



July 31, 2017

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U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

RE: Comments on Treasury's Review of Regulations

Dear Sir or Madam,

The American Benefits Council (the "Council") is a national nonprofit organization dedicated to protecting and fostering privately sponsored employee benefit plans. The Council's approximately 425 members are primarily large multistate U.S. employers that provide employee benefits to active and retired workers and their families. The Council's membership also includes organizations that provide employee benefit services to employers of all sizes. Collectively, the Council's members either directly sponsor or provide services to retirement and health plans covering virtually all Americans who participate in employer-sponsored benefit programs.

The Council commends the U.S. Department of Treasury (Treasury) for convening a regulatory reform task force and welcomes this opportunity to provide input for the task force to consider when identifying regulations for repeal, replacement or modification. As requested in the RFI, the Council has focused on regulations that (1) eliminate jobs or inhibit job creation, (2) are outdated, (3) are unnecessary, (4) are ineffective, (5) impose costs that exceed benefits, (6) create a serious inconsistency, or (7) are based on Executive Orders that have been rescinded or substantially modified.

The Council previously formed a Regulatory Reform Task Force within its membership and compiled a set of Regulatory Reform Principles that was approved by our Policy Board of Directors. These are a common sense set of principles intended to guide any type of regulatory reform. We have attached a copy of a document outlining these principles which the Council hopes will assist Treasury's regulatory reform task force during its review.

More specifically, the following is a summary of regulations that the Council suggests be considered by the task force for repeal, replacement or modification. The regulations are separated by retirement or health and welfare related guidance.

RETIREMENT REGULATIONS

Electronic delivery of participant communications

Treasury and the Department of Labor (DOL) have different rules regarding the use of electronic delivery of participant communications, and both sets of rules are out of date, adopted before the development of the smartphone. Treasury and DOL can adopt uniform updated rules that permit electronic delivery, including through a secure website, to be the default means of providing participant communications, as long as participants have the right to opt for paper at no charge. See the Receiving Electronic Statements To Improve Retiree Earnings Act (S. 3417), a bipartisan Senate bill from the 114th Congress.

Expand IRS' plan correction program ("EPCRS")

The Internal Revenue Service (IRS) has established a very effective and workable correction program for plan qualification errors. This excellent program should be expanded to permit plan loan errors to be corrected through self-correction, rather than through costly and time-consuming submissions to the IRS. In addition, the correction program should be expanded to cover IRAs, with a focus on inadvertent errors for which the IRA owner was not at fault but is nevertheless subject to sanctions under the law. See Section 235 of H.R. 1270 from the 113th Congress introduced by Senator Hatch (referred to below as the "Hatch bill") and Section 402 of H.R. 2117 from the 113th Congress introduced by Representative Richard Neal (D-MA) (referred to below as the "Neal bill").

Repeal the one bad apple rule with respect to MEPs

Treasury has adopted regulations under which violations of the tax qualification rules by any employer in a MEP disqualifies the entire MEP. This is an unnecessarily harsh rule that has adversely affected the willingness of small employers to join a MEP. Treasury can amend either its regulations or its correction program to only impose the disqualification sanction on the portion of a defined contribution MEP attributable to the employer that caused the violation. See Section 101(a) of the Retirement Enhancement and Savings Act of 2016 ("RESA").

Modify the Treasury nondiscrimination rules to avoid forcing defined benefit plans to freeze

Employers looking to exit the defined benefit system generally have two options: (1) freeze the plan entirely so that no one accrues any more benefits, or (2) close the plan to new hires so existing employees continue to accrue more benefits. The latter approach has been taken by many employers to avoid a jarring change for employees. But under the current nondiscrimination rules, the grandfathered group of employees under the latter approach gradually becomes disproportionately highly paid because of attrition among lower paid employees and greater seniority among the grandfathered group. This would cause the plan to fail the nondiscrimination rules. To avoid disqualification, employers are effectively forced to completely freeze the plan, taking away benefits. Treasury proposed regulations that addressed about 20% of the problem, leaving hundreds of thousands of employees vulnerable to a freeze. Treasury can address the problem by adopting in regulations the approach approved unanimously by Senate Finance in Section 205 of RESA.

Reporting simplification for small business retirement plans

In order to reduce costs for small businesses, service providers have developed a way to streamline plan administration by offering retirement plans to small businesses across the country with a common trustee, a common named fiduciary, a common plan administrator, a common set of investment options, a common plan year, and a common record-keeper. So any small employer participating in this arrangement would have its own plan, but the administrative framework would be the same as the framework for potentially thousands of other small business plans. However, under current law, each of these small business plans must file a separate Form 5500, even though much of the information in every one of the Form 5500s is identical. This is an unnecessary expense, and unfortunately a material expense. DOL and Treasury can revise the rules to permit a single Form 5500 to be filed by the common plan administrator of defined contribution plans that also have a common named fiduciary, administrator, investment menu, plan year, and trustee. DOL and Treasury could require such single Form 5500 to contain such information about the separate plans as is necessary to ensure that DOL and Treasury receive all needed information. See the bipartisan House and Senate bills H.R. 1688 and S. 695 and RESA Section 202.

Consolidate overlapping retirement plan notices

Participants are inundated with overlapping and redundant disclosures. Each requirement is well intended and generally helpful in a vacuum, but in total, the requirements have led to disclosure overload. This in turn leads to a vast number of participants actually reading very little if anything. In order to address this, Treasury

can permit plans to consolidate notices in accordance with Section 222(a) of the Hatch bill and Section 408(a) of the Neal bill. This effort should be coordinated with the DOL and, with respect to retirement plans that offer company stock as investment alternative, the coordination and consolidation efforts should include the SEC.

Withdrawal of IRS Notice announcing the future issuance of retroactive regulations contrary to statute

In July of 2015, the IRS issued [Notice 2015-49](#), which announced the IRS' intent to issue regulations under which the acceleration of annuity payments being made by a defined benefit plan would violate the required minimum distribution ("RMD") rules under Code Section 401(a)(9). This Notice did not make sense from a technical perspective: the IRS relied on a Code Section prohibiting excessive deferral in order to prohibit acceleration of benefits. The object of the Notice was based on a policy objective to slow down the de-risking of pension plans. Pension plans had been offering lump sums to participants in pay status, which is now prohibited under the Notice because the Notice announced the IRS' intent to make the regulatory amendments retroactively effective as of the date the Notice was issued in July of 2015. The Notice should be withdrawn. The Council has concerns about the substance of the Notice, but we are currently just requesting that the regular notice and comment process be used without retroactive effect.

Update mortality tables for purposes of required minimum distribution rules

Very generally, upon attaining age 70 ½ (or in some cases retirement), IRA and defined contribution plan participants must begin taking distributions over their joint life expectancy with their beneficiary. The regulations on life expectancy were finalized in 2002 based on data that was already out of date in 2002. Treasury can update their life expectancy tables based on up-to-date data on life expectancy. See Section 232 of the Hatch bill.

QLAC proposal No. 1: fix a glitch

In 2014, Treasury published final regulations on qualifying longevity annuity contracts ("QLACs"). QLACs are generally deferred annuities without a cash value that begin payment at the end of an individual's life expectancy. Because payments start so late, QLACs are a very inexpensive way for retirees to hedge the risk of outliving their savings in defined contribution plans and IRAs.

The 2014 regulations generally exempted QLACs from the RMD rules until payments commence, which was necessary to make QLACs workable. However, the

QLAC regulations limit the premiums an individual can pay for a QLAC to the lesser of (1) \$125,000 or (2) 25% of the individual's account balance under the plan or IRA. The \$125,000 limit applies across all types of arrangements, whereas the 25% limit applies separately to each DC plan and collectively to all IRAs that an individual owns. For purposes of the 25% limit, the account balance of an IRA is determined as of December 31st of the previous calendar year.

It is rare for a DC plan to offer a QLAC option directly. As a result, generally the only way for a DC plan participant to directly obtain a QLAC is by doing a direct rollover to buy a QLAC in an IRA. But this is very hard to do because the IRS has taken the position that the 25% test applies in this case to the IRA, which often has a zero account balance as of the prior year. In practice, this effectively precludes rollovers to buy QLACs unless the participant is willing to roll over four times the QLAC purchase price and wait a year. The IRS can clarify that in the context of a direct rollover from a plan to an IRA, the 25% test applies against the plan balance, not the zero IRA balance.

QLAC proposal No. 2: facilitate the sales of QLACs with spousal survivor rights

The QLAC regulations prescribe very different rules depending upon whether the owner's beneficiary is his or her spouse, with much more restrictive rules on death benefits if the beneficiary is not the spouse.

The regulations do not address how the QLAC death benefit rules apply if the beneficiary is the owner's spouse on the date the contract is issued but because of a subsequent divorce is no longer the owner's spouse when the annuity payments commence or when the owner dies. If a beneficiary's status as a spouse or non-spouse is determined after a QLAC is issued, *e.g.*, on the date annuity payments commence, a contract that was issued with permissible benefits might be viewed as providing impermissible benefits merely because of the divorce. To avoid this issue, some insurers have decided to just offer single life QLACs, which deprives spouses of important benefits.

The solution to this problem is for Treasury to clarify that a divorce occurring after a QLAC is purchased but before payments commence will not affect the permissibility of the joint and survivor benefits previously purchased under the contract if a qualified domestic relations order ("QDRO") (in the case of a retirement plan) or a divorce or separation instrument (in the case of an IRA) does not modify the treatment of the former spouse as the beneficiary under the QLAC. This is consistent with the RMD and QDRO rules, but the lack of clarity is adversely affecting the QLAC market.

QLAC proposal No. 3: adjust the limit

At age 65, \$125,000 would purchase a QLAC (with a 2% COLA and a return of premium death benefit) paying approximately \$18,049 annually starting at age 80. This is not sufficient to protect a middle-income individual from the longevity risk. Treasury set the \$125,000, so it can increase that limit to \$200,000, which would increase the annual payment to \$29,047.

QLAC proposal No. 4: expand to defined benefit (“DB”) plans

The Council recommends that Treasury amend the QLAC regulations to allow DB plans the option of providing deeply deferred annuities directly from the plan under rules similar to those permitted for QLACs in defined contribution plans. This would allow a DB plan to provide more flexibility in distribution options (including offering a partial lump sum and the remainder in a deeply deferred annuity) and level the playing field with DC plans in this regard.

Managed payouts

There is a need for both guaranteed income for life and managed payouts during retirement. Each form of payment has attributes that are essential in some contexts. To facilitate managed payouts, Treasury should, to the extent that current rules do not treat managed payouts as a single stream of payments for purposes of various rules, such as consent to a distribution, update such rules to provide such treatment.

Remove RMD barriers for life annuities

Treasury can modify an actuarial test in the RMD regulations that apply to retirement plans. The test is intended to limit tax deferral by precluding commercial annuities from providing payments that start out small and increase excessively over time. In operation, however, the test commonly prohibits many important guarantees that provide only modest benefit increases under life annuities. For example, guaranteed annual increases of only 1 or 2%, return of premium death benefits, and period certain guarantees for participating annuities are commonly prohibited by this test. Without these types of guarantees, many individuals are unwilling to elect a life annuity under a DC plan or IRA.

Treasury can eliminate the test for commercial annuity guarantees that clearly do not implicate concerns over excessive tax deferral. These include (1) annuity payments that increase by less than 5% per year, (2) commutations or accelerations of future annuity payments, (3) participating annuities (typically issued by mutual insurance

companies), and (4) return of premium death benefits. The test would also be required to be revised to provide for automatic updates to the life expectancy tables that are used in the test so they stay current with mortality trends affecting annuity pricing.

Cash balance plans (“CBs”)

Treasury could allow CBs that credit interest based on true market rates of return to provide pay credits that benefit older and longer service workers in a way comparable to CB plans that provide interest based on fixed or deemed market returns (e.g., based on bond yields). Currently, CBs that credit market returns (e.g., reflecting returns on the plan’s own assets) must project interest to normal retirement age using the plan’s most current rate of return (with negative returns deemed to be 0%). This results in the inability to increase the ultimate pay credit rate relative to the initial pay credit by more than 1/3 in order to assure compliance with the 133-1/3 accrual rule test. For example, pay credit rates of 3% for the first 10 years of service, 4% for the next 10 years and 5% for years after 20 would not be permissible because 5% is 67% more than 3%, exceeding the allowable 33%. Yet such a scale would work rather easily for CBs that credit very modest fixed interest credit rates (e.g., 2.25%) or bond rates with modest annual minimum rates (e.g., 30-year Treasury bonds with 2.25% annual minimum rate).

Pension equity plans (“PEPs”)

PEPs are a form of hybrid defined benefit plan, like cash balance plans, but with a different type of benefit formula. Under a PEP, a lump sum benefit is determined based on a formula using final average pay. Although there has been much guidance on cash balance plans, there has been a relative dearth of guidance on PEPs, despite private sector requests for over 20 years. In this context, we have two requests.

First, if regulatory, administrative, or enforcement guidance is issued regarding PEPs, such guidance should not have any retroactive effect on any PEP that has been operating in good faith, reasonable reliance on existing authorities. The absence of PEP guidance should not give rise to retroactive “gotchas” when new guidance is finally issued.

Second, there is even more uncertainty regarding a type of PEP called an “implicit interest” PEP. Under an implicit interest PEP, when benefit credits cease (typically at termination of employment), the PEP lump sum benefit is converted into an annuity at normal retirement age, based on a deferred annuity factor. Such PEPs clearly qualify for hybrid plan treatment until benefit credits cease, and this should be clarified. In addition, the fact that such PEPs may cease to qualify for hybrid plan treatment after benefits credits cease should not have any application on whether the PEP benefits

qualify for hybrid plan treatment, such as whipsaw relief and the Pension Protection Act age discrimination safe harbor.

Delete penalty on more generous pension plan lump sum calculations

Code Section 417(e) provides a ceiling on the interest rates that can be used to value distributions, such as lump sum distributions. But employers are permitted to establish lower interest rates by, for example, providing that distributions will be valued using the lesser of the “applicable interest rate” (as defined in Code Section 417(e)(3)(C)) or a specified other rate.

Some employers have used this ability to use a lower interest rate to, for example, grandfather benefits from changes in the applicable interest rate under Code Section 417(e)(3). Other companies have simply picked a different set of assumptions and provide a value equal to the greater of the value using the plan’s assumptions or the value under the assumptions under Section 417(e)(3).

Employers in these situations may want to change the date for determining their non-417(e)(3) interest rates to, for example, an earlier date so as to facilitate communications to participants well before the beginning of the plan year. The change would be to a lookback month that is permitted under Proposed Regulation §1.417(e)-1(d)(4)(iv). Under specified circumstances, this change in the lookback month is permitted for the “applicable interest rate” under Proposed Regulation §1.417(e)-1(d)(9)(ii).

Treasury can amend the regulation to provide that the option to change the lookback month is permitted for not just the 417(e) rates, but also for any lower rates used by the plan. Otherwise, the law would simply be penalizing more generous employers with less flexible rules.

Guaranteed living withdrawal benefits

GLWBs are an insurance product that combines two important attributes: individual control over the assets and guaranteed income for life. The ability to sell GLWBs in retirement plans, however, has been inhibited by a lack of Treasury guidance on how these products are treated for nondiscrimination testing. Treasury can clarify that GLWB options can be limited on a nondiscriminatory basis to older employees, since the product guarantees are structured to make sense for those close to retirement, not for employees 20 or 30 years from retirement. See Section 303 of the Neal bill.

409A issues

Since 2008, the IRS has issued a series of Notices that permit plan sponsors to correct certain Section 409A operational and document failures (e.g., IRS Notice 2008-113, IRS Notice 2010-6 and IRS Notice 2010-80). Generally, these Notices require the employer plan sponsor to comply with several burdensome administrative and reporting steps before a correction is considered complete. The correction guidance often requires the employer plan sponsor to provide certain information statements to affected participants, and, in many instances, individuals may then have to file amended federal tax returns, with obvious cost and burden to the individual participants – even though there may be no additional federal tax liability owed by any party to the IRS. Additionally, the guidance generally can only be invoked for errors discovered within a fairly time-limited window. And in the event the error is discovered and corrected within this limited window of time, the participant can still be subject to a 20% penalty and other taxes even though the error was inadvertent.

We understand the IRS may desire to consolidate the existing Section 409A correction guidance into one revenue procedure on a going forward basis. In connection with the issuance of such a revenue procedure, or otherwise, there is an important opportunity for the IRS to take steps to simplify the existing correction rules to reduce unnecessary burdens and costs on employers and their employees.

To that end, where the facts demonstrate a Section 409A error was inadvertent and is fully corrected, the Council urges IRS to: (a) eliminate the requirement for plan sponsors to provide an information statement to affected participants, (b) eliminate the requirement that participants attach such an information statement to their annual tax return (e.g., the IRS could only require that the company attach it to its federal tax return for the respective tax year), and (c) eliminate the requirement for affected participants to have to file any amended tax returns. In the alternative, the Council urges the IRS to clarify that the timing for providing an information statement, if required, is based on the *year of correction* rather than the *year of discovery*. Lastly, the Council urges the IRS to expand the period allowed for operational correction (beyond the fairly time-limited period provided under the current rules).

There are a number of nonqualified deferred compensation issues that, if addressed, would help participants and plan sponsors ensure they are in compliance with 409A while at the same time simplifying the operation of such programs. For example, in the mergers and acquisitions area, guidance could clarify that unvested options held by employees of the target corporation at the closing can be converted into promises to pay cash equal to the option spread (based on the deal price) at the time that the options would have vested. Further, the regulations could be revised to provide that employment, severance and other similar agreement renegotiations between employees of the target corporation and the acquirer do not give rise to a “substitution” issue. The

Council believes it would be a good idea to have a meeting with appropriate representatives of the agency to discuss more ways to make Section 409A more efficient.

FBAR Filings

The Bank Secrecy Act has been interpreted to require bank trustees and U.S. corporate staff with only “signature authority” over a “foreign financial account” exceeding \$10,000 held for tax-favored retirement plans to file a Report of Foreign Bank and Financial Accounts (“FBAR”) with the Treasury Department’s Financial Crimes Enforcement Network (“FinCEN”). These responsible individuals are required to report their “signature authority” on their personal tax returns. Although FinCEN published final rules to address some questions and concerns in 2011 (and proposed a few additional changes in 2016), we urge Treasury to review FBAR reporting rules to reduce costs and burdens on the retirement plan community and corporate staffs. We also request that Treasury reexamine the need for tax-favored retirement plans to make FBAR filings generally since ERISA plans are subject to a plethora of federal reporting and fiduciary standards that make it extremely unlikely that any transaction of concern to FinCEN would occur. For a more detailed discussion of the Council’s FBAR recommendations, please see Appendix A at the end of this document.

HEALTH AND WELFARE REGULATIONS

The ACA has subjected employers to an increased and significant regulatory burden under Treasury regulations and other guidance. Unduly burdensome regulations increase administrative complexity and benefit plan costs to the detriment of employers, employees and plan participants. To the extent Treasury is considering modifying any regulations or other guidance, we strongly urge that it use a process that provides notice and opportunity for comment from stakeholders. Below is a list of proposals we recommend to reduce regulatory burdens on employers and employees.

Employer Shared Responsibility proposal No. 1: simplify the rules for determining whether an employee is “full-time”

Under the ACA’s employer shared responsibility or “employer mandate” rules as set forth in Code Section 4980H, an “applicable large employer” may be liable for an assessable payment if certain health care coverage requirements are not satisfied. Specifically, failure to offer certain coverage to a sufficient number of “full-time employees” can result in a penalty if a full-time employee is certified as eligible to receive an applicable premium tax credit or cost-sharing reduction when purchasing individual policies in the state or federal health exchange marketplaces.

Existing regulations under Code Section 4980H reflect complicated methodologies for determining whether certain employees are full-time (and therefore, must be offered coverage in order to avoid potential penalties). One administrative scheme, the “look-back measurement method,” requires employers to use measurement periods to determine whether employees work a full-time schedule and then treat them as full-time or not-full-time for an ensuing “stability period.” Employers have found this methodology extremely difficult to administer in practice. Another methodology, the “monthly measurement method,” which allows employers to make a monthly determination regarding whether an employee worked full-time hours, is marginally less complex, but it is less useful because an employer will not know whether an employee worked full-time hours in a month until after the month is over, and thus, may not have offered coverage in that month because it thought the employee would work part-time hours.

It would be helpful if Treasury allowed employers to determine an employee’s full-time status using alternative, simplified standards. One possibility would be to allow employers to categorize an employee based on a reasonable classification of that employee’s full-time or non-full-time classification rather than a look-back or monthly measurement methodology. If there is concern about abuse, Treasury could adopt a rule that, to the extent an employee classified as part-time actually works full-time in a year, it would call into question the reasonableness of a part-time classification in the following year.

In the alternative, Treasury, at a minimum, should revisit the Code Section 4980H regulations and seek ways to simplify rules that are needlessly complex and difficult to apply. Issues that regularly cause difficulty for employers include the rules relating to counting hours for and offering coverage to employees who separate from service and then are rehired and employees who go on leaves of absence. We would welcome the opportunity to discuss these issues with Treasury in the future.

Employer Shared Responsibility proposal No. 2: simplify affordability determinations

Even if an employer offers “minimum essential coverage” to a full-time employee, the employer may still be exposed to a potential penalty if the coverage is not considered “affordable” and the employee is certified as eligible to receive an applicable premium tax credit or cost-sharing reduction. Existing regulations set forth a set of safe harbors that employers can use to determine whether the coverage they offer is “affordable” for purposes of Code Section 4980H. Very generally, the regulations permit employers to use any of the following for this purpose, but must use the same safe harbor for all employees in the same category: (i) an employee’s wages for the calendar year as reported in Box 1 of his or her Form W-2; (ii) the employee’s rate of pay; or (iii) 100% of the federal poverty line. While we appreciate the issuance of these

safe harbors, they can be difficult for employers to apply for several reasons. For example, the rate of pay safe harbor is not always available because it can't be applied if an employee's salary is reduced during the year. Also, an employer won't know an employee's W-2 wages until the year is over, which makes it very difficult to set premium rates at the beginning of the year to ensure affordability, particularly with respect to variable hour employees. We recommend that the safe harbor be modified to allow an employer to base affordability on the prior year's W-2 wages.

The affordability rules could also be simplified with respect to wellness incentives. The current scheme for calculating deemed premium costs for affordability purposes, in situations where a premium incentive is related to a tobacco or non-tobacco wellness program, is needlessly complicated. The current scheme results in employers calculating not just the employee's actual premium payment (i.e., self-only, self-plus-spouse, self-plus-family) (taking into account all wellness incentives), but also the cost of the lowest cost self-only rate available to the employee. The latter is adjusted further by only taking into account tobacco-related incentives, irrespective of whether the employee actually earned the incentive.

Employers should be allowed to calculate and report, for affordability purposes, the lowest-cost premium cost available to the employee, without regard to any potential wellness premium incentives that might apply.

Employer Shared Responsibility proposal No. 3: eliminate rules discouraging employers from offering "opt-out" arrangements

Historically, many employers have offered employees the choice of receiving additional compensation if they opt not to enroll in employer-sponsored coverage. Offering this option has become significantly more complicated because Treasury has taken the position that an employee who elects coverage, and therefore forgoes an unconditional opt-out payment, is in an economically equivalent position to an employee who elects a salary reduction to pay for coverage. Therefore, if an employer offers additional compensation to employees who opt out of employer-sponsored health coverage, the additional compensation offered will count against the affordability of the health coverage for all employees, even those who elect coverage (effectively making the coverage less affordable for the employees). This, in turn, would make it easier for an employee to qualify for a premium tax credit (if he or she declines the coverage and chooses to purchase individual insurance through a Marketplace), and makes it more likely the employer could be subject to a penalty under the employer shared responsibility rules for not offering coverage that meets the affordability standard. Further complicating matters, Treasury has taken the position that amounts made available under certain *conditional* opt-out arrangements will not count against affordability if the arrangement satisfies certain conditions (an "eligible opt-out arrangement").

We believe that opt-out arrangements are not truly analogous to salary reduction arrangements, and eliminating choice for both the employee and employer makes little practical sense. Therefore, we urge Treasury to consider rescinding existing regulatory rules and other guidance that counts additional compensation offered to employees who chooses to opt out of employer-sponsored health coverage against the affordability of that coverage.

Employer shared responsibility proposal No. 4: make the multiemployer interim relief permanent

There is currently a “transition rule” in the Code Section 4980H regulations providing that if an employer is required by a collective bargaining agreement or participation agreement to make contributions to a multiemployer plan for a collectively bargained employee, it will be considered to make an offer of coverage to the applicable collectively bargained employee for Code Section 4980H purposes so long as the multiemployer plan (subject to the plan’s eligibility rules) offers affordable, minimum value coverage to the collectively bargained employee and his or her child. This rule is vitally important to employers that have collectively bargained employees who participate in multiemployer plans, as the employer shared responsibility rules and associated reporting would be almost impossible to administer for these employees in its absence. We strongly urge that Treasury make this rule permanent.

Employer shared responsibility proposal No. 5: eliminate any requirement that disability hours be counted for purposes of determining who is a “full-time employee”

Under existing Treasury guidance, for purposes of determining who is a full-time employee, an employer must credit “hours of service” for employees receiving short-term or long-term disability, unless the payments are made from an arrangement to which the employer did not contribute directly or indirectly. This rule may require an employer to credit an employee who is receiving disability payments with “hours of service” and offer health coverage under the employer shared responsibility rules, even if the employee is not actually performing work and has not been for an extended period of time. This rule is challenging for employers to administer, and we request that Treasury eliminate it altogether.

Employer shared responsibility proposal No. 6: establish design-based safe harbors for the minimum value requirement

Under the employer shared responsibility rules, penalties can apply if the coverage offered to full-time employees is not considered to provide “minimum value.” In the preamble to proposed regulations issued in 2013, Treasury stated that it intended to issue additional guidance providing certain safe harbor plan designs that would satisfy the minimum value threshold without having to use the HHS minimum value calculator. Treasury has not yet issued this guidance. We encourage Treasury to issue additional design-based safe harbors that could easily be used by employers in determining whether their plans meet the minimum value standard.

Section 6055/6056 reporting proposal No. 1: maintain the relief from penalties for employers who make good faith efforts to comply with the information reporting requirements

The new ACA tax reporting requirements under Code sections 6055 and 6056 have been extremely complex, costly, and burdensome for employers. For the initial reporting years (2016 and 2017), Treasury has stated that it will not impose penalties under Code sections 6721 and 6722 on employers that can show that they have made good faith efforts to comply with the information reporting requirements.

As employers continue to tackle the ongoing compliance challenges raised by these reporting requirements, we encourage Treasury to maintain its position that penalties will not be assessed, provided that employers are attempting to satisfy their obligations in good faith. We note that current Treasury guidance does not address many of the situations that employers are attempting to navigate (for example, reporting requirements when an employer is acquired and changes controlled groups mid-year in the context of a merger or acquisition, or the reporting requirements as they relate to expatriate coverage). This is all the more reason to keep the good faith standard in effect for the foreseeable future.

Section 6055/6056 reporting proposal No. 2: assist employers with SSN reporting and verification rules

One aspect of the ACA tax reporting requirements that has been particularly challenging involves the reporting and verification of social security numbers (“SSNs”) for non-employee family members, such as spouses and children. Employers do not have a method of verification (as they do in the W-2 context) because the Social Security Administration (“SSA”) database cannot be accessed by employers for Code Section 6055/6056 reporting purposes. At a minimum, Treasury could provide a means for employers to access IRS/SSA databases prior to filing for purposes of name/SSN

matching. Treasury should also permit employers to identify employees and family members by using a non-SSN identifier, such as a member ID number that the employee could also report on his or her Form 1040.

Section 6055/6056 reporting proposal No. 3: provide relief from reporting deadline

Currently, employers are generally required to provide Forms 1095-C and Forms 1095-B to employees by no later than January 31 of the year following the end of the year for which the reporting is required (i.e., by January 31, 2017 for 2016 reporting data). It is extremely difficult for many employers to accurately complete and issue the forms by January 31, as they need to compile a significant amount of information, prepare the forms, and leave sufficient time to print the forms and prepare the mailing. As just one example, an employee who is terminated in October through December of one year may not even make a COBRA election until January through March of the following year, which may significantly impact the information which has to be reported on the relevant form. For these reasons, the IRS provided an automatic extension of the January 31 furnishing deadline for the 2015 and 2016 calendar years (for the Forms due in 2016 and 2017, respectively).

To address this on-going concern, Treasury could provide an opportunity for employers to obtain an automatic 30-day extension to furnish the Forms 1095-C and Forms 1095-B to individuals, similar to the automatic extension for Forms 1095-C and 1095-B filed with the IRS, provided that the reporting entity sends a letter to the IRS that is postmarked no later than by January 31 and includes (i) filer name and TIN, (ii) type of return, (iii) an explanation of the reason for the need for the extension.

Section 6055/6056 reporting proposal No. 4: allow reporting for employers on a controlled group basis

Currently, each individual employer in a controlled group must separately file Forms 1094-C and 1095-C if they have full-time employees, even though whether an employer is an “applicable large employer” required to report is determined on a controlled group basis. This has been problematic for employers, because sometimes they have a common paymaster in the controlled group that issues/ files the Form W-2s, and it may not be entirely clear who the specific common law employer of the employee is. The only reason to require separate filing relates to determining whether each employer in the controlled group is offering coverage to at least 95% of its full-time employees (in accordance with the employer shared responsibility rules). As an alternative to requiring each controlled group member to report separately, IRS could allow the controlled group to report as a whole, and add a column to the Form 1094-C allowing the controlled group to attest whether each member offered coverage to at least 95% of its full-time employees.

Section 4980I 40% High-Cost Plan Tax

The “Cadillac Tax” enacted as part of the ACA imposes a 40% percent tax on the value of employer-sponsored health plans above a threshold pursuant to Code Section 4980I. While the Cadillac Tax was intended to address only overly generous plans, it will disproportionately affect plans that are more costly for reasons unrelated to the generosity of benefits, including the demographics of the covered population or location in high cost areas. Instead of reducing the actual costs of health care, the Cadillac tax compels employers to shift costs to workers to avoid exceeding the tax thresholds. We support a full repeal of Code Section 4980I and will continue to advocate for Congressional action to eliminate it.

Although the administrative burdens and detrimental impact of Code Section 4980I cannot be fully alleviated by regulatory action, to the extent it is not repealed, we urge Treasury to work with employers and insurers to take whatever regulatory steps it can to make the administration of the tax as workable as possible.

We also reiterate our recommendation for development of safe harbor actuarial value methodologies for purposes of determining the amount of any Code Section 4980I tax liability. We are very concerned that the cost-based methodology, if not paired with appropriate safe harbor alternatives, will result in disparate treatment of employers and could cause reduced coverage and/or increased out-of-pocket exposure for employees in high cost areas or for the disabled or chronically ill. We would welcome the opportunity to discuss this issue in more detail.

Allow stand-alone Health Reimbursement Arrangements

Under current Treasury guidance that was issued post-ACA, an employer cannot sponsor a stand-alone HRA for its employees unless the HRA is integrated with an employer-sponsored major medical plan. We encourage Treasury to rescind this guidance, particularly as it relates to HRAs that reimburse out-of-pocket medical expense (as opposed to individual market premium reimbursement). Employers should be permitted to offer some health benefit without the tie-in to a major medical plan, with the important caveat that adequate rules should be established to protect the individual markets against any related anti-selection. This not only provides increased flexibility for employers, it will also allow for increased choice for employees and their families to enroll in coverage that is the most suited to them. Further, it will help shore up the individual markets and related risk pools because it would allow additional covered lives under the Marketplace.

Electronic Delivery of participant communications

As Treasury is aware, the Code and other federal statutes require that employers/plan sponsors distribute a myriad of notices to employees and their families with respect to health and welfare plans, for example, the Forms 1095-C, COBRA notices, and the Summary of Benefits and Coverage. The majority of American workers rely on email and other electronic means of communication in their daily personal and working lives. We reiterate our comments above regarding the electronic delivery (as discussed in the context of retirement plans) and urge Treasury develop revised delivery rules that take into account the widespread use of, and familiarity with, electronic means of communications by today's American worker and their families.

Health savings accounts ("HSAs") proposal No. 1: centralize and aggregate guidance to facilitate compliance and understating by employers, providers, and accountholders

Below, we list five separate proposals relating to HSAs and HDHP coverage. One common complaint from employers is that historically, Treasury has issued guidance regarding HSAs through a number of different avenues (Notices, Revenue Rulings, FAQs, etc.) and it is difficult to research the agency's position on discreet issues. We recommend Treasury establish a centralized resource for compiling the guidance developed with regard to HSAs and HDHPs going forward.

HSA proposal No. 2: clarify that fixed indemnity coverage and specified disease coverage do not disqualify an individual from contributing to an HSA

Treasury should clarify that hospital indemnity or other fixed indemnity excepted benefit coverage and specified disease or illness coverage (as defined in Code Section 9832(c)(3)) does not disqualify an individual from contributing to an HSA. Among the types of permitted insurance for HSA purposes are fixed indemnity insurance (e.g., hospital indemnity insurance that pays \$100 a day) and insurance for specified disease or illness (e.g., cancer coverage). These two types of coverage are "excepted benefits." The term "excepted benefit" has been defined in Code Section 9832 since HIPAA was enacted in 1996. Although the two definitions should be the same, the HSA provision has slight wording differences from the definition in Code Section 9832, which has created some unnecessary confusion on occasion and could lead some individuals to unnecessarily question whether an HSA is right for them. Treasury should eliminate this confusion by confirming that references to such types of coverage in Code Section 223 have the same meaning as in Code Section 9832.

HSA proposal No. 3: allow a high-deductible health plan (“HDHP”) to cover drugs and services for chronic conditions with no deductible as preventive care

Code Section 223(c)(2)(C) provides that a plan will not fail to be treated as an HDHP by reason of failing to have a deductible for preventive care. The IRS has, in the past, issued guidance regarding how this provision applies to certain treatments and drugs. We would support regulatory action establishing that the preventive care safe harbor encompasses drugs and services used to treat chronic conditions and that HDHPs can cover these drugs and services before the deductible is met.

HSA proposal No. 4: clarify that Medicare Part A enrollment does not disqualify individuals from eligibility to make HSA contributions

A growing number of Americans are remaining in the workforce beyond age 65 and participating in employer-sponsored health coverage. This coverage often includes HSA-qualified high deductible health plans. Treasury should clarify in guidance that individuals age 65 and over who are otherwise eligible for HSA contributions are not made ineligible due to Medicare Part A enrollment, particularly since Medicare Part A enrollment is automatic for some individuals.

HSA proposal No. 5: clarify that HSAs can reimburse the cost of continuation coverage in lieu of COBRA

Code Section 223(d)(2)(C)(i) provides that premiums for continuation coverage required under Federal law (i.e. COBRA) are qualified medical expenses that can be reimbursed by an HSA. However, most other premium payments generally are not considered qualified medical expenses. Some employers offer continuation coverage that is not required under Federal law, but provides valuable coverage to former employees - most notably, retiree health coverage for individuals who are not Medicare-eligible. We urge Treasury to adopt a rule that provides that payments made by a former employee for continuation coverage in lieu of COBRA are also qualified medical expenses.

HSA proposal No. 6: encourage access to care through on-site medical clinics or telemedicine

Treasury should issue guidance allowing employers to provide care at on-site medical clinics or via telemedicine providers on a pre-deductible basis to employees and eligible dependents regardless of whether they are enrolled in HSA-eligible HDHPs.

Cafeteria plan proposal No. 1: simplify the proposed nondiscrimination rules

Treasury issued proposed regulations relating to cafeteria plans under Code Section 125 almost 10 years ago, in 2007. The nondiscrimination rules in those proposed regulations are complex and in some instances inconsistent with the Code provisions and have been very difficult for employers to understand and apply (which may explain why the regulations have not yet been finalized after a decade). Treasury should revisit those proposed regulations and reissue them with a goal of creating a regime that reflects nondiscrimination principles while being manageable for employers.

Cafeteria plan proposal No. 2: allow for retroactive elections under certain circumstances

Retroactive election changes under a cafeteria plan are generally not allowed, except in very limited circumstances, such as when a newborn or adopted child is enrolled under a HIPAA special enrollment period and coverage is retroactive to the birth, adoption, or placement for adoption. (For example, where an employee gives birth to a new child, but fails to provide advance or immediate notice of the desire to elect a new level of coverage, such as family coverage, to add the child to the employer's health plan.) Under those circumstances, an employee may change his or her election to pay for the cost of the retroactive coverage. In addition, the cafeteria plan rules allow for a limited 30-day window period for new hires during which elections can be retroactive. However, there may be other circumstances in which it is appropriate to allow individuals to make retroactive elections, including, for example, where facts and circumstances indicate the employee's inadvertent failure to notice the employer's plan of the otherwise qualifying mid-year election change event. Accordingly, where all relevant facts demonstrate their intended good faith compliance, Treasury should revise its rules to allow retroactive elections for other permitted changes in status.

Cafeteria plan proposal No. 3: allow FSA and HDHP elections to reflect changes in status

Treasury should adopt a rule that specifically permits employees to change their health FSA election (from a general purpose FSA to a limited purpose FSA and vice versa) mid-plan year when they have a change in status event and change from a HDHP to a non-HDHP and vice versa. This would better reflect the complexities that exist with mid-year enrollments and would help ensure that employees are not disqualified from contributing to an HSA merely because they previously elected coverage under a general purpose FSA.

Cafeteria plan proposal No. 4: eliminate need for certification from employees when a reduction in hours creates an opportunity to change an election

Under current guidance, there is a requirement that employers get a certification from employees if they wish to change their election when they have a reduction in hours to less than 30 per week and intend to enroll in other coverage or they intend to enroll in Marketplace coverage. This requirement is burdensome for employers, has a minimal effect on curbing abuse, and should be eliminated.

Form W-2 reporting requirements proposal No. 1: clarify when employers must provide employees with corrected forms

Currently, employers are unsure whether they need to issue corrected Form W-2s to employees for errors discovered that were made more than 3 years ago. Treasury should adopt a parallel 3-year statute of limitations for W-2s furnished to employees that exist for Form W-2s filed with the IRS. It is unnecessarily burdensome for employers to have different obligations with respect to forms issued to employees than they do for forms filed with the IRS. We recommend that the rules reflect parity.

Form W-2 reporting requirements proposal No. 2: eliminate the requirement to report the value of health care benefits

The ACA established a requirement that employers report the total value of employer-sponsored health coverage on the Form W-2. This reporting imposes unnecessary administrative burden. While this reporting requirement may bear some relationship to the impending Code Section 4980I tax, that tax has been delayed for a number of years, and even then clarification of the health costs subject to tax will first need to be established, by regulation or otherwise. The W-2 reporting requirement with regard to the value of employer-sponsored coverage should be eliminated or delayed.

Form W-2 reporting requirements proposal No. 3: clarify *de minimis* safe harbor for Form W-2 corrections

Earlier this year, the IRS issued Notice 2017-09 regarding Form W-2 corrections when amounts reported are incorrect by \$100 or less. The guidance requires the employer to advise the employee of the ability to elect to receive a corrected information return, even if the error is under the \$100 threshold. However, no guidance was provided regarding the content of the notice or how the notice should be provided. Further information regarding this requirement would be helpful, and it would be

particularly useful if IRS issued a streamlined model notice and ensured that the notice was not more onerous than issuing a corrected W-2.

Eliminate Form 8928

Treasury should do away with the self-reporting scheme for certain plan violations, as currently required by Form 8928. Instead, the agencies should rely on the normal audit process, or propose an amnesty program, similar to the DOL program for late/non-filers of Forms 5500.

Fixed indemnity plan guidance, if issued, must acknowledge an employer's lack of knowledge regarding the extent of a taxable benefit to the employee

IRS issued Chief Counsel Memorandum (CCA) 201703013 in January, 2017, which examined certain tax arrangements involving so-called "wellness plans" and concluded that the arrangements in question did not result in the tax benefits promised by promoters. While the tax treatment of benefits under traditional fixed indemnity policies has long been settled (see, e.g., Rev. Rul. 69-154., only any "excess" reimbursement is taxable), and was not the subject of the CCA, the CCA included some broad language that caused some confusion.

Then, in May 2017, the IRS issued CCA 201719025 in which it eliminated the confusion generated by the prior CCM. The May 2017 CCA specifically confirmed that Rev. Rul. 69-154 remains in effect and reiterated that only the portion of the benefit in excess of the unreimbursed medical expense is taxable in the case of traditional fixed indemnity health plans. Although some employees who have fixed indemnity policies may have to include some amount of the benefits received in their gross income if they have an excess reimbursement, it does not follow that employers have reporting obligations with respect to any taxable amounts. The taxable amount, if any, depends on a number of factors, including the amount of the medical expenses incurred by the individual and any other insurance payments or reimbursements received by the employee. This is information that only the employee, and not the employer or the issuer, has.

To the extent that the Treasury/IRS is considering issuing further clarifying guidance, we urge Treasury/IRS to take account of the fact that employers and issuers generally will lack the necessary information to report any taxable benefits received by employees, and to reflect this acknowledgement in any future clarification/guidance.

PHSA Section 2716 (nondiscrimination for insured plans)

Although the ACA established nondiscrimination rules for insured plans, IRS Notice 2011-1 advised that compliance would not be required until there was agency guidance or regulations explaining how those rules would operate. We support Treasury's non-enforcement posture until it issues guidance. However, because the Code Section 105(h) nondiscrimination rules that are referenced in PHSA Section 2716 are open to interpretation and confusing, we request that, to the extent Treasury pursues rulemaking with respect to PHSA Section 2716, it take a holistic approach and consider both PHSA Section 2716 and Code Section 105(h) together to ensure that any future guidance is consistent. We also urge Treasury work to ensure that any resulting rules are simple to apply and do not have adverse consequences for benefit design and employees' access and utilization of health care coverage.

If you have any questions about these comments, please contact [Jan Jacobson](#), the Council's senior counsel, retirement policy, for retirement related regulations, and [Kathryn Wilber](#) for health and welfare related regulations. Both can be reached at 202-289-6700.

Sincerely,



Jan Jacobson
Senior Counsel, Retirement Policy
American Benefits Council



Kathryn Wilber
Senior Counsel, Health Policy
American Benefits Council

APPENDIX A

___ 31 CFR § 1010.350 – Reports of Foreign Financial Accounts (and Proposed Amendments, 81 Fed. Reg. 12613, Mar. 10, 2016)

Background

Under the Bank Secrecy Act, the Secretary of the Treasury –

“shall require a resident or citizen of the United States or a person in, and doing business in, the United States, to ... keep records and file reports, when the resident, citizen, or person makes a transaction or maintains a relation for any person with a foreign financial agency.

Form 114, Report of Foreign Bank and Financial Accounts (“FBAR”), is the vehicle by which these reports are furnished and filed with the Treasury Department’s Financial Crimes Enforcement Network (“FinCEN”).

While the Bank Secrecy Act was enacted in 1970, it was not until 2009 or so that it became widely known that bank trustees and US corporate staff with only “signature authority” over a “foreign financial account” exceeding \$10,000 held for tax-favored retirement plans were required to file FBAR. Similarly, it was generally at that time that employees of US companies became aware of the possible need for them to file reports for the foreign financial accounts they oversee, including accounts maintained by numerous domestic and foreign subsidiaries of their employers.

The significance of these potential FBAR filing obligations was dramatically magnified by the fact that these responsible individuals were required to report their “signature authority” on their *personal tax returns* (Form 1040, Sch. B, Part III). Needless to say, the pension and corporate finance communities became immediately concerned and urged Treasury to publish guidance that would clarify their obligations and provide appropriate exemptions. FinCEN published final rules to address these matters in 2011. 76 Fed. Reg. 10234 (Feb. 24, 2011).

Ongoing Costs and Burdens

While the 2011 regulations addressed some fundamental concerns, FBAR filing issues persist and the fact remains that institutional trustees for US retirement plans are required to file thousands of FBAR reports each year that have no rational connection to the enforcement goals of the Bank Secrecy Act. In IR-2016-42 (Mar. 15, 2016), the IRS reported –

“In 2015, FinCEN received a record high 1,163,229 FBARs, up more than 8 percent from the prior year. In fact, FBAR filings have grown on average by 17 percent per year during the last five years, according to FinCEN data.”

While we do not have access to the underlying reports, we believe it is reasonable to assume that a significant portion of the huge increase in FBAR filings is associated with US retirement plan accounts and domestic corporate departments. These filings come at a substantial additional cost to US companies and plan sponsors.

Recommendations

We urge Treasury to review FBAR reporting rules to reduce costs and burdens on the retirement plan community and corporate staffs. For example, Treasury should reject the March 2016 FinCEN proposal to remove the current rules that simplify compliance for filers with more than 25 foreign accounts. This proposal will only increase compliance costs for trustees of corporate retirement plans, who are already subject to extensive compliance obligations under ERISA.

Similarly, we urge Treasury to promptly adopt a final rule that puts to rest the longstanding confusion and uncertainty surrounding the need for employees of US companies to file FBAR reports of foreign accounts of various domestic and foreign corporate affiliates, including where they have “overlapping signature authority.” In March 2016, FinCEN proposed rules that would provide such relief as long as the accounts are reported by SEC registered companies, but that proposal may not be currently relied upon. *See Prop. Reg. § 1010.350(f)(2)*. Instead, FinCEN has issued a string of one-year extensions (most recently, FinCEN Notice 2016-1) that defer the potential individual filing obligations – leaving open the possibility that FBAR filings may be required as far back as for the 2011 filing year by hundreds or thousands of corporate employees. FinCEN should promptly finalize the 2016 proposal in this area and make it applicable to FBAR filings for all prior years.

Finally, we respectfully submit that Treasury should completely reexamine the need for tax-favored retirement plans to make FBAR filings generally. In this regard, we believe that granting a broad exemption to ERISA plans would save many millions of dollars in compliance costs and alleviate needless regulatory burdens with virtually no adverse effect on FinCEN’s compliance efforts. In this regard, ERISA plans are subject to a plethora of federal reporting and fiduciary standards that make it extremely unlikely that any transactions of concern to FinCEN would occur.