LEGISLATIVE AND REGULATORY DEVELOPMENTS IN 2019 OF INTEREST TO CHURCH-SPONSORED EMPLOYEE BENEFIT PLANS AND PROGRAMS

Presented to the Church Benefits Association
December 4, 2019
Jacksonville, Florida

By: Danny Miller, Allison Gardner and Hillary Cinocca
Conner & Winters, LLP
Suite 600
1850 M Street, NW
Washington, D.C. 20036
(202) 887-5711

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I. LEGISLATION AND LEGISLATIVE INITIATIVES

A. Church Alliance Legislative Initiatives

1. Non-QCCO Legislation

During the review of pre-approved volume submitter church plan 403(b)(9) documents in early 2017, the Internal Revenue Service ("IRS") 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.[1] 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 Internal Revenue Code ("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. At the request of the Church Alliance, a provision was added to the Retirement Enhancement and Savings Act of 2018 ("RESA") and the Family Savings Act of 2018 which clarifies that non-QCCOs can participate in church 403(b)(9) retirement income account plans.[2]

On February 6, 2019, Representative Ron Kind (D-WI) introduced the Retirement Enhancement and Savings Act of 2019 (H.R. 1007). Senator Chuck Grassley (R-IA) introduced the related Senate bill with the same name (S. 972) April 1, 2019. The 2019 RESA bills are almost identical to the 2018 RESA bill, and Section 113 of the 2019 RESA bills includes the non-QCCO fix.[3]

On May 23, 2019, the Setting Every Community Up for Retirement Enhancement Act (H.R. 1994) ("SECURE Act"), which was introduced by Representative Richard Neal (D-MA), passed the House. It was received in the Senate June 3, 2019. The SECURE Act includes the clarification that non-QCCOs can participate in 403(b) retirement income

[1] 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 or church-associated tax-exempt organization that is not a non-QCCO.

[2] *See* section 113 of S. 2526, Retirement Enhancement and Savings Act of 2018 and section 108 of H.R. 6757, Family Savings Act of 2018.

[3] *See* sections 113 of S. 972 and H.R. 1007, Retirement Enhancement and Savings Act of 2019. *See* also section 108 of H.R. 1084, Family Savings Act of 2019.

account plans. The Church Alliance lobbied with other stakeholders for the Senate to vote on the SECURE Act prior to the August recess or for the legislation to be added to the debt ceiling/budget caps legislation. In the end, the Senate did not include it in the debt ceiling/budget caps package and the Senate leadership was not able to come to agreement for the SECURE Act to be considered as a stand-alone measure prior to the August recess.

Senate bill 836 was introduced on March 14, 2019 by Senator Pat Roberts (R-KS) and has been referred to the Committee on Finance. This stand-alone bill would clarify the 403(b)(9) non-QCCO issue through an amendment to the Code.[4] The Church Alliance has communicated with House Ways & Means Committee members attempting to get an identical bill introduced in the House.

The Church Alliance continues to consider various avenues for clarification of the non-QCCO issue and will continue to urge the Senate to vote on the SECURE Act either as a stand-alone measure or with adoption through another legislative vehicle. The next opportunity for such a vote will be in December, before Congress adjourns for the holidays, through legislation to fund the fiscal year 2020. However, the current impeachment proceeding and other issues consuming Congress may prevent it from being able to advance passage of the SECURE Act by year end. In the fall of 2019, the Church Alliance met with Treasury Assistant Secretary for Tax Policy David Kautter regarding the 403(b)(9) non-QCCO issue. Assistant Secretary Kautter would like the issue to be clarified through legislation but indicated that he remained open to dialogue about considering regulatory relief if the SECURE Act's passage becomes delayed too long past year end.

On November 5, 2019, ninety-one executive officers and leaders (including the Chair of the Church Alliance) signed a letter to Majority and Minority leaders of the Senate urging quick passage of the SECURE Act before the end of the year.

2. Commodity Pool Operator Fix

The Dodd-Frank Act amended the Commodity Exchange Act's definition of "commodity pool operator" ("CPO"), expanding the universe of entities that must register as such. Under the applicable regulations, church plans are generally excluded from the "pool" definition in 17 CFR §4.10(d)(1). However, there is some concern that if an entity (e.g., a church benefits board), commingles plan assets with non-plan assets for investment purposes, then it could qualify as a "pool" if it trades in qualifying commodity interests and, therefore, would be required to register as a commodity pool operator. Trading in qualifying commodity interests includes investing or retaining investment managers that invest in such interests.

The Church Alliance worked with the office of Senator Amy Klobuchar (D-MN) to clarify the Dodd-Frank CPO legislation. This resulted in the introduction of Senate bill 552 on February 26, 2019. Representative Amy Craig (D-MN) introduced H.R. 4250 in

[4] As discussed below, the Church Alliance is also working with the Treasury regarding a regulatory fix to the non-QCCO issue.

the House on September 9, 2019, and it is identical to S. 552. Representative Craig is working to secure a Republican cosponsor for her bill. H.R. 4250 was referred to the subcommittee on Commodity Exchanges, Energy and Credit on September 18, 2019. The Church Alliance has met with Representative Craig's staff to express appreciation for her efforts and leadership with respect to this bill.[5]

B. Proposed Legislation

1. Retirement Enhancement and Savings Act of 2019

As discussed above Representative Ron Kind (D-WI) introduced RESA(H.R. 1007) in the House on February 6, 2019. Senator Church Grassley (R-IA) introduced a related bill in the Senate by the same name on April 1, 2019 (S. 972). The Senate version has been referred to the Committee on Finance.

RESA amends the Code and the Employee Retirement Income Security Act of 1974 ("ERISA") to modify requirements for tax-favored retirement savings accounts, employer-provided retirement plans, and retirement benefits for federal judges. With respect to employer-provided retirement plans, the bill modifies requirements regarding:

- multiple employer plans;
- automatic enrollment and nonelective contributions;
- plan loans;
- terminating or transferring plans;
- reporting and disclosure rules;
- nondiscrimination rules;
- selecting lifetime income providers; and
- Pension Benefit Guaranty Corporation premiums.

RESA also increases the tax credit for small employer pension plan start-up costs and allows a tax credit for small employers that establish retirement plans that include automatic enrollment.[6]

With respect to IRAs, the bill: (i) treats taxable non-tuition fellowship and stipend payments as compensation, and (ii) repeals the maximum age for traditional IRA contributions.

The bill also modifies various tax provisions to:

- reinstate and increase the tax exclusion for benefits provided to volunteer firefighters and emergency medical responders;
- revise the post-death minimum distribution requirements; and

[5] The Church Alliance believes that CFTC reauthorization legislation may be a vehicle under which to pass the desired CPO changes.

[6] This tax credit is not available to small nonprofit employees.

- increase penalties for failing to file tax or retirement plan returns.

As stated earlier in Section I.A.1, RESA also includes the 403(b)(9) non-QCCO clarification requested by Church Alliance.

2. Family Savings Act of 2019

Representative Mike Kelly (R-PA) introduced the Family and Savings Act of 2019 (H.R. 1084) in the House on February 7, 2019. The bill would amend the Code to encourage retirement and family savings by:

- providing an exemption from lifetime required minimum distribution rules for participants whose aggregated retirement accounts have a balance of $50,000 or less;
- allowing for a new tax-preferred universal savings accounts to which individuals could contribute up to $2,500 each year;
- expanding the use of 529 education savings accounts to include apprenticeship fees, student loan payments, and home-schooling expenses, as well as to allow an account for an unborn child;
- allowing for a distribution from retirement plan savings in the event of a birth or adoption of a child;
- including a fiduciary safe harbor for the selection of a lifetime income provider for an annuity guaranteed retirement income contract.

The Family and Savings Act of 2019 also includes the 403(b)(9) non-QCCO clarification contained in RESA, with the same retroactive effective date beginning before, on, or after the date of the enactment of the Act.

3. Setting Every Community Up for Retirement Act of 2019

As discussed above, the SECURE Act (H.R. 1994), which was introduced by Representative Richard Neal (D-MA), passed the House on May 23, 2019. It was received in the Senate on June 3, 2019. In addition to including the clarification that non-QCCOs can participate in 403(b) retirement income account plans, the SECURE Act would amend the Code to provide that the failure of one employer in a multiple employer retirement plan to meet certain requirements will not cause the multiple employer plan as a whole to fail. Instead, the failure will require the transfer of plan assets related to the employer involved in the failure to another plan of the employer or its successor, an eligible retirement plan, IRA, or some other arrangement as the IRS determines is in the best interested of the employees of such employer. This is commonly known as the "one bad apple" rule. *See*

Section II.A.14. for a more detailed discussion of proposed regulations on multiple employer plans that include an exception to the "one bad apple" rule.[7]

In addition, the SECURE Act establishes pooled employer plans that do not require an employer participating in such a plan to have common characteristics. A pooled employer plan is an individual account plan that provides benefits to the employees of two or more employers. It can be a 401(k) plan or an IRA-based plan. The SECURE Act would allow these pooled employer plans to be maintained by unrelated employers, thus arguably allowing small employers to band together (whether they are related or not) and enjoy lower administrative costs for a pooled employer plan that would be treated like a single employer plan under ERISA.

The SECURE Act would also:

- Beginning after 2019, increase the cap for automatic contributions to pension plans from 10% to 15% of employee compensation.
- Limit the annual safe harbor notice to matching contribution plans and permit amendments to nonelective status at any time before the 30th day before the end of the plan year.
- Increase the tax credit for small employer pension plan startup costs.[8]
- Add a new tax credit for three years for small employers' startup costs for new pension plans that include automatic enrollment features.
- Prescribe that stipends and non-tuition fellowships are treated as compensation for purposes of the retirement savings tax deduction.
- Repeal the restriction on contributions to IRAs by individuals who have reached 70½.
- Prohibit the funding of plan loans through credit cards or similar types of arrangements.
- Require Treasury to issue guidance on the treatment of custodial accounts on the termination of 403(b) plans.
- Effective beginning as early as 2021, require certain long-term employees who are at least 21 years old and annually work more than 500 hours, but less than 1,000 hours, to be eligible to participate in defined contribution plans.
- Beginning in 2020, provide for a $5,000 penalty-free distribution from a defined contribution plan upon a qualified birth or adoption of a child, with amounts in certain circumstances being eligible to be repaid.
- Increase the mandatory distribution age from 70½ to 72 years beginning with distributions required to be made after December 31, 2019, for those that attain age 70½ years after that date.
- Allow an employer that adopts a stock bonus, pension, profit sharing, or annuity plan after the close of a taxable year, but before the time to file the tax return for

[7] *See* Section 11.A.15. for a more detailed discussion of a comment letter filed by the Church Alliance with respect to these proposed regulations.

[8] This credit is not available to small nonprofit employers.

that taxable year, to elect to treat the plan as having been adopted as of the last day of that taxable year.

- Require certain retirement plans with the same trustee, named fiduciary, plan administrator, plan years, and investment options, to file aggregate 5500 reports.
- Require a new benefit statement for defined contribution plan participants that includes a lifetime income disclosure at least once during any 12-month period. The bill requires the Secretary to issue a model statement within one year of the SECURE Act being enacted. The statement will not be required until at least a year after the model notice is issued.
- Provide fiduciaries a safe harbor for the selection of an insurer for a guaranteed retirement income contract.
- Modify nondiscrimination rules for closed plans to allow participants to continue to accrue benefits that may otherwise not pass testing.
- Reduce the PBGC premium rates for Cooperative and Small Employer Charity ("CSEC") plans for plan years beginning after 2018.
- Beginning in 2019, expand 529 education savings accounts to cover costs associated with registered apprenticeships, qualified education student loan repayments not to exceed $10,000, and certain costs associated with elementary and secondary education.

4. Retirement Security and Savings Act of 2019

On May 13, 2019, Senator Rob Portman (D-OH) introduced the Retirement Security and Savings Act of 2019 (S. 1431) (the "Portman-Cardin Bill"). It was referred to the Committee on Finance. This proposed legislation would establish a new automatic enrollment safe harbor called a Secure Deferral Arrangement that would be in addition to the existing automatic enrollment safe harbor. The new safe harbor would start automatic deferrals at 6% of compensation, increasing deferrals by one percent each year up to a maximum of 10%. Under this new safe harbor, employers would also be required to make matching contributions on behalf of all non-highly compensated employees equal to 100% of each dollar of after-tax or elective contributions up to 2% of pay, 50% of each dollar of after-tax or elective contributions on the next 4% of pay, and 20% of each dollar of after-tax or elective contributions on the next 4% of pay. In addition, the bill would create a special tax credit for small employers, generally those with less than 100 employees, related to matching contributions made on behalf of non-highly compensated employees.

The Portman-Cardin Bill would also:

- Permit non-spousal beneficiaries to directly roll over amounts from 403(a), 403(b), and 457(b) plans, in addition to 401(a) plans.
- Beginning in 2023, increase the age for required beginning dates for distributions to April 1 of the year following the year the participant reaches age 72 (and beginning in 2030 increase the required distribution age to age 75).

- For employers with 25 or fewer employees, increase the annual tax credit for implementing a qualified retirement plan.[9]
- Expand the scope of self-correction under the Employee Plans Compliance Resolution System ("EPCRS") for certain plan failures including certain inadvertent qualification failures and certain loan failures.
- Permit distributions from terminated 403(b) plans if the employer does not establish or maintain a successor 403(b) plan.
- Permit employers to make matching contributions under 401(k), 403(b), or 457 plans as well as a SIMPLE IRA with respect to "qualified student loan payments."
- Allow an employer with 401(a) and 403(b) plans to permit transfers from participant account balances between these two types of plans. It would also allow employers with both defined contribution 401(a) and 403(b) plans to merge these plans.
- Harmonize the new hardship withdrawal rules for 401(k) plans, by allowing 403(b) plan participants to receive hardship distributions from salary reduction contributions, qualified non-elective contributions ("QNECs"), qualified matching contributions ("QMACs"), and the related earnings on each. The bill would also remove the requirement that 403(b) participants have to take plan loans prior to receiving a hardship distribution.
- Permit Roth IRA rollovers into qualified plans, 403(b) plans, and governmental 457(b) plans.

5. Wall Street Tax Act of 2019

On March 5, 2019, Representative Peter DeFazio (D-OR) introduced the Wall Street Tax Act of 2019 (H.R. 1516). Senator Brian Schatz (D-HI) introduced an identical bill by the same name in the Senate on the same date (S. 647). Both bills have been referred to the relevant committees. The Wall Street Tax Act imposes a financial transaction tax on the sale of stocks, bonds and derivatives at 0.1% (i.e., 10 basis points). The bill is intended to target "unproductive and speculative trading." It appears to apply to transactions within defined contribution plans.[10]

6. Medicare for All Act of 2019

Representative Pramila Jayapal (D-WA) introduced the Medicare for All Act of 2019 (H. R. 1384) in the House on February 27, 2019. Senator Bernie Sanders (D-VT) introduced a similar bill with the same name (S. 1129) in the Senate on April 10, 2019. Both bills if passed would have immense impact on employer health plans. Employer plans could only exist to supplement the government provided benefits, and most employer-provided health plans would be eliminated. The bills would provide benefits to all U.S. residents and create a comprehensive single-payer benefits system. Generally, benefits would be provided at no cost to participants. However, certain cost-sharing may be

[9] This credit is not available to non-profit employers.

[10] Some commentators have suggested that this tax could increase expense ratios of equity and mutual funds by 31%. This could ultimately reduce a plan participant's retirement savings by 5% over their lifetime.

imposed for prescription benefits. The bills if passed, would make it illegal for employers to provide benefits that are duplicative of those provided under the Medicare for All Act. Under the House bill, benefits would generally become effective two years after enactment (one year for individuals younger than 19 or older than 55). Under the Senate bill, benefits would generally become effective four years after enactment (one year for individuals younger than 19).

In addition to proposals by presidential candidates, various other similar bills have been introduced in Congress this year.[11]

7. Surprise Medical Billing Legislation

On June 24, 2019, President Trump issued an executive order requiring the Department of Health and Human Services ("HHS") to submit a report to the President regarding surprise medical billing. Both parties in Congress are focused on surprise medical billing issues, although Congress remains divided on the various proposals. However, because of the bipartisan support and growing public concern about surprise medical billing, these issues could be near the top of the Congressional legislative agenda. Impeachment proceedings may, however, delay a compromise or progress on this topic.

Many surprise medical bills involve emergency care when a patient goes to an out-of-network emergency provider, but Congress is focused on a comprehensive approach to deal with surprise medical bills. The proposed legislation addresses emergency services as well as post-emergency/maternal services when out of network services continue to be provided to patients who are not yet stable enough to be transferred to an in-network facility. The proposed bills also address scheduled care at an in-network facility that involves an out-of-network ancillary provider (such as anesthesiologists, radiologists, pathologists, laboratory services, or imaging services).

The Stopping the Outrageous Practice of Surprise Medical Bills Act of 2019 (S. 1531) was introduced in the Senate by Senator Bill Cassidy (R-LA) on May 16, 2019. This proposed legislation would not allow cost-sharing greater than that allowed for in-network benefits with respect to surprise medical bills stemming from: 1) emergency services, 2) post-emergency services provided by an out-of-network provider (unless the patient is sable and has consented), and 3) services provided by out-of-network providers at an in-

[11] Keeping Health Insurance Affordable Act of 2019 (S. 3) (Introduced in the Senate January 3, 2019 by Senator Benjamin Cardin (D-MD)); the Medicare-X Choice Act of 2019 (H.R. 2000 and S. 981) (Introduced in the House April 1, 2019 by Representative Antonio Delgado (D-NY) and introduced in the Senate April 2, 2019 by Senator Michael Bennet (D-CO)); the Choice Act (H.R. 2085 and S. 1033) (introduced in the House April 4, 2019 by Representative Janice Schakowsky (D-IL) with an identical bill titled the Consumer Health Options and Insurance Competition Enhancement Act introduced in the Senate by Senator Sheldon Whitehouse (D-RI) on the same date); the Medicare for America Act (H.R. 2452) introduced in the House May 1, 2019 by Representative Rosa DeLauro (D-LA)); the Choose Medicare Act (H.R. 2463 and S. 1261) (introduced in the House and Senate on May 1, 2019 by Representative Cedric Richmond (D-LA) and Senator Jeff Merkley (D-OR)); and the Medicare Buy-In and Health Care Stabilization Act of 2019 (H.R. 1346) (introduced in the House February 25, 2019 by Representative Brian Higgins (D-NY) with the related bill (named the Medicare at 50 Act) (S. 470) introduced February 13, 2019 in the Senate by Senator Debbie Stabenow (D-MI)).

network facility. This legislation would not preempt state laws, with the strictest law, either federal or state applying. Other surprise medical billing proposed legislation includes the Protecting People from Surprise Medical Bills Act (H.R. 3502) that was introduced by Representative Raul Ruiz (D-CA) June 26, 2019, the No Surprise Act (H.S. 3630) that was introduced by Representative Frank Pallone (D-NJ) on July 11, 2019, and the Lower Health Care Costs Act (S. 1895) that was introduced by Senator Lamar Alexander (R-TN) on June 19, 2019. The Church Alliance is focused on potential legislation in the area of surprise medical billing. It has had discussions with Senator Lamar Alexander's staff related to S. 1895. The main issue of focus for church plans pertains to requesting relief from attestation and disclosure requirements.

Each of the proposed bills aims to address surprise medical billing concerns. Almost half of the U.S. states have passed some sort of surprise medical billing laws to protect consumers, and some of these state laws have been used to formulate the proposed federal bills.

II. REGULATORY INITIATIVES AND OTHER GUIDANCE

A. Internal Revenue Service

1. Revisions to Church Plan Definition

The IRS is updating the existing final regulations on the definition of a church plan in Code section 414(e) to conform those regulations to changes made to Code section 414(e) in 1980. On August 20, 2018 and November 26, 2018, the Church Alliance submitted church plan definition pre-rulemaking comments to the IRS.[12] On June 7, 2019, the Church Alliance submitted another comment letter to the IRS in response to a Request for Comments on the 2019-2020 Priority Guidance Plan that was contained in IRS Notice 2019-30 (the "June 7, 2019 Comment Letter"). The Church Alliance's first priority is the update needed to the church plan definition.[13]

The August 20, 2018 Church Alliance letter recommends that the revised regulations:

- confirm that welfare plans, like retirement plans, may qualify as church plans;
- clarify that the term "beneficiaries" includes all individuals who benefit directly through the employee participant, such as dependents and joint annuitants;

[12] See Appendix A for information to access both Church Alliance comment letters on revisions to the church plan regulations.

[13] Rather than repeat its positions stated in the August 20, 2018 and November 26, 2018 letters, the June 7, 2019 Comment Letter provided links to both of these prior letters and urged the Treasury to review the Church Alliance's comments and to incorporate the substantive suggestions in new proposed regulations. The second priority item discussed in the June 7, 2019 Comment Letter related to clarifications regarding the parking excise tax. *See* Section II.A.17 for a more detailed discussion of the parking excise tax. See Appendix A for information to access the Church Alliance comment letter dated June 7, 2019.

- reverse the approach taken in existing regulations that church plan status is lost by having one or more participating "non-church" employers or having non-church employees in a plan. Church plans therefore would be permitted to have an insubstantial number[14] of non-church employee participants;
- clarify that a plan will be a church plan if it is both established and maintained by a church, even if no principal purpose organization is used to administer or fund the plan.
- an organization's "principal purpose" will be the administration or funding of employee benefit plans if the majority of either the time spent or expense incurred by the organization or its members or employees relates to administration and/or funding of employee benefits plans;
- affirm that a benefit plan administration committee with at least one member can be a principal purpose organization, that the committee member(s) need not be members of the church by or with which the sponsoring employer is controlled or associated, and that individuals can be designated as committee members by virtue of the office or position they hold;
- broadly define the terms "minister" and "exercise of ministry;"
- clarify that the "control" requirement of Code section 414(e)(3)(B)(ii) can be met by canonical, ecclesiastical or similar control and provide three suggested safe harbors;
- affirm the logical conclusion of reading Code section 414(e)(3)(B) and 414(e)(3)(C) together, so that an employee of two or more churches is deemed to be an employee of each church;
- provide five safe harbor tests to allow entities to determine whether they are "associated with" a church within the meaning of Code section 414(e)(3)(D);
- clarify that multiple churches maintaining a church plan together are not required to demonstrate common religious bonds and convictions (if each church could establish and maintain a church plan under Code section 414(e));
- clarify that the Code section 414(e)(3)(E) definition of "employee" includes former employees receiving post-separation retirement, health or welfare benefits;
- clarify that any type of failure to meet the requirements of Code section 414(e) is correctable so long as the correction is made within the correction period specified in Code section 414(e)(4)(3); and
- expand the regulations to clarify that church plans can be administered by a separately incorporated plan administrator (such as a pension board or bank), or a separately incorporated third-party administrator (such as a medical claims administrator).

The November 26, 2018 Church Alliance comment letter discussed one additional issue as a supplement to the August 20, 2018 comment letter. The additional issue the Church Alliance seeks to clarify is the definition of "convention or association of churches" which is not defined in Code section 414(e).

[14] For this purpose, "insubstantial" would be defined as 15% or less.

In Revenue Ruling 74-224,[15] the IRS noted that a "convention or association of churches" is not limited to a group of churches that are of the same denomination. This Revenue Ruling was referenced in a 2013 private letter ruling ("PLR").[16] In the 2013 PLR, the IRS concluded that an "association of churches" included a tax-exempt organization comprised of churches from two different denominations where the organization engaged in the cooperative undertaking of carrying out the religious and charitable ministries of the churches.

The Church Alliance recommends that, consistent with Revenue Ruling 74-224, the new church plan regulations state that a "convention or association of churches" can include churches of multiple denominations as long as the requirements of Code section 414(e) are otherwise satisfied. It also recommends that regulations specifically prescribe that: 1) an organization can be controlled by or associated with an "association of churches" if it is controlled by or associated with two or more churches, 2) plans of tax-exempt organizations controlled by or associated with an "association of churches" that are autonomous or nondenominational without formal polity can be church plans if they otherwise meet the requirements for a church plan, and 3) the definition of "convention or association of churches" permits the inclusion of separate units of a church or convention or association of churches to fall within an actual "convention or association of churches."

2. Extension of Temporary Nondiscrimination Relief for Closed Defined Benefit Plans through 2020

On August 23, 2019, the IRS issued Notice 2019-49[17] which extends through 2020 the nondiscrimination relief for closed frozen defined benefit plans that meet the requirements of IRS Notice 2014-5.[18] Closed defined benefit plans are those that provide ongoing accruals but have been amended to limit those accruals to some or all of the employees who participated in the plan as of a specified date. IRS Notice 2014-5 permitted plans that were closed before December 13, 2013 that satisfied certain conditions to demonstrate satisfaction of the "nondiscrimination in amount" requirement of Treasury Regulation section 1.401(a)(4)-1(b)(2) on the basis of equivalent benefits even if such plans do not meet any of the existing eligibility conditions for testing on that basis. The extension of this nondiscrimination relief was due to expire for plan years beginning in 2020.

The relief provided by Notice 2019-49 did not extend to frozen plans' inadvertent triggering of nondiscrimination violations as a result of benefits, rights, and features that apply only to grandfathered participants. On November 13, 2019, the IRS released Notice 2019-60 to address these issues. Under this guidance a frozen plan will be considered as satisfying the benefits, rights, and features rules with respect to the benefits, rights, or features that were provided under such plan at the time the plan was frozen.

[15] 1974-1 C.B. 61.

[16] PLR 201309028 (Mar. 1, 2013).

[17] 2019-37 I.R.B. 699.

[18] IRS Notice 2014-5 was previously extended through Notices 2015-28, 2016-57, 2017-45 and 2018-69. The relief extended through Notice 2018-69 is set to expire at the end of 2019.

The SECURE Act, if passed, includes provisions that could provide a more permanent fix to these nondiscrimination issues.

3. Updates to Employee Plans Compliance Resolution System

On April 19, 2019 the IRS issued Revenue Procedure 2019-19,[19] which modifies and supersedes former EPCRS correction guidance found in Revenue Procedure 2018-52.[20] This Revenue Procedure is effective for corrections and submissions made on or after April 19, 2019. Revenue Procedure 2019-19 continues to offer the following three correction programs: the self-correction program ("SCP"), the voluntary correction program ("VCP"), and the audit CAP program to be used for certain resolved failures discovered during an IRS audit. The new Revenue Procedure is a limited update and was published primarily to expand the SCP. It permits the correction through the SCP for certain plan document failures, certain plan loan failures, and certain operational failures through plan amendment.

SCP is now available for the following types of loan failures if certain conditions are met.

- Loans that do not meet the exception requirements of Code section 72(p)(2) (i.e., the maximum loan amount, maximum term, and level amortization requirement).
- Defaulted loans.
- Failure to obtain spousal consent for a plan loan, as required by the plan terms.
- The number of plan loans allowed to a participant exceeds the maximum allowed per the plan terms.

Beginning effective April 1, 2019, all VCP submissions must be submitted electronically through the use of the www.pay.gov website. Employers must set up a pay.gov account prior to submitting a VCP application through the website. process by

4. Disaster Relief[21] – Hurricanes Florence and Michael

The IRS, in connection with the issuance of proposed hardship distribution rules on November 9, 2018, extended the relief to victims of the recent hurricanes Michael and Florence. Participants in 401(k) plans, employees of public schools and tax-exempt organization with 403(b) tax-sheltered annuities, as well as state and local government employees with 457(b) plans were eligible to take advantage of streamlined loan

[19] 2019-19 I.R.B. 1086.

[20] 2018-42 I.R.B. 611.

[21] Detailed descriptions of disaster areas and relief granted by the IRS, the DOL, and the PBGC is available at the following websites. For the IRS see: https://www.irs.gov/newsroom/tax-relief-in-disaster-situations, for the DOL see: http://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief, and for the PBGC see https://www.pbgc.gov/prac/other-guidance/Disaster-Relief.

procedures and liberalized hardship distribution rules.[22] To qualify for this relief, hardship withdrawals must have been made by March 15, 2019. A plan may be amended to apply the revised safe harbor expenses relating to losses, including loss of income, incurred by an employee on account of a disaster that occurs in 2018 (such as Hurricane Florence or Hurricane Michael) provided the employee's principal residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance with respect to the disaster.

See Section II.A.7. for a more detailed discussion of the final hardship distribution rules issued on September 23, 2019. Such rules include a new safe harbor distribution event provision permitting retirement plan distributions in certain areas following federally declared disasters.

5. Guidance on Determination Letter Program

Effective beginning January 1, 2017, determination letter applications for individually-designed retirement plans can only be submitted for initial plan qualification, qualification upon plan termination, and in certain other limited circumstances identified in subsequent published guidance. In IRS Notice 2018-24,[23] the IRS requested comments on the potential expansion of the scope of the determination letter program for individually-designed plans during the 2019 calendar year. In Revenue Procedure 2019-20,[24] issued May 13, 2019, the IRS provided for a limited expansion of the determination letter program for individually-designed plans.

The IRS has published frequently asked questions with helpful information and links related to the determination letter process.[25] Information provided includes the type of forms to use when requesting a determination letter, user fees, whether a restated plan document and redlined copy is required, and where to send determination letter requests. Contact information is also included to request assistance and check the status of a determination letter.

6. Required Amendments List and Operational Compliance List

On December 10, 2018, the IRS issued Notice 2018-91[26] which contains the list of amendments certain retirement plans need to make for the 2018 plan year. The IRS has stated that it plans to publish this list annually now that the 5-year remedial amendment cycle for individually-designed plans has been discontinued. There were no entries listed

[22] See https://www.irs.gov/newsroom/proposed-hardship-withdrawal-regulations-include-relief-for-disaster-victims-retirement-plans-can-now-make-loans-hardship-distributions-to-victims-of-hurricanes-michael-and-florence for more information.

[23] 2018-17 I.R.B. 507.

[24] 2019-20 I.R.B. 1182.

[25] See https://www.irs.gov/retirement-plans/determination-letters-for-individually-designed-retirement-plans-faqs

[26] 2018-50 I.R.B. 985.

for the 2018 year.[27] The 2017 required amendments (required to be adopted by December 31, 2019) include changes for cash balance plans required by final regulations issued in 2015, changes to benefit restrictions for eligible cooperative or charity plans, and a change for pension plans allowing participants to receive their benefits in both a partial lump-sum and annuity payment. Plan sponsors will generally be required to adopt an item on the required amendment list by the end of the second calendar year following the year the required amendments list is published.

The IRS also publishes an "Operational Compliance List"[28] which identifies changes in qualification requirements during a calendar year. This list is helpful for plan sponsors to achieve operational compliance even before required amendments are adopted by plans. It may also be a helpful tool to identify mandatory and discretionary plan amendments as well as other significant guidance that impacts daily plan operation.

7. Final Regulations on Hardship Distributions

On September 23, 2019, the IRS issued final regulations related to hardship distributions for 401(k) and 403(b) plans.[29] The final hardship regulations are substantially similar to the proposed rules that had been issued by the IRS on November 9, 2018.[30] Generally, plans that complied with the proposed regulations will satisfy the final regulations.

Code sections 401(k)(2)(b) and 403(b)(11) provide that employee elective deferrals may be distributed from a plan only on or after the occurrence of certain events, including hardship. Treasury Regulation section 1.403(b)-6(d)(2) provides that a 403(b) hardship distribution is subject to the rules and restrictions set forth in Treasury Regulation section 1.401(k)-1(d)(3) and is limited to the aggregate dollar amount of a participant's section 403(b) elective deferrals, without earnings thereon. Code section 403(b)(11) provides that no income attributable to employee elective deferral contributions may distributed.

The final rule:

- Modifies the safe harbor list of expenses for which distributions are deemed to be made on account of immediate and heavy financial need by:
  - adding "primary beneficiary under the plan" as an individual for whom qualifying medical, educational, and funeral expenses may be incurred;
  - modifying the safe harbor provision permitting a hardship distribution related to damage to a principal residence that would qualify for casualty deduction under Code section 165 to provide that the new limitations added by the Tax Cuts and Jobs Act of 2017 ("TCJA") and set forth in Code

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

[28] The Operational Compliance List is available at this website only and will not be published in an Internal Revenue Bulletin. https://www.irs/gov/retirement-plans/operational-compliance-list.

[29] 84 Fed. Reg. 49,651 (Sept. 23, 2019).

[30] 83 Fed. Reg. 56,763 (Nov. 14, 2018).

section 165(h)(5) do not apply. This is optional for 2018 and 2019 plan years, but mandatory beginning January 1, 2020; and

- adding a new type of expense to the list relating to expenses incurred as a result of certain natural disasters relating to losses, including loss of income, provided that the employee's principal residence or principal place of employment at the time of the disaster was located in an area designated by the Federal Emergency Management Agency ("FEMA") for individual assistance with respect to the disaster.[31]

The revised list of safe harbor expenses may be applied to distributions made on or after a date that is as early as January 1, 2018. Thus, for example, a plan that made hardship distributions relating to casualty losses deductible under Code section 165 without regard to changes made to Code section 165 by the TCJA may be amended to apply the revised safe harbor expense relating to casualty losses to distributions made in 2018 so that plan provisions will conform to the plan's operation.

- Effective for plan years beginning after December 31, 2018, modifies the rules for determining whether a distribution is necessary to satisfy an immediate and heavy financial need by eliminating:
  - any requirement to take plan loans prior to obtaining a hardship distribution (making this change is not required – plan sponsors can choose to continue to require a participant to take out a plan loan before receiving a hardship distribution, or can choose to eliminate it for plan years beginning after December 31, 2018); and
  - any requirements that an employee be prohibited from making elective contributions and employee contributions after receipt of a hardship distribution. The final hardship regulations <u>do not permit</u> a plan to provide for a suspension of elective contributions as a condition of obtaining a hardship distribution. However, this prohibition only applies for distributions made on or after January 1, 2020. Plan sponsors could however choose to implement this change in 2019. In addition, the prohibition for suspending an employee's elective deferral contributions as a condition of obtaining a hardship distribution may be applied as of the first day of the first plan year beginning after December 31, 2018, even if the distribution was made in the prior plan year. Therefore, a calendar year plan that provides for hardship distributions may be amended to provide: 1) that an employee who receives a hardship distribution in the second half of the 2018 plan year will be prohibited from making any elective deferral contributions until January 1, 2019, or 2) may continue to provide that contributions will be suspended until exhaustion of the originally scheduled 6 months.

[31] This is optional beginning in 2019, but it can be applied as early as January 1, 2018. This new hardship withdrawal relief is not as broad as relief granted through guidance from past individual disasters. But this new hardship reason will eliminate any delay or uncertainty for participants related to accessing plan funds following a federally declared disaster.

- Eliminates the rules under which the determination of whether a distribution is necessary to satisfy a financial need is based on all relevant facts and circumstances and instead provides one general standard for determining whether a distribution is necessary. Under this new general standard:
    - a hardship distribution may not exceed the amount of an employee's financial need (including any amounts necessary to pay any federal, state or local income taxes or penalties reasonably anticipated to result from the distribution);
    - the employee must have obtained other available non-hardship distributions under the employer's plans (not including plan loans); and
    - the employee must represent that he or she has insufficient cash or other liquid assets reasonably available to satisfy the financial need. This requirement is applicable beginning with withdrawals in 2020.
        - An employee could make a representation that he or she has "insufficient cash or other liquid assets reasonably available" to satisfy their immediate and heavy financial need, even if the employee does have some cash or other liquid assets available. For example, cash or liquid assets that are earmarked for rent would not be considered to be reasonably available to the employee.
        - A plan administrator may rely on such a representation unless the plan administrator has actual knowledge to the contrary. The plan administrator does not have an obligation to inquire into the financial condition of an employee
        - The proposed regulations provided that an employee's representation could be made "in writing, by an electronic medium, or in such other form prescribed by the Commissioner." The final regulations clarify that a verbal representation, such as through a recoded telephone call is also acceptable for this employee representation since it fits the definition of electronic medium.
- The final rules permit hardship distributions for 401(k) plans from employee elective contributions, QNECS, QMACS, traditional safe harbor contributions, and earnings on these contributions, regardless of when contributed or earned. Plan sponsors can decide whether their 401(k) plans will limit the type of contributions available for hardship distributions and whether earnings on those contributions may be withdrawn.
- The final rules permit hardship distributions for 403(b) plans from employee elective contributions, and QNECS and QMACS that are <u>not</u> held in a 403(b)(7) custodial account. Thus, QNECs and QMACs in a non-custodial 403(b) annuity plan (e.g., 403(b)(1) or 403(b)(9)) are eligible for hardship distributions. Because of the limitation in Code section 403(b)(11), earnings and income attributable to elective deferrals will continue to be ineligible for distribution on account of hardship in 403(b) plans.

Plan amendments for these changes will be required. For an individually-designed plan, the deadline to amend a plan to reflect these changes will be the end of the second calendar year that begins after the issuance of the required amendments list that includes the hardship withdrawal change. Therefore, if the hardship regulation changes are included

in the 2019 required amendment list (generally published in December), the amendments must be adopted by December 31, 2021. For 403(b) plans, the current remedial amendment period applies. Therefore, any 403(b) plan amendments reflecting hardship withdrawal changes are due by March 31, 2020. Further guidance may extend this deadline.

8. Retirement Plan Limits for 2020

The cost-of-living and required statutory limit adjustments applicable to retirement plans for 2020 are as follows:[32]

Contribution limit for defined contribution plan under Code § 415(c)	**$57,000** (*$1,000 increase*)
Benefit limitation for defined benefit plan under Code § 415(b)	**$230,000** *($5,000 increase)*
Elective deferral limit under Code § 402(g)	**$19,500** *($500 increase)*
Age 50 catch-up contribution limit under Code § 414(v)	**$6,500** *($500 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	**$19,500** (*$500 increase*)
Annual compensation limit under Code § 401(a)(17)	**$285,000** (*$5,000 increase)*
HCE compensation definition dollar threshold[33]	**$130,000**[34] *($5,000 increase)*
Dollar threshold limitation for key employee determination in top-heavy plan	**$185,000** *($5,000 increase*)
Contribution limit for a SIMPLE retirement plan	**$13,500** *($500 increase)*
Participant compensation eligibility amount under Code § 408(k)(2)(C) for simplified employee pension (SEP) employer contributions	**$600** *(no increase)*

9. Health Savings Account Limits

The IRS has announced the maximum contribution levels for Health Savings Accounts ("HSAs") and out-of-pocket spending limits for high deductible health plans ("HDHPs") that must be used in conjunction with HSAs for 2020.[35] The relevant amounts for 2020 are as follows:

[32] IRS Notice 2019-59.

[33] This definition of highly compensated employee is also used in several welfare plan nondiscrimination tests.

[34] For the 2020 plan year, an employee who earns more than $125,000 in 2019 is an highly compensated employee. For the 2021 plan year, an employee who earns more than $130,000 in 2020 is an highly compensated employee.

[35] Rev. Proc. 2019-25, 2019-22 I.R.B. 1261.

Annual HSA contribution limit	**$3,550 –** individual coverage *($50 increase)* **$7,100 –** family coverage *($100 increase)*
Catch-up contribution limit over age 55	**$1,000** *(no change)*
Maximum HDHP out-of-pocket limit	**$6,900 –** individual coverage (*$150 increase*) **$13,800 –** family coverage (*$300 increase*)
HDHP minimum deductible	**$1,400 –** individual coverage (*$50 increase*) **$2,800 –** family coverage (*$100 increase*)

10. Flexible Spending Account and Qualified Transportation Fringe Benefit Limits

The IRS has announced the maximum contribution levels for health care and dependent care flexible spending account ("FSA") arrangements.[36] The IRS also announced the monthly limitation under Code Section 132(f)(2)(A) regarding the aggregate fringe benefit exclusion amount for transportation in a commuter highway vehicle and any transit pass as well as the monthly limitation under Code section 132(f)(2)(B) regarding the fringe benefit exclusion amount for qualified parking. The relevant amounts for 2020 are as follows:

Annual contribution limit for Health Care FSA	**$2,750** *($50 increase)*
Annual contribution limit for Dependent Care FSA	**$5,000**[37] *(no change)*
Monthly contribution fringe benefit exclusion limit for Qualified Mass Transportation and Qualified Parking	**$270** *($5 increase)*

11. Additional Preventive Care Benefits Permitted under High Deductible Health Plans

On July 17, 2019, the IRS issued Notice 2019-45[38] detailing new types of medical care for various chronic conditions that will be viewed as preventive care benefits and thus may be provided without application of a deductible under HDHPs. In order for individuals covered by HDHPs to contribute to HSAs, they must not have any disqualifying health coverage and must meet certain limits with respect to the minimum deductibles. Generally, under Code section 223(c)(2)(A), an HDHP may not provide benefits until the minimum deductible for the applicable plan year has been met. However, an HDHP is not required to have a deductible for preventive care benefits.[39]

[36] Rev. Proc. 2019-44.

[37] The maximum tax-exempt benefits for dependent care assistance is not indexed for inflation and remains unchanged at $5,000. The maximum for a dependent care flexible spending account is $2,500 (rather than $5,000) for married taxpayers filing separately.

[38] 2019-32 I.R.B. 593.

[39] Code section 223(c)(2)(C) provides a safe harbor for the absence of a deductible for preventive care within the meaning of section 1861 of the Social Security Act, except as otherwise provided by guidance issued by the Treasury

IRS Notice 2019-45 provides that the following services and items provided for individuals with the specified chronic conditions listed will be treated as preventive care benefits.[40]

PREVENTIVE CARE AND ITEMS FOR SPECIFIED CONDITIONS	FOR INDIVIDUALS DIAGNOSED WITH THE FOLLOWING CONDITIONS
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

Department or by the IRS. Notice 2004-23 (2004-1 C.B. 725), and Q&As 26 and 27 of Notice 2004-50 (2004-2 C.B. 196), provide guidance on preventive care benefits allowed to be provided by a HDHP. Notice 2013-57 (2013-40 I.R.B. 293) provides that any item that is a preventive service under section 2713 of the Public Health Service Act will also be treated as preventive care under Code section 223(c)(2)(C).

[40] Although this IRS Notice clarified that these benefits will be treated as preventive care for individuals with the listed conditions for purposes of Code section 223(c)(2)(C), this IRS Notices does not treat these services and items as preventive care required to be provided without cost sharing for purposes of Section 2713 of the Public Health Service Act and does not impact the definition of preventive care detailed in Section 54.9815-2713.

12. Recovery of Mistaken HSA Contributions

On December 28, 2018, the IRS released information letter 218-0033,[41] providing details of specific situations of the types of errors that may be corrected concerning mistaken contributions to HSAs by employers.[42] Previously, IRS Notice 2008-59[43] described the limited circumstances under which an employer could seek recoupment of incorrectly contributed HSA contributions. The limited circumstances included HSA contributions made to employees who were never HSA-eligible and contributions in excess of the annual statutory contribution limit.

The information letter notes that Notice 2008-59 was not intended to provide an exclusive list of circumstances in which an employer could request the return of incorrectly contributed HSA amounts. The letter goes on to state that "if there is clear documentary evidence demonstrating that there was an administrative or process error, an employer may request that the financial institution return the amounts to the employer, with any correction putting the parties in the same position that they would have been in had the error not occurred." In addition to those situations described in Notice 2008-59, the IRS states that the following types of errors may be corrected using the standard noted above:

- HSA contributions for a pay period that exceed an employee's payroll withholding election;
- Amounts mistakenly contributed to an employee due to an "incorrect spreadsheet" or "similar names are confused with one another";
- Contributions incorrectly entered by a payroll administrator (either internal or third-party);
- Additional contributions received due to the transmission of a duplicate payroll file,
- Over or under contributions resulting from delayed processing of a payroll withhold change for an employee;
- Disparity between elected annual contribution and incorrect contributions, such as over an incorrect number of pay periods; and
- Over-contributions resulting from a misplaced decimal point.

If an employer intends to make any such corrections, it should maintain documents explaining how the mistaken contributions occurred. The IRS information letter does not provide the same level of reliance as IRS guidance issued in a Notice, Revenue Ruling, or Revenue Procedure, but it does offer insight into how the IRS will interpret Notice 2008-59.

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[41] *See* https://www.irs.gov/pub/irs-wd/18-0033.pdf. Information Letter 2018-0033, released by the IRS on December 28, 2018, was initially provided on September 9, 2015 as a response to a request for information concerning mistaken contributions to HSAs made by employers.

[42] Previously, IRS Notice 2008-59 described the limited circumstances under which an employer could seek recoupment of incorrectly contributed HSA contributions. The limited circumstances included HSA contributions made to employees who were never HSA-eligible and contributions in excess of the annual statutory contribution limit.

[43] 2008-29 I.R.B. 123.

13. Failure to Cash a Distribution Check from a Qualified Retirement Plan

On September 3, 2019, the IRS issued Revenue Ruling 2019-19.[44] Revenue Ruling 2019-19 provides that a qualified plan participant's failure to cash a plan distribution check received in 2019 will not permit the participant to exclude the distribution amount from his or her gross income in that year under Code section 402(a). In addition, the revenue ruling states that an employer's withholding and reporting obligations under Code sections 3405 and 6047(d) are also not altered based on the fact that a plan participant failed to cash a qualified plan distribution check. The IRS noted that for purposes of its position taken in the revenue ruling, it did not matter whether the plan participant kept the check, sent it back, destroyed it, or cashed it in a subsequent year.

Revenue Ruling 2019-19 notes that the Department of Treasury and the IRS will continue to analyze issues related to other situations involving uncashed retirement plan checks such as situations involving missing participants with plan benefits.

14. Proposed Regulations on Multiple Employer Plans

In July of 2019, the IRS issued proposed regulations[45] relating to the so-called "one bad apple rule." Under this rule, if one employer in a multiple employer plan violates a Code qualification requirement, then the entire plan can lose its qualified status.

The proposed regulations provide an exception to the "one bad apple rule" if the following requirements are satisfied:

- Eligibility Requirements: The plan implements certain practices and procedures to promote compliance with applicable requirements of the Code.
- Notice: The plan administrator provides notice to the non-compliant employer and an opportunity to take remedial action with respect to the qualification failure.
- Spin Off: If the non-compliant employer fails to take remedial action, then the plan administrator implements a spin off of the plan assets held on behalf of employees of the non-compliant employer.
- IRS Information Request: The plan administrator complies with information requests in connection with an IRS examination of the spun-off plan.

The proposed regulations also indicate that the IRS intends to revise EPCRS to reflect the new rules and provide guidance on when a plan utilizing the exception to the "one bad apple rule" is eligible for correction under EPCRS.

On October 1, 2019, the Church Alliance filed a comment letter on the proposed regulations.[46] In the comment letter, the Church Alliance requested that the IRS clarify whether the new rule applies to 403(b) plans. The Church Alliance also expressed concern about the spin off requirement included in the new rules and suggested alternative

[44] 2019-36 I.R.B. 674.

[45] 84 Fed. Reg. 31,777 (July 3, 2019).

[46] See Appendix A for information to access the Church Alliance comment letter.

approaches that would end the non-compliant employer's participation in the plan without impacting existing participant accounts.

15. Retiree Lump-Sum Windows

On June 9, 2015, the IRS issued Notice 2015-49[47] to inform taxpayers that they intend to amend the required minimum distribution ("RMD") regulations under Code section 401(a)(9)[48] to address the use of lump sum payments to replace pensions being paid by a qualified defined benefit pension plan. These arrangements are commonly referred to as retiree lump-sum windows. The 2015 Notice states that the amended regulations will generally prohibit defined benefit plans from implementing retiree lump-sum windows as of July 9, 2015, subject to certain limited exceptions. After the 2015 Notice was issued, private letter rulings and determination letters issued by the IRS or the IRS Office of Chief Counsel involving a plan that provides for a retiree lump-sum window generally started including a caveat expressing no opinion as to the federal tax consequences related to the use of the retiree lump sum window.

On March 6, 2019, the IRS issued Notice 2019-18,[49] which states that the IRS no longer intends to propose the amendments to the RMD regulations that were described in Notice 2015-49 but intends to continue studying retiree lump-sum windows. Until further guidance is issued, a plan amendment providing for a retiree lump-sum window program will not cause the plan to violate Code section 401(a)(9) although the IRS will continue to evaluate the plan to determine whether it complies with other sections of the Code. In addition, the IRS will not issue private letter rulings regarding retiree lump-sum windows, and determination letters will no longer include the caveat stating that the IRS expresses no opinion regarding the tax consequences of a retiree lump-sum window.

16. Relief from Once-In-Always-In Condition for Excluding Part-Time Employees from Making Elective Deferrals Under a 403(b) Plan

The IRS issued Notice 2018-95[50] on December 4, 2018, providing relief for 403(b) plans regarding incorrectly excluding certain part-time employees from plan participation. Non-QCCOs must comply with the universal availability rule requiring all employees to have an opportunity to make elective deferral contributions to the employer's 403(b) plan. The IRS permits certain categories of employees to be excluded from making elective

[47] 2015-30 I.R.B. 79.

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

[49] 2019-13 I.R.B. 915.

[50] 2018-52 I.R.B. 1058.

deferrals, including part-time employees who "normally work less than 20 hours per week."

The notice includes the following two rules regarding exclusion of part-time employees in 403(b) plans:

- First-year exclusion condition: During an employee's first year of employment, the employee can be excluded if the employer reasonably expects the employee to work fewer than 1,000 hours during the year.
- Preceding-year exclusion condition: For each plan year after the first year, the employee must actually work fewer than 1,000 hours in the preceding 12-month period to be excluded in the second and future years.

This second rule is often referred to as the once-in, always-in ("OIAI") rule. Many employers have been excluding part-time employees who previously worked 1,000 hours or more in a year, but later returned to working less than 1,000 hours per year. The IRS became aware of this common misinterpretation and issued a "relief period" and a "fresh start" in Notice 2018-95, as follows:

- Relief period: During the relief period, a plan will not be treated as failing to satisfy the conditions of the part-time exclusion because the plan did not follow the OIAI requirement. The relief period begins with taxable years starting on or after January 1, 2009 (the general effective date of the 403(b) regulations) and ends on the last day of the last exclusion year[51] that ends before December 31, 2019.
- Fresh start: The IRS will not assert that there is an operational plan error if the part-time exclusion is applied as if the OIAI requirement first became effective January 1, 2018 and the plan was operated during the relief period in compliance with the OIAI exclusion or pursuant to relief described in Notice 2018-95.

An employer has until March 31, 2020 to amend plan language to reflect the actual application of the OIAI requirement.[52]

17. Clarifications on Parking Excise Tax

The TCJA added section 512(a)(7) to the Code, which causes certain parking-related expenses paid or incurred by tax-exempt organizations to be treated as unrelated business taxable income and taxed under the unrelated business income tax ("UBIT") rules. Specifically, Code section 512(a)(7) requires the unrelated business taxable income of an organization to be increased by any amount for which a deduction is not allowable under Code section 274 and which is paid or incurred by the organization for any qualified

[51] An exclusion year is generally the period during which an employee's hours are measured to determine whether the employee satisfied the 1,000-hour requirement. The Notice provides additional information regarding exclusion years.

[52] The IRS previously issued the following sample plan language in the Listings of Required Modifications #17: "…Once an Employee becomes eligible to have Elective Deferrals made on his or her behalf under the Plan under this standard, the Employee cannot be excluded from eligibility to have Elective Deferrals made on his or her behalf in any later year under this standard."

transportation fringe benefit, any parking facility used in connection with qualified parking, or any on-premises athletic facility.

In December of 2018, the IRS issued Notice 2018-99,[53] clarifying that the tax under Code section 512(a)(7) must be calculated based on the total parking expenses incurred in connection with providing the parking, and not the value of the employee parking. Total parking expenses are expenses paid by the employer that include (but are not limited to) repairs, maintenance, utility costs, insurance, property taxes, interest, snow and ice removal, leaf removal, trash removal, cleaning, landscaping, parking lot attendant expenses, security, and rent or lease payments.

If the primary use of the parking facility is to provide parking to the general public, then the total parking expenses are exempt from the excise tax (except for expenses related to any spots specifically reserved for employees). The "primary use" of the parking facility is to provide parking to the general public if more than 50% of actual or estimated usage of the parking spots in the parking facility are not specifically reserved for employees.

The excise tax is reported on Form 990-T, which churches do not normally file.[54] This is not a popular tax, and several bills have been introduced repealing the tax.

The Church Alliance filed a comment letter on February 22, 2019 in response to Notice 2018-99.[55] The comment letter requests clarification and additional relief, including enforcement relief or a delay in enforcement for churches and integrated auxiliaries of churches as a result of First Amendment concerns. In the event the enforcement relief cannot be granted, the comment letter requests certain clarifications and other relief further described in the letter.

The Church Alliance also submitted a comment letter on June 7, 2019 in response to the IRS request for comments on the 2019-2020 Priority Guidance Plan.[56] In this letter, the Church Alliance advised the IRS that one of its top two priorities is further guidance on the parking excise tax provision.[57]

[53] 2018-52 I.R.B. 1067.

[54] The enactment of Code section 512(a)(7) may result in certain tax-exempt organizations owing UBIT and having to pay estimated income tax for the first time. Accordingly, in Notice 2018-100, 2018-52 I.R.B. 1074, the IRS waived the penalty for failing to pay estimated income taxes on or before December 17, 2018 for certain tax-exempt organizations that owe an excise tax under Code section 512(a)(7) and that were not required to file a Form 990-T for the taxable year immediately preceding the organization's first taxable year ending after December 31, 2017.

[55] See Appendix A for information to access the Church Alliance comment letter.

[56] See Appendix A for information to access the Church Alliance comment letter.

[57] The other top priority listed in the comment letter is further guidance on the church plan definition regulations. The church plan definition regulations are further discussed in Section II.A.1. of this report.

18. Guidance on Excise Tax on Compensation in Excess of $1 Million Paid by Certain Tax-Exempt Organizations

The TCJA added Section 4960 to the Code, imposing an employer-paid 21% excise tax on excess executive compensation paid by tax-exempt organizations. In December of 2018, the IRS issued Notice 2019-09, which provides interim guidance on the excise tax. The notice also states that the IRS intends to issue proposed regulations on the excise tax that will incorporate the guidance provided in the notice and any future guidance. Until further guidance is issued, the notice states that taxpayers are required to rely on a good faith, reasonable interpretation of the statute, which would include the guidance set forth in the notice.

Under Code section 4960, excess executive compensation includes:

a. Any *remuneration* paid (other than an excess parachute payment) by an applicable tax-exempt organization for a taxable year with respect to employment of any *covered employee* in excess of $1 million, plus

b. Any excess *parachute payment* paid by such organization to any covered employee.

A "covered employee" is any employee (or former employee) of an applicable tax-exempt organization if the employee is one of the five highest compensated employees of the organization for the taxable year or was a covered employee of the organization (or a predecessor) for any preceding taxable year beginning after December 31, 2016. The covered employee list must be monitored and will grow over time.

"Remuneration" means wages as defined for income tax withholding purposes, but does not include any designated Roth contribution. Remuneration is treated as paid when there is no substantial risk of forfeiture of the rights to such remuneration, even if it has not yet been actually received by the covered employee. It is important to note that wages for withholding purposes does not include compensation received in exercise of ministry by an ordained, licensed or commissioned pastor, and such compensation will therefore not be treated as remuneration under Code Section 4960.

A "parachute payment" is a payment in the nature of compensation to (or for the benefit of) a covered employee if the payment is made as a result of the employee's involuntary separation from employment, and the aggregate present value of all such payments equals or exceeds three times the base amount.[58] The excise tax applies as a result of an excess parachute payment, even if the covered employee's remuneration is less than $1 million. Parachute payments do not include payments under a qualified retirement plan, a simplified employee pension plan, a simple retirement account, or a Section 403(b) tax-deferred annuity. Parachute payments include nonqualified deferred compensation payments. Accordingly, the 21% excise tax could be triggered if an executive (covered

[58] "Base amount" is defined as the average annualized compensation includible in the covered employee's gross income for the five taxable years ending before the date of the employee's separation from employment.

employee) participates in a nonqualified deferred compensation plan, is involuntarily terminated, and as a result receives a large payment from a nonqualified plan.

Payments from 457(b) plans do not count as excess parachute payments, but are treated as wages and therefore constitute remuneration for Code section 4960 purposes. Payments from 457(f) plans also constitute remuneration.

19. PATH Act Guidance

On December 18, 2015, President Obama signed the Protecting Americans from Tax Hikes Act of 2015 ("PATH Act")[59] into law. Section 336 of the PATH Act contains important provisions applicable to church retirement and welfare benefit plans, including provisions:

- Clarifying the application of the controlled group rules to church plans;
- Preempting any state law directly or indirectly prohibiting or restricting the inclusion of an automatic contribution arrangement in any church plan;
- Providing that certain transfers and mergers will not be treated as distributions includable in gross income; and
- Permitting church plan assets to be invested in a group trust described in Revenue Ruling 2011-1 without adversely affecting the tax status of the group trust.

In 2018, the IRS requested comments on certain PATH Act provisions affecting church plans. The Church Alliance submitted a comment letter on December 21, 2018 in response to the IRS's request for comments.[60] The comment letter requests:

- Guidance permitting church plans offering automatic enrollment to rely on existing guidance applicable to ERISA plans as a safe harbor in designing automatic enrollment provisions;
- Additional guidance regarding certain church plan transfers and mergers; and
- Revision of revenue rulings issued prior to the PATH Act to correspond with the PATH Act provision permitting church plan investments in collective trusts.

The letter also explains the Church Alliance's understanding of the recordkeeping requirements applicable to a revocation of an election to aggregate or disaggregate church-related organizations under the controlled group rules.

20. UBIT Under Code Section 512(a)(6)

The TCJA added section 512(a)(6) to the Code. Section 512(a)(6) requires a tax-exempt organization with more than one unrelated trade or business to calculate UBIT separately for each trade or business. Some have suggested that investments by the

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

[60] See Appendix A for information to access the Church Alliance comment letter.

retirement plan of a tax-exempt organization in alternative investments might be considered a trade or business for purposes of this provision.

On August 21, 2018, the IRS issued Notice 2018-67[61] to request comments on the calculation of UBIT under Code Section 512(a)(6) for tax-exempt organizations with more than one unrelated trade or business. The Church Alliance submitted a comment letter in response to the IRS's request for comments on December 3, 2018.[62] The comment letter proposes methods of complying with Code section 512(a)(6) that would reduce burdens on church plans and suggests that the effective date of this provision be delayed until further guidance is issued.

21. Remedial Amendment Periods for Correcting 403(b) Plan Defects

The final 403(b) regulations that were issued in 2017 included a written plan document requirement. In 2013, the IRS issued Revenue Procedure 2013-22[63] under which it established a remedial amendment period ("RAP") to allow an employer to retroactively correct defects in the form of its written plan document by either adopting a 403(b) pre-approved plan or amending its individually-designed plan document no later than the end of the RAP. The RAP is available only if an employer adopted a written plan on or before the first day of the RAP, which is the later of January 1, 2010 or the effective date of the plan. In Revenue Procedure 2017-18,[64] the IRS announced that the last day of the RAP is March 31, 2020. Accordingly, a plan that does not satisfy the 403(b) requirements at any time during the RAP has until March 31, 2020 either to adopt a 403(b) pre-approved plan or correct any defects in the form of its individually-designed plan document.

On September 30, the IRS issued Revenue Procedure 2019-39,[65] which establishes a system of RAPs for both individually-designed and pre-approved 403(b) plans for form defects first occuring after March 1, 2020. In addition, the revenue procedure extends the end of the March 31, 2020 RAP under certain circumstances to ensure that plans have time to adopt amendments for changes occuring near the end of the initial RAP. The revenue procedure also provides deadlines for the adoption of 403(b) individually-designed and pre-approved plan amendments.

Although the RAPs allow plans additional time for amendments, plans must still be operated in accordance with any changes in law on the date such changes become effective. The IRS currently maintains an operational compliance list on its website for sponsors of qualified plans.[66] The IRS intends to begin including changes in the 403(b) requirements on the operational compliance list.

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[61] 2018-36 I.R.B. 409.

[62] See Appendix A for information to access the Church Alliance comment letter.

[63] 2013-18 I.R.B. 985.

[64] 2017-5 I.R.B. 743.

[65] 2019-42 I.R.B. 945.

[66] *See* https://www.irs.gov/retirement-plans/operational-compliance-list.

With respect to pre-approved 403(b) plans, the revenue procedure also establishes a system of recurring six-year cycles. Under this system, the IRS will permit pre-approved plan sponsors to apply for opinion or advisory letters for plans during a one-year submission period that will generally occur at the beginning of each cycle. The IRS will provide guidance on the procedures and dates for submitting applications for opinion or advisory letters and the date by which an employer must adopt a newly approved plan. The IRS expects the adoption deadline to provide almost all employers with about two years to adopt the newly approved plan. The submission period for the next cycle is not expected to begin until 2023.

22. Proposed Regulations on Withholding for Certain Periodic and Non-Periodic Payments

In May of 2019, the IRS issued proposed regulations regarding withholding on certain periodic and nonperiodic distributions from employer deferred compensation plans, individual retirement plans, and commercial annuities.[67] The regulations do not apply to eligible rollover distributions or distributions to nonresident aliens. The regulations generally incorporate the guidance set forth in Notice 87-7[68] along with certain additional provisions and clarifications.

The proposed regulations provide that a payor is not required to withhold if a payee provides a residence address within the United States and elects no withholding. For this purpose, the proposed regulations would treat an APO, FPO, or DPO military or diplomatic post office address as a United States address rather than a foreign address. In contrast, a payor would be required to withhold (and a payee would not be entitled to opt out of withholding) if:

- a payee provides a residence address outside of the United States;
- a payee has not provided a residence address to the payor; or
- a payee provides a residence address within the United States but provides payment instructions indicating that the funds are to be delivered outside of the United States.

Until final regulations are issued, taxpayers may continue to rely on the existing guidance set forth in Notice 87-7. In addition, taxpayers may rely on the provision of the proposed regulations relating to withholding on distributions to payees who have provided the payor with a military or diplomatic post office address.

23. Proposed Regulations on Form 990

In September of 2019, the IRS issued proposed regulations that would update the information reporting regulations under Code section 6033.[69] These regulations require organizations exempt from tax under Code section 501(a) to file a Form 990 series return,

[67] 84 Fed. Reg. 25,209 (May 31, 2019).

[68] 1987-1 C.B. 420.

[69] 84 Fed. Reg. 47,447 (Sept. 10, 2019).

unless the organization is subect to an exemption. The proposed regulations would update the existing regulations to reflect certain statutory amendments to Code section 6033 and certain IRS rulings that include exemptions from the filing requirements.

The proposed regulations do not incorporate Revenue Procedure 96-10,[70] which relieves from the Form 990 filing requirement certain organizations that are operated, controlled, or supervised by one or more churches, integrated auxilaries, or conventions or associations of churches. The preamble to the proposed regulations states that Revenue Procedure 96-10 is not incorporated because it is unclear whether it still applies. According to the preamble, the IRS believes most of the organizations described in the revenue procedure are likely classified as supporting organizations under Code section 509(a)(3). As a result of the Pension Protection Act of 2006, the IRS is no longer permitted to relieve a supporting organization of its filing requirements. Based on this change, the IRS expects that few (if any) organizations still rely on Revenue Procedure 96-10.

The IRS is requesting comments on the "continued usefulness" of Revenue Procedure 96-10. The Church Alliance is considering filing a comment letter on this issue for church benefits boards and other church financial service organizations (e.g., church foundations or church loan extension funds) that rely on Revenue Procedure 96-10 as support for the exemption from the Form 990 filing requirement.[71] Comments must be filed by December 9, 2019.

24. Proposed Regulations Updating Required Minimum Distribution Tables

On November 8, 2019, the IRS issued proposed regulations[72] updating the life expectancy and distribution period tables used to calculate RMDs from retirement plans and individual retirement accounts. The proposed changes adjust the tables for longer life expectancies, which would allow individuals to withdraw smaller annual amounts from their retirement plans or accounts. The updated tables are proposed to apply for distribution calendar years beginning on or after January 1, 2021, subject to certain transition rules set forth therein. The IRS has requested comments on the proposed regulations by January 7, 2020.

B. Department of Labor

1. Proposed Electronic Disclosure Rules

In October, the Department of Labor ("DOL") issued proposed regulations that would permit retirement plans subject to ERISA to satisfy certain disclosure requirements by notifying participants that required information will be available on a website.[73] ERISA

[70] 1996-1 C.B. 138.

[71] Some church benefits boards may rely on other sources to establish an exemption from the Form 990 filing requirement, such as a separate ruling from the IRS stating that the organization is exempt from the filing requirement.

[72] 84 Fed. Reg. 60,812 (Nov. 8, 2019).

[73] 84 Fed. Reg. 56,894 (Oct. 23, 2019).

plans are also entitled to continue relying on the existing DOL safe harbors for electronic delivery. The proposed regulations only apply to disclosures by ERISA retirement plans, but the DOL is considering and requesting comments regarding whether the safe harbor should be extended to welfare plans.[74]

Under the proposed regulations, a plan administrator would be required to furnish a one-time paper notice of internet availability that some or all covered documents will be furnished electronically. A covered document includes any document that the plan administrator is required to furnish under Title 1 of ERISA, other than documents that must be furnished upon request. The notice must be sent to current employees before using the safe harbor and to all new employees. Participants who prefer to receive the disclosures on paper will be permitted to opt out of electronic disclosure.

Participants and beneficiaries entitled to receive covered documents must either provide the employer or plan administrator with an electronic address (e.g., an e-mail address or internet-connected smartphone number) or have an e-mail address assigned by the employer for this purpose. At the time a covered document is made available on the website, the plan administrator would be required to provide participants a notice of internet availability by e-mail or in another manner permitted by the proposed regulations. The covered document must remain available on the website until it has been superseded.

The proposed regulations include a description of the content that must be included in the notice. Although the notice must be furnished separately from other documents, one notice can be issued for several types of covered documents. If one notice is used for several documents, then it must be furnished at least once each plan year and no more than 14 months following the prior notice.

If an employee terminates employment, then the plan administrator must take steps to ensure that the individual's electronic address is still valid or obtain a new electronic address. In addition, if an electronic address becomes inoperable, then the plan administrator must treat the individual as if he or she opted out of electronic delivery while taking reasonable steps to fix the problem.

2. Association Health Plans

The DOL final rules on association health plans issued in June of 2018 would expand the definition of "employer" under ERISA for purposes of providing health care benefits.[75] The change would permit small employers and sole proprietors to access the less restrictive requirements applicable to large group plans.

[74] Although the regulations are not applicable to church plans, we are providing information on them as a guide to how church plans might want to disclose certain information available to plan participants.

[75] 83 Fed. Reg. 28,912 (June 21, 2018). These regulations do not apply to plans that are not subject to ERISA, such as non-electing church plans. However, we mention this because of their similarity to the multiple employer nature of church health care plans.

The final rule also establishes requirements for groups or associations formed for the purpose of providing health benefits. One requirement is that employers in the association have a "commonality of interest," which can be established by:

- Employers being in the same trade, industry, line of business or profession; or
- Employers having a principal place of business in a region that does not exceed the boundaries of the same state or metropolitan area (even if such area includes more than one state).

In March of 2019, a federal district judge struck down a key part of the rules, stating that they are an "end run" around the Patient Protection and Affordable Care Act ("ACA") and ignore the language and purpose of ERISA and the ACA.[76] The Department of Justice ("DOJ") filed an appeal, which has not yet been decided.

The DOL issued a statement regarding the district court ruling on April 29, 2019.[77] In the statement, the DOL stated that it will not pursue enforcement actions for violations stemming from good faith actions taken before the district court's decision in reliance on the final rules, provided that plans pay health benefit claims as promised. In addition, the statement provides that the DOL will not take action against existing association health plans for continuing to provide benefits to members who enrolled in good faith prior to the district court decision through the end of the plan year or contract term that was in effect at the time of such decision.

3. Final Regulations on Multiple Employer Retirement Plans

In July, the DOL issued final regulations[78] expanding the availability of multiple employer retirement plans under ERISA. Under the final rule, an employer group or association or a professional employer organization ("PEO") is permitted to sponsor a multiple employer retirement plan under ERISA if it satisfies certain criteria. One of the requirements applicable to a group or association is that the employers in the group or association have a "commonality of interest." Similar to the regulations applicable to association health plans, a "commonality of interest" exists if the employers are in the same trade, industry, line of business, or profession or if the employers have the same principal place of business in a region that does not exceed the boundaries of the same state or metropolitan area (even if such area includes more than one state).

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

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

[78] 84 Fed. Reg. 37,508 (July 31, 2019). These regulations do not apply to plans that are not subject to ERISA, such as non-electing church plans. However, we mention this in this report because of the issuance of similar regulations by the IRS. On the same date the final regulations were issued, the DOL issued a request for information regarding whether ERISA regulations should be amended to expand the available of multiple employer retirement plans to unrelated employers. 84 Fed. Reg. 37,545 (July 31, 2019).

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

1. Mental Health Parity FAQs and Model Disclosure Request Form

On September 5, 2019, the DOL, HHS, and the Department of Treasury (the "Agencies") issued final frequently asked questions ("FAQs")[79] on the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The FAQs are substantially the same as the proposed FAQs that were issued in 2018. The Agencies also released a model disclosure form that participants can use to request information from plans about treatment limitations imposed on mental health benefits.

To satisfy the parity requirements, any financial requirements (*e.g.*, co-payments and co-insurances) or treatment limitations (*e.g.*, visit limits) imposed on the mental health/substance use disorder benefits cannot be more restrictive than the predominant financial requirements or treatment limitations imposed on substantially all of the medical/surgical benefits in a classification.[80] Treatment limitations include both quantitative treatment limitations, which are expressed numerically, and nonquantitative treatment limitations ("NQTL"), which otherwise limit the scope or duration of benefits for treatments under the plan. With respect to NQTLs, a plan may not impose a NQTL on mental health or substance use disorder benefits in a classification unless any processes, strategies, evidentiary standards and other factors in applying the NQTLs are comparable to, and are applied no more stringently than, those used in applying the NQTL to medical and surgical benefits in the same classification.

The FAQs provide additional guidance regarding NQTLs. In particular, the FAQs clarify the following:

- A plan may not apply a medical management standard limiting or excluding benefits based on whether a treatment is experimental or investigative that is applied more stringently to mental health or substance abuse disorder benefits as compared to medical or surgical benefits;
- A plan may not apply more stringent guidelines when setting dosage limits for prescription drugs to treat mental health or substance abuse disorder;
- A plan may not reduce reimbursement rates for non-physician practitioners providing mental health or substance abuse disorder services without using a comparable process with respect to reimbursement of non-physician providers of medical or surgical services;
- A plan may not exclude coverage for inpatient, out-of-network treatment outside of a hospital for eating disorders when the plan covers such treatments for medical or surgical conditions following physician authorization and a determination that the treatment is medically appropriate based on clinical standards of care; and

[79] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf.

[80] The six classifications of benefits are (1) inpatient, in-network; (2) inpatient, out-of network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

- A plan may generally exclude all benefits for a particular condition without violating the MHPAEA.

The FAQs also include guidance on certain provisions of federal law that may require disclosures regarding mental health and substance abuse disorder benefits.

2. Proposed Regulations Requiring Advance Disclosure of Price and Cost-Sharing Information to Participants

On November 15, 2019, the Agencies released a proposed rule[81] requiring non-grandfathered group health plans to make health care pricing information more accessible. Specifically, the proposed regulations would require non-grandfathered group health plans to make available:

- out-of-pocket cost information for all covered health care items and services to participants, beneficiaries, and enrollees through a website and in a paper form upon request; and
- in-network negotiated rates with in-network providers and historical out-of-network allowed amounts to the public through a website.

The regulations are proposed to apply for plan years beginning at least one year after the issuance of final regulations. The Agencies requested comments on the proposed regulations.

D. Equal Employment Opportunity Commission

1. Court Vacates Incentive Provisions of Final Wellness Regulations

The Americans with Disabilities Act ("ADA") generally prohibits employers from making disability-related inquiries and medical examinations unless the inquiry or exam is "voluntary" and part of an employee health program available at the employee's worksite. 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

[81] *See* https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-25011.pdf (to be published in the Federal Register on November 27, 2019).

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

In September of 2017, the EEOC filed a status report with the Court stating that it intended to issue proposed rules by August of 2018 and final rules by October of 2019. The EEOC's report also indicated 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.

AARP then filed a motion requesting the court to reconsider its decision and vacate the rules. On December 20, 2017, the court vacated the 30% incentive portion of the rules as of January 1, 2019 and directed the EEOC to propose new rules by August 31, 2018, stating that the 2021 timeframe for the new rules is "unacceptable."[83] Consistent with that decision, on December 20, 2018, the EEOC issued final rules removing the incentive section of the ADA regulations at 29 C.F.R. 1630.14(d)(3) effective as of January 1, 2019. Although the ADA's 30% incentive provision has been removed, the other ADA wellness requirements remain in effect, such as the ADA notice requirement.

The EEOC has yet to issue new rules, and the EEOC has no current deadline for issuing such regulations related to the wellness program incentives. Although the court, as noted above, had initially set a deadline of August 31, 2018, it later conceded that it had no authority to order the EEOC to issue new regulations under a certain timeline. In the Spring of 2019, the EEOC indicated it was developing a Notice of Proposed Rule Making for December 2019 to address wellness programs under the ADA in response to the previous court ruling.[84]

A lawsuit seeking class action certification was filed in the district court of Connecticut on July 16, 2019 against Yale University related to its wellness program and the penalty employees must pay if they chose not to participate.[85] On October 17, 2019, plaintiffs filed an amended complaint. The named plaintiffs are union employees of Yale University. The annual penalty imposed upon employees who choose not to participate in Yale's wellness program is $25 per week, or $1,300 per year which is deducted directly from employees' pay checks. The complaint alleges that Yale employees are put in an

[82] *AARP v. U.S. Equal Employment Opportunity Comm'n*, 267 F.Supp.3d 14 (D.D.C. 2017).

[83] *AARP v. U.S. Equal Employment Opportunity Comm'n*, 292 F.Supp.3d 238 (D.D.C. 2017).

[84] See https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201904&RIN=3046-AB10. The EEOC had previously indicated it may issue new regulations related to the wellness incentives in June of 2019.

[85] *Kwesell v. Yale University*, No.: 3:19-cv-01098 (KAD) (U.S. Dist. Conn. Plaintiff's compliant filed July 16, 2019). An amended complaint was filed October 17, 2019.

"untenable position: either divulge protected information (including prior insurance claims data) and submit to invasive medical examinations and testing or forfeit a substantial portion of their salary to keep their personal medial and genetic information private." The complaint asserts Yale's very high non-participation penalty violates participants' civil rights, as well as the protections of the ADA and GINA since it coerces employees to participate, effectively making the wellness program not voluntary in nature. Yale's wellness program requires employees and spouses to complete (dependent upon their age) various exams, screenings, and vaccines. Certain participants are also required to consult with a health coach.

Yale filed its answer to the complaint November 15, 2019.[86] In its answer it asserts that Yale's wellness program is voluntary and denies the allegations that the program violates the requirements of the ADA or GINA with respect to the claims of the individual plaintiffs and with respect to the claims of the class. Yale asserts several affirmatives defenses including that: 1) plaintiff's lack standing with respect to the claims under GINA, 2) plaintiff's claims are barred by the doctrines of waiver and estoppel, 3) plaintiff's voluntarily agreed to the wellness program through their collective bargaining agreements, and 4) each plaintiff made voluntary choices as to whether to pay a fee in lieu of participating in the wellness program or seeking an appropriate exemption.

E. Securities and Exchange Commission

1. Regulation Best Interest and Other Guidance

On June 5, 2019, the Securities and Exchange Commission ("SEC") released the following guidance: (i) a final rule providing guidance on the standard of conduct applicable to broker-dealers (also known as "Regulation Best Interest"); (ii) a final rule on the Form CRS Relationship Summary; and (iii) two SEC interpretations under the Investment Advisors Act of 1940 regarding the solely incidental prong of the broker-dealer exclusion from the definition of investment advisor and the standard of conduct for investment advisers.[87]

Regulation Best Interest is probably the most significant part of the guidance. Effective June 30, 2020, Regulation Best Interest will require a broker-dealer to act in the best interest of a retail customer at the time it makes a recommendation to a customer regarding any securities transaction or investment strategy involving securities. Regulation Best Interest is designed to make it clear that a broker-dealer may not put its financial interests ahead of the interests of a retail customer in making recommendations. A retail customer includes retirement plan participants, which means that call center recommendations to participants regarding investments, distributions, and rollovers can be subject to the rule. However, church plans enjoy broad exemptions from federal and state securities laws, including the Investment Advisors Act of 1940.

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[86] *Kwesell v. Yale University*, No.: 3:19-cv-01098 (KD) (U.S. Dist. Conn. Defendant's answer to the first amended complaint filed November 15, 2019).

[87] *See* https://www.sec.gov/news/press-release/2019-89.

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, 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. Final Regulations on Health Reimbursement Arrangements and Other Account-Based Plans

On June 13, 2019, the Agencies issued final regulations[88] that expand the use of health reimbursement arrangements ("HRAs") by permitting HRAs that are integrated with individual health insurance coverage ("individual coverage health reimbursement arrangements" or "ICHRAs") and limited, excepted benefit HRAs. The final regulations substantially follow the proposed regulations that were issued in 2018 but include some changes. Under the final regulations, employers are permitted to offer ICHRAs and limited, excepted benefit HRAs to employees beginning on or after January 1, 2020.

The IRS also issued proposed regulations[89] on September 27, 2019 addressing the interaction between the employer shared responsibility provisions under Code section 4980H, the nondiscrimination rules under Code section 105(h) for self-insured group health plans, and the ICHRAs permitted under the final regulations. The proposed regulations impact ICHRAs but do not apply to limited, excepted benefit HRAs.

A description of the requirements applicable to ICHRAs and limited, excepted benefit HRAs and the provisions included in the proposed regulations is set forth below.

ICHRAs

An HRA or other account-based plan is considered a group health plan. Therefore, it is subject to the requirements under the ACA that apply to other group health plans. However, on its own, an HRA or other account-based plan typically would not comply with ACA provisions that prohibit annual limits on benefits or require preventive care at no cost. To meet these requirements, prior guidance permitted an HRA or other account-based plan to be integrated with an employer's group health plan that complies with the ACA, but did not permit an HRA to be integrated with individual health insurance coverage to satisfy these requirements.

The final regulations remove the current prohibition against integrating HRAs with individual health coverage and permit employers to establish ICHRAs.[90] Under the final regulations, an ICHRA is considered integrated with individual health insurance coverage if:

[88] 84 Fed. Reg. 28,888 (June 20, 2019).

[89] 84 Fed. Reg. 51,471 (Sept. 30, 2019).

[90] The final regulations do not include a limit on the amount that an employer may contribute to an ICHRA.

- ICHRA participants are enrolled in individual health insurance coverage that complies with the annual limit and preventive care requirements.[91]
- The employer does not offer a group health plan to a class of employees eligible for the ICHRA (as further described below).
- The ICHRA is offered on the "same terms" to all employees in the same class.[92]
- Participants are permitted to opt out of and waive future ICHRA reimbursements annually (and generally prior to the beginning of the plan year) and, at termination of employment, either the remaining amounts are forfeited or the employee may opt out or waive reimbursements.
- The ICHRA substantiates that ICHRA participants are enrolled in individual health insurance coverage for the plan year and for any month in which an expense was incurred and for which reimbursement was requested.[93]
- The ICHRA provides notice at least 90 days before the start of the plan year or, for employees who become eligible after the 90-day notice is provided, before the employee is first eligible.

These requirements will allow employers to offer a group health plan to one specified class of employees and an integrated ICHRA to another specified class of employees based on the classes defined in the regulation. Under the regulations, the permissible classes[94] include full-time employees, part-time employees, seasonal employees, salaried employees, non-salaried employees, employees who have not satisfied a waiting period, non-resident aliens with no U.S.-source income, and employees whose principal place of employment is in the same rating area (and a combination of the above).[95] The regulations include minimum class size requirements for employers who offer a group health plan to some employees and an ICHRA to other employees. The final regulations also include special rules for new hires under which an employer may offer new employees an ICHRA while continuing to offer coverage under a group health plan to existing employees.

Importantly, the final regulations also clarify that ICHRAs can be integrated with Medicare and used to reimburse premiums for Medicare Part A, B, C or D and Medigap policies, as long as the above requirements are satisfied. Accordingly, the employer would still be required to offer

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[91] The final regulations clarify that all individual health insurance coverage (except for individual health coverage consisting solely of excepted benefits) would satisfy this requirement.

[92] The final regulations clarify that the maximum dollar amount made available under an ICHRA may increase as the number of the participant's dependents who are covered under the ICHRA increases or as the age of a participant increases, provided certain requirements are satisfied.

[93] ICHRAs can also reimburse participants for other qualifying medical expenses (e.g., co-pays and deductibles) as long as such reimbursement complies with the Code section 105(h) nondiscrimination requirements.

[94] The proposed regulations also included employees who have not attained age 25 prior to the beginning of the plan year as a permissible class. The final regulations do not include this class of employees because of concerns expressed by insurance companies regarding adverse selection.

[95] On December 28, 2018, the Church Alliance submitted a comment letter on the proposed regulations requesting that churches be permitted to adopt employment classifications based on nondiscriminatory religious requirements. This would have permitted churches to offer a group health plan to ministers and an HRA to lay employees. However, this provision was not included in the final regulations. See Appendix A for information to access the Church Alliance comment letter.

the ICHRA on the "same terms" to all employees in the same class, regardless of Medicare eligibility. This means that the ICHRAs of some employees in the class may be integrated with individual health insurance while the ICHRAs of other employees in the class are integrated with Medicare.[96]

In conjunction with the final regulations,[97] the Agencies also issued model notices that can be used to satisfy the notice requirements included in the final regulations, a model attestation that participants can use to substantiate enrollment in individual health coverage, and frequently asked questions about ICHRAs.

Excepted Benefit HRA

The regulations also permit employers to offer stand-alone HRAs under which medical expenses and certain types of premiums may be reimbursed. This type of HRA is considered an excepted benefit that is not subject to the market reform provisions of the ACA. An excepted benefit HRA must satisfy the following requirements:

- Employers must offer major medical coverage in addition to the HRA to employees;
- The reimbursement amount is limited to $1,800 per year (as adjusted), not including any carryover amounts;[98]
- The HRA generally may not be used to reimburse premiums other than premiums for COBRA (or other continuation coverage) or excepted benefit coverage; and
- The HRA must be made available on the same terms to all similarly situated employees without regard to any health factor.

When applying the $1,800 limit, the final regulations state that the amounts made available under all HRAs (or other account-based plans) offered by an employer to a participant for the same time period must be aggregated. HRAs reimbursing only excepted benefits are not included in this determination.

Proposed Regulations

The September 27, 2019 proposed regulations include guidance on how to structure ICHRAs to avoid the employer shared responsibility penalty under Code section 4980H. Under the employer shared responsibility provisions of the ACA, an applicable large employer is subject to a penalty if at least one full-time employee receives a subsidy for individual coverage through a state-run health care exchange and the employer either (a) does not offer minimum essential

[96] The regulations do not permit an employer to offer an ICHRA only to employees enrolled in Medicare. Instead, the employer would be required to offer the ICHRA to all employees in one of the permissible classes.

[97] The preamble to the final regulations also clarifies that HRAs that reimburse employees only for health insurance policy premiums are not subject to the nondiscrimination rules under Code Section 105(h). In addition, the final regulations provide guidance on the interaction between ICHRAs and HSAs. The final regulations also permit an employer to allow employees covered by an ICHRA who purchase health insurance coverage outside of an Exchange to pay the portion of the individual health insurance premium that is not covered by an ICHRA through a cafeteria plan.

[98] The final regulations indicate that the IRS will issue the indexed amount by June 1 of the preceding year.

coverage to at least 95% of its full-time employees (the "A Penalty"); or (b) offers coverage that does not provide minimum value or is not affordable (the "B Penalty").

Under the proposed regulations, an ICHRA is considered minimum essential coverage for purposes of avoiding the A Penalty. For purposes of the B Penalty, the proposed regulations include the following two new safe harbors[99] that can be used to determine whether the coverage provided under an ICHRA is affordable:

- Look-Back Month Safe Harbor: This safe harbor permits an employer to determine if an ICHRA is affordable by using the monthly premium for the applicable lowest cost silver plan for January of the prior calendar year (or January of the current calendar year for non-calendar year plans).
- Location-Based Safe Harbor: Under this safe harbor, an employer can determine if an ICHRA is affordable by using the lowest cost silver plan for the location of the employee's primary site of employment. The employee's primary site of employment is generally the location where the employer reasonably expects the employee to perform services on the first day of the plan year (or the first day the ICHRA will take effect for employees who become eligible during the plan year).[100]

An employer can apply different safe harbors for the different classes of employees included in the final regulations governing ICHRAs, as long as it does so on a uniform and consistent basis for all employees in that class. An HRA that satisfies the affordability requirement is treated as satisfying the minimum value requirement.

The proposed regulations also provide guidance on the interaction between ICHRAs and the nondiscrimination requirements that apply to self-insured health plans under Code section 105(h). The proposed regulations provide that an employer will not violate the nondiscrimination requirements if it varies the amounts available under ICHRAs based on age in the manner permitted under the ICHRA final regulations. In addition, the IRS notes that ICHRAs are subject to the rule prohibiting nondiscrimination in operation, which means that an ICHRA may violate the nondiscrimination rules if a disproportionate number of highly compensated employees qualify for and use the maximum amount available under the ICHRA.

The regulations are proposed to apply to plan years beginning on or after January 1, 2020. In addition, employers are permitted to rely on the proposed regulations for any period that begins before the date that is six months following the date final regulations are published.[101]

[99] The proposed regulations also permit employers to continue to use the W-2 wages, rate of pay, and federal poverty level affordability safe harbors that are included in the existing 4980H regulations.

[100] The proposed regulations provide additional guidance for employees who regularly work from home, employees whose site of employment changes during the year, and employees working in a rating area that includes more than one lowest-cost silver plan.

[101] The proposed regulations also indicate that the IRS will be releasing future guidance on the Form 1095-B and 1095-C reporting requirements for ICHRAs.

B. Contraceptive Coverage Update

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 co-payment, co-insurance 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."[102] The revised religious employer exemption covered:

- churches;
- conventions and associations of churches; and
- integrated auxiliaries.[103]

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 a 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:

[102] 78 Fed. Reg. 39,870 (July 2, 2013).

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

- opposes coverage for some or all of the contraceptive services required to be covered on account of religious objections;
- 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.[104]

As discussed above, an eligible organization entitled to the accommodation 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).[105]

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 a state's "affordable insurance 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 nonprofit religious organizations could provide notice of their religious objections to providing contraceptive coverage.[106] 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.[107]

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[104] 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.

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

[106] 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 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 fell short of the needs of eligible organizations because they were 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 continued to violate the Establishment Clause of the U.S. Constitution.

[107] 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*.

In July 2015, the Agencies finalized the interim final regulations issued in August 2014.[108] The final regulations also describe the content requirements of the alternative notice and describe accommodations for closely-held for-profit entities.[109]

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 filed on behalf of 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 filed on behalf of the government indicated that the accommodation could be modified in this way for insured plans but notes that this approach would not work for self-insured plans.

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."[110] 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.

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.[111] 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 such organizations health care plans receive the full range of contraceptive coverage without cost sharing. In

[108] 80 Fed. Reg. 41,318 (July 14, 2015).

[109] 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.

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

[111] 81 Fed. Reg. 47,741 (July 22, 2016).

particular, the Agencies requested information regarding alternative approaches that would work for insured plans as well as self-insured plans.[112]

3. 2017 Regulatory Guidance and Ensuing Litigation

On January 9, 2017, the Agencies issued FAQ Part 36[113] 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 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 rules discussed below are the result of that re-examination.

On October 6, 2017, the Agencies issued interim final rules[114] addressing religious and moral exemptions and accommodations for coverage of certain preventive services under the ACA. The Agencies issued final regulations on November 7, 2018, which are substantially the same as the interim final rules and include in the preamble responses to public comments on the interim final regulations.

These 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. The final rules were effective January 14, 2019.

The first rule[115] issues an expanded exemption to a broader range of entities and individuals that object to contraceptive coverage based on strongly held religious beliefs,

[112] 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 decided not to expand the exemption, then the Church Alliance requested that the Agencies adjust the notification required to qualify for the accommodation.

[113] Available at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resourcecenter/faqs/aca-part-36.pdf.

[114] The Church Alliance filed a comment letter on December 5, 2017 regarding the interim final rules. In the comment letter, the Church Alliance requested that the Agencies: (1) clarify that an employer adopting an exempt plan cannot be penalized; (2) provide guidance on how an organization can revoke its use of the accommodation; and (3) refrain from requiring a form of certification to claim or maintain the exemption.

[115] 83 Fed. Reg. 57,536 (Nov. 15, 2018).

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 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 rule[116] issued by the Agencies addresses moral exemptions and accommodations for coverage of certain preventive services under the ACA. This 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.[117]

The rules do not define religious or moral objections. However, the HHS Fact Sheet explains the following:

> Based on case law, the preamble to the rule explains that moral convictions are protected in ways similar to religious beliefs, when the convictions are those: (1) that a person deeply and sincerely holds; (2) that are purely ethical or moral in source and content; (3) but that nevertheless impose … a duty; (4) and that certainly occupy … a place parallel to that filled by … God in traditionally religious persons, such that one could say the beliefs function as a religion.[118]

No self-certification, filing or notice to the Agencies is required under the 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.

After the issuance of the interim final rules, district judges in California and Pennsylvania enjoined the enforcement of these two rules, finding that the agencies did not follow proper procedures in issuing the regulations and that the regulations exceeded

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[116] 83 Fed. Reg. 57,592 (Nov. 15, 2018).

[117] In the case of insurers, exempted insurance plans can only be purchased by employers or individuals having moral objections.

[118] Available at: https://www.hhs.gov/about/news/2018/11/07/fact-sheet-final-rules-on-religious-and-moral-exemptions-and-accommodation-for-coverage-of-certain-preventive-services-under-affordable-care-act.html (quotations omitted).

statutory authority.[119] On December 31, 2018, the Ninth Circuit Court of Appeals affirmed in part and vacated in part the district court decision in *California v. Health and Human Services*[120] holding that the district court abused its discretion by issuing a nationwide preliminary injunction. However, on July 12, 2019, the Third Circuit Court of Appeals affirmed the district court's order in *Pennsylvania v. Trump* granting the nationwide preliminary injunction.[121] Therefore, despite the ruling in *California v. Health and Human Services*, the *Pennsylvania v. Trump* decision provides a nationwide injunction blocking implementation of the expanded contraceptive coverage exemptions.

However, litigation continues. On May 15, 2019, the United States District Court of North Dakota granted a group of religious employers a permanent injunction against enforcement of the ACA's contraceptive mandate, and the Agencies conceded in that case that the mandate violates the Religious Freedom Restoration Act ("RFRA").[122]

Even more recently on October 22, 2019, the Ninth Circuit issued another opinion on appeal in *California v. U.S. Dept. of Health & Human Services*[123] after the district court issued a preliminary injunction barring the enforcement of the rules in thirteen states.[124] The Ninth Circuit held that the district court had not abused its discretion by extending a preliminary injunction prohibiting the enforcement of the final regulations in these thirteen states, that the states had standing to sue, and that the Third Circuit's upholding of a nationwide injunction in *Pennsylvania v. Trump* did not make the issues in the case moot. The Ninth Circuit also determined that the expanded exemptions in the final regulations violated the Administrative Procedures Act and that the ACA contraceptive mandate did not violate the RFRA because the process likely does not substantially burden the exercise of religion. As part of its decision to affirm the preliminary injunction, the Ninth Circuit also noted that the states and district are likely to suffer substantial irreparable harm from the final regulations.

The Trump administration continues to press the United States Supreme Court to finally resolve years of litigation surrounding the contraceptive mandate and the religious and moral exemptions. On October 3, 2019, the Trump Administration filed a petition with the Supreme Court urging the high court to review the Third Circuit's decision in

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[119] *Pennsylvania v. Trump*, 281 F.Supp.3d 553 (E.D. Penn. 2017); *California v. Health and Human Services*, 281 F.Supp.3d 806 (N.D. Cal. 2017).

[120] *California v. Health and Human Services*, 2018 WL 6566752 (9th Cir. 2018).

[121] *Pennsylvania v. Trump*, 2019 WL 3057657 (3rd Cir. 2019).

[122] *Christian Employers Alliance v. Aza*r, 2019 WL 2130142 (D. N.D. 2019). The Religious Freedom Restoration Act, 42 U.S.C., Section 2000bb-1(b).

[123] *State of California v. U.S. Dept Of Health & Human Services*, (2019, CA9) 2019 WL 5382250.

[124] The district court in California granted the injunction request of thirteen states blocking enforcement of the final regulations regarding the contraceptive mandate exceptions. The thirteen states are California, Connecticut, Delaware, Hawaii, Illinois, Maryland, Minnesota, New York, North Carolina, Rhode Island, Vermont, Virginia, Washington, and the District of Columbia.

Pennsylvania v. Trump.[125] On October 1, 2019, Saints Peter and Paul Home, a Catholic charity care home located in Pittsburgh, Pennsylvania established and maintained by Little Sisters of the Poor, also filed a petition with the Supreme Court to review the Third Circuit's decision in *Pennsylvania v Trump*.[126] The petitions ask the high court to definitively resolve once and for all the ongoing issues surrounding the contraceptive mandate, the religious and moral exemptions, the executive branch's authority to create exemptions, procedural rulemaking standards, and RFRA.[127]

C. Court Upholds Final Regulations on Short-Term, Limited-Duration Insurance

Short-term, limited-duration insurance ("STLDI") is a type of insurance designed to fill temporary gaps in coverage when an individual is moving to a different plan or coverage. Although STLDI is not an excepted benefit, it is exempt from the ACA market reform provisions because it is not considered individual insurance coverage. In August of 2018, the Agencies amended the STLDI regulations to increase the maximum term of coverage from 3 months to 12 months. In addition, the amended regulations permit STLDI to have a total duration of no more than a total of 36 months, taking into account renewals or extensions.[128]

A lawsuit was filed on September 14, 2018 challenging the amended regulations as contrary to the ACA and the Health Insurance Portability and Accountability Act ("HIPAA"). On July 19, 2019, the U.S. District Court for the District of Columbia rejected the plaintiffs' claim and upheld the amended regulations.[129] The plaintiffs filed an appeal on July 30, 2019.

D. Individual Mandate Litigation Ruling

In February of 2018, a lawsuit was filed challenging the constitutionality of the individual mandate. Because the U.S. Supreme Court upheld the individual mandate in 2012 as a legitimate use of Congress' taxing power, the plaintiffs argued that the reduction of the individual mandate penalty to zero under the TCJA makes it unconstitutional. The plaintiffs also argued that the

[125] *Trump v. Pennsylvania*, No. 19-454, petition for writ of certiorari filed with the United Sates Supreme Court on October 3, 2019.

[126] *Little Sisters of the Poor Saints Peter & Paul Home v Commonwealth of Pennsylvania,* No. 19-431, petition for writ of certiorari filed with the United States Supreme Court on October 1, 2019.

[127] Sixteen Republican state attorney generals have filed an amicus brief backing the Trump Administration's and Saints Peter & Paul Home's petitions for Supreme Court review. The sixteen states are: Texas, Alabama, Alaska, Arizona, Arkansas, Georgia, Kansas, Louisiana, Missouri, Montana, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, and West Virginia. Ninety-two Republican members of congress also filed amicus briefs urging the Supreme Court to review the issue of "whether the federal government lawfully exempted religious objectors from the contraceptive mandate." Additional amicus briefs have been filed including those by the American Center for Law & Justice, the Cato Institute, the Jewish Coalition for Religious Liberty, The Foundation for Moral Law, and the U.S. Conference of Catholic Bishops in support of the Trump Administration's and Saints Peter & Paul Home's petitions .

[128] 83 Fed. Reg. 38,212 (Aug. 3, 2018).

[129] *Assoc. for Cmty. Affiliated Plans, et al. v. U.S. Dept. of Treas.*, 392 F.Supp.3d 22 (D.D.C. 2019).

individual mandate cannot be severed from the rest of the ACA and, therefore, the entire law is unconstitutional.

Democratic state attorneys general from several states and the District of Columbia intervened in the case to defend the ACA. They argued that the individual mandate is still constitutional and, even if the court determines it is unconstitutional, it can be severed from the rest of the ACA.

In December 2018, the court declared the individual mandate unconstitutional.[130] The court also declared the entire ACA invalid after determining that the remaining provisions are inseverable from the individual mandate. An appeal has been filed in the Fifth Circuit.

At the district court level, the DOJ did not defend the individual mandate but argued that most of the other provisions were severable. The DOJ then changed its position and informed the Fifth Circuit Court of Appeals that it agrees with the district court that the entire ACA should be invalidated.

E. Legislation to Eliminate Cadillac Tax

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

The Cadillac tax was originally effective in 2018, but was delayed until 2020 (i.e., tax years beginning after 2019) by the Consolidated Appropriations Act, 2016.[131] In January of 2018, the Cadillac tax was further delayed to 2022 by a provision included in legislation to fund the government and end a temporary government shutdown.[132]

In July, the House of Representatives passed the Middle Class Health Benefits Tax Repeal Act of 2019 (H.R. 748) that would eliminate the Cadillac tax. The legislation has been introduced in the Senate (S. 684).

F. Patient-Centered Outcome Research Institute Adjusted Fee Ends

The ACA included 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 was generally imposed on health insurance issuers and plan sponsors of self-insured health plans for each plan or policy year ending after

[130] *Texas v. United States of America*, 340 F.Supp.3d 579 (N.D. Tex. 2018).

[131] Public Law 114-113 (2015).

[132] Public Law 115-120 (2018).

September 30, 2012, and before October 1, 2019. Accordingly, the PCORI fee no longer applies for plan or policy years ending on or after October 1, 2019.

G. Proposed HHS Rule on Section 1557 Nondiscrimination Rules

On December 31, 2016, a federal district judge issued a preliminary injunction to prevent the implementation of certain provisions of the final rule issued under section 1557 of the ACA.[133] 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 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 on 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 reviewed the regulations.[134] The court stated that the injunction remained effective throughout the stay.

In July 2019, HHS issued proposed regulations[135] that would significantly revise the existing section 1557 regulations to, among other things, address legal concerns and clarify the scope of the section 1557 regulations. The proposed regulations would apply section 1557 to the health care activities of entities not principally engaged in health care only to the extent the activities are funded by HHS. In addition, the proposed regulations include an exemption for self-insured health plans subject to ERISA unless such plans receive HHS assistance or are principally engaged in the business of providing health care. The proposed regulations would also repeal the definition of sex discrimination, which currently includes discrimination on the basis of gender identity and termination of pregnancy.

The Church Alliance submitted a comment letter on the proposed regulations on August 13, 2019.[136] The comment letter requests that the exemption for self-insured plans be expanded to include self-insured health care plans that are not subject to ERISA, such as church health care plans.

On October 15, 2019, in light of the issuance of the proposed regulations, the district court vacated the portions of the regulations that prohibit discrimination on the basis of gender identity

[133] 81 Fed. Reg. 31,376 (May 18, 2016).

[134] *Franciscan Alliance, Inc. v. Price*, No. 7:16-cv-00108-O, 2017 WL 3616652 (N.D. Tex. July 10, 2017).

[135] 84 Fed. Reg. 27,846 (June 14, 2019).

[136] See Appendix A for information to access the Church Alliance comment letter.

and termination of pregnancy.[137] The court determined that these provisions violated the Administrative Procedures Act and the RFRA.

H. Request for Information on Grandfathered Health Plans

In February 2019, the Agencies issued a request for information ("RFI") on grandfathered health plans. The RFI requests comments on the challenges grandfathered health plans face in avoiding a loss of grandfathered plan status and how the Agencies can assist grandfathered health plans in preserving grandfathered plan status in ways that would benefit employers and participants.

The Church Alliance filed a comment letter in March in response to the RFI.[138] The comment letter responds to many of the specific questions asked by the Agencies in the RFI, including what actions the Agencies could take to assist plan sponsors in preserving grandfathered plan status, what challenges plan sponsors face in retaining grandfathered plan status, the primary reasons for preserving grandfathered plan status, the reasons participants have chosen to remain in grandfathered plans where alternatives are available, and the factors considered by plan sponsors in deciding whether to retain grandfathered plan status.

I. FAQ Providing Guidance on Certain Limitations on Cost Sharing

The ACA imposes an out-of-pocket cost sharing limit on all non-grandfathered group health plans. For plan years beginning in 2020, the maximum annual limit is $8,150 for self-only coverage and $16,300 for other than self-only coverage. In 2019, HHS issued regulations addressing how coupons or discounts offered by drug manufacturers to enrollees for certain name brand prescription drugs count toward the annual limit on cost sharing. Specifically, the regulations state that plans are permitted to exclude the value of coupons from the annual limit on cost sharing when a medically appropriate generic drug is available. The Agencies recognize that this provision can be read to indicate that group health plans are required to count the coupon toward the annual limit on cost sharing in any other circumstance.

The Agencies also recognize that this requirement could be interpreted to conflict with the HDHP rules that allow eligible individuals to establish HSAs. These rules require the HDHP to disregard drug discounts in determining if the minimum HDHP deductible has been satisfied. A plan sponsor would not be able to comply with both the HDHP rule and the HHS regulation cost-sharing rule in the case where a coupon is paid for a brand name drug with no available generic alternative.

Accordingly, the Agencies issued FAQ guidance[139] recognizing the potential conflict between the HHS regulations and the HDHP guidance. To address the conflict, HHS, in consultation with the IRS and DOL, intends to issue clarifying regulations. Until these regulations become effective, the Agencies will not initiate any enforcement action against plans that exclude

[137] *Franciscan Alliance, Inc. v. Azar,* No. 7:16-cv-00108-O, 2019 WL 5157100 (N.D. Tex. 2019).

[138] See Appendix A for information to access the Church Alliance comment letter.

[139] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-40.

the value of drug coupons from the annual cost sharing limit even if there is not any available medically appropriate generic drug.

J. Summary of Benefits and Coverage Requirements

In December of 2018, the IRS issued a request for comments on the disclosure of the summary of benefits and coverage ("SBC").[140] On February 1, 2019, the Church Alliance submitted a comment letter on the SBC disclosure requirements,[141] requesting that:

- Church plans be permitted to electronically distribute SBCs without regard to the ERISA requirements;
- Plans be permitted to make language assistance available instead of translating SBCs;
- Plans be allowed to provide the SBC at the time they receive the application or initial enrollment instead of "at the time of application"; and
- The online example calculator be revised to be clearer, more intuitive, and provide more representative examples.

In addition, DOL and HHS have issued a new SBC template, updated instructions, and other related materials.[142] The updated documents are required to be used beginning on the first day of the first open enrollment period for plan years beginning on or after January 1, 2020 with respect to coverage for plan years beginning after that date. The updated documents were not heavily revised but update the template to reflect the elimination of the individual shared responsibility payment.

K. Large Employers Ask for Suspension of Employer Mandate

The ERISA Industry Committee ("ERIC") recently sent a letter to the IRS requesting a suspension of the employer mandate penalties under the ACA until the IRS has implemented a better process for determining when an employer is liable for the penalties.[143] Under the ACA, an applicable large employer is subject to the employer shared responsibility penalty if, in addition to certain other conditions, at least one full-time employee receives a subsidy for individual coverage through an Exchange.

The letter indicates that the IRS has been assessing penalties against employers without making adequate efforts to determine whether the assessments are appropriate using information that is readily available to the IRS. Instead, the IRS is relying on employees' representations that they are full-time employees who were not offered coverage. These representations are made when an individual applies for federal subsidies. Based on the experience of certain large employers, ERIC is asking the IRS to suspend the employer mandate penalties until it is able to

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[140] 83 Fed. Reg. 62,402 (Dec. 3, 2018).

[141] See Appendix A for information to access the Church Alliance comment letter.

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

[143] *See* https://www.eric.org/eric-sends-irs-letter-on-aca-penalties/.

establish a process that ensures employers are only assessed a penalty for full-time employees who were legitimately entitled to a subsidy for health care coverage on an Exchange.

L. Final Regulations Rescinding Requirements for Health Plans to Obtain Health Plan Identifiers

The Administrative Simplification provisions of HIPAA intend to improve HIPAA transactions by reducing burdens and costs. To achieve this goal, HIPAA required HHS to adopt standards for a unique health plan identifier to be used with the electronic transmission of health information. On September 5, 2012, HHS adopted a final rule setting forth the standards for a national unique health plan identifier ("HPID") and other entity identifiers ("OEIDs").[144] The final rule included the adoption of the HPID as the standard unique identifier for health plans, required all covered entities to use an HPID whenever a covered entity identifies a health plan in a covered transaction, and adopted a data element to serve as an OEID.

HHS received feedback regarding challenges the final rule imposed including provider burden, implementation costs, and inefficiencies. Health plans and insurers generally preferred to use Payer IDs rather than HPIDs in their HIPAA transactions. A Payer ID is one of several identifiers used to denote payers in HIPAA transactions (for example, the National Association of Insurance Commissioners' ("NAIC") company code). Based on industry feedback, HHS subsequently announced October 31, 2014 that covered entities would not be penalized for non-compliance with the HPID and OEID final rule.[145]

On December 19, 2018, HHS issued a proposed rule to rescind the HPID and OEIDs.[146] Commenters supported this proposed rule noting that, in addition to the preference to use Payer IDs, there was no need or value in the HPID, and that eliminating the HPIDs and OEIDs would reduce the burden and cost on self-funded groups and health plans. This proposed rule was adopted in a final rule on October 28, 2019, and it rescinds the requirement for health plans to obtain HPIDs and eliminates the voluntary acquisition and use of OEIDs.[147] The final rule simplifies the process for deactivating the existing identifiers in order to limit costs to covered entities. The rule is set to become effective on December 27, 2019. On or after the effective date of the final rule, any active HPID or OEID record will be automatically deactivated in the Health Plan and Other Entity Enumeration System, and all active Health Insurance Oversight System users will be notified of the impending deactivation. Health Plan and Other Entity Enumeration System users will be able to capture data about their HPID or OEID on the system for 60 days following December 27, 2019.

[144] 45 CFR Part 162, 77 Fed. Reg. 54664 (September 5, 2012).

[145] See https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Unique-Identifier/HPID.

[146] 45 CFR Part 162, 83 Fed. Reg. 65118 (December 19, 2018).

[147] 45 CFR Part 162, 84 Fed. Reg. 57621 (October 28, 2019).

IV. LITIGATION

A. Challenges to Church Plan Status

Numerous 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 initially 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,[148] Seventh,[149] and Ninth[150] Circuit Courts of Appeals all ruled in favor of the plaintiffs with respect to this argument and held that the defined benefit plans maintained by the respective health care systems were not church plans. These three health care systems filed petitions for writs of certiorari with the U.S. Supreme Court, asking the Court to determine that their pension plans are "church plans" under ERISA.[151] The U.S. Supreme Court agreed to take these cases, heard oral arguments in March 2017 and issued its decision in June of 2017.

The U.S. Supreme Court unanimously decided in *Advocate Health Care Network et al. v. Stapleton et al.*,[152] 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.

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[148] *Kaplan v. St. Peter's Healthcare System*, 2015 WL 9487719 (3rd Cir., 2015).

[149] *Stapleton v. Advocate Health Care Network*, 817 F.3d 517 (7th Cir., 2016).

[150] *Rollins v. Dignity Health*, 2016 WL 3997259 (9th Cir., 2016).

[151] 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.

[152] 137 S. Ct. 1652 (2017).

However, the church plan status litigation is not over, although a number of cases did settle after the Supreme Court's *Advocate* decision. Although the Supreme Court settled the question of who can establish a church plan, the trial courts in several cases are now considering three open questions:

- whether a retirement plan committee of a church-associated hospital qualifies as a "principal purpose organization" maintaining the plan, as required by Code section 414(e);
- whether the hospitals involved remain, under the facts at hand, "controlled by or associated with" a church, as also required under §414(e); and
- 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 heard oral arguments related to all three of these questions in *Medina v. Catholic Health Initiatives*. (The trial court in *Medina* had ruled in favor of the defendant healthcare system on all three questions left open by the U.S. Supreme Court's decision in *Advocate*.) An opinion by the Tenth Circuit Court of Appeals was issued on December 19, 2017.[153] The court held that Catholic Health Initiatives was associated with the Catholic Church, that a benefits plan administration committee can be a principal purpose organization and that the ERISA church plan exemption is constitutional. Similar decisions were reached by trial courts in *Smith v. OFS Healthcare System et.al*,[154] and *Feather v. SSM Health*.[155] However, August 13, 2019, the Seventh Circuit vacated the district court's grant of summary judgment in *Smith* and remanded the case stating that the district court abused its discretion in granting summary judgement, and that discovery should continue.[156]

The fact that ERISA does not apply to church plans does not mean that claims cannot be made against church plans. In the absence of ERISA preemption, state law applies. Following the *Advocate* decision, plaintiffs in some of the church plan status cases amended their complaints to add state law claims.

A recent church plan case alleging state law claims is *Hartshorne v. The Roman Catholic Diocese of Albany, New York*.[157] On September 10, 2019, the Legal Aid Society of Northeastern New York, the AARP Foundation, the Legal Services of NYC-Brooklyn Legal Services, and

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[153] *Medina v. Catholic Health Initiatives, et. al.*, 877 F.3d 1213 (10th Cir., 2017).

[154] No. 3:16-cv-00467 (S.D. Il. 2018).

[155] No. 4:16-cv-01669 (E.D. Mo. 2018). This case was appealed to the Eight Circuit. August 2, 2019, the Eight Circuit entered a judgement granting the parties joint stipulation for dismissal of the case (No. 18-2823 (8th Cir. 2019)).

[156] *Smith v. OSF Healthcare System, et.al.* No. 18-3325 (7th Cir. 2019). No settlement was reached in the case during a settlement conference held October 23, 2019 (No. 16-467-SMY-RJD (S.D. Il. 2019)).

[157] *Hartshorne v. The Roman Catholic Diocese of Albany, New York* (docket number 2019-1989 filed September 10, 2019). See https://www.aarp.org/content/dam/aarp/aarp_foundation/litigation/2019/Hartshorne-v-The-Roman-Catholic-Diocese-Albany-NY-complaint.pdf.

attorney David Pratt jointly filed a case on behalf of former workers[158] of St. Clare's Hospital[159] of Schenectady, New York against the Roman Catholic Diocese of Albany New York. The lawsuit alleges violation of New York state laws concerning contracts and fiduciary duties related to pension benefits that were drastically reduced or eliminated. The lawsuit further alleges that defendants underfunded the pension plan while simultaneously and repeatedly reassuring plan participants that they would receive pension benefits.[160] Another recent church plan case involving state law claims is *Stephen DelSesto, as Receiver and Administrator of the St. Joseph Health Services of Rhode Island Retirement Plan, et. al. v Prospect CharterCare, LLC, et. al.*[161] This case revolves around the St. Joseph Health Services of Rhode Island's pension plan that has been placed in receivership. The case is being pursued as a class action. Plaintiffs allege that the plan did qualify as a church plan and that St. Joseph Health Services of Rhode Island was not "controlled by or associated with a church or convention or association of churches." In addition to ERISA claims with respect to the pension plan related to breaches of minimum funding and fiduciary duties, the plaintiffs allege several other causes of action, including state law claims for fraudulent misrepresentations and omissions to state regulators, breach of contract claims, claims for violations of the Rhode Island Hospital Conversions Act, and claims for breaches of Rhode Island's state fiduciary laws. On October 22, 2019, the parties jointly submitted a proposed plan for limited discovery and related motions for summary judgment. The filing stated that the parties believe a renewed effort at mediation may be warranted after the parties complete limited discovery or once the Court has ruled on the motions for summary judgment related to whether the St. Joseph Health Services of Rhode Island Retirement Plan ceased to be a church plan exempt from ERISA. On October 29, 2019, the District Court of Rhode Island stated that plaintiffs' motion for summary judgment as to whether the plan is a church plan is to be filed no earlier than November 29, 2019 and not later than December 29, 2019. The Church Alliance continues to monitor the progress of these church plan status cases.

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. In the past, most of these cases have been filed against large, for-profit

[158] Plaintiffs in the case were all fully vested in their pension plan benefits and either already eligible to receive benefits or would become eligible upon reaching age 65.

[159] St. Clare's Hospital of Schenectady, New York is a part of the Roman Catholic Diocese of Albany. The complaint alleges that the Diocese is the original sponsor of St. Clare's Corporation which was formerly known as St. Clare's Hospital of Schenectady, New York, and that the Diocese donated the land on which the hospital was built. The hospital closed in June 2008. The Board of Directors of St. Clare's Corporation filed a petition for the corporation's dissolution on March 22, 2019. This petition stated that the "sole creditor of the corporation is the St. Clare's Hospital Retirement Income Plan" with the amount currently estimated to be due by the corporation to the plan equal to $53,500,000. The Attorney General has objected to the dissolution and has moved for leave to conduct discovery.

[160] Beginning in 1998 there were several years where the plan was funded with either nominal contributions or no contributions. The plan was frozen February 1, 2006 with participants not accruing any additional years of service for benefit calculations after such date. The communication to participants about this change stated that "as long as they were vested when they left the Hospital, they would receive their pension benefit."

[161] No. 1:18-CV-00328-WES-LDA (Dist. R.I. 2018).

companies sponsoring 401(k) plans. However, a number of cases were and also have been filed against college and university 403(b) plans. The higher education organization lawsuits generally allege imprudent management of their 403(b) plans and payment of excessive plan fees. Decisions have been reached in some of these cases, and for the most part, they have been favorable for the college and university plan sponsors.[162] However, five universities have settled with plaintiffs including Brown University, Duke University, the University of Chicago, Johns Hopkins, and Vanderbilt University.[163] Columbia University lost its motion to dismiss in August 2017 and the class action was certified in November 2018. In October of 2019, a federal judge indicated that factual disputes existed that could not be resolved without a trial.[164] Although plaintiffs in these ERISA 403(b) fee litigation cases have yet to receive final favorable decision in court, these cases could continue for another two or three years.

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 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.[165]

C. Housing Allowance Litigation Update

In *Freedom From Religion Foundation v. Lew*,[166] the Freedom from Religion Foundation ("Foundation") challenged (on Constitutional grounds) the exclusion of the housing allowance from the gross income of a minister. The trial court initially ruled that the Foundation had standing

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[162] Georgetown University, University of Pennsylvania, Northwestern University, Washington University in Saint Lewis, New York University, and George Washington University have succeeded in having their cases dismissed. The trial court dismissal of the University of Pennsylvania litigation was partially overturned on appeal. The New York University trial court decision was upheld on appeal.

[163] The University of Chicago settled its 403(b) litigation in May 2018 for $6.5 million and other plan structural changes including agreeing not to increase per-participant recordkeeping fees for three years. Duke settled its 403(b) litigation in January 2019 for $10.65 million and other non-monetary actions. Vanderbilt settled its 403(b) litigation in April 2019 for $14.5 million and other non-monetary actions including contractually prohibiting the recordkeeper from using participant information data to market or sell products or services to plan participants. (see *Cassell v. Vanderbilt Univ.*, No.3:16-cv-02086 (M.D. Tenn.)). Johns Hopkins University settled its 403(b) litigation in August 2019 for $14 million and other non-monetary actions including requiring the university to retain an independent consultant to assist plan fiduciaries in a review of the plan's investment structure. (*See Kelly v. Johns Hopkins University*, case number 1:16-cv-02835-GLR (N.D. Maryland 2019)).

[164] *Cates et al. v. The Trustees of Columbia University in the City of New York et al.,* case number 1:16-cv-06524 (U.S. Dist. Ct. for the So. Dist. Of NY).

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

[166] 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.

to sue because the individual co-presidents of the Foundation (also plaintiffs in the case) were excluded from claiming a "housing allowance" income tax exclusion granted to clergy. 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 clergy, 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.[167] However, in its opinion, the Seventh Circuit provided a roadmap describing how the Foundation and its co-presidents could establish standing to pursue their claim. The Seventh Circuit 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 roadmap provided by the Seventh Circuit on the standing issue, and on April 6, 2016, filed another complaint in the Western District of Wisconsin.[168] The government conceded that the plaintiffs now had 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 heard by the same judge, Judge Barbara Crabb, who held that Code section 107 was unconstitutional in 2013, before the Seventh Circuit vacated her decision. On October 24, 2016, Judge Crabb dismissed for lack of standing the portion of the Foundation's complaint that Code section 107(1) housing (the in-kind housing exclusion) is unconstitutional but granted standing with respect to clergy housing allowance excludable under Code section 107(2). On October 5, 2017, Judge Crabb once again found the housing allowance provision of Code section 107(2) to be unconstitutional.[169]

The case was appealed to the Seventh Circuit Court of Appeals.[170] Oral arguments were heard before a three-judge panel on October 24, 2018 and on March 15, 2019 the Seventh Circuit reversed the district court and held that Code section 107(2) is constitutional and does not violate the Establishment Clause.[171] The Seventh Circuit considered the case *de novo* applying two relevant Establishment Clause tests, the *Lemon* test and the "historical significance" test.[172] The

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[167] 773 F.3d 815 (7th Cir., 2014).

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

[169] *Gaylor v. Mnuchin,* 278 F. Supp. 3d. 1081 (W.D. Wis. 2017).

[170] *Gaylor v. Mnuchin*, No. 3:16-cv-00215 (7th Cir. 2018).

[171] *Gaylor v. Mnuchin,* 919 F.3d 420 (7th Cir. 2019). The Seventh Circuit agreed with the district court that the Freedom From Religion Foundation and its members that were plaintiffs had standing to sue.

[172] The *Lemon* test is set forth in *Lemon v Kurtman*, 403 U.S. 602 (1971) and the "historical significance" test is set forth in *Town of Greece v. Galloway*, 572 U.S. 565, 576 (2014).

court determined that all three prongs of the *Lemon* test were met and that Code section 107(2): 1) has a secular legislative purpose, 2) neither advances nor inhibits religion as its principal or primary effect, and 3) does not cause an excessive government entanglement with religion. The court also determined that Code section 107(2) does not violate the Establishment Clause under the "historical significance" test. The court stated that the housing allowance provisions of Code section 107(2) "falls into play between the joints of the Free Exercise Clause and the Establishment Clause: neither commanded by the former, nor proscribed by the latter" and thus was constitutional. The Foundation announced in June that it would not seek review of the case by the Supreme Court.[173]

However, in July, the Humanist Society of Greater Phoenix announced that it plans to challenge the constitutionality of the parsonage allowance.[174] Executive Director Luke Douglas said that the Humanist Society of Greater Phoenix's end goal is "equality" and that he thinks a cap on the exempt amount allowed or a broadening of the Code to allow groups like the Humanist Society of Greater Phoenix to have the same benefits as churches would be ideal.

D. Ninth Circuit Found Arbitration Provision in ERISA Plan Enforceable

In the current litigious society, plan sponsors and fiduciaries should be aware of risks and liabilities surrounding benefit plans and seek avenues to mitigate risk. On August 20, 2019, the Ninth Circuit's decision in *Dorman v. Charles Schwab Corporation*[175] upheld the enforcement of arbitration provisions contained in an ERISA 401(k) plan document. Although arbitration has been used in the past to decide ERISA issues, this is the first case to enforce arbitration provisions held solely within an ERISA plan document.

The plaintiff, Michael Dorman, filed a putative class action in federal court alleging breaches of fiduciary duties. The 401(k) plan document at issue included an arbitration clause stating that "[a]ny claim, dispute, or breach arising out of or in any way related to the Plan shall be settled by binding arbitration" and must be resolved by individual arbitration and not through a class or collective arbitration. Based on this plan provision, the defendant Schwab filed a motion to compel individual arbitration. The district court denied the motion concluding that the plan's arbitration provision was not enforceable for fiduciary duty claims. The Ninth Circuit reversed and upheld the application of the arbitration provisions, documented in the ERISA plan, to individual participants. It remains to be seen if other courts and circuits will follow *Dorman*.

However, in considering whether to add arbitration provisions to plan documents, plan sponsors and fiduciaries should carefully consider the advantages and disadvantages related to whether arbitration or federal litigation could be more beneficial. Arbitration may be less

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[173] On June 14, 2019, the Foundation announced that although it had full confidence in the merits of its position to challenge the clergy housing allowance, it "did not feel the same confidence" in how the current Supreme Court would rule in the case. However, the Foundation noted that by not pursing the challenge at this time, it was making it "possible for another challenge to be taken in the future" if the make up of the Supreme Court changed. (*See* https://ffrf.org/news/news-releases/item/34911-clergy-housing-allowance-boondoggle-continues-for-now).

[174] See https://www.azmirror.com/2019/07/19/phoenix-humanists-to-claim-tax-break-to-tax-code/.

[175] *Dorman v. Charles Schwab Corp*., No. 18-15281, 2019 WL 3939644 (9th Cir. 2019).

expensive to pursue than federal litigation, but it may be less predictable and would not generate precedent which could be helpful in future cases or arbitrations. Arbitrators also tend to look for a compromise rather than to rule in favor of one party or the other, and arbitration decisions generally cannot be appealed. Mandatory plan arbitration provisions could also ultimately result in more claims being pursued through this avenue than would otherwise have been pursued though litigation. In addition, deciding benefit plan issues through arbitration could result in inconsistent rulings, making plans administration difficult.

E. Status of Participant Data as Possible Plan Asset

In April 2019, Vanderbilt University settled a lawsuit[176] for $14.5 million dollars related to a variety of claims, including that the recordkeeping fees did not consider "the value of the vendors' access to Plan participants and their data for marketing purposes." As part of the settlement, Vanderbilt agreed that, for future recordkeeping agreements, plan fiduciaries would contractually prohibit the recordkeeper from using participant information acquired because of its recordkeeping services and that, unless the transaction were participant-initiated, recordkeepers would not market or sell products or services to plan participants. Vanderbilt also agreed to direct its current recordkeeper to follow these restrictions. In a separate case involving Northwestern University,[177] a district court determined that participant information was not a "plan asset." The Vanderbilt settlement and the allegations in the Northwestern case point out the need for fiduciaries to be aware of how plan participant data is used and protected.

F. Anti-Assignment Provision in Administrative Services Agreement Found Unenforceable

Anti-assignment provision are important provisions to include in plan documents and summary plan descriptions. In a recent case, a physicians' group sued a plan sponsor and the plan's third-party administrator when it was paid less than $9,000 of a $123,000 pediatric neurological surgery bill. The physicians' group pursued the lawsuit relying on an assignment of benefits and an authorized representative designation that had been executed by the minor patient's parents.[178] The plan's third party administrator and plan sponsor argued for dismissal based on an anti-assignment clause contained in the plan's administrative services agreement with the third party administrator. However, the physician's group successfully argued that the anti-assignment provision in the services agreement was not enforceable because it was not contained in a "plan document."

Courts have enforced anti-assignment provisions in plan documents. The court in this case reasoned that the purpose of the requirement for the provision to be contained in the plan document is to enable participants to determine their rights and obligations under the plan. The court held that the inclusion of an anti-assignment provision merely in a services agreement between the plan

[176] *Cassell v. Vanderbilt Univ*., No. 3:16-cv-02086 (M.D. Tenn).

[177] *Divane v. Northwestern Univ*., 16-cv-08157 (N.D. Ill., 2d.).

[178] *Long Island Neurological Associates v. Highmark Blue Shield*, 2019 WL 1284263 (E.D. N.Y. 2019).

sponsor and the third-party administrator is not sufficient and that plan participants and beneficiaries are not bound by the terms of such an agreement.

In this case, the anti-assignment language did not appear in the relevant plan document or its summary plan description. It does appear to be important that anti-assignment provisions be disclosed to participants, so plan sponsors should consider including such provisions in both their plan document and in employee communications such as a summary plan description.

G. Form 990 Litigation

Nonbelief Relief, the charitable arm of the Freedom from Religion Foundation, filed a complaint[179] in the U.S. District Court for the District of Columbia on October 11, 2018, after its tax-exempt status was automatically revoked. The IRS revocation notice said the relief organization failed to file a Form 990 information return for three consecutive years. In its complaint, Nonbelief Relief said it objects to having to file Form 990 while churches and church-related organizations do not.

On September 30, 2019, the court issued an Order indicating that both the Defendant's and a Defendant-Intervenor's Motions to Dismiss the case will be granted.[180] However, the Order also states that it is not a final decision subject to appeal and that the court will issue a Memorandum Opinion setting forth its rationale and final decision within the next 30 days. Although 30 days has passed, the Court has not yet issued a final decision.

V. OTHER

A. State Paid Family Leave Requirements

Currently, the federal Family Medical Leave Act ("FMLA") requires employers with at least 50 employees to permit employees to take up to 12 weeks of unpaid leave for certain reasons, including the birth or adoption of a child, to care for a sick family member, or as a result of a medical condition of the employee. Many states also have laws that permit employees to take a leave of absence for family or medical reasons. Several states have adopted family leave laws that either expand the amount of leave or the reasons for the leave. In addition, a few states have decided to require paid leave under certain circumstances, including California, New Jersey, Rhode Island, New York, Washington, and the District of Columbia.

B. California Flexible Spending Account Notice Law

In August, California enacted a state law requiring an employer to notify an employee participating in an FSA of any deadline to withdraw funds before the end of the year.[181] Although not entirely clear, the law appears directed at FSAs that require employees who terminate employment or otherwise lose FSA eligibility during a plan year to submit claims prior to the end of the plan year. The law applies to all types of FSAs, including dependent care flexible spending

[179] *Nonbelief Relief, Inc. v. Kautter*, No. 18-cv-2347 (D. D.C. 2018).

[180] *Nonbelief Relief, Inc. v. Rettig et al.*, No. 1:18-cv-02347-TJK (D.D.C. 2019).

[181] Assembly Bill No. 1554.

accounts, health flexible spending accounts, and adoption assistance flexible spending accounts. The law also requires notice to be provided in two different forms, only one of which may be electronic.[182]

The law would most likely be preempted for health care FSAs subject to ERISA. However, health care FSAs that are not subject to ERISA (such as those maintained by churches) and all dependent care FSAs would be subject to the law.

C. California Consumer Privacy Act of 2018

On June 28, 2018, the California legislature passed Assembly Bill 375,[183] the most comprehensive privacy bill in the United States to date. The California Consumer Privacy Act ("Act") will go into effect on January 1, 2020, and applies to any organization that conducts business in California that has annual gross revenue in excess of $25,000,000; annually buys, receives for the business's commercial purposes, sells, or shares for commercial purposes the personal information of 50,000 or more consumers, households, or devices, alone or in combination; or derives 50 percent or more of its annual revenue from selling consumers' personal information. The California Attorney General will not enforce the law until July 1, 2020.[184] It appears that nonprofits are not subject to this law because the Act defines affected businesses as those organized or operated for the profit or financial benefit of shareholders or other owners.

The Act grants consumers (broadly defined as California residents) five rights with respect to their personal information and imposes several notice requirements and other requirements on businesses. Generally, the Act:

- grants a consumer the right to request a business to disclose the categories and specific pieces of personal information that it collects about the consumer, the categories of sources from which that information is collected, the business purposes for collecting or selling the information, and the categories of third parties with which the information is shared;
- grants a consumer the right to request deletion of personal information and requires the business to delete such information upon receipt of a verified request;
- grants a consumer a right to request that a business that sells the consumer's personal information, or discloses it for a business purpose, disclose the categories of information that it collects and categories of information and the identity of third parties to which the information was sold or disclosed and requires a business to provide this information in response to a verifiable consumer request;
- authorizes a consumer to opt out of the sale of personal information by a business and prohibits the business from discriminating against the consumer for exercising this right, including by charging the consumer who opts out a different price or providing the

[182] The law includes the following non-exclusive list of permissible notice forms: e-mail, telephone, text message, mail, and in-person notification.

[183] Available at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB375.

[184] See CA Civ Code Section 1798.185 (2018). Proposed regulations were released October 10, 2019 and are open for public comment through December 6, 2019. Public hearings are scheduled to be held December 2nd, 4th and 5th. The Attorney General will release final regulations following the comment period.

consumer a different quality of goods or services, except if the difference is reasonably related to value provided by the consumer's data;

- requires a business to make disclosures at or before the collection about the information and the purposes for which it is used;
- authorizes businesses to offer financial incentives for collection of personal information;
- prohibits a business from selling the personal information of a consumer under 16 years of age, unless affirmatively authorized;
- prescribes various definitions for its purposes and defines "personal information" with reference to a broad list of characteristics and behaviors, personal and commercial, as well as inferences drawn from this information; and
- prohibits the provisions described above from restricting the ability of the business to comply with federal, state, or local laws.

The Act also provides a civil private right of action in connection with certain unauthorized access and exfiltration, theft, or disclosure of a consumer's nonencrypted or nonredacted personal information. The California Attorney General may also assess penalties of $2,500 for unintentional violations and $7,500 for intentional violations. The Act does not apply to information governed by HIPAA.

On September 13, 2019, the California legislature passed Assembly Bill 25 which amends the Act.[185] Generally, the amendment provides a one-year exemption from certain provisions of the Act for transactions and records within the context of employment. The intent of the amendment is to provide legislators time to draft additional legislation to specifically addresses privacy protections with respect to employee data. The one-year exception does not exempt employers from the requirements under the Act to notify employees, at or before the time of collection, of the categories of personal information to be collected and the purpose for which the personal information will be used.

D. Rhode Island Law Requiring Funding Notice for Non-ERISA Church Pension Plans

The State of Rhode Island enacted a law effective June 28, 2019[186] requiring church defined benefit pension plans with 200 or more plan participants to furnish such participants, within seven months after the end of the plan fiscal year, a statement that includes the funded percentage of the plan as well as the assets and liabilities of the plan as compared to the prior fiscal year end. The statement is also required to include funding receipts and disbursements made to and from the plan over the preceding twelve-month period. Plan administrators of church pension plans may therefore be required to provide this information regarding their plans financial status beginning seven months after the end of their plan's fiscal year. Questions remain as to whether the plan sponsor or the plan administrator needs to be located in the State of Rhode Island for the law to apply. In addition, it is not clear if only plan participants in the State of Rhode Island count toward

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[185] See http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB25. Governor Gavin Newsom signed the amendments October 11, 2019.

[186] Rhode Island Section 28-7.1-4. The law requires plans not covered by ERISA that have 200 or more plan members to comply with the provisions of 29 U.S.C. §1024(b)(3). The Rhode Island statute does not apply to governmental plans.

the 200-plan participant threshold requirement and if so, how Rhode Island residency is determined. Questions also remain as to whether ERISA actuarial assumptions are to be used when developing this new notice.

E. Social Security Cost of Living Adjustments

On October 10, 2019, the Social Security Administration announced the cost-of-living adjustments for 2020.[187] The cost-of-living adjustments for 2020 are as follows:

Increase in monthly benefits	1.6%
Maximum earnings subject to Social Security taxes	$137,700 (*$4,800 increase*)
Maximum earnings subject to Medicare taxes	Unlimited
Exempted earnings amount:[188] • In year prior to year during which retiree reaches full retirement age • In year during which retiree reaches full retirement age	$18,240 *($600 increase)* $48,600 *($1,680 increase)*

[187] Social Security Press Release, October 10, 2019, https://www.ssa.gov/news/press/releases/2019/#10-2019-1.

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

APPENDIX A – RECENT CHURCH ALLIANCE COMMENT LETTERS

The following recent Church Alliance Comment Letters may be accessed from the following link: https://www.church-alliance.org/focus-areas/comment-letters.

- Church Alliance Comment Letter on Church Plan Regulations (August 20, 2018 and November 26, 2018)
- Church Alliance Comment Letter on Top Priorities – Incorporating Prior Comment Letters (June 7, 2019)
- Church Alliance Comment Letter on Relief from the "One Bad Apple" Rule for Multiple Employer Plans (October 1, 2019)
- Church Alliance Comment Letter on Unrelated Business Income Tax on Transportation Fringe Benefits (February 22, 2019)
- Church Alliance Comment Letter on PATH Act Church Plan Clarification (December 21, 2018)
- Church Alliance Comment Letter on Unrelated Business Income Tax (December 3, 2018)
- Church Alliance Comment Letter on Health Reimbursement Arrangement Proposed Rule (December 28, 2018)
- Church Alliance Comment Letter on Exemption from ACA Section 1557 Non-Discrimination Rules (August 13, 2019)
- Church Alliance Comment Letter on Grandfathered Group Health Plans (March 27, 2019)
- Church Alliance Comment Letter on Burdens Relating to the Production and Distribution of the Summary of Benefits Coverage (February 1, 2019)