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Submitted Electronically via: ***www.regulations.gov***

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N–5655
Attn: RIN 1210–AB37
Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

RE: Comments In Response to Proposed ERISA Section 408(b)(2)(B) Compensation Disclosure Regulations (RIN 1210–AB37)

To Whom It May Concern:

The ERISA Industry Committee ("ERIC") respectfully submits the following comments in response to the Notice of Proposed Rulemaking, requiring providers of "pharmacy benefit management services" and affiliated providers of brokerage and consulting services to disclose information about their compensation to fiduciaries of self-insured group health plans subject to the Employee Retirement Income Security Act ("ERISA"). These disclosures – which are required under ERISA section 408(b)(2)(B) – are needed so that plan fiduciaries can assess the reasonableness of the contracts with these service providers, including the reasonableness of the service providers' compensation.

ERIC is the only national trade association that advocates exclusively on behalf of large employers on health, retirement, and compensation public policies on the federal, state, and local levels. ERIC's member companies offer comprehensive group health benefits to their employees in compliance with the myriad federal laws, including ERISA, the Internal Revenue Code, and the Public Health Service. ERIC supports the ability of its large employer member companies to tailor retirement, health, and compensation benefits to meet the unique needs of their workforce, providing benefits to millions of workers, retirees, and their families across the country.

I. COMMENTS RELATING TO THE TERM "PHARMACY BENEFIT MANAGEMENT SERVICES"

A. The Department Has the Requisite Authority to Define "Pharmacy Benefit Management Services" In These Regulations

ERISA section 505 gives the Department the authority to define an otherwise undefined statutory term through regulations.[1] A relevant example of the Department acting on this authority: Defining the term "plan asset" in regulations.

[1] *See* Section 505 of the Employee Retirement Income Security Act ("ERISA").

Here, the term "plan asset" is not fully defined in the statute. And, in an effort to further define the term "plan asset" for purposes of ERISA, the Department developed and finalized what we now know as the "plan asset" regulations.[2] Through these "plan asset" regulations, the Department effectively created a functional definition of an ERISA "plan asset" that governs ERISA fiduciary status and ERISA's prohibited transaction rules.

"Pharmacy benefit management services" is a statutory term set forth in ERISA section 408(b)(2)(B). However, the term "pharmacy benefit management services" is undefined in the statute. As a result, on account of the Department's authority to further define a statutory term in regulations (as noted above), the Department clearly has the authority to develop through these regulations a definition of "pharmacy benefit management services" for purposes of 408(b)(2)(B)'s Compensation Disclosure requirements.

B. ERIC Supports the List of "Pharmacy Benefit Management Services" Enumerated in These Regulations

ERIC effectively supports the enumerated list of "pharmacy benefit management services" set forth in these proposed regulations that, if provided by a service provider to a self-insured group health plan, would require this service provider to disclose specified compensation streams also enumerated in these regulations.

However, ERIC suggests that the Department more specifically define what it means to "perform regulatory compliance" with respect to the self-insured plan's prescription drug benefits. Without more detail, we believe that certain service providers to a self-insured plan (e.g., a regulatory attorney or benefit consultant) who are generally not the target of these regulations may be subject to these proposed Compensation Disclosure requirements.

C. ERIC Agrees that ANY Entity Providing "Pharmacy Benefit Management Services" Should Be Subject to These Regulations, Including GPOs

Although these regulations target Pharmacy Benefit Managers ("PBMs"), we applaud the Department for making clear that an entity does ***not*** have to explicitly be a PBM to be subject to these Compensation Disclosure requirements.

Stated differently, we commend the Department for extending these Compensation Disclosure requirements to ***any*** entity providing "pharmacy benefit management services" to a self-insured plan, which not only includes PBMs, but may also include Third-Party Administrators ("TPAs"), consultants, and other organizations providing services for the self-insured plan.

We also fully support the Department's efforts to confirm that offshore Group Purchasing Organizations ("GPOs") established by a PBM or a related plan service provider are subject to the Compensation Disclosure requirements set forth in these regulations.

[2] *See, e.g.*, 29 C.F.R. § 2510.3-101.

ERIC recommends that the Department go even further in final regulations. That is, we believe that the Department must clearly state that GPOs ***must*** disclose the compensation they receive in connection with providing "pharmacy benefit management services" to a self-insured plan. In our opinion, it does not matter whether the GPO is considered an "affiliate" or an "agent" of a PBM that is itself providing "pharmacy benefit management services." Final regulations ***should specifically list out a GPO***, along with ***any*** entity – irrespective of its name – that performs the same functions traditionally performed by a GPO, as entities subject to these Compensation Disclosure requirements.

ERIC also believes that the Department should not stop there. We believe that the Department must also ***specifically enumerate a list*** of entities that would be subject to these proposed regulations through their affiliation with offshore GPOs, including (1) any entity that contracts with the self-insured plan or plan sponsor, (2) any "drug branding" or "labeling/marketer" entity that purchases drugs from drug manufacturers and then "private-labels" any and all purchased drugs, (3) any GPO-owned or controlled pharmacy dispensing channel (e.g., retail, mail-order, or specialty pharmacy), (4) drug "sourcing" or wholesale entities owned in part or in whole by the same holding company, and (5) any rebate aggregator or similar entity that collects manufacturer payments and distributes those payments throughout the vertically integrated enterprise. In short, each and every entity woven into this type of structure ***must be listed as an entity*** that is subject to the proposed Compensation Disclosure requirements. This should include "joint venture" affiliates as well.

Consistent with the Department's authority to define "pharmacy benefit management services" in regulations, the Department has the authority to list out those entities that perform these "types" of services, and thus, can appropriately specify what entities are subject to these proposed requirements.

II. COMMENTS RELATING TO THE "TYPES" OF COMPENSATION TO BE DISLCOSED

A. The Department Has the Requisite Authority to Define the "Types" of Compensation To Be Disclosed In These Regulations

As explained above, the Department has the authority to define an otherwise undefined statutory term set forth in ERISA through regulations. Importantly, the terms "direct compensation" and "indirect compensation" are only generally defined in the statute. And, to create a functional definition of "direct compensation" and "indirect compensation" that must be disclosed by entities providing "pharmacy benefit management services" to a self-insured plan, the Department appropriately defined in these regulations the types of compensation that commonly flow throughout the prescription drug supply chain.

ERIC supports the enumerated compensation streams under these proposed regulations, and recommends that the Department remain vigilant in monitoring entities providing "pharmacy benefit management services" to make sure that these entities do not consider – or "label" – the compensation streams otherwise enumerated in these proposed regulations as something else so as to avoid and evade these Compensation Disclosure requirements.[3]

[3] By way of example, the Department must ensure that these entities do not consider – or label – "spread compensation" as defined in these proposed regulations as something else so as to avoid and evade disclosing spread compensation as required under these proposed rules.

In our opinion, the Department must give itself the greatest amount of flexibility to respond to actions taken by entities otherwise subject to these regulations to avoid and evade these Compensation Disclosure requirements, and the Department must act swiftly through the release of guidance or undertaking enforcement actions when such malfeasance is detected.

The Department should also add the following to the list of enumerated compensation streams:

- Fees a drug manufacturer pays a PBM for access to the prescription drug claims data adjudicated by the PBM, as well as predictive analytics performed by the PBM identifying utilization trends;
- Fees a drug manufacturer pays to the PBM for access to PBM-owned dispensing channels such as specialty pharmacies; and
- Any amounts paid by the drug manufacturer to a PBM under a risk-sharing arrangement.

In addition, and consistent with the above points related to offshore GPOs, the Department should ensure that all of the payments and remuneration that flows throughout a vertically integrated GPO/PBM structure are captured by the regulation, including spread compensation generated by the "labeling/marketer" entity (i.e., the difference between the acquisition cost and the transfer price for "private-labeled" drugs). We also recommend that all payments distributed throughout the vertically integrated enterprise, including revenue-sharing among the GPO, "labeling/marketer," rebate aggregator, and PBM, as well as specialized rebates such as market-share rebates and performance and non-performance rebates are subject to these Compensation Disclosure requirements.

III. COMMENTS RELATING TO THE "TYPES" OF INFORMATION TO BE DISCLOSED

The Department would require an entity providing "pharmacy benefit management services" to disclose the "types" of compensation streams (noted above) in an Initial Disclosure (prior to entering into or renewing a service agreement with the entity), and also, in a Semiannual Disclosure (every 6 months beginning after the date the service agreement is entered into). The Initial Disclosure would also include a description of the services provided to the plan, along with a statement of whether the entity is an ERISA fiduciary or not, which are consistent with what the existing ERISA section 408(b)(2)(B) statute requires to be disclosed.

The Department would add a required disclosure to the Semiannual Disclosure, here: the identification and explanation of a 5% or more increase in any of the compensation streams disclosed in the Initial Disclosure, and also, the Department would require the covered service provider entity to include a statement that the plan has a right to audit this entity in both the Initial and Semiannual Disclosures (we discuss these audit rights in more detail below).

ERIC supports all of the "types" of information to be disclosed in the Initial and Semiannual Disclosures. We also recommend that the Department consider adding to the Initial Disclosure the following:

- An entity providing "pharmacy benefit management services" to the plan that receives Request for Proposal ("RFP") responses from other entities seeking to provide "pharmacy benefit management services" to the plan must (1) disclose the "net effective cost" of the plan's covered prescription drugs set forth in all of the RFP responses collected by this entity and (2) provide a description of the total net cost for each respective RFP response collected by this entity for the applicable plan year presented in a net effective, standardized format.
- For these purposes, the term "net effective cost" means (1) all drug manufacturer price concessions that would be guaranteed to the plan and (2) the total annual cost to the plan calculated as a sum of: (a) the aggregate ingredient cost after dispensing minus rebates passed through to the plan across the benefit and (b) the aggregate dollars received from bona fide service fees received from all drug manufacturers across the benefit.
- "Bona fide service fees" would mean fees that represent fair-market value for bona fide, itemized services actually performed on behalf of a drug manufacturer, customer, or client and that the manufacturer, customer, or client would otherwise perform or contract for in the absence of a service agreement, and that are not passed on in whole or in part to a client or customer of an entity, whether or not the entity takes possession of the drug.

IV. COMMENTS RELATING TO SHARING DISLCOSED INFORMATION

A. ERIC Supports Sharing the Disclosed Compensation Information With Other Plan Service Providers – This Same Requirement Must Be Incorporated Into the Gag Clause Prohibition

On February 23, 2023, the Department issued a series of Frequently Asked Questions ("FAQs") implementing the requirements under ERISA section 724, commonly referred to as the "Gag Clause Prohibition." Importantly, the February 23rd guidance confirmed that an agreement between (1) a group health plan and (2) an entity that possesses and controls the plan's pricing and health claims data (i.e., the owner of a provider network or a TPA that adjudicates the plan's health claims) *cannot* include a contractual provision that restricts access to the plan's pricing and health claims data. The Department subsequently issued another set of FAQs on January 14, 2025, explaining that "downstream" agreements cannot restrict the sharing of health claims data with the plan sponsor and the plan's business associates. They further explained that owners of the provider network cannot impose conditions on sharing health claims data with the plan's business associates.

Despite the statute – plus these two sets of FAQs – TPAs and owners of the provider networks ***continue to refuse*** to share pricing and health claims data with the health plan. These TPAs and owners of the provider networks also ***continue to restrict*** access to the data through agreements (i.e., confidentiality agreements) these entities have with the plan sponsor or companies hired to help administer the plan.

These proposed regulations would explicitly prohibit confidentiality agreements when it comes to disclosing the compensation information included in a 408(b)(2)(B) Compensation Disclosure furnished to a plan fiduciary by an entity providing "pharmacy benefit management services."

In other words, these proposed regulations would allow a self-insured plan and its plan sponsor to share the disclosed compensation information with other third-party service providers, with an important caveat: a third-party plan service provider *must agree not* to disclose this information with fourth parties.

ERIC fully supports this proposed requirement, and we strongly recommend that the Department finalize this requirement. In addition, ERIC recommends that the Department confirm that this same data-sharing requirement applies to a plan's pricing and health claims data under the Gag Clause Prohibition.

As discussed above, the Department's February 23rd and January 14th guidance are being ignored by TPAs and owners of the provider networks. The Department should take this opportunity to confirm that under ERISA section 724 (1) confidentiality agreements ***cannot*** prohibit the sharing of pricing and health claims data and (2) TPAs and owners of the provider networks ***cannot*** continue to undermine responsible plan fiduciaries and their service providers ability to evaluate and analyze plan-related data for purposes of keeping health plan costs low and performing functions that are necessary to satisfy the plan sponsor's ERISA's fiduciary duties.

V. COMMENTS RELATING TO AUDIT RIGHTS

A. ERIC Supports the Prohibition Against Limiting a Plan's/Plan Sponsor's Audit Rights

In virtually every administrative services agreement between (1) a self-insured plan or its plan sponsor and (2) a third-party entity hired to provide services to the plan, the agreement will include contractual provisions limiting the plan's/plan sponsor's ability to audit the functions of this service provider. The plan and plan sponsor, however, *must* have an unfettered right to audit the service provider to, among other things:

- Confirm that the plan service provider is furnishing services consistent with their contractual obligations;
- Identify pricing distortions such as spread pricing or undisclosed administrative markups;
- Identify conflicts of interest and potential self-dealing arrangements involving other plan service providers; and
- Evaluate whether compensation paid to the service provider is reasonable.

In short, auditing the functions of a service provider to the health plan is a fiduciary obligation, and any limitations placed on the plan's/plan sponsor's ability to audit the service provider's functions prevent the plan/plan sponsor from doing their job and satisfying their fiduciary duties.

ERIC applauds the Department's proposed directive that the plan/plan sponsor must have the right to audit an entity providing "pharmacy benefit management services" at least once per year to make sure that this service provider is fully disclosing the required compensation information. We also commend the Department for prohibiting the service provider from placing limits on (1) the period of the audit, (2) the location of the audit, and (3) the number of records that the plan/plan sponsor can review during the audit. We further commend the Department for its directive that the plan/plan sponsor has a right to select an auditor of its own choosing, and also, confirmation that the service provider cannot place any limitations on this auditor.

ERIC believes that ***all*** of these same prohibitions on limiting the plan's/plan sponsor's audit rights should be applied to ***any*** and ***all*** monitoring functions that the plan sponsor must engage in to satisfy its fiduciary obligations. As discussed more fully below, this includes prohibiting limitations on a plan's/plan sponsor's ability to audit the plan's health claims data.

B. Prohibiting Limits on Audit Rights Should Be Extended to Auditing Health Claims Data

Accessing complete and accurate health claims data is essential for plan sponsors to satisfy their ERISA fiduciary duties. Stated differently, if a plan sponsor does not have access to a complete and accurate set of claims data, the plan sponsor cannot satisfy their fiduciary duties because the plan sponsor may be unable to:

- Verify whether incurred claims are being paid correctly and in accordance with the plan document;
- Identify and recover mistaken payments and overpayments made with plan assets;
- Detect fraud, waste, abuse, and improper billing practices;
- Understand cost drivers and utilization patterns in order to manage plan costs responsibly; and
- Make prudent procurement, contracting, and plan design decisions.

Importantly, plan sponsors must have access to a complete and accurate set of claims data without material exclusions. In other words, plan sponsors must have access to:

- All adjudicated claims data;
- Provider identifiers and service details;
- Allowed amounts and paid amounts;
- Contracted reimbursement rates and pricing methodologies; and
- Network identifiers and contract references.

The bottom-line is this -- a plan sponsor cannot demonstrate prudence or ensure that plan assets are being used solely for the benefit of participants without the ability to review how claims are actually being paid.

Therefore, we ask that the Department extend the same prohibitions on limiting a plan's/plan sponsor's audit rights set forth in these proposed regulations to audits of the plan's health claims data. This includes prohibiting the service provider from charging the plan/plan sponsor large sums of money to simply gain access to the plan's claims data (which is a rampant problem today). This also includes the ability for the plan/plan sponsor to select its own auditor to audit the plan's claims data, as well as the prohibition against placing limits on (1) the auditor, (2) the period of the audit, (3) the location of the audit, and (4) the number of records that the plan/plan sponsor can review during the audit.

VI. COMMENTS RELATING TO HEALTH CLAIMS DATA

A. Health Claims Data Is "Compensation" to an Entity Providing Services to a Self-Insured Health Plan and Must Be Disclosed to the Plan Fiduciary

1. *Health Claims Data Is Valuable*

The health claims data generated by self-insured health plans is widely recognized as a valuable commercial asset. Market evidence demonstrates this value, including the following:

- ***Optum's Acquisition of Change Healthcare (~$13B)*** – A significant portion of the transaction value reflected the clearinghouse infrastructure and claims transaction datasets used across the U.S. healthcare payment system.
- ***IQVIA Valuation (~$30B+ market capitalization)*** **–** IQVIA's valuation is largely attributable to its healthcare data platforms built from aggregated claims and pharmacy datasets used by life sciences companies.

In addition, there are existing databases and datasets established and maintained by companies that charge significant dollars to any organization, corporation, start-up company, and even researchers that may want to access the health claims data housed in the database/dataset, including:

- ***FAIR Health Database*** – This is one of the largest healthcare claims repositories in the U.S., used for benchmarking reimbursement rates and healthcare pricing analytics.
- ***MarketScan Datasets (formerly IBM Watson Health)*** – This dataset includes employer-sponsored health plan and health insurance insurer-based claims data covering more than 100 million lives.
- ***Optum Clinformatics Data Mart*** – Medical claims and pharmacy data covering tens of millions of insured individuals.

The bottom-line is health claims data is valuable.

2. *Health Claims Data Originates from the Self-Insured Health Plan and Its Participants*

Health claims are incurred by participants covered under a self-insured health plan. These health claims are then paid for with assets of the self-insured plan. Based on this alone, a strong argument can be made that health claims data is an ERISA "plan asset."[4]

Notwithstanding the above point, it is clear that health claims data originates from the plan and its participants. It is also clear that health claims data exists solely because of the existence of the self-insured plan and the coverage that it provides participants when they incur a health claim.

[4] The Department should consider modifying the existing "plan asset" regulations to (1) clarify that health claims data is an ERISA "plan asset" and (2) confirm that a plan service provider that possesses and controls a plan's health claims data has discretionary authority to use and dispense of an ERISA "plan asset," thus confirming that this service provider is an ERISA fiduciary and subject to the same ERISA fiduciary duties applicable to plan sponsors of a self-insured health plan.

3. *The Self-Insured Health Plan Owns Its Health Claims Data, But an Entity Providing Services to the Plan Generates an Economic Benefit From the Plan's Claims Data*

Although the self-insured plan retains ownership of its claims data, when a service provider adjudicates the plan's health claims, this service provider retains, aggregates, and effectively commercializes the claims data. Upon commercializing the claims data, the service provider may sell it to the databases and datasets discussed above. Alternatively, this service provider may sell the claims data directly to a drug manufacturer for a fee, which as noted above, should be an enumerated compensation stream. Upon the sale of the claims data in either case, this service provider receives an economic benefit that would not exist but for the service provider's relationship with the plan.

Even in cases where a service provider that adjudicates the plan's health claims data does not sell the claims data to the databases and datasets discussed above, the service provider may use the plan's claims data to negotiate rates for specified medical items and services furnished by specified medical providers in a geographic region, then build a network of these providers, and then "rent" this provider network to a self-insured plan or a third-party intermediary for a fee. Similar to the scenario noted above, this service provider uses a self-insured plan's claims data to derive an economic benefit that would not exist but for the service provider's relationship with the plan.

This economic benefit that is generated on account of the service relationship with the plan can appropriately be considered "compensation" to the service provider. As "compensation," this entity providing services to the plan can appropriately be required to disclose the plan's claims data to the plan's fiduciary under ERISA section 408(b)(2)(B).

Stated differently, and as stated above, the Department has the authority to define "direct compensation" and "indirect compensation" for purposes of ERISA section 408(b)(2)(B). As a result, we believe that it is within the Department's authority to treat an economic benefit to a service provider that is generated on account of the service provider's relationship with the plan as "compensation," thereby requiring the service provider to disclose the plan's claims data to the plan fiduciary.

VII. COMMENTS RELATING TO TPAs AND ERISA SECTION 408(b)(2)(B)

A. TPAs Providing "Third-Party Administrative Services" Are Subject to ERISA's 408(b)(2)(B)'s Compensation Disclosure Requirements

The Chair and Ranking Member of the House Education & the Workforce Committee sent a letter to the Department on December 14, 2022, stating that Congress always intended to require TPAs to furnish to a plan fiduciary a 408(b)(2)(B) Compensation Disclosure if the TPA performed services such as:[5]

- Developing a provider network;
- Processing claims and maintaining records; and
- Negotiating rates.

[5] https://www.eric.org/wp-content/uploads/2026/04/Transparency-408b2-Congressional-Letter-to-the-DOL.pdf

Congress – through the Consolidated Appropriations Act of 2026 ("CAA 2026") – has now confirmed its original intent by amending ERISA section 408(b)(2)(B) and clarifying that ***any*** entity providing the types of services enumerated in the statute's "list of services" is subject to 408(b)(2)(B)'s Compensation Disclosure requirements.[6] This includes TPAs providing "third-party administrative services."

By amending the statute to effectuate Congress's original intent, Congress effectively mandated that the Department develop and release regulations that would require TPAs to disclose the "direct compensation" and "indirect compensation" they receive when providing service to, for example, a self-insured health plan. ERIC believes that the Department should do just that and recommends that the Department use these proposed regulations as a template.

For example, just like the Department has the authority to further define what "pharmacy benefit management services" means for purposes of ERISA section 408(b)(2)(B) in regulations (as discussed above), the Department has the authority to define what "third-party administrative services" means for purposes of ERISA section 408(b)(2)(B) in regulations. We suggest that the Department start with the types of "third-party administrative services" the Chair and Ranking Member of the House Education & the Workforce Committee suggested in their December 14, 2022 letter. The Department must also identify additional services that would constitute "third-party administrative services," thereby triggering ERISA section 408(b)(2)(B)'s Compensation Disclosure requirements.

As also discussed above, the Department has the authority to identify and define various compensation streams that flow throughout the TPA ecosystem as "direct compensation" and "indirect compensation" that therefore must be disclosed by an entity providing the enumerated "third-party administrative services." These compensation streams could include, among other things:

- Network Access Fees;
- Shared Savings;
- Incentive Fees; and
- Spread Compensation.

The Department should also identify additional compensation streams that could and should be disclosed by entities providing "third-party administrative services."

With respect to the audit rights requirement set forth in these proposed regulations, ERIC recommends that the Department also prohibit entities providing "third-party administrative services" from limiting the plan's and plan sponsor's ability to audit the functions of these service providers.

And lastly, and importantly, similar to the requirement set forth in these regulations to prohibit confidentiality agreements and permit data-sharing, the Department should allow a plan/plan sponsor to share any of the disclosed compensation information relating to entities providing "third-party administrative services" with another third-party providing services to the plan, so long as this third-party agrees not to share this information with fourth parties.

[6] *See* Section 6702 if the Consolidated Appropriations Act of 2026 ("CAA 2026").

VIII. COMMENTS RELATING TO THE PROPOSED EFFECTIVE AND APPLICABILTY DATES

With the enactment of CAA 2026 – and in particular, the enactment of Section 6701 of CAA 2026 which requires PBMs to disclose to a group health plan, among other things, the PBM's compensation, the PBM's distribution channels and payment practices, and the gross and net amounts a plan pays for covered prescription drugs[7] – we believe that many commenters will ask the Department to delay the effective and applicability dates for these proposed regulations.

ERIC strenuously opposes such a request. We urge the Department to finalize these proposed requirements as soon as reasonably possible. However, we recommend that the Department provide a slightly longer period for the regulations to become effective.

Specifically, we ask that the Department consider an effective date of January 1, 2027, as opposed to the proposed July 1, 2026 effective date. This would allow for a more workable landscape for ensuring compliance, a goal we share with the Department. ERIC respects the additional work that will now be required of plan service providers to comply with the proposed Compensation Disclosure requirements. We believe that the Department should give these service providers ample time after any final regulations are issued – which we would expect would be sometime late Summer or early Fall – to evaluate, analyze, and put appropriate systems in place to comply with the final rules.

We also note that it would be reasonable to align the effective date with "calendar year plans," which make up the lion's share of the self-insured group health plans in existence today.

Should the Department choose to establish an applicability date, then developing an applicability date that is 60 calendar days after the effective date of any final regulations is reasonable. However, we believe that if the Department chooses an effective date of January 1, 2027 – thereby making these disclosure requirements effective for plan years beginning on or after January 1, 2027 – there is little need for a particular applicability date.

But again, delaying the effective and applicability dates of these proposed regulations to coincide with, for example, the effective date of Section 6701 of the CAA 2026 – which is effectively not until August 2028 – is unreasonable, against public policy, and not in the best interest of plan participants.

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Thank you for your attention to these very important issues. Please do not hesitate to contact me at 202-789-1400 or jgelfand@eric.org with any questions or if we can serve as a resource.

Sincerely,

James P. Gelfand
President & CEO

[7] *See* Section 6701 of CAA 20226.