AMERICAN BENEFITS COUNCIL

PUBLIC POLICY RECOMMENDATIONS

Stabilizing Employee Benefit Programs Will Help Get America 'Back to Business'

June 2, 2020 (Updated August 4, 2020)

In early March 2020, when the COVID-19 pandemic began to be felt in the United States, the vital importance of employer-sponsored benefit plans became immediately apparent. In two ways, the American Benefits Council has worked with Congress and the executive branch in response to the twin health and economic crises resulting from the pandemic: we have advocated for legislative and regulatory measures to protect employee benefit programs for workers, retirees and families. And we have urged policymakers to make certain targeted changes to benefit plan rules to better enable plans to help workers and employers during this most challenging time.

With great speed Congress and the executive branch have enacted numerous legislative and regulatory changes, many at the strong urging of the Council and our allies. Enactment of the Families First Coronavirus Response Act (H.R. 6201) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act (H.R. 748), along with ongoing executive branch action, constitute a solid foundation for relief and recovery. Yet more must be done to better protect the health and financial security of the tens of millions of people served by the employer-sponsored benefits system. Similarly, some measures have been put into place or proposed that would impede the operation of benefit programs. The Council has been at the forefront of efforts to (1) advocate for additional public policy action to strengthen benefit programs that support participants, and (2) steer lawmakers and regulators away from well-intentioned, but problematic proposals.

Described below are brief descriptions of the Council's outstanding legislative and regulatory priorities relating to health, retirement and paid programs. This is an updated version of our June 2, 2020 document, with updates signified by red text. We urge policymakers to carefully consider and promptly address these matters as they negotiate a compromise between the U.S. House of Representatives-passed Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act (H.R. 6800) and the Health, Economic Assistance, Liability Protection and Schools (HEALS) Act developed by Senate Republicans. The current situation is extremely dynamic and the Council is continually identifying additional policy recommendations.

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HEALTH POLICY RECOMMENDATIONS

GOAL: Support continued employer sponsorship of health coverage and continued coverage for employees facing furlough, a reduction in wages, or job loss.

ISSUE: Employer-provided health plans constitute good, reliable coverage that operates more cost-effectively and are widely preferred by Americans to other types of coverage. During the pandemic, many employers are seeking to continue providing benefits to furloughed employees. Millions of other workers have lost their jobs and face the prospect of paying the full cost of COBRA health coverage. At the same time countless employers are continuing to provide health coverage to their remaining employees despite the company's economic distress. Policymakers should help make it possible to maintain employer health plan sponsorship and keep individuals in employer plans, including the many millions who have lost their jobs.

RECOMMENDATIONS:

- For the duration of the pandemic, provide a subsidy of no less than 90% of premiums for COBRA continuation coverage (and continuation of coverage for health plans not subject to ERISA, such as church plans), allowing those who lose their job to retain employer-sponsored health insurance. Correspondingly, policymakers must approve mechanisms that streamline how individuals elect and enroll in COBRA. The guidance recently issued by the executive branch significantly extending COBRA election and premium payment deadlines does not address the issue of affordability and therefore does not obviate the need for this legislation. In fact, it may increase the need for COBRA subsidies as the guidance will result in individuals facing even more significant, accumulated premium payments. Without financial help, the guidance could inadvertently incentivize individuals to *delay* COBRA election and forgo needed health care. We commend the inclusion of a provision in the HEROES Act– as approved by the U.S. House of Representatives – to cover the cost of COBRA coverage for workers who have recently lost their health insurance due to a job loss or furlough resulting from the COVID-19 crisis.

- Help make it possible for financially distressed employers and multiemployer health funds to continue sponsorship of health coverage for workers still employed and for furloughed employees whose employers are continuing to pay the employees' share of premiums.

- Reduce the risk of future premium spikes by protecting sponsors of self-funded health plans from extremely high claims costs, through development of risk corridors or reinsurance that would apply if costs exceed a certain threshold.

- Allow Health Savings Account (HSA) balances to pay for health insurance premiums during a federally designated public health emergency.

GOAL: Increase access to and affordability of the individual market for health care coverage.

ISSUE: A stable and affordable individual insurance marketplace is an important complement for employer-sponsored health coverage, since it provides a source of coverage for part-time or seasonal workers or others who may not be eligible for an employer-provided plan. These individuals, as well as people who have no connection to the workforce, should be able to find reliable and affordable coverage in a stable individual health insurance market, including the Affordable Care Act (ACA) marketplaces. This priority predates the current pandemic, but is increasingly important in an environment where people are in dire need of medical treatment but have lost job-based coverage.

RECOMMENDATIONS:

- Increase the number of individuals eligible for premium assistance by raising the income limits above 400% of the federal poverty level.
- Permit uninsured individuals to access coverage in the marketplaces through an additional special enrollment period.
- Eliminate the possibility that individuals may need to repay the premium assistance they receive during the year if their household income is ultimately higher than they expected.
- Reduce paperwork and unnecessary requirements for individuals seeking to enroll in the individual market during the pandemic.

GOAL: Provide additional flexibility for employers to offer more robust services at on-site employee clinics

ISSUE: On-site clinics increase access to primary care and management of chronic diseases by enabling employees to access such care at an on-site employee clinic. This also promotes social distancing by allowing employees to access such care in settings other than a hospital, urgent care center or physician's office. Unfortunately, barriers exist to accessing such care at on-site clinics. Specifically, an HSA-eligible high-deductible health plan (HDHP) has limited ability to offer such care at on-site clinics on a pre-deductible basis and the ability to receive services at such an on-site clinic (even if

not part of the HDHP) may otherwise preclude an individual from eligibility to contribute to an HSA.

RECOMMENDATIONS:

- Allow HSA-eligible HDHPs to cover more robust services, including primary care services and management of chronic conditions, at on-site clinics without cost-sharing.

- Allow individuals with access to on-site clinics that provide more robust services (even if not part of the HDHP) to contribute to HSAs. As recommended by the Council, under the HEALS Act, individuals with access to an employer on-site clinic that provides a variety of specified medical items and services (including management of chronic conditions or diseases, preventive care for chronic conditions, and testing, vaccines and treatment for COVID-19) would not be precluded from contributing to an HSA through December 31, 2021.

GOAL: Provide additional flexibility for employers to offer more robust coverage of chronic disease prevention.

ISSUE: Those with chronic underlying conditions are at higher risk for severe illness related to COVID-19 and long-term complications. It is more critical than ever that individuals with chronic conditions have access to care. However, HSA-eligible HDHPs have limited ability to offer services and medications to manage chronic conditions on a pre-deductible basis for the full range of illnesses.

RECOMMENDATION:

- Include the bipartisan Chronic Disease Management Act (S. 3200) in the next legislative vehicle to address the ongoing COVID-19 pandemic to allow HSA-eligible HDHPs to provide access to health care services and medications that manage chronic conditions on a pre-deductible basis.

GOAL: Increase the ability to offer telehealth to employees

ISSUE: Many employers are making efforts to expand telehealth coverage during this crisis to help employees and their families practice social distancing and to protect the public health. The provision allowing HSA-eligible HDHPs to cover telehealth services without cost-sharing under the CARES Act is an important positive step. However, some employers also wish to provide telehealth services to employees who are not benefits eligible or who opted out of the employer's group health plan. A number of

employers have done so on a limited basis consistent with current "excepted benefit" regulations. However, others wish to provide more comprehensive telehealth coverage to these employees. Nevertheless, such robust standalone telehealth programs covering non-benefits eligible individuals could run afoul of the ACA market reforms.

RECOMMENDATIONS:

- Ensure that an employer's offer of telehealth services does not result in a violation of the ACA market reforms to the extent the benefits provided give rise to an "ongoing administrative scheme" (i.e., an ERISA plan) and provide significant benefits in the nature of medical care. Regulatory agencies could accomplish this flexibility by adopting a non-enforcement policy that applies to the current plan year and any plan year that begins before the end of the public health emergency, or by issuing additional "excepted benefit" guidance. As recommended by the Council, the U.S. departments of Labor, Treasury and Health and Human Services issued guidance allowing large employers to offer robust standalone telehealth coverage to non-benefits eligible employees for plan years beginning during the public health emergency. The Senate's HEALS Act proposal codified this guidance and characterized the arrangement as an excepted benefit, which is helpful as it clarifies the application of other group health plan laws to such an arrangement. The HEALS Act provision expires for plan years beginning on or after January 1, 2022, or plan years beginning on or after when the public health emergency ends, whichever is later.

- Make permanent the CARES Act provision allowing HSA-eligible HDHPs to cover telehealth services on a pre-deductible basis.

- Remove state barriers to telehealth care.

GOAL: Ensure that screening and treatment of infectious diseases may be covered by HSA-eligible HDHPs on a pre-deductible basis.

ISSUE: Critical to responding to the pandemic is removing barriers to testing for, and treatment of, COVID-19. Internal Revenue Service (IRS) Notice 2020-15 was a helpful step in clarifying that an HDHP may provide benefits under the plan's deductible for medical care services and supplies to test for and treat COVID-19. The notice applies until such time as further guidance is issued. This guidance should be codified and extended to ensure that going forward HSA-eligible HDHPs can waive the deducible for the testing and treatment of infectious diseases.

RECOMMENDATION:

- Add "screening and treatment of infectious disease" to the definition of preventive care, under the provision in the Internal Revenue Code allowing preventive care to be provided pre-deductible in an HSA-eligible HDHP.

GOAL: Increase flexibility for health and dependent care flexible spending arrangements (FSAs).

ISSUE: Many physicians, dentists and other health professionals have been compelled to stop performing non-emergency and/or elective procedures because health care resources are focused on COVID-19 services and to help avoid interaction with the health system unless necessary. Consequently, many employees' health costs for 2020 will be significantly less than had been expected. Additionally, employees may be looking for other financial means to address various essential personal expenses. Conversely, some employees will have significantly greater medical expenses than had been expected. Employees' health flexible spending arrangement (health FSA) elections for 2020 did not take, and could not have taken, these circumstances into account. At the same time, a great many child care centers, child care providers and camps are no longer providing services and will not be able to do so for the foreseeable future. There is also significant uncertainty with regard to whether child care services will be needed later this year. Thus, employees generally made dependent care FSA elections based on completely different circumstances than the ones that currently exist.

Many employees expect to have substantial amounts remaining in their health and dependent care FSAs at the end of the year because of amounts already contributed or because they are unable to reduce their elections at this time.

We commend the inclusion of provisions in the HEROES Act to provide flexibility for cafeteria plans, health flexible spending arrangements (FSAs), and dependent care FSAs in light of the COVID-19 crisis, and similar flexibility reflected in guidance from the U.S. Treasury Department and IRS in Notice 2020-29. However, that guidance generally applies only through the end of 2020.

RECOMMENDATIONS:

- Allow employers to permit employees to reduce, suspend or increase their health FSA or dependent care FSA contributions at least once not only in the current plan year (as is allowed under Notice 2020-29), but also in each plan year through 2021, at the discretion of the employer, to account for changing and uncertain health and childcare needs.

- To avoid forfeiture of substantial health and dependent care FSA amounts following the end of the current plan year and plan years through 2021, allow employers to permit: (a) additional carryover of funds for health FSAs, (b)

carryover of funds for dependent care FSAs, (c) longer grace periods for health and dependent care FSAs, and (d) a combination of carryover and a grace period for health and dependent care FSAs. As recommended by the Council, the HEALS Act, like the HEROES Act, would allow health FSAs and dependent carryover FSA amounts to carryover from 2020 to 2021.

- Allow employers to permit employees who lost their jobs during the public health emergency to cash-out unused amounts from health and dependent care FSAs.

GOAL: Increase the ability of individuals to participate in direct primary care (DPC) arrangements.

ISSUE: Access to primary care services is essential for individuals, including during this pandemic, to manage chronic conditions and maintain general health. Direct Primary Care (DPC) arrangements, whereby consumers pay providers a fixed monthly fee in exchange for a set number of visits and basic treatments, are a valuable option for many individuals. These arrangements typically enable remote care, including telehealth. However, barriers exist, including that individuals participating in a DPC arrangement appear to be precluded from contributing to an HSA and using it to pay for the DPC arrangement fees.

RECOMMENDATION:

- Permit individuals with DPC arrangements to contribute to HSAs and to use HSAs to pay for DPC-related fees, along the lines of what is provided in the Primary Care Enhancement Act (H.R. 3708) or through the regulatory process (including in response to Executive Order 13877, "Improving Price and Quality Transparency in American Healthcare to Put Patients First"). Treasury and IRS proposed regulations providing that amounts paid for DPC arrangements may be reimbursed from health reimbursement arrangements (HRAs) but that most DPC arrangements preclude an individual from contributing to an HSA. The Council is preparing comments to emphasize the need for Congress to allow individuals with DPC arrangements to contribute to HSAs.

GOAL: Enhance COVID-19 testing and contact tracing capabilities.

ISSUE: Until widespread testing and contact tracing are available, community spread will continue to threaten or slow the nation's transition back to normal. The Families First Act and CARES Act provisions that provide for plans to cover COVID-19 testing and an eventual COVID-19 vaccine without cost-sharing were a step in the right direction. But further action is needed. The widespread testing needed for public health

surveillance purposes and to facilitate returning employees to the workplace safely calls for dedicated federal funding commensurate with the critically of the task.

RECOMMENDATION:

- Support policies that enhance the availability of reliable and prompt testing and contact tracing capabilities. The HEALS Act includes a "Safe and Healthy Workplace" refundable payroll tax credit for employers equal to 50% of an employer's "qualified employee protection expenses," which could include testing for COVID-19, personal protective equipment and cleaning supplies and "qualified workplace reconfiguration expenses" (capped based on the number of employees). This provision is, in part, responsive to the Council's recommendation that Congress provide federal testing assistance for employers, as noted in this document and as further outlined in a July 21 employer group letter to Congress. To support the efforts of employers to return their employees to work safely, additional federal resources for robust testing are needed.

GOAL: Support health care workers on the front lines.

ISSUE: Hospital workers, health care providers and others making sacrifices on the front lines of this crisis should have the resources they need to do their critical work while maximizing their own safety. Additionally, adequate access to primary care services is necessary to mitigate conditions that not only make individuals more vulnerable to COVID-19, but also to identify and address other conditions that will be more serious and expensive to treat if not detected early because primary care services have been delayed.

RECOMMENDATIONS:

- Ensure that hospitals and frontline workers have the supplies and capacity needed to confront the pandemic, including, for frontline workers and their families, access to affordable childcare and health coverage.

- Provide immediate financial relief to primary care providers in need to protect access to primary care**.**

- Remove licensing barriers that preclude many health care providers from applying their skills and training in service to patients in vital need of medical care, in hot-spot areas with the highest needs.

- Support flexibility for the use of telehealth and related technologies, including as described above.

GOAL: Protect patients from "surprise" balance bills.

ISSUE: Surprise medical bills come after a patient receives services at an out-of-network facility in an emergency situation and/or uses an in-network facility but some services provided there are rendered by out-of-network providers. While all efforts should be made to support the health care system and providers who are on the front lines fighting COVID-19, we must also guard against excessive charges to patients and health plans by out-of-network providers. The HEROES Act appropriately includes a provision to prohibit balance billing for COVID-19 testing and treatment by health care providers who receive financial assistance pursuant to other provisions of the legislation. Congress should prohibit surprise bills for patients and require the use of a market-based benchmark price approach to balance billing.

RECOMMENDATIONS:

- Base out-of-network medical provider reimbursements on the local median in-network negotiated rate, as provided in the version of the Lower Health Care Costs Act (S. 1895) approved by the U.S. Senate Health, Education, Labor and Pensions (HELP) Committee.

- Clarify that the CARES Act requirement that plans pay providers the "cash price" or billed charge for COVID-19 testing provided out-of-network applies only to the COVID-19 test and does not apply to other items and services furnished during the related visit. Consistent with the Council's request, the regulatory agencies issued guidance confirming that the requirement under the CARES Act of plans to pay the "cash price" applies to the COVID-19 test, but not any other items and services.

- Group health plans should not be mandated to waive cost-sharing for COVID-19 treatment. Although many employers are choosing to waive cost-sharing for COVID-19 treatment, others have decided not to avoid treating this particular condition differently from many other serious conditions also affecting employees. Any requirements that might be imposed along these lines must be paired with a ban on balance billing by out-of-network providers for such treatment and a cap on reimbursement to out-of-network providers at the Medicare rate or the local median in-network negotiated rate.

PAID LEAVE POLICY RECOMMENDATIONS

GOAL: Help employers offer paid leave on a uniform and consistent basis nationwide.

ISSUE: The development of myriad state and local paid leave laws has been a serious growing problem for employers and employees alike, well before the COVID-19 outbreak. As with all types of employee benefits, Council member companies are at the forefront of comprehensive and innovative programs to provide essential protections to employees and help them balance personal and work responsibilities.

As more states and political subdivisions enact paid leave laws, it has become increasingly difficult for large, multistate employers to consistently offer and administer paid leave. Many state and local mandates use completely different definitions of such things as "family members," "reasons for leave," "eligibility requirements," "funding mechanisms" and other terms. As a result, employers have had to design leave programs to meet numerous administrative and other requirements, rather than to meet employer and employee objectives. This issue is more important than ever, as the pandemic is a national crisis that demands a national response, rather than validating a patchwork of inconsistent and often contradictory state and local requirements.

RECOMMENDATION:

- Any federal action imposing paid sick leave or paid family and medical leave requirements should expressly preempt the panoply of state and municipal laws that create significant administrative burdens for multistate employers. The U.S. Department of Labor issued a request for information on paid leave policies and the impacts on employers and employees. The Council is preparing comments in response, which will reflect this recommendation.

RETIREMENT POLICY RECOMMENDATIONS

GOAL: Support sponsors of traditional defined benefit pension plans.

ISSUE: Defined benefit pensions provide reliable financial security for participants, but the severe decline in asset values and continued low, and even further declining, interest rates as a result of the economic consequences of the pandemic, have dramatically increased plan liabilities. In response to this concern the CARES Act delayed until January 1, 2021, the date by which plan sponsors would need to make 2020 contributions (with interest). The Council has pointed out that this might still require companies to make the contribution by December 31, 2020 (the last business day of the year). The HEALS Act addresses this problem by moving the date to January 4, 2021.

RECOMMENDATIONS:

Enact the proposals included in the HEROES Act which:

- Provides interest rate "smoothing," consistent with prior temporary relief set to phase out starting in 2021, by lowering the 10% interest rate corridor to 5%, effective in 2020.
- Delays the phase-out of the 5% corridor until 2026.
- Establishes a permanent 5% floor for the 25-year interest rate averages.
- Permanently reduces all shortfall amortization bases to zero for all plan years beginning before January 1, 2020.
- Allows all shortfalls to be amortized over 15 years rather than seven years.
- In addition to the provisions in the HEROES Act, "smooth out" plan asset valuations by recognizing unexpected gains and losses in assets over five years as long as the actuarial value of assets remains within 20% of fair market value.

GOAL: Provide relief from exorbitantly high pension insurance premiums.

ISSUE: Single-employer plan Pension Benefit Guaranty Corporation (PBGC) premiums are too high and are requiring employer plan sponsors to spend significant sums that, due to the economic crisis accompanying the pandemic, would be far better directed to funding the pension plan itself or other efforts to enable employers to retain or rehire workers. In 2006, the flat rate premium was $19. Today, it is $83, more than four times the level 14 years ago. This year the cap on the per-participant total premium owed by a

plan will be $644 ($561 for the variable rate premium and $83 for the flat rate premium). And because very different rules govern the determination of a plan's funded status for "funding" versus "PBGC premium" purposes, this full $644 per participant premium may well be owed by plans that are actually *more than* 100% funded for funding purposes.

Under current law, premiums paid to the PBGC cannot be used for any other government purpose. Yet for *budget* purposes, premium increases are often taken into account to offset other expenditures completely unrelated to pensions (e.g. the Highway Trust Fund). This is not appropriate since premiums could never legally be used to actually pay for such other expenditures. Similarly, reductions in PBGC premiums do not reduce the funds actually available to the government to pay for other expenditures. So there is no legitimate basis to treat either premium increases or decreases in this manner.

RECOMMENDATIONS:

- For plan years beginning in 2020 and 2021, reduce the cap on the variable rate premium, to $83 (i.e., the same as the flat rate premium) so that the maximum per-participant premium would be $166).

- Eliminate the effects of all the indexing and adjustments to the rate during the last 13 years, so that the rate is returned to .9%. This is similar conceptually to the provision in the Retirement Security and Savings Act (S. 1431) eliminating indexing after 2018.

- Single-employer plan premium increases and decreases should not be taken into account for budget purposes.

GOAL: Support defined benefit pension plan participants.

ISSUE: Under the "benefit restriction" rules applicable to private sector single-employer defined benefit pensions, if a plan's funded level is below specified levels, it is restricted from paying lump sums and/or accruing additional benefits. Many employers do not want to be compelled to restrict these valuable benefits for plan participants, especially given the current economic situation.

RECOMMENDATION:

- Extend the CARES Act provision by allowing a plan to use its funded status for the last plan year ending before 2020 (or, at the employer's option, the last plan year beginning before 2020) for purposes of applying the benefit restrictions to subsequent plan years beginning no later than July 1, 2021.

GOAL: Help defined contribution retirement plan participants receive loans and coronavirus-related distributions (CRDs) when necessary.

ISSUE: In a pandemic emergency, especially in light of the corresponding economic downturn, plan beneficiaries facing financial distress should be able to access retirement assets to which they are entitled with minimum administrative delay. The CARES Act included substantial relief from rules related to plan loans and hardship withdrawals, while IRS Notice 2020-42 eased spousal consent and notarization requirements as requested in a previous version of this document.

Additionally, under the CARES Act, a "qualified individual" (QI) can take a coronavirus-related distribution (CRD) and/or loan of up to $100,000 or the individual's vested balance in their retirement account. In response to the Council's earlier requests for broader CRD and loan eligibility (for individuals who have been affected in ways other than layoffs or furloughs), the IRS expanded this eligibility in Notice 2020-50.

However, additional measures and clarifications are necessary.

RECOMMENDATION:

- Clarify when a furloughed employee experiences a *bona fide* "leave of absence" and the extent to which an employee who is unable to work without pay because of a shelter in place order is experiencing a *bona fide* leave of absence. This is important to clarify because the pre-pandemic rules governing loans include the ability to suspend loan repayments for participants who are experiencing a *bona fide* leave of absence. Employers and participants may want to avail themselves of the relief provided by this rule given the current economic crisis.

GOAL: Decrease required retirement plan distributions when retirement accounts have suffered significant losses.

ISSUE: Participants are required to take minimum distributions from their retirement accounts starting at age 72. When the assets in the accounts have significantly decreased due to the economic crisis these required distributions can significantly affect the participant's ability to make the account last through their entire retirement. This problem was recognized in the CARES Act with the elimination of the required minimum distribution for 2020 (and certain 2019 required minimum distributions). However, other measures as noted below will enable retirement plan accounts to have more time to recover the losses experienced by the current market downturn.

RECOMMENDATIONS:

- Waive minimum required distributions for 2019 as provided in the HEROES Act.

- Increase the required minimum distribution age from 72 to 75 to enable many individuals who do not *currently* need the income from the plan to preserve it so that the value of their account has more time to recover to provide retirement income when the individuals *will* need it.

GOAL: Implement CARES Act provisions relating to retirement plans

ISSUE: The CARES Act contained a number of provisions that have an impact on retirement programs and plan participants. To implement these provisions of law, additional guidance is needed.

RECOMMENDATIONS:

- A good faith standard should be applied with respect to implementation and administration of the law in recognition that additional guidance will be needed on an expedited basis as new issues are uncovered.

- As recommended by the Council, the HEALS Act includes a number of important retroactive technical corrections to the special coronavirus-related distribution (CRD) options and rollover rules for retirement savings plans and also expands permissible loans from certain retirement plans. These technical corrections should be included in the next pandemic measure.

GOAL: Support increased "catch up" retirement plan contributions.

ISSUE: The downturn in financial markets has severely affected defined contribution retirement plan accounts. Moreover, many individuals are without work and, therefore, are falling behind in their ability to contribute to an employer-sponsored retirement plan. Once these individuals are again able to participate they should be permitted to supplement their existing retirement plan balances with additional contributions. Higher so-called "catch up" contribution limits for older workers who will not have many years to make contributions will help some of them restore retirement savings assets. Unless and until retirement plan assets recover, more older workers will delay retirement. This will create a further barrier to hire and rehire younger workers who are unemployed.

RECOMMENDATION:

- Reduce the age for catch-up contributions to age 45.
- Increase catch-up contribution limit to $10,000 for those over age 60.

GOAL: Help individuals manage student loan debt through employer programs.

ISSUE: Even prior to the pandemic, many employees with student loans were experiencing significant financial challenges and the inability to save for retirement. This is even truer now. Employer programs can help these employees pay down their debt while also saving for retirement. The CARES Act allowed employers to help employees pay back student debt tax-free (up to $5,250 per year) until the end of 2020. This is a positive step, but other strategies are also needed.

RECOMMENDATIONS:

- Extend and make permanent the CARES Act provision that allows employers to help employees pay back student debt.
- Enact the provision from the bipartisan Retirement Parity for Student Loans Act (H.R. 6276/S. 1428), which would permit employer sponsors of 401(k), 403(b), SIMPLE and governmental 457(b) retirement plans to make matching contributions to workers as if their student loan payments were salary reduction contributions.
- The IRS should issue a generally applicable revenue ruling that would clarify for plan sponsors that they are able to make retirement contributions based on an employee's ongoing student loan repayment.

GOAL: Plan sponsors should generally be permitted to self-correct inadvertent plan violations under the IRS' Employee Plans Compliance Resolution System (EPCRS) without a submission to the IRS or a fee payable to the IRS.

ISSUE: With the changes in the rules governing retirement plans in response to the economic crisis created by the pandemic, and the inability of many plan sponsors and service providers to have onsite work during this time, there is a potential for increased inadvertent errors. The process for correcting inadvertent plan violations under the IRS' Employee Plans Compliance Resolution System (EPCRS) is too complicated despite regulatory efforts to simplify it. Many errors can be easily corrected and would, in fact, be able to be corrected more quickly if submission to the IRS and fees could be avoided.

Given the current situation, the easiest way to remedy the problem is to allow expanded self-correction.

RECOMMENDATION:

- All inadvertent plan violations could be self-corrected under EPCRS without a submission or fee to the IRS, provided that this rule would not apply if the IRS discovers the violation on audit and the employer has not at that point taken actions that demonstrate a commitment to correct the violation.

GOAL: Comprehensive guidance on plan fiduciary responsibilities with respect to unresponsive and missing participants is needed.

ISSUE: Due to the increased number of terminations of employment and the insolvency of many employers, guidance related to missing and unresponsive retirement plan participants is more important than ever. The U.S. Department of Labor has conducted a robust audit program but has not provided guidance for ongoing plans dealing with this challenge. Plan fiduciaries and participants need the certainty of clear guidance that includes a safe harbor so they know how to meet compliance standards and so that participants know what to expect.

RECOMMENDATIONS:

- A safe-harbor for plan fiduciaries should be adopted similar to the one provided in the bipartisan Retirement Savings Lost and Found Act (in the115th Congress, S. 2474/H.R. 6540) that outlines the steps an employer must take to satisfy the fiduciary responsibility for searching for missing participants and engaging nonresponsive participants. A plan participant registry should be established that can be searched by plan fiduciaries as well as participants.

- Legislation should also allow ongoing plans, under certain circumstances, to send funds to the PBGC, so that agency can take responsibility for helping missing participants receive the benefits to which they are entitled.

GOAL: Reform the rules regarding inadvertent overpayments to participants so that plan sponsors do not have to seek repayment from participants.

ISSUE: The complexity of administering a retirement plan can sometimes result in a plan incorrectly calculating benefit payments for a participant, especially in a defined benefit plan. Sometimes these errors result in an overpayment to a participant. IRS correction procedures in some cases require plans to seek to recoup from participants a discovered overpayment, sometimes months or even years after the overpayment was

made. This often causes significant distress for participants – many of whom are retirees – who had no idea the plan incorrectly calculated their benefits.

Further complicating matters, in many cases an overpayment was rolled over to an IRA or another plan because the participant incorrectly believed that such amount was eligible for rollover treatment. Additionally, the process for recoupment can be so cumbersome and costly to plan sponsors, that it would be preferable to permit the participant to retain the overpayment. The current economic environment is putting significant pressure on many individuals and plan sponsors. The impact of recoupment on the individual could be particularly harsh and also difficult for plan sponsors to administer.

RECOMMENDATION:

- Reform the recoupment rules to ensure that a plan sponsor does not have to collect an overpayment from the participant and rollovers of inadvertent overpayments are treated as valid rollovers.

GOAL: Extend and modify the provision of law permitting surplus pension assets to be used for retiree health and life insurance benefits.

ISSUE: Current law (Section 420 of the Internal Revenue Code) allows a portion of a generously overfunded defined benefit pension plan's surplus assets to be used to fund retiree welfare benefits (health care benefits and group life insurance coverage) for the plan's retirees. Extending this provision and making it more usable by companies would provide a prudent financial funding resource and protect these important benefits at a time when employers are facing cash liquidity issues resulting from the pandemic.

RECOMMENDATION:

- Reduce the funded status threshold for *de minimis* transfers from defined benefit pension plans to pay for retiree welfare benefits and extend the effective date of the provision.

GOAL: Simplify communication by eliminating unnecessary notices to employees not enrolled in the retirement plan.

ISSUE: The current economic downturn, has given rise to an enormous amount of communication being sent to plan participants. Under current law, even *non-participants* -- individuals who are eligible to participate in a plan, but have chosen not to do so,

must be sent the same reports and disclosures as participants enrolled in the plan. It is confusing and unnecessary to provide materials that do not relate to these employees.

RECOMMENDATION:

- Plan sponsors should not be required to send individuals not enrolled in a plan unnecessary notices they receive under current law. Instead, such individuals should receive an annual reminder of their eligibility to participate in the plan. This would be much more effective in encouraging them to participate.

GOAL: Extend the SECURE Act multiple employer plan (MEP) reforms to 403(b) plans.

ISSUE: Given the economic impact of the pandemic there needs to be a concerted effort to help all types of employers maintain retirement plans. The SECURE Act facilitated broader coverage among small employers by (1) permitting completely unrelated employers to join together in an "open MEP" to achieve greater economies of scale, and (2) eliminating the so-called "one bad apple" rule that punishes compliant employers in a MEP for the violations of another employer in the MEP. These reforms, however, did not apply to 403(b) plans, which are particularly prevalent among educational institutions that are among the entities most severely affected by the pandemic.

RECOMMENDATION:

- Make the SECURE Act MEP reforms applicable to 403(b) plans.

GOAL: Allow small employers joining a multiple employer plan (MEP) to benefit from the small employer start-up credit.

ISSUE: As the economy begins to recover, it will be important to encourage small employers to sponsor a retirement plan for their employees. Currently, the small employer start-up credit related to a Multiple Employer Plan (MEP) only applies for the first three years that the plan is in effect. Consequently, if a small employer joins a MEP that has already been in existence for at least three years, the employer is not eligible for the credit. This is a material disadvantage for MEPs and needs to be addressed if MEPs are to fulfill their full potential in broadening coverage among small employers.

RECOMMENDATION:

- A small employer joining a MEP should be eligible for the start-up credit for the first three years of the employer's participation in the MEP.

GOAL: Correct the defined benefit pension plan mortality tables to more accurately determine appropriate funding obligations.

ISSUE: Prior to the pandemic, higher PBGC premiums and uncertain plan funding obligations had put enormous pressure on companies to maintain their defined benefit pension plans. The economic crisis caused by the pandemic has made this situation substantially worse because it has resulted in sudden significantly greater funding obligations in the short-term (when plan sponsors may have the least ability to make these contributions), notwithstanding the long-term nature of defined benefit pensions. These obligations can fluctuate depending on interest rates and other factors, such as the mortality table that must be used for calculating a plan's funding obligations.

The Department of Treasury is required to update every ten years the mortality table that defined benefit plans use for these purposes. The most recent update was included in regulations published in 2017 and had the estimated effect of increasing plan sponsor costs by more than $36 billion over 10 years. The mortality tables were flawed inasmuch as they used a higher rate of future mortality improvement than the rate used by the Social Security Administration or any other regulatory organization.

RECOMMENDATION:

- Prohibit the mortality table regulations from assuming future mortality improvements at any age that are greater than 0.78% (i.e., the weighted average used by the Social Security Administration.)

The Council is a public policy organization whose members include over 220 of the world's largest corporations, as ranked by Fortune and Forbes. Collectively, the Council's members either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.