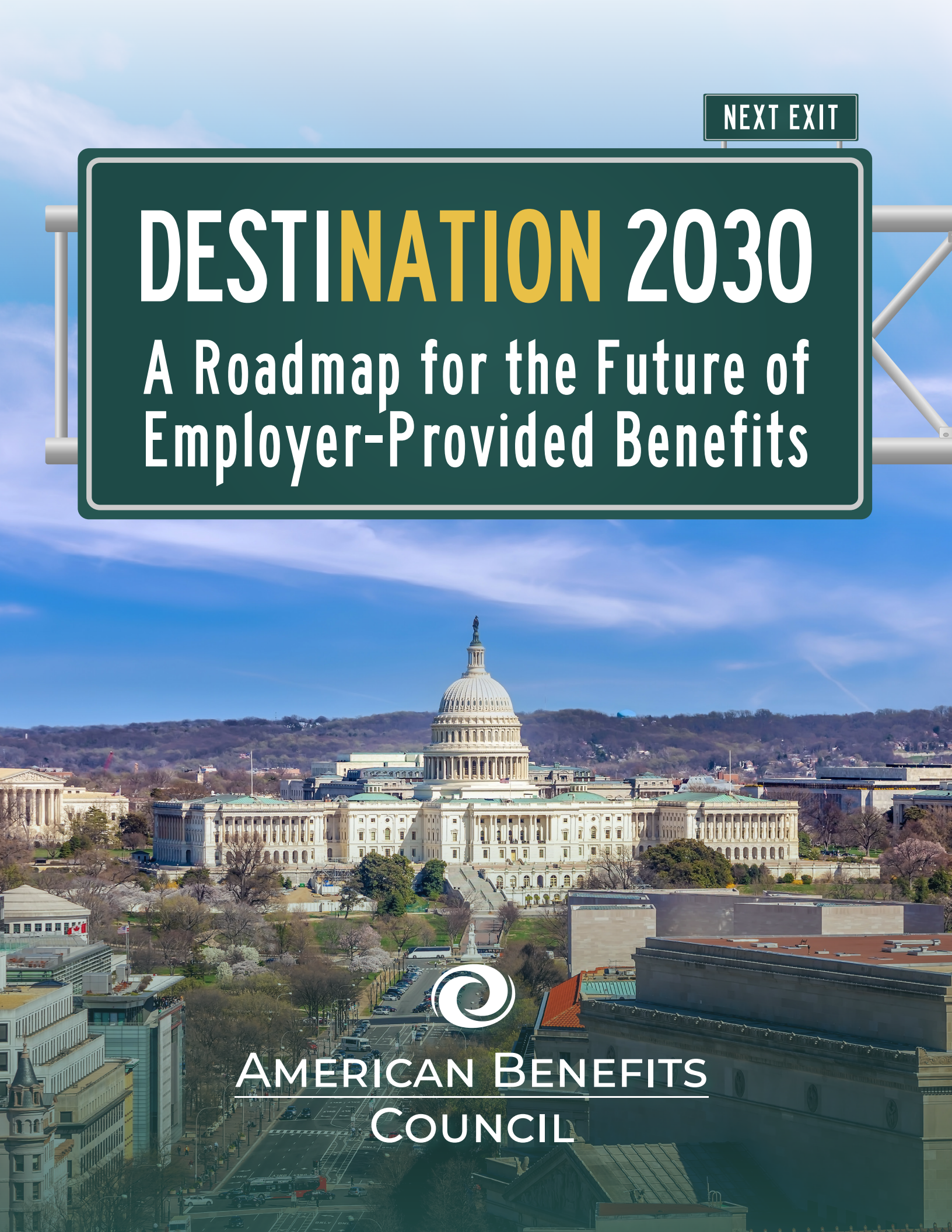

NEXT EXIT
DESTINATION 2030
A Roadmap for the Future of Employer-Provided Benefits
American Benefits Council

AMERICAN BENEFITS COUNCIL

Contents

Foreword

OVER THE COURSE OF MY 37 YEARS with the American Benefits Council I have had the privilege of working with our members and my staff colleagues on several strategic plans. All of them have been developed through a thoughtful, deliberative process that evolved over at least a year. On each occasion I have admired (but not been surprised by) the extraordinary amount of time, expertise and insights that strategic plan task force members, and the Policy Board of Directors as a whole, have devoted to the effort.

Each of these initiatives involved envisioning the future and articulating what was needed to elevate the ability of employers to improve the lives of the people they serve through the programs their companies design, sponsor or administer. The long-term public policy strategic plan that appears on the following pages – *DESTI**NATION** 2030: A Roadmap for the Future of Employee Benefits* – is no exception.

This report is very lengthy. That is because it not only describes where the road will lead us, but also includes the construction materials required to pave the road that will take us there. It would have been a sufficiently monumental achievement just to have set forth, in such a comprehensive way, a description of our current employee benefits system, the challenges it faces and goals to be pursued to address those challenges. That is what is so eloquently provided in Parts I and II of this report.

But the task force members who developed the strategic plan with continued input from the full Policy Board of Directors did not stop there. Instead, they added Part III – a compendium of 79 legislative and regulatory recommendations to help achieve those goals. And accompanying each recommendation is a description of the current obstacle to be overcome or opportunity to be pursued, and an explanation of how each proposal can help achieve the stated objective.

Because the strategic plan includes specific policy proposals it will, quite literally, be used every day to inform and guide our policy advocacy. And periodically over the next five years that the plan encompasses, we will evaluate our success: which recommendations have been achieved, which are no longer relevant, and which require our continued efforts.

The American Benefits Council membership is drawn from numerous industries with diverse workforces and employee benefit plan designs. At its core are over 240 major employer plan sponsors. Members also include various other companies and firms that design, administer, advise or provide other services to those employers. It is not surprising, therefore, that certain members and segments of the membership would have preferred that some of the 79 recommendations had not been included and, as individual companies or organizations, they do not endorse them all. But, to their great credit, those companies and organizations did what they have *always* done in our nearly 58-year history: they respected that American Benefits Council is a voice for employers. Accordingly, it is with great pride that we are able to say that this extraordinary and very detailed strategic plan was approved ***unanimously*** by the Policy Board of Directors.

Lastly, the timing of the release of this strategic plan is ideal. It not only coincides with a new political order in Washington, D.C., but also new leadership at the American Benefits Council as Katy Johnson assumes the presidency. With her many skills, including a keen sense of direction, we are – with great enthusiasm – headed down the road toward shaping the future of employee benefits.

James A. Klein

Acknowledgements

The development of this strategic plan is the result of countless hours over a period of more than a year by several dedicated board members of the American Benefits Council and staff colleagues.

Jason Hammersla, Council vice president, communications, deserves praise that is difficult to adequately express in words alone. He took this monumental undertaking and put it into a framework that enabled the Long-term Public Policy Strategic Plan Task Force, the Policy Board of Directors and the Council staff to approach this initiative in a logical and organized manner. He started by leading the Policy Board through development of a vision statement and then elicited from the board members the five categories of challenges and four goals to meet each of those challenges that comprise the basis for the strategic plan.

Once a volunteer task force was assembled, Jason organized the process for evaluating the many policy recommendations that comprise Part III of the plan. He was the lead researcher and drafter of the text of the report, worked with the design firm to finalize its publication and organized its public rollout.

The Council was extraordinarily fortunate to benefit from the leadership of **Tami Simon** as task force chair. Her vision, extensive employee benefits expertise and skill at forging consensus were indispensable for the process to move forward efficiently and effectively. At all times she ensured that every voice was heard and challenged task force members to propose new ideas for inclusion in the plan. Tami went above-and-beyond by frequently reaching out to task force members in-between scheduled meetings to confirm they were satisfied with the group's progress; and ensure they were each actively involved in presenting task force proposals at the Policy Board meetings.

Tami is also the author of large portions of the strategic plan. Most importantly, on the numerous occasions where there were conflicting perspectives on how best to proceed on a specific topic, she came up with a solution that everyone could readily support.

Tami and Jason devoted many additional hours envisioning how the ultimate "document" would look in both digital and printed form and how it can best be accessed and most effectively deployed in support of the Council's policy advocacy.

The task force members were generous with both their time and insights. For a period of several months they participated in a virtual session every other week – not to mention time spent in-between meetings evaluating proposed policy recommendations.

The Council policy staff was essential in providing historical context, substantive knowledge and political insight for numerous legislative and regulatory proposals that were considered; and for ensuring that the views of board members not serving on the task force were heard. Those colleagues were: **Lynn Dudley** senior vice president, global retirement and compensation policy; **Diann Howland**, vice president, legislative affairs; **Katy Johnson**, then-senior counsel, health policy; and **Ilyse Schuman**, senior vice president, health and paid leave policy. **Kent Mason** (Davis and Harman LLP) and **Seth Perretta** (Groom Law Group, Chartered) provided their exceptional legal expertise in analyzing proposals developed by the task force.

As always, the rest of the Council staff provided support to their colleagues who were most directly engaged in the process. Our thanks to **Deanna Johnson,** vice president, membership, **Mary Lindsay,** Executive Assistant, **Nick Otto,** Digital Content Manager, **Jill Randolph**, senior director, legislative and political affairs and **Sondra Williams,** Manager, Member and Staff Engagement.

The document's graphic design and layout are a credit to **Alston Taggart** and **Kevin Sample** of Studio Red Design. Their other work can be found at www.studiored.us.

Finally, the full Policy Board of Directors devoted time at numerous successive meetings to thoughtfully consider interim proposals from the task force and provide valuable feedback. As ERISA's 50th anniversary year wrapped-up in December 2024 they reviewed the final report and unanimously approved it.

Thanks to this comprehensive approach to developing the strategic plan, it will be an essential guide for the Council's advocacy over the next five years.

Executive Summary

THE YEAR 2024 MARKED THE 50TH ANNIVERSARY OF THE EMPLOYEE Retirement Income Security Act of 1974 (ERISA), the law that codified national retirement, health and welfare benefit protections for U.S. workers, retirees and their families. Consistent with the evolution of other significant U.S. legislation, in the five decades that followed its passage, ERISA has been continuously refined and amended by new legislation, regulatory guidance and judicial challenges. Since its enactment, the law has allowed employers to provide a consistent benefits experience to all employees, regardless of their location in the United States. This, in turn, has made it possible for millions of Americans to receive reliable, high-quality and cost-effective employee benefits from their employers, contributing positively to the holistic well-being of America's workforce.

The American Benefits Council has been a champion for employers, a trusted and credible source of expertise for policymakers, and the guardian of the employer-sponsored system since 1967. And the Council and our member companies are firm believers in the promise, progress and future possibilities of the employer-sponsored benefit system. Moving forward from ERISA's 50th anniversary is the ideal opportunity to present this 2030 Public Policy Strategic Plan that sets forth policy recommendations to preserve what currently works and propel forward the progress to which our members are dedicated.

Age 50 traditionally represents just the right combination of experience, wisdom and energy to achieve greater success. That is precisely what this strategic plan is intended to provide for the employer-sponsored benefits system and the millions of Americans who rely upon it.

A Roadmap to 2030

This strategic plan begins by offering a brief history of ERISA, what it was designed to achieve, and other significant events affecting the U.S. labor market. It then reviews the fundamental elements of the Council's prior strategic plans and identifies the organization's foundational vision and values. These include:

- **The value of tax incentives for benefit plans and principles for smart tax policy.** Longstanding, bipartisan tax policy is essential to the success of the employer-sponsored benefits system.
- **ERISA's primacy, and the balancing act between federal and state action.** The core of this strategic plan is the reliance on the primacy of ERISA and the federal standard created by its essential preemption clause.

OUR MISSION

The American Benefits Council advocates for employers, connecting public policy and private-sector solutions to shape employee benefits for the evolving global workforce.

This 2030 strategic plan describes the five most pressing challenges facing employer-sponsors today, provides four goals to address each challenge and then offers detailed policy recommendations for meeting those goals.

TABLE 1 | A Framework for the Future

CHALLENGES				
Improving Holistic Well-Being	**Legal and Regulatory Uncertainty**	**Demand for Personalized and Individualized Benefits**	**Increased Individual Responsibility**	**Aligning Health Care Cost and Quality**
GOALS				
GOAL 1: Eliminate barriers to retirement savings	**GOAL 5:** Protect and affirm ERISA	**GOAL 9:** Improve employee benefits equity	**GOAL 13:** Support financial literacy and retirement readiness	**GOAL 17:** Reform provider payment systems and practices to incentivize value-based care
GOAL 2: Promote sustainable employee health and well-being	**GOAL 6:** Promote stability of employee benefits policy	**GOAL 10:** Increase access to personalized and individualized benefits	**GOAL 14:** Preserve access to defined contribution health programs and enhance consumer-directed health plans	**GOAL 18:** Prevent cost-shifting to private payers
GOAL 3: Improve the mental and behavioral health of employees and their families	**GOAL 7:** Promote flexibility in employee benefit plan design and operation	**GOAL 11:** Harness technology to improve access and outcomes	**GOAL 15:** Maintain public safety net programs	**GOAL 19:** Encourage competition within the health care industry
GOAL 4: Improve public health and disaster preparedness	**GOAL 8:** Prevent excessive or unwarranted regulation, litigation and enforcement	**GOAL 12:** Promote flexibility for employer-provided paid leave programs	**GOAL 16:** Support and modernize defined benefit retirement plans	**GOAL 20:** Promote access to affordable, effective, safe and innovative prescription drugs and therapies

- **The critical partnership between people, employers and government.** The provision of employee benefits requires each stakeholder group to play an important role.
- **The importance of bipartisanship for stable benefits policy.** Stability in the law is necessary for the perpetuation of the employer-sponsored system.
- **Flexibility drives coverage and innovation.** Benefit plans must be deployable, administrable and accessible in a variety of forms and platforms and scalable for different kinds of workers.

With that backdrop, the plan outlines the challenges faced by today's employers and proposes goals to surmount those challenges, as shown below.

Finally — and what separates this strategic plan from many others — we offer specific public policy recommendations to achieve those goals. The 79 recommendations herein cover a wide swath of workforce and benefits topics, constituting the Council's most ambitious policy agenda to date.

A. Core Issues: ERISA and Tax Policy

A1: Preserve, protect and defend federal preemption for all employer-sponsored retirement, health and other welfare plans subject to ERISA.

This federal preemption (1) ensures state and local laws do not inhibit the ability of employers to choose their plan design, benefits or administration and (2) preserves the ability of employers to treat their employees equitably nationwide.

A2: Preserve, protect, defend and enhance the current tax incentives supporting participation in employer-provided retirement plans — both the full federal tax deferral for participating employees and the tax deduction for plan sponsors.

A3: Preserve, protect and defend the current tax incentives for employer-provided health coverage — both the full federal income tax exclusion for employees and the tax deduction for employers.

FIGURE 1 | Organizing Our Recommendations for the Future

B. Retirement Security

B1: If legislation is enacted mandating that employers maintain a retirement plan, the mandate must be paired with universal protection from state laws under ERISA.

B2: Increase the compensation, contribution and benefit thresholds for retirement plans.

B3: Increase the thresholds for "catch-up" contributions, especially for caregivers.

C. Safe Harbors and Compliance

C1: Support the ability of plan sponsors to locate missing plan participants by (1) establishing a safe harbor for employers locating missing retirement plan participants and (2) developing a missing participant data registry in a way that safeguards private participant and beneficiary information.

C2: The DOL should include fiduciary safe harbors when issuing regulatory guidance affecting retirement savings plans, to promote rather than stifle innovation.

C3: Enable employers to provide more robust financial education through a simplified compliance process that protects participants and safeguards plan sponsors from fiduciary liability.

D. SECURE and SECURE 2.0 Act Implementation

D1: Ensure regulatory guidance implementing retirement policy legislation, such as SECURE Act, SECURE 2.0 or any future guidance, is clear, timely and administrable.

D2: Affirm and codify in statute that employers can, on a voluntary basis, automatically re-enroll defined contribution plan participants in the employer plan every three years, with tax credits to encourage small employers to adopt a re-enrollment provision.

D3: Build on SECURE Act advancements like pooled employer plans and defined contribution groups to give independent workers enhanced opportunities to save for retirement.

E. Retirement Plan Investments

E1: Facilitate the use of lifetime income options within defined contribution plans.

E2: Uphold the ability of retirement plan fiduciaries to make investment decisions as long as those decisions meet ERISA's duties of prudence and loyalty, including whether to make available alternative investments.

E3: Protect the ability of plans to offer brokerage windows without burdens on plan sponsors, such as fiduciary responsibility to oversee the investments made through those windows.

E4: Support parity for retirement investors with individual, non-plan investors by (1) maintaining the current-law rules regarding how the closing rules work for trading mutual funds, and (2) opposing any "hard-close" proposals.

E5: Provide investment parity for participants in 403(b) plans with other defined contribution plan participants by permitting such plans to invest in collective investment trusts and unregistered insurance company separate accounts.

F. Defined Benefit Plans

F1: Adjust PBGC premiums based on the agency's funded status, so if PBGC is sufficiently well funded that it does not need the current level of premiums, premiums would be reduced.

F2: Take premium increases and decreases off budget, because premiums cannot be used for any purpose other than paying benefits and PBGC administrative costs.

F3: Prevent an anticipated wave of plan terminations by permitting non-terminated plans to use surplus assets in a manner similar to what would be permitted if the plan were terminated.

F4: Permit unusable surplus assets in retiree health 401(h) accounts in pension plans to be used to shore up the retirement benefits in the pension plan and to provide other benefits.

F5: Protect employers by reducing funding volatility and protect participants from benefit restrictions that take away earned rights.

F6: Facilitate a growing type of traditional defined benefit plan, where benefits are adjusted to some extent based on plan asset returns.

F7: Update the accounting rules for market-based cash balance plans to base the valuation generally on the value of the notional account balances, which would materially improve the accuracy of the valuations.

F8: Preserve the voluntary nature of the private retirement plan system by protecting the ability to terminate a defined benefit plan or enter into a partial pension risk transfer without new and unnecessary burdens.

G. Small Employer Issues

G1: Expand and enhance the small business tax credit to encourage broader adoption of qualified retirement plans.

G2: Support multiple employer plan arrangements by allowing plans grandfathered from the automatic enrollment rules to join a multiple employer plan (including a pooled employer plan) without losing grandfathered status.

H. Paying for Value

H1: Support employers' access to, and utilization of, nationally available price and quality transparency data from third parties including hospitals, group health plans, pharmacy benefit managers and insurers.

H2: Support the ability of employers to provide value-based coverage, including through centers of excellence, preferred provider networks and other innovative plan designs.

H3: Support policies that promote the use of evidence-based care resulting in high-value physical, mental and behavioral health care, including expanded adoption and implementation of more accurate evidence-based measures of provider care quality.

H4: Preserve the ability of employer-sponsored health plans to impose reasonable medical management techniques to ensure that the care provided is clinically appropriate and high-quality and to ensure that coverage remains affordable.

H5: Preserve the ability of employers to offer affordable, high-quality health coverage to retirees and their families, including through employer group waiver plans.

H6: Reject impractical and burdensome benefit requirements for employer-sponsored plans that would increase health care costs without improving value or quality.

I. Health Equity

I1: Ensure hospital and other health care provider quality measurements account for health equity.

I2: Support the ability of employers and health plans to collect, share and use race, ethnicity, and other relevant demographic data for the purpose of advancing health equity.

I3: Fund programs to promote diversity in the health care provider workforce, particularly in the fields of primary and mental health care.

J. Prescription Drugs

J1: Increase transparency throughout the pharmaceutical distribution system and supply chain, including transparency by PBMs to employers and by drug manufacturers, to ensure that public and private payers spend resources wisely while maintaining patient access to effective therapies.

J2: Preserve the ability of employers to design pharmacy benefits in a way that incentivizes high-value care, ensures safety, controls costs and facilitates coverage of a broad range of prescription drugs, while avoiding cost-shifting to employer-sponsored plans.

J3: Remove barriers to employer coverage of high-value, often high-cost, innovative drug therapies and encourage innovation by supporting the ability of employer plans to align drug prices with value.

K. Competition and Consolidation

K1: Ensure the No Surprises Act achieves the twin goals of the statute: to (1) protect consumers from "surprise" medical billing and (2) lower health care costs by defending against efforts to undermine the NSA, by improving the independent dispute resolution process and by incentivizing providers to join networks, rather than to remain out-of-network.

K2: Enforce and enhance antitrust law to prevent consolidation in the health care provider market, which drives up prices without improving quality.

K3: Restrict the use of "all-or-nothing," "anti-steering," "anti-tiering" and "most-favored-nation" contract terms by large hospital systems, which force plans and insurers to contract with all affiliated facilities and providers and prevent employers from steering patients toward lower-cost, higher-quality care.

K4: Expand site-neutral payment reform and enact legislation to promote transparent billing practices.

L. Mental and Behavioral Health

L1: Ensure guidance under the Mental Health Parity and Addiction Equity Act (1) is clear enough to support compliance, (2) does not undermine the quality or affordability of mental health and substance use disorder benefits and (3) incorporates a fair and reasonable enforcement regime that focuses on access to mental and behavioral health care while minimizing unnecessary burdens.

L2: Enact sustained funding to expand and provide ongoing training to the mental health workforce, particularly in professional shortage areas and mental health care deserts.

L3: Improve access to mental health care through more flexible state and federal licensing regimes.

M. Health Care Workforce

M1: Expand access to telehealth services.

M2: Enact policies to increase the number of primary care providers, improve access to primary care and support integration of other services with primary care.

M3: Support the development of new provider directory models, such as a centralized database that facilitates greater accuracy, navigability and usefulness to employees.

N. Consumer-Directed Health

N1: Expand the category of high-value preventive care, including medicines that can be provided on a pre-deductible basis in HSA-eligible HDHPs.

N2: Allow HSA-eligible HDHPs to provide more robust medical services at an on-site or near-site clinic on a pre-deductible basis.

N3: Expand access to HSAs by allowing a range of HDHP designs, such as a simplified actuarial value test or split deductibles for medical services and prescription drugs.

O. Plan Sponsor Flexibility

O1: Enact legislation providing for a portable, tax-preferred investment vehicle that can be used to pay for medical care, even if the account owner is not enrolled in an HDHP.

O2: Clarify and confirm the ability of employers to repurpose excess assets in welfare benefit funds, including voluntary employees' beneficiary associations, to pay for other company-sponsored welfare benefits.

O3: Ensure individual coverage health reimbursement arrangements are a viable option for employers and employees.

O4: Reject policies that would threaten or undermine a stable and robust individual insurance market, which is essential alongside employer-sponsored insurance.

P. Paid Leave

P1: Support access to paid leave benefits for all workers by establishing voluntary national paid leave standards that allow employers to provide valuable, user-friendly, uniform and administrable leave to employees irrespective of where the employees live or work. By adopting these standards, employers would be deemed to satisfy all state and local paid leave requirements.

Q. Litigation Matters

Q1: Enact legislation enforcing federal judicial pleading standards in benefits class-action lawsuits.

Q2: Preserve the "abuse of discretion" standard that applies to plan fiduciary interpretations of plan terms and benefit determination decisions.

Q3: Ensure plans may continue to use arbitration clauses and class action waivers to manage litigation costs and focus resources on providing benefits to participants.

R. Other Employer-Sponsored Programs

R1: Support the use of employee assistance programs to deliver timely and meaningful benefits to an evolving workforce, as a supplement to comprehensive, high-quality employer-sponsored medical coverage.

R2: Make permanent and enhance the ability of employers to use educational assistance programs to help employees repay student loan debt.

R3: Enable employers to offer family-building benefits in an equitable way, including under the tax code, for the full range of family structures that exist, if the employer so chooses.

R4: Protect the ability of employers to offer affordable, high-value ancillary voluntary benefits to employees and their families to supplement comprehensive major medical coverage.

S. Miscellaneous Tax Recommendations

S1: Increase the maximum excludable amount for tax-preferred dependent care assistance programs and index it to keep up with inflation.

S2: Permit employers to offer a qualified financial well-being plan to employees on a tax-free basis.

S3: Expand the ability of employers to offer tax-preferred benefits to address social determinants of health, including nutrition- and transportation-related benefits.

T. Regulating the Regulators

T1: Establish clear, consistent and transparent processes for agency investigations, including reasonable time frames for plan audits.

T2: Adopt a "least burdensome compliance" standard, under which federal agencies would be required to verify that prescribed rules minimize costs and burdens for the regulated community.

T3: Adopt a regulatory standard that permits employers to meet notice and reporting requirements in the most efficient manner as long as the intended objective is met.

T4: Simplify employer disclosure and reporting requirements by facilitating electronic disclosure where useful and appropriate, eliminating outdated or confusing disclosures, clarifying reporting standards and giving employers flexibility to design notices to maximize their usefulness.

T5: Improve agency implementation of rules by enhancing coordination among and within agencies.

T6: Modernize federal data analysis related to employee benefits to ensure the metrics used to make policy decisions are accurate, more meaningful and responsibly used.

U. Public Plans

U1: Preserve the core federal and state social safety net programs — Social Security, Medicare and Medicaid — to ensure all Americans have adequate health and financial security.

U2: Clarify that employers with fewer than 20 employees may allow their employer-sponsored health plan to be primary with Medicare providing secondary coverage for Medicare-eligible employees.

U3: Reform the public health system to prepare for future pandemics.

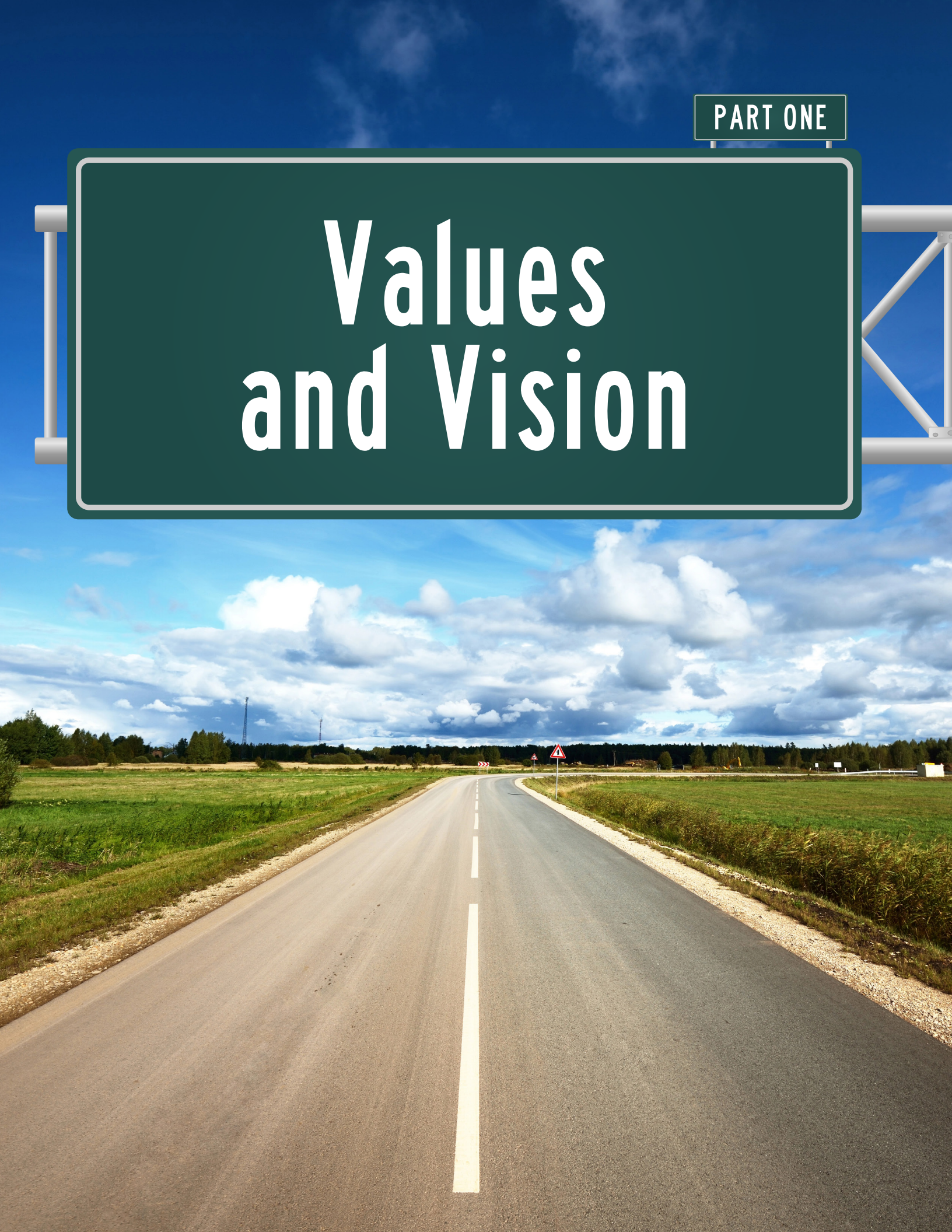
V. Leveraging Technology

V1: Support public policy that appropriately allows emerging or evolving technologies to transform and improve health and financial well-being.

V2: Public policy should not impede employers' use of secure and unbiased emerging technologies to fulfill their plan sponsor obligations and for the benefit of plan participants.

V3: Ensure public policy aimed at strengthening data privacy and security is undertaken in a way that (1) is not duplicative of or inconsistent with existing legal protections, (2) is targeted at "bad actors," (3) does not impose unnecessary burdens or liability on regulated entities and (4) is sufficiently flexible to evolve with emerging technology.

This framework represents the Council's roadmap for the next five years to reach a destination that further supports holistic workforce well-being.


PART ONE
Values
and Vision

You Are Here.

NO JOURNEY CAN BEGIN UNTIL YOU KNOW WHERE YOU ARE. IN THIS section, we describe the milestones and conditions that brought us to our present-day circumstances. *The First 50 Years* explains how, 50 years after the enactment of the Employee Retirement Income Security Act of 1974 (ERISA), the landmark benefits law stands as a beacon for plan sponsors. *The Unique Role of Employee Benefits* shows how the employer-sponsored benefits system holds unmatched value for beneficiaries and taxpayers. *Standing the Test of Time* reveals how the events of the outside world have shaped employee benefits policy and renewed a global interest in holistic well-being.

The First 50 Years | The Unique Role of Employer-Provided Benefits | Standing the Test of Time

The First 50 Years

On Labor Day 1974, President Gerald Ford signed ERISA into law, enacting the landmark statute that effectively created the current framework for voluntarily established private employer retirement, health and other welfare benefit plans.

The lengthy legislative process that led to the ultimate passage of ERISA was made *necessary* by the absence of adequate protections for benefit plan participants. The law's enactment was made *possible* by the inclusion of the federal preemption provision that labor and management, Democrats and Republicans, determined essential.

The result of this compromise is a system that promotes fairness, innovation and security on behalf of hundreds of millions of Americans and their families. Today, more than 178 million people are covered by employer-provided health insurance coverage[1] while more than 151 million American workers, retirees and dependents enjoy the security provided by employer-sponsored retirement plans.[2]

The provision of voluntary, privately managed benefits by American employers over the last 50 years affords a wide range of advantages to workers, retirees and their families while lowering overall tax burdens and facilitating economic growth and stability.

This strategic plan rests on the strong foundation of ERISA. In Parts One and Two, we explain how and why protecting and affirming this landmark law is imperative for the future, supported by a recommendation to preserve its essential preemption provision. With care, ERISA — and those it helps — will prosper another 50 years and beyond.

"Today, more than 178 million people are covered by employer-provided health insurance coverage[1] while more than 151 million American workers, retirees and dependents enjoy the security provided by employer-sponsored retirement plans.[2]

The enactment of ERISA on Labor Day 1974 denotes the modern era of employer-sponsored benefits. The landmark law set forth the obligations of employee benefit plan sponsors and established federal preemption of state law as a vital element of benefit plan governance.

"The police want to ask you a few questions about where you get such good health insurance at such an affordable rate."

The Unique Role of Employer-Provided Benefits

American employers, and by extension, employee benefits professionals, are conditioned to respond to the benefits needs and interests of their workforce. Companies' talent recruitment and retention strategies require a commitment to high-quality core benefits like health coverage, retirement savings plans and paid leave programs, as well as other ancillary offerings like disability insurance, life insurance and education benefits.

Here, we describe the value employers add to those benefit offerings — not only for the employees themselves, but to the nation.

Health and Welfare Benefits

Employer-sponsored health coverage is the bedrock of our private, market-based health insurance system. As of 2023, employer-provided health insurance plans covered more than half of all Americans and comprised 82% of the total private health insurance market.[3] Employer-sponsored group health care plans offer multiple advantages to working individuals, their families and retirees:

- **Risk pooling:** By providing coverage through the workplace, these plans bring together large, stable groups of individuals for reasons unrelated to age, income or health status, resulting in more affordable health coverage.
- **Market strength:** Employer coverage more successfully addresses the challenges of providing health coverage that plague efforts to establish viable alternative markets (*e.g.*, access, affordability, adverse selection).
- **Quality and innovation:** Employment-based health plans deliver quality health coverage and remain at the forefront of innovation (*e.g.*, wellness, cost-containment, delivery of quality care).
- **Cost sharing:** Employers pay for the bulk of coverage — an average of 83% of health care costs for covered workers enrolled in individual-only coverage and 73% of the cost of family coverage.[4] Along with accepting substantial fiduciary responsibilities, employers bear the bulk of the expense of premiums and benefit

BY THE NUMBERS: HEALTH PLANS

TABLE 2 | Number and Percentage of People by Health Insurance Coverage Status and Type, 2023

Coverage Type	2023	
	Number (in thousands)	Percent
Total	**331,700**	-
Any health plan	305,200	92.0%
Any private plan	216,800	65.4%
Employment-based	**178,200**	**53.7%**
Direct-purchase	33,850	10.2%
Marketplace coverage	13,320	4.0%
TRICARE	8,721	2.6%
Any public plan	120,400	36.3%
Medicare	62,550	18.9%
Medicaid	62,700	18.9%
VA and CHAMPVA	3,171	1.0%
Uninsured	26,440	8.0%

Note: Estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year

Source: U.S. Census Bureau, "Health Insurance Coverage in the United States: 2023," September 2024.

WHAT'S IN A NAME?

In the early years of ERISA, a common myth was that ERISA only applies to retirement plans because the word "retirement" is included in the law's name and "health" is not. However, ERISA established the foundation for sponsorship of retirement, health and other "welfare" benefit programs including life and disability insurance.

costs due to their commitment to provide affordable coverage to employees.

- **Tax advantages:** As detailed later in this strategic plan, the tax incentives associated with employee benefit plan sponsorship and participation provide tremendous value to employees and their families, as well as a substantial return on investment for the federal government.

Over the years, attempts from some policymakers (on both ends of the philosophical spectrum) to pass legislation that would impose greater health care related responsibility and expense on either individuals or the federal government have failed. This is primarily because enlightened lawmakers have understood that the employer-sponsored benefits system is an effective means of delivering high-quality health coverage and most people with employer-provided coverage prefer it over other options.[5] Nonetheless, several aspects of the current health system require improvement, including affordability for workers and employers alike. The policy recommendations in this document address these concerns and suggest strengthening the social safety net for individuals not covered by employer-sponsored health coverage.

Retirement Benefits

According to the most recent federal data, more than 151 million people participated in workplace retirement plans in 2022, more than 100 million of whom are actively accruing benefits.[6] Most participants are covered by large plans with at least 100 participants (see Table 3).

Despite high participation rates, with the average American living longer, Americans need to save more for retirement to avoid depleting their savings too soon into retirement — and to supplement the limited income replacement offered by Social Security. While people may choose to save for retirement through individual market options sold outside of employer plans, employer-sponsored pension plans and defined contribution arrangements like 401(k) plans provide:

- **Protection:** ERISA includes valuable fiduciary protection for plan participants because fiduciaries must act in the best interests of those participants.
- **Lower fees:** Employers are able to negotiate lower administrative, investment and other fees as a result of economies of scale.
- **Diversification:** Retirement plans generally offer a wide range of investment options for plan participants (and directly diversify assets in the case of pension plans).
- **Cost sharing:** Many employers offer retirement plan contributions, such as matching contributions, to help workers save for retirement. And in the case of most pension plans, the employer funds the entire benefit.
- **Efficiency:** Employers have streamlined administrative and recordkeeping processes, resulting in more efficient and cost-effective services to plan participants.
- **Fairness:** Nondiscrimination rules promote fairness across employee compensation bands.
- **Education:** Employer plans typically include educational tools and resources to help employees make sound investment choices.
- **Flexibility:** Plan features like plan loans and hardship distributions without penalty allow employees to meet emergency financial needs while still encouraging and preserving retirement savings.

BY THE NUMBERS: RETIREMENT PLANS

TABLE 3 | Number of Retirement Plans and Participants (Total and Plans with 100 or more Participants), 2022

	Total			Plans with 100 or more Participants		
	Number of Plans	Total Participants (thousands)	Active Participants (thousands)	Number of Plans	Total Participants [thousands] (Percentage of Total)	Active Participants [thousands] (Percentage of Total)
Total	801,371	151,516	103,936	98,147	137,355 (91%)	92,956 (89%)
Defined Benefit	46,508	30,205	11,333	6,391	29,723 (98%)	10,997 (97%)
Defined Contribution	754,862	121,311	92,602	91,756	107,632 (89%)	81,959 (89%)

Source: U.S. Department of Labor Employee Benefits Security Administration, Private Pension Plan Bulletin: Abstract of 2022 Form 5500 Annual Reports, Tables A1 and A1(a), September 2024

- **Lower tax burden:** For the American taxpayer, greater workplace savings means less reliance and cost burden on public programs such as Social Security.

Retirement assets constitute trillions of dollars in stable, long-term investment capital for our economy, helping companies grow, add jobs and raise wages. As of the fourth quarter of 2023, the combined financial assets in private-sector defined benefit plans and defined contribution plans alone represented $12.9 trillion.[7] Looking at the entire retirement savings market, including individual retirement accounts (IRAs), annuities and government plans, the total amount of retirement assets is now $40 trillion,[8] roughly equivalent to the GDPs of China, Japan, Germany, India, the U.K., France and Canada *combined*.[9]

In light of the value employer-sponsored retirement plans provide to individual workers and the U.S. economy, public policy should create incentives to increase employee participation and contributions, expand plan sponsorship and ease administrative burdens for all stakeholders.

Paid Leave Programs

The COVID-19 pandemic underscored for the nation the importance of paid leave,[10] including sick, mental health, "safe" leave and family and medical leave. Increasing financial pressures, coupled with the demands of health and family, result in unpaid leave not being a realistic option for many working families. Through an employer, workers can obtain and manage their valued paid leave seamlessly and promptly without needing to comply with burdensome administrative processes required by many public leave programs.

The American Benefits Council is a champion for employers, a trusted and credible resource for policymakers and the guardian of the employer-sponsored system.

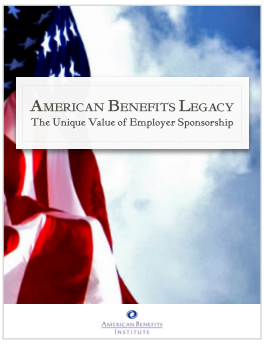
Employer-sponsored plans also mitigate the additional overhead costs, complexities and inconsistencies of state and local public programs. Paid leave is good business. A 2023 study found paid sick leave resulted in higher employee morale and job satisfaction, increased retention, better profitability and improved firm performance.[11]

The Council's member companies recognize the importance of helping employees care for a new child or tend to their own health issue or that of a family member. This is why we strongly support universal access to paid leave, as reflected in our statement of principles on paid leave adopted in 2020. This strategic plan advocates for private-sector solutions allowing employers to treat workers equitably regardless of where they live or work. To support employer-provided paid leave benefits, federal legislation must promote the harmonization of state programs so multistate employers can treat their workers equitably nationwide.

Standing the Tests of Time

The continued success of today's employer-sponsored benefits system is not a foregone conclusion and should not be taken for granted. As in ERISA's first 50 years, employee benefit legislation still requires ongoing refinements reflecting new and evolving needs. It has been 10 years since the publication of our last strategic plan. In that time, the world has faced unprecedented challenges including widespread natural disasters, the COVID-19 pandemic and significant social movements. Some of these events became catalysts for legislative activity affecting employee benefits.

This timeline highlights some of the most significant domestic events and underscores the importance of a flexible, principles-based strategic plan through 2030.



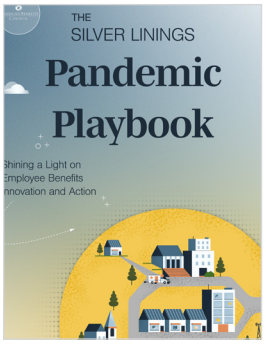
"Employer-sponsored benefits provide a unique value that has had an important role in achieving the prosperity and security that American workers have long enjoyed. As such, they represent a national legacy that needs to be appreciated and preserved.

The real-world impacts of these events, some of which appear at first glance to be only tangentially related to benefits (if at all), nevertheless have the potential to affect employers, employees, families and communities in profound and lasting ways. This dynamic underscores the importance of a flexible, principles-based strategic plan that not only advances our priority policy agenda but prepares us for unintended consequences and other downstream effects.

An Inf(l)ection Point

Many of the events noted above — most notably the COVID-19 pandemic — profoundly influenced U.S. business, and as a result, company leaders were often required to react quickly and decisively. If, as Albert Einstein said, "in the midst of every crisis lies great opportunity," the pandemic was an object lesson in employers and policymakers seizing that opportunity to work in tandem for the greater good.

Throughout this period, employee benefits were an essential vehicle for providing critically necessary aid to employees and their families. As the Council detailed in its 2021 report, *The Silver Linings Pandemic Playbook*,[12] employers responded by enhancing their health benefit plans to protect against and treat COVID-19, instituting emergency savings programs to help families experiencing economic challenges, expanding employee assistance programs and relaxing time-off policies to support child and eldercare needs.



Employers also saw a greater overlap in occupational health efforts to protect workers and the role of employee benefits. In 2020, while issuing workplace standards to mitigate the virus's impact on workplaces, the U.S. Occupational Safety and Health Administration (OSHA) expressly acknowledged the interdependence of occupational health and employer-sponsored health insurance.[13]

Meanwhile, Congress and the executive branch responded by passing and implementing a series of emergency measures, such as the Families First Coronavirus Response Act of 2020, the Coronavirus Aid, Relief and Economic Security Act of 2020 and the American Rescue Plan Act of 2021. These and other laws:

TIMELINE 1 | The Past is Prologue

2014

Nonwhites become the majority of U.S. newborns and public-school students: Underscores increased population and workforce diversity, shaping the future of employee benefit needs

2015

Same-sex marriage legalized in United States: Benefit plans compelled to revisit eligibility requirement

2016

Millennials become largest generation in labor force: Coupled with baby-boomer retirements, plans must evolve to suit changing needs and desires

2017

Bill to "repeal and replace" the Affordable Care Act defeated on Senate floor

2018

The most recent major tax reform legislation, the 'Tax Cuts and Jobs Act,' enacted through budget reconciliation process, setting up expiration of tax rates and a new tax reform debate in 2025

2019

U.S. unemployment reaches record low: Companies increase their focus on employee attraction

'SECURE Act' retirement legislation signed into law

2020

COVID-19 pandemic sweeps the globe: Creates an inflection point for employers around the world; global economy thrown into disarray; companies assume major role in public health infrastructure; work-from-home becomes commonplace for many workers; health systems severely strained

"Great Resignation" takes root: As employees re-evaluate their priorities, employers revisit employee retention efforts, including competitive compensation and benefits

No Surprises Act enacted as part of Consolidated Appropriations Act 2021: Represents most significant health policy legislation since Affordable Care Act

2021

'Build Back Better Act' proposes establishment of a national paid family and medical leave program, but the legislation is never enacted

2022

***Dobbs v. Jackson Women's Health Organization* ruling overturns Roe v. Wade:** Employers forced to grapple with new questions about access to abortion coverage

2023

'SECURE 2.0 Act' retirement legislation signed into law

2024

***Loper Bright v. Raimondo* negates *Chevron* deference:** Ruling resets relationship between legislative, regulatory and judicial branches of government

- Permitted expanded coverage of telehealth and other remote care.
- Allowed greater opportunities for hardship withdrawals and loans from retirement plans.
- Provided relief from required minimum distribution requirements for defined contribution plans and IRAs.
- Offered critical minimum funding reform for defined benefit pension plans based directly on Council proposals.
- Expanded paid sick and family medical leave and enhanced tax credits for employers offering emergency leave.
- Provided for coverage of COVID-19 tests without cost sharing.
- Allowed employer contributions based on qualified student loan repayments.
- extended fully subsidized COBRA coverage
- expanded tax benefits for employer-paid dependent care assistance
- increased subsidies for health coverage in Affordable Care Act (ACA) exchanges
- provided flexible spending account (FSA) relief including prospective mid-year election changes and rollover of unused funds for both health and dependent care FSAs

Just as American employers should be proud of their leadership and efforts to support workers during the pandemic, the Council is proud to have championed many of these emergency initiatives, which undoubtedly saved thousands, if not millions, of workers and their families from health and financial hardship.

The More Things Change: Evolving Employee Benefit Strategies

PRIOR COUNCIL STRATEGIC PLANS FOCUSED ON *PERSONAL FINANCIAL security* and then evolved to *personal health and financial wellbeing*. This strategic plan further builds upon those concepts and recognizes that to achieve sustainable workforce well-being, benefits must address not only physical and financial health, but also the many other elements affecting a person's holistic well-being.

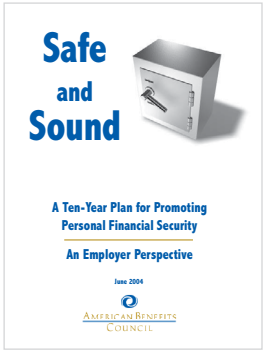
***Safe and Sound* (2004) | A 2020 Vision (2014) | DEST*INATION* 2030 (2025)**

2004 Strategic Plan: *Safe and Sound*

In 2004, the Council published *Safe and Sound, A Ten-Year Plan for Promoting Personal Financial Security,*[14] centered on the concept of promoting "personal financial security" — the measure of an individual's ability to live a long, healthy life and prepare for a comfortable retirement at a reasonable cost. The Council outlined several objectives to meet this need:

- Retirement systems should have incentives encouraging employers and employees to contribute adequate amounts to retirement savings programs and preparing employees to manage their assets to last throughout retirement.
- Active employee health care systems should promote broad coverage and empower purchasers to be effective health care consumers.
- Retiree health and long-term care systems should help ensure adequate health care security in retirement while still allowing retirees to continue the level of income they have come to enjoy.
- Stock plan ownership arrangements should advance personal financial security through accumulation of capital.

In articulating these broad goals and 41 associated policy recommendations, *Safe and Sound* plotted a course through an acutely transitional era in employee benefits, characterized by a widespread shift away from defined benefit plans and toward defined contribution (or "consumer-driven") programs. In this environment, the roles and expectations of the three key stakeholders — employers, individuals and the government — were changing rapidly. The traditional paternalistic philosophy of "providing" security to employees yielded to a greater emphasis on the aim of "promoting" income and benefits security. The upshot was not simple metamorphosis, but also an explosion of innovative plan designs. This was especially true during the period between the 2008 recession and 2020 pandemic, when the economy boomed and competition for talent was intense. It was challenging to keep pace with this period of innovation and brought about an urgent need for more market flexibility.

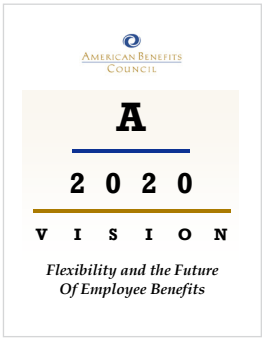


2014 Strategic Plan: *A 2020 Vision*

In 2014, the Council published *A 2020 Vision: Flexibility and the Future of Employee Benefits.*[15] This strategic plan offered a six-year time horizon with a greater emphasis on emerging trends that would shape the future.

The framers of this strategic plan firmly rejected the notion of "one-size-fits-all" approaches to health and financial security and (quite accurately) predicted four trends that would affect employee benefits and described how the employer-sponsored system was well-positioned to accommodate them:

- Integration of personal health and financial well-being, rather than health and retirement benefits existing in separate silos



- Global competitiveness driving benefit plan design
- Emphasis on simplicity and predictability in benefit plan administration
- Maximum flexibility for employers and employees

A 2020 Vision promoted five broad goals all employee benefits public policy should aspire to achieve — sustainability, empowerment, value, innovation and leveraging technology. These five goals were then supported by 46 specific policy recommendations, designed to improve employees' "personal health and financial well-being" (a progression from "security" ten years prior).

STRATEGIES DELIVER RESULTS

Our strategic plans helped the Council successfully navigate four presidential administrations and served as the guideposts of our advocacy efforts. The Council provided leadership and expertise during consideration of the most consequential employee benefits-related laws of the past two decades, the extensive regulations implementing those laws and other landmark developments in the courts and in the states including:

- **The debate, passage and implementation of the ACA.**
- **The development and enactment of three landmark retirement savings reform measures: The Pension Protection Act of 2006 (PPA), the Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019 and the SECURE 2.0 Act of 2022.**
- **The Tax Cuts and Jobs Act of 2017.**
- **The attempt to repeal the ACA.**
- **The No Surprises Act of 2020.**
- **The dramatic rise of state lawmaking activity.**
- **Major Supreme Court decisions including those addressing marriage equality and abortion**
- **Pandemic-related legislation affecting employee benefits.**
- **Supporting numerous other consequential measures, such as repeal of the 40% "Cadillac Tax" on employer-provided health plans.**
- **Defeating dozens of potentially harmful legislative proposals.**

2025 Strategic Plan: A Roadmap for the Future

The social contract defining what employees expect from their employers, and vice versa, has evolved since the drafting of our last strategic plan. One of the enduring legacies of the pandemic — and the first 25 years of the millennium — is the recognition that **"health" is more than just physical fitness or absence of disease. It is an integrated view of an individual's complete — or holistic — state of being.**

The 2025 strategic plan acknowledges the need to focus on holistic well-being comprised of six dimensions:

- **Physical health:** A state of well-being relating to the body and its ability to perform daily activities without restriction. This includes the absence and prevention of disease, illness and injury. Physical health can be affected by many factors such as diet, exercise, sleep, behaviors, access to medical care, and genetics.
- **Financial health:** A state of being secure in the expectation one will be able to sustain one's living conditions and general welfare throughout retirement and in the face of potential adverse events.
- **Mental and behavioral health:** An individual's cognitive, emotional and behavioral state, including resilience to stress and a sense of purpose.
- **Occupational health and safety:** The promotion and maintenance of workers' health, safety and welfare. This includes preventing work-related diseases, illnesses and injuries.
- **Environmental well-being:** How workplaces and workspaces — and, indeed, the greater community — are influenced by environmental factors such as climate, pollution, natural resources and commuting.
- **Social well-being:** Social connections, relationships and personal expression. In the work context, it includes a person's ability to build relationships with colleagues based on mutual respect, support, authenticity, recognition and trust.

FIGURE 2 | The Evolution of Employee Benefits

Personal Financial Security

A state of being secure in the expectation one will be able to sustain one's living conditions and general welfare throughout retirement and in the face of potential adverse events. *-Safe and Sound, 2004*

Personal Health and Financial Well-Being

Embraces a broader view of income protection that incorporates not only health coverage and retirement savings, but also life insurance, disability and long-term care. *-A 2020 Vision, 2014*

Holistic Well-Being

An integrated view of an individual's health and security, which includes physical, mental, financial, occupational, environmental and social well-being.

This integrated approach is already deeply embedded in many companies' talent acquisition and retention strategies. These organizations appreciate that employers who do not take this approach do so at their own peril. McKinsey Health Institute found that "employee disengagement and attrition — more common among workers with lower well-being — could cost a median-sized S&P company between $228 – $355 million a year in lost productivity."[16]

An organization that invests in the holistic well-being of its people will reap the financial rewards of such an approach. A study by the Health Enhancement Research Organization (HERO) found stocks of organizations offering evidence-based workplace health promotion practices appreciated by 235% compared with the S&P 500 portfolio appreciation of 159% over a six-year period. The study concluded that "[r]obust investment in workforce health and well-being appears to be one of the multiple practices pursued by high-performing, well-managed companies."[17] As the introduction to Deloitte's 2024 Global Human Capital Trends report explained, "prioritizing human sustainability — the degree to which the organization creates value for people as human beings, leaving them with greater health and well-being, stronger skills and greater employability, good jobs, opportunities for advancement, more equity, and heightened feelings of belonging and purpose — can drive not only better human outcomes, but better business outcomes, too, in a mutually reinforcing cycle."[18]

Beyond the employee/employer relationship, an employee's holistic well-being also has an impact on the broader community. In 2022, Gallup concluded that "employee well-being starts at work," influencing not just physical and financial well-being, but also social and community well-being.[19] Sound employee benefits public policy supports holistic workforce well-being because it strengthens the health of our nation.

FIGURE 3 | Hitting the Target: Holistic Workforce Well-Being

The Values Paving the Road to 2030

BUILDING ON ERISA'S LEGACY AND THE COUNCIL'S TWO PRIOR strategic plans, this section articulates the Council's current core values forming the basis for our 2030 policy goals and recommendations.

All Together Now: Partnership Among People, Employers and the Government

The oft-referenced three-legged stool traditionally referred to the three sources of retirement security: employer-sponsored retirement plans, Social Security and individual savings — effectively bringing together individual, public and employer support structures for the benefit of the American worker. This partnership-based framework also applies to other employee benefits, such as health and time off.

People have primary responsibility for maintaining their own well-being, which includes good nutrition, exercise and fiscal responsibility. Individuals have seen their role change most dramatically over the last several decades as they are no longer viewed merely as the recipients of employer-provided benefits, but also as consumers, patients and investors. These expanded roles require active engagement and decisive action at several stages of a person's life, often on behalf of family members as well as themselves.

Employers are key contributors to the holistic well-being of the U.S. workforce. While core business drivers may differ by industry, fostering a healthy and productive workforce is a universal business imperative.

Employers support workforce well-being by sponsoring programs to help workers, retirees and their families lead healthy and secure lives. Employers are also becoming more aware of how the physical environment of where an individual works affects their well-being and have implemented programs to address those needs such as ergonomic support, remote work policies, sustainable work environments, personalized work sites and on-site occupational health services.

Recognizing that individuals benefit from living in a healthy society, some employers are increasingly demonstrating a commitment to improve communities through charitable giving, education, diverse workplace culture and neighborhood clean-up.

The course an employer takes depends on several factors including available resources, the competitive landscape, organizational philosophy, and a unique understanding of employees' wants and needs. Public policy should preserve employers' freedom to offer and communicate meaningful and innovative employee benefits.

Government is the steward of public policy and entrusted with establishing and enforcing rules keeping each leg of the stool sturdy. The onus is chiefly on the legislative and executive branches of government to make and enforce policy. However, the judiciary is often asked to help control against misunderstandings of the law's intent or frivolous but lucrative class-action lawsuits against plan sponsors and service providers.

The public sector is also the nation's most prominent employee benefit plan sponsor. In its role as an employer, the federal government sponsors the world's largest employer-sponsored health insurance plan, the Federal Employees Health Benefits Program, covering active civilian employees, their families and retirees – nearly 8.3 million in all.[20] And almost all current federal employees are covered by the Federal Employees Retirement System and the Federal Thrift Savings Plan.

The federal government also is the *de facto* "plan sponsor" of public benefit programs, such as Social Security and Medicare, which provide millions of Americans with essential

retirement income, health care coverage, disability income and job loss insurance, to supplement employer plans and serve as a social safety net. While these programs each offer vital resources, they each struggle with fiscal and administrative challenges, making their alignment alongside the employer-sponsored system all the more important. It is crucial, however, that the public sector continues to maintain its obligation to keep the playing field level rather than leveraging its own bargaining power to shift costs to private payers.

The Federal and State Balancing Act

In the 1932 case *New State Ice Co. v. Liebmann*, U.S. Supreme Court Justice Louis Brandeis immortalized the notion that states are the "laboratories of democracy," theorizing that "a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." The idea has found purchase among Republicans, for whom states' rights are a fortification against federal overreach, and among Democrats, who regard federal action (or lack thereof) as insufficiently progressive. Nearly a century later, the "risk" in Brandeis's telling is much less benign. For multistate employers confronted with emboldened state lawmakers attempting to address the interests and concerns of an array of stakeholders, providing consistent and uniform employee benefits to employees regardless of where they live, or work has become a taller order.

The debate over federalism dates to the nation's founding and cannot be resolved in this strategic plan or exclusively in the domain of employee benefits. And while we recognize that states play a role in certain public policy arenas, the core of this strategic plan is the reliance on the primacy of ERISA and the federal standard created by its essential preemption clause.

> **"Employee benefits policy has often been an oasis of bipartisanship in an otherwise barren desert.**

As articulated in greater detail later in this strategic plan, ERISA preemption of state law is the foundation of our strong employer-sponsored benefits system. Today, preemption is under attack at the state level, disrupting that balance by imposing a panoply of requirements that, if left unchecked, will make continued plan sponsorship untenable.

FROM WHERE WE SIT: THE THREE-LEGGED STOOL

"The first in order of time is individual insurance . . . the second, a variety of employee benefit plans of which Group insurance is an outstanding American contribution; and the third, social security — designed by the government for the well-being of our fellow citizens . . . Each has its own function to perform and need not, and should not, be competitive with the others. When soundly conceived, each class of insurance can perform its role better because of the other two classes. Properly integrated, they may be looked upon as a three-legged stool affording solid and well-rounded protection for the citizen."

— Reinhard Hohaus, 1949

On Bipartisanship: The Lifeblood of Good Policy

At the time of ERISA's passage and for the first few decades thereafter, comprehensive legislation of any kind (not just measures relating to employee benefits) could generally only become law if it was supported on a bipartisan basis. Both political parties in Congress were comprised of lawmakers who spanned the philosophical spectrum. There were enough moderate-liberal Republicans and moderate-conservative Democrats in office that consequential legislation had little chance of passing without their support. To win those votes the policy being considered had to represent a compromise and thereby pass on a bipartisan basis.

Today we are faced with precisely the opposite situation. Over the past 20 years or so, moderate lawmakers in both parties have become nearly extinct. For the most part, consequential legislation is only likely to pass if *one* party controls both houses of Congress *and* the White House. Without the need to attract support from across the aisle, legislation is often crafted with a distinctly partisan slant and often passes on a strict party-line vote, or perhaps with support from just a few members of the other party.

One result of this phenomenon occurs when the political winds shift following an election and the new majority seeks to undo what the prior regime enacted. If the party shift is only in the executive branch, then the new administration

tries through the regulatory process to undo as much of the previously enacted legislation as possible. Either way, plan sponsors are denied what they need: certainty.

Employee benefits policy has not been immune to this prevailing partisan environment. Fortuitously, however, employee benefits policy has often been a welcome oasis in an otherwise barren desert. Bipartisan retirement policy especially presents reason for optimism, considering the recent enactment of SECURE and SECURE 2.0 legislation. Bipartisan measures to compel greater cost transparency in the health care arena and collective efforts to forge a federal paid leave policy offer a glimmer of hope in other areas. More of this needs to happen because only through durable, bipartisan policymaking, in which both parties feel a sense of ownership, will employers feel confident of a stable environment in which to sponsor benefit plans.

Stability in the law is necessary to perpetuate good employee benefits policy and the employer-sponsored system. To that end, we point to the four necessary conditions to achieve stable governance, as set forth by the U.S. Institute of Peace:[21]

1. Provision of essential services.
2. Stewardship of "state" (*i.e.*, federal) resources.
3. Solitical moderation and accountability.
4. Civic participation and empowerment.

Employee benefits policy is an exemplar of all four values, by virtue of its societal importance, its economic efficiency, its bipartisan support and its role in empowering individuals.

It is outside the Council's mission to advocate for national political reform. However, we strongly encourage Congress and executive branch officials to embrace bipartisanship, evidence-based decision-making and a focus on long-term solutions rather than short-term victories.

This will be particularly important in light of the U.S. Supreme Court's 2024 decision in *Loper Bright Enterprises v. Raimondo*, in which the high court struck down the decades-old "*Chevron* doctrine" granting broad deference to rulemaking agencies. To stand up to judicial scrutiny, and prevent inconsistencies from jurisdiction to jurisdiction, legislators must provide as much clarity as possible within legislation itself. Since Congress typically does not possess the technical expertise nor the time to develop the rules and guidance necessary to implement laws, Congress at a minimum must explicitly grant that discretion to the executive branch agencies so that — for better or worse — there is a high degree of certainty and stability when regulations are published.

"It's just a shame we can't come together and find a bipartisan solution in which our party comes out ahead."

Flexibility is Valuable Currency

In *A 2020 Vision*, the Council posited that "maximum flexibility" for employers and employees would be essential for employers operating in a global, diverse economy. While legislative and regulatory flexibility are paramount in this discussion, the needs of today's workforce go beyond mere rules and statutes.

- Today's employees are seeking flexibility in how, when and where they work, a movement brought about largely by technological advancements and accelerated by the COVID-19 pandemic. This means benefit plans must be deployable, administrable and accessible in a variety of forms and platforms, and scalable for itinerant, seasonal and part-time workers. Indeed, in one survey, nearly two-thirds of U.S. workers considered flexibility to be a key part of compensation,[22] and more than half of individuals in a separate survey said they would give up a 10 to 20% salary increase for more flexibility.[23]
- As we speculated in *A 2020 Vision*, historic silos that existed between traditional health and retirement plans are dissolving in favor of a more integrated

approach that could include environmental safety and thriving communities.

- Organizations will need to embrace, adopt, and secure new technologies — including artificial intelligence — not only to keep pace with those utilized by younger workers but to create efficiencies.
- Employers will also need to practice cultural flexibility in light of the various U.S. demographic shifts and reconsider traditional age-based job profiles, as some retirees re-enter the workforce to explore second or third careers.

Tax Policy: The Fuel in the Employee Benefits Engine

Longstanding, bipartisan tax policy is essential to the success of the employer-sponsored benefits system. Our current system of federal tax incentives encourages employers to sponsor, design and fund benefit plans and individuals to seek financial protection from high health costs and inadequate retirement income through participation in those plans. For both retirement and health plans, employer contributions are tax deductible. But it is the tax benefits for individuals that are most frequently coming under scrutiny.

Retirement Plan Tax Incentives

The U.S. retirement savings system successfully encourages individuals to participate by allowing the deferral of income tax on contributions to employer-sponsored defined contribution plans and IRAs, up to certain limits, and on the earnings on those contributions. This provides a strong incentive for individuals at all income levels to save for retirement and encourages employers to sponsor plans that deliver meaningful benefits to Americans along the income scale.

That a tax deferral heightens an individual's incentive to participate is a crucial point as it does not result in a loss or expenditure of tax revenue, because the revenue is eventually collected on both the plan contributions and the related earnings when benefits are paid at retirement. Hence, the tax collected may actually be higher in present value terms at the time the benefits are distributed than they would have been at the time of contribution.

The pre-tax treatment of retirement savings is a powerful motivator for individuals. To be sure, there is a role for post-tax retirement vehicles (*i.e.* "Roth" treatment[24]). But the pre-tax structure allows employees to save more on a paycheck-by-paycheck basis than would be the case with after-tax contributions, which is particularly important for low- and middle-income families trying to make the most of scarce dollars.

The current tax incentives also support the voluntary nature of our employer-sponsored retirement system. Employer nonelective and matching contributions are not treated as wages with respect to the recipients and are therefore exempt from federal (and typically state) payroll taxes, allowing companies greater flexibility in compensation.

Some argue the current tax incentive system is a less-than-optimal structure because the tax exclusion provides a tax benefit proportional to an individual's income tax bracket, with a greater benefit being received by higher income individuals to whom a higher marginal tax rate applies. Accordingly, some have proposed replacing it with after-tax contributions paired with a tax credit, capped at a dollar or percentage level. As we noted in 2010,[25] during a previous (and, thankfully, repelled) attack on these incentives, a revised tax regime of this kind would actually reduce plan participation and individual retirement account (IRA) usage, provide less tax savings than today's structure, deter plan sponsorship and impose administrative complexities and costs on remaining plans.

Health Plan Tax Incentives

Under current law, the value of employer-provided health insurance coverage is excluded from employees' wages, resulting in such value not being subject to federal (and typically state) income and payroll taxes. For the better part of a century, federal law has protected employees from tax on this coverage, which is a major reason employer-provided health insurance is so prevalent.

Incentivizing employers to maintain health coverage reduces the financial consequences to the government of providing direct subsidies to many individuals who would otherwise obtain coverage through the health insurance exchanges/marketplaces established by the ACA.

Although the tax expenditure for employer-sponsored health coverage has been painted as "regressive" because the "tax benefit" favors higher-income individuals, the expenditure is in fact quite *progressive.* The value of the "health benefit" it provides is more significant for lower-income individuals, for whom it would be a greater financial burden to purchase coverage absent an employer-sponsored plan.

EQUATION 1 | The Benefits Bargain: Health Plans

BENEFITS PAID BY GROUP HEALTH INSURANCE PLANS, 2023		FORGONE REVENUE ATTRIBUTABLE TO TAX EXCLUSION FOR EMPLOYER-PROVIDED HEALTH COVERAGE, 2023		FOR EVERY $1 OF TAX EXPENDITURE, EMPLOYERS PAID
$1.3 TRILLION	÷	$216 BILLION	=	$6.02 IN BENEFITS

EQUATION 2 | The Benefits Bargain: Retirement Plans

EMPLOYER RETIREMENT PLANS PAID OUT, 2023		FORGONE REVENUE ATTRIBUTABLE TO TAX DEFERRAL FOR DEFINED BENEFIT AND DEFINED CONTRIBUTION PLANS, 2023		FOR EVERY $1 OF TAX EXPENDITURE, EMPLOYERS PAID
$1.9 TRILLION	÷	$204 BILLION	=	$9.31 IN BENEFITS

Naturally, given the perception of "lost revenue" due to the tax-favored treatment of employer-sponsored health coverage, some lawmakers periodically seek to eliminate or cap the current income exclusion, thereby "unlocking" revenue offsets for broader tax reform or other initiatives. Each time, the Council has explained even modest changes in the tax rules would result in dangerous disruption including increased taxes and health insurance costs for millions of employees. Support for these tax incentives ensures ongoing private-sector involvement, reducing the reliance on government programs and maintaining a competitive health insurance market.

The Benefits Bargain

Officially, the tax incentives for employer-provided health and retirement plans are regularly scored as the two largest income tax "expenditures" in the federal budget. Taken together, the exclusion from an individual's income tax of contributions to employer-sponsored health and retirement plans represents a theoretical cost of $6.1 trillion over the next 10 years. By comparison, the individual tax deduction for mortgage interest is projected to cost "only" $828 billion over the same period.[26]

Unfortunately, most armchair analysis stops there without consideration of the value to the federal treasury. A more comprehensive look reveals that the "cost" of these tax incentives is a bargain.

A simplified method of evaluating the efficacy of tax incentives is to calculate the return on investment for each dollar of forgone revenue. Over several decades, this demonstrates the enormous value of the tax-favored treatment of employer-sponsored benefits. According to the White House Office of Management and Budget, for example, $216 billion in "forgone revenue" in 2023 was attributable to the income tax exclusion for employer-provided health coverage.[27] Meanwhile, the Bureau of Economic Analysis (BEA) shows employer group health insurance funds paid out $1.3 trillion that same year.[28] $1.3 trillion divided by $216 billion reveals every dollar of federal expenditure yields $6.02 in benefits for covered employees and their families. No other government health care program can demonstrate as much value gained per dollar spent.

Likewise, the "forgone revenue" attributable to the tax incentives for retirement plans (setting aside the future taxes collected at distribution) equaled $204 billion in 2023.[29] According to BEA, employer plans paid out $1.9 trillion in benefits in that same year.[30] Dividing $1.9 trillion by $204 billion reveals $9.31 in benefits are provided for every tax dollar spent. This only accounts for the *present* value of each dollar of savings, not the ultimate cash flow value enhanced by years of investment growth.

According to a 2024 analysis of Congressional Budget Office data performed by the Employee Benefit Research Institute, the federal government provided an average subsidy of $2,400 to each individual covered by employment-based coverage. By comparison, the federal government spent an average of $6,000 to subsidize each person receiving individual (non-group) coverage and $7,200 per person with Medicare/Children's Health Insurance Plan coverage.[31]

Policymakers who advocate scrapping employer-sponsored benefits — or the tax incentives making these benefits possible — should be aware of this compelling return on investment and understand it would cost *far* more to provide the same level of health and financial security outside of the employer-sponsored system.

Tax Policy Principles

ERISA is the landmark statute dealing exclusively with employer-sponsored benefit plans, but it shares jurisdiction over these programs with the Internal Revenue Code ("the Code"). Any comprehensive change to the Code therefore has implications for employer plans. Numerous policy recommendations in this strategic plan will require modifications to the Code and could be included in tax legislation or a budget reconciliation measure. Other recommendations in this plan may carry an upfront cost that could be offset by revenue raised elsewhere.

As Congress pursues comprehensive tax reform or smaller tax measures, the Council will adhere to the following principles:

- ***Do no harm to employer plans.*** Voluntary, employer-sponsored benefit programs being vitally important for assuring holistic workforce well-being, the current tax incentives must be preserved, protected and defended. If the tax structure is altered and employers were to exit the system, costs to the federal and state budgets would increase as more employees become eligible for public programs.
- ***Treat tax incentives for employer plans as prudent investments.*** Employer-provided benefits generate enormous value for plan participants, employers and the federal government. But much of this value is captured outside of the traditional 10-year congressional budget window. These tax incentives should be recognized not simply as expenditures, but instead for what they are — long-term investments.
- ***Employer plans are not "piggy banks."*** Because conventional budget estimates mask the value (and distort the costs) of employer plans, there is a tendency to think of the tax incentives as a convenient source of untapped revenue. Policymakers must avoid the temptation to cap or eliminate these incentives to pay for unrelated tax policy changes or other government spending.
- ***Pursue opportunities to expand the employer-sponsored system.*** Policymakers should continue to permit tax-favored approaches to financing employee benefits and ensure favorable tax treatment is available for individuals outside the employer system, as well.

A Path to 2030

CONSISTENT WITH THE VALUES ESTABLISHED ABOVE, THE COUNCIL resolves to move forward with a clear vision for the future — and the public policy that will dictate that future.

In the service of this vision statement, our strategic plan describes the five most pressing challenges facing employer-sponsors today, provides four goals to address each challenge, and then offers detailed policy recommendations for meeting those goals.

This framework represents the Council's roadmap for the next five years. We look forward to cooperation and collaboration with other stakeholders in the employee benefits arena, and with policymakers on the journey to our DESTI**NATION**.

Public policy should preserve and support the advancement of employer-sponsored benefit plans, which aim to improve the holistic well-being of employees, retirees and their families.


PART TWO
Challenges
& Goals

TABLE 4 | A Framework for the Future

CHALLENGES				
Improving Holistic Well-Being	**Legal and Regulatory Uncertainty**	**Demand for Personalized and Individualized Benefits**	**Increased Individual Responsibility**	**Aligning Health Care Cost and Quality**
GOALS				
GOAL 1: Eliminate barriers to retirement savings	**GOAL 5:** Protect and affirm ERISA	**GOAL 9:** Improve employee benefits equity	**GOAL 13:** Support financial literacy and retirement readiness	**GOAL 17:** Reform provider payment systems and practices to incentivize value-based care
GOAL 2: Promote sustainable employee health and well-being	**GOAL 6:** Promote stability of employee benefits policy	**GOAL 10:** Increase access to personalized and individualized benefits	**GOAL 14:** Preserve access to defined contribution health programs and enhance consumer-directed health plans	**GOAL 18:** Prevent cost-shifting to private payers
GOAL 3: Improve the mental and behavioral health of employees and their families	**GOAL 7:** Promote flexibility in employee benefit plan design and operation	**GOAL 11:** Harness technology to improve access and outcomes	**GOAL 15:** Maintain public safety net programs	**GOAL 19:** Encourage competition within the health care industry
GOAL 4: Improve public health and disaster preparedness	**GOAL 8:** Prevent excessive or unwarranted regulation, litigation and enforcement	**GOAL 12:** Promote flexibility for employer-provided paid leave programs	**GOAL 16:** Support and modernize defined benefit retirement plans	**GOAL 20:** Promote access to affordable, effective, safe and innovative prescription drugs and therapies

As illustrated in the chart above, this section of the strategic plan explains the five primary challenges affecting employee benefit plan sponsors and offers four goals each to surmount them. This approach acknowledges the seriousness of these obstacles and is a reflection of the American Benefits Council's commitment to address these impediments. The 20 goals, set on a framework of fundamental challenges, constitute the Council's roadmap to a stronger employee benefits system.

Every journey comes with its share of headwinds. Understanding the headwinds facing employee benefits and its stakeholders is necessary to then identify relevant and timely goals and recommendations. That said, the term "challenge" should not necessarily be read to mean something inherently negative. In fact, some challenges are not only desirable (such as aligning health care cost and quality) but intentional. Nevertheless, these must still be managed and addressed with care.

Given the naturally overlapping nature of some of the challenges identified in this strategic plan, some goals address more than one of them. This is deliberate and further underscores the holistic nature of these topics. Part Three of the strategic plan, provides 79 policy recommendations explicitly addressing multiple goals.

> **"Understanding the headwinds facing employee benefits and its stakeholders is necessary to then identify relevant and timely goals and recommendations.**

Challenge: Improving Holistic Well-Being

AS DESCRIBED IN PART ONE, AN INTEGRATED VIEW OF AN INDIVIDUAL'S health includes consideration of several interrelated pieces including their physical, mental, financial, occupational, environmental and social well-being. Research has shown the complementary nature of these elements, each affecting the other.[32] However, employee benefit programs traditionally considered each of these elements separately. For instance, while there is a strong connection between stress-related mental health conditions and financial insecurity,[33] in the past few benefit programs offered financial literacy as part of their mental health treatment protocols. To address this challenge, many employers are now offering benefits that support an individual's long-term well-being, rather than only intermittent assistance or acute care. Doing so results in a more engaged, productive and loyal workforce.

Today, comprehensive major medical coverage accounts for a growing list of needs. Dental and vision programs are now seen as essential, and mental and behavioral health needs are recognized as equally important as physiological health. The very concept of "health" has evolved from a "lack of illness" to a sustained state of "well-being." The hidden cost of "presenteeism" — the act of simply "showing up" rather than truly working — has an estimated annual cost of $1.5 trillion, compared to only $150 billion for absenteeism. This speaks to the need for well-being that cannot be measured with a thermometer.

Similarly, compensation used to address an employee's immediate remuneration needs and a retirement plan solved for a post-work income stream. Today, more holistic "financial well-being" also includes features like emergency savings, tuition and loan assistance, debt consolidation, tax preparedness, financial literacy and more.

Health and financial well-being are now recognized as deeply intertwined. Health care costs (including prescription drug costs) threaten to consume an enormous share of post-retirement income, and present-day health costs erode one's ability to save for retirement.

Employees have taken notice. The global economy's gradual shift toward a more highly skilled labor force, coupled with changing population demographics, is a catalyst for changing expectations between employers and their workers. In the war for talent — especially the intermittent tight labor markets over the past 25 years — employee benefits are a primary differentiator in recruitment and retention strategies.

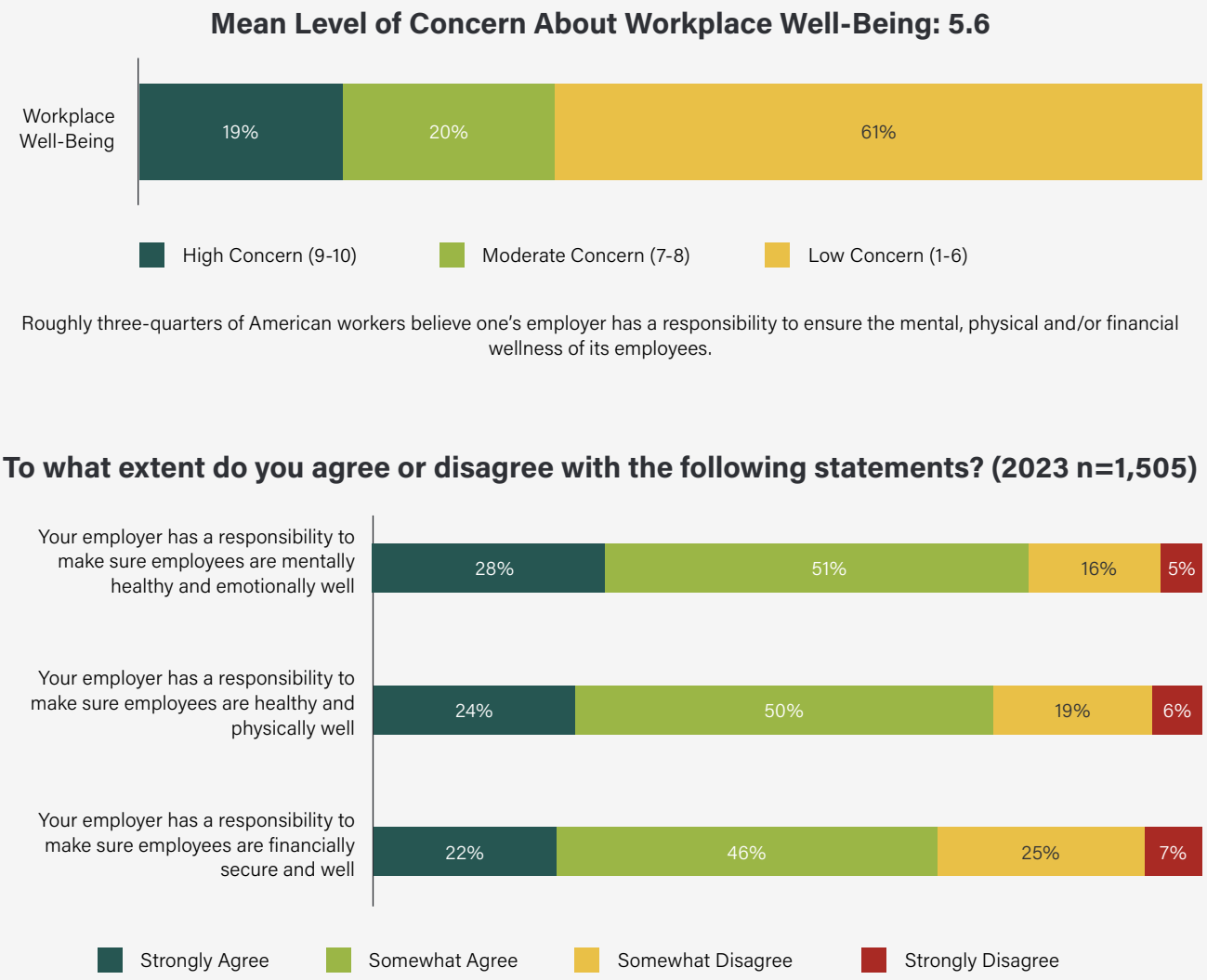
The challenge is balancing the rapidly evolving portfolio of benefits (and benefit-adjacent) programs. Achieving the following goals will help plan sponsors do just that:

- Eliminate barriers to retirement savings
- Promote sustainable employee health and well-being
- Improve the mental and behavioral health of employees and their families
- Improve public health and disaster preparedness

GOAL 1
Eliminate barriers to retirement savings

Participation in a workplace retirement plan is one of the most reliable predictors of economic security during retirement, with outcomes improving further based on the degree of individual engagement, consistency and duration of participation.[34] Despite this compelling data, too many

CHART 1 | Workplace Well-Being: Who Has It, and Who Is Responsible for It?



Source: Employee Benefit Research Institute & Greenwald Research, *2023 Workplace Wellness Survey*, December 7, 2023

Americans are either unable or unwilling to adequately save enough for retirement let alone household emergencies.[35] While plan design features such as automatic enrollment and escalation help mitigate some of the barriers to retirement plan participation, obstacles persist:

- **Debt:** U.S. household debt ballooned to $17.94 trillion in the third quarter of 2024. Much of this ($12.6 trillion) is mortgage debt, but a still-staggering $1.6 trillion is student loan debt and $1.2 trillion is credit card debt.[36] Many young, low-income workers or new hires entering the workforce from higher education are therefore incapable (or fearful) of contributing to a retirement plan that further lowers their take-home pay. Employers continue to develop solutions to address employee debt burdens while also encouraging saving for retirement, including offering programs allowing employers to match student loan repayment dollars with retirement plan contributions. Public policy should continue to encourage such innovations.
- **Health care costs:** Even over the past five years during which consumer inflation surged, medical inflation continues to outpace overall inflation. Since 2000, the price of health care (*e.g.*, insurance, drugs, medical equipment and especially hospital care) increased by 119%. By contrast, prices for all consumer goods and services rose by 85% in the same period.[37] Removing health costs from the "all consumer goods and services," the contrast between health and non-health inflation

is even more pronounced. Bringing health care costs down is one of the other four challenges noted in this report and, accordingly, has its own associated goals and corresponding recommendations. But it bears mentioning here, because these expenses are especially punishing to those with limited margins for saving — and increase the need for adequate savings in retirement.

- **Caregiving:** According to the Annie E. Casey Foundation, the cost of childcare increased 220% in the last three decades,[38] prompting more than one in five employee caregivers in the "sandwich generation" to leave a job because of additional caregiving responsibilities.[39] Many others are also tasked with caring for elderly parents and grandparents, sometimes while required to also absorb their elderly parents' or grandparents' health care costs. In many cases, either the caregiver, those being cared for, or both, are themselves afflicted by punishing chronic disease, further underscoring the need for improved preventive care in Goal 2. For these individuals, saving for retirement can become an afterthought. While the caregiving crisis in the U.S. extends far beyond any one employer's reach, organizations are intimately affected by this challenge daily and have a vested interest in helping address it.
- **Housing:** As of 2023, the United States faced a housing supply gap of 2.5 million units and "housing markets continue to struggle with a growing shortage of new homes, the result of more than a decade of under-building relative to population growth."[40] Homeowners and renters are increasingly burdened in recent years by climbing housing costs.[41] This leads to an increasing share of one's earnings spent on housing and the potential absence of home equity for younger generations who cannot afford to purchase a residence. While housing policy is even further outside the Council's area of expertise, employers by and large support policies to create affordable housing. Some employers subsidize a portion of a new homeowner's closing costs, pay for relocation, provide access to favorable mortgage rates and offer home repair benefits.

Public policy should address the corrosive nature of these and other economic headwinds in retirement savings by, in part, empowering employers and employer plans to help more people through innovative plan design. In so doing, we will not only create a more effective savings paradigm, but also improve individuals' financial security.

GOAL 2
Promote consistent and sustainable employee health and well-being

"Consistent and sustainable" employee health and well-being means engaging with a person at each life stage, helping them achieve and maintain health, rather than simply "treat illness." This approach to health care not only breeds higher productivity, reduces absenteeism and presenteeism, and increases job satisfaction, it benefits the employer's bottom line. A 2024 analysis by the Kaiser Family Foundation found in 2021, 5% of the population accounted for nearly half of all health spending and 1% of the population accounted for 24% of all health spending.[42] Many of these high-cost individuals suffer with chronic disease. According to the Centers for Disease Control, an estimated 129 million people in the U.S. have at least one major chronic disease (*e.g.*, heart disease, cancer, diabetes, obesity, hypertension) and an increasing proportion of Americans have multiple chronic conditions. Approximately 90% of our annual $4.1 trillion health care expenditure is attributed to managing and treating chronic diseases and mental health conditions.[43]

New approaches to health care delivery and innovations in health care coverage can help reduce chronic illness, inspire healthier behaviors and drive more consistent and sustainable holistic well-being.

GOAL 3
Improve the mental and behavioral health of employees and their families

Employers have spent decades addressing the significance of mental and behavioral health. Their commitment to behavioral health care coverage recognizes that it is vital to the health, well-being and productivity of their workforce. Moreover, mental health conditions and medical conditions are often co-morbidities. Thus, treating an employee's mental health also supports their general health and well-being. To advance those efforts, the Council played a key role in educating policymakers on the importance of sound mental and behavioral health policy, including issues related to the enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

COVID-19 served as a stark reminder of this issue, taking a profound toll likely to be felt for many years. If there was ever any doubt, **there is now widespread recognition that mental and behavioral health are key components of holistic well-being.** Employers are on the front lines of providing increased access to mental health care and are embarking on innovative solutions to address the needs of their workforces. These strategies feature collaborative care models integrating behavioral health with primary care, removing the stigma associated with mental illness, enhancing Employee Assistance Programs (EAPs) and telehealth offerings, and combating the opioid crisis.

Unfortunately, the mental and behavioral health provider infrastructure has failed to keep pace with the increasing demand. Provider workforce shortages are widespread, with 122 million people — nearly half of the U.S. population — living in a mental health provider shortage area.[44] There are 340 people for every one mental health provider in the United States[45] and, sadly, more than half (55%) of adults with a mental illness do not receive treatment.[46] These shortages contribute to a lack of access and other challenges including increased emergency room utilization.[47] Provider network directories are often outdated, further compounding access problems. The lack of a diverse mental health care provider workforce[48] contributes to limited mental health treatment among minority populations. And so, even with insurance coverage, individuals with mental health needs face challenges accessing care. Improving the mental and behavioral health of employees and their families is not just a worthy goal, it is imperative to holistic well-being.

GOAL 4
Improve public health and disaster preparedness

In addition to highlighting the mental and behavioral health needs in the U.S. described above, the pandemic exposed gaps in the federal disaster response system. Seemingly overnight, businesses were given a crash course in virology, epidemiology and immunology, all while managing economic instability, historic supply chain problems and fundamental changes in the employee/employer relationship.

In 2021, the Council published the *Silver Linings Pandemic Playbook: Shining the Light on Employee Benefits Innovation and Action*, a compendium of emergency health and financial measures undertaken by employers at the nadir of the crisis. At the same time, as shown in Part One, the Council also called on policymakers to undertake a series of actions designed to provide relief to employers and their communities. The COVID-19 pandemic is not the only disaster to have global effect. In 2023 alone, damage from global natural disasters totaled $380 billion in economic losses, driven by significant earthquakes and severe convective storm activity in the U.S. and Europe.[49]

As one research paper astutely notes, "the public sector spends far less on risk reduction than on recovery, and it fails to target scarce risk reduction dollars to the highest-need and highest-risk areas."[50] This approach is especially concerning in light of climate change and the weather events associated with it.[51] Increasingly frequent and severe hurricanes,

tornadoes, wildfires, floods, mudslides and more are projected to exacerbate the costs to businesses in the form of physical damage, snarled supply chains and displaced employees.

Also looming is the risk of so-called "black swan" events — high-impact events difficult to predict under normal circumstances such as a foreign or domestic terrorism incident. While the nation has made great strides in homeland security, a proportional number of threats have also emerged. The potential consequences of a material terrorist event are unfathomable, but our infrastructure must nevertheless be prepared for it.

Another public health crisis within our lifetimes — whether epidemiological, environmental or man-made — seems inevitable, less a question of "whether" than "when." To prevent a repeat of the disorganization, disruption and loss of life associated with COVID-19 policymakers should invest now in approaches to streamline and simplify the government's rapid response. And if employers are again called upon to serve a leading role, they need flexibility to act quickly.

Challenge: Legal and Regulatory Uncertainty

BENEFIT PLAN SPONSORSHIP IS A SIGNIFICANT, LONG-TERM investment in a company's resources. The value proposition, for both employers and employees, is superior employee benefits create efficiencies that increase productivity, lower costs and reduce obstacles for employees. This, in turn, can create increased employee engagement, motivation, good health and retirement readiness. However, when these efficiencies break down — as they do in the face of expanded legal and regulatory uncertainty — the value proposition also diminishes, threatening to undermine these valued benefits for employees.

At a minimum, **employee benefits policy should minimize uncertainty by creating a framework upon which plan sponsors can rely.** At best, this framework will support employer innovation to advance health and financial well-being — as embodied by the work performed by employers over the past decade (see inset).[52]

Recognizing the prerogative of lawmakers to change policy as they see fit, they are also obliged to do so in a reasonable way that considers the value of stability and certainty over time and avoids whiplash from one Congress or one White House administration to the next. This means making evidence-based decisions and embracing the established roles — and acknowledging the views — of their partners in the three-legged stool of employee benefits: employers and individuals. Employer plan sponsors need an environment that supports and encourages plan sponsorship and minimizes legal and regulatory uncertainty. This can be accomplished by meeting the following four goals:

- Protect and affirm ERISA
- Promote stability of employee benefits policy
- Promote flexibility in employee benefit plan design and operation
- Prevent excessive or unwarranted regulation, litigation and enforcement

GOAL 5
Protect and affirm ERISA

As described in Part One, the Employee Retirement Income Security Act of 1974 (ERISA) is the foundational legal framework of the voluntary, employer-sponsored employee benefit system. While needed to protect plan participants, the law's passage was made possible by creating the conditions for the entire employee benefits system to thrive.

ERISA's federal preemption principle is the linchpin of the law, allowing multistate employers to comply with one national set of requirements rather than the multitude of state and local laws, many of which are inconsistent. These laws also often seek to impose benefit requirements, plan design requirements or disclosure requirements that could lead to disparate and confusing treatment of employees based on where they happen to live or work.

Preemption helps to avoid policies that change too significantly and/or frequently — becoming more vulnerable to state disruption and making plan sponsorship untenable.

Uniform administration reduces the cost and burden of state-by-state compliance and allows for the equitable provision of benefits. ERISA also gives employers the freedom to apply innovative, value-driven practices on a consistent, nationwide basis.

BEING FOR THE BENEFIT OF PLAN PARTICIPANTS

ERISA functions as the keystone for employers and plan administrators. But, of course, it also sets forth fundamental standards protecting benefit plan participants. These include:

- **required disclosures regarding plan features and funding**
- **minimum standards for participation, vesting, benefit accrual and funding**
- **fiduciary responsibilities for those who manage and control plan assets**
- **a grievance and appeals process for participants**
- **a right of participants to sue for benefits and breaches of fiduciary duty**
- **insurance of benefits from defined benefit pension plans through the Pension Benefit Guaranty Corporation (PBGC)**

Through ERISA's federal framework, employers offer comprehensive, uniform coverage to employees that best reflects the unique needs of workers and their families. This helps plan participants receive lower cost-sharing, comprehensive coverage and the ability to keep the same health benefits even if they transfer to a different state. This in turn supports the mobility of talent within an employer's workforce. Similarly, retirement plan beneficiaries enjoy access to innovative plan designs that help them achieve financial security, like cash balance and other hybrid defined benefit plans, automatic enrollment in defined contribution plans, variable annuity plans and programs to assist employees pay down student debt.

Despite more than five decades of success, ERISA's preemption standard is not only vulnerable, it is under attack. Its preservation therefore remains a core tenet of the Council's advocacy agenda. Continuing to balance the needs of plan participants and sponsors is the surest path to holistic well-being. This strategic plan reflects the need to protect and reaffirm this codified U.S. employee benefit framework.

GOAL 6
Promote stability of benefits policy

As explained in Part One, employee benefits policy has often been an area of bipartisanship. However, some major benefit laws were controversial and partisan (*e.g.*, the Affordable Care Act (ACA)), facing attacks in Congress and the courts over many years. More generally, policy approaches affecting benefit plans vacillate even within and among regulatory agencies, depending on the political winds. This leads to several suboptimal trends and an unpredictable environment for plan sponsors.

For instance, in Congress, leaders of both parties show an increasing willingness to pass legislation through the "budget reconciliation" process. This allows for simple-majority approval in the Senate (rather than a 60-vote "supermajority") but can only include provisions with a federal revenue effect and cannot cost money outside of a 10-year budget window.

Such legislation, partisan by design, is notoriously fragile for two reasons. First, if there is no bipartisan constituency for improving or implementing a bill, unintended consequences identified after the law's passage are frozen in the statute. Second, such legislation frequently becomes a rhetorical target of the opposing party and could be repealed when a new party takes control of the levers of government. This political polarization also means even when legislation proceeds through Congress in regular order, it is seldom considered on its own merits and is instead attached to unrelated "must-pass" bills with limited opportunity for debate or amendment. In both cases, we have seen employee benefit plans used by legislators as "revenue raisers" through which money is extracted to pay for other unrelated priorities.

Even with this context, there are important examples of legislative success. The SECURE and SECURE 2.0 retirement legislation stand as a testament to the power of bipartisanship on retirement issues, of which the committees of jurisdiction and all of Congress should be proud. But congressional gridlock persists elsewhere and often has downstream effects at the regulatory level. When Congress is unable to act, or when Congress and the administration do not share a policy agenda, there is often an increase in actions the administration takes on its own — through executive order, regulations, subregulatory guidance and enforcement — to achieve its policy goals.

Regulations can then change back-and-forth frequently, depending on the political party of the executive branch, and more generally adds a great deal of pressure to the regulatory process. In the retirement plan space, this manifested in recent years — including with the U.S. Department of Labor — on topics like cybersecurity, cryptocurrency and fiduciary rules related to investment advice.

In the health care space, several rules have changed from administration to administration — including, for example, those on nondiscrimination under the ACA and on certain types of short-term insurance. There is a wider category of regulations perpetually at risk of being modified with each change in the party affiliation of the White House.

This increased instability makes it easier for political opponents to overturn regulations, whether through withdrawal by a subsequent administration or through the Congressional Review Act.

The practical effect forces employers to divert resources essential to their normal business operations. The cost of administration, printing, programming, consulting and legal advice are extremely high, and often there is not sufficient time to allow the lead time for compliance. Because employers typically budget for benefits up to 18 months prior to the actual plan year, sudden and unexpected cost increases — whether due to compliance requirements, increased spending or removal of cost controls — can result in downstream costs and reductions for employees.

Finally, these types of regulations tend to invite legal challenges, adding disruption and instability to the entire benefits system. Increased litigation challenging these final regulations, moreover, results in even more uncertainty for employers and plan participants. For instance, implementation of the No Surprises Act has been substantially undermined by more than 20 lawsuits filed by health provider groups challenging the reasonable regulations implementing that law. These litigation trends are only expected to increase.

As noted in the Part One discussion of the need for bipartisanship, the 2024 Supreme Court decision in *Loper Bright Enterprises v. Raimondo* will also likely affect legal stability, although in different ways. In that case, the high court overturned the 40-year-old *Chevron* doctrine under which courts were required to give deference to regulatory agency interpretations of unclear statutory provisions. In theory, this decision could enhance legal stability by reducing the instances in which agencies significantly change regulations over time in ways disruptive to plan sponsors. On the other hand, many workable rules could now be challenged under the Administrative Procedures Act under *Loper Bright.* This could lead to disruption and even greater disparity of legal interpretations in different federal districts and circuits than already exists today, and corresponding greater uncertainty.

Adding to the potential confusion, district courts are increasingly issuing nationwide injunctions, rather than rulings that just apply in their district or circuit, which has caused concern in some instances.

The Council will continue to work closely with all three branches of government to support stability. We will encourage Congress to address possible ambiguities, either directly or through the explicit provision of discretion to regulatory agencies, which would preserve the deference accorded to them. Similarly, we will encourage the regulators to ensure that all stakeholders' views are considered while developing regulatory guidance. Finally, we will continue to encourage the courts to reject frivolous lawsuits aimed at further confusing and subverting congressional and regulatory intent.

Taken together, long-term investment and innovation will be chilled if employers cannot be assured the rules they follow today will still apply tomorrow. While we appreciate the ability at times for the federal agencies to quickly issue needed guidance (like the extensive guidance provided nimbly throughout the COVID-19 pandemic), we also support procedural mechanisms to encourage more durable long-term policymaking.

GOAL 7
Promote flexibility in employee benefit plan design and operation

Employers are driven by the same inventive spirit that transforms their core businesses. Legislation and regulations should be drafted with flexibility and a willingness to "think outside the box" encouraging employee benefit innovation and problem solving tailored to address a company's workforce needs. To be sure, employers have a rich heritage of innovating in benefits delivery,[53] from the establishment of the 401(k) plan to value-based health care designs. In fact, employers are often successful where government programs struggle.

The private sector, for example, developed automatic enrollment in 401(k) plans to broaden plan participation. When employees struggled with the challenges of investing for a lifetime of evolving needs and risk tolerance, the private sector created target-date funds and managed accounts. In the 1980s and 1990s, with interest in traditional defined benefit plans waning, cash balance plans were invented. To encourage this innovation, public policy and regulatory guidance should be drafted to focus on the goal or desired outcome, rather than rules requiring employers to comply with highly prescriptive processes to achieve said goals. We appreciate that major policies often include important guardrails and, because employers are compliance-minded, we often request detailed guidance from the agencies. But conceptually, a focus on goals and outcomes could support different approaches, as long as each meets the required objective and abides by appropriate strictures. The U.S. rulemaking system is best served when it focuses on the "what" not on the "how." Accordingly, it is also important employers be given choices as to whether and when to adopt various innovations.

> **Public policy and regulatory guidance should be drafted to focus on the goal or desired outcome.**

FOLLOW THE LEADER

In 2018, the Council partnered with Mercer to profile employers taking meaningful action to transform the health care system.

Leading the Way: Employer Innovations in Health Coverage **describes programs developed by a diverse collection of large employers, designed to (1) align payment with value, (2) incentivize quality care, (3) personalize the employee's experience, and (4) embrace disruption in the health care market.**

Many of these innovations, once groundbreaking, have now become much more commonplace among employer plan sponsors.

GOAL 8
Prevent excessive or unwarranted regulation, litigation and enforcement

The judicial branch is responsible for articulating what the law means and resolving disputes, and the executive branch is responsible for enforcing compliance with laws. Each function is crucially important in a healthy system of laws.

The Council supports targeted enforcement as a valuable deterrent, as isolated incidents of illegal or illicit behavior cast all employers in a bad light and such behavior can harm employees. In some cases, however, perceived gaps in the law or high-profile instances of malfeasance can prompt regulators to act too aggressively, inadvertently threatening good actors as well.

Several troubling examples of enforcement surfaced in recent history. The Biden administration broadly asserted its power to enforce noncompliance with amendments to MHPAEA — even before final rules were completed or effective. And while the administration expressed concerns that compliance with MHPAEA did not meet expectations, the lack of clear and meaningful implementing regulations posed a serious barrier to group health plans meeting their compliance obligations. This was especially the case with respect to the mental health "non-quantitative comparative analysis" requirement.

In the retirement arena, while both employers and the DOL want to pay benefits to missing participants or their beneficiaries, the DOL may not assume employers are acting in good faith to find missing participants, despite the extraordinary time and expense (often much greater than the amount of assets to be paid) employers in fact devote to finding participants. Instead, employers have been subject to lengthy and costly audits, some lasting more than seven years.

Excessive and unwarranted litigation raises similar concerns, including the accelerating trend of class-action litigation for breach of fiduciary duty under ERISA. Once isolated to 401(k) fees, some plaintiffs' lawyers are now expanding into other retirement plan areas (*e.g.*, target date fund selection, pension risk transfers and 401(k) forfeitures) and to health plan fiduciaries as well.

Many of these lawsuits are designed primarily to survive a motion to dismiss, triggering the time-consuming and costly "discovery" phase, which in turn elicits settlements paying those same attorneys significant legal fees. From 2015 to 2020, for example, plaintiffs secured nearly $1 billion in settlements, of which $330 million was used to pay attorney's fees.[54] The data proves the real beneficiaries are the plaintiffs' lawyers, not the participants. From 2009 to 2016, attorneys representing plaintiffs in breach of fiduciary duty lawsuits are estimated to have collected roughly $204 million for themselves, while only securing an average per participant award of $116.[55] Excessive litigation drives up the cost of plan sponsorship and ultimately reduces benefits.

In the examples above, employers were not given the benefit of the doubt, despite evidence to the contrary, or were repeatedly required to submit themselves to challenges brought forth in bad faith. **The Council and its members believe both the drafting and enforcement of public policy should be approached as a cooperative exercise based in good faith by all parties (unless proven otherwise) and excessive, meritless litigation should be deterred.**

Challenge: Demand for Personalized and Individualized Benefits

THE EMPLOYEE POPULATION, LIKE THE UNITED STATES ITSELF, IS growing more diverse. According to the Census Bureau's Diversity Index, which measures the likelihood of two people chosen at random being from different racial or ethnic groups, the U.S. population was 61.1% diverse in 2020, up from 54.9% in 2010.[56] In 2023, foreign-born workers made up 18.6% of the U.S. civilian labor force.[57]

The global economy, furthermore, is comprised of multinational companies, a cohort dominated by U.S.-based firms.[58] In 2021, U.S. multinational companies employed 43.3 million workers worldwide. **With differences in race, ethnicity and nationality come differences in cultural norms, traditions and expectations – including who and what should be covered in an employee benefit plan.**

Much has been written about women in the workplace, largely because gender equality continues to lag for female employees. In 2023, the U.S. labor force participation rate for women in their prime working age reached an all-time high of 77.8%, compared to 89.1% for men (a noticeable *decrease* from 15 years prior).[59] Despite an increasing share of the workforce — and more widespread acknowledgment of workforce inequity inspired by the "Me Too" movement — career advancement and compensation for women remains slower and lower than for men. As argued in a 2023 McKinsey/LeanIn.org report, "Women are more ambitious than ever, and workplace flexibility is fueling them."[60] This extends far beyond mere work-from-home policies to paid leave, educational and family building benefits.

Most employers are now at least conversant with the varied needs of the LGBTQ+ community, especially since the Defense of Marriage Act was struck down by Supreme Court decisions (*United States v. Windsor* (2013) and *Obergefell v. Hodges* (2015)), paving the way for broader acceptance of same-sex marriages. Attending to this demographic requires engagement on issues like adoption and surrogacy, as well as issues gaining more focus recently including gender affirmation care.[61]

Another source of diversity affecting the workplace is age. Even by the narrowest definition, at least four generations are currently employed today,[62] each with their own inherent values and tendencies.[63] Coupled with trends in longevity, people of all ages work alongside one another, mixing traditional age-based seniority. Employers must manage the different generational norms related to absence management, benefit priorities, communications, engagement, training, and even performance feedback.

Lastly, social determinants of health — the nonmedical factors influencing health outcomes — expose a link between socio-economically disadvantaged communities and high-cost health care utilization.[64] These determinants are an important predictor of future health care costs[65] and have obvious implications for retirement saving as well.

Designing benefits programs to meet the panoply of needs requires a flexible, inclusive and strategic approach and public policy to match by meeting the following goals:

- Improve employee benefits equity
- Increase access to personalized benefits
- Harness technology to improve access and outcomes
- Promote flexibility for employer-provided paid leave programs

GOAL 9
Improve employee benefits equity

For years, many companies have described diversity, equity and inclusion (DEI) as a core tenet of their corporate values. Dozens of studies show a direct correlation between a diverse workforce and a company's positive financial performance.[66] This commitment to DEI (or lack thereof) was tested in the wake of the "Black Lives Matter" protests following the murder of George Floyd in 2020. Chief DEI Officers became more common in the U.S., tasked with ensuring all employees can thrive and succeed. DEI advocates hoped this was finally the broad acceptance of their movement.

However, more recently, the U.S. has seen the pendulum swing in the opposite direction with social and political criticism of DEI initiatives.[67] Some high-profile business leaders, for instance, have publicly attacked DEI programs, while litigation challenging such initiatives has also increased. Over two dozen states have proposed anti-DEI bills banning antiracism programs by higher education institutions.

We may well be witnessing the DEI movement finding its equilibrium. And while the backlash sent a few DEI programs underground,[68] many organizations remain unwaveringly committed to its principles.

In the context of employee benefits, we can assess improved equity by measuring advancement on three measures:

- **Availability:** Do the right programs exist to adequately meet the needs of a diverse workforce?
- **Access:** Are the same programs accessible to everyone with the same workforce characteristics, no matter how they identify or where they live and work?
- **Outcomes:** Are the programs functioning in such a way that all workers are achieving positive outcomes?

Achieving improved employee benefits equity means advocating for public policy that (1) supports ERISA's framework allowing employers to provide equitable access to benefits, regardless of demographics, and (2) helps employers offer benefit programs that produce equally valuable outcomes for all plan participants.

GOAL 10
Increase access to personalized and individualized benefits

Personalized benefits are designed to cater to the needs of various populations within a diverse workforce (*e.g.*, role, location, service). Employers offering personalized benefits often develop profiles or "personas" of each employee group that identify common characteristics among its group members. This helps the employer deliver benefit offerings, services and communications to best serve each group's characteristics.

Individualized benefits are designed to have the flexibility to address the needs or preferences of an individual who may differ from similarly situated workforce members. For instance, two 35-year-old female managers residing in Cleveland may have very different health care priorities, despite their similar demographic characteristics. Individualized health benefits offer each plan participant the opportunity to access the most appropriate services provided by the plan for their specific needs.

Health benefits evolved to offer a range of personalized services, from acute treatment of certain ailments requiring a comprehensive health plan with easy access to specialists, to precision medicine treating patients based on their genes, environment and lifestyle. Likewise, retirement benefits permit employees to adjust their investments to their own risk tolerance and time horizon, while also adjusting contribution levels and balancing current and future needs. Flexible working hours, remote work options, and floating holidays expanded the flexibility and relevance of paid time off for many employees.

In all these cases, **benefits policy should continue to encourage innovative approaches to meeting people's health, retirement and time-off needs, while also appreciating some of these new approaches could be costly, inapplicable or require too much risk for some employers.** (It is also essential that health benefits policy continue to allow employers to pool risk, to provide high-quality, affordable access to a wide range of health care services). As such, policy must allow employer plan sponsors (and associated third parties) to adopt plan designs, education and communications approaches best reflecting the needs of their population. Individualized benefits transcend traditional health, retirement and paid time off employee benefits and we continue to see expansion of, for example:

- Integrated medicine
- Targeted wellness programs
- Expanded professional development opportunities
- Tuition reimbursement, debt repayment and scholarships
- Housing expense assistance
- Sabbaticals
- Sustainability-focused programs (*e.g.*, composting services, bicycle commuter benefits, organic farming coop memberships)

In a particularly promising development, the Internal Revenue Service (IRS) recently issued a private letter ruling[69] giving one plan sponsor the green light to implement a flexible benefit design allowing employees to allocate employer contributions across a range of health, retirement and education vehicles, including 401(k) plans, health reimbursement arrangements (HRAs), health savings accounts (HSAs) and educational assistance programs. Like all private letter rulings, this is specific to the employer who requested it and cannot be broadly applied to other organizations. But it does indicate a potential openness on the part of the IRS to creative plan designs and opens the door to broader codification by Congress.

Many employers are beginning to leverage "big data" to better understand an employee's needs and preferences. This information then helps human resource departments develop customized communications to make those employees aware of desirable offerings. In the end, providing options to customize a portfolio of solutions will maximize well-being.

GOAL 11
Harness technology to improve access and outcomes

Advances in technology help human resource professionals better meet the evolving, diverse needs of their workforce. For instance:

- Cloud-based, software-as-a-service platforms reduce administrative costs by automating many processes.
- Technology-enabled tools assist plan administrators in communicating with participants in multiple locations, languages and formats.
- Technology improves data management and governance.
- Decision support tools enable plan participants' explorations of the pros and cons of their benefit options based on their individual needs, budget, and preferences.
- Online provider databases are a more effective means of providing access and information on available health care providers compared to published provider directories, which quickly become out-of-date.
- Online applications offer retirement plan participants real time information about plan investment performance.
- Analytics help plan sponsors track utilization and better target who may need additional support to more effectively understand their benefit options.
- Pharmacy portals provide vital information to health plan participants about covered medications, available cost-savings options, and the timing of refills.
- Telehealth has revolutionized the delivery of health care, especially mental and behavioral services.
- Emerging technologies like artificial intelligence foster more personalized benefits education.
- Robotics and nanotechnology have the potential to radically improve diagnostic, surgical and pharmaceutical treatment.
- Technology is a key factor in effectively offering consumer-driven health benefits. Not unlike *Consumer Reports*, many of today's benefit administration platforms enable plan participants to better understand their choices and make smarter decisions for their personal health care needs. Decision support tools, informational materials, quality metrics, online calculators, real-time provider directories, cost comparisons and other tools empower participants to become smarter health care consumers.

Technological advances tend to move faster than policy, which frequently results in outdated guidance. The Council endorses public policy that supports employer innovation and enables employers to use technology as it becomes available.

GOAL 12
Promote flexibility for employer-provided paid leave programs

The COVID-19 pandemic highlighted the vital need for employer-sponsored paid leave programs. This is all the more salient for a diverse workforce, for whom time off needs can vary widely.

The Council's member companies recognize the importance of paid leave, which is why, overwhelmingly, most sponsor generous programs. The advantages of these programs apply not only to employees but to employers and the nation as a whole.

As observed in a research paper for *Compensation and Benefits Review*, paid leave assists workers "in addressing conflict and tension that occurs in deciding between competing important priorities; often employees have to choose between taking care of one's own health or the health of family members versus earning a wage or keeping one's job, and/or risking the health of coworkers by coming into work while ill. … Without dedicated paid leave for family/personal reasons, people repurpose vacation time (if they have it), which over time contributes to burnout and other negative mental health outcomes like depression."[70] And unlike federally mandated FMLA leave, paid leave typically offers more flexibility to care for a wider selection of people and situations.

The business case for employers offering paid leave is compelling. Employers benefit from reduced employee stress, burnout and presenteeism.[71] Employees with access to paid leave are more productive and demonstrate higher levels of satisfaction, and the combination of increased productivity and labor force participation bolsters economic growth.[72]

Federal, state and local communities and taxpayers also benefit from employer-sponsored paid leave plans. In addition to reducing reliance on public assistance programs,[73] paid leave benefits help ensure individuals who are ill do not feel compelled to come to the workplace, where they might infect co-workers, customers and other members of the public.

Nevertheless, the United States remains the only industrialized country without a national paid leave program. To reach the goal of expanding access to paid leave for all Americans, federal legislative solutions must support and leverage employer-provided paid leave benefits. To do so, it is critical federal legislation promotes the harmonization of existing and potential forthcoming state paid leave programs so that multi-state employers can treat their employees equitably across the country.

The Council supports federal legislation expanding access to paid leave in keeping with the Council's long-established principles,[74] which emphasize:

- Federal paid family and medical leave legislation should protect and build on private-sector solutions allowing employers to provide coverage either through self-funding and/or private insurance.
- Employers must have the ability to treat employees equitably, regardless of their location. Similarly situated employees for the same employer should expect their eligibility to receive paid leave, and the benefits and administration of the leave program, to be consistent wherever in the United States they live or work.
- Federal standards for paid leave programs must ensure employers operating in more than one jurisdiction are not subject to the cost and administrative burden of complying with various state or local paid leave requirements that may be inconsistent or even contradictory.

As articulated earlier, multi-state companies face the significant challenge of navigating a maze of increasingly complex and inconsistent state paid leave mandates (including paid family leave, *see* Figure 4) undermining their ability to offer valuable benefits on a consistent basis nationwide. Striving toward this goal requires the development of a federal solution to simplify administration for companies already providing generous paid leave.

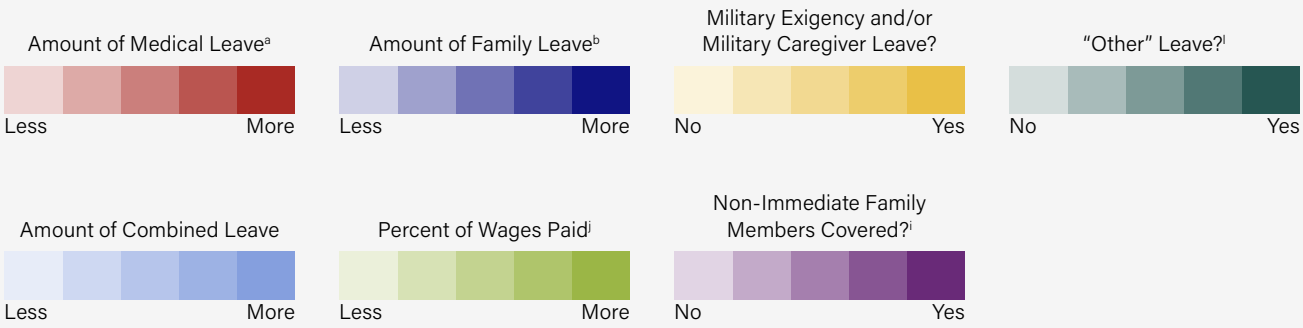
TABLE 5 | Time Out: Traditional Categories of Leave

U.S. Government Mandated Leave	**Paid** ▪ Jury duty or witness leave ▪ Military Leave	**Unpaid** ▪ FMLA Leave ▪ Childbirth, adoption, foster care ▪ Care for spouse, child or parent ▪ Employee's own health condition ▪ Care due to spouse, child or parent on active duty
Voluntary Leave Offerings: Family and Medical	**Planned** ▪ Maternity/paternity leave ▪ Sick leave (employee) ▪ Family leave	**Unplanned** ▪ Personal Days ▪ Sick leave (employee) ▪ Family leave ▪ Funeral or bereavement leave
Voluntary Leave Offerings: Leisure and Other	**Planned** ▪ Holidays ▪ Vacations ▪ Sabbaticals ▪ Volunteering and community service	**Unplanned** ▪ Personal days

Source: H. Kristl Davison and Adam Scott Blackburn, Compensation and Benefits Review, "The Case for Offering Paid Leave: Benefits to the Employer, Employee, and Society," January 2023

FIGURE 4 | Weaving the Patchwork: How Mandatory Paid Family Leave Laws Stitch Together

Locations with Mandatory PFL Laws[c]	Medical Leave (weeks)[a]	Family Leave (weeks)[b]	Military Exigency And/Or Military Caregiver Leave?	"Other" Leave?[l]	Combined Leave (weeks)	Percent of Wages Paid[j]	Non-Immediate Family Members Covered?[i]
CA	52[d]	8	Yes[h]	None	52[d]	60 - 70%	None
CO	12 or 16[f]	12	Yes[h]	1 type	12 or 16[f]	90% then 50%	2 types
CT	12 or 14[f]	12	Yes	2 types	12 or 14[f]	95% then 60%	1 type
DC	12	12	No	1 type	12 or 14[g]	90% then 50%	None
DE (eff. 1/1/2026)	6[e]	6 or 12[e]	Yes[h]	None	12	80%	None
MD (eff. 7/1/2026)	12	12	Yes	None	24	90% then 50%	None
MA	20	12	Yes	None	26	80% then 50%	None
ME (eff. 5/1/2026)	12	12	Yes	3 types	12	90% then 66%	2 types
MN (eff. 1/1/2026)	12	12	Yes	1 type	20	90% then 66% then 55%	3 types
NJ	26[d]	12	No	2 types	38[d]	85%	1 type
NY	26[d]	12	Yes[h]	1 type	26[d]	67%	None
OR	12 or 14[f]	12	No	1 type	12 or 14[f]	100% then 50%	3 types
RI	30*	6[m]	No	None	30[d]	4.62%[k]	None
CA	12 or 14[f]	12	Yes[h]	1 type	16 or 18[f]	90% then 50%	2 types



a For this graphic, Medical Leave refers to qualifying absences related to the employee's own serious health condition or disability, depending on applicable law

b For this graphic, Family Leave refers to qualifying absences related to bonding or caring for a family member with a serious health condition

c Effective date represents date benefits become available for all forms of leave

d Length of absence due to state statutory disability insurance (SDI) laws

e 6 weeks in 24-month period = employee or family member serious health condition; 12 weeks in 12-month period = bonding

f Additional weeks possible if pregnancy complications

g Additional weeks possible for prenatal care and bonding

h Military Exigency Only

i For this graphic, Immediate Family Members Include: child, parent, in-laws, spouse, domestic partner, sibling, grandparent, and grandchild

j Non-Immediate Family Members Include: equivalent of family relationship by close association, individual who lives in employee's home, expectation of care, etc.

k Amount of pay to Employee will depend on certain factors, such as their average weekly wage ("AWW"), the statewide AWW and the maximum weekly pay established by each program

l Unlike other PFL laws, which typically measure amount of pay based on the employee's AWW, RI measures based on the employee's highest earning quarter in the base period

m "Other" Leave can include, but is not limited to, Bereavement Leave, Safe Time, Bone Marrow or Organ Donation, Prenatal Care, Public Health Emergencies, or COVID related absences.

n Becomes 7 weeks (1/1/2025), and then 8 weeks (1/1/2026)

Challenge: Increased Individual Responsibility

AS DESCRIBED IN PART ONE, THE THREE-LEGGED STOOL OF EMPLOYEE benefits asks individuals to take part in maintaining their own holistic well-being. That role, however, expanded over the last several decades, as many employers moved away from traditionally "paternalistic" defined benefits and embraced the notion that employees who are more involved in their benefits will be smarter consumers of those programs.

Coined by various stakeholders as "consumerism," "employee accountability," "shared responsibility" and "individual responsibility," this shift not only means increased choice and involvement by employees, but also increased responsibility and risk to budget, save, invest and spend wisely. Employers commonly partner with service providers to offer employees helpful education and broad-based tools like risk tolerance assessments and calculators.

The advent of "default" architecture, including automatic enrollment and target-date funds, to some degree relieved employees of the need to take direct action to enroll in benefit plans. Policymakers should continue enhancing these designs. But there is a limit to defined contribution plan defaults, and in any case these features are not a substitute for financial literacy and safety nets.

If a growing number of employees operate in a system empowering them, they will continue to need up-to-date information and tools to make smart benefits decisions. Employers want to continue to help their employees manage these responsibilities and look forward to partnering with policymakers to facilitate assistance in the effort to meet the following goals:

- Support financial literacy and retirement readiness
- Preserve access to defined contribution health programs and enhance consumer-directed health plans
- Maintain public safety net programs
- Support and modernize defined benefit retirement plans

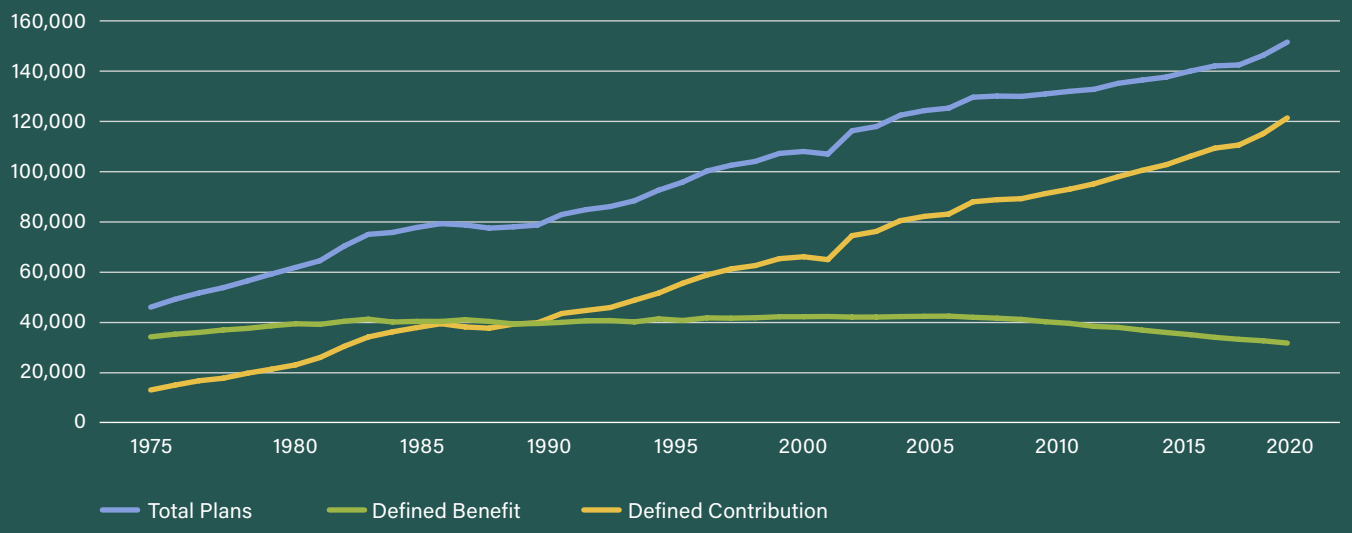
GOAL 13
Support financial literacy and retirement readiness

Americans' personal savings rate — measured as the ratio of personal savings to disposable income — hovered between 5% and 10% during the 1970s and 1980s. After an outlying spike during the pandemic, it now sits at a paltry 3.6%,[75] reflecting a host of cultural and economic changes (*see* Chart 3). This is particularly troubling since the Social Security Administration's Old-Age and Survivors Insurance (OASI) Trust Fund is precariously underfunded and projected to fall short of its full obligations within 10 years (see Goal 15). Even if policymakers take steps to replenish the Social Security system, such reforms may yet result in reduced payments to some beneficiaries.

"Help! I haven't saved enough for retirement!"

THE GREAT DB-TO-DC SHIFT

CHART 2 | Retirement Plan Participants



Source: U.S. Department of Labor Employee Benefits Security Administration, *Private Pension Plan Bulletin Historical Tables and Graphs 1975-2022*, Table E5, September 2024

The chart above tells a familiar story: in 1975, shortly after the enactment of ERISA, there were 103,346 defined benefit pension plans and 207,748 defined contribution retirement plans. As of 2021, there were 46,388 defined benefit plans (a 55% decrease) and 718,736 defined contribution plans (a 245% increase).[171]

What is seldom acknowledged is this shift to a predominantly defined contribution system led to more opportunities to save for retirement. (The total number of plans has more than doubled, from 311,094 to 765,124, while the U.S. working population has only increased by roughly 55% over a similar period, meaning the ratio of plans to workers increased significantly).[172]

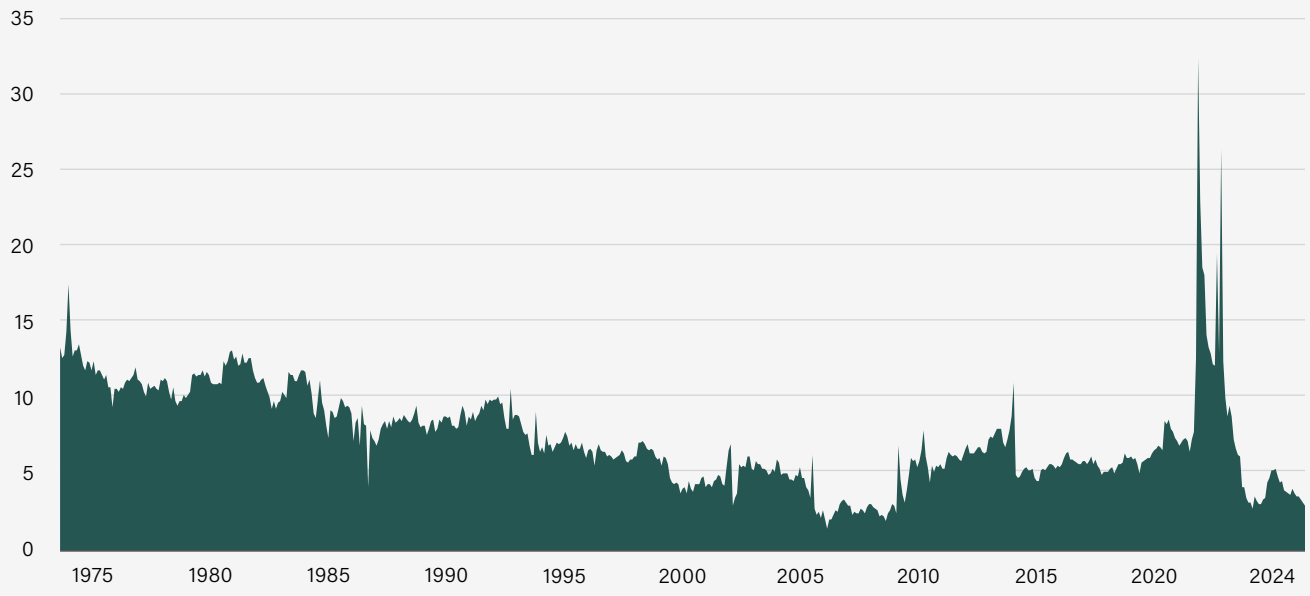
TABLE 6 | Percentage of private industry workers with access to Health Savings Accounts

Year	All workers	Less than 100 workers	100-499 workers	500 workers or more
2014	22%	14%	29%	33%
2015	24%	15%	32%	36%
2016	25%	16%	35%	38%
2017	26%	17%	34%	40%
2018	28%	18%	36%	43%
2019	30%	20%	38%	47%
2020	32%	20%	40%	52%
2021	34%	24%	42%	56%
2022	35%	24%	44%	55%
2023	36%	25%	45%	56%

Source: U.S. Department of Labor Bureau of Labor Statistics, Fact Sheet: High-Deductible Health Plans and Health Savings Accounts," Table 3, Last Modified April 11, 2024

Consumerism in health care took root later, with HSAs established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Today, more than a third (36%) of all workers have access to an HSA, up from 22%, 10 years prior. Among large companies, access is even greater and accelerating faster.[173] Again, the Council views this as progress, as more employees have access to a style of health care coverage that works for them.

CHART 3 | S.O.S.: America's Personal Saving Rate, 1975-Present



Source: Federal Reserve Bank of St. Louis, "Personal Saving Rate," Accessed November 27, 2024

These various factors make financial literacy much more vital. Americans need to understand how to successfully manage their assets if they are to be financially secure. Financial literacy includes understanding the basics of budgeting, credit, debt, savings, tax strategy, asset allocation and diversification, home ownership and more. Being informed and realistic about future needs (*e.g.*, health care expenses, caregiver needs, costs of living) and preferences (*e.g.*, retirement age, travel, hobbies) will play a key role in this exercise.

Related to broader financial literacy is retirement readiness. This requires employees eligible to participate in employer-sponsored retirement programs to fully understand their options under those programs and how to successfully navigate them to meet their financial goals. Employers also have a vested interest in achieving this objective. An actual or perceived lack of financial security can directly affect an individual's holistic well-being, engagement and productivity — negatively affecting the workplace. Also, employees who work past when they had hoped or planned to retire can create talent stagnation and hurt the advancement opportunities of generations who follow in the organization. Individuals without adequate savings also tend to rely more on employer-subsidized health benefits, which could raise the costs for the company. Finally, having financially literate and secure retirees reflects positively on an employer and helps attract and retain talent.

To that end, employers are motivated to help provide their employees with the tools they need to become financially literate and retirement ready. Many employers offer an array of training and education programs, decision support tools, access to financial advisors, debt consolidation services and loan repayment programs, among others. A recent survey of employers found 70% of plans provide "financial wellness services," such as financial planning tools or student debt tools, up from 17% just six years prior.[76]

The Council and its membership support public policy that gives employers the latitude to provide financial education and flexibility to develop new and innovative ways to deliver such support — without incurring fiduciary liability.

GOAL 14
Preserve access to defined contribution health programs and enhance consumer-directed health plans

Consumer-focused health benefit offerings have become increasingly prevalent among employers and employees.[77] These programs generally give the individual an account from which they may pay for certain medical expenses, shifting some economic decision-making from the employer to the employee.

Health reimbursement arrangements (HRAs) were first described by the IRS as an employer-funded health benefit in 2002. These arrangements reimbursed employees tax-free for qualified medical expenses including insurance premiums and out-of-pocket expenses. Since then, HRAs have expanded into different types of arrangements including group coverage HRAs and excepted benefit HRAs, among others.

Flexible spending arrangements (FSAs) addressed some of the criticisms of HRAs (*e.g.*, employees not being allowed to contribute) by offering employees the option to contribute their own funds on a tax-free basis for certain qualified expenses. The health FSA allows employees to contribute pre-tax dollars through payroll deductions to pay for certain medical expenses (but not insurance premiums). Employers may also contribute to health FSAs, subject to certain limitations. Similarly, pre-tax dollars can be applied to a dependent care FSA for eligible child and elder care expenses.

President George W. Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,[78] which created HSAs, replacing Archer medical savings accounts. In the employer-sponsored health plan context, HSAs allow employees enrolled in a qualifying high deductible health plan (HDHP) to contribute, grow and withdraw money on a tax preferred basis – up to annual IRS limits – for medical expenses. Today, more than half of all workers have access to an HDHP (up from 33% 10 years prior) and more than a third (36%) of all workers have access to an HSA (up from 22%).[79] This trend means more employees have access to a style of health care coverage that can work for their individual needs and preferences. HSAs are also flexible enough to help people save money for retirement health care expenses, especially if they do not have retiree medical coverage and retire before they are Medicare eligible. Just as importantly, because HDHPs and HSAs constitute a growing share of the health coverage market, they can also serve as valuable platforms for health policy advancements, such as preventive care, chronic illness treatment and telemedicine.

More recently, employers were permitted to offer a defined contribution type of health plan — an individual coverage HRA — in which the employer provides a set amount of money in an HRA that the employee uses to purchase coverage in the individual health insurance market. As explained later in this document, the plan design requirements for individual coverage HRAs include essential guardrails to protect employees and the individual insurance market.

While some consumer-directed health plans and defined contribution health approaches may not be appropriate for everyone, and must not supplant traditional major medical coverage, public policy should preserve access to such programs as a choice for employees. Consumer-directed health plans also could be enhanced. Employers should be afforded the flexibility to design a health benefits strategy and plans best suiting the needs of their workforce.

GOAL 15
Maintain safety net programs

As described in Part One, the three-legged stool of employee benefits relies on the government to provide the nation's safety net programs alongside the private employer-sponsored system and individual responsibility. The Council believes strongly in the private, voluntary employer-sponsored benefits system, which produces broadly positive outcomes at a fraction of the cost of public plans. Nevertheless, because employment is impermanent and there is an increased level of risk for participants in defined contribution programs, it is vital that government-sponsored social safety net programs exist to work hand-in-hand with the private system.

The three classic components of our social safety net — Medicare, Medicaid and Social Security — each have a role to play alongside the employer-sponsored system.

- **Medicare:** Employees need to be confident their basic health care needs will be met in retirement. Employee confidence is also essential for employers to deploy workforce management and succession planning strategies. If Medicare were to be defunded or degraded in any way, workers would be much more reluctant to retire. Medicare also plays an important policy role. As the largest purchaser of health care in the nation, Medicare holds substantial influence in the price of care and payment policies by providers. Encouraging smart reform within the Medicare system allows employers to help drive positive changes in the private market. Conversely, Medicare policies can inadvertently shift costs to private payers, a problem worthy of its own goal and interventions.
- **Social Security:** The three-legged stool of retirement savings includes the mandatory Social Security program, designed to provide a minimum level of financial security for American workers in retirement. Employment-based

retirement plans (encouraged through our tax system) supplement the basic Social Security safety net. And individual savings have, ideally, served to fill in the remaining gaps. These three components are intentionally and necessarily intertwined. The employer-sponsored retirement system has, since ERISA, been the backbone of our nation's savings effort and remains strong. But the nationwide personal savings rate remains (and is expected to remain) low. If the Social Security program were to falter, employer plans would face exceptional pressure.

- **Medicaid:** In most cases, while Medicaid does not directly affect employer-sponsored health benefits because so few employees qualify for the program, Medicaid also has an impact on health care and insurance policy. Unlike Medicare, it is notably a state-administered program, with implications for both federal governance and intrastate health policy.
- While not considered a "traditional" safety-net program like the big three above, the **Affordable Care Act's public exchanges** function as such, being a partially subsidized marketplace for those without access to employer coverage. The exchanges are particularly important to employers as a venue for two key members of the American workforce: independent contractors and early retirees.

Unfortunately, **the Medicare and Social Security trustees' reports paint an unsettling picture of the future, especially given the aging population and lower birth rates.** In 2024, Medicare's trustees reported the Medicare Hospital Insurance trust fund will become insolvent in 2036 and faces a 75-year shortfall of up to 0.35 to 1.17% of payroll. Meanwhile, the Social Security trustees' report projects the Social Security Old-Age and Survivors Insurance (OASI) trust fund will deplete its reserves by 2033.[80] Upon insolvency, all beneficiaries will face a 21% across-the-board benefit cut. It seems inevitable that Congress will need to grapple with these projections in the near future.

In 2000, the Council published a white paper, *Looking to the Future: A New Perspective on the Social Security Problem*,[81] which spelled out a series of tough choices and policy recommendations related to the program's financing structure, investment strategy and potential benefit reductions. Since the threats remain unchanged, the conclusions and proposals remain as relevant today as a quarter century ago — even more so, given the passage of time within which needed changes have not been made. For today's workers, the operative question is: how can they prepare for a possible future where the retirement age is raised, benefits are reduced, or payroll taxes increased? If private plans are to take on a greater share of importance for retirees, the system and everyone in it must be fortified.

While it is beyond the ability of the Council to solve the challenges facing these safety net programs, we intend to address these broader issues with the twin objectives of (1) preserving these essential programs, and (2) ensuring they continue to complement (rather than burden) the successful employer-sponsored benefits system.

GOAL 16
Support and modernize defined benefit retirement plans

As shown earlier, the number of defined benefit plans declined by more than half since ERISA's enactment. Despite these decreasing numbers, the Council has urged policymakers for decades to protect and encourage pension plan sponsorship.

The value of defined benefit plans continues to be significant. For employees, defined benefit plans offer guaranteed, professionally managed and annuitized benefits with no funding risk. For employers, defined benefit plans also can be an effective workforce management tool. A company faced with the need to reduce the size of its workforce, for example, can "deem" employees to have an additional number of years of service, thereby boosting their pension benefit and encouraging a voluntary retirement in lieu of a layoff. For the nation, defined benefit plans play a critical role in producing lifetime retirement income that Social Security is unable to offer. In 2022 alone, defined benefit plans disbursed more than $287 billion in benefits to participants and beneficiaries.[82] And for the U.S. economy, defined benefit pensions provide a ready source of professionally managed investment capital. Despite declines in defined benefit plan sponsorship over nearly 40 years, private sector defined benefit plans still held $3.2 trillion in assets as of the first quarter of 2024.[83]

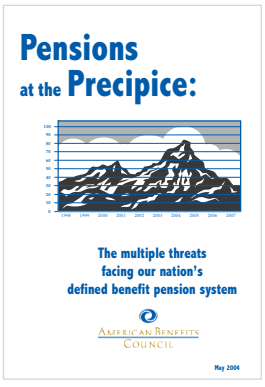


TABLE 7 | How Safe is the Safety Net? Key Findings of the 2024 Trustees Reports

	Social Security		Medicare	
	Old-Age and Survivors Insurance (OASI)	**Disability Insurance (DI)**	**Hospital Insurance (HI)**	**Supplementary Medical Insurance (SMI)**
Types of benefits paid from the trust fund	Retirement and survivor benefits	Disability benefits	Inpatient hospital and post-acute care (Part A)	Physician and outpatient care (Part B), and prescription drugs (Part D)
Full scheduled benefits are expected to be payable until	2033	At least through 2098	2036	Indefinitely
Percentage of scheduled benefits payable at time of reserve depletion	79% (The percent of scheduled benefits payable is projected to decline to 69 percent by 2098)	—	89% (The percent of scheduled benefits payable is projected to decline to 87 percent by 2048 before gradually increasing to 100 percent by 2098.)	—
75-year actuarial balance, as a percent of taxable payroll	-3.63	.14	-.35	—

Source: U.S. Social Security Administration, "Summary of the 2024 Annual Reports: Social Security and Medicare Boards of Trustees," Table 1, May 6, 2024

In 2004, the Council released a white paper, *Pensions at the Precipice: The Multiple Threats Facing our Nation's Defined Benefit Pension System*,[84] outlining the imminent dangers associated with pension plan sponsorship — including numerous misguided policy decisions, which stunted the growth of hybrid plans in their infancy.

Sadly, some of these threats came to pass, some remain, and others have risen in their wake — most notably the heavy burden of PBGC premiums.

In 2023, the Council released a set of common-sense proposals to bolster the defined benefit pension system,[85] asserting the solution to America's retirement savings shortcomings is not to turn away from those employer-sponsored benefits, but instead, to build on them. Those specific proposals are woven into this strategic plan.

Challenge: Aligning Health Care Cost & Quality

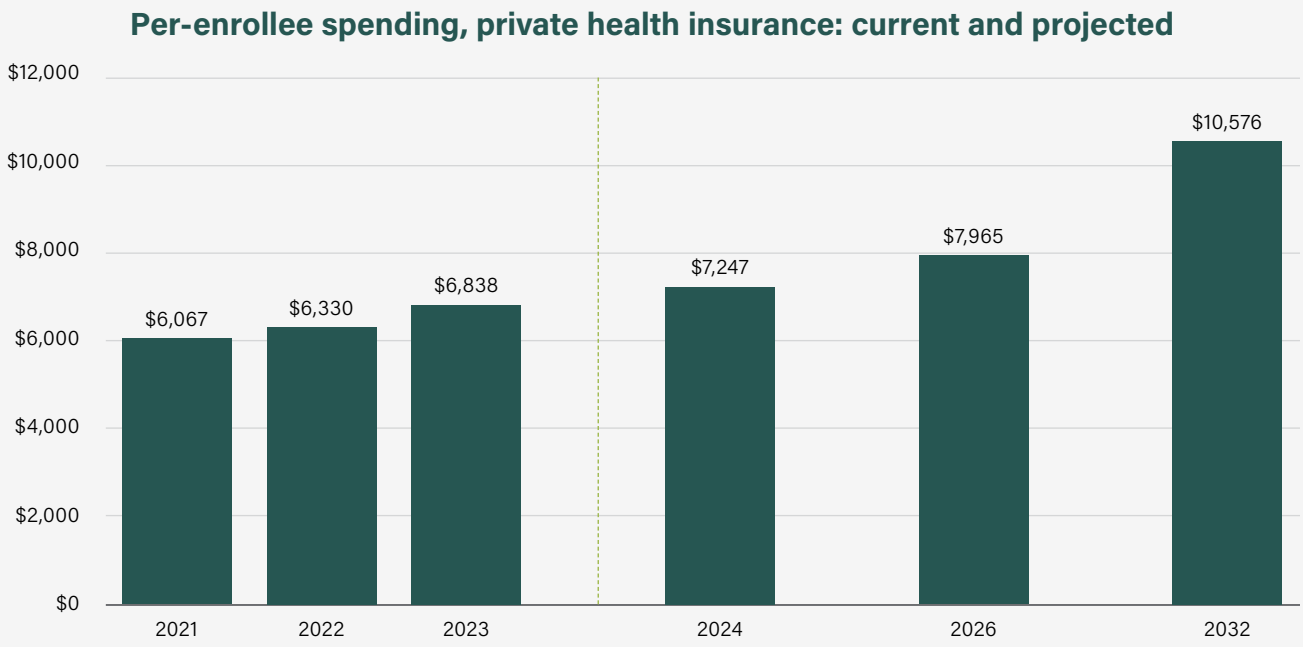
NATIONAL HEALTH CARE SPENDING IN 2022 TOTALED $4.5 TRILLION — 17% of GDP — and is projected to grow faster than GDP through 2031.[86] And yet, patients are seeing little to no improvement in the quality of their care. Despite extensive efforts by employers, if value is the quotient of quality divided by cost, the U.S. health care system is suffering a severe value deficit.

As a foundational matter, it is necessary to understand what is driving the increase in health care spending and to address those root causes. On this issue, research demonstrates increased prices, rather than increased utilization, primarily drive spending growth. Nonetheless, market consolidation, lack of transparency and fundamental market failures stifles competition and increased costs as misaligned incentives reward providers for quantity rather than quality. Moreover, an aging population and the prevalence of chronic conditions are fueling higher prices.[87]

Any effort to address this challenge must recognize the many facets of the problem:

- Paying for value means helping beneficiaries shop effectively for care and helping employers deploy their purchasing power effectively. A lack of price and quality transparency makes both tasks very difficult.
- Provider consolidation, especially affecting rural areas and other health care "deserts," prevents competition from moderating prices. Several studies found that

CHART 5 | The Never-Ending Story: Soaring Health Care Costs



Note: Data after 2022 is projected.

Source: Sean P. Keehan, Jacqueline A. Fiore, John A. Poisal, Gigi A. Cuckler, Andrea M. Sisko, Sheila D. Smith, Andrew J. Madison and Kathryn E. Rennie; "National Health Expenditure Projections, 2022–31: Growth To Stabilize Once The COVID-19 Public Health Emergency Ends," *Health Affairs* Vol. 42, No. 7, June 14, 2023

consolidation leads to higher spending, which reflects both the price and volume of care.

- A substantial and increasing number of Americans suffer from chronic illness.[88] According to the U.S. Centers for Disease Control and Prevention, 90% of the nation's annual health care expenditures were for people with chronic physical and mental health conditions.[89]
- Innovations in diagnosis and treatment coincided with an aging U.S. population with higher risk of health care conditions. There are currently about 55.8 million Americans aged 65 and older, and in 2034, that number is expected to rise to 77 million.[90]
- Outdated, opaque and misleading payment systems further obscure the true cost of care.
- Worsened health conditions often result from delays in receiving treatment, in some cases for over a year or more. These delays are primarily due to a concern for the cost of care, as well as delays in available appointments, caused largely by the health care provider shortage and increased rates of physician burnout. A severe lack of primary care providers in particular further exacerbates this capacity issue.

For as much as these costs have been passed along to employer plan sponsors, the effect on household budgets has been especially acute — and even more so for retirees, for those in underserved areas and among low-income families. According to the National Bureau of Economic Research, "every 10% increase in health insurance costs reduces the chances of being employed by 1.6%. It also reduces hours worked by 1%. Two-thirds of a premium increase is paid for with wages and the remaining third from a reduction in benefits."[91]

"I think maybe we represent spiraling health care costs."

The trend is unsustainable. Individuals, employers and policymakers all seem to agree on this point. In a recent survey, 1,200 voters were asked what concerns them the most about health care. Worries about costs (of premiums, co-pays, deductibles and prescription drugs) collectively dwarfed all other concerns and outscored the next-most popular answer, "quality of care," by more than double (46% to 17%).[92]

Addressing health care costs has been at the core of the Council's advocacy for many years. Congress has begun to tackle this issue, with the bipartisan consideration of the Lower Costs, More Transparency Act (H.R.5378, 118th Congress) evidencing recognition on both sides of the political aisle.

Health care cost growth must be addressed through structural reform. The following goals aspire to address the root causes of rising costs and promote value-based payments:

- Reform provider payment systems and practices to incentivize value-based care
- Prevent cost-shifting to private payers
- Encourage competition within the health care industry
- Promote access to affordable, effective, safe and innovative prescription drugs and therapies

DESERTED

In a 2023 study, researchers conducted an exercise to build international consensus for a definition of the term, "medical deserts." They concluded "medical deserts" are areas where population health care needs are unmet partially or totally due to lack of adequate access or improper quality of health care services caused by (1) insufficient human resources in health or (2) facilities, (3) long waiting times, (4) disproportionate high costs of services or (5) other socio-cultural barriers.[174]

The problem is especially prevalent in rural communities. Though about 20 percent of the U.S. population lives in rural areas, only about 10 percent of U.S. doctors practice in rural areas.[175] And according to the Association of American Medical Colleges, of the more than 7,200 federally designated health professional shortage areas, three out of five are in rural regions.[176]

GOAL 17
Reform provider payment systems and practices to incentivize value-based care

The traditional U.S. fee-for-service (FFS) payment approach, a model where health care services are paid for separately, rather than bundled, has led to misaligned incentives that reward *quantity* rather than *quality*. The model pays providers a fee for each service such as office visits, labs, tests, procedures, etc. This model raises costs and discourages the efficiency of integrated health care. Despite some efforts to reform this payment system (*e.g.*, capitation and bundled payments),[93] FFS remains the dominant health care payment model in the U.S.

As illustrated in the Council's 2018 report *Leading the Way: Employer Innovations in Health Coverage*,[94] some employers are designing their group health plans to address this flawed payment system by including value-based insurance design[95] and value-based purchasing.[96] These approaches can potentially transform our system by realigning incentives to keep participants healthier and lower costs for both the employer and plan participants. Many employers that successfully decreased the rate of health care spending did so by analyzing their plan data to better understand how much is being spent on specific services and then using plan design features to more effectively address those costs. Depending on the service, employers can help plan participants in several ways, such as making them aware of higher-quality and lower-cost health care providers, increasing notice of alternate sites of care, providing education on various treatment options, offering second opinion services, covering medical travel and best-in-class provider networks, among others.

Notwithstanding these efforts, **a full-scale shift toward a competitive and value-driven health care market is predicated on further improvements in price and quality transparency.** This includes:

- Continued implementation, and improvement, of statutory and regulatory price transparency requirements for hospitals and health plans.
- Increased accountability for, and transparency from, the entire prescription drug pricing system, including pharmacy benefit managers (PBMs) and drug manufacturers.

DOING LESS WITH MORE

"Despite spending more money per capita on health care than any similarly large and wealthy nation, the United States has a lower life expectancy than peer nations and has seen worsening health outcomes since the onset of the COVID-19 pandemic."

— Peterson-KFF Health System Tracker, "How does the quality of the U.S. health system compare to other countries?"

- Improved access to robust clinical quality and patient experience data at the practice or individual doctor level, including technology that allows this information to be shared with plans and for plans to communicate with providers.
- Development of more uniform, consistent and complete quality metrics.
- Enforcement of transparent billing practices.
- Increasing the health care workforce to meet the demands of a value-driven marketplace and to create a competitive marketplace.
- Validation of employer initiatives to prevent or manage high-cost conditions, including chronic illness.

We are appreciative and optimistic that recent emphasis by policymakers on the need for transparency continues to gain momentum. This would allow employers enhanced access to vital health plan cost data, and also the ability to use market intelligence to analyze how their health care dollars are spent and take action to direct those resources to high-quality, cost-effective providers. This transparency is a key factor in provider payment reform, necessary to help control rising health care costs while maintaining (and improving) the quality of health care.

Adherence to and enforcement of ERISA preemption is also of vital importance, as state laws dictating provider minimum reimbursements and blanket coverage mandates could impede employers from pursuing value-based care.

GOAL 18
Prevent cost-shifting to private payers

Inspired by polling data, including that provided by the Council,[97] lawmakers are keenly aware of the scourge of health care costs and put forth several measures to address it. As a result of political polarization, some of these proposals are only able to pass Congress when made a part of the budget reconciliation process. Budget reconciliation allows for expedited consideration of certain tax, spending and debt limit legislation, and requires only a simple majority (rather than a super-majority in the Senate) for passage (*see* Figure 5).

Because budget reconciliation legislation prohibits inclusion of provisions without a direct federal revenue effect, measures designed to reduce costs for the federal government may not be able to include corresponding provisions that would prevent cost-shifting to employer plans. Thus, the constraints of the budget reconciliation process may not allow consideration of policies to align cost with value in the commercial market.

In other cases, because employer plan sponsors are perceived as having "deep pockets," policymakers are sometimes willing to cap costs for employees, leaving employers and insurers to make up the difference but without considering the second-order impact on employees. This is because ultimately, at least some costs are passed on to employees in the form of higher premium contributions, reduced compensation or benefit cuts elsewhere. Well-intended legislation limiting out-of-pocket costs for a certain drug, for example, may have the upfront advantage of easing a patient's experience at the pharmacy counter. Those costs must be absorbed by someone — typically, the plan sponsor. And because company budgets are finite and are determined many months in advance, that money may come out of the employee bonus pool. Such measures may seem popular on the surface, but the hidden downstream effects do nothing to lower costs or improve outcomes and may in fact weaken overall well-being.

FIGURE 5 | A Work in Process? Budget Reconciliation at a Glance

What is it?

Permits legislation impacting revenues and spending to pass the Senate with 51 votes rather than the 60-vote filibuster threshold. Spending, revenue, or the debt limit may be addressed under reconciliation together or separately, but only once per budget resolution, and only one budget resolution is approved for each fiscal year.

What has it been used for?

- Inflation Reduction Act (IRA) (2022)
- Portions of Affordable Care Act (ACA) (2010)
- American Rescue Plan Act (ARPA) (2021)
- Extenders, capital gains rate extension (TIPRA) (2006)
- Tax Cuts & Jobs Act (TCJA) (2017)
- "Bush tax cuts" (EGTRRA) (2001)

What is the process?

House and Senate approve budget with reconciliation instructions → Committees report legislation meeting instructions → House and Senate approve same bill, President signs

- A reconciliation directive may instruct a committee to report legislation increasing revenues by an amount, which is a minimum
- OR a directive may instruct a committee to report language increasing spending by a certain amount, which is a maximum

What can't be included?

The Byrd Rule deems extraneous provisions that:

- Do not produce a change in outlays or revenues
- Produce changes in outlays or revenue that are merely incidental
- Increase net outlays or decrease revenue during a fiscal year after those covered by the bill
- Increase outlays or decrease revenue if the provision's title as a whole fails to achieve the committee's instructions
- Are outside the jurisdiction of committee that submitted the title or provision
- Change Social Security

Examples of the Byrd Rule in action

- TCJA: expanding 529 accounts to home-school deemed incidental to non-budgetary policy
- ACA repeal effort: eliminating essential health benefits, selling insurance across state lines ruled as no revenue effect
- Revenue-raising provisions taking effect in later years of the budget window enabled permanency of TCJA corporate rate cut by clearing rule on decreasing revenue in years beyond the budget window

Source: Washington Council Ernst & Young, "Budget Reconciliation Basics," August 2024

GOAL 19
Encourage competition within the health care industry

Hospital spending currently accounts for 44% of total personal health care spending for the privately insured, and hospital price increases are key drivers of recent growth in per capita spending among the privately insured.[98] The Foundation for Research on Equal Opportunity stated in its 2020 report on price transparency that "[o]ne of the greatest challenges to affordable health care is the high cost of American hospitals. The most important driver of higher prices for hospital care, in turn, is the rise of regional hospital monopolies. Hospitals are merging into large hospital systems and using their market power to demand higher and higher prices from the privately insured and the uninsured."[99]

Clearly, hospital and provider consolidation is fueling price increases. Provider consolidation can be between those who offer the same or similar services (horizonal mergers), different services along the same supply chain (vertical mergers), and services offered in different geographic markets (cross-market mergers). And some providers are also creating other types of affiliations such as joint ventures. While this consolidation may help increase operational efficiencies, coordination of care, and number of available providers within the community being served, it also reduces competition, which may in turn increase the cost and reduce service quality (see Figures 6-8).

And this type of market power can have other effects — locally dominant provider systems can leverage their significant market share to require employer-sponsored plans contract with the system's affiliated facilities regardless of cost or quality. These anti-competitive contract terms add even more leverage and stand in the way of affordability and value-based care innovation and limit plan sponsors' flexibility in plan design to promote access to high-value care.

In addition, as hospital systems have continued to purchase physician practices, some of those systems have begun to characterize medical treatment taking place at the practice as "hospital services" instead of "professional services." This facility-based fee structure means higher reimbursements to the hospital. A similar incentive results from disparities in reimbursement rates for the same or similar services at *varying* sites of outpatient care — hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs) and freestanding physician offices.

For the private market to succeed, public policy must aim to reduce incentives that further encourage market consolidation, drive greater price transparency and eliminate anti-competitive practices.

GOAL 20
Ensure access to affordable, safe, effective and innovative prescription drugs

The COVID-19 pandemic was an object lesson in the importance of America's pharmaceutical industry. Under enormous pressure and in unprecedented time, drugmakers developed vaccines and treatments that likely saved millions of lives.

Employers appreciate that pharmaceutical drug therapies play a significant role in treating and curing injury, illness and disease. These medications allow millions of people across the globe to overcome debilitating conditions, return to work and live longer, healthier, more productive lives. Moreover, money spent wisely on drugs can reduce hospital, physician and other medical expenditures.

Nonetheless, prescription drug costs continue to represent a considerable portion of overall plan costs. Employers have implemented innovative strategies to manage these costs while ensuring that employees and families retain access to needed drugs and services. However, employers remain deeply concerned about prescription drug costs, particularly the cost of specialty drugs, and the absence of appropriate price — and cost – transparency across the entire drug supply chain and pricing system, including with regard to drug manufacturers and PBMs.

The current rebate structure, for instance, is complex and opaque for many employers, making it hard for them, plan participants and beneficiaries to understand the true prices and value of drugs. Employers continue to encounter barriers to PBM pricing transparency. Employers cannot effectively manage prescription drug costs unless they can see the full picture of rebates, fees and other remuneration generated from manufacturers and other parties, drug definition criteria and amounts charged to pharmacies. It is also important to address misaligned incentives and pricing models that may lead to higher prescription drug costs for employers and employees without increased value.[100]

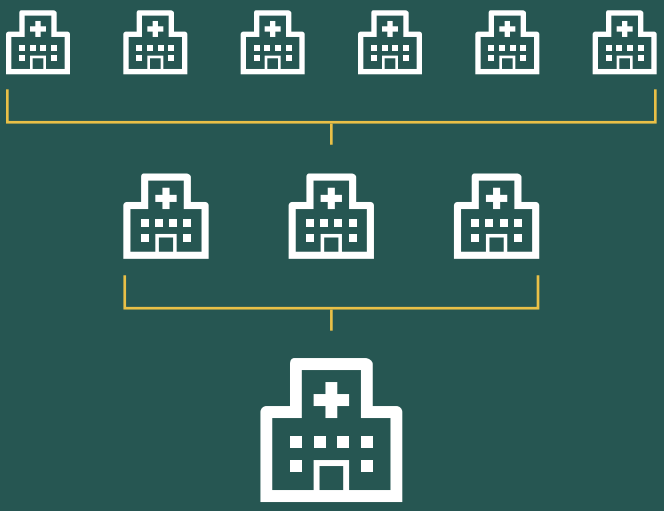
THE INCREDIBLE SHRINKING HEALTH CARE MARKET

Runaway hospital consolidation is weakening the competitive economic market forces needed to align health care cost with value.[177]

FIGURE 6 | Concentrated

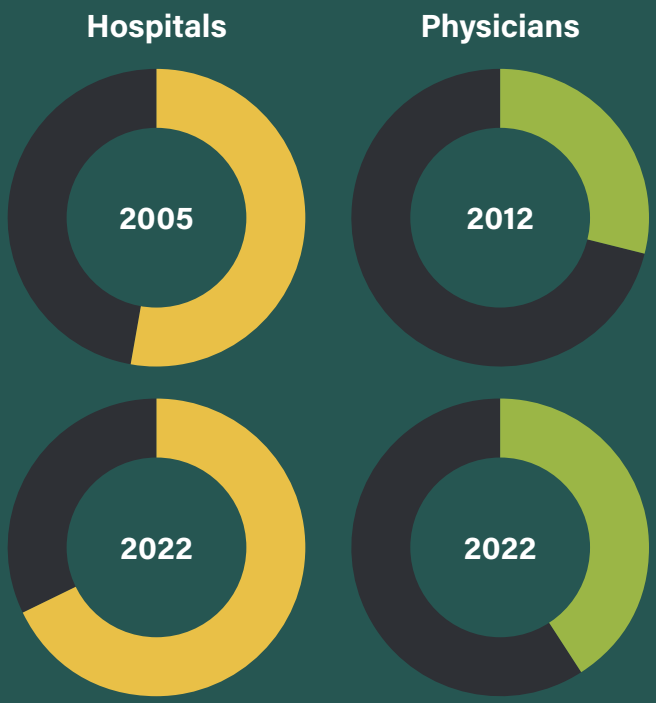
An estimated 117 million people live in a concentrated hospital market, whereas 160 million reside in a competitive hospital market.

FIGURE 7 | Combined



There were 1,573 hospital mergers from 1998 to 2017 and another 428 hospital and health system mergers announced from 2018 to 2023.[178]

FIGURE 8 | Consumed



By 2022, two thirds (68%) of all community hospitals were part of a larger system, as compared to 53% in 2005, while 41% of all physicians were part of a larger system, as compared to 29% just 10 years earlier.[179]

Employers are also concerned that many drugs continue to experience access shortages, causing patients to forego necessary and sometimes lifesaving treatment. Despite recent efforts by the U.S. Food and Drug Administration (FDA) and U.S. Department of Health and Human Services (HHS), drug shortages continue to rise in the United States, reaching a record-high of 323 drugs in the first quarter of 2024.[101] Policymakers and the regulatory agencies must recognize and seek to prevent this growing challenge.

Today we stand on the precipice of an evolutionary leap forward in pharmaceutical medicine. Innovative medical treatments and drug delivery methods offer new hope to individuals who suffer from serious conditions. This momentum forward has its costs. Biosimilar drugs, for example, have increased in recent years, offering a cost-effective alternative to biologic medications. Biosimilars have no clinically significant difference as compared to their similar, but not identical, biologic counterparts. They contain the same active substance of an already authorized biologic, but often contain minor differences in their inactive compounds. As of August 2023, 42 biosimilars were approved in the United States and 74 in the European Union,[102] indicating significant opportunities to expand access to more cost-effective biosimilars for U.S. patients.

Pharmacogenetics now identify how a person's genetic makeup may have an impact on the effectiveness of a medication in their body. This field of precision medicine can also help doctors prescribe drugs resulting in fewer side effects. And where today's medicines and surgeries have not sufficiently worked to treat disease, new "living drugs" — such as cell and gene therapies — offer hope. Gene therapy aims to treat a disease or condition by fixing or replacing a faulty gene with a healthy one. Cell therapy involves placing cells into a body to treat a health condition. The FDA has already approved several gene and cell therapies to treat people with a variety of conditions such as prostate cancer, sickle cell disease, hemophilia A and B, lymphoma, melanoma, leukemia, spinal muscular atrophy, bladder cancer, and diabetes. As of late May 2024, 14 gene therapies were FDA-approved, nine of which were given since August 2022, and this quick pace is expected to continue.

"Today we stand on the precipice of an evolutionary leap forward in pharmaceutical medicine. This momentum forward has its costs.

Nanotechnology gained significant momentum in recent years as well, because its unique physical and biological properties appear to boost the effectiveness of drug and gene therapies. Additionally, the diagnosis and treatment of some diseases will benefit from the emerging field of gene theragnostics, a combination of nanoparticles, gene therapy and medical imaging. These exciting advances, however, come with a hefty price tag,[103] raising concerns over their long-term viability. To encourage private payers to cover gene therapy, some manufacturers are offering a partial reimbursement if the treatment is not effective. But despite such efforts to mitigate the high price tags, industry analysts remain concerned with the long-term feasibility of these treatments. Worries persist over the extent to which existing stop-loss carriers and reinsurance models address the costs to employers' group health plans of cell and gene therapies, particularly as the number of such innovations increase over time.

The Council is committed to working with policymakers to encourage ongoing innovation in pharmaceuticals, support expedited approvals when appropriate to help reach a greater number of patients, help employers develop ways to defray these high costs and support competition and remove barriers to expanded access. To begin reforming the U.S. drug pricing system — from manufacturers, to PBMs, to pharmacies, to payers and to the end user — vital steps include more price transparency and promotion of value-based pricing for expensive and innovative therapies.


PART THREE
Policy
Recommendations

A STRATEGIC PLAN IS MORE THAN MERE PHILOSOPHY, OR EVEN THE establishment of lofty goals. A roadmap can tell you where you are and where you are going, but it is useless if the organization does not have the will to move forward.

Our strategic plan is a plan of *action*. Enumerated below are 79 policy recommendations designed to help policymakers achieve or advance one or more of the 20 overarching goals set forth in Part Two.

For each recommendation, we provide a detailed explanation of why it is necessary and, in many cases, how it can be implemented. ***Each is accompanied by icons indicating which of the 20 goals the recommendation would address.***

The recommendations are organized, for ease of reading, in groups by topic and numbered for quick reference. The first of these groups, Core Issues, comprises the most fundamental and critical matters for policymakers to consider. Beyond that, the order in which these groups are presented (and the sequence of the recommendations within those groups) is not intended to imply priority order. The American Benefits Council membership is rich and diverse; not everyone does or will agree on what is *most* important. But every recommendation here is important to a critical mass of employers — and, by extension, the many employees and families they serve.

We also stress that, while not every single Council member organization necessarily endorses each of these recommendations in isolation, the strategic plan as a whole received overwhelming support from the Council's Policy Board of Directors and, indeed, was approved ***unanimously.*** This collaborative spirit underscores the collective commitment to a strong employee benefits system that supports American workers and their families.

Compared to the roughly 40 policy recommendations articulated in each of the Council's previous two strategic plans, DESTI**NATION** 2030 represents our most ambitious advocacy agenda to date. This underscores the seriousness of the challenges before us, the importance of the goals ahead of us and the Council's commitment to being a part of the solution.

Part Three Table of Contents

Key to Goals Satisfied

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GOAL 4: Improve public health and disaster preparedness

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GOAL 6: Promote stability of benefits policy

GOAL 7: Promote flexibility in employee benefit plan design and operation

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GOAL 19: Encourage competition within the health care industry

GOAL 20: Ensure access to affordable, safe, effective and innovative prescription drugs

A. Core Issues: ERISA and Tax Policy

A1: Preserve, protect and defend federal preemption for all employer-sponsored retirement, health and other welfare plans subject to ERISA.

This federal preemption (1) ensures that state and local laws do not inhibit the ability of employers to choose their plan design, benefits or administration and (2) preserves the ability of employers to treat their employees equitably nationwide.

The preemption language enshrined in the Employee Retirement Income Security Act of 1974 (ERISA) — described by its authors as the "crowning achievement" of the law — provides a uniform federal framework within which employers can operate their benefit plans. Employers therefore view ERISA preemption as essential to the sponsorship of health and retirement benefits.

ERISA preempts most state laws relating to any employee benefit plan covered by the law. The purpose of preemption is to enable employers to establish uniform administrative frameworks that provide a set of standard procedures to guide the processing of claims and disbursement of benefits. State or local laws affecting benefit plans may not challenge, duplicate or add to the requirements imposed by ERISA.

Numerous states, cities and localities have sought to impose new employee benefit standards in an attempt to "pierce the veil" of preemption — or bypass it entirely.

Health Coverage

Over the past five decades since ERISA's enactment, employers developed innovative solutions tackling rising health care costs, health service quality, benefit inequities and preventive care. These innovations were possible because of ERISA's nationwide uniformity, enabling employers to provide affordable, high-value and equitable benefits to their workers, wherever they live or work. These efforts are valuable not only to working families but also were the catalysts for improvements across the entire U.S. health care system.

However, several states are undermining employers' ability to offer uniform nationwide benefits, diluting their effectiveness and affordability. This trend is most apparent with regard to pharmacy benefits, where several states enacted laws to control pharmacy network standards, reimbursement rates, and cost-sharing practices for pharmacy benefit managers with respect to self-funded ERISA plans. There is concern these efforts will expand, affecting other key aspects of self-insured plan design. These laws could obstruct employers' efforts to design plans aimed at controlling costs and requiring high standards of care for their workforce. It is critical that ERISA preemption is preserved to ensure the continuation of employer innovation and the affordable, high-value health coverage it enables.

Retirement Savings

Uniform plan design and administration is also essential for multi-state employers to sponsor retirement benefits.

Some states and localities have proposed and adopted their own rules related to or affecting workplace retirement plans. Such initiatives generally seek to establish "automatic IRA" coverage mandates for employers on behalf of those without sufficient access to employer plans. While well-intentioned, these rules erode ERISA's uniform standards and can tilt the playing field unfairly toward state-run plans at the expense of private sector employer-sponsored arrangements, which provide far greater benefits with many more protections.

While most large businesses are generally not the target of these ordinances, as they typically operate in more

than one state, they frequently bear an outsized burden of compliance due to a patchwork of different and conflicting rules. Paradoxically, it is not the actual coverage mandate that is burdensome, but rather the cost of proving one's exemption from it.

Ultimately this results in increased costs and administrative burdens for employer-sponsored plans and, if unchecked, could cause employees performing the same job for the same employer, albeit in different locations, to receive very different benefits. Employers could also face increased litigation risk in multiple venues from a plethora of state-law claims.

It is critical to remember the private retirement system is voluntary. If a national employer is faced with inconsistent rules in different states, perhaps with no coordination about which state rule applies in certain multi-state situations, the costs and risks of maintaining a plan would skyrocket. At a minimum, these costs would materially reduce retirement benefits. More broadly, at some point the actual number of plans would diminish.

Furthermore, without ERISA preemption, employers would not be able to leverage economies of scale that nationwide plan design, administration and negotiation affords. Without ERISA preemption, employers could not provide a consistent employee experience, which in turn would create greater confusion, complexity, frustration and cost for both employees and employers.

Employee benefits should be tailored to the workforce's needs, not its geography. ERISA allows employers to apply innovative, value-driven practices on a consistent, nationwide basis. ●

A2: Preserve, protect, defend and enhance the current tax incentives supporting participation in employer-provided retirement plans — both the full federal tax deferral for participating employees and the tax deduction for plan sponsors.

As articulated earlier in Part One, the tax incentives enshrined in current law are fundamental to the success of the employer-sponsored retirement savings system. The tax deduction encourages employers to establish and maintain plans and the tax deferral applicable to employer-sponsored retirement plans constitutes a tremendous bargain for employees. Nevertheless, proposals periodically arise to alter or eliminate these incentives.

The U.S. retirement savings system successfully encourages individuals to save for retirement by allowing the deferral of income tax on benefit accruals under defined benefit plans and on contributions to employer-sponsored defined contribution plans and individual retirement arrangements (IRAs), up to certain limits, and on the earnings on those contributions. This tax incentive provides a strong incentive for individuals at all income levels to save for retirement and encourages employers to sponsor plans delivering meaningful benefits to Americans along the income scale.

Although the deferral of income tax on employer and pre-tax employee contributions to defined benefit and defined contribution plans is scored as a significant (if theoretical) revenue loss to the federal government within the traditional 10-year budget window, it is important to remember the majority of this tax revenue on contributions to traditional retirement plans is not truly "lost" because it is taxed on distribution. ("Roth" plans are, of course, an exception to this rule.) Contributions and investment earnings to retirement plans accumulate on a tax-deferred basis until the participant receives a benefit payment— often decades down the line — at which point it is taxed as ordinary income rather than capital gains.

Nevertheless, some policymakers propose replacing the current tax incentives with a system of after-tax contributions to retirement plans, paired with a tax credit, capped at a dollar or percentage level. But this critique of the current structure is misplaced, and the proposed solution would

be counterproductive. A revised tax regime of this kind would reduce plan participation and individual retirement account (IRA) usage, provide less tax savings than today's structure, deter plan sponsorship and impose administrative complexities and costs on remaining plans.[104]

In a federal revenue deficit environment, enormous pressure settles on lawmakers to curtail the value of retirement tax incentives. Because financial security in retirement depends on saving more, not less, every effort should be made to stave off such caps and preserve current tax policy. ●

A3: Preserve, protect and defend the current tax incentives for employer-provided health coverage — both the full federal income tax exclusion for employees and the tax deduction for employers.

Employers play a critical role in the health care system and drive innovations from which the entire health system benefits. Indeed, employer-provided health coverage is the core of America's health care system. More Americans rely on their employers for health coverage than any other source (such as the individual insurance markets or government programs). For the better part of a century, federal law has protected employees from tax on this coverage, which is a major reason employer-provided health insurance is so prevalent.

The tax expenditure for employer-provided health coverage affords significant business and societal benefits for employers, employees and the federal government. America's employers recognize helping employees thrive has a measurable impact on virtually every aspect of their business.

"I wish to make note of what is to many the crowning achievement of this legislation, the reservation to federal authority [of] the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent state and local regulation.

— **Representative John Dent (D-PA), one of the authors of ERISA, addressing the U.S. House of Representatives, August 20, 1974**[180]

For employees and their families, employer-provided health coverage enables access to high-value health care. The expenditure is in fact quite *progressive* because the value of the "health benefit" it provides is more significant for lower-income individuals, for whom it would be a greater financial burden to purchase coverage absent an employer-sponsored plan.

The longstanding tax exclusion for employer-provided health coverage represents a tremendous bargain to the federal government itself. As explained in *The Benefits Bargain* in Part One, it would cost taxpayers substantially more to provide the same level of financial protection for health expenses if provided through a direct government program rather than incentivizing the employer-provided system, based on our own calculations of the tax expenditure and benefits paid, as well as Employee Benefit Research Institute analysis of federal subsidies for different types of coverage.[105]

On this, employers and individuals agree: In a June 2024 survey of 1,200 registered voters, people opposed proposals to tax employer-provided health insurance by a margin of three to one (58% oppose vs. 18% in favor). Among those with an employer-provided plan, two-thirds opposed the proposal (67% oppose vs. 16% in favor). Opposition was also bipartisan, with 61% of Republicans, 62% of independents and 52% of Democrats opposing the proposal.[106]

The Council strongly opposes legislative proposals to tax employer-provided health coverage and will continue to urge policymakers to reject this misguided and short-sighted idea. ●

B. Retirement Security

B1: If legislation is enacted mandating that employers maintain a retirement plan, the mandate must be paired with universal protection from state laws under ERISA.

In recent years, Representative Richard Neal (D-MA) — the senior Democrat on the U.S. House of Representatives Ways and Means Committee — sought to advance legislation that would require employers to provide a retirement plan to their employees (such as the Automatic IRA Act (H.R. 7293, 118th Congress)).

The vast majority of large employers (like those in the American Benefits Council's membership) already provide a retirement plan and recognize the importance of expanding coverage. Whether the Council can support a mandate will depend on the details of the measure, namely: What are the specific requirements employers will need to meet, and what are the incentives for existing plans?

The mandate must not result in any increased administrative burden for existing plans to prove they offer retirement coverage. That extends to protection from all the many state law mandates that arose over the past decade. The responsibility of determining whether employers are in compliance with state laws must fall on the state itself, perhaps aided by a nationwide, standardized process for affirming exempt status.

The more a mandate can replicate the existing standards and best practices of employer plans, the easier it will be for employers to comply and the more successful the program will be. ●

B2: Increase the compensation, contribution and benefit thresholds for retirement plans.

One of the prevailing criticisms of the employer-provided defined contribution system is based on the argument it overwhelmingly favors the wealthy at the expense of lower- and middle-income workers. Such arguments are often used to justify *lowering* the compensation and contribution thresholds for these plans, when in fact lawmakers should do the opposite.

Increased limits and more appropriate indexing will allow individuals to save more effectively. Reducing the tax incentives on retirement plans — whether in support of an income equality argument or in an attempt to increase federal revenue — would reduce the flexibility employees need to save effectively over their working lives when there will be large variations in their ability to set aside money for retirement.

Higher limits help incentivize small business proprietors and senior managers to establish, maintain and enhance retirement plans, which in turn improve retirement outcomes for all employees. Nondiscrimination and top-heavy rules already protect rank-and-file participants from overly disparate retirement contributions. At a minimum, these limits should continue to be indexed to keep pace with inflation. ●

B3: Increase the thresholds for "catch-up" contributions, especially for caregivers.

A catch-up contribution is an elective deferral made by a participant age 50 or older that exceeds a statutory limit, a plan-imposed limit, or the actual deferral percentage (ADP) test limit for highly compensated employees (HCEs). SECURE 2.0 permits plans offering catch-up contributions to increase the catch-up limits for participants aged 60, 61, 62, or 63 beginning in 2025.

"Catch-up" contributions are specifically designed to improve retirement readiness for participants nearing the end of their careers. For a variety of reasons, many employees find it difficult to save for retirement at the start of their careers. At lower income levels, other financial considerations like student debt, transportation and housing can "crowd out" savings contributions. It makes sense, therefore, to allow workers nearing retirement — when their earning power is typically at its peak — to compensate by contributing larger amounts. Considering the decline in defined benefit plans, which could create substantive benefits for mid- and late-career hires in ways that defined contribution plans cannot, catch-up contributions are a vital tool for savers.

For the same reasons overall limits should be higher, catch-up contribution limits should also be raised. Policymakers can and should also use the catch-up vehicle to help caregivers, especially those who have chosen to exit the workforce temporarily. Research shows that "prime-age women are substantially more likely than men to remain out of the workforce due to caregiving responsibilities, primarily to care for children full-time," with half of women surveyed saying they are unemployed because they are caring for others.[107] Giving these women the opportunity to "to make up for lost time" is critically important for improving gender equity with respect to retirement security.

Under one proposal, for example, a family caregiver would be provided an additional year of the higher age 60-63 catch-up contributions for every year the individual provided family caregiving and was correspondingly unemployed or underemployed. ●

C. Safe Harbors and Compliance

C1: Support the ability of plan sponsors to locate missing plan participants by (1) establishing a safe harbor for employers locating missing retirement plan participants and (2) developing a missing participant data registry in a way that safeguards private participant and beneficiary information.

Retirement plan administrators sometimes have missing and unresponsive participants for a variety of reasons, many of which are beyond an administrator's control. Nevertheless, the U.S. Department of Labor (DOL) has applied intense scrutiny to employer plan sponsors through constant, lengthy and costly plan audits and has scolded plan administrators for "inadequate recordkeeping practices, ineffective processes for communicating with such participants and beneficiaries, and faulty procedures for searching for participants and beneficiaries for whom they have incorrect or incomplete contact information."[108]

In January 2021, the department issued a "best practices" document for fiduciaries setting forth "red flags" indicating a problem with missing or unresponsive participants. But the guidance does not help plan sponsors, because it would be impractical for any plan to practice the "best practices." To do so would impose unreasonable costs on the remaining participants and may bring the plan sponsor no closer to a solution. In some instances, for example, such as legacy plans arising from mergers and acquisitions, lost participants are less likely to respond to direct communication from an employer for whom they did not work.

For more than a decade, the American Benefits Council has highlighted the critical need for a reasonable and actionable safe harbor from the department articulating what plan sponsors must do to try to find missing participants. For example, in Revenue Ruling 2020-24[109] and Revenue Procedure 2020-46,[110] the Internal Revenue Service (IRS) provided guidance on exactly what a plan must undertake to find a missing participant:

- A search for alternate contact information (address, telephone, or email) contained by the plan, related plan, plan sponsor and publicly available records or directories.
- Use of a commercial locator service, a credit reporting agency or a proprietary internet search tool for locating individuals.
- The mailing of a contact letter sent by U. S. Postal Service via certified mail to the last known address and to any other alternate address found.

Another example of a feasible safe harbor is contained in the bipartisan Retirement Lost and Found Act as introduced in 2018 by Senators Elizabeth Warren (D-MA) and Steve Daines (R-MT) as S. 2474 and by Representatives Suzanne Bonamici (D-OR) and Luke Messer (R-IN) as H.R. 6540.

To help plan participants, the SECURE 2.0 Act of 2022 directed the DOL to establish an online, searchable database by December 29, 2024. Initially, the DOL planned to populate the database using information collected by the IRS on Form 8955-SSA. That approach, however, was never contemplated by Congress. The IRS, furthermore, wisely declined to give this information to DOL, citing rules protecting confidentiality and limiting the disclosure of information provided on IRS returns.

Consequently, the DOL is now proposing to collect various data voluntarily from retirement plans — dating back many years — to populate the Lost and Found database. While the Council supports the aim and development of the Lost and Found database, we expressed serious concerns about the DOL's proposed new approach including potential liability in case of data breaches and compliance with privacy laws. We encourage the DOL to be more collaborative in finding a solution to the problem, perhaps bringing their own channels to bear in contacting missing participants. ●

C2: The DOL should include fiduciary safe harbors when issuing regulatory guidance affecting retirement savings plans, to promote rather than stifle innovation.

In our experience, plan fiduciaries work very hard to comply with their duties under the Employee Retirement Income Security Act of 1974 (ERISA). They very much want what is best for participants, and to avoid unnecessary challenges and litigation that drains resources away from benefiting participants. We have reached a difficult stage where there simply is not a safe path to avoid litigation.

In one recent example, a retirement plan fiduciary overseeing its plan's investment options hired an expert investment consultant to advise them. The expert consultant did its job and reviewed the plan's investments, approved most of them and recommended additional discussion of others. That discussion occurred. This seems like a model of best practices. Instead, the court allowed a suit to proceed forward against this fiduciary because the fiduciary did not specifically have an on-the-record discussion of an investment option that the investment consultant had approved.

That lawsuit and many others have been allowed to proceed, despite the plaintiffs not alleging any knowledge of any violations of ERISA or any defect in the process used by the fiduciary to select investments. As noted above, this problem is attributable to the courts not enforcing the pleading standards, which require specific allegations regarding an impermissible process.

The same case involved a claim that plan fees charged on a per-participant basis were too high in later years when the plan was larger, so that per-participant fees should have been going down. The fiduciary noted, in fact, that fees had been decreasing. The court responded this could indicate fees were too high in earlier years. In short, there is no safe path forward in many situations today, which is a harmful and counterproductive situation that will undermine retirement security.

Enforcement of pleading standards is one excellent solution to this issue. But why should baseless suits be brought at all? Another approach would be to work with the DOL to develop practical safe harbors for plan fiduciaries to follow to insulate them from liability. Under a reasonable safe harbor, for example, a plan fiduciary could be insulated from liability with respect to the selection of available plan investments if a plan fiduciary engages a qualified independent investment consultant, meets regularly with that consultant, is presented with the consultant's analysis, follows up on any recommendation of the consultant and periodically reviews the consultant. This is clearly a prudent process, which is exactly what ERISA requires.

Fiduciaries should act in the best interests of plan participants — not the plaintiff's bar. Policymakers need to host a public dialogue about this type of safe harbor, which would save billions of dollars over many years — dollars that can be used to pay benefits. Importantly, any such safe harbors need to be only that — an acknowledgement of common best practice, not *de facto* creating a new and very detailed or specific standard that must be met. ●

C3: Enable employers to provide more robust financial education through a simplified compliance process that protects participants and safeguards plan sponsors and plan administrators from fiduciary liability.

Employer plan sponsors hold a privileged position of trust among plan participants. This is why employers take their fiduciary duties very seriously.

In a predominantly defined contribution plan world, employees are tasked with immense responsibility for their own investment decisions and are naturally desirous of information that can assist in making wise choices. While investment *advice* — personalized and prescriptive — carries expanded fiduciary responsibility and liability, employers have focused their efforts on financial *education* — generalized and objective — for plan participants. This commonly includes financial wellness programs to support their employees in managing all elements of their financial situation, such as retirement, health, consumer debt, college debt and home purchases.

It is very important to have a balanced regulatory approach supporting the valued interactions between plan participants, plan sponsors and service providers without introducing unnecessary complexity, uncertainty or risk of liability.

All employees of a plan sponsor should therefore continue to be excluded from investment advice fiduciary status, as should a host of other educational and informational services provided by plans for the benefit of participants. ●

D. SECURE and SECURE 2.0 Act Implementation

D1: Ensure that regulatory guidance implementing retirement policy legislation, such as SECURE Act SECURE 2.0 or any future guidance, is clear, timely and administrable.

The SECURE and SECURE 2.0 legislation — to which the American Benefits Council contributed substantially through specific policy provisions and practical advice — each represented important steps forward for retirement savings access.

The enactment of these measures presents an object lesson for policymakers tasked with implementing the laws. The ease of establishing and incorporating these valuable changes could make the difference between widespread adoption and missed opportunity.

At the time of this writing, the Council is engaged with executive branch agencies as they prepare to issue critical regulations and guidance on certain key provisions of SECURE 2.0, such as:

Changes to Catch-up Contributions: SECURE 2.0 generally provides that a 401(k), 403(b), or governmental Section 457(b) plan allowing catch-up contributions must require such contributions to be designated as Roth contributions made pursuant to an employee election. This requirement is limited to an eligible participant whose Federal Insurance Contribution Act (FICA) wages for the preceding calendar year exceeded $145,000.

The Council was instrumental in persuading the Internal Revenue Service (IRS) to provide a transition period for implementation until 2026,[111] giving employers time to update their systems to accommodate this new provision. Just as importantly, however, this delay also gives the U.S. Treasury Department time to issue important clarifying guidance, without which employers will be unable to comply. Such guidance is needed on, for example:

- Whether a plan may require that all catch-up contributions be made on a Roth basis.
- The need for separate participant elections.
- Corrections of erroneous pre-tax contributions.

Electronic disclosure: The SECURE 2.0 Act amended the Employee Retirement Income Security Act of 1974 (ERISA) to provide that — with respect to defined contribution retirement plans relying on the 2002 and 2020 electronic delivery safe harbors — unless a participant elects otherwise, the plan is required to provide a paper benefit statement at least once annually. For defined benefit plans using the 2020 regulations, unless a participant elects otherwise, the statement that must be provided once every three years under ERISA must be a paper statement.

In developing future guidance, the U.S. Department of Labor (DOL) also raised the prospect of conditioning safe harbors on "access in fact" to electronic delivery and reverting to paper if an individual forgoes access in fact. Specifically, the DOL is asking if plan administrators are able to confirm, reliably and accurately, whether an individual actually accessed, and for what length of time, an electric document.

This would be an acute example of an unreasonable burden on plan sponsors. As the Council noted in a letter to the DOL,[112] even when technologically feasible to do so, plan administrators should not be required to monitor participants' website activity any more than they should be required to monitor whether a participant opens their paper mail, let alone reads the contents inside. Plan administrators have a responsibility to furnish certain plan information to participants, and as long as the applicable furnishing

standards are met — whether by paper or through electronic means — the plan administrator's responsibility very appropriately and necessarily ends at that point.

Emergency Savings Accounts: the SECURE 2.0 Act created two distinct emergency savings opportunities for retirement plan participants. The first and simplest of these permits penalty-free distributions of up to $1,000 from tax-exempt retirement plans for emergency personal expenses. The second and more complex provision allows a defined contribution plan sponsor to include a pension-linked emergency savings account (PLESA), from which small amounts can be accessed without penalty in the case of emergency. Council members are still evaluating their need for guidance on these issues. ●

D2: Affirm and codify in statute that employers can, on a voluntary basis, automatically re-enroll defined contribution plan participants in the employer plan every three years, with tax credits to encourage small employers to adopt a re-enrollment provision.

The Council has long supported "automatic" plan features, which harness the power of behavioral economics to drive favorable outcomes.

Voluntary automatic enrollment, first sanctioned in the United States a generation ago, has already had a material impact on the number of retirement plan participants[113] and the amounts saved.[114] Automatic escalation, a key element of the SECURE 2.0 Act, will help savers invest more as their tenure increases.[115] In one simulation, a transition of voluntary to automatic enrollment resulted in an aggregate wealth ratio increase of 16.3% without automatic escalation and an even more substantial 28.8% increase when escalation (rising to 15% of pay) is factored in.[116]

The next frontier is automatic re-enrollment, which ensures those who initially opt out of their employer's retirement plan are not left out permanently. While we firmly believe such measures are already permitted, we recommend a legislative measure to formally affirm this voluntary effort by employers, making clear that re-enrollment has been permissible under existing law.

For example, under the Auto Reenroll Act (H.R. 4924/S. 2517 in the 118th Congress), employees who initially opted out of contributing to their employer's retirement plan could be "reenrolled" in the plan within the next one to three years, giving them another opportunity to begin making contributions without the need to take any other action. Employees who are automatically reenrolled may opt out of contributing again as needed.

Automatic reenrollment is an especially meaningful tool for low- and middle-income employees who may have had other financial needs and priorities when they were first subject to automatic enrollment in a plan. Without an automatic reenrollment feature, employees who initially opted out are less likely in the future to re-evaluate whether they are now in a position to begin saving for retirement and take the steps necessary to begin making contributions. ●

D3: Build on SECURE Act advancements like pooled employer plans (PEPs) and defined contribution groups (DCGs) to give independent workers enhanced opportunities to save for retirement.

Over the past several years, a broader understanding of the independent workforce (and its subset, the "gig" economy) has presented opportunities and challenges for Council member companies. Most, if not all, Council member companies still rely primarily on a traditional workforce and desire reassurance that employee classification and benefits systems companies rely upon will not be disturbed. Other companies, however, may be considering whether and how to engage independent workers to fulfill certain roles or projects, with contributions toward benefits being a possible recruitment tool.

In 2018, the Council developed a set of principles to guide future advocacy efforts with respect to legislative and regulatory proposals addressing the independent workforce.[117] In keeping with these principles, the Council recommends a five-part plan to expand retirement savings opportunities for independent workers. This plan builds on the establishment of pooled employer plans (PEPs) and defined contribution groups (DCGs) in the SECURE Act of 2019.

1. Clarify that contributions by a company directly to a PEP or DCG in which an independent worker participates as an employee would have no effect on the worker's independent contractor status with respect to the company. This is critically important for employers who require assurance the current law employment classification rules will not be compromised.
2. Direct regulatory agencies to promote and facilitate arrangements like PEPs, DCGs and Simplified Employee Pensions (SEPs) for independent workers through guidance providing appropriate relief from unnecessary regulatory burdens.
3. Modify the audit rules for PEPs to exempt participating employers with fewer than 100 participants in the PEP, which would reduce audit costs and would mean PEPs could become available to gig workers without having to charge them for part of the audit costs.
4. Allow plans in a DCG subject to the audit requirement to jointly file a single audit as if they were part of the same plan. This could reduce costs by more than $6,000 per employer with 100 or more participants.
5. Increase the plan asset threshold under which plans for independent workers are exempted from burdensome paperwork requirements.

A DECLARATION FOR INDEPENDENTS

The Council's principles for the provision of benefits to independent workers are embodied by ...

- **Choice: Recognize independent work as the product of a free labor market, addressing the desires of workers and companies that benefit from such services.**
- **Coverage: Allow companies to help independent workers obtain [access to affordable] health and retirement coverage on a group basis.**
- **Consistency: Build on the federal framework for plan design and administration.**
- **Cooperation: Ensure that future policies support and enhance the existing and successful employer-sponsored benefit system.**
- **Creativity: Support company innovation for attracting and retaining talent.**

E. Retirement Plan Investments

E1: Facilitate the use of lifetime income options within defined contribution plans.

One of the biggest threats to a secure retirement is *longevity risk*: the possibility of outliving one's retirement savings. While mortality improvements are obviously positive and largely predictable, *decumulation* — the spending down of assets in retirement — is a growing challenge, itself exacerbated by inflation risk and surging health care costs.

Longevity risk also has implications for human resource strategy, in that helping older workers retire with confidence gives employers more workforce predictability.

While workplace retirement savings vehicles are optimized for asset accumulation, defined contribution plans currently have few tools at their disposal for addressing longevity risk. Even where employers have the opportunity to make lifetime income options more available, the threat of litigation stifles innovation.

"You're in great shape. I hope you have enough retirement savings to last another 30 years."

Policymakers should not require the use of lifetime income options but can facilitate voluntary approaches within defined contribution plans, such as:

1. Encouraging the U.S. Department of Labor (DOL) to issue guidance that would allow (but would not require) plan sponsors to establish lifetime income products as a qualified default investment alternative (QDIA). The Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019 included some provisions designed to give employers some comfort in this area. These provisions need to be implemented and supported.
2. Establishing rules for employer-provided financial education expressly permitting the discussion of lifetime income options as a means of mitigating longevity risk (see Recommendation E2 and the American Benefits Council's written comments on the DOL's proposed rules modifying the fiduciary definition.[118])

E2: Uphold the ability of retirement plan fiduciaries to make investment decisions as long as those decisions meet ERISA's duties of prudence and loyalty, including whether to make available alternative investments.

The growing diversity of today's workforce is matched only by the growing diversity of investment options in the financial marketplace. Mutual funds and index funds have long been staples of the traditional 401(k) plan. But the past three decades have featured endless new offerings, from "lifecycle" and target-date funds in the early part of the century to purpose-driven investments like environmental, social and governance (ESG) funds and new markets like marijuana and cryptocurrency.

The sheer number of choices is daunting for plan fiduciaries — without even considering the confusing legal status of some of these options and potential social and political blowback from employees and other stakeholders. And yet, employees often seek out these choices while employers seek to meet employee needs and wants whenever possible.

The Council believes firmly in the importance of plan fiduciaries acting in accordance with the Employee Retirement Income Security Act of 1974's (ERISA) duties of prudence and loyalty when making investment-related decisions. Employers take those duties very seriously when acting as fiduciaries and making decisions regarding plan assets. The Council also endorses the long-held view that a fiduciary may not subordinate the interests of participants and beneficiaries in their retirement income or financial benefits under the plan to pursue collateral objectives.

ERISA takes a non-prescriptive approach with the duties it imposes on plan fiduciaries, giving fiduciaries the leeway they need to determine how best to fulfill those duties in a wide variety of situations. Key to making those determinations is the fiduciary's use of a sound process. Because meeting ERISA's fiduciary duties requires flexibility on the part of fiduciaries, it is vital that DOL regulations and guidance — on ESG investing or any other investment-related matter — do not inappropriately restrict a fiduciary's flexibility in determining how best to meet its obligations. We also encourage the DOL to look for additional opportunities to ensure the investment duties' regulations focus remains on fiduciaries' need for flexibility and supporting the use of a sound, prudent process.

One way in which retirement plan sponsors embrace flexibility — and provide options for participants — is through the availability of brokerage windows, which allow participants to seek out specific investments that meet their particular wants and needs. It is vitally important that employers not be exposed to fiduciary liability for investments within a brokerage window (see next recommendation).

E3: Protect the ability of plans to offer brokerage windows without burdens on plan sponsors or plan administrators, such as fiduciary responsibility to oversee the investments made through those windows.

Brokerage windows are an important tool for plan sponsors that can benefit all participants, whether they utilize the feature or not. Brokerage windows allow plans to avoid the very real risks of confusing or even paralyzing employees with a broad investment menu, while at the same time satisfying the desires of a smaller group of participants for more investment options. If brokerage windows become unavailable as a practical matter due to the imposition of unworkable rules, more investment choices will likely be designated, which may not be the optimal result in many circumstances.

Recent scrutiny of tangential and controversial investment matters — cryptocurrency, for example, among others — raises the specter of regulators imposing on employers a "duty to monitor" investments within a brokerage window. This would be extremely burdensome and costly — if practicable at all — and would likely limit their availability.

E4: Support parity for retirement investors with individual, non-plan investors by (1) maintaining the current-law rules regarding how the closing rules work for trading mutual funds and (2) opposing any "hard-close" proposals.

Under a past and present Securities and Exchange Commission (SEC) proposal, a direction to purchase or redeem mutual fund shares would only be eligible to receive the current day's price if the order is received by the fund, its designated transfer agent or a registered securities clearing agency before the fund's pricing time, which is generally 4 p.m. Eastern Time. Consequently, this "hard close" would prevent current day pricing, as permitted under the SEC's existing rules, when a direction to purchase or redeem mutual fund shares is received by an intermediary — such as a retirement plan recordkeeper or third-party administrator (TPA) — before the 4 p.m. deadline, and subsequently transmitted to the fund after such deadline.

Not only would this proposal increase the costs incurred by these retirement savers, it would also disadvantage them by unfairly forcing them to accept significant delays between the time they provide investment directions and the time their investments are valued — a delay not encountered by investors who place their orders directly with mutual funds, and will be much shorter for investors placing orders outside of a retirement plan. The Council is also concerned about the ways in which a hard close would eliminate beneficial features currently available to retirement savers and distort the investment selection preferences of plan sponsors and fiduciaries. Moreover, in addition to creating these direct harms for retirement plans and their participants, a hard close would add significant costs to retirement plan administration and mutual fund order processing (costs that will be passed on, directly or indirectly, to Americans saving in plans).

E5: Provide investment parity for participants in 403(b) plans with other defined contribution plan participants by permitting such plans to invest in collective investment trusts (CITs) and unregistered insurance company separate accounts.

Because of an historical anomaly, 403(b) plans are not permitted to invest in collective investment trusts (CITs) or unregistered insurance company separate accounts. Originally, 403(b) plans were typically sold on a retail basis, directly from insurers to employees. Accordingly, 403(b) plans were generally viewed as individual retirement arrangements, rather than employer-sponsored plans, from a securities law perspective. This explains why sales of CITs and unregistered separate accounts were not permitted.

Today, the vast majority of 403(b) plans are managed by employers (*i.e.*, charities and public educational institutions) and they are functionally no different from 401(k) plans, so the restriction to higher-cost registered products no longer makes sense. Still other employers may sponsor both 401(k) plans and 403(b) plans as a result of past mergers and acquisitions. The Council is recommending 403(b) plans be permitted access to the same lower cost institutional funds available to virtually all other retirement plans (including 401(k) plans, governmental 457 plans, and the federal Thrift Savings Plan) — specifically CITs and unregistered insurance company separate accounts.

F. Defined Benefit Plans

Enact the following measures to protect and enhance defined benefit plans:

F1: Adjust PBGC premiums based on the agency's funded status, so if PBGC is sufficiently well funded that it does not need the current level of premiums, premiums would be reduced.

F2: Take premium increases and decreases off budget, because premiums cannot be used for any purpose other than paying benefits and PBGC administrative costs.

F3: Prevent an anticipated wave of plan terminations by permitting non-terminated plans to use surplus assets in a manner similar to what would be permitted if the plan were terminated.

F4: Permit unusable surplus assets in retiree health 401(h) accounts in pension plans to be used to shore up the retirement benefits in the pension plan and to provide other benefits.

F5: Protect employers by reducing funding volatility and protect participants from benefit restrictions that take away earned rights.

F6: Facilitate a growing type of traditional defined benefit plan, where benefits are adjusted to some extent based on plan asset returns.

F7: Update the accounting rules for market-based cash balance plans to base the valuation generally on the value of the notional account balances, which would materially improve the accuracy of the valuations.

The decline in the single-employer defined benefit plan system in the past 25 years has been alarming. In 1998, for example, 49% of Fortune 500 companies offered a traditional defined benefit plan open to new salaried employees. By 2021 that number had declined to 3%. The decline accelerated starting in 2006, when premiums payable to the Pension Benefit Guaranty Corporation (PBGC) began increasing dramatically. From 1998 to 2006, the number of open traditional defined benefit plans decreased by about 50%; from 2006 to 2021, the decline was 87%.[119] The top factors influencing plan sponsors' propensity toward risk transfer activity are accounting and earnings volatility, balance sheet liability management, funding volatility and PBGC premiums.

As the decline of the single-employer defined benefit plan system has continued, many have discussed the need to incorporate elements of the defined benefit plan system into the defined contribution system. We support those efforts. But the most effective way to promote the beneficial components of the defined benefit system is to strengthen that system. In October 2023, the American Benefits Council issued "Proposals for Enhancing Retirement Security by Strengthening the Single-Employer Defined Benefit Plan System,"[120] much of which is incorporated in this strategic plan (the exception being Proposal No. 8 from the 2023 document, which has already been adopted).

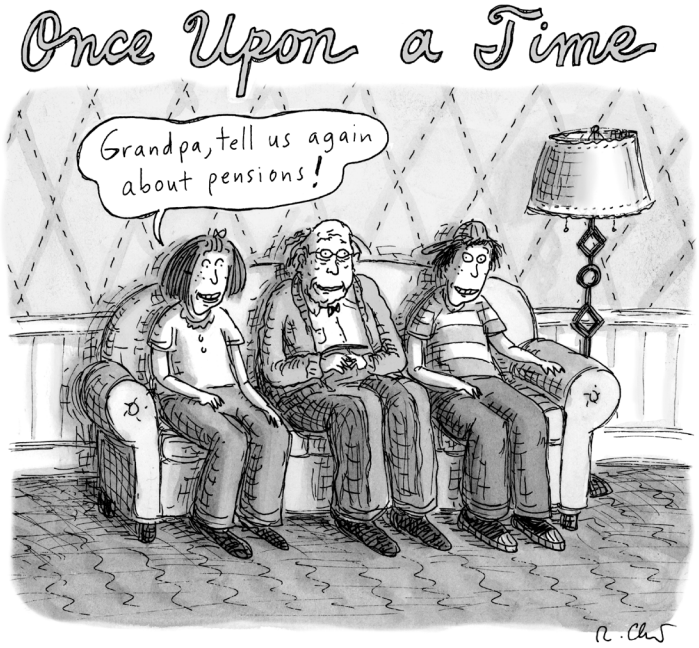
Strengthening the defined benefit system, as with our recommended package of reforms, would (1) give participants access to guaranteed income for life, (2) ensure spouses' rights to retirement benefits are protected, (3) protect participants from market fluctuations and (4) allow retirees to use their defined contribution savings to address unexpected retirement costs, while relying on their defined benefit plan income to pay for everyday expenses. ●

F8: Preserve the voluntary nature of the private retirement plan system by protecting the ability to terminate a defined benefit plan or enter into a partial pension risk transfer without new and unnecessary burdens.

The Council believes strongly in the defined benefit pension system, as demonstrated by the comprehensive policy recommendations located elsewhere in this strategic plan. The current inhospitable economic and regulatory environment for defined benefit pension plans, however, requires plan sponsors have an "off-ramp" to exit the system while maintaining benefits for plan participants. The practice of hiring an insurer to assume responsibility for defined benefit plan assets (commonly known as "derisking" or "risk transfer") is common and essential for preserving the voluntary nature of the defined benefit system. If plans do not have the option of exiting the system safely, they will be reluctant to enter the system at all.

The U.S. Department of Labor (DOL) has signaled an interest in making changes to Interpretive Bulletin (IB) 95-1, which sets forth the agency's views on the fiduciary duty to select the safest available annuity in the context of a pension risk transfer. In 2023, observing a mandate from the SECURE 2.0 Act, the ERISA Advisory Council studied the issue and concluded that no material substantive changes should be made to IB 95-1. The Council supports this view and opposes further changes to this longstanding guidance. In 2024 the DOL issued its report on IB 95-1, following the Council's advice in recommending no immediate changes to IB 95-1 and emphasizing any changes should be made through the notice and comment process.

We welcomed the thoughtful approach taken in the report. However, the DOL did indicate an interest in revisiting these issues, so we must remain vigilant in protecting the voluntary nature of the system. ●



G. Small Employer Issues

G1: Expand and enhance the small business tax credit to encourage broader adoption of qualified retirement plans.

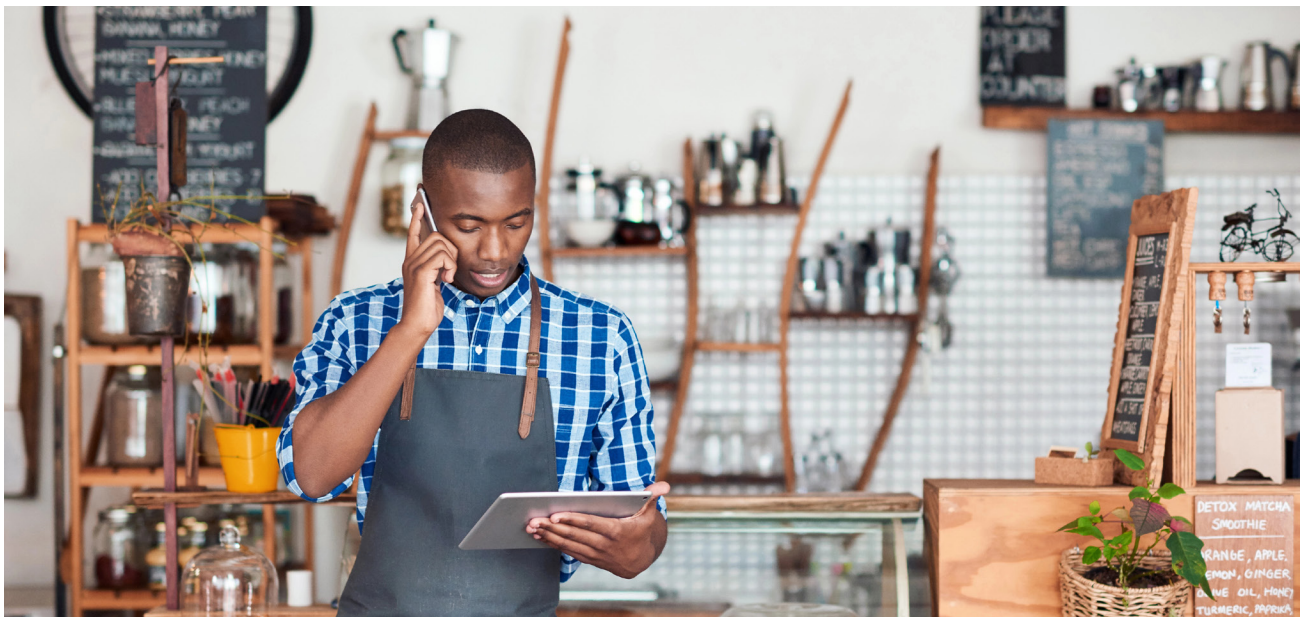
It is generally accepted among experts and policymakers that participation in a workplace retirement plan is essential to one's sense of financial security. The Employee Benefit Research Institute's annual Retirement Confidence Survey shows that 77% of individuals with a retirement plan are at least "somewhat confident" in their ability to have enough money to live comfortably throughout their retirement, as compared to 34% without a plan.[121]

The primary objective of retirement policy, therefore, should be to bring as many people as possible into the employer-sponsored retirement system. For most American Benefits Council members, who already sponsor plans, efforts have focused on improving take-up (through programs like automatic enrollment) and education (on the value of saving early in one's career).

The low-hanging fruit, however, is in the small business workforce. According to the U.S. Department of Labor (DOL) Bureau of Labor Statistics, for establishments with fewer than 50 workers, the access rate to defined contribution plans was 52% (compared to 85% at establishments with 500 or more workers) and 5% for defined benefit plans (compared to 38%).

One of the most significant obstacles to plan formation is cost. The small business retirement plan tax credit, which reduces the cost of establishing a qualified retirement plan, has been enhanced in the SECURE Act and SECURE 2.0 and the American Benefits Council believes it can be boosted even further.

The principle behind automatic enrollment can therefore be applied to employers: by dramatically reducing the cost of the first three years of sponsorship to practically free for small businesses, we can turn inertia in our favor and get employers in the habit of helping their employees save. ●



G2: Support multiple employer plan arrangements by allowing plans that are grandfathered from the automatic enrollment rules to join a multiple employer plan (including a pooled employer plan) without losing grandfathered status.

One of the important provisions recommended by the Council and enacted as part of SECURE and SECURE 2.0 legislation was the added flexibility afforded to multiple employer plans (MEPs) and pooled employer plans (PEPs), which allow two or more unrelated companies to jointly sponsor a retirement plan, thereby reducing plan administration and achieving economies of scale.

MEPs and PEPs can be efficient tools for bringing more people into the employer-sponsored retirement savings system, especially among employees of small businesses, where plan access and take-up has lagged far behind larger companies.

When the Internal Revenue Service issued Notice 2024-2[122] — helpful question-and-answer guidance designed to implement the SECURE 2.0 Act — it inadvertently created a disparity between MEPs adopted before the enactment date and those adopted after the enactment date.

Under Q&A A-3 of Notice 2024-02, it appears if a single-employer plan that includes a pre-enactment qualified cash or deferred arrangement (CODA) is merged into a PEP or other MEP established on or after December 29, 2022, the single-employer plan loses its status as having a pre-enactment qualified CODA. Thus, that employer's part of the PEP or MEP will become subject to the automatic enrollment requirements of Code Section 414A.

We do not think that Congress intended to severely limit employer choice by making the selection of a "post-enactment" PEP or MEP very disadvantageous. Yet that is what was done retroactively in IRS Notice 2024-2. We therefore call upon Congress or the IRS to correct this by clarifying that grandfathered CODAs do not lose their grandfathered status by reason of joining any PEP or other MEP. ●

H. Paying for Value

H1: Support employers' access to, and utilization of, nationally available price and quality transparency data from third parties including hospitals, group health plans, drug manufacturers, pharmacy benefit managers and insurers.

A competitive and value-driven health care market is predicated on transparency. Increased access to pricing data enables market forces to work more effectively and efficiently, ultimately leading to better cost and quality outcomes. Removing barriers to accessing and using price information is foundational to unleashing the power of transparency to help employers drive lower cost and higher value health care.

Many employers that have had success in decreasing the rate of health care spending have done so by analyzing their plan data to better understand how much is being spent on specific services. They then use plan design features to encourage lower utilization overall or engagement of higher-value, relatively lower-cost providers. Programs focused on value-based benefit design and value-based payment reform can potentially transform our system by realigning incentives to keep participants healthier — while at the same time lowering costs. These changes are not feasible without transparency and plan sponsor access to pricing data.

Although there has been substantial focus on price transparency in recent years, we recognize price is just one side of the value equation — quality is the other. Efforts by employers to pursue innovative strategies to improve the value of health care are hampered by inconsistent and incomplete quality metrics. It is often difficult, for example, for employers to get robust clinical quality and patient experience data at the practice or individual doctor level to validate high performing networks. Congress and federal regulators should facilitate cost-effective access to quality data to allow employers, other innovators and academics to define and evolve the quality metrics. Harmonized quality measures coupled with price metrics are the foundation for employer's innovative payment reforms.

More generally, transparency is not an end, in and of itself. The underlying objective of improved transparency is ultimately to improve value — that is, enhance quality while lowering costs. This also means increased transparency must be simple and secure and limit employers' exposure to liability.

There has been a substantial focus on transparency in health care in the last several years, both in the legislative and regulatory arenas. More work is needed for these efforts to support improvements in the value of care. Measures to advance this recommendation include:

- Codifying and strengthening hospital price transparency rules and the transparency in coverage rules (under Section 2715A of the Public Health Service Act).
- Establishment of a federal all-payer claims database, under which price and quality data would be available on a national basis rather than forcing employers to comply with numerous, incompatible state databases.
- Standardizing common data formats.
- Ensuring employers may choose to share their plan data with third-party vendors in order to operate and improve their plans.
- Requiring greater transparency across the drug pricing system, including with regard to pharmacy benefit managers (PBMs) and drug manufacturers.

Moreover, it is essential these policies be developed in a way that ensures the data is useful, clear and actionable for employers; avoids duplication or conflict with existing requirements; minimizes burden for employers and costs for employees; allows for improvement and enhancement over time as technology develops; and involves input from a range of stakeholders to ensure these goals are achieved.

H2: Support the ability of employers to provide value-based coverage, including through centers of excellence, preferred provider networks and other innovative plan designs.

When employers couple their commitment to employees with their drive for innovation, they can play a powerful role in lowering health care costs and increasing quality for individuals — and the health care system as a whole.

Long before the COVID-19 pandemic, employers were pioneering initiatives to lower health costs and improve quality through various value-based strategies. This was the message of *Leading the Way: Employer Innovations in Health Coverage*, a report from the American Benefits Council and Mercer showing how employers are lowering costs and improving quality through innovation. It is also a vital component of *American Benefits Legacy: The Unique Value of Employer Sponsorship*,[123] describing the important contribution that employer-sponsored coverage makes to the health and well-being of working families.

Impediments remain, however. Misaligned incentives reward providers for quantity rather than quality. Market consolidation and lack of transparency and fundamental market failures stifle competition and patient choice and increase costs.

Large hospital systems attempt to leverage their significant market share by forcing plans to contract with all affiliated facilities and prevent educating patients about lower-cost, higher-quality care. These anti-competitive terms in the form of "all-or-nothing," "anti-steering," "anti-tiering" and "most-favored-nation" contract provisions foster inflated costs and limit a plan sponsor's flexibility in plan design to promote access to high-value care.

And when widely adopted, value-based care should be extended to pharmacy benefits and other high-cost treatments like gene therapies. Payers should be able to contract with manufacturers in such a way that links reimbursement to outcomes.

In addition to improved price and quality transparency (see the previous recommendation), and other recommendations related to supporting competition and addressing consolidation, this objective can also be achieved by expanding access to primary care physicians, who can help guide patients toward high-value care.

H3: Support policies that promote the use of evidence-based care resulting in high-value physical, mental and behavioral health care, including expanded adoption and implementation of more accurate evidence-based measures of provider care quality.

Evidence-based care is critical to the value equation with respect to behavioral health, which includes mental health and substance use disorder care, as well as medical benefits. There must be more focus on measuring the quality of such care. Employers are innovators and always look for ways to increase employee access to high-value behavioral health services, hold down costs and improve quality.

The use of outcome measures has been limited by lack of provider adoption or technology infrastructure to measure and report outcomes at scale. Employers can play an important role in driving toward value-based behavioral health care as well as medical care. However, the development and adoption of appropriate measurement tools are critical in this effort.

We encourage policymakers to promote the use of evidence-based care by providers, including funding to support its adoption and implementation across the country.

H4: Preserve the ability of employer-sponsored health plans to impose reasonable medical management techniques to ensure that the care provided is clinically appropriate and high-quality and to ensure that coverage remains accessible and affordable.

Employers and health plans carefully design, and use, an array of, medical management techniques in health plans for many important purposes, including to:

- Manage quality and cost.
- Confirm the level of care is appropriate.
- Ensure treatments are safe, medically necessary, in accordance with generally accepted standards of care and are clinically proven.
- Help prevent unexpected out-of-pocket costs for participants and beneficiaries seeking non-covered or not medically necessary services.

Medical management techniques include prior authorization, step therapy and concurrent review. Some of these practices received negative attention in recent years. Policymakers at the federal and state levels have begun to focus their attention here, including medical management of mental health and substance use disorder benefits.

We understand the impact medical management has on participants and the importance of medical decisions being made between patients and their doctors. We also understand some may be of the view that less medical management is always beneficial for participants. Research suggests this is not the case: an extensive literature review related to medical overuse found that that many tests are overused, overtreatment is common, and unnecessary care can lead to patient harm.[124]

Medical management is not applied to undermine access to care. Medical management policies are resource intensive and not implemented lightly. They are used carefully to address important quality and safety issues, and to ensure clinically appropriate care is provided to enrollees and their dependents.

It is, for example, an important tool to protect against a repeat of the issues that gave rise, in part, to the opioid epidemic.

Providing access to health care is of the utmost importance to employers — but not just availability to any care, access to high-value, effective, safe, affordable care. Reasonable medical management is essential to ensuring access to this type of care and it is important that employers retain this important set of tools to root out care that is not safe, high-quality, evidence-based or necessary.

H5: Preserve the ability of employers to offer affordable, high-quality health coverage to retirees and their families, including through employer group waiver plans (EGWPs).

Many employers sponsor health plans for retired employees and their dependents, with approximately half offering retiree benefits through Medicare Advantage (in plans referred to as employer group waiver plans or EGWPs). As detailed in a 2023 white paper,[125] EGWPs are popular because they can be customized for the unions and employers that offer them. This is because the Centers for Medicare and Medicaid Services (CMS) has the authority to waive/modify Medicare Advantage requirements that hinder EGWPs, and CMS has done so in several cases (*e.g.*, employers can set their own open enrollment window, offer supplemental benefits and subsidize premiums).

EGWPs often provide additional benefits beyond a typical Medicare Advantage plan (such as reduced co-pays) and are designed to be similar to employer-sponsored coverage provided to active employees, in that the coverage is coordinated and comprehensive. This can improve the transition for employees from active employee plans to retiree plans.

EGWPs also allow employers to leverage the value associated more generally with Medicare Advantage, including a range of supplemental benefits (*e.g.*, vision benefits, dental benefits, hearing exams, fitness benefits), low or no supplemental premiums, a high satisfaction rate among seniors and lower rates of avoidable hospitalizations, as compared to traditional Medicare.

Because of the value of EGWPs to retirees and employers and the prevalence of these plans, it is important that CMS take employers into account as key stakeholders on Medicare Advantage issues. Policymakers should avoid undermining the ability of employers to offer EGWPs, including by refraining from increasing burdens or costs on EGWPs, such as through significant reductions in payments to EGWPs through Medicare Advantage.

H6: Reject impractical and burdensome benefit requirements for employer-sponsored plans that would increase health care costs without improving value or quality.

The establishment of specific benefit mandates that increase costs and do not provide value threatens the viability of employer-provided health care coverage and represents a slippery slope toward unaffordability.

As an example, recent legislation (the Restore Protections for Dialysis Patients Act, or RPDPA) compelling employer plans to abide by a vague and unnecessary benefit mandate and parity requirement related to end-stage renal disease (ESRD) would increase costs for employers and employees without improving the quality of dialysis services. Under the broad and vague language of the bill, plans would be required to cover any item and service a dialysis provider deems necessary at whatever reimbursement rate the provider wishes to charge, regardless of the value and appropriateness of such item or service.

Contrary to its stated purpose, the RPDPA will not inure to the benefit of those with ESRD. It will, however, allow dialysis providers in an already highly concentrated market to collect higher reimbursements from employer plan sponsors, increasing costs, complexity and confusion for employers and employees.

Enactment of the RPDPA would open the floodgates to other provider groups seeking mandates for their particular treatment areas. The Council believes comprehensive, affordable and holistic well-being can be achieved through higher-value care, not through layering of benefit mandates that increase cost, not value. And this principle applies with regard to all policymaking — including at the federal, state and local levels (notwithstanding that the Employee Retirement Income Security Act of 1974 (ERISA) should preempt these types of benefits mandates at the state and local level).

I. Health Equity

I1: Ensure hospital and other health care provider quality measurements account for health equity.

Providers and suppliers participating in Medicare must comply with various Centers for Medicare and Medicaid Services (CMS) regulations as a condition of Medicare participation. These regulations are intended to, among other things, promote higher quality and more efficient health care for Medicare beneficiaries. As part of these efforts, CMS has implemented a quality reporting program requiring hospitals and other providers to submit information to CMS on the quality of care provided and some of that data is made available on Medicare's Hospital Compare website (some data is kept confidential). CMS also provides "Overall Star Ratings" for hospitals providing care for Medicare beneficiaries.[126]

Over the years, CMS has made efforts to improve its quality reporting program, including expanding required data from Medicare participants to CMS to be stratified by race and ethnicity for certain quality measures. This is intended to allow CMS to evaluate not just the overall quality of the hospital but also the care the hospital provides to different segments of the population. This has been part of broader efforts by CMS to address health care inequities.

Employers evaluating providers as part of a value-based purchasing approach rely on quality evaluations performed by CMS, among other data. As such, the American Benefits Council supports CMS's work to improve its quality reporting program generally. More specifically, the Council has been supportive of efforts by CMS to integrate health-equity related information into the Medicare hospital quality reporting systems to reduce health care disparities and improve health outcomes for all populations. This is intended to ensure patients receive equitable treatment and outcomes, controlled for both overall quality and community characteristics.

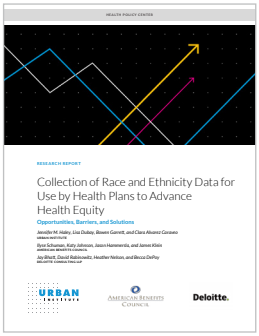
As the agencies make these calculations and continue with this program, it is important that CMS continues to provide reporting on overall quality and also fosters the ability to see the quality data and outcomes segmented by various populations, for example, by race and ethnicity.

CMS should also consider possible hospital data reporting on additional patient social and behavioral risks (*e.g.*, gender identity, geographic location) with appropriate privacy and antidiscrimination protections. Moreover, although some of the information CMS obtains from hospitals is kept confidential, the Council has asked that, as much as possible, the data collected be made available to the public, including to employers, to have the broadest positive impact on improving quality and reducing inequities. ●

I2: Support the ability of employers and health plans to collect, share and use race, ethnicity, and other relevant demographic data for the purpose of advancing health equity.

As sponsors of health insurance coverage for nearly 180 million Americans, employers can play a unique role in efforts to understand and address health inequities. But lack of complete and consistent data on enrollees' race and ethnicity, and other relevant demographic data, can inhibit progress.

While the White House Office of Management and Budget recently updated federal standards for the collection of health plan data, the full picture of health equity remains cloudy.



As articulated in a 2022 paper the Council developed with Urban Institute and Deloitte Consulting LLP,[127] we recommend public policy actions to improve data collection.

These include organized community engagement campaigns to establish and improve trust throughout the health ecosystem and continued standardization of self-reported data collection practices. Increased regulatory clarity with regard to the permissibility of data sharing is also important to these efforts. Relevant federal agencies such as the Equal Employment Opportunity Commission and the U.S. Department of Health and Human Services should work together to develop guidance about the ability of employers, providers, and community partners to share race and ethnicity data with health plans.

By communicating more clearly the value of improved race and ethnicity data collection and showing the feasibility and value in reducing disparities, policymakers can help encourage cultural shifts within organizations toward data collection to advance health equity. Improved data collection of other demographic information (*e.g.*, primary language, socioeconomic status, gender identity, sexual orientation, disability status) could also be beneficial, subject to appropriate privacy and confidentiality protections. ●

I3: Fund programs to promote diversity in the health care provider workforce, particularly in the fields of primary and mental health care.

Research suggests that a lack of diversity in the health care workforce worsens health disparities — and health outcomes — across communities.[128] The COVID-19 pandemic demonstrated the urgency of developing a robust and qualified primary care and behavioral health workforce in communities across the country.

By increasing health care workforce diversity, particularly in the fields of primary care and mental health, providers can meet the needs of an increasingly diverse patient population. As outlined earlier in Goal 9, the evolving diversity of patients (both acknowledged and self-identified) exposes a need for providers who represent a broad cross-section of the patient population, not only by racial and ethnic identity (including preferred language) but sexual orientation, gender identity and faith claims as well.

Given the importance of communication with and comprehension of one's health care provider, language barriers can present a dangerous obstacle to effective care. Additionally, culture is a highly variable construct that can have a significant impact on health care experience. Multilingualism and cultural sensitivity are therefore a valuable

tool in delivering optimal care and should be encouraged through public policy.

Fortifying the health professional workforce is essential to reducing the disproportionate impact of diseases and illness on racial and ethnic minorities. As eloquently stated in a recent Urban Institute brief, "evidence shows having a workforce that reflects the diversity of the communities they serve improves access to health care, builds stronger physician-patient relationships, and provides culturally relevant care."[129]

We urge Congress to provide sustainable funding to build a more diverse health care workforce that better reflects the diverse U.S. population, thereby improving access and outcomes for all. ●

J. Prescription Drugs

J1: Increase transparency throughout the pharmaceutical distribution system and supply chain, including transparency by PBMs to employers and by drug manufacturers, to ensure that public and private payers spend resources wisely while maintaining patient access to effective therapies.

The American Benefits Council strongly supports legislation to require greater transparency and accountability across the drug pricing system, including with respect to pharmacy benefit managers (PBMs) and drug manufacturers. Employers appreciate that pharmaceutical drug therapies play a significant role in treating and curing injury, illness and disease. They allow millions of Americans to overcome debilitating conditions, return to work and live longer, healthier, more productive lives. Moreover, money spent wisely on drugs can reduce hospital, physician and other medical expenditures.

Prescription drug costs, nonetheless, continue to represent a considerable portion of a group health plan's overall costs. In an effort to manage drug costs, employers implemented innovative strategies while ensuring employees and families have access to needed drugs and services. Many of these strategies were developed by, or in concert with, PBMs. However, employers remain deeply concerned about prescription drug costs, particularly that of specialty drugs, and the absence of appropriate price — and cost — transparency across the entire drug pricing system, particularly with regard to drug manufacturers and PBMs.

The current rebate structure is complex and opaque for many employers, making it hard for them and plan participants and beneficiaries to understand the true prices and value of drugs. One of our main goals is to support initiatives that increase transparency throughout the pharmaceutical distribution ecosystem to ensure public and private payers spend resources more wisely. This means expanded transparency with respect to rebates, discounts, fees and other payments from manufacturers to PBMs and PBM-contracting entities such as rebate aggregators or group purchasing organizations. Transparency must be meaningful and comprehensive enough to encompass PBM business arrangements as they continue to evolve. Transparency also includes compensation disclosures from service providers. Increased transparency that is actionable, and greater accountability, could help employers and employees make better informed purchasing decisions and lead to higher value pharmacy expenditures.

J2: Preserve the ability of employers to design pharmacy benefits in a way that incentivizes high-value care, ensures safety, controls costs and facilitates coverage of a broad range of prescription drugs, while avoiding cost-shifting to employer-sponsored plans.

Pharmaceutical drug therapies play a significant role in treating and curing injury, illness and disease. They allow millions of Americans to overcome debilitating conditions, return to work and live longer, healthier, more productive lives. Money spent wisely on drugs, moreover, can reduce hospital, physician and other medical expenditures. These benefits, however, often come with significant financial costs to employers as well as workers and their families.

With all of this in mind, employers make extensive efforts to design the health plans they offer to ensure access to high-value medicines, and to manage costs and ensure safety and quality for plan participants. These include: carefully designed pharmacy networks and preferred pharmacy networks, cost-sharing incentives for specific pharmacies and in some cases mail-order pharmacies; plan designs under which the cost of drug manufacturer coupons are not counted toward out-of-pocket maximums in the plan (so called "co-pay accumulators"); medical management techniques (e.g., step therapy, prior authorization) to ensure participants receive the highest-value, safest medicines; and the application of annual dollar limits and/or exclusion from the out-of-pocket maximums under the plan for drugs that are not "essential health benefits" under the Affordable Care Act.

Activity at the federal and state level, and in some cases in the courts, has undermined the ability of employers to implement these plan designs. The Council fully appreciates the importance of access to medicines, the difficulties for consumers when cost is a barrier to vital medicine, and related consumer frustration. But this is precisely why the Council works to defend against proposals that undermine employer plan designs. The ability to develop plan designs along these lines is necessary to preserve the ability of employers to offer robust coverage of an array of drugs, while also ensuring value, safety, quality and affordability.

To support the ability of employers to continue to offer broad prescription drug coverage, efforts to lower prescription drug costs, including in specific markets such as Medicare, must not shift costs to the many millions of employees participating in employer-sponsored plans. The Council supports reforms to lower prescription drug costs and increase value for public and private payers alike, rather than policies that simply shift costs within the drug pricing system.

J3: Remove barriers to employer coverage of high-value, often high-cost, innovative drug therapies and encourage innovation by supporting the ability of employer plans to align drug prices with value.

New, innovative drugs, including cell and gene therapies, have the potential to improve long-term health and extend the lives of patients. Employers recognize the potential value of new therapies to help their employees and family members live longer, healthier lives. As plan sponsors they have a vested interest in ensuring employees have access to these life-saving new therapies as science and technology continue to evolve. In time, such drug therapies may improve health outcomes, increase productivity and reduce health care utilization — and thereby reduce costs. In the meantime, however, the upfront costs of these therapies can be astounding.

Because the Affordable Care Act (ACA) prohibits annual or lifetime benefit limits on essential health benefits, the cost to a health plan for a single drug (assuming it is an essential health benefit) can exceed a million dollars in a year. This is unsustainable long-term.

Employers are increasingly concerned about the cost of existing and future high-cost specialty and non-specialty drugs. Tackling this challenge, while harnessing the value of innovative new therapies, requires stakeholders to come together and explore market-based solutions, public-private partnerships and government action. We encourage stakeholders and policymakers to explore innovative ways to reduce barriers for employers to cover innovative high-cost drugs, including specialty drugs, for their employees and to share in the savings associated with such coverage. As part of these efforts, we encourage stakeholders and policymakers to consider ways to promote competition and remove barriers in the drug supply chain, to help reduce costs and improve health outcomes. It is also important in these efforts, that plans retain the ability to decide the scope and extent of coverage and apply medical management to protect access and support affordability.

Employers are already at the forefront of innovative value-based payment models. Reforms are needed to enable value-based pricing that ensures the price we pay for prescription drugs reflects the benefits they provide and protects meaningful innovation. As employers and policymakers turn to specialty drug coverage, employers can lead the way in pioneering innovative payment models. Government policy should facilitate, not hinder, these efforts.

K. Competition and Consolidation

K1: Ensure that the No Surprises Act (NSA) achieves the twin goals of the statute: to (1) protect consumers from "surprise" medical billing and (2) lower health care costs, by defending against efforts to undermine the NSA, by improving the independent dispute resolution process and by incentivizing providers to join networks, rather than to remain out-of-network.

"Surprise" medical bills are financially and emotionally devastating to participants already dealing with the challenges of a medical emergency or serious health condition. The financial burden imposed by surprise bills was often borne, in part, by plan sponsors who stepped in to provide financial protection for employees and their families. Moreover, the occurrence of surprise billing practices by providers undermined plans' efforts to develop high-quality, cost-effective network designs, as some provider groups and types were incentivized to remain out-of-network. This is why the American Benefits Council expended considerable effort to support a federal solution to the scourge of surprise medical bills. Ultimately this led to the enactment of the NSA, which had the twin goals of eliminating surprise medical bills and reducing overall health care costs to the system caused by surprise billing practices.

Major progress has been made on the first goal, as many millions of surprise bills have been prevented since enactment. But the Council continues to focus on the second goal — the reduction of overall health care costs caused by surprise billing practices. Strong continued efforts are needed by regulators and other stakeholders to ensure the NSA, as implemented, meets this objective.

The Council supports the agencies' attempts to implement the law, through our comment letters and "friend of the court" briefs. But implementation was significantly destabilized by more than 20 lawsuits filed by providers challenging NSA-related rulemaking. Health care providers often prevailed, leaving major parts of the implementation regulations invalidated or on hold while the litigation continues. Despite these headwinds, the Council encourages the federal agencies to continue to defend and develop regulations that will support the NSA's goal of lowering health care costs. It is also essential that the agencies continue to provide guidance to assist plans in complying with a dynamic regulatory landscape due to ongoing litigation and to take that complexity into account in enforcement.

Employers remain concerned about the excessive volume of disputes initiated by providers via the federal independent dispute resolution (IDR) process established per the NSA. The IDR process is intended to ensure out-of-network providers in the covered situations receive adequate remuneration. An IDR process that is unpredictable and lacks reasonable guardrails, however, could lead to abuse and overuse. This means increased administrative and other IDR-related costs for plans and participants and could also undermine the willingness of providers to accept reasonable out-of-network reimbursements or to go or stay in-network and to accept reasonable in-network rates.

It is essential that the agencies proceed with regulations and guidance facilitating a predictable, workable, efficient IDR process. This includes development of a centralized and standardized IDR portal for communication between plans and providers and to train IDR entities to ensure they understand the NSA, its goals and its implementing regulations. In light of reports providers are prevailing in IDR in the vast majority of cases, the agencies must take a close look at how the system is currently operating to ensure it is fair for all parties.

Moreover, the Council supports continued transparency from the agencies related to the implementation of the

NSA, including continued public reports on the IDR process and qualifying payment amount audits. This continued transparency will help support implementation and shine a light on issues that may merit further guidance to ensure the law meets its goals as intended.

In addition, the Council supports efforts to address surprise bills in the context of ground ambulances (as the NSA only addressed air ambulances) but notes policy solutions must be pursued in a way to avoid increased health care costs and substantial burdens. The Council also continues to monitor billing practices more generally to identify additional areas where policymaking might be useful in lowering health care costs.

Lastly, we note that within the time frame of this strategic plan, it may be necessary to enact fundamental changes to the NSA, or at least the IDR process, to meet its objectives. ●

K2: Enforce and enhance antitrust law to prevent consolidation in the health care provider market, which drives up prices without improving quality.

As described under Goal 19, hospital market consolidation is a major driver of health care spending growth and therefore a major concern for employers. Regional hospital monopolies and other forms of health care provider consolidation drive up prices and corrode the competitive market forces needed to align health care costs with value. In concentrated provider markets, prices do not flow from competitive market negotiations but from outsized leverage the market concentration affords, and higher prices are the result. This threatens the ability of employers to offer affordable health coverage. More broadly, hospital consolidation represents a direct threat to functional and efficient health care markets.

As the Council stated in an April 2022 letter to the Federal Trade Commission (FTC) and U.S. Department of Justice (DOJ), "we applaud [efforts]... that seek to tackle hospital consolidation and enhance transparency in the health care market. We also ... urge the administration and Congress to continue to work to restore competition and prevent further consolidation in health care markets in order to lower health care costs for American families."[130]

To address the major issues caused by provider consolidation, the federal government, including the FTC and DOJ, should fully apply federal antitrust laws to horizontal and vertical integration in the health care system that leads to higher health care costs for participants. Also, the FTC should establish stricter review and enforcement of hospital and physician practice consolidation, including mergers and hospital acquisitions of physician practices, upon completion of its study under the Merger Retrospective Program. Based on the results of the study, the FTC should make recommendations to Congress to prevent consolidation and increase market competition. ●

K3: Restrict the use of "all-or-nothing," "anti-steering," "anti-tiering" and "most-favored-nation" contract terms by large hospital systems, which force plans and insurers to contract with all affiliated facilities and providers and prevent employers from steering patients toward lower-cost, higher-quality care.

In concentrated markets, prices do not flow from competitive negotiations, but from the outsized leverage market concentration affords. Large hospital systems attempt to leverage their significant market share by forcing plans to contract with all affiliated facilities and prevent steering patients toward lower-cost, higher-quality care. These anti-competitive terms in the form of "all-or-nothing," "anti-steering," "anti-tiering" and "most-favored-nation" contract provisions foster inflated costs and limit plan sponsors' flexibility in plan design to promote access to high-value care (see Recommendation H2).

Congress should address the anti-competitive contract terms disrupting market dynamics and raising the cost of health care services across the system. Legislation, such as the bipartisan Healthy Competition for Better Care Act (S. 1451/H.R. 3120, 118th Congress) would increase competition and promote lower costs by restricting such contract terms and enabling more employer-sponsored group health plans to enter into agreements with providers that guide enrollees to high-value providers and provide incentives to encourage enrollees to seek higher-quality, lower cost care.

Congress should enact such legislation to lower costs by promoting competition in the health care market and employer innovations that prioritize high-value care. ●

K4: Expand site-neutral payment reform and enact legislation to promote transparent billing practices.

Hospital spending is the largest health spending category in the United States, accounting for almost one-third of all expenditures.[131] This is being fueled by hospital consolidation and vertical integration with physician practices. Such integration can result in patient referrals to higher-priced hospitals within the system and away from lower-priced community providers. Ending Medicare payment policies incentivizing consolidation is a key action Congress can take to increase competition and, thereby, lower health care costs.

A way to rein in consolidation is for Congress and the U.S. Department of Health and Human Services (HHS) to expand implementation of site-neutral payment reform, which aligns payment rates for certain services across the three main sites where patients receive outpatient care. Policies that reduce providers' incentive to consolidate also would deter some hospitals and physicians from merging with or acquiring rival firms.

One such incentive results from differences in payment rates for the same or similar services at different sites of outpatient care - hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs) and freestanding physician offices. Medicare (and private health insurance) generally pays the highest rates for services provided in HOPDs and lowest rates for services performed in freestanding physician offices. For services provided in freestanding clinician offices, Medicare makes a single payment to the practitioner under the physician fee schedule. For services provided in HOPDs or ASCs, Medicare makes two payments: one for the clinician's

professional fee and one for the HOPD or ASC facility fee under the relevant payment system. In 2022, for example, Medicare paid 141% more in an HOPD than in a freestanding office for the first hour of chemotherapy infusion (counting both the professional fee and facility fee).[132]

According to the Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare payment policy, this disparity incentivizes consolidation of physician practices with hospitals—which in turn results in care being provided in settings with the highest payment rates. This increases costs without significant improvements in patient outcomes. MedPAC's recommendations to align payment rates across the different ambulatory settings for a greater number of services would have saved an estimated $6.6 billion to Medicare in 2019 and $1.7 billion reduction in beneficiary cost-sharing.[133] Effects for the commercial market are likely even greater.

Research by University of Minnesota economist Steve Parente estimates expanding site-neutral payment reform could result in nearly $60 billion in savings annually if adopted in the commercial market.[134] The Council urges Congress and HHS to expand site-neutral payment reforms while protecting access to care in underserved rural and urban communities. This would discourage provider consolidation and hospital acquisitions of physician practices.

Congress should advance legislation to:

- Create parity in Medicare payments for hospital outpatient department services furnished off-campus by requiring that drug administration out-patient department services furnished off-campus be subject to the ASC rate rather than the HOPD rate.
- Provide for site-neutral payments under the Medicare program for certain services furnished in ambulatory settings as recommended by the Medicare Payment Advisory Commission.
- Eliminate the "grandfathering" exception from site-neutral payments for HOPDs billing Medicare before 2015 and for cancer hospitals while maintaining the exception for dedicated emergency departments.

Such measures will decrease public and private spending, ensure patients receive the right care in the right setting, lower taxpayer and beneficiary costs and increase patient access.

A related policy to promote transparency in hospital billing practices would also stem hospital acquisition of physician practices that drive higher cost care. After hospitals acquire physician practices, the charges for the services provided by acquired physicians rose by an average of 14.1%.[135] Hospitals apply billing practices portraying services delivered at these sites as "hospital services" as opposed to "professional services" to receive the higher facility reimbursement fee. This billing practice is possible because hospitals are not required to specify where services are provided when they bill.

The Council also strongly supports legislation to promote "transparent billing" (also commonly known as "honest billing") practices by requiring each off-campus outpatient department of a hospital to include a unique identification number on claims for services. This will help payors distinguish among sites of service to apply the appropriate payment amount.

American voters are also paying attention to this surge in "junk fees" associated with provider consolidation. By about two to one (54% to 23%), voters favor the adoption of site-neutral payment policies. They also overwhelmingly said patients should not be charged hospital fees if they receive off-site care, such as at a doctor's office owned by the hospital (76% agree) or for a telemedicine appointment (82% agree).[136]

The provisions included in the bipartisan Lower Costs, More Transparency Act (H.R.5378, 118th Congress) advancing these policies represent positive and important steps toward lowering health care costs. While more still needs to be done, this legislation lays essential groundwork for reaching this goal. ●

L. Mental and Behavioral Health

L1: Ensure that guidance under the Mental Health Parity and Addiction Equity Act (MHPAEA) (1) is clear enough to support compliance, (2) does not undermine the quality or affordability of mental health and substance use disorder benefits and (3) incorporates a fair and reasonable enforcement regime that focuses on access to mental and behavioral health care while minimizing unnecessary burdens.

The American Benefits Council has long advocated on mental health parity, including when legislation was developed. We have been and continue to be strongly supportive of mental health parity. It cannot be overstated how important compliance with MHPAEA is to employers and how many resources — including time, effort and money — Council members and the employer community as a whole invest to comply with MHPAEA.

The lack of clear and meaningful implementing regulations and guidance, however, remains a significant barrier to employer-sponsored plans meeting their compliance obligations, particularly with regard to the "comparative analysis" requirement for non-quantitative treatment limitations (NQTLs) under the Consolidated Appropriations Act of 2021. Employers' concern and confusion was amplified by reports from the tri-agencies (the U.S. departments of Labor, Health and Human Services, and Treasury) that no comparative analysis submitted by any plan has yet to be found compliant.

As a result, the Council has repeatedly requested clear guidance from the regulators. We are hopeful the additional detail on the comparative analysis requirement included in final regulations issued in September 2024 will support compliance. It is also essential the tri-agencies continue to provide further guidance as needed, and any enforcement be applied in a predictable manner, avoiding inconsistent regional variation and excessive burdens. To date, the tri-agencies have not provided examples of compliant or noncompliant generic NQTL comparative analyses, leaving plans and employers unsure of compliance criteria. Stakeholders currently face a frustrating trial-and-error process in achieving NQTL compliance. We continue to advocate for standard examples or a sample NQTL analysis to streamline information collection and ensure consistent enforcement of compliance standards.

It is also important that the tri-agencies continue to routinely release clear and detailed reports on their continuing compliance activities so the stakeholder community can learn from such enforcement. It is essential that efforts be made to mitigate the burdensome nature of the comparative analysis to minimize cost impact on employees and their families. The federal government estimates the cost for self-funded plans receiving a generic non-quantitative treatment limitations (NQTL) comparative analysis, which they then need to customize, is between $50,000 and $150,000.[137] Compliance costs like these take away from employer spending on actual benefits.

As to the substance of the 2024 final rules, as a foundational matter, employers are more than willing to do their part to support the mental health of employees and their families. The Council is aligned with the goal of supporting access to mental health and substance use disorder benefits. That said, Council members are concerned about certain aspects of the final regulations, including the ambiguous "meaningful benefit" coverage requirement, the vague standard for "material difference" in outcomes data and the requirement that fiduciaries make a certification related to the comparative analysis. Council members also expressed concerns about the changing definitions, including new more complicated rules to determine when an item of services is considered medical/surgical or mental health/substance use disorder. We will continue to advocate for guidance, including changes to current guidance, as needed, to address the provisions

noted above and ensure the rules are clear and fair, support access to mental and behavioral health and avoid imposing unnecessary burdens. The tri-agencies must take the newness and complexity of the regulations into account in enforcement in the first several years of application and apply a good faith compliance standard.

Going forward, in policymaking and enforcement, it should be recognized that substantial challenges and barriers remain in accessing care, outside the scope of MHPAEA and outside the control of employers and group health plans — notably the shortage of mental health providers (as explained in Recommendation L2) and the unwillingness of certain providers to join networks (and difficulties with in-network, in-patient care in mental health and substance use disorder facilities). These important policy issues also must be addressed for robust access to mental health and substance use disorder care to be achieved.

It is also key, going forward, that policymakers understand the extent to which employers rely on their service providers, including their third-party administrators and others, with regard to mental health and substance use disorder benefits and networks and compliance with the complicated rules of mental health parity.

More generally, the Council urges policymakers to recognize the best way to support compliance with MHPAEA is through

providing clear guidance and compliance assistance rather than through new or increased penalties or new bases for litigation. Employers do not need the threat of additional penalties or liability to spur compliance with MHPAEA; they are already completely committed. Moreover, consequences already exist for non-compliance that are more than adequate. What is needed instead are clear, workable, reasonable rules and an enforcement regime directing plans and employers to support compliance. ●

L2: Enact sustained funding to expand and provide ongoing training to the mental health workforce, particularly in professional shortage areas and mental health care deserts.

In many ways, employers have been on the front lines of the battle to combat the mental health and substance use disorder crisis. Their commitment to behavioral health care coverage is predicated on the recognition that it is vital to the health, well-being and productivity of their workforce. Employers work hard to reduce the stigma associated with behavioral health, thereby increasing willingness on the part of employees to seek assistance. While this is a very positive and long overdue step, employees remain frustrated by challenges in access to high-quality, affordable care for their employees and families, including the shortage of mental health providers.

As noted in Goal 3, provider workforce challenges are widespread. Public policy can alleviate this shortage by supplying funding for behavioral health educational programs recruiting students for a full range of vocations including psychologists, psychiatrists, therapists, social workers and skilled nurses. Sustained funding to support the mental health workforce, particularly in professional shortage areas, is sorely needed and will bring vital care to mental health care deserts. Funding is also needed specifically to support programs recruiting diverse students into behavioral health professions. It is crucial the mental health workforce reflects the diversity

of those seeking care by identifying candidates from a broad range of socioeconomic, ethnic and experiential backgrounds.

Expanding the mental health workforce can also stem from policies aimed at retraining the existing workforce. Such incentives should feature providing flexibility in licensing and promoting the availability of behavioral health services within primary care practices, expanding the use of digital health and asynchronous care and expanding incentives for students to enter the mental health and substance use disorder workforce. ●

L3: Improve access to mental health care through more flexible state and federal licensing regimes.

Obviously, the supply of psychiatrists, psychologists or therapists must expand to meet growing demand for mental health care. But other kinds of providers can also boost the capacity of, and gateway to, appropriate care, such as nurses, navigators and life coaches. These "subclinical" providers may be able to identify and triage lower-intensity issues before they become more severe.

We recognize that licensure standards provide critical protections for consumers. But inconsistencies from state to state constitute a barrier to access. A more flexible licensing regime will allow subclinical providers to deliver high-quality care (consistent with value-based payment policies) for individuals with routine or non-debilitating mental health issues to free up more highly trained mental health physicians for more severe cases.

Importantly, plans should not be forced to include subclinical providers in their networks at the same reimbursement rates (or at all) or to expand access to out-of-network providers. Instead, the ultimate objective should be to give plans more options and flexibility to serve employees in need.

It is also worth noting that employer efforts to leverage telehealth to promote mental health care access are limited by state variation in regulations surrounding telehealth as well as licensing requirements that stop telehealth services at the state line. Employers and plans often face provider shortages in certain geographic areas that increased use of telehealth may help alleviate. We urge state policymakers to remove state licensing requirements for telehealth services so patients in private plans can turn to telehealth to access the mental health care they need, while ensuring patients continue to receive high-quality care. ●

M. Health Care Workforce

M1: Expand access to telehealth services.

The telehealth revolution, accelerated by the COVID-19 pandemic, has demonstrated its potential to modernize the delivery of health care and now serves as a virtual contributor to the physical and emotional well-being for millions of American workers. As of 2022, 80% of respondents in one survey reported having accessed care via telemedicine at some point in their lives, "becoming the preferred channel for prescription care and minor illness."[138] Among its many benefits, expanding telehealth has become vitally important for improving and maintaining equitable access to care, as many rural and isolated areas lack adequate and accessible primary care, among other types of care.

Employers view telehealth as embedded within the health care delivery system, increasing access where critical shortages exist (such as behavioral health), improving the patient experience and health outcomes, better managing chronic care and making health care more efficient. This is especially so with respect to mental and behavioral health, where mental health conditions represent almost 69% of telehealth claims.[139]

Nevertheless, employers face ongoing barriers in their efforts to more fully leverage telehealth. We commend Congress for temporarily extending a number of times the ability of health savings account (HSA)-eligible high-deductible health plans to cover telehealth services on a pre-deductible basis. However, employers need certainty that the ability to cover telehealth on a pre-deductible basis can be embedded within their plan design. Employers also want to ensure employees can affordably access the care they need through telehealth, whether enrolled in a high-deductible health plan or not. Employer efforts to promote health care access and value through telehealth are limited by state variation in regulation as well as licensing requirements that stop telehealth services at the state line.

To help address the workforce shortage and expand access to care, especially with respect to behavioral health providers, policymakers should:

- Permanently extend the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 provision allowing telehealth to be provided on a pre-deductible basis for individuals enrolled in HSA-eligible high-deductible health plans (HDHPs). Legislation such as the Telehealth Expansion Act (H.R. 1843, 118th Congress; soon to be reintroduced in the 119th Congress) would make the CARES Act provision permanent.
- Remove unnecessary state licensing barriers to telehealth services that ensure patients continue to receive high-quality care.
- Support employers' ability to provide stand-alone telehealth services to employees who are not benefits-eligible. ●

M2: Enact policies to increase the number of primary care providers, improve access to primary care and support integration of other services with primary care.

Primary care plays a critical role in preventing and managing chronic conditions and is the gateway to appropriate, coordinated care. Employers are deeply concerned about the widespread shortage of primary care providers. Almost 76 million Americans currently live in areas suffering from a primary care health professional shortage, and more than 13,000 practitioners are needed to fill this gap.[140]

Policymakers have a role to play in bolstering the primary care workforce. Federal support for medical residency training — graduate medical education (GME) — is the largest source of national funding for the health care workforce. We call on Congress to further strengthen GME programs to meet workforce needs. Specifically, the federal GME programs should be restructured by building a pipeline of primary care physicians and physicians practicing in underserved and rural communities. The reauthorization of the Teaching Health Centers GME program, funded by the U.S. Health Resources

"Should I change our primary-care provider from YouTube to TikTok?"

and Services Administration, presents an important opportunity for Congress to enact policy to bring physicians to medically underserved and rural communities.

Public policy can also increase access to primary care by helping individuals participate in direct primary care (DPC) arrangements, whereby consumers pay providers a fixed monthly fee in exchange for a set number of visits and basic treatments. Under current law, in general, individuals participating in a DPC arrangement are effectively precluded from contributing to an HSA and using it to pay for DPC fees. Legislation such as the Primary Care Enhancement Act (S. 629/H.R. 3029, 118th Congress) would permit individuals with DPC arrangements to contribute to HSAs and use HSA funds to pay for DPC-related fees.

And for those with access to primary care, we can make that care more coordinated. Fragmented behavioral health care and physical health care systems, for example, can result in poorer outcomes and less efficient care. For many patients seeking help for a behavioral health issue, their primary care doctor is frequently their first stop. Integration with primary care can better identify patients in need of behavioral care services, reduce its stigma, more effectively manage care, and more efficiently leverage behavioral health providers' bandwidth. ●

M3: Support the development of new provider directory models, such as a centralized database that facilitates greater accuracy, navigability and usefulness to employees.

Inaccurate information in health plans' provider directories — including when a provider is incorrectly listed as taking new patients, and even current addresses and phone numbers — compounds problems for individuals in accessing care. These inaccuracies are not only frustrating for patients in need of care, but also inadvertently encourage the use of out-of-network providers.

Requiring health care providers and facilities to notify the group health plan or issuer whether they are accepting new patients will help avoid such a result. Platforms that consolidate and reconcile provider data and send it back to plans (and other multi-plan directories) to populate their consumer-facing provider directories could serve as a single source of accurate provider information.[141] Such directories could also be paired with actionable pricing and quality information that could constitute a transformative leap in consumer health care navigation.

Through a single source of provider information, health plans, other purchasers, and providers can come together to make the exchange and maintenance of provider directory information more accurate and efficient, thereby improving patient access to care. ●

N. Consumer-Directed Health

N1: Expand the category of high-value preventive care, including medicines that can be provided on a pre-deductible basis in HSA-eligible HDHPs.

Chronic conditions not only put immense burdens on the individuals who struggle with them, but they also represent an enormous drain on the economy in the form of high health care costs and reduced employee productivity. As noted in Goal 2, chronic disease is itself a chronic problem for the health care system.

Employers recognize the cost and the value of prevention, as well as the value of managing existing chronic conditions to prevent the onset of related comorbidities. Preventive health care initiatives lower health care costs and allow employees to live longer, healthier and more productive lives. However, the ability of employers offering high-deductible health plans (HDHPs) paired with health savings accounts (HSAs) to provide care for chronic conditions has historically been hampered by the rules for HDHPs providing that only "preventive" care can be covered pre-deductible in HDHPs. This has historically not been interpreted to encompass treatment for an existing condition, including chronic conditions.

Modernizing the law and regulations on this issue is an important step in tackling the problem of chronic illness. As a result of advocacy by the American Benefits Council and others, in 2019 the U.S. Treasury Department and Internal Revenue Service (IRS) released guidance providing that certain medical care services received and items purchased, including prescription drugs, for certain chronic conditions should be classified as preventive care for someone with that chronic condition, for purposes of the HDHP rules.[142] The guidance provided an exclusive list of 14 types of treatments for specific chronic conditions considered to be preventive care.

While this guidance was helpful, Treasury and IRS must consider ways to expand the notice, to capture additional preventive treatments for chronic conditions and, more generally, make the guidance more flexible and adaptable so it can capture medical advancements over time, including new treatments for the conditions already listed in the guidance.

In addition, to guarantee this guidance remains in effect, the Council also advocates for codification of the general principles laid out in Notice 2019-45, through the Chronic Disease Management Act (CDMA) (S. 655, 118th Congress). If legislation such as this is were enacted, it would amend the Internal Revenue Code (Code) to reflect that under the HDHP/HSA rules preventive care includes chronic care for low-cost treatments shown to be highly effective at preventing exacerbation of chronic conditions or preventing the development of secondary conditions.

Unfortunately, because cost estimates from the Congressional Budget Office (CBO) are limited to a 10-year period, CBO estimates may not fully, or even partially, reflect the long-term value and savings from current preventive health expenditures, thereby hampering legislative efforts to address chronic conditions. To improve the chances of enactment of the CDMA and other legislation promoting preventive care, the Council supported the Preventive Health Savings Act (S. 118/H.R. 776, 118th Congress). Such legislation would specifically define preventive care and instruct CBO to extend its analysis beyond the existing 10-year budget window to two additional 10-year periods offering a fuller analysis of the potential impact of preventive health legislative proposals.

Enacting these policies would yield enormous benefits to consumers, employers, and payers alike including better health, enhanced workplace productivity, and the avoidance of unnecessary emergency care visits and hospitalizations to the benefit of patients and our health care system overall. ●

N2: Allow HSA-eligible high-deductible health plans to provide more robust medical services at an on-site or near-site clinic on a pre-deductible basis.

On-site and near-site medical clinics are a popular way for employers to offer employees access to the health care they need, especially primary care, by removing one of the major barriers — that is, the need to travel to and from the doctor's office and to take time off work. According to one 2021 study, 31% of all companies with at least 5,000 employees offer a primary care clinic to their employees.[143]

However, employers sponsoring HSA-compatible HDHPs are restricted in the type of services that can be offered for free at on-site or near-site clinics before an individual meets his or her deductible. Under Treasury and IRS guidance, enrollees in HDHPs may only have access to free health care or health care at charges below fair market value from an employer's on-site clinic if it does not provide "significant benefits in the nature of medical care." Examples of insignificant medical care include physicals and immunizations, allergy injections, nonprescription pain relievers and treatment for injuries caused by accidents at work.

Because most on-site and near-site clinics provide services beyond those Treasury and the IRS have described as insignificant, employers generally charge employees who seek to be HSA-eligible the fair market value for items and services provided at on-site and near-site clinics (before the deductible is met). However, this requirement reduces clinic utilization, which undermines the goals of increased access to and use of primary care and reductions to health care spending.

As such, the Council supports legislative efforts to allow on-site and near-site clinics to provide an expanded set of services for free — not subject to a deductible or other charges. ●

N3: Expand access to HSAs by allowing a range of HDHP designs, such as a simplified actuarial value test or split deductibles for medical services and prescription drugs.

As described in Goal 14, the prevalence of employers sponsoring HDHPs coupled with HSAs is growing. Employers who offer an HDHP/HSA do so to make health coverage more affordable, encourage a wiser consumption of health services and allow tax-free spending on a wide range of qualified medical expenses. While HDHPs expose employees to higher out-of-pocket costs, they often have lower premiums, and when coupled with an HSA, provide a highly valued, tax preferred savings vehicle to cover out-of-pocket medical claims costs.

At the same time, some significant restrictions apply to HDHP plan design, as set out in the Code and in guidance by Treasury and IRS, undermining the ability of employers to design certain benefits features in the way they would like. Only preventive care, for example, can be provided pre-deductible. Many Council members would like to provide certain additional services on a pre-deductible basis, such as primary care and mental health care, to incentivize and ensure access to those vital types of services.

To make these programs even more accessible to employers and employees, the Council supports policies expanding options for plan designs to be coupled with HSAs. For example, Congress could pass legislation allowing a health plan to be HSA-compatible if it has no more than a certain actuarial value or "AV" (*i.e.*, in general, the total average costs for services covered by the plan for which it will pay), for example, no more than 80% AV. This more flexible plan design contrasts with current HDHPs, which can only cover preventive care on a first-dollar basis and must have a minimum deductible. Under an AV model, the employer would have more leeway to determine the deductible, cost-sharing, and items covered on a pre-deductible basis (or with little cost-sharing), within the confines of the AV upper limit. This is consistent with the spirit of the current model to continue to encourage employees to be wise consumers of health care. If this policy is pursued, plans will need clear guidance on how to calculate the AV.

Similarly, legislation could authorize innovative plan designs like an HDHP with a "split deductible," creating separate deductibles for medical services and prescription drugs. If applied to 2025 limits, this would allow a plan covering an individual to specify a $0 deductible for all prescription drugs and apply the entire $1,650 minimum deductible for medical services — or any combination best suiting the needs of the plan as long as the minimum deductible totals $1,650 for individual coverage and $3,300 for family coverage. ●

O. Plan Sponsor Flexibility

O1: Enact legislation providing for a portable, tax-preferred investment vehicle that can be used to pay for medical care, even if the account owner is not enrolled in an HDHP.

Health savings accounts (HSAs) are highly valued vehicles that help workers and their families mitigate the impact of high health care costs. Since only those with high-deductible health plans (HDHPs) have access to HSAs, the American Benefits Council also commends efforts to enable more individuals to engage in tax-preferred savings for medical expenses and to allow employers the option to offer these vehicles, if they so choose.

These efforts include the development of legislation establishing Health Out-of-Pocket Expense (HOPE) accounts to provide a portable, tax-preferred savings vehicle for medical expenses to the millions of people not participating in HDHPs. In considering new tax-preferred medical expense savings vehicles, it is important Congress align these initiatives with others to expand and improve HSAs, to protect the vitally important current tax-favored treatment of HSAs and other health savings vehicles, engage with stakeholders for feedback, and continue to address the underlying drivers of rising health care costs. ●

O2: Clarify and confirm the ability of employers to repurpose excess assets in welfare benefit funds, including VEBAs, to pay for other company-sponsored welfare benefits.

Employers commonly set aside assets in welfare benefit funds, such as voluntary employees' beneficiary associations (VEBAs), to provide a reserve for future employee programs, such as post-retirement medical benefits. However, many welfare benefit funds have accumulated surplus assets over time for various reasons, such as health care reform, changes in participant demographics or strong investment performance.

Many employers would like to repurpose such surplus assets to fund other welfare benefits for employees and their beneficiaries, such as active medical plans. Concern exists, however, that in some circumstances, the Internal Revenue Service (IRS) could consider such repurposing an employer "reversion," which would be subject to a 100% excise tax. Neither the U.S. Treasury Department nor the IRS have published guidance on this issue. In the past, the IRS would issue rulings for specific employers confirming the excise tax does not apply. These were extremely helpful to employers and the individuals served by those employer-provided benefits. Unfortunately, the IRS stopped issuing these rulings in 2019 and indicated they would instead issue guidance of general applicability.

Due to the IRS' "no rule" position and delay in guidance, employers face unwarranted uncertainty. It is essential that Treasury and the IRS provide guidance giving employers this certainty to access substantial welfare benefit fund assets to provide benefits to employees and their beneficiaries. It would also be very helpful if the IRS would resume issuing rulings (at least in the absence of clarifying guidance) confirming the excise tax does not apply. ●

O3: Ensure ICHRAs are a viable option for employers and employees.

Current regulations, first effective in 2020, permit employers to provide and fund an individual coverage health reimbursement arrangement (ICHRA) — a type of stand-alone health reimbursement arrangement (HRA) — an employee can use to purchase health insurance coverage on the individual market and pay for other medical expenses.

The regulations establishing ICHRAs impose several very important requirements, such as (1) an employer may not offer both an ICHRA and traditional coverage to the same class of employees, (2) an individual with an ICHRA must be enrolled in individual coverage, and (3) ICHRAs must be offered on the same terms within a class of employees. The Council supports these guardrails as essential safeguards to mitigate against the risk of adverse selection in the individual market, by avoiding the movement of higher-risk, higher-cost employees from employer-sponsored plans to the individual market.

The U.S. departments of Treasury, Labor and Health and Human Services also issued proposed regulations addressing the extent to which an offer of an ICHRA by a large employer can satisfy the employer mandate under the Affordable Care Act (ACA). (Final rules were released in mid-January 2021 but then withdrawn by the Biden administration).

Currently, very few large plan sponsors offer — or are considering offering — ICHRAs. There are several reasons for this: employers are hesitant to make major changes to current health plan offerings because employees are generally satisfied and because of concerns about the cost of coverage, uncertainty and instability in the individual market. There is also potential for employees to be overwhelmed by choosing and maintaining coverage in the individual market.

Although the offering of an ICHRA may not fit the benefit strategies for all employers, establishment of ICHRAs is a longtime part of the Council's health policy agenda., They may be attractive options to those companies and employees seeking a more defined contribution approach to health care coverage. It is possible that, over time, this approach may become more attractive to certain employers, especially if the individual market is perceived as more stable and consistent across the country.

This recommendation includes simplifying the rules regarding how a large employer can offer an ICHRA to full-time employees to satisfy the ACA employer mandate. Other improvements to the general rules for ICHRAs are welcome, while still ensuring the stability of the individual market. In general, the flexibility in the existing regulations should be maintained (*e.g.*, the ability to offer both ICHRAs and group excepted benefits to the same class of employees).

As a general matter, it is essential that additional policymaking related to ICHRAs continue to include adequate protections against adverse selection or risk segmentation, to ensure stable, well-functioning individual and employer-sponsored insurance markets. Otherwise, employers will be unwilling to utilize this expanded option. It is also essential ICHRAs continue to operate as an *additional* tool for employers in designing employer-sponsored benefit plans. In no way should they undermine the ability of employers to continue to offer traditional employer-sponsored plans, which are the backbone of America's system of health coverage. ●

O4: Reject policies that would threaten or undermine a stable and robust individual insurance market, which is essential alongside employer-sponsored insurance.

Employers have a vested interest in a strong, viable individual health insurance marketplace that can serve individuals and families without access to employer-provided insurance. Such a market is especially essential for independent workers and contractors, early retirees and those between jobs who would prefer not to avail themselves of COBRA continuation coverage or those for whom COBRA is unaffordable.

Depending on the extent to which ACA premium subsidies are available, the individual market can also provide highly affordable health coverage options for some individuals. More generally, a strong individual market helps support a healthier population overall, which helps ensure a healthier, more productive workforce and a healthier pool of individuals from which employers can hire. For employers who choose to deploy defined contribution health coverage designs, and for those who do not sponsor subsidized pre-65 retiree medical programs, a functional individual market is especially important.

We urge Congress and the federal agencies to support a stable and robust individual market and avoid policies that will undermine and destabilize the individual market. For example, it is essential that changes to, or expansions of, policies related to defined contribution health coverage be done in a way that does not lead to more adverse risk in the individual market.

P. Paid Leave

P1: Support access to paid leave benefits for all workers by establishing voluntary national paid leave standards that allow employers to provide valuable, user-friendly, uniform and administrable leave to employees irrespective of where the employees live or work. By adopting these standards, employers would be deemed to satisfy all state and local paid leave requirements.

As described in Goal 12, American Benefits Council member companies recognize the importance of paid leave and provide generous benefits to their employees. Employer-based leave programs benefit employees and their employers, as well as governments and taxpayers more broadly.

However, multi-state companies face the significant challenge of navigating a maze of increasingly complex and inconsistent state paid leave mandates undermining their ability to offer valuable benefits to their employees on a consistent basis nationwide. The patchwork of state laws can stifle employer innovation and preclude employers from treating their employees equitably regardless of where they live or work. This is particularly challenging because of how varied these laws and proposals are in terms of their substantive and procedural components — encompassing a panoply of leave types, from parental and disability leave to jury duty, sabbaticals and pet care leave. The increasingly remote and mobile nature of the modern workforce makes this picture even more convoluted.

To reach the goal of expanding access to paid leave, federal legislative solutions must facilitate support and leverage these plans. The mission of expanding access to paid leave in a fiscally responsible and sustainable way cannot be accomplished without supporting employer-provided paid leave programs, which encourage competitive pricing and service innovations providing optionality unavailable through a government-only program.

It is critical for federal legislation and regulations to promote the harmonization of existing and potential forthcoming state

paid leave programs so multi-state employers can treat their employees equitably across the country, recognizing multiple approaches to achieve this objective.

Consistent with the Council's principles on paid leave,[144] we support federal legislation expanding access to paid leave and propose a voluntary federal private plan option for paid family and medical leave (PFML) benefits.[145] Under this proposal, employers who opt to provide paid family and medical leave benefits to their employees nationwide meeting the minimum standards of the voluntary federal private plan option would be deemed in compliance with state requirements. We stress this voluntary federal private plan option must be reasonable, affordable and administrable.

We commend the bipartisan U.S. House of Representatives Paid Family Leave Working Group for including the coordination and harmonization of paid leave benefits across states as a core pillar of its legislative framework. The creation of an "Interstate Paid Leave Action Network (I-PLAN)" to drive improvements in the coordination and harmonization of benefits across the growing number of states with their own paid leave programs could lay helpful and needed groundwork. To "do so in a way that works for states, employers, and employees,"[146] the harmonization must be meaningful, reasonable, long-term, administrable and actionable.

On this path, Congress could take these constructive steps to drive greater harmonization of requirements among the growing number of states with their own paid family and medical leave laws:

- Facilitate communication and coordination among the states and with stakeholders to harmonize varied state PFML conditions and administrative and substantive requirements.
- Focus on identifying key inconsistent qualitative conditions, such as eligibility requirements, qualifying absences, definition of covered family members, coordination of benefits, treatment of remote and hybrid employees, intermittent leave, and confidentiality, and then recommending adjustments that promote harmonization and consistency.
- Study and adopt quantitative equivalency standards on certain key metrics, such as the length of benefits and wage replacement, to enable multi-state companies to design paid leave programs that meet the requirements of each state's private plan option.
- Adopt uniform recordkeeping, reporting and data collection requirements.

These proposals could help lay critical groundwork for enabling employers to provide valuable paid leave benefits to their employees in a uniform, efficient and user-friendly manner nationwide. ●

Q. Litigation Matters

Q1: Enact legislation enforcing federal judicial pleading standards in benefits class action lawsuits.

Over the past decade, plan sponsors increasingly have become the targets of large and expensive class-action litigation. Especially in the retirement plan context, such lawsuits have typically included boilerplate language asserting that the plan fiduciaries have not selected prudent investment options, even though the lawsuits have generally not contained any facts indicating that fiduciaries used an imprudent process to select investments.

The most classic version of this type of litigation is the wave of "excessive 401(k) fee" cases that swept up numerous plan sponsors in the early 2000s. Since then, we have seen similar allegations related to selection of target-date funds and pension risk transfers. This is merely the tip of a dangerous iceberg. We are now seeing a spate of lawsuits related to disposition of forfeitures even where plan documents give employers flexibility on how to use them.

The Employee Retirement Income Security Act of 1974 (ERISA) does not require plan sponsors to always select investments that would be considered prudent *with the benefit of hindsight,* instead simply requiring the process used to select investments be prudent, with the goal of maximizing future performance, without unjustified risk. Because these lawsuits contain no facts indicating a flawed fiduciary process, they generally have not properly alleged ERISA violations. Significantly, these retirement plan lawsuits are often filed solely with the objective of generating material monetary settlements and therefore the key to a "successful" lawsuit is surviving the motion to dismiss for failure to allege an ERISA violation. If the suit is not dismissed, the cost of the next step — discovery — is extremely expensive for defendants, often forcing employers to settle, which provides plaintiffs' lawyers with the money and incentive to file many more suits.

There is also a growth in similar fee-based litigation with respect to employer-sponsored health and welfare plans. This new wave of litigation appears to borrow heavily from the retirement plan litigation "handbook." They seek to bring large dollar fiduciary-based class action claims focused on surviving a motion to dismiss to move to the more expensive discovery phase where plaintiffs can then pursue material financial settlements regardless of the overall merits of the underlying claims.

The courts need to correctly apply very clear pleading standards in ruling on motions to dismiss in both health and retirement plan cases. Existing pleading standards require that a complaint contain facts indicating the fiduciary's process in selecting investments was imprudent. Under these standards, courts need to dismiss complaints that do not contain plausible allegations of an imprudent process in selecting investments.

The American Benefits Council calls upon the federal judiciary to observe and enforce these pleading standards. We also encourage Congress and the executive branch — especially the U.S. Department of Labor (DOL) — to file *amicus* briefs demanding the same.

Q2: Preserve the "abuse of discretion" standard that applies to plan fiduciary interpretations of plan terms and benefit determination decisions.

Under U.S. Supreme Court precedent, if an ERISA-covered plan provides a fiduciary with discretion to interpret the plan terms and make benefits determinations, and those determinations are challenged in court, the fiduciary's decisions are given deference by the reviewing court.

As background on this standard, under the "abuse of discretion" standard, a reviewing court cannot reverse a lower court decision without a definite and firm conviction that the lower court committed a clear error of judgment in the conclusion it reached upon a weighing of relevant factors. In the context of benefits litigation, it is vital courts observe this standard especially for allegations of breach of fiduciary duty, where challenging facts can inappropriately overshadow legitimate standards.

The Employee and Retiree Access to Justice Act,[147] which narrowly passed the U.S. House of Representatives in the 117th Congress but was not taken up by the Senate, would have eliminated the "abuse of discretion" standard that applies to fiduciary benefit determinations, forcing reviewing courts to apply the *de novo* standard of review to all appeals of benefit claims. This effectively means the court is instructed to ignore the plan's entire claims review process and determinations. Such a change would make it much more attractive for plaintiffs' lawyers to sue the plan since they would be able to disregard any determination made by the plan administrator.

That legislation would have also prohibited the provision of discretion to plan fiduciaries, requiring all unclear plan issues to be litigated. Obviously, this result could not have been intended.

The Council will continue to oppose legislative proposals that would eliminate the "abuse of discretion" standard and will, through its *amicus* brief program, urge federal courts to observe it where applicable.

Q3: Ensure plans may continue to use arbitration clauses and class action waivers to manage litigation costs and focus resources on providing benefits to participants.

Excessive ERISA litigation, driven largely by plaintiffs' attorneys seeking quick settlements, often results in enormous costs for plan sponsors and little recovery for participants. Arbitration clauses and class-action waivers are commonly included in benefit plan agreements to protect plans and plan participants from the cost of litigation and the fees paid to plaintiffs' lawyers.

Arbitration creates an environment promoting resolution of disputes without litigation. This is true in the case of both health and retirement plans. Arbitration is an important tool for facilitating the timely receipt of benefits owed to participants, as opposed to class-action lawsuits that can result in decades-long litigation yielding significant plan-wide awards and attorney fees but relatively modest per-participant awards.

The Employee and Retiree Access to Justice Act cited above — included a provision that would deem arbitration clauses, class action waivers and discretionary clauses in employer benefit plans "unenforceable" under ERISA. Considering the weak enforcement of pleading standards fueling a flood of litigation in the retirement plan context, we are very concerned that including such provisions in future legislation would ignore the value of arbitration clauses for participants and plans, and elimination of such clauses would further exacerbate the problem of excessive litigation.

The right of plan sponsors to use arbitration clauses and class-action waivers should be preserved as a means for promoting employee benefit plan offerings.

R. Other Employer-Sponsored Programs

R1: Support the use of employee assistance programs (EAPs) to deliver timely and meaningful benefits to an evolving workforce, as a supplement to comprehensive, high-quality employer-sponsored medical coverage.

In addition to the comprehensive, high-quality and affordable health insurance plans large employers offer to their employees, many employers supplement this coverage with additional programs addressing specific workforce needs. EAPs are an effective and efficient way to deliver these extra benefits including to those employees not enrolled in the health plan. EAPs, which are usually offered free of charge to employees, typically offer a wide range of benefits, including referral services and limited substance use disorder and mental health counseling, financial counseling and legal services, among other benefits. With an EAP, a plan sponsor can greatly expand the network of providers available to its participants.

Following the enactment of the Affordable Care Act (ACA), EAPs were officially designated as "excepted benefits" by the relevant regulatory agencies, meaning this type of health plan is not subject to many of the rules applying to traditional major medical plans, such as the ACA's market reforms and the mental health parity rules. (EAPs are subject to various other requirements, such as the reporting and disclosure requirements under the Employee Retirement Income Security Act of 1974 (ERISA) and the Consolidated Omnibus Budget Reconciliation Act (COBRA).) This designation as an excepted benefit helped EAPs continue to exist post-ACA, because of their limited nature, EAPs would generally not have been able to comply with all of the ACA requirements for traditional group health plans. This guidance solidified EAPs' valuable role in supplementing major medical health coverage.

According to the ACA, to qualify as an excepted benefit, an EAP must meet several requirements, including that it not "provide significant benefits in the nature of medical care," not be coordinated with benefits under any other group health plan, and not impose any premiums or cost-sharing on participants. EAPs played an important role during the COVID-19 pandemic and continue to provide valued benefits to employees post-pandemic as the mental health crisis continues. As explained in the American Benefits Council's *Silver Linings Pandemic Playbook*, many employers expanded and enhanced the EAPs they offered in recent years, providing more robust mental health benefits and adding telehealth and web-based benefits. Employers saw increased utilization of EAPs and positive reactions from employees as well. Employers also commonly use EAPs to improve affordability and access to certain therapies and services (such as critical illness and home health care) not typically provided in traditional major medical plans. EAPs also have the advantage of being available to all of the employers' employees, not just those enrolled in the traditional health plan offered by the organization, and so EAPs give employers the ability to provide benefits to address the needs of the workforce broadly.

In light of the diverse needs of today's workforce and the ongoing mental health needs of employees, it is important employers continue to be able to offer EAPs to address the evolving needs of workers and provide these highly valued benefits alongside major medical coverage. To the extent the agencies feel it is necessary in the future to provide additional guidance on the scope of EAPs as excepted benefits, it is essential they consider the value of these plans to employees and avoid undermining these important programs.

R2: Make permanent and enhance the ability of employers to use educational assistance programs to help employees repay student loan debt.

As of September 2023, 43 million U.S. borrowers collectively owed more than $1.6 trillion in federal student loans. Adding private loans brings the amount above $1.7 trillion, so that total student debt exceeds debt from auto loans and credit cards.[148] Student debt therefore represents a significant barrier to an individual's ability to save, especially for younger workers (for whom every dollar saved takes on added importance, due to compounding) and for racial and ethnic minorities (who are more likely to struggle with debt repayment).[149]

In recent years employers innovated to meet employee demand for student debt assistance. Pursuant to a private letter ruling from the Internal Revenue Service (IRS),[150] some companies now treat student loan repayments as elective contributions to the plan solely for purposes of eligibility for a "matching" contribution.

Separately, under educational assistance programs, employers can provide employees with up to $5,250, tax free, per calendar year, to spend on tuition, fees and similar expenses.

Under a special temporary rule, educational assistance benefits can include principal or interest payments on qualified education loans. However, this option is available only for payments an employer makes pursuant to such a program after March 27, 2020, and before January 1, 2026.

The Council recommends making this special rule permanent, increasing the amount of the allowance to a budgetarily acceptable amount and indexing it to inflation.

R3: Enable employers to offer family-building benefits in an equitable way, including under the tax code, for the full range of family structures that exist, if the employer so chooses.

Family-building benefits have been a focus for employers and employees in recent years. Offering, or expanding, these benefits is part of the conversation in light of an increased focus on health equity, including for women and LGBTQ+ individuals, and the decision of the U.S. Supreme Court in *Dobbs v. Jackson Women's Health Organization*. Family-building benefits encompass an array of offerings, including invitro fertilization (IVF), fertility preservation (*e.g.*, egg freezing), surrogacy, and adoption. While many employers have long made these benefits available in at least some circumstances, recent efforts include expanding eligibility for these benefits to employees without regard to, for example, marital status or existence of a medical infertility diagnosis.[151]

Data shows how important these benefits are to some employees, with a recent survey of LGBTQ+ individuals finding that 83% of respondents would consider leaving their employer for one that offered family building benefits and 76% indicating they are concerned about the cost of family building.[152] As such, in addition to addressing health equity issues, the ability to offer these benefits helps employers with recruitment and retention.

For these reasons, it is important for policymakers to preserve the option for employers to offer these benefits. Policymakers should also address one current barrier to equitable fertility benefits – namely, the tax rules. Currently, fertility benefits

can only be provided on a tax-preferred basis if the employee has a medical diagnosis of infertility (and in some other limited circumstances), whereas many employees without an infertility diagnosis, including some LGBTQ+ individuals, want or need to use fertility benefits to build a family. As a result, some employers offer more limited benefits than they would like. Others offer these benefits more broadly, but they must grapple with the taxation of the benefits, which is a burdensome process and presents a disparity as compared to employees with an infertility diagnosis.

To address these issues, policymakers should pursue the changes needed to allow employers to offer tax-preferred fertility benefits to all employees looking to build a family. In the meantime, it would also be helpful for the U.S. Treasury Department and the IRS to issue guidance of general applicability explaining more clearly the current scope of the rules for when fertility treatments are, and are not, considered medical care.

R4: Protect the ability of employers to offer affordable, high-value ancillary voluntary benefits to employees and their families to supplement comprehensive major medical coverage.

Employers highly value the ability to offer a range of benefits to employees and their families, in addition to comprehensive health coverage, including what are commonly referred to as "voluntary benefits." Voluntary benefits are typically ancillary benefits fully insured by third-party licensed carriers and usually entirely employee-paid, often on a pre-tax basis through a cafeteria plan established by the employer. Employers have long offered voluntary benefits because they enrich the core benefit offerings and support employees' overall well-being.[153] The ability to offer voluntary benefits has also been a tool employers use to attract and retain

employees.[154] These policies work in tandem with and are not a substitute for major medical coverage.

More specifically, employers and employees alike value fixed indemnity insurance. It provides amounts — paid to the employee or their family members — upon hospitalization or other illness, to use for any purpose, in recognition of the fact the employee or their family members are likely to have incurred unreimbursed medical expenses. Given the likelihood of incurring unreimbursed medical expenses, the amounts payable under these types of insurance are often used by employees to pay out-of-pocket health care costs not covered by their major medical health plan (*i.e.*, deductible, copayments or other cost-sharing, which can be particularly helpful for individuals with high deductible health plans (HDHPs)) and to pay for transportation, lodging, childcare and rent. In one 2022 study, 92% of consumers surveyed were satisfied with their fixed indemnity insurance and 97% said service from the fixed indemnity insurer was excellent or good.[155]

The pandemic and high levels of inflation put a spotlight on benefits like fixed indemnity insurance, which can provide extra support and financial protection for employees in a health crisis, especially where prolonged hospitalization is required. This is particularly true for those with lower incomes and the substantial number of Americans with no emergency savings.

It is important that policymakers do not undermine the ability of employers to offer voluntary benefits including fixed indemnity insurance. In 2023, the tri-agencies (the U.S. departments of Labor, Treasury and Health and Human Services) proposed several policies substantially limiting the ability of employers to offer fixed indemnity insurance through changes to the scope of the benefits and the taxation of these policies. The agencies did not finalize the proposed rules, but if they choose to engage in further rulemaking in the future, it is essential the agencies consider the value of these voluntary benefits and work to preserve them including their current tax treatment and scope of benefits.[156]

The Council also fully appreciates the concerns previously raised by the agencies about potentially deceptive or aggressive marketing of fixed indemnity insurance to consumers who are unaware of the limits of the policies they purchase. While these "bad actors" are the exception to the rule, the Council agrees it is of the utmost importance that individuals understand the insurance they are purchasing and its limitations. We support efforts to achieve that goal, both through regulations and enforcement.

S. Miscellaneous Tax Recommendations

S1: Increase the maximum excludable amount for tax-preferred dependent care assistance programs and index it to keep up with inflation.

A 2023 study by the Women's Bureau of the U.S. Department of Labor (DOL), based on the National Database of Childcare Prices, reported that "childcare prices are untenable for families across all care types, age groups, and county population sizes." This analysis of data across 47 states shows childcare prices per child ranged from $4,810 a year for school-age home-based care in small counties to $15,417 for infant center-based care in very large counties. As a share of income in 2018, childcare represented about 8% of family income for school-age home-based care in small counties all the way up to 19.3% of family income for center-based infant care in very large counties.[157]

Similarly, the Economic Policy Institute ranked the top 10 states or state equivalents with the highest childcare expenses for preschool, infant care, and day care, ranging up to $24,243. Childcare costs impose a substantial burden, particularly on low-income working families. Policies that make childcare more affordable for working parents — or that allow parents to enter the labor force — can help alleviate this burden.[158]

The paucity of affordable childcare is an issue stretching far beyond the workplace. Employers are nevertheless frequently called upon by their employees to help them meet this fundamental economic challenge — and by policymakers to demonstrate a commitment to gender equity. To support pay and retirement equity and improve productivity, public policy should help caregivers participate in the workforce if they so choose.

In principle, the American Benefits Council generally supports public and private efforts to increase childcare capacity, which is at the heart of the issue. But in terms of public policy in the employee benefits realm, a good first step — and the simplest available measure — would be updating the current employee contribution limit to pre-tax dependent care assistance programs.

Inflation has sent prices soaring since the COVID-19 pandemic — with consumer prices rising nearly 21% since February 2020.[159] The current $5,000 annual limit, established in 1986, would be more than $14,000 today if it had been indexed to inflation.[160]

The current annual limit is wildly inadequate for addressing childcare expenses. We recommend raising the limit to an amount better reflecting the current cost of childcare and indexing it to inflation going forward. Relatedly, additional changes to dependent care assistance programs may be warranted as well, including revisions to the nondiscrimination rules to allow employees to take advantage of increased limits. ●

S2: Permit employers to offer a qualified financial well-being plan to employees on a tax-free basis.

As articulated under Goal 13, employees must have some degree of financial literacy. For employers seeking to reward talent — and prepare them for retirement — employee financial literacy is a business imperative.

Employers should be permitted to offer a qualified financial well-being plan to their employees, under which financial well-being benefits provided by the organization (such as financial literacy, insurance and debt education, retirement planning and estate planning) would not be considered income to the employee and would not invoke fiduciary liability for employers. In addition, under such a plan, as in the case of 401(k) contributions by employees, they may elect to reduce their taxable compensation to pay for financial well-being benefits on a pre-tax basis. An employee who makes $50,000, for example, could elect to receive $49,500 in taxable pay and $500 as a nontaxable reimbursement from the employer for a $500 financial literacy course offered by a third party.

A qualified financial well-being plan must be an employer-sponsored plan offered to a group of employees that does not favor the highly compensated, under the same rules followed by qualified retirement plans. In addition, the employer is required to provide annual notices to eligible employees regarding the qualified financial well-being plan and identifying at least one educational financial literacy course reasonably available to employees. The objective would be to ensure that low- and middle-income employees know about reasonably priced ways to enhance their financial literacy.

To enhance such programs even further, small businesses could also be made eligible for a 100% tax credit for the cost of a financial literacy program, up to an annual limit of $1,000 (indexed) per non-highly compensated employee covered by the program.

While such programs would necessarily entail a federal revenue cost, it can and should be considered as an investment in the American workforce that improves retirement outcomes (thereby reducing reliance on public plans) and injects additional investment capital into the financial markets. ●

S3: Expand the ability of employers to offer tax-preferred benefits to address social determinants of health, including nutrition and transportation related benefits.

Social determinants of health (SDOH) are the nonmedical factors that can influence a person's health. From the moment of birth and throughout life, a person's health status can be largely predicted by factors outside the traditional medical care delivery system. These influences most often relate to social, economic, demographic or geographic conditions shaping a person's daily life such as:

- Income
- Education and early childhood development
- Employment status and job security
- Food and nutrition
- Housing
- Community
- The environment and pollutants
- Transportation
- Safety
- Ethnicity, religion, race, gender, sexual orientation
- Political conflict
- Access to affordable and high-quality health care

Social determinants can affect a person's health even more than the health care they receive or their lifestyle choices.[161] For example, a 2023 study found a direct correlation between neighborhood social conditions and high-cost health outcomes and, by extension, SDOH are also high predictors of high-cost health care utilization.[162]

Health disparities or health inequities arise when the differences in health outcomes are unevenly distributed and avoidable among certain groups of people. The World Health Organization points to the U.S. having a greater percentage of citizens negatively affected by these disparities than do peer countries.[163] SDOH also have important implications for retirement saving, especially with health care as a leading expense for most retired Americans.[164]

The Department of Health and Human Services (HHS) is taking a multifaceted approach to address SDOH across multiple federal programs through "timely and accessible data, integration of public health, health care, and social services, and whole-of-government collaborations, in order to advance health equity, improve health outcomes, and improve wellbeing over the life course."[165] Additional agency activity and public policy — in some cases well outside the health and employee benefit realm — will almost certainly help to address the increasing cost of medical care in the U.S. Policymakers should consider how to support these goals, particularly by expanding the ability of employers to provide benefits related to SDOH in a tax preferred manner. ●

T. Regulating the Regulators

T1: Establish clear, consistent and transparent processes for agency investigations, including reasonable time frames for plan audits.

Enforcement of the law is a fundamental role and responsibility of the executive branch. And audits by agencies can be a valuable tool in the enforcement toolbelt. But for audits to be effective and fair, they must also be efficient, consistent and transparent. Over the years, the lack of those elements has caused confusion and concern for employers.

In Recommendation C1, we alluded to intense audit activity by the U.S. Department of Labor (DOL). Some of these audits lasted up to seven years or more. In a September 9, 2023, letter to Acting Secretary of Labor Julie Su from the U.S. House of Representatives Education and the Workforce Chair Virginia Foxx (R-NC) and Subcommittee on Health, Employment, Labor and Pensions Chair Bob Good (R-VA), the lawmakers cited "disturbing reports from stakeholders" that the DOL Employee Benefits Security Administration (EBSA) "is failing to conduct its enforcement in a timely manner, creating unacceptable burdens for retirement plan sponsors and negatively impacting retirement savers, retirees, and their families. … In May 2021, GAO found that 17 percent of all investigations opened in 2017 were still open four years later."[166]

Elsewhere, the DOL is auditing companies and collecting plan participant information — including unredacted Social Security numbers and banking information — to determine whether cybersecurity breaches occurred. This collection raises broader concerns about DOL's gathering and use of personally identifiable information.

In the health care context, we know that some audits related to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), among other health plan issues, are highly burdensome, difficult to prepare for and respond to, have unpredictable regional variation and include confusing, inconsistent questions.

Fundamentally, it is imperative the regulated community understand their compliance obligations and the standards upon which they will be evaluated. This can only be accomplished through the issuance of clear and timely administrative guidance and the disclosure and consistent application of enumerated standards. Anything less can have a chilling effect on the sponsorship and maintenance of employer plans.

Recognizing that regulatory agencies must use audits to fulfill their obligations, we strongly encourage the establishment of clear, consistent and transparent processes for these investigations. Such processes should include standards for the amount and nature of information sought by auditors, clear criteria for opening and closing investigations and reasonable time frames for active investigations. A standardized, prescriptive "checklist" would help employers prepare and collect relevant information for the auditors, reducing the duration and complexity of the process.

These processes will not only save plan sponsors (and plan participants) time and money, they will also lend additional credibility to the audits and auditors themselves.

T2: Adopt a "least burdensome compliance" standard, under which federal agencies would be required to verify that prescribed rules minimize costs and burdens for the regulated community.

Plan sponsors value and appreciate the important role of regulatory guidance and the safeguards it provides to protect these valuable workforce programs. In some cases, however, increased regulatory requirements impose significant burdens on plan sponsors that can undermine the shared goal of providing the American workforce valuable benefit programs strengthening workers' health and financial well-being. These burdens not only draw resources away from the benefit plans themselves, but also result in the unintended consequence of discouraging continued plan sponsorship.

For example, the DOL's enhanced enforcement with respect to missing retirement plan participants has a laudable goal. But some of the recommended actions prescribed by the agency — such as those listed in DOL's 2021 "best practices" guidance — frequently cost plan sponsors more than the amount of the orphaned benefit.

Likewise, the objectives serviced by some plan sponsor reporting and disclosure mandates — to participants and government entities, some of which are duplicative — could often be more easily and efficiently advanced. This could be through streamlined requirements leveraging information technology and more coordinated communications, knowledge management, and information sharing between and within agencies.

The American Benefits Council believes lawmakers — and employee benefit plan participants — would be better served approaching rulemaking from a starting position of trust, rather than suspicion, and cooperation rather than enforcement. A "least burdensome compliance" standard would embed this mutually beneficial philosophy in the compliance process and result in better outcomes for plan participants.

In practice, this means regulators should ensure guidance — formal or informal — meets the objectives originally created by statute and is not unreasonably burdensome, duplicative or in conflict with other rules.

T3: Adopt a regulatory standard that permits employers to meet notice and reporting requirements in the most efficient manner as long as the intended objective is met.

If the ultimate shared goal is a benefits system that maximizes benefits for the most people, regulatory and compliance directives should focus on desired outcomes rather than desired actions. Consistent with the "least burdensome compliance" standard in the previous recommendation, regulations and other guidance issued by the executive branch should provide employers the stated objectives and helpful guidelines, rather than highly prescriptive mandates.

Employers and their workforces vary considerably in terms of resources, structure, culture, goals, operations and process, among other things. Allowing employers to comply with agency guidance by designing and following approaches best suited for their organization and workforce's needs will lead to more effective and successful compliance. When given this flexibility, plan sponsors have been the sources of significant innovation positively impacting the entire employee benefit ecosystem.

Regulations that force plan sponsors to follow rigid compliance regimes hamstring organizations from meeting the goals of the rules most effectively. Such regimes not only function as an obstacle to innovation but also frustrate plan participants and others, who desire benefits that address their most pressing needs in a relevant and easily administered way.

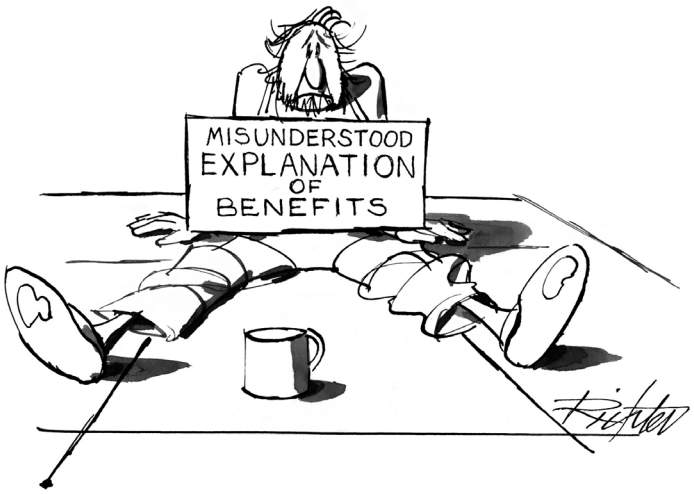
An example worth emulating is the standards of the Health Insurance Portability and Accountability Act (HIPAA) Security Rule.[167] The standards were designed to be "technology neutral" and give entities covered by the law the flexibility to use the latest and most appropriate technologies available to meet their legal obligations. This approach has been effective, not only in achieving the underlying policy goals, but also in fostering a stronger partnership and collaboration between the U.S. Department of Health and Human Services (HHS), the Office of Civil Rights (tasked with HIPAA's civil enforcement) and regulated covered entities.

This approach would effectively be "future proof" in that it is inherently adaptive to technological advancements — as opposed to piecemeal safe harbor approaches that are sometimes obsolete by the time they are issued.

T4: Simplify employer disclosure and reporting requirements by facilitating electronic disclosure where useful and appropriate, eliminating outdated or confusing disclosures, clarifying reporting standards and giving employers flexibility to design notices to maximize their usefulness.

One of the most critical functions of a benefits plan administrator is the communication of vital plan information to participants. Some plan disclosures are mandated by law and others are simply best practices to help individuals understand their rights and make wise and timely choices. In all cases, transparency is the ideal.

Unfortunately, the volume and redundancy of required benefit plan disclosures adversely affect transparency for participants to the point where excessive amounts of information means they tend to read none of it. Furthermore, a surfeit of paper notices can be expensive, with costs passed along to plan participants.



Disclosure therefore should follow five basic principles of transparency:

- Communications should be readily accessible.
- Communications should be written in a manner free of jargon and understandable to the broadest set of recipients.
- Communications should be concise and limited to the most essential information, since recipients will be desensitized by excessive volume or frequency of disclosures.
- Communications should be coordinated to prevent conflicts and confusion by recipients.
- The content of communications should be consistent, based on clear rules and optional model notices provided by regulators.

If a plan sponsor's benefit plan disclosures meet these criteria, the plan sponsor should be permitted to design and provide such disclosures in a way to maximize their usefulness.

All retirement plan notices provided at enrollment and annually, for example, could be combined into a single "Quick Start" notice. This would require harmonization and streamlining of timing requirements. Certain duplicative and irrelevant notices, such as the summary annual report, the deferred vested pension statement and the notice of determination letter application, should be eliminated.

For the sake of both cost and accessibility, it is equally important for policymakers to expand electronic delivery of notices. Electronic delivery empowers plan participants with constant and real-time access to information about their benefits and other online tools assisting with health claims and retirement planning. Plan participants could more easily access and retain copies of benefit statements, search for relevant information, and link to pertinent information and options, such as increasing their retirement contributions. In addition, electronic engagement enables plan sponsors to improve communications with plan participants by linking to health and financial wellness opportunities and educational materials.

With respect to health and welfare plan-related notices, we note the DOL issued a voluntary e-delivery safe harbor in 2020 with respect to qualified retirement plans allowing employers to utilize a continuous access website to distribute Employee Retirement Income Security Act of 1974 (ERISA)-required notices to participants and beneficiaries. The safe harbor provides protections for participants who seek to receive paper communications, including by allowing participants to opt-out of e-delivery and/or obtain paper copies of the electronic communication. The American Benefits Council supports expanding this safe harbor to health and welfare plans for use by employers in distributing required health and welfare plan communications to participants, including (among others) the summary plan description (SPD), the summary of benefits and coverage (SBC), summary of material modifications (SMM) and explanations of benefits (EOB). Such a safe harbor would reduce administrative costs and burdens on plans and plan service providers, reduce paper waste and acknowledge the evolution of technology and communications used by most Americans today. ●

T5: Improve agency implementation of rules by enhancing coordination among and within agencies.

Employee benefit plans are complex enterprises governed by numerous statutes, regulations and executive branch agencies. For plans to operate effectively and efficiently, rules must be consistent. This can only be achieved by regulators working cooperatively.

Numerous examples of effective coordination serve as models for future policy. Most prominently, the tri-agencies (the U.S. departments of Labor, Treasury and Health and Human Services) work very well together to implement many key health plan provisions, including those under the Affordable Care Act, the No Surprises Act and several laws passed in response to the COVID-19 pandemic.

Nevertheless, examples also illustrate where conflicts disrupted employer-sponsored benefits. On the long-gestating and widely controversial "fiduciary definition" project governing the treatment of retirement plan investment advice, the DOL and the Securities and Exchange Commission (SEC) have operated on parallel tracks when coordination may have been advisable.

In one instance recounted by a Council member, the DOL Wage and Hour Division, which requires certain benefit levels be offered under prevailing wage laws, was found to be unaware of whether health savings accounts (HSAs) could meet their bona fide fringe benefit requirements, creating confusion with existing guidance from EBSA.

The executive branch should strive for further improvement by communicating their needs to Congress at the legislative drafting stage and by establishing processes and routines

bringing agency expertise together for coordinated rulemaking. Should another wide-ranging disaster strike — like the COVID-19 pandemic, which required extensive coordination and collaboration at all levels of government — it will be especially important that agencies have practice working together. ●

T6: Modernize federal data analysis related to employee benefits to ensure that the metrics used to make policy decisions are accurate, more meaningful and responsibly used.

Many of the metrics used by the federal government and others are outdated and therefore distort the true condition of the employee benefit system — most notably the prevailing statistics related to 401(k) participation and account balances. Policymakers should re-evaluate their data collection procedures to account for changes in practice over the past several decades, so policymakers are making better-informed decisions.

One stark example is the DOL Bureau of Labor Statistics Current Population Survey. This survey tool, which purports to reveal workers' aggregate participation in retirement plans, uses outdated language such as "do you participate in a pension plan" in reference to a retirement plan, inadvertently excluding defined contribution plan participants.

As the Social Security Administration conceded in a 2015 report, "the self-reported rates of offer, participation, and take up identified by workers are prone to reporting error either because of misunderstanding of survey questions or reporting procedures," and "the proportion of private-sector workers with pension offers and participation is higher than previous research has found, suggesting that future retirees may have wider access to retirement funds because of higher participation."[168] The BLS methodology persists nevertheless, and policymakers continue to use the tainted data to draw mistaken conclusions about the 401(k) system.

Another example is the frequent use of average 401(k) balances to assess the success of the employer-sponsored system. Such measurements are misleading because the addition of new plans or employees beginning to save at younger ages drives this number further and further down. Generally accepted measures of the health of the 401(k) system should analyze balances at (or near) retirement age, or with a certain number of years of tenure.

Here is another example: The bona fide fringe benefit requirements for employers subject to the Service Contract Act (SCA) and Davis Bacon Act (DBA) (regulated by the DOL Wage and Hour Division) are painfully outdated and have not historically kept up with guidance provided by EBSA. Given these are branches of the *same agency*, it would be much more efficient if SCA and DBA (and the mini-DBAs adopted by states/localities) simply cross reference to EBSA guidance to define what benefits qualify as bona fide fringe benefits under SCA and DBA. This same internal inconsistency should relate to benefits offered through both insured and self-funded group health plans (which are currently treated differently by Wage and Hour). ●

U. Public Plans

U1: Preserve the core federal and state social safety net programs — Social Security, Medicare and Medicaid — to ensure that all Americans have adequate health and financial security.

The employer-sponsored benefits system, as powerful and efficient as it may be, is only one leg of the proverbial "three-legged stool" that provides Americans with health and financial security. The other two legs must be preserved and improved.

Congress has the direct power to enhance one of those legs: government programs like Social Security, Medicare and Medicaid — the so-called "social safety net." Since these programs were ushered into existence in the mid-20th century, they have been indispensable in keeping millions of Americans out of poverty. Unfortunately, as described in Goal 15, these programs (especially Social Security and Medicare) are in dire financial condition.

Often cited as the "third rail" of American politics, reform of the nation's entitlement programs will be perilous, requiring difficult and unpopular choices. The American Benefits Council is resolved to evaluate any policy options for Social Security and Medicare to ensure they do not adversely affect the employer-sponsored system. In the meantime, we urge policymakers to find a bipartisan path forward to address this looming crisis. ●

U2: Clarify that employers with fewer than 20 employees may allow their employer-sponsored health plan to be primary with Medicare providing secondary coverage for Medicare-eligible employees.

Current law states an employer with fewer than 20 employees may take into account an employee's Medicare eligibility when providing health benefits. Exactly the opposite is the case for employers with 20 or more employees. Additionally, the statutory language permitting a small group health plan to be primary is a model of complexity. The result may be confusion among some employers who are rightly concerned about not violating the general Medicare Secondary Payer rule. Consequently, Medicare-eligible employees may have to immediately begin paying Medicare Part B premiums, whereas if they worked for a larger employer, they could defer paying Medicare Part B premiums until they retired.

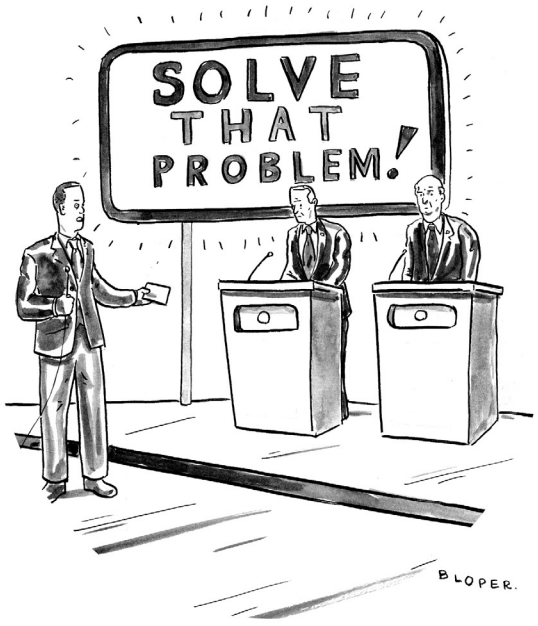
CMS should clarify that employers with fewer than 20 employees may — but are not required — elect to have their employer-sponsored plan continue as primary coverage. Any decision by such employers to pay primary to Medicare would represent a financial savings to the Medicare program. ●

U3: Reform the public health system to prepare for future pandemics.

The COVID-19 pandemic took a severe toll on families, businesses and national economies. Amid the chaos, the nation's employers were called upon to help employees and their families navigate a physical, mental and economic health crisis unprecedented in scope. Employers also served as an essential part of the fabric of the nation's public health network, particularly in light of the evident gaps and shortcomings of that network.

During the most fragile period of the crisis, employers were asked to take a leading role in testing and surveillance. To relieve pressure on overburdened hospitals and to promote social distancing, companies worked to expand telehealth coverage, primary care and worksite clinic options. And when vaccines were developed (at unprecedented speed), employer plan sponsors partnered with the federal government on education and distribution efforts.

At a time when companies across the globe were struggling to meet their bottom line, employers played a heroic part in the nation's resilience. It is unlikely the COVID-19 pandemic will be the last global pandemic we will face. It is therefore essential the gaps and shortcomings in the nation's public health system be filled so we can be better prepared for the next pandemic that is sure to come.



"The clock is ticking—will you solve the problem or pass it on to future generations, Congressman?"

Policymakers should address the shortcomings in our nation's public health and emergency response system. In part, that means recognizing the critical role played by employers and employer-sponsored health plans in filling often significant gaps in the nation's public health infrastructure and integrating employers in public health strategy and implementation. Employers must also have the flexibility to respond in the ways best for their particular workforce.

Specifically, this includes initiatives to:

- Strengthen federal and state preparedness and response capacity.
- Accelerate research and countermeasure discovery.
- Modernize and strengthen the supply chain for vital medical products, including personal protective equipment.
- Enhance development and combat shortages of medical products, including at-home tests.
- Prohibit excessive pricing practices for tests, vaccines and treatments as they shift from government-provided to privately funded programs.
- Improve testing infrastructure.
- Establish principles for clear and consistent public health messaging.
- Develop bipartisan funding mechanisms for all of the above.

Measures should also incorporate recommendations featured elsewhere in this strategic plan, such as the expansion of telehealth, improved access to mental and behavioral health care and uniform and consistent access to paid leave.

As sponsors of health care coverage for more than 178 million Americans, employers serve as one of the nation's first lines of defense against public health crises and other disasters. Public policy should give employers the tools to fulfill that role safely and consistently. ●

V. Technology and Innovation

Technology has become an integral part of American life. Insofar as technology is able to improve speed and efficiency, businesses use technology for a multitude of purposes, including the management and administration of employee benefit plans.

In this context, "technology" can be (but is not limited to) familiar tools like email, mobile apps and the Internet, as well as advanced technologies such as artificial intelligence (AI), generative AI, automation, robotics and virtual and augmented reality. Each of these, if sufficiently tested and found to be secure and free from bias, can increase value for employers and employees.

The use cases are many. Employers can and do deploy technology to analyze and learn more about the benefits needs and experiences of their workforce. They can then use that knowledge to deliver a better employee experience through improved plan design and responsiveness. Likewise, employees have assumed increasing responsibility for their financial, physical and mental well-being and therefore are in constant need of education and tools to help them make decisions.

V1: Support public policy that appropriately allows emerging or evolving technologies to transform and improve health and financial well-being.

Technology holds enormous power to (1) enhance the delivery and efficiency of high-value health care and improve quality outcomes, and (2) advance financial security through more sophisticated and responsive investment tools. As always, policymakers are charged with striking the proper balance between risks and rewards.

We strongly support proposals authorizing the judicious use of technology to benefit plan participants and oppose those unnecessarily restricting its use. One illustrative example of the latter is the Securities and Exchange Commission's (SEC) past proposal related to "predictive data analytics." A 2023 proposed rule[169] would have imposed broad and potentially burdensome conflict-of-interest requirements on broker-dealers and investment advisers who use even simple technologies to communicate with clients and fund investors or manage clients' assets.[170] Fortunately, the SEC decided to repropose this rule. But future, similar threats remain likely.

The American Benefits Council supports the regulation of new technologies that could be harmful to investors. We must, however, guard against casting the regulatory net so wide to effectively preclude — or unnecessarily increase the cost of — all technologies used in connection with investment issues. This would include basic technologies enabling retirement participants to determine (1) how much in total they need to save by retirement age, or (2) how much money they can afford to spend annually during retirement.

In the realm of health care, the topic of telehealth is often cited as having far-reaching potential for improving access to care, especially for those in rural areas or other health care "deserts." Elsewhere in this report, we offer targeted recommendations for improving telehealth specifically. This represents an object lesson in embracing the potential of technology rather than impeding it.

The medical and pharmaceutical fields are ripe for technological innovation, from gene therapy to vaccine development to nano-surgery. Employers have a vested interest in ensuring employees have access to life-saving new therapies as science and technology continue to evolve. Over time, this will improve health outcomes, increase productivity and reduce health care utilization — and lower cost. The up-front costs of these innovations, however, can be daunting to employers. Tackling this challenge faced by employers

while harnessing the value of technology and innovation calls upon policymakers and stakeholders to come together and explore market-based solutions, public-private partnerships and government action to recognize the promise, value and cost of these advancements.

V2: Public policy should not impede employers' use of secure and unbiased emerging technologies to fulfill their plan sponsor obligations and for the benefit of plan participants.

Because technology advances faster than the legislative or regulatory processes, the timeline for this strategic plan may exceed our ability to foresee new technologies — or their applications — in the near future. In the same way, even relatively permissive policies are destined to be obsolete before they can be applied.

In 2014, as part of its previous public policy strategic plan, the Council recommended Congress adopt a "presumption of good faith" standard allowing employers to leverage evolving technology as it becomes available, rather than waiting for regulatory approval. We continue to believe this is a worthy principle.

V3: Ensure public policy aimed at strengthening data privacy and security is undertaken in a way that (1) is not duplicative of or inconsistent with existing legal protections, (2) is targeted at "bad actors," (3) does not impose unnecessary burdens or liability on regulated entities, and (4) is sufficiently flexible to evolve with emerging technology.

Cybersecurity and data privacy are extremely high priorities for everyone. The Council is eager to work collaboratively with public and private entities on policies to ensure plan participants' health and financial data are protected.

Protection of health plan data in a world of evolving technology is a significant challenge, and correspondingly a focus for employer plan sponsors and policymakers alike. The rise of technology in health care, including virtual care, rightfully lauded elsewhere in this strategic plan, means more health information is potentially vulnerable. This puts increased importance on privacy and security controls.

At the same time, as noted previously, it is essential that, as policymakers formulate additional actions, they consider the complex and robust regime under the Health Insurance Portability and Accountability Act (HIPAA) already in place to secure health information held by health plans and their service providers. HIPAA's Security Standards provide an exceptionally strong foundation for cybersecurity, and group health plans spent significant resources to understand and comply with these rules. Any new laws or guidance must avoid being duplicative, inconsistent, or confusing regarding application to group health plans and others subject to HIPAA.

Moreover, in the retirement policy arena, we are alarmed by the U.S. Department of Labor's (DOL) recent attempts to use subpoena power over a service provider to obtain, without consent, plan participants' confidential information and personally identifiable information. The information sought included names, home addresses, phone numbers, email addresses, social security numbers, banking information, asset information, investment information, beneficiary information, and contribution levels. The collection of large

amounts of unredacted plan information creates substantial participant data security risk.

We urge the DOL to adopt five basic principles into its own information security policies and procedures.

1. Recognize security risks and safeguard data. All DOL staff must be held accountable for the protection of the data they hold.
2. Collect only statutorily required data. Consistent with HIPAA's privacy rule, which requires a covered entity to make reasonable efforts to limit use, disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose, the DOL should consider whether it could carry out its mission with less data (*e.g.*, request a sample rather than all available data). In addition to collecting only absolutely necessary data, DOL staff should only request redacted or anonymized participant data and refrain from requesting such data unless a breach is confirmed. Further, they should promptly destroy data and information when no longer needed.
3. Notify the public of all breaches in a timely manner. The DOL should be held to the highest standard possible with respect to reporting breaches to the public. When one has occurred, whether related to a government agency or a private sector company, the public should be notified promptly so markets, firms and individuals can take remedial steps.
4. Establish appropriate access controls for all sensitive information collected by the DOL so it is limited to only those at the DOL assigned to the investigation.
5. Limit liability for plan sponsors where breaches of cybersecurity are the result of a vendor for which the plan sponsor has completed reasonable due diligence and monitoring. Plan sponsors should not be expected to evaluate the strength of the vendor's cybersecurity protocols, as they may not have expertise in this area, and should be able to rely on the vendor's representations.

In addition, we understand policymakers' interest in quickly responding to a high-profile data breach with new policy proposals. But we urge policymakers to take the time necessary to develop policies that are sufficiently nuanced, account for current law and are not overly burdensome. We also affirm that all stakeholders involved with health and retirement plans need to do their part to keep participant data safe. But it should not be the sole focus of policymakers. Instead, policy should target the "bad actors" who actually commit the breaches with effective enforcement — through current mechanisms, if sufficient, or with additional penalties or efforts, if necessary.

As federal lawmakers seek to develop broad legislation on data privacy, in contrast to the current patchwork of state laws, they must preserve the existing federal legal framework with respect to employee benefit plans so as not to disrupt the operations and administration of such plans. ●

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Cost of insurance premiums: 21%
Quality of care: 17%
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About The American Benefits Council

What We Do

The American Benefits Council is a Washington, D.C.-based employee benefits public policy organization advocating for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees and families.

The Council works closely with Congress, the White House, executive branch agencies and the courts to champion legislation, regulation and legal rulings favorable to our members' needs, and to defend the employer-sponsored benefits system from proposals that would add burdens, liabilities and costs.

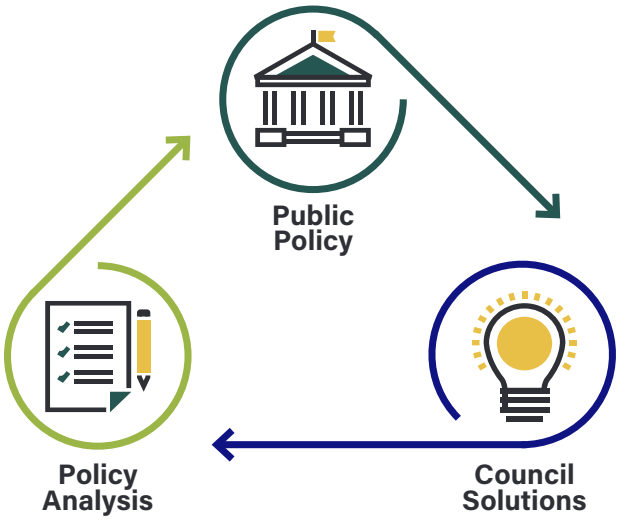
The Council engages extensively in the international arena on behalf of its multi-national companies, offering analysis, advocacy and assistance on a wide range of public policy initiatives through our network of global partner organizations.

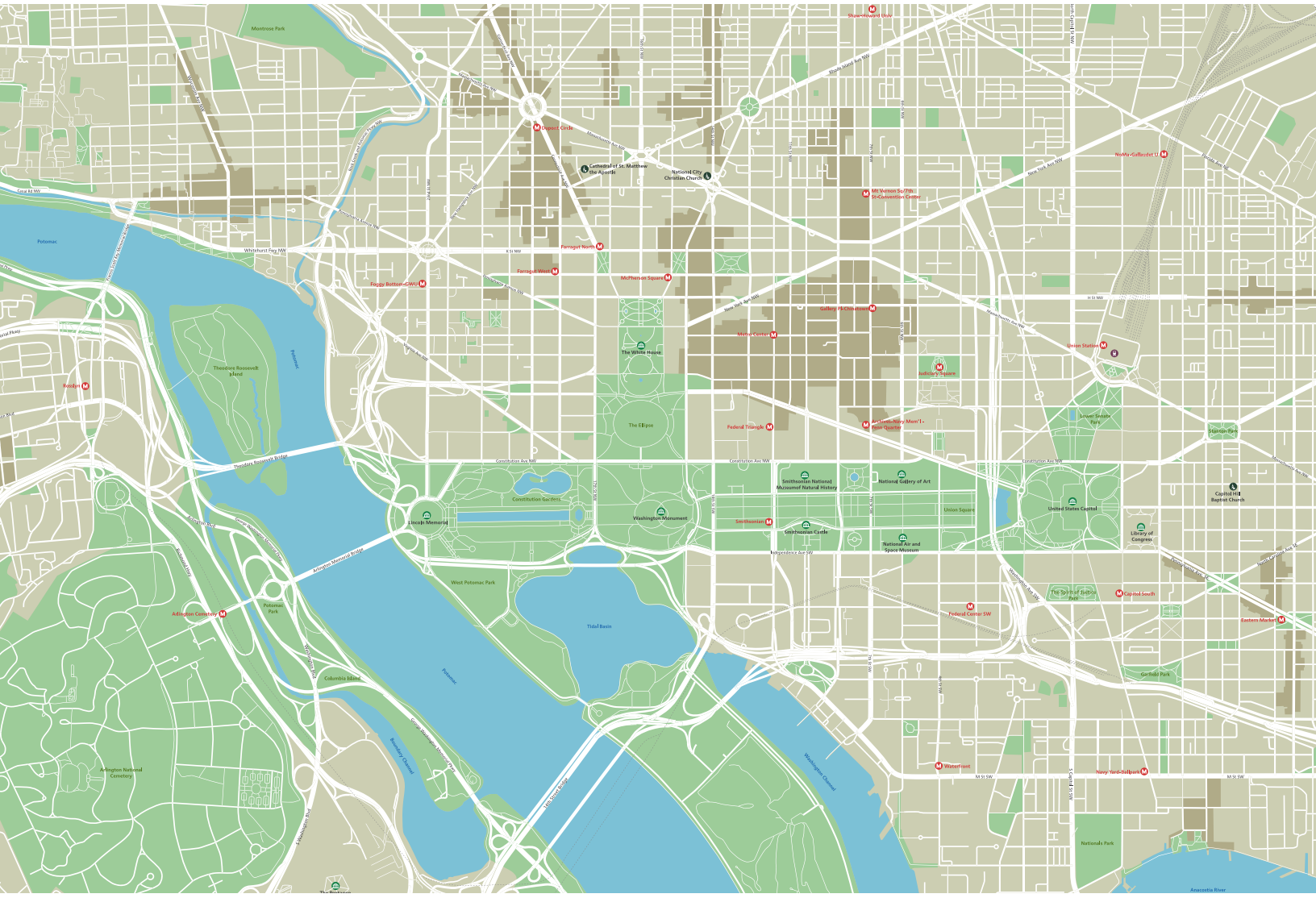
The Council is committed to both broad-based policy advocacy, as well as specialized assistance to member companies. We are a technical resource on benefits issues for lawmakers, the media and other industry trade associations. The Council frequently forges alliances with other public policy organizations to develop and communicate a collective business community position on benefits proposals.

Who We Are

The Council's membership is comprised of more than 430 members, including more than 240 major employer plan sponsors, and also includes organizations providing services to employers of all sizes regarding benefit programs. Collectively, the Council's members directly sponsor or provide services to retirement, health and paid leave plans covering virtually all Americans who receive employer-sponsored benefits.

FIGURE 6 | How Council Advocacy Works





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