plans ("HDHPs") that must be used in conjunction with HSAs for 2017.[90] The relevant amounts for 2017 are as follows:

Annual HSA contribution limit	**$3,400**– individual coverage (*$50 increase*) **$6,750**–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 (*no change*) **$13,100** – family coverage (*no change*)
HDHP minimum deductible	**$1,300** – individual coverage (*no change*) **$2,600** – family coverage (*no change*)

[88] https://www.dol.gov/whd/fmla/employerguide.pdf.

[89] https://www.dol.gov/whd/regs/compliance/posters/fmlaen.pdf

[90] Rev. Proc. 2016-28, 2016-20 I.R.B. 852.

E. Social Security Cost of Living Adjustments

On October 18, 2016, the Social Security Administration announced the cost of living adjustments for 2017. The cost of living adjustments for 2017 are as follows:

Increase in monthly benefits	0.3%
Maximum earnings subject to Social Security taxes	$127,200 (*$8,700 increase*)
Maximum earnings subject to Medicare taxes	Unlimited
Exempted earnings amount:[91] • 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.) • In year during which retiree reaches full retirement age (Note: This applies to persons turning 67 in 2017.)	 $16,920 *($1,200 increase)* $44,880 *($3,000 increase)*

[91] 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.

CHURCH ALLIANCE

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August 3, 2016

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Dear Mr. Neis and Mr. Tackney:

We are writing in regard to the Church Plan Clarification Act, which was enacted at the end of 2015 (Section 336 of Division P of the Consolidated Appropriations Act, 2016; Pub. L. No. 114-113; the "CPCA"). The CPCA addresses a number of urgent issues facing church retirement plans. After several years of advocating for the CPCA, members of the church benefits community are eager to move forward expeditiously under this new legislation.

The Church Alliance is a coalition of the chief executive officers of 37 church benefit boards, covering mainline and evangelical Protestant denominations, two branches of Judaism, and Catholic schools and institutions. Our member benefit programs provide retirement and health benefits to more than 1 million clergy, lay workers, and their family members. These church benefit boards, and the individuals covered by their programs, are directly impacted by the CPCA. The Church Alliance and its members have a keen interest in the timely implementation of the CPCA to help our member benefit programs continue to meet the needs of their beneficiaries.

As the Department of the Treasury ("Treasury") and Internal Revenue Service ("IRS") consider the implementation of the CPCA, the issuance of a notice or other similar guidance could be helpful as church

benefit programs seek to move forward under the new law. If the Treasury and IRS pursue such guidance, we respectfully request consideration of the following points:

I. Application of Controlled Group Rules to Church Plans – In General

As background, subject to certain exceptions, new Internal Revenue Code ("IRC") section 414(c)(2)(A) provides that an organization that is otherwise eligible to participate in a church plan shall not be aggregated with another organization unless (1) one such organization provides (directly or indirectly) at least 80 percent of the operating funds for the other organization during the preceding taxable year of the recipient organization, and (2) there is a degree of common management or supervision between the organizations so that the organization providing the operating funds is directly involved in the day-to-day operations of the other organization. For a nonqualified church-controlled organization ("non-QCCO"), IRC section 414(c)(2)(B) requires aggregation with other non-QCCOs or organizations that are not tax-exempt if at least 80 percent of the directors or trustees of such other organization or organizations are either representatives of, or directly or indirectly controlled by, the first non-QCCO.

We suggest that, for purposes of the rules described in IRC sections 414(c)(2)(A) and (B), the presence of the requisite common management or supervision (IRC section 414(c)(2)(A)) or direct or indirect control (IRC section 414(c)(2)(B)) should be determined based upon objective indications of *actual* participation in the management, supervision, or control of an organization. The mere *right* to participate in an organization's management, supervision, or control should not be sufficient for purposes of the aggregation rules provided by these sections. As an illustration, if the governing documents of an organization (the "first organization") that is otherwise eligible to participate in a church plan grants another organization (the "second organization") a right to appoint a member to the first organization's governing board, and the second organization provides at least 80 percent of the operating funds of the first organization, the two organizations will not be aggregated under the rule provided in IRC section 414(c)(2)(A) unless the second organization actually appoints an individual to serve on the first organization's governing board, and that individual does in fact participate in board meetings and other proceedings so as to influence the management and supervision of the first organization. If the second organization does not exercise its right to appoint a representative, the aggregation rule would not apply.

II. Application of Controlled Group Rules to Church Plans – Notice of Revocation of Permissive Aggregation/Disaggregation Election

For purposes of providing notice to the Treasury Secretary of a revocation of an election to permissively aggregate under new IRC section 414(c)(2)(C) or to permissively disaggregate

under new IRC section 414(c)(2)(D), we request that any guidance set forth the appropriate procedure for submitting such a notice.

As background, IRC section 414(c)(2)(C) provides that a church or convention or association of churches (or its designee) may elect to treat church-related organizations that are eligible to participate in a church plan as a single employer. IRC section 414(c)(2)(D) provides that an employer may elect to treat churches and entities that are not churches as separate employers. Both elections, once made, apply to all succeeding plan years unless revoked with notice provided to the Treasury Secretary.

We suggest that guidance clarify that such an election may be made in any reasonable manner, such as by executing a corporate resolution. Further, we suggest that guidance indicate that the revocation of such an election may be made by submitting a notice to that effect to the Treasury Secretary by mail to a designated physical address or by email to a designated email address. Such notice should include the date such revocation is intended to take effect.

To ensure that the filing of a revocation of election under IRC section 414(c)(2) is as efficient and easy to administer as possible, we suggest that the guidance not require any further notice of revocation beyond the notice to the Treasury Secretary.

III. Application of Contribution and Funding Limitations to 403(b) Grandfathered Defined Benefit Plans

As background, subsection (b) of the CPCA amends the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) ("TEFRA") to provide that defined benefit plans established under IRC section 403(b) are subject to the limitation on benefits applicable to defined benefit plans.[1] Previously under TEFRA, certain defined benefit arrangements established by church-related organizations and in effect on September 3, 1982 were subject to both the limitation on benefits applicable to defined benefit plans and the limitation on contributions applicable to defined contribution plans.[2] The amendment made by subsection (b) of the CPCA applies retroactively to IRC section 403(b) defined benefit plans established and in existence as of the date of enactment of the CPCA.

We request that, in the future, Treasury and IRS update the regulations under IRC section 415 and any other affected regulations or other guidance to reflect the amendment made by subsection (b) of the CPCA. In the meantime, we suggest that any guidance on the CPCA clarify that taxpayers should disregard any provision of the regulations under IRC section 415, or other regulations or guidance that indicates that IRC section 403(b) defined benefit plans are subject to the limitation on contributions applicable to defined contribution plans.

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[1] For the limitation on benefits applicable to defined benefit plans, *see* Treas. Reg. secs. 1.403(b)-10(f) and 1.415-1(b)(2) and (3).

[2] *See* Sec. 251(e)(5) of Pub. L. No. 97-248.

IV. Automatic Enrollment by Church Plans

Subsection (c) of the CPCA authorizes church plans to offer automatic enrollment to their beneficiaries, by preempting State law to the contrary. The CPCA auto-enrollment provision is largely based on the auto-enrollment provision for ERISA plans added by the Pension Protection Act of 2006 (Pub. L. No. 109-280; the "PPA"). Following the enactment of the PPA, the Department of Labor, Treasury, and IRS promulgated a significant amount of guidance on the auto-enrollment provision, particularly with respect to notice and default investment requirements. Because the CPCA auto-enrollment provision is modeled on the corresponding PPA provision, church plans would benefit from sub-regulatory guidance to bridge the gaps and resolve important implementation issues with respect to the legislation. Consequently, we suggest that any guidance permit church plans offering auto-enrollment to apply existing auto-enrollment guidance to their arrangements on a reasonable, good faith basis.

To further parallel the options available to benefit plans under the PPA, we suggest that guidance clarify that a church plan that offers an automatic contribution arrangement ("ACA") which satisfies the requirements of IRC section 414(w)(3) may elect to treat such ACA as an eligible automatic contribution arrangement ("EACA") under the rules that currently apply to ERISA plans – provided, however, that an electing church plan (under IRC section 410(d)) must comply with the regulations that are generally applicable to EACAs. In particular, the guidance should clarify that a church plan that elects to treat an ACA as an EACA may allow permissible withdrawals in accordance with section 1.414(w)-1 of the Treasury Regulations. Elective applicability of the EACA requirements and regulations will offer flexibility with respect to the number and type of notices that a church plan is obligated to provide to its beneficiaries.

In addition, we suggest that guidance indicate that a church plan that satisfies the qualified automatic contribution arrangement ("QACA") requirements of IRC Section 401(k)(13) be deemed to satisfy the automatic contribution arrangement requirements of subsection (c) of the CPCA, other than the default investment requirement of subsection (c)(4) (which must be satisfied independently under the facts and circumstances).

Lastly, we suggest that guidance indicate that any failures to satisfy the notice requirements of subsection (c)(3) of the CPCA, including failure to provide the notice on a timely basis, will not result in a loss of preemption provided that the failure is corrected within a reasonable amount of time after discovery.

V. Certain Plan Transfers and Mergers

Subsection (d) of the CPCA creates new IRC section 414(z), which allows for certain plan transfers and mergers. We suggest that any interim guidance clarify that section 414(z) does not require the issuance of regulations under IRC section 414(z) to be effective.

Additionally, it would be helpful for guidance to specify how to determine the accrued benefit for certain mergers and transfers under section 414(z). Specifically, we recommend that, for transactions under section 414(z) involving a transfer of all or any portion of an accrued benefit from a defined benefit plan to an individual account balance plan, the amount of such accrued benefit be determined in accordance with section 1.414(l)-1(b)(9) of the Treasury regulations, which provides that the present value of an accrued benefit must be determined on the basis of reasonable actuarial assumptions. Further, we recommend that, for this purpose, plan sponsors be permitted (but not required) to adopt the present value assumptions used by the Pension Benefit Guaranty Corporation (PBGC) as of the date of the merger or spinoff, and that such PBGC assumptions are deemed to be reasonable.

VI. Investments by Church Plans in Collective Trusts

Subsection (e) of the CPCA clarifies that the assets of a church plan or an organization described in section 414(e)(3)(A) that has as its principal purpose or function the administration of a church plan may be commingled and invested in a group trust described in IRS Revenue Ruling 81-100 (as modified by IRS Revenue Rulings 2004-67, 2011-1, and 2014-24), or any subsequent revenue ruling that supersedes or modifies such revenue ruling.[3] We request that the IRS update Revenue Ruling 2011-1 to reflect these section 336(e) provisions. Further, we request that the IRS confirm that no changes to Treas. Reg. sec. 1.403(b)-9(a)(6) are necessary to permit the commingling authorized under the CPCA section 336(e) provisions. Lastly, we request that the update to Revenue Ruling 2011-1 make clear that assets that can be permissibly commingled with church plan assets (such as assets exclusively devoted to church purposes) need not be subject to the exclusive benefit requirement that was applicable to group trusts under Revenue Ruling 2011-1. As to the timing for the requested update of Revenue Ruling 2011-1, we note that many providers of group trust investment funds may not allow investments permitted by section 336(e) of the CPCA until Revenue Ruling 2011-1 is updated to reflect these changes, so we ask that Revenue Ruling 2011-1 be updated as expeditiously as possible.

[3] Section 336(e) of the CPCA also provides that assets which are otherwise permitted to be commingled for investment purposes with the assets of church plans or section 414(e)(3)(A) organization assets can also be invested in an 81-100 group trust (for example, assets that are exclusively devoted to church purposes).

* * *

Thank you for your consideration of these points as Treasury and IRS contemplate potential guidance to implement the CPCA. Please do not hesitate to contact us if you have questions or we can be helpful in any way. We are grateful for your work on these issues of significant importance to the church benefits community.

Sincerely,

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On behalf of the Church Alliance

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NON-QCCO PARTICIPATION IN 403(B)(9) PLANS
HISTORY AND BACKGROUND

I. Introduction

The Church Alliance is writing regarding the ability of certain church-associated organizations to participate in 403(b)(9) church retirement income account plans. Members of the church benefits community recently received indications from the Internal Revenue Service ("IRS") that church-associated organizations that are non-qualified church-controlled organizations ("non-QCCOs") described in section 3121(w)(3)(B) of the Internal Revenue Code of 1986, as amended ("Code"), cannot participate in 403(b)(9) plans. We learned of this issue through the 403(b) pre-approved plan program, when reviewers indicated to church 403(b)(9) pre-approved plan submitters that qualified church-controlled organizations ("QCCOs") were not going to be permitted to participate in 403(b)(9) pre-approved plans, because QCCOs could become non-QCCOs, and non-QCCOs cannot participate in 403(b)(9) plans.

This issue has raised considerable concern for the Church Alliance and the 403(b)(9) plans and programs represented through it. This position is inconsistent with the understanding and practice of the church benefits community since section 403(b)(9) was added to the Code in 1982. Consequently, this issue is of enormous significance, and we appreciate the opportunity to meet with you to address it.

II. The Church Alliance and Non-QCCO Participation in 403(b)(9) Plans

The Church Alliance is an organization composed of the chief executives or executive directors of thirty-seven church benefit boards and programs, covering mainline and evangelical Protestant denominations, two branches of Judaism, and Catholic schools and institutions. Church Alliance members provide employee benefit plans, including 403(b)(9) church retirement income account plans, to approximately one million participants (clergy and lay workers) serving over 155,000 churches, parishes, synagogues and church-associated organizations across the country.

Non-QCCOs have been participating in 403(b)(9) church retirement income account plans since section 403(b)(9) was added to the Code in 1982. Notably, the Church Alliance estimates that over

1,400 non-QCCOs currently participate in various denominational 403(b)(9) plans.

It has been long-standing practice for non-QCCOS to participate in 403(b)(9) plans, as the church benefits community has relied on statutory language that we believe clearly allows them to participate. IRS 403(b) field auditors have, to our knowledge, never raised this issue when conducting audits of non-QCCOs that participate in 403(b)(9) plans. The issue only arose recently as part of the IRS 403(b) pre-approved plan process.

III. History of Code Section 403(b)(9)

Paragraph (b)(9) was added to Code section 403(b) by section 251 of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"). Section 251 of TEFRA was intended to accomplish two primary objectives: (1) to increase amounts that may be contributed to 403(b) annuities for ministers and church lay employees and (2) to permit churches and organizations described in Code section 414(e)(3)(A)[1] to continue to provide 403(b) annuities to such ministers and lay employees. (See Church Alliance summary of TEFRA, attached as Appendix A.)

By way of background, the need for Section 251 of TEFRA arose when the IRS commenced a study on limiting providers of section 403(b) annuities to insurance companies. A ruling request filed by a member of the Church Alliance on the section 403(b) status of its plans was suspended pending the outcome of that study. Shortly thereafter, the IRS published Revenue Ruling 82-102, which held that only insurance companies and registered mutual funds were able to issue section 403(b) annuities. In response, the Church Alliance worked with members of Congress and Treasury legislative counsel to draft language that eventually became Code section 403(b)(9). The legislation was expressly intended to permit churches and section 414(e)(3)(A) organizations to continue to provide 403(b) annuities.

The legislative history of section 251 of TEFRA illustrates that the addition of section 403(b)(9) to the Code focused primarily on the type of organizations that can *provide* 403(b) annuities and not on which organizations can *participate in* a church 403(b) plan. There is no evidence in the legislative history that Congress intended to limit the types of church-associated organizations eligible to participate in 403(b)(9) plans. The Church Alliance summary of section 251 of TEFRA, noted earlier, indicates that church plans under section 414(e) could continue to cover employees of organizations exempt from tax under Section 501(a) and which are controlled by or associated with a church or convention or association of churches. However, the summary made clear that only a church or a church section 414(e)(3)(A) organization can *establish or maintain*, i.e., be a provider of, a section 403(b)(9) annuity program.

Our view of the intended scope of Code section 403(b)(9) is buttressed by the General Explanation of the Revenue Provisions of TEFRA, prepared by the staff of the Joint Committee on Taxation and attached as Appendix B. The General Explanation indicates that section 403(b)(9) was added to the Code because Congress concluded that prior law provisions relating

[1] The IRS has ruled on numerous occasions that church benefit boards and retirement plan administration committees controlled by or associated with a church or convention of association of churches are organizations described in Code section 414(e)(3)(A). References in this paper to section 414(e)(3)(A) organizations are intended to include such church benefit boards and retirement plan administration committees.

to tax-sheltered annuities often made it difficult for churches to provide ministers and lay employees adequate retirement income. Page 330 of the General Explanation indicates that, for purposes of Code section 403(b)(9), the term "church" includes a convention or association of churches, or an organization which is exempt from tax and is controlled by or associated with a church or convention or association of churches. For this purpose, the General Explanation indicates that church employees include duly ordained, commissioned, or licensed ministers and lay employees, including employees of tax-exempt organizations (whether civil law corporations or otherwise organized) that are controlled by or associated with a church. The General Explanation states on page 331 that "a church-maintained retirement income account differs from a tax-sheltered annuity only in that the account is not maintained by an insurance company." Nothing in the General Explanation indicates that non-QCCOs are a category of church-controlled or associated organizations that are not permitted to participate in a 403(b)(9) retirement income account plan. To the contrary, it expressly states that employees of tax-exempt organizations that are controlled by or associated with a church or a convention or association of churches are to be treated as church employees eligible to participate in a 403(b)(9) plan—and both QCCOs and non-QCCOs are such organizations. (See page 330 of Appendix B.) A different conclusion would be highly unusual given that the distinction between QCCOs and non-QCCOs was not drawn until 1984, two years after section 403(b)(9) was added to the Code.[2]

Section 1120 of the Tax Reform Act of 1986 (TRA '86) also indicates that non-QCCOs can participate in 403(b)(9) plans. TRA '86 amended the rules applicable to annuities qualifying for favorable tax treatment under section 403(b) of the Code to require that such annuities generally must be purchased under a plan that is nondiscriminatory within the meaning of Code section 403(b)(12).[3] The term "annuities" as used in Code section 403(b) refers to annuity contracts, custodial accounts and retirement income accounts purchased under plans eligible for favorable tax treatment under Code section 403(b). Code section 403(b)(12) applies to all 403(b) annuity plans other than those contributed to by churches or church-controlled organizations described in Code section 3121(w)(3). Thus, in the case of church 403(b) plans, the nondiscrimination requirements of section 403(b)(12) do apply to non-QCCOs—churches (i.e., houses of worship) and QCCOs are exempt from these rules. In subjecting non-QCCOs to nondiscrimination requirements, Congress did not indicate that they could not participate in a 403(b)(9) plan—only that they are subject to such requirements, no matter the type of 403(b) plan in which they participate.

Notably, the addition of the nondiscrimination requirement for non-QCCOs in TRA '86 marked the first instance of a substantive difference in the rules applicable to various church-controlled organizations. Previously, the requirements applicable to QCCOs and non-QCCOs were largely aligned. Indeed, this was the case at the time that paragraph (b)(9) was added to Code section 403(b) in the 1982 TEFRA legislation, at a point in time when the 1984 DEFRA legislation's creation of a distinction between QCCOs and non-QCCOs was still two years away. The absence of any substantive difference in the tax treatment of QCCOs and non-QCCOs prior

[2] The Deficit Reduction Act of 1984 ("DEFRA '84") added subsection 3121(w) to the Code effective as of December 31, 1983. This subsection includes the definition of a QCCO and, by negative inference, a non-QCCO.

[3] The Technical and Miscellaneous Revenue Act of 1988 ("TAMRA '88") redesignated Code section 403(b)(10), which was added by TRA '86, as Code section 403(b)(12).

to TRA ’86 supports the conclusion that Code section 403(b) was meant to apply to both kinds of church-controlled organizations in the same way.

IV. Potential Impact on Non-QCCOs

If non-QCCOs are not permitted to participate in 403(b)(9) plans, these church-related employers and their employees will be denied access to several important plan design features that are important in the 403(b)(9) church plan context and will incur additional costs associated with any transition to a new 403(b) plan:

A. Investing in Non-Registered Funds and Collective Investment Trusts. If non-QCCOs cannot participate in 403(b)(9) plans and can only participate in 403(b)(1) annuity contracts and 403(b)(7) custodial accounts, the employees of non-QCCOs will have limited investment fund options. This is because 403(b)(1) plans must be invested in state-regulated insurance contracts and 403(b)(7) custodial accounts can only be invested in registered mutual funds. However, as permitted by Code section 403(b)(9), most church 403(b)(9) plans provide non-registered investment fund options, particularly socially screened funds that reflect the social policies and faith and belief of a church or convention or association of churches. These faith-based, screened funds are a very important component of the investment options offered by church 403(b)(9) plans and are generally not available in the registered mutual fund market. Many church 403(b)(9) plans also provide collective investment fund investment options, such as stable value funds, because of the lower fees generally associated with collective investment funds; these investment vehicles are also not an available investment option for a 403(b)(1) annuity contract or a 403(b)(7) custodial account.

B. Self-Annuitization. Many church 403(b)(9) plans offer annuities as a form of distribution, and, as permitted under the regulations governing 403(b)(9) retirement income accounts, “self-annuitize” these benefits. If non-QCCOs are forced to move to 403(b)(1) annuity contracts or 403(b)(7) plans, they will no longer be able to provide their workers with annuities that are provided by the plan itself. Self-annuitization is an important feature for church plans because it allows the church to retain the assets underlying the annuity in the 403(b)(9) plan, thereby realizing economies of scale that benefit all participants. In addition, participants often pay a lower fee to obtain these annuities than they would pay if they purchased an annuity from a commercial insurance company. Self-annuitized funds can also continue to be invested consistent with the social policies, faith and belief of a particular church or church convention or association.

C. Transition Costs for Former 403(b)(9) Funds. If non-QCCOs cannot participate in 403(b)(9) plans, the process for setting up a new 403(b)(7) plan for non-QCCO employees and transferring prior accumulations from 403(b)(9) plans into new 403(b)(7) plans will be costly for affected employers (and, if the plan was established or maintained by a section 414(e)(3)(A) organization, for that organization). If prior accumulations are not required to be transferred, the employer (or section 414(e)(3)(A) organization) will be faced with the administrative burden and expense of maintaining two plans, and participants employed by non-QCCOs will be forced to deal with the

confusion of having two different plans with different investment options. Also, the section 414(e)(3)(A) organization maintaining the 403(b)(9) plan may choose not to establish a separate 403(b)(7) plan for non-QCCOs due to cost concerns. Without having the option to participate in the denomination's 403(b) plan, some non-QCCOs may choose to stop offering a retirement plan to their employees.

V. Support for Non-QCCOs Participating in 403(b)(9) Plans

A. Plain Meaning of the Statute and Regulations. As noted earlier, Code section 403(b)(9) focuses primarily on the types of organizations that can establish or maintain 403(b)(9) plans, i.e., be a *provider* of such plans. It is critical to note that this focus is different from the issue of which types of employers can *participate in* 403(b)(9) plans. On the latter issue, Section 403(b)(9) clearly states that employees of 501(c)(3) organizations can participate in a 403(b)(9) plan, and employees of non-QCCOs are included in this category of employees.[4] Section 403(b)(9)(B) states:

> "For purposes of this paragraph, the term "retirement income account" means a defined contribution program established or maintained by a church, or a convention or association of churches, including an organization described in section 414(e)(3)(A), *to provide benefits under section 403(b) for an employee described in paragraph (1) or his beneficiaries*."

Paragraph 1 of Code section 403(b)(1)(A)(i) refers to employees employed by an employer described in section 501(c)(3) which is exempt from tax under section 501(a). A church or a convention or association of churches or an organization described in Code section 414(e)(3)(A) has to establish *or* maintain the plan, but participation is not limited to just the employees of these organizations. If Congress intended non-QCCOs to be excluded from participating in 403(b)(9) plans, it could have easily said so – by instead of using the words italicized above, simply stating "*to provide benefits under § 403(b) for its employees or their beneficiaries"* – but it did not. In fact, in imposing nondiscrimination requirements on 403(b) plans in 1986, Congress specifically made such requirements applicable to non-QCCOs. Since Congress used a broad approach to establish 403(b)(9) plan participant eligibility, the plain meaning of section 403(b)(9) supports non-QCCO participation in 403(b)(9) plans.

We believe that the regulations under Code section 403(b) are inconsistent with the statute. The Church Alliance noted this inconsistency in comment letters when the 403(b) regulations were issued in both proposed and final form. (See Church Alliance comment letters, attached as Appendix C.) Treasury regulation section 1.403(b)-2(b)(15) provides that a retirement income account is "a defined contribution program established or maintained by a church-related organization to provide benefits under section 403(b) for *its* employees or their beneficiaries . . ." (emphasis supplied). The regulations go on to

[4] As a practical matter, however, not "any" 501(c)(3) employer is allowed to participate in a church 403(b)(9) plan – only those controlled by or associated with a church as defined in Code section 414(e) can participate, in order to preserve the status of the 403(b)(9) plan as a church plan.

define a "church related organization" as "a church or a convention or association of churches, including an organization described in Code section 414(e)(3)(A)". But, as pointed out above, the statute solely clarifies that only "church-related organizations" as so defined can establish or maintain a section 403(b)(9) retirement income account. It does not state church plans can be established or maintained only for their employees. As noted by the Church Alliance in its comment letters, the regulations appear to be incorrect on this point.

B. IRS Notices, Announcements, Letter Rulings and Memorandums. Several IRS memoranda, rulings and notices have discussed non-QCCO participation in 403(b)(9) plans and have not suggested that participation by non-QCCOs in 403(b)(9) plans was not permitted.

1. GCM 39793 (July 17, 1989). In this General Counsel Memorandum, a church-affiliated private university participated in a 403(b)(9) church retirement income account plan. The IRS found that the university's 403(b)(9) plan was entitled to church plan status under Code section 414(e) and did not raise an issue about the ability of the university, a non-QCCO, to participate in a 403(b)(9) church retirement income account plan.

2. PLR 200816031. The IRS ruled that a retirement plan adopted by a corporation primarily for employees of individual church congregations, as well as those who serve in other supporting organizations and share common religious beliefs and convictions with the church there involved, constituted a church plan under Code section 414(e) and a retirement income account under Code section 403(b)(9).

3. IRS Notice 89-23. Notice 89-23 includes references to "retirement income accounts" when describing employers sponsoring 403(b) plans subject to retirement plan nondiscrimination testing. As discussed previously, only non-QCCOs participating in a retirement income account are subject to nondiscrimination testing; thus, this Notice suggests that the IRS believed non-QCCOs can participate in 403(b)(9) plans.

4. IRS Announcement 95-33. These "employee plan examination guidelines" provided that retirement income accounts are subject to nondiscrimination testing "except those maintained by §3121(w)(3) churches," again indicating that non-QCCOs can participate in retirement income accounts.

C. The 414(e)(3)(A) Cross-Reference. The cross-reference in Code section 403(b) to section 414(e)(3)(A) organizations further supports non-QCCO participation in 403(b)(9) retirement income account plans. The purpose of the cross-reference to Code section 414(e)(3)(A) is to identify the types of organizations, beyond churches or conventions or associations of churches, that can establish or maintain retirement income account plans, i.e., be a provider of 403(b) annuities. Section 414(e)(3)(A) organizations may, pursuant to the cross-referenced Code section, maintain a church plan not only for

employees of a church or a convention or association of churches, but also for employees of an organization "*which is exempt from tax under section 501 and which is controlled by or associated with a church or a convention or association of churches*." (This statutory text includes non-QCCOs.) See Code section 414(e)(3)(B)(ii). Thus, by cross-referencing section 414(e)(3)(A) to include organizations described therein as a type of organization that can be a provider of 403(b) annuities, Congress was acknowledging that section 414(e)(3)(A) organizations may maintain church plans for non-QCCOs, if those organizations satisfy the enumerated requirements. If Congress had intended to narrow the types of organizations to which 403(b) annuities can be provided under section 403(b)(9), it could have easily added a non-QCCO exclusion when cross-referencing section 414(e)(3)(A). However, no such exclusion exists.

The IRS has issued a number of rulings over the years that make it clear that the employees of church-associated hospitals, colleges, universities, nursing homes and the like, all of which are non-QCCOs[5], can participate in a church plan because they are deemed to be church employees under the rules described in the preceding paragraph. This means that these employees are employees for whom a 414(e)(3)(A) organization can fund or administer a retirement or welfare benefit plan or program. The cross-reference to a section 414(e)(3)(A) organization in section 403(b)(9) thus must be read to mean that 403(b)(9) retirement benefits can be provided for the benefit of employees of church-controlled or associated employers, and the employees of non-QCCOs are clearly included in this category of employees—the IRS has so ruled in numerous private letter rulings over the years.

VI. Conclusion

Non-QCCOs have had a long history of participating in church 403(b)(9) retirement income account plans and programs, and should be permitted to continue to do so. If it is determined they can no longer participate, denominations would need to either offer multiple types of 403(b) plans to cover all types of church-associated organizations, increasing administrative burden and cost that will inevitably reduce benefits to workers who have devoted their lives to religious institutions[6]or choose not to offer other 403(b) plans, which may cause some non-QCCOs to cease offering a retirement plan to their employees. In addition, employees of non-QCCOs would lose access to important non-registered, faith-based screened investment fund options and would not have the ability to obtain "self-annuitized" annuity payments. Based on the Church Alliance's work in 1982, we believe these results are contrary to the intent of Congress when it drafted and passed Code section 403(b)(9).

[5] It is almost certain, if not certain, that these organizations are non-QCCOs because they all provide goods, services or facilities to the general public and derive most, if not all, of their revenue from such provision.

[6] For example, a denomination that desires to sponsor a pre-approved 403(b)(9) plan could do so only for its churches, and would need to maintain a separate, non-pre-approved 403(b)(9) plan for its QCCOs, and a third type of plan, such as a 403(b)(7) plan, for its non-QCCOs.

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Retirement Income Accounts Under 403(b)(9) and Participation By Employees of Non-QCCOs

I. Introduction

This paper addresses the ability of certain church-controlled and church-associated organizations to participate in 403(b)(9) church retirement income account plans. Members of the church benefits community have been informed by the Internal Revenue Service ("IRS") that non-qualified church-controlled organizations ("non-QCCOs") described in section 3121(w)(3)(B) of the Internal Revenue Code of 1986, as amended ("Code") cannot participate in 403(b)(9) plans. On June 28, 2016, members of the Church Alliance met with staff from the IRS and a representative from the Treasury Department to discuss this issue. As indicated in that meeting, the Church Alliance learned of this issue through the 403(b) pre-approved plan program, when IRS reviewers indicated to church and secular 403(b)(9) pre-approved plan submitters that qualified church-controlled organizations ("QCCOs") would not be permitted to participate in 403(b)(9) pre-approved plans, because QCCOs could become non-QCCOs, and non-QCCOs cannot participate in 403(b)(9) plans.

This issue has raised considerable concern for the Church Alliance and the 403(b)(9) plans and programs represented through it. The position that non-QCCOs cannot participate in 403(b)(9) plans is inconsistent with the understanding and practice of the benefits community since section 403(b)(9) was added to the Code in 1982.

At the June 28 meeting, the IRS confirmed its position and asked whether the Church Alliance believes the IRS position in the final 403(b) regulations is legally supportable. This paper addresses the text and legislative history of Code section 403(b)(9) and concludes that the position in the final 403(b) regulations is not legally supportable; rather, it is in direct conflict with the statutory text and clear legislative intent of Code section 403(b)(9).

II. Background: Legislative History and Text of Code Section 403(b)(9)

Paragraph (b)(9) was added to Code section 403(b) by section 251 of the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248 ("TEFRA"). The need for section 251 of TEFRA arose when the IRS commenced a study on limiting providers of section 403(b) annuities to insurance companies. A ruling request filed by a member of the Church Alliance on the section 403(b) status of its plans was suspended pending the outcome of that study. Shortly thereafter, the IRS published Revenue Ruling 82-102, which held that only insurance companies and registered mutual funds could issue section 403(b) annuities. In

response, the Church Alliance worked with members of Congress and Treasury legislative counsel on language that eventually became Code section 403(b)(9).

The legislation was expressly intended to permit churches and section 414(e)(3)(A) organizations to continue to provide 403(b) annuities to employees of all types of church organizations. In testimony to a subcommittee of the Senate Finance Committee, Treasury Department Deputy Assistant Secretary of Tax Policy David G. Glickman stated that the bill "would make certain changes in the Internal Revenue Code relating to retirement arrangements under section 403(b), and to qualified plans for clergy and lay employees of churches, conventions or associations of churches, and organizations that are exempt from tax under section 501 and which are controlled by or associated with a church or convention or association of churches."[1] The Committee Report issued by the Senate Finance Committee (the "Senate Committee Report") later reiterated this intent behind Code section 403(b)(9) as follows:

> The committee also believes that the tax treatment of retirement savings provided church employees by an associated organization, such as a church pension board, should be clarified. . . . The bill revises the present-law rules relating to tax-sheltered annuity programs maintained by churches for their employees. The bill generally increases the ability of churches to provide retirement income for their employees and clarifies the status of such programs. For purposes of the bill's provisions, the term church includes a convention or association of churches, ***or an organization which is exempt from tax and is controlled by or associated with a church or convention or association of churches***[2]. ***Church employees include duly ordained, commissioned, or licensed ministers and lay employees, including employees of tax-exempt organizations (whether civil corporations or otherwise organized) which are controlled by or associated with a church.*** Senate Committee Report 97-494, page 324 (emphasis added).

Thus, Congress unequivocally expressed its intent to permit employees of all types of church organizations to participate in the newly created retirement income accounts. The Senate Finance Committee went on to explain retirement income accounts maintained by churches as follows:

> Under the bill, a retirement income account means a program established or maintained by a church to provide retirement benefits for its employees under the tax-sheltered annuity rules. Thus, a church-maintained retirement income account ***differs from a tax-sheltered annuity only in that the account is not maintained by an insurance company***. S. Report 97-494, page 325 (emphasis added).

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[1] Statement of David G. Glickman, Deputy Assistant Secretary for Tax Policy, Department of the Treasury, before the Subcommittee on Savings, Pensions and Investment Policy of the Committee on Finance, May 19, 1982.

[2] The text in bold is significant because, at the June 28 meeting, an IRS Chief Counsel attorney indicated that, if Code section 403(b)(9) contained a cross-reference to section 414(e)(3)(B)(ii), that would mean that non-QCCOs can participate in 403(b)(9) plans. The language in bold is identical to the language contained in Code section 414(e)(3)(B)(ii). (Code section 414(e)(3)(B)(ii) describes employers whose employees are deemed to be treated as employees of a church for purposes of determining whether a particular employer's employee benefit plans are church plans.)

Thus, it was the clear intent of Congress to allow certain church organizations, similar to insurance companies, to provide retirement benefits through an account that would be treated as a tax-sheltered annuity. As stated above by the Senate Finance Committee, **no other change to the 403(b) rules was intended**.[3]

These goals of Congress are reflected in the text of Code section 403(b)(9), which addresses two issues: (a) the treatment of contributions to a retirement income account (in paragraph (9)(A)); and (b) defining the new term "retirement income account", including describing which organizations may establish or maintain a retirement income account and the employees for whom benefits may be provided (in paragraph (9)(B)).

A. Treatment of Contributions to a Retirement Income Account

Congress provided that contributions to a retirement income account shall be treated as an annuity contract, and "***amounts paid by an employer described in paragraph (1)(A) to a retirement income account*** shall be treated as amounts contributed by the employer for an annuity contract for the employee on whose behalf such account is maintained." Code section 403(b)(9)(A) (emphasis added). Note the similarity to Code section 403(b)(7), which provides that "***amounts paid by an employer described in paragraph (1)(A) to a custodial account*** . . . shall be treated as amounts contributed by him for an annuity contract for his employee . . . ." Since both section 403(b)(7)(A) and section 403(b)(9)(A) reference "an employer described in paragraph (1)(A)" as the type of employer that may make payments that are to be treated as contributions to an annuity contract, both subsections must be describing the same type of employer, which includes "an employer described in section 501(c)(3)". Utilizing the same wording used in section 403(b)(7) is consistent with the Senate Finance Committee's statement that no other change to the 403(b) rules was intended.

B. What Constitutes a Retirement Income Account

Paragraph (9)(B) defines a retirement income account as a program established or maintained by "a church, or a convention or association of churches, including an organization described in section 414(e)(3)(A) . . . ." The purpose of establishing such retirement income accounts is to "provide benefits under section 403(b)" for certain employees. Thus, this language in the statute focuses on the types of organizations that may establish or maintain a retirement income account, i.e., be a ***provider*** of such a program to eligible church employees.

Paragraph (9)(B) goes on to address the types of employees for whom retirement income accounts may provide benefits. The text indicates that a retirement income account may be provided to "an employee described in paragraph (1) or his beneficiaries." Paragraph (1) of Code section 403(b), in subparagraph (A), refers to a broad range of employees, including those employed by "an employer described in section 501(c)(3), which is exempt from tax under section 501(a)." This description clearly includes the broad range of church employees described

[3] The Senate Committee Report is especially relevant to determining the proper scope to be given Code section 403(b)(9) because the House-passed version of TEFRA did not include a similar provision. The Conference Committee agreed to add the Senate 403(b)(9) provision to TEFRA when the bill was eventually passed by both chambers. See Conference Committee Report 97-760, page 636.

above in the Senate Committee Report. While this reference might be seen as overly broad, as a practical matter, not "any" 501(c)(3) employer is allowed to participate in a church 403(b)(9) plan; only those controlled by or associated with a church as defined in Code section 414(e) can participate, in order to preserve the status of the 403(b)(9) plan as a church plan.

III. Final Section 403(b) Regulations Conflict with Text of the Statute and Congressional Intent

The final 403(b) regulations indicate that a retirement income account under Code section 403(b)(9) is "for employees of a church-related organization (as defined in §1.403(b)-2)." "Church-related organization" is defined narrowly as "a church or a convention or association of churches, including an organization described in section 414(e)(3)(A)." Treas. Reg. § 1.403(b)-2(b)(6). "Church" is defined in turn as a "church as defined in section 3121(w)(3)(A) and a qualified church-controlled organization as defined in section 3121(w)(3)(B)." Treas. Reg. § 1.403(b)-2(b)(5). These narrow definitions omit employees of some church organizations (non-QCCOs), **excluding some of the very employees that the Senate Committee Report stated should be treated as church employees and eligible to participate in retirement income accounts.** Nowhere is such an exclusion found in the text of the statute or the legislative history.

If Congress had intended for retirement income accounts to benefit only employees of a narrower group of church organizations, it easily could have made that intention clear in the statute and legislative history. In fact, four years after TEFRA, when the Tax Reform Act of 1986 ("TRA '86') added the nondiscrimination requirements of paragraph (b)(12), Congress created a special, narrow definition of church and exempted that subset of church organizations from the new nondiscrimination requirements. Congress did not agree to offer that exemption to non-QCCOs, so those organizations were left out of the definition. Specifically, paragraph (b)(12)(B) specifies that "[f]or purposes of paragraph (1)(D)[the exemption from the nondiscrimination requirements], the term "church" has the meaning given to such term by section 3121(w)(3)(A). Such term shall include any qualified church-controlled organization (as defined in section 3121(w)(3)(B))." Congress could have easily created similar limiting language in paragraph (b)(9) had its intent been to limit participation in retirement income accounts to a narrower group of church employees.

Interestingly, the final 403(b) regulations' narrow definition of "church" appears to be modeled after the special, narrow definition of church that was created by TRA '86 to limit the scope of the nondiscrimination exemption. However, instead of applying this special, narrow definition only to the nondiscrimination requirements, as Congress intended,[4] the final 403(b) regulations apply this narrow definition of church to ***all*** of section 403(b)[5] – including paragraph (b)(9), which was enacted four years before paragraph (b)(12), and two years before the QCCO/non-QCCO distinction even existed.[6] By adopting this special, narrow definition of

[4] Code section 403(b)(12)(B) clearly states that the special, narrow definition of church applies only "[f]or purposes of paragraph (1)(D)", i.e., the nondiscrimination exemption. The Conference Report to TRA '86 indicates the same – that the narrow definition of church in paragraph (b)(12)(B) applies only "for purposes of this exclusion", i.e., the exemption from the nondiscrimination requirements. Conference Report 99-841, Vol. II., page 418.

[5] See Treasury Regulations §1.403(b)-2(a).

[6] The Deficit Reduction Act of 1984, P.L. 98-369 ("DEFRA '84") added subsection 3121(w) to the Code effective as of December 31, 1983. This subsection includes the definition of a QCCO and, by negative inference, a non-

church, which was created specifically for the nondiscrimination exemption, and applying it to all of section 403(b), the final 403(b) regulations are usurping the Congressional intent behind TEFRA. The Senate Committee Report's description of the types of employees who were intended to benefit from retirement income accounts ("employees of tax-exempt organizations (whether civil corporations or otherwise organized) which are controlled by or associated with a church") includes both employees of QCCOs and employees of non-QCCOs—there is nothing in the statute nor the legislative history that gives the IRS the authority to adopt an unrelated, narrow definition of church that continues retirement income account eligibility for employees of QCCOs, while establishing a sunset for the eligibility of employees of non-QCCOs.

Nowhere in the final 403(b) regulations, including the preamble, is there an explanation as to why the final regulations limit participation in retirement income accounts to a much narrower group of church employees than provided under the statute. This inconsistency was noticed by the Church Alliance when the regulations were proposed and finalized, and comment letters were submitted to point out the inconsistency. (See Church Alliance comment letters, attached.) Despite the comment letters being submitted, this inconsistency was never addressed in the preamble to the final regulations, or in educational outreach events attended by IRS personnel following publication of the final regulations. As a result, members of the Church Alliance (and secular administrators of retirement income accounts), relying on the clear reading of the statute, either believed that the text of the final regulations was inadvertently and unintentionally incomplete by not including non-QCCOs within the regulations' definition of "church," or interpreted the regulations in a manner that was consistent with the meaning and intent of the statute as reflected in the legislative history. In other words, such members thought that retirement income accounts could be provided to employees of an organization that is exempt from tax and is controlled by or associated with a church or convention or association of churches. So the practice of providing retirement income accounts to employees of non-QCCOs continued, and continues to this day.

Today, years after the final 403(b) regulations were published, this inconsistency is resurfacing, and staff from the IRS have confirmed their view that the final regulations do not permit employees of a non-QCCO to participate in a retirement income account. This view is at odds with the statutory text and legislative history of TEFRA, is legally unsupportable and, arguably, a violation of the Administrative Procedures Act.

IV. Conclusion

Nothing in the statute nor the legislative history indicates that non-QCCOs are a category of church-controlled or associated organizations that are not permitted to participate in a 403(b)(9) retirement income account plan. To the contrary, the Senate Committee Report clearly states that employees of tax-exempt organizations that are controlled by or associated with a church or a convention or association of churches are to be treated as church employees eligible to participate in a 403(b)(9) plan—and both QCCOs and non-QCCOs are such organizations.

QCCO. Code section 3121(w) relates to coverage for Social Security purposes – not retirement plans. Congress did choose to use the QCCO/non-QCCO distinction in section 403(b), but only for the purpose of indicating which type of church employers would be subject to the section 403(b)(12) nondiscrimination rules.

(See page 324 of the Senate Committee Report.) A different conclusion is not credible given that the distinction between QCCOs and non-QCCOs did not even exist until 1984, two years after section 403(b)(9) was added to the Code. The position in the final regulations, which narrowly defines "church-related organization" to exclude non-QCCOs, is in direct conflict with the statutory text and legislative history. As such, the Church Alliance believes that the final 403(b) regulations' position that non-QCCOs are unable to participate in 403(b)(9) plans is not legally supportable. For these reasons, the Church Alliance respectfully requests that this part of the final regulations be set aside and re-proposed or amended to accurately reflect the statutory text and legislative intent.

CHURCH ALLIANCE
Acting on Behalf of Church Benefits Programs

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September 20, 2016

BY ELECTRONIC DELIVERY

Centers for Medicare & Medicaid Services
Department of Health and Human Resources
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CMS – 9931 – NC: Request for Information

Dear Sir or Madam:

The Church Alliance submits this comment letter in response to a request for information ("RFI") on coverage for contraceptive services. The RFI was issued jointly by the Department of the Treasury, the Department of Labor and the Department of Health and Human Services ("HHS") (together, the "Departments") and published at 81 Fed. Reg. 47741 (July 22, 2016).

The Church Alliance has commented four times previously on the topic of the contraceptive services mandate (the "Mandate") under the Affordable Care Act (ACA):

- on September 28, 2011, on the interim final rules published at 76 Fed. Reg. 46621 (Aug. 3, 2011);
- on June 21, 2012, on the advance notice of proposed rulemaking published at 77 Fed. Reg. 16501 (Mar. 21, 2012);
- on April 8, 2013 on the notice of proposed rulemaking published at 78 Fed. Reg. 84566 (Feb. 6, 2013); and
- on October 27, 2014 on the notice of proposed rulemaking published at 79 Fed. Reg. 51092 (Aug. 27, 2014).

Copies of these earlier comments are available at http://church-alliance.org/initiatives/comment-letters (last visited September 6, 2016).

Executive Summary

The Church Alliance recognizes the Departments' efforts to respond to the needs of the community of church-affiliated employers through two

means of "accommodating" eligible organizations that have a religious objection to providing some or all contraceptive services required by the Mandate. Additionally, the Church Alliance is grateful for the opportunity to respond to the RFI. As stated in the Church Alliance's prior comment letters, and for the reasons discussed in those prior letters, the Church Alliance again urges the Departments to expand the religious employer exemption from the Mandate to a broader group of church-affiliated employers that object to the Mandate, and suggests they at least expand it to all objecting employers that maintain or participate in "church plans", as defined in Internal Revenue Code ("Code") section 414(e) ("Church Plans"), through which they provide health coverage to their employees. This comment letter also comments on the procedure described in the RFI as a "Notification to Issuers without Self-Certification" ("Notification"). Finally, this letter contains other suggestions for alternatives that would be less restrictive alternatives to the current two means of "accommodating" eligible organizations.

I. BACKGROUND ON THE CHURCH ALLIANCE

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, listed on the left of this letterhead, provide employee benefit plans, including in many cases health coverage, to approximately one million participants (clergy and lay workers) serving over 155,000 churches, synagogues and affiliated organizations. These health care plans generally are Church Plans.

All of the members of the Church Alliance share the common view that a church or an employer associated with a church ("church-affiliated employer") 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 most of the health care plans associated with the members of the Church Alliance do not impose any specific restrictions on contraceptive coverage. A few programs, reflecting the religious beliefs of the churches with which they are associated, exclude coverage for all contraceptives. Other programs whose associated churches do not object to contraception but hold fundamental convictions against abortion, exclude coverage for contraceptives that are or could be abortifacients, such as the so-called "morning-after pills" or "emergency contraceptives."

II. EXPAND THE RELIGIOUS EMPLOYER EXEMPTION

The current religious employer exemption from the Mandate continues to exclude bona fide religious organizations, because the exemption continues to reference statutory exemptions set out in Code sections 6033(a)(3)(A)(i) and (iii) that were crafted for another purpose – specifically, to exempt churches, their integrated auxiliaries, conventions or associations of churches and the exclusively religious activities of a religious order from the annual Form 990 filing requirement under Code section 6033. For the reasons discussed in its prior comments, the Church Alliance again urges the Departments to expand the religious employer exemption, and suggests they extend it at least to all objecting employers that maintain or participate in Church Plans, through which they provide health coverage to their employees.

III. LESS RESTRICTIVE ALTERNATIVES TO PROVIDE CONTRACEPTIVES

The Supreme Court of the United States in *Zubik, et al. v. Burwell 136 S. Ct. 1557* (2016) stated that the parties to the case "should be afforded an opportunity to arrive at an approach going forward that accommodates petitioners' religious exercise while at the same time ensuring that women covered by petitioners' health plans 'receive full and equal health coverage, including contraceptive coverage.'" *Id.* at 1560. In the RFI, the Departments specifically asked about an alternative described by the Supreme Court in *Zubik*, which is an alternative:

> "in which [objecting employers] would contract to provide health insurance for their employees, and in the course of obtaining such insurance, inform their insurance company that they do not want their health plan to include contraceptive coverage of the type to which they object on religious grounds. [The employers] would have no legal obligation to provide such contraceptive coverage, would not pay for such coverage, and would not be required to submit any separate notice to their insurer, to the Federal government or to their employees. At the same time, [the employers'] insurance compan[ies] – aware that [the employers] are not providing certain contraceptive coverage on religious grounds – would separately notify [the employers'] employees that the insurance company will provide cost-free contraceptive coverage, and that such coverage is not paid for by [the employers] and is not provided through the [employers'] health plan[s]."

RFI, page 47743.

The Church Alliance agrees that the above alternative described by the Supreme Court and repeated in the RFI would be acceptable for employers that are not exempted from the Mandate as religious employers if: 1) the scope of the organizations covered by this suggested approach would be broad enough to cover a wide array of church-affiliated employers, including at least all objecting employers providing insured health coverage through Church Plans, 2) the suggested approach would truly exempt the objecting employer, simply by the employer informing its insurer of its religious objection, 3) the contraceptive coverage truly is separate and independent from the coverage provided by the employer—in other words, it does not use the plan, does not involve the issuance of plan instruments, and does not use the plan's infrastructure or information, and 4) a suitable comparable accommodation or exemption also would be created for self-insured plans.

For objecting employers that participate in self-insured plans, the Church Alliance believes acceptable alternatives would be:

- As described above, the best alternative would be an expanded exemption for church-affiliated employers, expanded at least so objecting employers providing health coverage through Church Plans would be exempted from the Mandate.

- The Church Alliance suggests that if an objecting employer's self-insured plan has one or more third party administrators ("TPAs") that could provide separate cost-free contraceptive coverage to covered employees, the objecting employer could simply inform such TPAs of the employer's objection (which could be communicated in a variety of ways, including via the employer's contract with the TPA). Again, to be acceptable this coverage would have to be truly separate from the plan.

- Objecting employers with no such TPAs should be exempted from the Mandate, and the government could, by working with other third parties (such as insurers, other TPAs, health care providers, drug manufacturers or other nonprofits), provide separate contraceptive coverage to the employees of such employers.

    - Alternatively, such an objecting employer (with no TPA that could provide contraceptives) could inform HHS of its objection, with no further information being required from the objecting employer, and HHS then could work with third parties to offer such contraceptive services separately to the objecting employer's employees. With the information obtained from Internal Revenue Service (IRS) Forms 1095-B, 1095-C or W-2, HHS would be able to determine necessary information about the employees of such an employer, and offer such contraceptive coverage separately to such employees, at no cost to the objecting employer. Furthermore, because virtually everyone accessing prescription contraceptives will need to work with a doctor and pharmacy, the government could work with doctors and pharmacists to provide coverage "seamlessly" to women who want it.

The RFI specifically asked whether objecting organizations would have any objection to informing their issuers that they object to providing contraceptive coverage "on religious grounds". The Church Alliance states that it does not object to a requirement that such organizations that are not exempted from the Mandate as religious employers must inform their insurers (or TPAs, as applicable) that they object to providing contraceptive coverage "on religious grounds". Furthermore, the Church Alliance has no objection to a requirement that such a request be made in writing. However, the Church Alliance is concerned about (and some of its members object to) the requirement that the request be made via a particular form or in any way that the government will treat as allowing use of the health plan for purposes that violate the employer's religious beliefs, or otherwise creating new plan instruments to alter the plan. Furthermore, some objecting employers or administrators of self-insured plans of objecting employers may have already communicated such objections to their TPAs via contracts, formularies, set-up forms or otherwise, so a requirement that such a request be made via a particular form could cause uncertainty and possible penalties for such employers, with no added benefit to the Departments from the use of a particular form.

Importantly, the Church Alliance urges that an objecting employer that is not exempted as a religious employer and that participates in a multiple-employer Church Plan be exempted from the Mandate if either such employer, or another entity in the Church Plan (on behalf of such employer), communicates a religious objection to such employer's insurer or TPA. For example, churches that sponsor Church Plans or church-related administrators of such plans

providing health coverage should be allowed to inform an insurance company or TPA of an objection on behalf of many objecting employers, based on the religious beliefs of the church. It would create unnecessary paperwork and confusion, and may cause possible penalties for small employers with volunteer treasurers, if each such an objecting employer in a multiple-employer Church Plan would be required to separately inform the insurance company or TPA of its religious objection. Therefore, the Church Alliance strongly urges that a religious objection be allowed to be provided by another entity on behalf of an objecting employer in a multiple-employer Church Plan. In addition, the Church Alliance urges that such an objecting employer not be required to specifically grant written authority to the plan sponsor or plan administrator to object on its behalf, especially with a multiple-employer Church Plan, due to the added administrative burden this would impose on many small employers.

The Government could provide free contraceptive coverage in other ways without using eligible organizations' plans as a conduit, as the Church Alliance has suggested previously. More specifically, it could:

- provide tax incentives to consumers or producers of contraceptive products,

- "give tax incentives to contraception suppliers to provide these medications and services at no cost to consumers." *Korte*, 735 F.3d at 686; *Roman Catholic Archdiocese of N.Y.*, 987 F. Supp. 2d 232 at 255-56;

- modify the eligibility requirements for existing federal programs that provide health care subsidies on a massive scale, such as the Title X family planning program and the Medicaid program, or any number of other federal programs that already provide cost-free contraceptives to women; or

- permit employees of objecting church-affiliated employers to purchase fully subsidized coverage (either for contraceptives alone, or full plans) on the state and federal exchanges established under the ACA.

To the extent these alternatives require a funding source, the government could use credits against Exchange user fees (which it is already using for the existing "accommodation") or credits against the Health Insurance Providers Fee. Using these sources to fund benefits on the Exchanges would actually be far simpler than the current approach of using them as tradeable credits for entities that are not on the Exchanges at all. There are no doubt other alternatives. While some eligible organizations may oppose some of these alternatives on policy grounds, all of them are "less restrictive" than the existing "accommodation" because they would deliver free contraception without forcing eligible organizations to violate their beliefs. Moreover, these alternatives are eminently workable because, as noted above, the Government's objectives could be achieved through minor regulatory tweaks to existing programs.[1] Even if a new regulatory program were necessary, the Government can hardly object, as it has shown its willingness to create (and repeatedly modify) such programs – by, among other things, establishing the

[1] This remains true even if legislative action would be necessary. *McCutcheon v. FEC*, 134 S. Ct. 1434, 1458 (2014) (describing less restrictive alternatives requiring congressional action).

infrastructure by which TPAs are compensated under the accommodation. 45 C.F.R. section 156.50; *Hobby Lobby*, 134 S. Ct. at 2781 (stating that "nothing in RFRA" suggests that a less restrictive means cannot involve the creation of a new program).

IV. CONCLUSION

As stated in the Church Alliance's prior letters, we suggest that the Departments expand the types of church-affiliated employers exempted from the Mandate, at least to exempt any objecting employer that provides health coverage through a Church Plan.

If the Departments will not expand the exemption, the Church Alliance respectfully requests that the Departments at least adjust the Notification described in the RFI in the following ways:

- Allow a wide range of objecting church-affiliated employers to inform their insurer or TPA(s) of their religious objections to the Mandate, with no further obligation on such objecting employers;

- Allow a multiple-employer Church Plan sponsor or church-affiliated administrator to inform the plan's insurer or TPA of the religious objection on behalf of all church-affiliated employers that have adopted the plan, or otherwise allow an objecting employer to communicate its objection through another entity;

- Clarify that the information provided to the insurer or TPA as to such a religious objection would serve to exempt the objecting employer from any obligation to provide contraceptive services, and any contraceptive services offered or provided would be provided through a separate policy with no connection or cost to the objecting employer; and

- Ensure that any contraceptive coverage provided in this manner be truly separate in that it not use the plan at all. This means it should not involve the issuance of new plan documents by the employer, and should not involve use of the plan or the plan's infrastructure or information.

Please contact the undersigned at 202-778-9128 if you have any questions or wish to discuss this matter further.

Sincerely,

Karishma S. Page

Partner, K&L Gates
On Behalf of the Church Alliance

CHURCH ALLIANCE
Acting on Behalf of Church Benefits Programs

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July 22, 2016

Via Electronic Filing:

Brent J. Fields
Secretary
U.S. Securities and Exchange Commission
100 F Street, NE
Washington, DC 20549

Re: Comments on Incentive-Based Compensation Arrangements; File No. S7-07-16

Dear Mr. Fields:

The Church Alliance (the "Alliance") appreciates the opportunity to comment on the proposed rules, "Incentive-based Compensation Arrangements" (the "Proposed Rules") issued by the Securities Exchange Commission (the "SEC") and other federal regulatory agencies (together the "Joint Agencies").

The Church Alliance is a coalition of the chief executive officers of 37 church benefit boards, covering mainline and evangelical Protestant denominations, two branches of Judaism, and Catholic schools and institutions. Our member benefit programs provide retirement and health benefits to more than 1 million clergy, lay workers, and their family members.

As you know, Congress, in enacting Section 956 of the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act"), directed the Joint Agencies to issue rules or guidelines to limit incentive-based compensation arrangements that could pose systemic risks or that could threaten the safety and soundness of covered financial institutions. However, we believe the Proposed Rules in certain respects impose restraints on incentive compensation arrangements that exceed the intent of Section 956 as the rules apply to advisers to church plans that are exempted from the obligation to register as investment advisers pursuant to Section 203(b)(5) of the Investment Advisers Act of 1940 ("Advisers Act") ("church plan advisers"). Importantly, church plan advisers are tax-exempt organizations under Section 501(c)(3) of the Internal Revenue Code of 1986 ("IRC") and therefore already restricted in the compensation they can pay employees and other service providers.

While we recognize that Section 956 of Dodd-Frank references investment advisers as defined in the Advisers Act, without specifically excepting those that are not obligated to register as such under Section 203(b), we do not believe that Congress intended to apply incentive compensation rules designed for banks and other large financial institutions to church plan advisers simply because they meet the technical definition of "investment adviser" in the Advisers Act. In fact, Congress specifically created the exemptions in Section 203(b) recognizing that some who meet the technical definition of "investment adviser" should not be subject to the full regulation of the Advisers Act. Accordingly, we urge the SEC to specifically carve out from the Proposed Rules those who are exempted from the obligation to register as investment advisers pursuant to Section 203(b)(5) of the Advisers Act in order to limit the impact on these entities.

As mentioned above, the IRC already restricts the amount of compensation church plan advisers can pay their employees and other service providers. The payment of unreasonable compensation by a church plan adviser to an employee or other service provider could jeopardize the adviser's tax-exempt status. The exemption under IRC Section 501(c)(3) is limited to organizations "organized and operated exclusively" for religious, educational, or charitable purposes. The exemption is further conditioned on the organization being one "no part of the net income of which inures to the benefit of any private shareholder or individual."

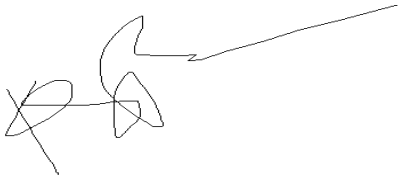
Additionally, IRC Section 4958 provides that, if any person who has or has had substantial influence over the affairs of a tax-exempt organization (a "disqualified person") engages in an "excess benefit transaction" (that is, a transaction where such a person receives disproportionate consideration for his or her activities for the organization), the officers, directors and trustees of the organization and the disqualified person are subject to substantial excise taxes.

Therefore, we further encourage the SEC to include in any final rules, or interpretive guidance, that a church plan adviser will be deemed to comply with the incentive-based compensation rules to the extent its compensation arrangements comply with applicable tax law rules regarding the compensation of persons associated with church plans.

If church plan advisers are not excluded from the scope of the rules, we encourage the SEC to provide guidance that (i) assets of the church (and church-related entities) associated with a church plan, with respect to which such church plan adviser provides investment advice, and (ii) assets of a church plan – held for the purpose of paying health, retirement and other benefits obligations to beneficiaries – will be deemed non-proprietary assets for purposes of calculating the adviser entity's average total consolidated assets under the rule. We believe that such assets would be more appropriately viewed as client assets under management, rather than adviser assets.

If you have any questions regarding any of these comments or if we can provide further information with respect to these or other regulatory issues, please do not hesitate to contact Karishma Shah Page of K&L Gates LLP at 202.778.9128. Thank you.

Very truly yours,



Karishma Shah Page
Partner, K&L Gates LLP
On Behalf of the Church Alliance