LEGISLATIVE AND REGULATORY DEVELOPMENTS IN 2017 OF INTEREST TO CHURCH-SPONSORED EMPLOYEE BENEFIT PLANS AND PROGRAMS

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I. Legislation and Legislative Initiatives

A. Church Alliance Legislative Initiatives

1. 403(b)(9) Legislation

At the request of the Church Alliance, a provision was added to the Retirement Enhancement and Savings Act of 2016 that clarifies that non-qualified church controlled organization ("non-QCCOs") can participate in church 403(b)(9) retirement income account plans.[1]

Legislation was introduced in the House and Senate in May to ensure that all church affiliated organizations have access to church 403(b)(9) retirement income account plans.[2] The Church Alliance has been actively lobbying legislators to move the 403(b)(9) provisions as a standalone bill in the House and Senate, and has been working to add cosponsors in both houses, both Democrats and Republicans, to demonstrate bipartisan support. The Church Alliance is working on a strategy for potential inclusion in tax legislation should the opportunity arise, and has been staying in close contact with its champions to ensure they are prepared for any options that might become available.

2. Harmonization

As proposals to "consolidate" or "harmonize" defined contribution plans arise on Capitol Hill, the Church Alliance has been working in concert with a group of stakeholders to educate policymakers about the disruption such proposals would cause to 403(b) plans. Senate staff has asked the various stakeholders for constructive proposals that could serve as a substitute for harmful harmonization proposals, while still being responsive to Congress members' desire to simplify the tax code. The Church Alliance, along with other coalition members, prepared a document analyzing the effects of consolidation and offering options for streamlining the rules for different types of plans.[3]

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[1] *See* section 115 of S. 3471, Retirement Enhancement and Savings Act of 2016. The non-QCCO issue is also described in more detail in part II.A.4 of this report.

[2] *See* S. 674; H.R. 2341.

[3] The coalition's document is attached as Appendix A.

3. Commodity Pool Operator ("CPO") Fix

The Dodd-Frank Act amended the Commodity Exchange Act's definition of "commodity pool operator," expanding the universe of entities that must register as such. Under Regulation 4.5(a)(4)(v), church plans are generally excluded from the "pool" definition in Regulation 4.10(d)(1). However, there is some concern that if an entity, e.g., a church benefits board, commingles plan assets with non-plan assets, then it could qualify as a "pool" if it trades in qualifying commodity interests and therefore would be required to register as a commodity pool operator. Trading in qualifying commodity interests includes investing or retaining investment managers that invest in qualifying commodity interests.

The Church Alliance continues to participate in Capitol Hill meetings with members of the informal "CPO coalition" regarding the status of the Commodity Futures Trading Commission ("CFTC") reauthorization (the potential legislative vehicle for the CPO issue described in the previous paragraph) and the CPO fix. With new commissioners and staff in place at the CFTC, the Church Alliance is assessing whether there may be a new avenue for regulatory relief on the CPO issue, and if so, will pursue meetings with key CFTC commissioners and staff.

B. Legislation

1. 21st Century Cures Act

On December 13, 2016, President Obama signed the 21st Century Cures Act (the "Act") [4] into law. Among other things, the Act expands the enforcement of the Mental Health Parity and Addiction Equity Act and, effective January 1, 2017, allows qualified small employers to offer a new type of health reimbursement arrangement ("HRA") known as a "qualified small employer health reimbursement arrangement" (or a "QSEHRA").[5]

a. Mental Health Parity Enforcement

The Act requires the Department of Health and Human Services ("HHS"), the Internal Revenue Service ("IRS") and the DOL, which are the agencies ("Agencies") in charge of enforcing compliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA") to provide additional guidance to plans on compliance with the MHPAEA and to audit plans when violations are

[4] Public Law No. 114-255.

[5] The Department of Labor ("DOL") subsequently issued frequently asked questions providing additional guidance applicable to QSEHRAs. The FAQs are available at: https://www.dol/gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-35.pdf. This guidance discusses how the QSEHRA legislation impacted earlier employer payment plan and health reimbursement arrangement guidance and explained relief available for plan years beginning on or before December 31, 2016.

discovered. Importantly, the Act requires the following with respect to the enforcement of MHPAEA compliance:

- The Act requires the Agencies to issue additional guidance to assist plans with MHPAEA compliance, including guidance on nonquantitative treatment limitations;

- The Act requires the Agencies to audit the documents of plans or health insurance issuers with five or more MHPAEA violations; and

- For plans that cover eating disorder benefits (including residential treatment), the benefits must be covered in accordance with the MHPAEA requirements.

Since the Act was passed, the Agencies have issued FAQ guidance[6] providing additional guidance on MHPAEA compliance along with a request for comments.

b. Qualified Small Employer Health Reimbursement Arrangement

QSEHRAs are not considered "group health plans" under the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010 (the "ACA"); thus, the market reform requirements will not apply to QSEHRAs. Employers eligible to offer a QSEHRA are those employers that (i) are not applicable large employers as defined under the ACA[7] and (ii) do not offer a group health plan to any of their employees. Eligible qualified small employers will be allowed to pay or reimburse employees' eligible medical care expenses (in particular, individual health insurance premiums) through a QSEHRA on a pre-tax basis.

A QSEHRA must meet the following requirements:

- The QSEHRA must be provided on the same terms to all eligible employees of the eligible employer, subject to certain exceptions.

- The QSEHRA must be funded solely by the eligible employer (no employee salary reduction contributions are allowed).

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[6] Available at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf. The FAQs discuss disclosure obligations for plans and issuers with respect to mental health and substance abuse disorder benefits.

[7] Under the ACA, an applicable large employer is an employer that employed at least 50 full-time employees, including full-time equivalent employees, on business days during the preceding calendar year.

- The QSEHRA must provide for the payment of, or reimbursement of, eligible medical care expenses (as described in section 213(d) of the Internal Revenue Code of 1986 as amended ("Code")) incurred by the eligible employee or the eligible employee's family members (including premiums for individual health coverage), but only after the employee provides proof of health coverage.[8]

- The employer must ensure that, in 2017, annual payments or reimbursements from the QSEHRA do not exceed $4,950 ($10,000 if family members are covered under the QSEHRA),[9] as adjusted (or a pro-rated amount for the number of months the individual is covered).

An eligible employer funding a QSEHRA must provide an annual written notice[10] to eligible employees not later than 90 days before the beginning of the year (or, in the case of an employee who is not eligible to participate in the QSEHRA as of the beginning of a year, the date on which the eligible employee is first eligible to participate in the QSEHRA). The Act also included transition relief under which an employer was not treated as failing to provide a notice if the notice was provided no later than 90 days after enactment of the Act (that is, by March 16, 2017). The notice must contain certain information specified in the Act. If the employer fails to provide the required written notice (unless it can be shown the failure is due to reasonable cause and not willful neglect), the employer is liable for a penalty equal to $50 per employee per incident of failure, up to a total amount of $2,500 per calendar year.

The Act also includes the following provisions applicable to QSEHRAs:

- QSEHRA coverage reduces the amount of the premium tax credit available to covered employees who are eligible for the credit.

- Employees must have minimum essential coverage for the month in which medical care is provided for QSEHRA payments to be tax-free.

- The employer must report the total amount of permitted benefits under a QSEHRA on Forms W-2.

- QSEHRAs are not subject to federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") continuation coverage requirements.

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[8] The Act does not describe the types of proof that are considered acceptable.

[9] In 2018, the limits are $5,050 for self-only coverage and $10,250 for family coverage.

[10] The written notice deadline was postponed temporarily by the IRS in Notice 2017-20 and finalized in Notice 2017-67, as discussed in Section II.A.2 of this report.

Finally, the Act extended the transitional relief provided under Treasury Notice 2015-17 to employer payment plans for plan years beginning on or before December 31, 2016. This means that the excise tax under Code section 4980D will not be imposed for any failure to satisfy the market reforms by employer payment plans of small employers during those plan years (*i.e.*, those that are not applicable large employers) that pay, or reimburse employees for, individual health policy premiums or Medicare Part B or Part D premiums. Such employers are not required to file IRS Form 8928 solely because of having such an arrangement for plan years beginning on or before December 31, 2016. Please note that this relief does not extend to stand-alone HRAs or other arrangements to reimburse employees for medical expenses other than insurance premiums and that other laws (such as the Medicare secondary payer rules) may restrict Medicare Part B or Part D reimbursements in certain cases.

2. Hurricane Relief Provisions in Disaster Tax Relief and Airport and Airway Extensions Act of 2017

On September 29, 2017, President Trump signed into law the Disaster Tax Relief and Airport and Airway Extension Act of 2017 ("Disaster Tax Relief Act"). [11] Among other provisions, the Disaster Tax Relief Act provides targeted tax relief for taxpayers impacted by Hurricanes Harvey, Irma and Maria, including provisions that:

- Provide an exception to the 10% early retirement plan withdrawal penalty for qualified hurricane distributions of $100,000 or less;

- Allow the amount of a qualified hurricane distribution required to be included in gross income for a taxable year to be included ratably over the three-taxable-year-period beginning with such taxable year;

- Allow participants to repay qualified hurricane distributions at any time during the three-year period beginning on the day after the date on which the distribution was received;

- Allow participants to re-contribute qualified eligible retirement plan distributions for home purchases cancelled due to eligible disasters; and

- Increase retirement plan loan maximums to $100,000 (instead of $50,000) and provide repayment flexibility for loans for qualified hurricane relief.

If retirement plans allow participants to take advantage of the above hurricane relief provisions, plan documents must be amended to include such provisions on or

[11] Public Law No. 115-63. The IRS also published guidance giving administrative relief for taxpayers impacted by the hurricanes – that regulatory guidance is discussed in Section II.A.5 of this report.

before the last day of the first plan year beginning on or after January 1, 2019 (December 31, 2019 for calendar year plans).

II. Regulatory Initiatives and Other Guidance

A. Internal Revenue Service

1. Hardship Withdrawal Substantiation Guidance

In a memorandum to IRS employees issued in February 2017,[12] the IRS provided guidelines for documenting and approving safe-harbor hardship withdrawals. In this guidance, the IRS confirmed that documentation supporting the financial hardship must be obtained by the employer or third-party administrator. A summary of the information in the source documents can also be obtained, if the employer or third-party administrator provides a notice to the participant that contains the following information:

- the hardship distribution is taxable and additional taxes could apply;
- the amount of the distribution cannot exceed the participant's immediate and heavy financial need;
- the hardship distribution cannot be made from earnings on elective contributions or from qualified nonelective contribution or qualified matching contribution accounts; and
- the recipient agrees to preserve source documents and to make them available at any time, upon request, to the employer or administrator.

The guidance also describes the types of information that can be used to document hardship events.

In an online article,[13] the IRS emphasizes that, if a third-party administrator handles hardship withdrawals for a plan, the plan sponsor is ultimately responsible for compliance. The article also states that plan sponsors must obtain and keep hardship withdrawal records, and that it is insufficient for participants to keep their own hardship withdrawal records unless the summary substantiation method for safe harbor hardship distributions described above is used.

[12] Available at: https://www.irs.gov/pub/foia/ig/spder/tege-04-0217-0008.pdf.
[13] Available at: https://www.irs.gov/retirement-plans/its-up-to-plan-sponsors-to-track-loans-hardship-distributions.

2. Qualified Small Employer Health Reimbursement Arrangements

On February 27, 2017, the IRS issued Notice 2017-20,[14] under which employers providing a QSEHRA to eligible employees for a year beginning in 2017 are not required to furnish the initial written notice to employees until after further guidance has been issued. The notice also states that future guidance will specify a deadline for providing the initial notice that is no earlier than 90 days following the issuance of such guidance. In addition, the notice waives the penalty for failing to provide the initial notice before the extended deadline and states that employers furnishing the notice before the future guidance is issued may rely on a reasonable good faith interpretation of the statute in determining the content of the notice.

IRS Notice 2017-67,[15] issued on October 31, 2017, provides guidance on the requirements for providing a QSEHRA, the tax consequences of the arrangement, and the requirements for providing written notice of the arrangement to eligible employees. The guidance is presented in sections corresponding to the general topics listed below.

- Eligible Employer (questions 1-7). This section addresses when an employer is, becomes, or loses its eligible employer status. The notice clarifies that, if a small employer offers a group health plan only to former employees, it is still eligible to offer a QSEHRA to its active employees. In addition, the notice states that if one employer in a controlled group of employers offers a group health plan to its employees, then no other employers in the controlled group can offer a QSEHRA to their employees.

- Eligible Employee (questions 8-11). This section of the notice discusses the definition of eligible employee for purposes of a QSEHRA, and clarifies the definitions of "part-time" and "seasonal" employees who can be excluded from QSEHRA participation. It states that QSEHRAs cannot be offered to retirees or other former employees, and that an eligible employee may not waive participation in a QSEHRA.

- Same Terms Requirement (questions 12-26). This section provides guidance on when a QSEHRA satisfies the requirement that it be provided on the same terms to all eligible employees. A QSEHRA must be operated on a uniform and consistent basis with respect to all eligible employees, but different employees provided the same permitted benefit can be reimbursed different amounts because they submitted different expenses for reimbursement. A QSEHRA can provide for reimbursement up to a single dollar amount regardless of whether an eligible employee has self-only or family coverage, and can determine the permitted benefit based on the eligible employee's family size and age on the first day of the plan year. If a QSEHRA is provided

[14] 2017-11 I.R.B. 1010.
[15] 2017-47 I.R.B. 517.

to two or more eligible employees covered under the same family health insurance policy, the QSEHRA must provide separate permitted benefits to each employee. Each employer in a controlled group must provide a QSEHRA to all eligible employees.

- Statutory Dollar Limits (questions 27-34). The indexed statutory dollar limits for 2017 are $4,950 for self-only coverage and $10,050 for family coverage. The 2018 limits are $5,050 for self-only coverage and $10,250 for family coverage. If carryover amounts are allowed, an eligible employee's carryover amount cannot be added to the newly available amount to provide a total permitted benefit that exceeds the statutory dollar limit. For newly eligible employees, the statutory dollar limits are prorated to reflect the actual number of months that an eligible employee is provided the QSEHRA. A mistaken reimbursement from a QSEHRA in excess of the statutory dollar limit may be repaid by the eligible employee with after-tax funds, as long as the repayment is made before March 15 of the year following the year in which the excess reimbursement was made.

- Written Notice Requirement (questions 35-39). This section provides guidance describing when an eligible employer is required to furnish the required annual written notice. If the employer provides a QSEHRA during 2017 or 2018, the initial written notice must be furnished to eligible employees by the later of February 18, 2018, or 90 days before the first day of the plan year of the QSEHRA.[16] The notice must be furnished to newly eligible employees on or before the first day the employee becomes eligible to participate in the QSEHRA. The written notice can be provided electronically. The guidance describes what information must be included in the written notice, including the amount of the permitted benefit, a statement that the eligible employee must inform a marketplace to which he/she is applying for advance payments of the premium tax credit of the amount of the permitted benefit under the QSEHRA, a statement that if the eligible employee does not have minimum essential coverage ("MEC") for any month, the employee may be liable for a penalty, and that any reimbursements under the QSEHRA for expenses incurred in the month will be includible in gross income.

- MEC/Proof of MEC Requirements (questions 40-43). This section describes the tax consequences to an eligible employee who mistakenly received reimbursements from a QSEHRA for a month during which the employee did not have MEC. Such amounts are included in the gross income of the employee. The guidance also describes the documentation required to prove the eligible employee has MEC for the month during which an expense was incurred before a QSEHRA can reimburse the expense. The documentation can be an insurance card or explanation of benefits from an insurance

[16] Notice 2017-67 thus extended the transition relief provided in the 21st Century Cures Act QSEHRA legislation and is the future guidance discussed in Notice 2017-20.

company, or an attestation from the employee that the individual has MEC, the date coverage began, and the provider's name.

- Substantiation Requirement (questions 44-45). This section states that the flexible spending account substantiation requirements can be used for employees to substantiate medical expenses eligible for reimbursement under the QSEHRA. If the QSEHRA mistakenly reimburses medical expenses that are not substantiated, all payments to that employee (both substantiated and unsubstantiated) on or after the date the mistaken reimbursement was made become taxable to the employee.

- Reimbursement of Medical Expenses (questions 46-56). This section discusses reimbursement issues and states that employees cannot receive taxable payments of unused permitted benefit amounts at the end of the year. A QSEHRA can reimburse policy premiums of other family members who are covered under a policy different than the policy covering the employee. A QSEHRA may make reimbursements available ratably on a month-by-month basis rather than making the full amount of the annual permitted benefit available at the beginning of the year. A QSEHRA can include a run-out period, and may reimburse expenses for over-the-counter drugs purchased without a prescription, but such reimbursements would be taxable to the eligible employee.

- Reporting Requirement (questions 57-64). This section states that the employer must report the amount of the QSEHRA payments and reimbursements the eligible employee is entitled to receive in Box 12 of Form W-2 using code FF, without regard to the amount of payments or reimbursements actually received. If the QSEHRA is a non-calendar year plan, the amount reported is prorated for the calendar year. The Notice also discusses how taxable amounts distributed from the QSEHRA are reported.

- Coordination with Premium Tax Credits (questions 65-71). A premium tax credit is not available for an individual who is offered an employer group health plan that provides MEC, is affordable and provides minimum value. This section discusses the affordability calculation and clarifies that the premium tax credit reduction for an eligible employee who is provided a QSEHRA for a coverage month is 1/12 of the employee's permitted benefit.

- Failure to Satisfy the Requirements to be a QSEHRA (questions 73-74). This section describes what causes an arrangement to fail to be a QSEHRA, including not being provided by an eligible employer, not being provided on the same terms to all eligible employees, reimbursing medical expenses without first requiring proof of MEC, or providing benefits in excess of the statutory dollar limit. If an arrangement reimburses medical expenses without full substantiation, in advance of receiving substantiation, or reimburses non-medical expenses, then the arrangement is not a QSEHRA and all amounts

paid under the arrangement are included in every employee's gross income and wages. The Notice also confirms that a QSEHRA is subject to the annual Patient-Centered Outcomes Research (PCORI) fee for years ending before September 30, 2019.

- Interaction with HSA Requirements (questions 75-78). This section discusses the interaction between QSEHRAs and HSAs, and clarifies that, if an individual is provided a QSEHRA that can reimburse any medical expense, including cost sharing, he/she fails to be eligible for an HSA. However, if the QSEHRA only reimburses premiums, he or she can still participate in a HSA.

- Effective Date (question 79). The guidance in Notice 2017-67 applies to plan years beginning on or after November 20, 2017.

3. Proposed Regulations on Qualified Nonelective Contributions and Qualified Matching Contributions

In January, the IRS issued proposed regulations[17] amending the definitions of a Qualified Nonelective Contribution ("QNEC") and a Qualified Matching Contribution ("QMAC"). The revised definitions will make it easier for affected plan sponsors to use assets from plan forfeiture accounts to fund QNECs and QMACs.

QNECs and QMACs can be used to correct certain operational failures under the Employee Plans Compliance Resolution System ("EPCRS"), to correct actual deferral percentage ("ADP") or actual contribution percentage ("ACP") testing failures and to fund employer contributions required for safe harbor 401(k) or 403(b) plans. Current regulations require QNECs and QMACs to be nonforfeitable (or fully vested) at the time they are contributed to the plan. This requirement has been interpreted as prohibiting forfeitures from being used to fund QNECs and QMACs because forfeitures would have been subject to a vesting schedule at the time they were contributed to the plan.

The proposed regulations would amend the existing regulations to require QNECs and QMACs to be fully vested at the time they are allocated to a participant's account, instead of at the time they are contributed to the plan. The amended definition will allow forfeitures to be used to fund QNECs and QMACs.

The regulations are proposed to be effective on or after the date of publication of final regulations. However, taxpayers are permitted to rely on the proposed regulations for periods prior to the publication of final regulations.

4. 403(b) Pre-Approved Plan Program and Non-QCCO Issue

The IRS issued advisory and opinion letters on pre-approved 403(b) plans on March 31, 2017. During the review of volume submitter church plan documents, the IRS

[17] 82 Fed. Reg. 5477 (Jan. 18, 2017).

informed a submitter that qualified church controlled organizations ("QCCOs") were not eligible to participate in pre-approved 403(b)(9) plans because QCCOs could become non-QCCOs, and non-QCCOs are not eligible to participate in 403(b)(9) plans.[18] 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. As mentioned above in Section I.A.1 of this report, 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, as well as in S. 674 and H.R. 2341 which are separate standalone bills. On October 23, 2017, the Church Alliance sent a letter to Congressional leadership communicating the importance and urgency of clarifying this issue.[19]

Even if there is legislative clarification that non-QCCOs can participate in 403(b)(9) plans, it is not clear that the IRS will open the pre-approved 403(b) plan program to allow participation by QCCOs and non-QCCOs in pre-approved 403(b)(9) plans. However, if the non-QCCO issue is clarified through legislation, the Church Alliance will ask the IRS to re-open the pre-approved 403(b) program so that church plan sponsors can allow QCCOs and non-QCCOs to be eligible employers in 403(b)(9) pre-approved plans.

5. Hurricane Harvey and Hurricane Irma Relief

The IRS recently issued Announcements 2017–11[20] and 2017-13[21] that allow taxpayers adversely affected by Hurricanes Harvey and Irma to more easily access retirement plan assets to alleviate hardships caused by the hurricanes. The Announcements ease verification procedures for retirement plan loans and hardship distributions and expand distributions to any hardship (including food and housing), not just the types described in Treasury regulations.

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[18] QCCOs and non-QCCOs are defined in section 3121(w)(3)(B) of the Code. A non-QCCO is any church-controlled tax-exempt organization described in Code section 501(c)(3) which (i) offers goods, services, or facilities for sale, other than on an incidental basis, to the general public, other than goods, services, or facilities which are sold at a nominal charge which is substantially less than the cost of providing such goods, services, or facilities; and (ii) normally receives more than 25 percent of its support from either governmental sources or receipts from admissions, sales of merchandise, performance of services, or furnishing of facilities, in activities which are not unrelated trades or businesses, or both. A QCCO is any church controlled tax-exempt organization that is not a non-QCCO.

[19] The Church Alliance letter is attached as Appendix B.

[20] 2017-39 I.R.B. 255.

[21] 2017-40 I.R.B. 271.

A retirement plan that provides for hardship distributions or loans may make loans or distributions for a need arising from Hurricane Harvey or Irma to:

- employees (or former employees) whose principal residence on August 23, 2017 (for Hurricane Harvey) or on September 4, 2017 (for Hurricane Irma) was in one of the counties identified for individual assistance by the Federal Emergency Management Agency ("FEMA");

- employees (or former employees) whose place of employment on August 23, 2017 (for Hurricane Harvey) or on September 4, 2017 (for Hurricane Irma) was in one of the counties identified by FEMA; or

- employees (or former employee) whose grandparents, parents, children, grandchildren, dependents or spouse had a principal place of residence or place of employment in one of these counties on August 23, 2017 (for Hurricane Harvey) or on September 4, 2017 (for Hurricane Irma).

To qualify for the relief under these Announcements, a distribution must be made because of hardship resulting from Hurricane Harvey on or after August 23, 2017, or from Hurricane Irma on or after September 4, 2017, but no later than January 31, 2018. Plan administrators may rely initially on representations from employees or former employees as to the need for and the amount of a hardship distribution, unless the plan administrator has actual knowledge to the contrary. No post-distribution contribution restrictions (i.e., ceasing employee elective deferral contributions for six months) are required. The plan administrator must make a good faith, diligent effort under the circumstances to comply with procedural requirements and, as soon as practicable, make a reasonable attempt to assemble any documentation.

Plans that do not currently provide for loans or hardship distributions may make loans or hardship distributions described in the announcements if the plans are amended to include these provisions no later than the end of the first plan year beginning after December 31, 2017 (December 31, 2018 for calendar year plans).

In general, normal hardship distribution requirements and spousal consent rules continue to apply. Except to the extent the distribution consists of already-taxed amounts, any hardship distribution described in the announcements will be includible in the taxpayer's gross income.

IRS Announcement 2017-15[22] provides similar relief provisions to taxpayers adversely affected by Hurricane Maria and the California wildfires.

[22] 2017-47 I.R.B. 534.

6. IRS Guidance on Required Amendments and Operational Compliance

The IRS previously established five-year remedial amendment cycles for submitting qualified plans to the IRS for a determination letter. Revenue Procedure 2016-37[23] officially eliminated this five-year remedial amendment cycle for qualified plans as of January 1, 2017.

The IRS further stated that each year it would publish both a Required Amendment List ("RA List") and an Operational Compliance List. The RA List is an annual list of the amendments required for an individually-designed plan to maintain its qualified status. 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. The Operational Compliance List identifies changes in qualification requirements that are effective during a calendar year. Although plans may be amended retroactively to comply with qualification requirements if certain requirements are satisfied, all plans are required to operate in compliance with changes in the qualification requirements as of their effective date.

a. Required Amendments List

In Notice 2016-80,[24] the IRS issued the 2016 RA List. The remedial amendment period for a disqualifying provision arising as the result of a change in qualification requirements that appears on the 2016 RA List is December 31, 2018. Accordingly, December 31, 2018 is also the plan amendment deadline for any such disqualifying provision (although a later date may apply to a governmental plan).

In general, the RA List includes statutory and administrative changes in qualification requirements that are first effective during the plan year in which the list is published. The RA List for a year does not include guidance issued or legislation enacted after the list has been prepared or any of the following:

- Statutory changes in qualification requirements for which the Treasury Department or IRS expect to issue future guidance;
- Changes in qualification requirements that permit (but do not require) optional plan provisions; and
- Changes in tax laws affecting qualified plans that do not change the qualification requirements under Code section 401(a).

The RA List is divided into two parts – Part A and Part B. Part A covers changes in qualification requirements that generally would require an amendment to most plans or to most plans of the type affected by the change. Part B includes changes in qualification requirements that the Treasury Department and IRS anticipate will not require amendments in most plans but might require an amendment in some plans as the result of an unusual provision.

[23] 2016-29 I.R.B. 136.
[24] 2016-52 I.R.B. 918.

The 2016 RA List includes no changes under Part A that would generally require an amendment in most plans. Under Part B, the list only includes one change relating to collectively-bargained defined benefit plans and the restrictions on accelerated distributions from underfunded single-employer plans in employer bankruptcy under Code section 436.

b. Operational Compliance List

The IRS has posted the first Operational Compliance List[25] to its website. The Operational Compliance List identifies matters that may involve mandatory or discretionary plan amendments for certain plans and may contain other significant guidance that affects daily operations of plans. The current Operational Compliance List includes items that are effective in both 2016 and 2017.

7. Changes to Pre-Approved Plan Program

On June 30, 2017, the IRS issued Revenue Procedure 2017-41[26] which makes significant changes to the pre-approved plan program. According to the IRS, "This revenue procedure modifies the IRS's historic approach to pre-approved Plans in order to expand the Provider market and encourage employers that currently maintain individually designed plans to convert to the pre-approved plan format."

The revenue procedure replaces the current master and prototype and volume submitter programs with a single opinion letter program. The new opinion letter program now involves two types of plans – standardized and nonstandardized plans. The plan document may consist of either a basic plan document with an adoption agreement or a single plan document. In addition, the revenue procedure permits an adopting employer of a nonstandardized plan to adopt minor modifications of the pre-approved language.

The revenue procedure also expands the plan designs permitted under the pre-approved plan program to include, among other things, a money purchase plan, 401(k) and profit-sharing plan in the same pre-approved document; and a non-electing church plan.

The IRS will no longer rule on the exempt status of a pre-approved plan's related trust or custodial account. In addition, the IRS will not consider Title I of ERISA when issuing opinion letters.

The revenue procedure also requests comments on whether an employer converting from an individually designed plan to a pre-approved plan should be permitted to maintain certain legacy benefit formulas (which are often added because of mergers and acquisitions). Specifically, the IRS requests comments on the extent to which including legacy benefit formulas in an appendix to the plan document would affect reliance on a plan's opinion letter.

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[25] *See* https://www.irs.gov/retirement-plans/operational-compliance-list.
[26] 2017-29 I.R.B. 92.

8. Church Extension Fund 403(b)(9) Investment Option Issue

Several denominational benefits boards offer plan investment options in which participants can invest in debt instruments issued by what are commonly referred to as church extension funds. These extension funds use the funds provided through the plan investment option to make loans to churches to assist in building projects. The IRS recently released Chief Counsel Memorandum 201742022 stating that such investment options are not allowed in a 403(b)(9) retirement income account plan, because such funds are viewed as providing an indirect loan from the plan to the employer, thereby violating the exclusive benefit rule applicable to 403(b)(9) plans.[27] Although direct loans are prohibited by regulation,[28] indirect loans are not expressly prohibited. The Church Alliance intends to discuss this issue with Treasury representatives, hopefully in the near future.

9. Tax Treatment of Fixed-Indemnity Health Plan Benefits

On December 12, 2016, the IRS issued Chief Counsel Memorandum 201703013, which provides guidance on the tax treatment of payments received by an employee under a fixed indemnity health plan and under wellness programs providing fixed indemnity cash payments for participation. In the memorandum, the IRS defines a fixed indemnity health plan as a plan that pays covered individuals a specified amount for the occurrence of certain health-related activities (e.g., office visits or days in the hospital) where the amount paid is not related to the amount of medical expenses incurred or coordinated with other health coverage.

Code section 105 generally permits an employer to exclude from an employee's gross income amounts received through employer-provided health insurance that are used to reimburse medical expenses. A fixed indemnity plan pays set amounts upon the occurrence of a specified event, regardless of the amount of medical expenses incurred. Accordingly, the IRS concluded in the memorandum that payments under a fixed indemnity plan that qualifies as an accident and health plan under Code section 106 are included in an employee's gross income. An exception exists if premiums are paid on an after-tax basis. Under this exception, employees may exclude benefit payments received through the fixed-indemnity plan from gross income under Code section 104.

10. Comments on Elimination of Regulations

On June 14, the Department of the Treasury issued a request for information ("RFI") seeking stakeholder input on regulatory changes it could make in furtherance of President Trump's January 30, 2017 executive order directing agencies to eliminate two regulations for each new regulation issued. The Department of the Treasury was seeking

[27] The exclusive benefit rule found in section 1.403(b)-9(a)(2)(i)(C) of the Treasury Regulations requires that the assets held in a 403(b)(9) plan account cannot be used for, or diverted to, purposes other than for the exclusive benefit of plan participants or their beneficiaries.

[28] Treasury Reg. 1.403(b)-9(a)(2)(i)(C) prohibits any loan or extension of credit from assets in the plan to the employer.

stakeholder views and recommendations on regulations that can be eliminated, modified, or streamlined to reduce burdens. On July 31, 2017, the Church Alliance submitted a comment letter[29] to the Department of the Treasury highlighting the unique nature and structure of church plans and approaches the IRS could take to provide meaningful relief. The letter also urged resolution of the issue regarding the IRS stance that non-QCCOs cannot participate in 403(b)(9) plans.

11. IRS Letter 226-J

The IRS announced on its website[30] on November 2, 2017, that it will be sending Letter 226-J's to certain employers by the end of 2017. Letter 226-J is the initial letter issued to Applicable Large Employers ("ALEs") to notify them that they may be liable for an Employer Shared Responsibility Payment ("ESRP") for the 2015 calendar year. The determination of whether an ALE may be liable for a 2015 ESRP and the amount of the proposed ESRP in Letter 226-J are based on information from the 2015 Forms 1094-C and 1095-C filed by the ALE and the individual income tax returns filed by the ALE's employees. Employers should read the letter and attachments carefully, and complete and return Form 14764 (indicating agreement or disagreement with the letter). A response is generally due within 30 days.

12. Retirement Plan Limits for 2018

The cost-of-living and required statutory limit adjustments applicable to retirement plans for 2018 are as follows:[31]

Contribution limit for defined contribution plan under Code § 415(c)	**$55,000** (*$1,000 increase*)
Benefit limitation for defined benefit plan under Code § 415(b)	**$220,000** *($5,000 increase)*
Elective deferral limit under Code § 402(g)	**$18,500** *($500 increase)*
Age 50 catch-up contribution limit under Code § 414(v)	**$6,000** *(no increase)*
Age 50 catch-up contribution limit for SIMPLE plan	**$3,000** (*no increase*)
Contribution limit for a Code § 457(b) eligible deferred compensation plan	**$18,500** (*$500 increase*)
Annual compensation limit under Code § 401(a)(17)	**$275,000** (*$5,000 increase)*
HCE compensation definition dollar threshold	**$120,000** *(no increase)*
Dollar threshold limitation for key employee determination in	**$175,000** *(no increase*)

[29] The July 31, 2017 comment letter is attached as Appendix C.
[30] See https://www.irs.gov/individuals/understanding-your-letter-226-j.
[31] 2017-45 I.R.B. 486.

top-heavy plan	
Contribution limit for a SIMPLE retirement plan	**$12,500** *(no increase)*
Participant compensation eligibility amount under Code § 408(k)(2)(C) for simplified employee pension (SEP) employer contributions	**$600** *(no increase)*

B. Department of Labor

1. Delayed Effective Date for Fiduciary Rule

In October of 2010, the DOL proposed a rule[32] 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."[33] 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.[34] The proposed rule also applied to an individual retirement account ("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.

On April 6, 2016, the DOL unveiled a substantially revised final version of the fiduciary rule[35] that is intended to ensure that retirement plan participants obtain investment advice which is in their best interest. The final rule applies to ERISA plans and IRAs, but not health and welfare plans without an investment component, such as health savings accounts ("HSAs"). The rule states that a person renders "investment advice" and becomes a fiduciary if the person makes a recommendation to a plan, plan

[32] 75 Fed. Reg. 65,263 (Oct. 22, 2010).
[33] EBSA News Release (Sept. 19, 2011).
[34] 80 Fed. Reg. 21,928 (Apr. 20, 2015).
[35] 81 Fed. Reg. 20,946 (Apr. 8, 2016).

fiduciary, participant, beneficiary, IRA or IRA owner for a fee or compensation to act or refrain from acting with respect to investment decisions, investment management or IRAs (including rollovers, transfers or distributions).

The fiduciary rule includes a best-interest-contract exemption ("BICE") for investment advice fiduciaries and prohibited transaction exemptions, but note that it does not apply to all investment fiduciaries. The BICE allows investment advice fiduciaries to receive compensation that would otherwise be forbidden for providing investment advice to plan participant and beneficiaries, IRA owners and plan sponsors of small non-participant-directed plans with respect to certain investment products, provided the requirements set forth in the rule are satisfied.

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

The fiduciary rule was scheduled to go into effect on April 10, 2017. On February 3, 2017, President Trump issued a memorandum[36] stating that the fiduciary rule may not be consistent with the policies of his administration and directing the DOL to:

- examine the fiduciary rule to determine whether it may adversely affect the ability of participants to gain access to retirement information and financial advice;

- prepare an updated economic and legal analysis concerning the likely impact of the fiduciary rule to consider, generally, whether it harms investors and the ability to obtain retirement services; and

- if there is potential harm to investors, to publish a proposed rule rescinding or revising the fiduciary rule.

On March 1, 2017, the DOL issued a rule proposing a 60-day delay in the effective date of the fiduciary rule. The DOL subsequently issued Field Assistance Bulletin ("FAB") 2017-01 on March 10, 2017 to state that it will not enforce the new fiduciary rule during any gap period that results from the fiduciary rule becoming applicable before the delay is implemented. The IRS then issued Announcement 2017-4[37] on March 27, 2017 to provide relief from certain excise taxes under Code section

[36] Available at: https://www.whitehouse.gov/the-press-office/2017/02/03/presidential-memorandum-fiduciary-duty-rule.
[37] 2017-16 I.R.B. 1106.

4975 that would otherwise apply during the temporary enforcement policy described in FAB 2017-01.

On April 4, 2017, the DOL released the final rule[38] extending the applicability of the application of the fiduciary rule from April 10, 2017 to June 9, 2017. Certain requirements under the rule (including the BICE) have a phased implementation period ending on January 1, 2018, and the DOL has proposed to extend the end of this period until July 1, 2019.[39]

The DOL issued two additional temporary enforcement policies in FAB 2017-02 and FAB 2017-03. In FAB 2017-02, the DOL stated that it will not pursue claims against fiduciaries who are working diligently and in good faith to comply with the fiduciary duty rule and exemptions or treat them as being in violation of the rule and exemptions. In FAB 2017-03, the DOL stated that it will not treat a fiduciary as violating the BICE or one of the prohibited transaction exemptions commonly referred to as the principal transactions exemption if the sole failure of the fiduciary is to comply with the arbitration limitation. The arbitration limitation makes the exemptions unavailable if the financial institution's contract with a retirement investor limits an investor's right to participate in a class action or other court action.

Since January, the DOL has also issued several FAQs[40] providing additional guidance on the fiduciary rule.

2. Nevada Fiduciary Legislation.

In July 2017, the Nevada legislature passed legislation that imposes fiduciary responsibility on broker-dealers, registered investment advisers and some financial services sales representatives. These individuals were previously excluded from Nevada state law covering the fiduciary duties imposed on "financial planners." The legislation will not be effective, as a practical matter, until regulations are issued under it.

Some practitioners have questioned the law's applicability to financial planners who provide services to an employee benefit plan covered by ERISA. Church plans are not subject to ERISA, so the so-called "ERISA preemption" is not available to such plans.

Legislators in California and New York are considering the passage of similar legislation. The Church Alliance is following these state legislative developments to assess their possible impact on church plans.

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[38] 82.Fed. Reg. 16,902 (Apr. 7, 2017).
[39] 82 Fed. Reg. 41,365 (Aug. 31, 2017).
[40] Available at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/coi-rules-and-exemptions-part-2.pdf, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/coi-transition-period-1.pdf; https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/coi-transition-period-2.pdf.

3. Final Rule on Disability Claims and Appeals

In December of 2016, the DOL issued a final rule[41] amending the claims procedure regulations for plans providing disability benefits. The final rule, which is substantially the same as the proposed rule, revises the current rules by adopting some of the protections for disability claims that are currently applicable to group health plan claims under the ACA. Importantly, the final rule would require that:

- Claims and appeals be adjudicated in a manner designed to ensure independence and impartiality of the persons involved in the decision;

- Denial notices include the reason for the denial and the standards applied in reaching the decision, including the basis for disagreeing with the views of health care professionals, vocational professionals or disability benefit determinations by the Social Security Administration;

- Claimants be given timely notice of their right to access the entire claim file and other relevant documents and the right to present evidence and testimony in support of the claim;

- Claimants be given notice and an opportunity to respond before appeal denials are based on new or additional evidence or rationales;

- Claimants be entitled to seek review in court if the plan fails to comply with the claims procedure requirements unless the failure resulted from a minor error;

- Certain rescissions of coverage be treated as adverse benefit determinations subject to the claims and appeals procedures; and

- Notices and disclosures be written in a culturally and linguistically appropriate manner.

The final rule was scheduled to go into effect January 1, 2018, but the DOL recently proposed to delay the effective date until April 1, 2018.[42] On November 22, 2017, the DOL issued a final rule[43] delaying the applicability date for 90 days – through April 1, 2018. The DOL said the delay is necessary to enable it to carefully consider comments and data as part of Executive Order 13777 to examine regulatory alternatives that meet its objectives of ensuring the full and fair review of disability benefits claims while not imposing unnecessary costs and adverse consequences.

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[41] 81 Fed. Reg. 92,316 (Dec. 19, 2016).
[42] 82 Fed. Reg. 47,409 (Oct. 12, 2017).
[43] The final rule is scheduled to be published in the Federal Register on November 29, 2017.

III. Patient Protection and Affordable Care Act

The ACA, which was signed into law by President Obama in March of 2010, imposed sweeping changes on the delivery of health care in this country and has had a major impact on all players in the health care market (including individuals and insurers). Since the ACA's enactment, HHS, the DOL, and the Department of 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. 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."[44] The revised religious employer exemption would cover:

- churches;
- conventions and associations of churches; and
- integrated auxiliaries.[45]

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[44] 78 Fed. Reg. 39,870 (July 2, 2013).

[45] 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

Accommodation for Other Religious Organizations

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

- 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.[46]

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).[47]

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 TPA 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 TPA 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

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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.

[46] 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.

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

providing contraceptive coverage.[48] Under the interim rules, religious non-profits are still 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 the DOL will then notify insurers and TPAs so that enrollees may receive separate coverage for such services.[49]

In July 2015, the Agencies finalized the interim final regulations issued in August 2014.[50] The final regulations also describe the content requirements of the alternative notice and describe accommodations for closely-held for-profit entities.[51]

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

[48] 79 Fed. Reg. 51,092 (Aug. 27, 2014). On October 27, 2014, the Church Alliance filed a comment letter on the interim final regulation. In that letter, the Church Alliance expressed its concern that the interim regulations fail to protect the religious rights of religious organizations that object to providing some or all contraceptive coverage through their employee benefit plans established for their employees and their dependents. The Church Alliance noted that the latest version of the accommodation still falls short of the needs of eligible organizations because they are still required to act contrary to their beliefs by maintaining a contractual relationship with third parties that facilitate delivery of the contraceptive coverage they oppose. The letter further argued that the regulations continue to violate the Establishment Clause.

[49] 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 was in response to the Supreme Court decision in *Hobby Lobby*.

[50] 80 Fed. Reg. 41,318 (July 14, 2015).

[51] The final rules defined 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 believed that this definition included all of the for-profit companies that have challenged the contraceptive-coverage requirement on religious grounds. The rules finalized standards concerning documentation and disclosure of a closely held for-profit entity's decision not to provide coverage for contraceptive services.

could be modified in this way for insured plans, but notes that this approach would not work for self-insured plans.

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 anticipated that those courts will "allow the parties sufficient time to resolve any outstanding issues between them."[52] The Court also stated that it expressed 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.

The litigation on remand from the Supreme Court remains unresolved, although the parties are discussing a possible settlement.

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.[53] The request for information asked 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. 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 by:

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

- allowing 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;

- clarifying that notifying the insurer or TPA as to such religious objection would exempt the employer from any obligation to provide contraceptive

[52] *Zubik v. Burwell*, 136 S. Ct. 1557 (2016).
[53] 81 Fed. Reg. 47,741 (July 22, 2016).

services, and any contraceptive services would be provided through a separate policy without any connection or cost to the employer; and

- ensuring 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.

3. 2017 Regulatory Guidance

On January 9, 2017, the Agencies issued FAQ Part 36[54] which included a statement that, after reviewing comments submitted in response to the 2016 request for information and considering various options, the Agencies could not find a way at that time to amend the accommodation so as to satisfy objecting eligible organizations while pursing the Agencies' policy goals.

On May 4, 2017, the President issued an "Executive Order Promoting Free Speech and Religious Liberty" that instructed the Secretaries of the Agencies to consider issuing amended regulations, consistent with applicable law, to address conscience-based objections to the preventive-care mandate regarding contraceptive coverage. The two interim final rules discussed below are the result of that re-examination.

On October 6, 2017, the Agencies released two interim final rules addressing religious and moral exemptions and accommodations for coverage of certain preventive services under the ACA. These interim final rules protect religious beliefs (and add exemptions for moral beliefs) and expand exemptions to certain entities and individuals whose non-grandfathered health plans are subject to a mandate of contraceptive coverage through guidance issued pursuant to the ACA. The rules do not alter the discretion of the Health Resources and Services Administration to maintain the guidelines requiring contraceptive coverage where no regulatorily recognized objection exists. The rules also leave the accommodation process in place as an optional process for certain exempt entities that wish to use it voluntarily and will provide contraceptives to persons covered by the plans of entities that use it. The two interim final rules and temporary regulations were effective on October 6, 2017.

The first interim final rule[55] issues an expanded exemption to a broader range of entities and individuals that object to contraceptive coverage based on strongly held religious beliefs, while continuing to offer the existing accommodation as an optional alternative. The expanded exemption encompasses non-governmental, non-grandfathered health plan sponsors that also object to the provision of contraceptive coverage based on sincerely held religious beliefs, including publicly held and closely held for-profit corporations (regardless of size), religious employers, nonprofits, higher education institutions, and insurance issuers, to the extent they provide a plan to otherwise exempt

[54] Available at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-36.pdf.
[55] 82 Fed. Reg. 197 47,792 (0ct. 13, 2017).

entities. The exemption in this rule also allows, but does not require, issuers and employers to omit contraceptives from coverage provided to objecting individuals.

The second interim final rule[56] issued by the Agencies addresses moral exemptions and accommodations for coverage of certain preventive services under the ACA. This interim final rule incorporates conscience protections into the contraceptive mandate and expands exemptions to the mandate to protect certain entities and individuals that object to coverage of some or all contraceptives based on sincerely held moral convictions (but not religious beliefs). Employers that can claim this exemption include non-governmental, privately held for-profit employers (the exemption is not available to plan sponsors that are publicly traded), nonprofits, higher education institutions and insurers, but exempted insurance plans can only be purchased by employers or individuals having moral objections.

The two interim rules do not define religious or moral objections. The HHS Fact Sheet (and the preamble to the second interim final rule) state that courts have recognized exemptions in certain areas for individuals who object on the basis of moral convictions: "(1) that the individual deeply and sincerely holds; (2) that are purely ethical or moral in source and content; (3) but that nevertheless impose on him a duty; (4) and that 'certainly occupy in the life of that individual a place parallel to that filled by…God in traditionally religious persons,' such that one could say his beliefs function as a religion in his life."

No self-certification, filing or notice to the Agencies is required under the interim rules for employers or individuals objecting to the provision of contraceptives on religious or moral grounds. Plans subject to ERISA must continue to follow required notice procedures for changing covered benefits, including revising summaries of benefits and coverage and issuing a summary of material modification within the required timeframe.

B. Executive Order Directing the Delay of ACA Implementation

On January 20, 2017, President Trump issued an Executive Order directing the Secretary of HHS and the heads of all other executive departments and agencies with ACA responsibilities to exercise all authority and discretion available to them to "waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the [ACA] that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers" and others. The order also requires the same persons to exercise all authority and discretion available to them to provide greater flexibility to states in implementing healthcare programs and to encourage the development of an open market in interstate commerce for healthcare services and health insurance.

On October 12, 2017 President Trump announced he would halt ACA subsidy payments to insurers. In response, 18 states and the District of Columbia filed a lawsuit to have the action declared unlawful and requested the issuance of an injunction. On October 25, 2017, a federal

[56] 82 Fed. Reg. 197 47,838 (0ct. 13, 2017).

judge for the Northern District of California[57] denied the request from 18 attorneys general to force the Trump administration to resume ACA subsidy payments, holding that resuming payments to insurers would be counterproductive because most states had already taken action assuming the payments would be stopped. The judge did not decide the question of whether the federal government must continue funding the cost-sharing reduction payments without a specific congressional appropriation.

C. Executive Order on HRAs, Association Health Plans and Short-Term Insurance

On October 12, 2017 President Trump signed an Executive Order directing the Agencies to consider issuing proposed regulations or expanding guidance on HRAs, association health plans ("AHPs") and short-term insurance. The order covers the following issues:

- HRAs – It directs the Agencies to consider issuing proposed regulations or revising guidance within 120 days of the date of the order "to increase the usability of HRAs, to expand employers' ability to offer HRAs to their employees and to allow HRAs to be used in conjunction with nongroup coverage."

- AHPs – The order also requires the DOL to consider proposing regulations or revising guidance to expand access to health coverage by allowing employers to form AHPs, which would allow small employers to group together to self-insure or purchase large group health insurance. The order also suggests allowing AHPs to be formed across state lines.

- Short-Term, Limited Duration Insurance – In addition, the order requires the Agencies to consider proposing regulations or revising guidance within 60 days of the date of the order to expand the availability of short-term, limited duration insurance so that it covers longer periods and can be renewed by the consumer.

The Executive Order also requires the Agencies to consider public comments on any proposed regulations and to provide a report to the President within certain timeframes that describes the extent to which current guidance fails to conform to the policies set forth in the Order and identifies actions that could be taken in furtherance of such policies.

D. 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,

[57] *State of California et. al. v. Trump et. al*., No. 3:17-cv-05895 (N. D. Cal. 2017).

and $2 for each covered life in the second plan year ending after September 30, 2012, is subject to indexing. In October, the IRS issued Notice 2017-61,[58] increasing the amount used to calculate the fee to $2.39 for plan and policy years ending on or after October 1, 2017, and before October 1, 2018.

E. Section 1557 Nondiscrimination Rules

On December 31, 2016, a federal district judge issued a preliminary injunction[59] to prevent the implementation of certain provisions of the final rule issued last year under section 1557 of the ACA.[60] Section 1557 prohibits discrimination under any health program or activity that received Federal financial assistance on any grounds prohibited by Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination and Employment Act of 1975 and section 504 of the Rehabilitation Act of 1973. The prohibited grounds for discrimination under these laws include race, color, national origin, age, disability, and sex.

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 plaintiffs, in the district court case referenced above, sued HHS, arguing that it exceeded its authority in interpreting sex discrimination as including gender identity and termination of pregnancy. The district court agreed and issued an injunction temporarily delaying the implementation of the portion of the regulations prohibiting discrimination of the basis of gender identity and termination of pregnancy. The injunction does not delay the implementation of the remaining provisions of the final rule.

In July 2017, the court granted a stay and suspended the proceedings until HHS reviews the regulations.[61] The court stated that the injunction remains effective throughout the stay.

F. Church Alliance Comment Letters

On July 12, the Church Alliance submitted a comment letter[62] to the Centers for Medicare and Medicaid Services ("CMS") in response to its request for information on approaches to reducing the regulatory burdens imposed by the ACA. In the letter, the Church

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[58] 2017-43 I.R.B. 371.
[59] *Franciscan Alliance, Inc. v. Burwell*, 227 F.Supp.3d 660 (N.D. Tex. 2016).
[60] 81 Fed. Reg. 31,376 (May 18, 2016).
[61] *Franciscan Alliance, Inc. v. Price*, No. 7:16-cv-00108-O, 2017 WL 3616652 (N.D. Tex. July 10, 2017).
[62] The July 12, 2017 comment letter is attached as Appendix D.

Alliance highlighted the unique nature and structure of church plans, the challenges presented by various features of the ACA, and approaches the agencies and departments could take to provide meaningful relief. The Church Alliance took the opportunity to encourage HHS to consider: (1) the creation of a church health plan exchange under its regulatory flexibility; (2) making small business health care tax credits available to employers in the SHOP program equally available to employers in church plans; and (3) preserving existing church plan exemptions from state insurance laws.

On July 31, the Church Alliance submitted a comment letter[63] in response to a request for information from the Department of the Treasury on ways in which Treasury regulations could be eliminated or modified to reduce burdens. The Church Alliance took the opportunity to suggest, with respect to health plans: (1) eliminating several regulations that are either outdated, unnecessary, or unduly burdensome, (2) continuing relief or flexibility regarding Affordable Care Act and tax code requirements, (3) recognizing church plans as issuers of coverage eligible for the small business health care tax credits for employers in the modified SHOP program, and (4) preserving existing church plan exemptions from state insurance laws.

IV. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

A. Reconsideration of Wellness Rules

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. Title II of the Genetic Nondiscrimination Act of 2008 ("GINA") includes an exception to the prohibition on the use of genetic information for voluntary wellness programs that do not condition inducements for employees on the provision of genetic information.

On May 16, 2016, the Equal Employment Opportunity Commission ("EEOC") finalized rules on employer wellness programs under both the ADA and GINA. The final rules generally allow incentives of up to 30% of the cost of self-only coverage for participation in a wellness program.

In October of 2016, the American Association of Retired Persons ("AARP") filed a lawsuit against the EEOC arguing that the 30% incentive is inconsistent with the requirement that the wellness program be "voluntary" under the ADA and GINA. AARP also argued that employees who cannot afford to pay a 30% increase in premiums would be forced to disclose protected information even if they would not otherwise choose to disclose such information.

The U.S. District Court for the District of Columbia ruled[64] in August of 2017 that the EEOC failed to adequately justify its interpretation of the term "voluntary" as permitting a 30% incentive and remanded the rules to the EEOC for reconsideration. The Court decided not to

[63] The July 31, 2017 comment letter is attached as Appendix E.

[64] *AARP v. U.S. Equal Employment Opportunity Comm'n*, No. 16-2113 (JDB), 2017 WL 3614430 (D.D.C. Aug. 22, 2017).

vacate the rules because of concerns that vacating the rules would have "significant disruptive consequences."

In September, the EEOC filed a status report with the Court stating that it intends to issue proposed rules by August of 2018 and final rules by October of 2019. The EEOC's report also indicates that any amended rule probably would not be applicable until the beginning of 2021 so that employers have time to bring their plans into compliance.

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:

- the defined benefit plans maintained by the respective defendant health care systems do not comply with ERISA and have engaged in prohibited transactions;
- the defendants have purposefully ignored ERISA requirements that are meant to protect participants by improperly claiming to be church plans, exempt from ERISA; and
- 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 was 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 could not qualify as church plans.

The Third,[65] Seventh,[66] and Ninth[67] Circuit Courts of Appeals 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. The defendants in the Third, Seventh, and Ninth Circuit Court of Appeals cases 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.[68] The U.S. Supreme

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[65] *Kaplan v. St. Peter's Healthcare System*, 2015 WL 9487719 (3rd Cir., 2015).
[66] *Stapleton v. Advocate Health Care Network*, 817 F.3d 517 (7th Cir., 2016).
[67] *Rollins v. Dignity Health*, 2016 WL 3997259 (9th Cir., 2016).
[68] 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 brief in support of the certiorari petitions filed with the U.S. Supreme Court in *Kaplan, Stapleton,* and *Rollins,* along with a brief on the merits, after the certiorari petitions were granted.

Court agreed to take the case, heard oral arguments in March and issued an order in June of 2017.

The U.S. Supreme Court unanimously decided in *Advocate Health Care Network et al. v. Stapleton et al.*,[69] that church plans can be established by church-affiliated organizations (in this case, church-affiliated hospitals) and do not have to be established by the church with which they are affiliated, as plaintiffs were claiming in this case. This Supreme Court decision reversed the three Court of Appeals decisions which held that church plans must be established by a church. Applying the rules of statutory construction, the Supreme Court disagreed with the Courts of Appeals, stating that a plan maintained by a church-affiliated organization can be a church plan, even if the church-affiliated organization established it.

The church plan status litigation is not over. Although the Supreme Court settled the question of who can establish a church plan, the trial courts in several cases, including *Kaplan*, *Stapleton* and *Rollins*, are now considering three open questions:

(1) whether a retirement plan committee of a church-associated hospital qualifies as a "principal purpose organization" maintaining the plan, as required by Code §414(e);

(2) whether the hospitals involved remain, under the facts at hand, "controlled by or associated with" a church, as also required under §414(e); and

(3) whether the church plan exemption from ERISA is unconstitutional under the Establishment Clause of the United States Constitution.

On September 7, 2017, the Tenth Circuit Court of Appeals in Denver heard oral arguments related to all three of these questions in *Medina v. Catholic Health Initiatives*.[70] The trial court in *Medina* ruled on all three questions left open by the U.S. Supreme Court's decision in *Advocate*. A decision by the Tenth Circuit in *Medina* is expected before year end.

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 in 2015, 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

[69] 137 S. Ct. 1652 (2017).
[70] *Medina v. Catholic Health Initiatives, et. al.,* No. 0:16-cv-01005 (10th Cir., 2016).

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. Portico also filed a petition for certiorari with the U.S. Supreme Court, asking the Court to decide the subject matter jurisdiction issue. The U.S. Supreme Court did not grant the writ. The case is now proceeding at the trial court level.[71]

C. Housing Allowance Litigation Update

In *Freedom From Religion Foundation v. Lew*,[72] 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 and remanded it back to the lower court with instructions to dismiss the complaint for lack of standing. [73] 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 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 in the Western District of Wisconsin. [74] 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. The re-filed case was 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

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[71] *Bacon et. al. v. Board of Pensions of the Evangelical Lutheran Church in America*, No. 27-CV-15-3425 (D. Minn. 2015).

[72] 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.

[73] 773 F.3d 815 (7th Cir., 2014).

[74] *Gaylor v. Lew*, No. 3:16-cv-00215 (W.D. Wis. 2016).

Code section 107(2). On October 5, 2017, Judge Crabb once again found the housing allowance provision of Code section 107(2) to be unconstitutional.[75] The case is expected to be appealed to the Seventh Circuit Court of Appeals, with a decision issued in 2018.

VI. Other

A. HIPAA Business Associate Audits

HHS reports that desk audits of 41 Health Insurance Portability and Accountability Act of 1996 ("HIPAA") business associates are underway. HHS has now completed desk audits of 200 to 250 covered entities (health care providers, clearinghouses, and group health plans). Covered entities that were selected for desk audits provided HHS with the names of their business associates, which are persons or entities that perform work that use or disclose protected health information on behalf of a covered entity.

The business associate desk audits are the second phase of HIPAA compliance audits focused on evaluating how well HIPAA-covered entities and business associates are complying with the privacy, security and breach notification rules. HHS reports that after the desk audits are complete, on-site audits will follow.

B. State-Run IRAs

Over the past several years, eight states[76] enacted state-run IRAs, and many other states were 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 of participation. The definition of which employers are subject to the law varies from state to state.

In May of 2017, Congress repealed a DOL rule exempting the state-run IRAs from ERISA, making state-run IRAs subject to federal law. Even though the repeal of the exemption will make it more difficult to run state IRA programs, some states are still moving ahead. For example, the OregonSaves program is being phased in beginning in November, and requires Oregon employers with 100 or more employees to register for the program and either certify that they already offer their workers access to a qualified retirement plan or automatically enroll their employees in OregonSaves. [77]

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[75] *Gaylor v. Mnuchin*, No. 3:16-cv-00215 bbc (W.D. Wis. 2017).

[76] California, Connecticut, Illinois, Maryland, Massachusetts, New Jersey, Oregon and Washington have enacted state-run IRA legislation.

[77] The ERISA Industry Committee filed a lawsuit against the OregonSaves program, challenging the application of the program for ERISA-covered plans, based on ERISA preemption.

C. Executive Order on Religious Liberty

On May 4, 2017, President Trump issued an Executive Order Promoting Free Speech and Religious Liberty. The Order requires all executive departments and agencies, to the greatest extent practicable and to the extent permitted by law, to respect and protect the freedom of persons and organizations to engage in religious and political speech. In particular, it orders the Secretary of the Treasury to ensure, to the extent permitted by law, that the Department of the Treasury does not take any adverse action against any individual, house of worship, or other religious organization on the basis that such individual or organization speaks or has spoken about moral or political issues from a religious perspective, where the Department of the Treasury has, consistent with law, not ordinarily treated speech of similar character as participation or intervention in a political campaign on behalf of (or in opposition to) a candidate for public office. The Order also required the Secretary of the Treasury, the Secretary of Labor, and the Secretary of HHS to consider issuing amended regulations, consistent with applicable law, to address conscience-based objections to the preventive-care mandate. In response to the Order, the federal Attorney General's office issued a 25-page memorandum[78] providing guidance interpreting religious liberty protections in federal law to federal administrative agencies and executive departments.

D. Tax Reform

On July 17, the Church Alliance submitted a letter to Senate Finance Committee ("SFC") Chairman Orrin Hatch in response to his request for comments from stakeholders regarding tax reform.[79] The comment letter explains to the SFC how several longstanding provisions of the tax code have been carefully tailored to the needs of churches and church ministry organizations, and that retaining and strengthening these provisions should be a part of tax reform. Specifically, the comment letter requests:

- clarification that all church-affiliated organizations, including "non-QCCOs," may participate in a church § 403(b)(9) retirement plan;
- preservation of the parsonage allowance;
- retaining retirement plan provisions important to church organizations that could be lost if retirement plan types under the tax code (401(a), 403(b), 401(k), 457(b), etc.) are consolidated or harmonized;
- parity between church retirement plans and IRAs with respect to required minimum distributions and qualified charitable distributions (as retirement plans are subject to less favorable rules than IRAs);

[78] The Memorandum is available at: https://www.justice.gov/opa/press-release/file/1001891/download?utm_medium=email&utm_source=govdelivery.

[79] The July 17, 2017 comment letter is attached as Appendix F.

- (avoiding legislation that would impose taxes on dividends or other earnings of investment portfolios of tax-exempt organizations; and

- avoiding legislation that would reduce current limits on pre-tax elective deferral contributions to certain retirement plans and require any contributions in excess of the reduced limits to be treated as post-tax or "Roth" contributions.

On August 2, 2017, the Church Alliance submitted a letter to the House Committee on Ways and Means Subcommittee on Tax Policy describing priorities for tax reform.[80]

At the time this report was finalized, the House had passed its version of tax reform legislation on November 20, and the Senate's version of tax reform is scheduled to be debated on the Senate floor the week of November 27. Following Senate action, a conference committee will in all likelihood be appointed to resolve the differences between the House and Senate tax reform bills.

E. HSA Limits for 2018

The IRS has announced the maximum contribution levels for HSAs and out-of-pocket spending limits for high deductible health plans ("HDHPs") that must be used in conjunction with HSAs for 2018.[81] The relevant amounts for 2018 are as follows:

Annual HSA contribution limit	**$3,450** – individual coverage (*$50 increase*) **$6,900** – family coverage (*$150 increase*)
Catch-up contribution limit over age 55	**$1,000** (*no change*)
Maximum HDHP out-of-pocket limit	**$6,650** – individual coverage (*$100 increase*) **$13,300** – family coverage (*$200 increase*)
HDHP minimum deductible	**$1,350** – individual coverage (*$50 increase*) **$2,700** – family coverage (*$100 increase*)

[80] The August 2, 2017 letter is attached as Appendix G.
[81] Rev. Proc. 2017-37, 2017-21 I.R.B. 1252.

F. Social Security Cost of Living Adjustments

On October 18, 2016, the Social Security Administration announced the cost of living adjustments for 2018.[82] The cost of living adjustments for 2018 are as follows:

Increase in monthly benefits	2.0%
Maximum earnings subject to Social Security taxes	$128,700 (*$1,500 increase*)
Maximum earnings subject to Medicare taxes	Unlimited
Exempted earnings amount:[83] • In year prior to year during which retiree reaches full retirement age • In year during which retiree reaches full retirement age	 $17,040 *($120 increase)* $45,360 *($480 increase)*

[82] Social Security Press Release, October 13, 2017.

[83] 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.