AMERICAN BENEFITS COUNCIL

April 29, 2011

Submitted electronically to http://www.regulations.gov

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

Re: *Reducing Regulatory Burdens: Retrospective Review Under Executive Order 13563*

Dear Sir or Madam:

I am writing on behalf of the American Benefits Council (the "Council") in response to the Treasury Department's recent request under Executive Order 13563 for suggestions on how it can streamline its guidance and eliminate unnecessary regulatory burdens.

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans. Accordingly, our comments focus on issues affecting employee benefit plans and individual retirement arrangements ("IRAs").

The regulation of employee benefit plans has grown exponentially in recent years, and the employee benefits field is becoming an area of the law that is well-known for its complexity and burdensome regulatory regime. This perception undermines the voluntary employer-maintained benefit plan system. Excessive administrative burdens also adversely affect American workers since the costs of plan administration are often borne by participants as well as plan sponsors. Thus, as an overarching comment, we urge the Treasury Department ("Department") to conduct a comprehensive review of the complicated web of employee benefits guidance with an eye to simplifying and minimizing compliance costs. Our specific suggestions are below.

Plan Amendments and Determination Letters

Tax-qualified retirement plans must be periodically amended to comply with current law. Current law evolves with new legislation and regulation. In recent years, this evolution has come at a breakneck speed and employers have been forced to amend their plans at an alarming rate.[1] These serial amendments are often a sore spot for employers and plan service providers. Many plans need to be amended every year to reflect law changes.[2] These changes are often esoteric and do not have a material effect on the vast majority of plans or participants.[3] Nonetheless, employers must incur costs and devote resources to periodic amendments. To make matters worse, the relevant rules often require interim amendments before all of the guidance is issued and then subsequent amendments.[4]

Employers routinely submit their plans for determination letters. In recent years, the Internal Revenue Service has simplified the determination letter process through implementation of a staggered remedial amendment period process, but the remedial amendment period rules are exceedingly complicated.[5] Moreover, the determination letter rules are not coordinated with the timing rules for plan amendments. Employers often restate their plans in anticipation of a determination letter filing but the amendments are generally required on an entirely different time frame.[6] The Council believes that these rules should be coordinated, for example, by extending the remedial amendment period to the applicable determination letter due date.

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[1] For example, in the last 5 years, plans have had to be amended to reflect the Small Business Jobs Act of 2010, the Worker, Retiree, and Employer Recovery Act of 2008, the Heroes Earnings Assistance and Relief Tax Act of 2008, the U.S. Troops Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007, and the Pension Protection Act of 2006.

[2] In fact, the Internal Revenue Service publishes an annual list of the cumulative changes that must be made to plan documents. *See, e.g.*, Notice 2010-90, 2010-52 I.R.B. 909 (listing more than twenty new plan qualification requirements that were not in the 2009 or earlier cumulative lists).

[3] For example, most plans had to be amended to reflect the final section 415 regulations, which prescribe the rules governing the maximum benefits and contributions that may be provided under a plan, even though many of the plans do not have benefits or contribution levels that approach the section 415 limits.

[4] For example, plans that added Roth elective deferral features in 2006 when the statute first permitted such arrangements had to be amended to reflect such features before final Roth regulations were published in April, 2007. The Internal Revenue Service helpfully published good faith model amendments, but these provisions had to be subsequently updated and integrated into the plan document. *See* Notice 2006-44, 2006-1 C.B. 889.

[5] *See* Rev. Proc. 2007-44, 2007-28 I.R.B. 54, *modified by* Rev. Proc. 2008-56, 2008-40 I.R.B. 826 and Rev. Proc. 2009-36, 2009-35 I.R.B. 304, *modified in part by* Notice 2009-97, 2009-52 I.R.B. 972 and Notice 2010-77, 2010-51 I.R.B. 851.

[6] We note that the Advisory Committee on Tax Exempt and Government Entities (ACT) recently made a series of recommendations along these lines. *See* ACT Report of Recommendations (June 9, 2010).

This area is ripe for simplification. We appreciate the need for appropriate plan documents and that there are a variety of plan designs, including both prototype and individually designed plans, but the current set of rules is simply far too complicated and burdensome relative to its benefits. Thus, the Council strongly recommends that the Treasury Department undertake to simplify the plan amendment and determination letter process.

CORRECTION OF OPERATIONAL DEFECTS

The Council greatly appreciates the Internal Revenue Service's Employee Plans Compliance Resolution System ("EPCRS"), which allows plan administrators to correct plan defects.[7] EPCRS is a valuable and important part of the retirement plan system. In administering EPCRS, the Internal Revenue Service often exercises judgments about the costs and appropriate method of correction. The Council believes that there are a number of circumstances in which the Service could strike a more reasonable balance.

There are any number of examples. Among others, we question whether the methods used to adjust corrective contributions to reflect the time value of money are justified. These methods often require participant-specific calculations in plans that permit participant-investment direction.[8] We also question whether the level of corrective contributions necessary to adjust for a failure to make elective deferrals appropriately reflects the lost deferral opportunity, particularly in plans where the failure involves an automatic deferral or escalation feature.[9] By way of another example, the current rules do not allow for the correction of participant loan defects without the involvement of the Internal Revenue Service, which drives up the cost of correction and slows down the correction process.[10] Taken as a whole, we believe that EPCRS is an area of the employee benefits law where substantial improvements could be made that will reduce the administrative burden of the program without adversely affecting the benefits of the program.

In addition to the above, the Council encourages the Department to consider issuing EPCRS-like rules for welfare plans. Welfare plan sponsors and administrators, notwithstanding their best efforts, may find that a plan has been administered contrary to its written plan terms or applicable law. For example, a plan that is intended to only reimburse certain Code section 213 qualified medical expense (such as premiums only)

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[7] Rev. Proc. 2008-50, 2008-35 I.R.B. 464.

[8] *Id.* at § 6.02(4).

[9] *Id.* at Appendix A.05(2) (safe harbor method of correction requiring a corrective contribution equal to 50% of the lost deferral).

[10] *Id.* at §6.07(2) (providing that loan defects may only be corrected through VCP, which requires a submission to the Internal Revenue Service).

may inadvertently reimburse a participant for an excluded Code section 213 medical expense (or an expense that does not qualify as a Code section 213 medical expense). Such operational failures can give rise to a myriad of complex tax reporting and withholding issues for sponsors and their affected employees, and may result in the issuance of amended Form W-2s where the failure relates to a prior tax year. In some instances, the operational failure may even compel a plan sponsor to pursue a costly voluntary closing agreement with the IRS. It is our understanding that certain branches in the IRS have indicated that they are no longer willing to enter into such voluntary closing agreements absent more broad consensus within the Department regarding the implications to welfare plans of these types of administrative failures. As a result, employers and administrators may find themselves confronting a plan operational failure with no apparent way to efficiently resolve the matter. Accordingly, the Council urges the Department to consider issuing EPCRS-rules, in proposed form and subject to public comment, that allow for self-correction of inadvertent operational failures with respect to welfare plans.

WITHHOLDING

Many service providers provide tax reporting and withholding services to both employer-maintained tax-qualified plans and IRAs.[11] However, the rules for these two types of arrangements have substantial differences that appear to be arbitrary and that impose administrative burdens on payors. We suggest that Treasury consider steps that may simplify the process, although we realize that legislation is necessary for some changes.

Consider, for example, withholding for systematic withdrawals from a plan or IRA. If the systematic withdrawals are for a period of 10 years or more, the participant can make a withholding election.[12] However, the manner in which the election is made depends on the type of retirement vehicle. The election is made on the Form W-4P if the arrangement is a plan and it may be made in a variety of different ways, including the distribution election form, if the arrangement is an IRA.[13] We believe that guidance applicable to both types of arrangements should be the same and that the guidance should accommodate flexibility in withholding elections.

ELECTRONIC DELIVERY OF NOTICES

[11] Our comments apply equally to governmental section 457(b) plans and section 403(b) plans.

[12] Code § 3405(a).

[13] *See* IRS, Form W-4P, *Withholding Certificate for Pension or Annuity Payments* (2011); IRS News Release 83-3 (January 7, 1983).

The Council greatly appreciates the guidance the Internal Revenue Service has issued on the use of paperless media to provide notices and disclosures that are required for plans and IRAs.[14] The Internal Revenue Service's use of a standard that turns on whether participants are able to effectively access disclosures is very useful. The Council believes, however, that the use of paperless media could be expanded, which would reduce the cost of plan administration and potentially increase participant benefits.

In particular, we believe that guidance should permit many of the relevant notices to be posted on a secure internet website. There is currently a disconnect between the delivery requirements for tax notices and the fact that many plans provide for investment elections and communicate to participants through a secure website. For example, the section 402(f) notice, which describes the tax consequences of distributions and rollovers, must be affirmatively delivered, often at material cost. It should instead be permissible to post the notice to a secure website. To the extent that there are concerns about access and awareness, posting could be permitted if the plan administrator provides notice of the availability of the information (and access to paper copies).[15] This "post-with-a-push" concept is well-suited to striking a balance between limiting plan costs and ensuring access to, and awareness of, the various notices.

GOOD FAITH COMPLIANCE STANDARD

As mentioned above, the pace of legislation and regulation affecting employee benefit plans has greatly accelerated in recent years. Many of these changes have somewhat unrealistic effective dates. Legislation may, for example, have an effective date that is earlier than it is possible for the Treasury Department to issue interpretive guidance. Thus, plans are often put in the position of having to comply with unclear or ambiguous rules. Moreover, employers typically have a range of options from which to choose and therefore must analyze, price, seek approval, negotiate with the unions, communicate with employees, implement with service providers and amend plans in order to satisfy these law changes. These steps take time, particularly for large employers. Plan sponsors often fret that they will have to make retroactive changes after the guidance is issued or that modest interpretive differences will have substantial effects. There does not, however, appear to be a consistent approach to compliance before final rules are published and effective. We suggest that a single approach should be taken, namely that the Treasury Department treat reasonable good-faith compliance

[14] Treas. Reg. § 1.401(a)-21.

[15] *See* Field Assistance Bulletin 2006-03, in which the Department of Labor authorized this approach for periodic benefit statements.

prior to the effective date of final rules as compliance. This is sometimes the case but we believe that it should be the rule.[16]

One recent example of this pertains to new Code section 162(m)(6), which generally imposes a deduction limitation on certain remuneration paid by covered health insurance providers ("CHIPs") to applicable individuals. Per Notice 2011-2, it appears that CHIPS generally are required to allocate deferred compensation and earnings thereon to the year in which it is earned. The Notice, however, provides no additional guidance for employers regarding how to perform this allocation.[17] Given the absence of any clear and enumerated rules regarding how to allocate deferred compensation, we urge the Department to provide guidance clarifying that reasonable good-faith compliance by a CHIP, whether by reference to existing Notice 2008-94 or otherwise, constitutes compliance for purposes of Code section 162(m)(6).

NOTICE AND COMMENT

There are also circumstances in which the Treasury Department announces new interpretive positions without the benefit of the notice-and-comment process or even a prospective effective date. While these occurrences are the exception rather than the rule, they are enormously disruptive and create the impression of arbitrary government action. Consider, for example, the model section 402(f) notice that was published as part of Notice 2009-68[18] in September, 2009. The notice was intended as a description of current law but it included a novel interpretation of the basis recovery rules applicable to partial distributions.[19] That interpretation has had enormous costs for plans with participants raising questions and payors having to wrestle with whether the interpretation fairly represents the law. Our point is simply that the Treasury Department needs to act diligently to minimize the announcement of guidance without the benefit of input from interested stakeholders.

Another example is the new adult child requirement as added to Code by the Patient Protection and Affordable Care Act ("ACA") ("Adult Child Requirement"). The Adult Child Requirement generally requires plans to make dependent child coverage

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[16] *See, e.g.*, T.D. 9447 (publishing on February 24, 2009 final regulations governing automatic enrollment arrangements but providing good-faith compliance only for plan years beginning in 2008, thus, on its face requiring strict compliance prior to the January 1, 2010 effective date).

[17] The IRS did request comments on whether the allocation rules set forth in Notice 2008-94, which apply to Code section 162(m)(5), should apply to Code section 162(m)(6) as well.

[18] 2009-39 I.R.B. 423.

[19] This issue was exacerbated by a newsletter published in March, 2010 that suggested a similar interpretation. *See* IRS, Employee Plans News, Volume 10, Spring 2010, *available at* http://www.irs.gov/pub/irs-tege/spr10.pdf.

available for children until their attainment of age 26, without regard to any financial or domicile requirements. Following the enactment of ACA, employers generally were very eager to understand this new requirement, including with respect to who constitutes a "child." Notwithstanding several requests by employers and the Council for clarification regarding who is a "child" for this purpose, the interim final regulations issued by the Department as well as the Departments of Labor ("DOL") and Health and Human Services ("HHS") failed to provide a definition of "child." With a rapidly approaching open enrollment period and start to the 2011 plan year, many employers were therefore compelled to make their own good faith determinations regarding who constitutes a "child" for purposes of this new rule. In late September 2010, with open enrollment already underway for some employers and fast approaching for others, the Department, in conjunction with DOL and HHS, issued sub-regulatory guidance on the issue. Although the guidance was intended to be helpful by setting forth a safe harbor definition of "child", for many the guidance was too late and in some instances resulted in significant confusion and concern. This is because some employers in good faith had adopted a definition of "child" for their plans that differed from the safe harbor definition. Accordingly, for these employers, the issuance of the sub-regulatory guidance raised the specter that their prior good faith interpretation may be insufficient. Had the agencies simply issued proposed guidance earlier in 2011 as requested, employers (as well as other stakeholders) would have been provided opportunity for public comment and sufficient time to comply with any final rule Instead, many employers were left confused and concerned about their ongoing obligations with respect to the new Adult Child Requirement.[20]

NONDISCRIMINATION RULES FOR GROUP HEALTH PLANS

Section 2716 of the Public Health Service Act ("PHSA"), as added by ACA, imposes new nondiscrimination requirements for insured group health plans. As set forth in the Council's March 11, 2011 comment letter to this Department, our members greatly appreciate the important transition relief that was made part of Notice 2011-1. The Notice generally delayed the application of the new rules until the plan years beginning after 2011. There remains, however, a significant possibility that imposing new

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[20] As the above examples demonstrate, all parties, including the Department, are best served when the Department issues substantive guidance in proposed form pursuant to the Administrative Procedures Act ("APA"). Per the APA, federal agencies are generally required, prior to the promulgation of any regulation, to publish in the Federal Register a general notice of proposed rulemaking. In addition, the APA requires that such proposed rulemaking be subject to a comment period during which interested members of the public may submit their comments regarding the rulemaking. The APA provides only limited exceptions to this rule, such as where "the agency for good cause finds . . . that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest." 5 U.S.C. § 553(b). Although the APA gives the Department the authority to depart from notice-and-comment rulemaking under appropriate circumstances, the Council urges the Department to exercise such authority only when absolutely necessary.

nondiscrimination rules for insured plans prior to 2014 will compel some employers to eliminate group medical coverage for their employees, both highly and non-highly compensated. Thus, as set forth in our March 11th letter, unless and until meaningful alternatives to employer-sponsored coverage exist – such as beginning in 2014 when individuals can access comprehensive medical coverage through state-based exchanges as well as significant premium and cost-sharing tax credits – the new insured plan nondiscrimination rules should not be made effective; otherwise a significant number of families may find themselves without access to vital employer-sponsored medical coverage. For a fuller discussion of this and other important comments regarding new PHSA section 2716, please refer to our March 11th comment letter.

The Council also urges the Department to review and modernize the existing nondiscrimination rules for self-insured arrangements under Code section 105(h), whether as part of its current rulemaking activities regarding insured group arrangements or otherwise. The existing nondiscrimination rules for self-insured arrangements are out of date and fail to take account of modern business practices, including with respect to defined contribution health arrangements and retiree health benefits. Moreover, the existing regulations leave many important questions without a clear answer. For example, there remains substantial confusion among stakeholders and perhaps within the Department as well regarding what constitutes a "benefit" (*e.g.*, whether a "benefit" encompasses employer premium subsidies or eligibility rules such as waiting periods). Additionally many questions remain about the mechanics of the eligibility test and how to establish a nondiscriminatory classification (*e.g.*, whether one can utilize the prior version of the Code section 410(b) regulations, which generally did not utilize strict numeric parameters set forth in the current version of the regulations).

These and other questions exist in large part because of the Department's long-standing position that it will not issue private letter rulings regarding a plan's compliance with Code section 105(h). The end result of this position is that many employers have struggled to understand their obligations under Code section 105(h), especially in the face of an ever-changing workforce and related benefit designs. To assist employers, such as the Council's members, in complying with Code section 105(h), we urge the Department to begin the process of reviewing and updating the existing regulations for self-insured arrangements. As part of this process, we request that the Department issue a request for information ("RFI") specifically with respect to self-insured arrangements, similar to the RFI it issued with respect to PHSA section 2716 and insured group arrangements. Additionally, we request that any future guidance take account of the changing regulatory landscape for group health plans per ACA. Lastly, we request that any future guidance be issued in proposed form to allow for important and meaningful public comment by all interested stakeholders.

CAFETERIA PLANS

In August 2007, the Department issued new proposed cafeteria plan regulations interpreting section 125 of the Code. The Council and other stakeholders submitted extensive comments on the proposed regulations. To date the Department has not issued final regulations.

Given the passage of time, as well as the subsequent enactment of the ACA, we recommend that the Department issue a Request for Information (RFI) related to the proposed regulations to provide additional opportunity for public comment before they are published in final form. We encourage the Department to consider ways in which the rules should be modified to take account of the recent enactment of the ACA, which imposes a range of very significant changes related to health care coverage, especially after 2013. Many of these changes are likely to implicate cafeteria plans. For example, we suggest the Department consider ways in which the nondiscrimination rules should be revised to ensure that employers and employees alike are not disadvantaged post-2013 by the lower utilization rates that should be expected by certain non-highly compensated employees; specifically, lower-income individuals who receive federal premium and cost-sharing subsidies and thus have a lesser need for salary reduction through a cafeteria plan.

INTERNATIONAL ISSUES

The Council also believes that the employee benefit plan rules need to be crafted with a sensitivity to the fact that many employers are multinationals. Many employers maintain plans covering employees in different countries and employers are often perplexed by the challenges of complying with the tax rules of different jurisdictions and in some cases existing law is unclear adding to the confusion. We realize that the Internal Revenue Service cannot always harmonize these rules but we think a sensitivity to the international implications of plan rules is appropriate.

One recent example is the confusion that resulted from informal guidance suggesting that plans covering only Puerto Rican residents (plans described in section 1022(i)(1) of ERISA) may not participate in an 81-100 trust. The Internal Revenue Service has since issued relief and a request for comment but much of the chaos that ensued could have been avoided by a greater attention to the complexities facing multinational employers.[21]

Another example involves the tax treatment of non-U.S. citizens who are transferred to the U.S. These inpatriate employees are often covered by funded retirement plans at the time they transfer to the U.S. but ongoing contributions are not made with respect to U.S. employment. The foreign plans are often broad-based arrangements but they

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[21] *See* Rev. Rul. 2011-1, 2011-2 I.R.B. 251 (providing relief for plans described in section 1022(i)(1) of ERISA).

almost invariably do not satisfy the U.S. tax-qualification requirements. As a result, the inpatriate employees are technically covered by funded nonqualified deferred compensation plans, which means that section 402(b) of the Code is potentially applicable when these employees become subject to U.S. tax on their worldwide income, for example, because they become U.S. residents. Section 402(b)(4) imposes a mark-to-market tax regime (i.e., tax on earnings as they accrue) on highly compensated employees who are covered by funded nonqualified deferred compensation plans. This regime encourages employers to maintain plans that satisfy the U.S. tax-qualification requirements but that policy is inapplicable to foreign plans. There are good reasons for concluding that inpatriates are not taxable on the earnings attributable to foreign service but there is no guidance clearly addressing the issue. Given the substantial increase in global mobility assignments, it is important that the Treasury Department eliminate barriers to international transfers and the Council urges the Department to clarify that section 402(b)(4) is inapplicable in this context.

Another recent example pertains to the treatment of both inpatriate and expatriate health plans, *i.e.*, plans covering foreign nationals working in the United States and plans covering U.S. nationals working abroad, respectively, under the nondiscrimination requirements of Code section 105(h) and new PHSA section 2716. The existing Code section 105(h) regulations do not adequately address whether and/or the extent to which the nondiscrimination requirements apply to inpatriate or expatriate plans. To the extent that these regulations are interpreted to apply to these types of plans, very few of these arrangements are likely to be able to comply with the existing regulations given the unique realities of such plans.[22] This issue takes on increased relevance in light of new PHSA section 2716, which, as discussed above, imposes nondiscrimination requirements on insured group arrangements as well. Accordingly, the Council urges the Department to issue proposed guidance clarifying the status of inpatriate and expatriate plans for purposes of both Code section 105(h) and new PHSA section 2716.

INTERAGENCY COORDINATION

The Council also recommends that the Treasury Department consider whether its rules are synchronized with the rules of its sister agencies. A number of different agencies share oversight responsibility for the voluntary employer-maintained benefit plan system, including, among others, the Department of Labor, the Securities & Exchange Commission, the Department of Health and Human Services ("HHS"), the Equal Employment Opportunity Commission ("EEOC"), and the Commodity Futures Trading Commission ("CFTC"). The overlapping regulations of the different agencies

[22] This is in large part due to the fact that many covered individuals qualify as highly compensated individuals and because the inpatriate or expatriate coverage oftentimes must differ from that offered to other employees to ensure comprehensive coverage for the inpatriate or expatriate (such as because of differences in provider networks or reimbursable procedures or expenses).

frequently create administrative challenges for plans, For example, an administrative error in the operation of a plan may necessitate multiple corrections under the guidelines issued by different agencies. Similarly, plans may need to comply with a number of different rules governing the use of electronic media to provide notices and disclosures. The Council believes that the relevant agencies should work together to develop rules that work seamlessly together. The overlapping regulatory regimes are often uncoordinated and a source of significant frustration for plan sponsors and administrators.

BALANCING BURDENS AND BENEFITS

As a final overarching comment, the Council urges the Department to carefully consider the administrative burdens of guidance. While we appreciate the importance of rules that are appropriately protective of participant interests, these interests are not well-served by unnecessarily broad and overly burdensome requirements. Moreover, as the pace of legislation affecting plans has accelerated, it is inevitable that new rules will have both intended and unintended consequences. Regulations should be crafted with an eye to effecting legislative intent while limiting and mitigating the unintended consequences and burdens for plan administration.

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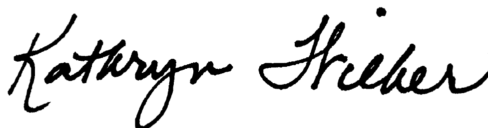
We appreciate the opportunity to comment on the need for regulatory simplification, and we look forward to working with you on these important changes.

Sincerely,

Jan Jacobson

Senior Counsel, Retirement Policy

Kathryn Wilber



Senior Counsel, Health Policy