MBA HEALTH INSURANCE TRUST

March 5, 2018

Via Federal eRulemaking Portal (www.regulations.gov)

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Re: Response to Request for Comments on Proposed Rulemaking
Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans
RIN 1210-AB85

Dear Office of Regulations and Interpretations:

The Trustees of the Master Builders Association of King and Snohomish Counties Employee Benefit Group Insurance Trust ("MBA Trust") appreciate the opportunity to submit comments with respect to the proposed regulation that the Department of Labor is considering with respect to association health plans ("AHPs"). The MBA Trust is the Pacific Northwest's largest industry–specific healthcare program, providing coverage to tens of thousands of men, women, and children across the State of Washington. Member employees and their families have access to a variety of benefit plan options for medical, dental, vision, life, and disability coverage. Most of our membership consists of employers with fewer than 50 employees.

The members of the MBA Trust qualify as a bona fide association of employers, and the health and welfare benefits that we provide constitute an employee welfare benefit plan sponsored and maintained by a single "employer" under section 3(5) of the Employee Retirement Income Security Act of 1974, including amendments and implementing regulations thereto ("ERISA"). This status has been previously confirmed and continues to be recognized by the Washington State Office of the Insurance Commissioner.

For the reasons discussed herein, the MBA Trust opposes the adoption of the proposed regulation regarding the Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, RIN 1210-AB85 (Jan. 5, 2018) (the "Proposed Regulation") in its current form.

Summary

In our comments below, we address the proposed commonality of interest and nondiscrimination provisions, and our related concerns of adverse selection, market disruption, and state regulatory

authority of these provisions in their current form. The following is a summary of our comments, which are described in greater detail in the "Discussion" section below.

I. The proposed commonality of interest requirement under the Proposed Regulation conflicts with the principles and policy goals of ERISA, promotes formation of AHPs that cannot be distinguished from commercial insurance enterprises, and ultimately is not in the best interest of member employees and their families.

II. The concerns raised with respect to adverse selection, market disruption, and discrimination against employers and individuals are not resolved by the proposed nondiscrimination provisions, which conflict with key Affordable Care Act ("ACA") Requirements, and are in fact exacerbated by the Proposed Regulation.

III. The Proposed Regulation must be analyzed for potential impact on a State with well-established laws and regulations governing formation and operation of AHPs, such as the State of Washington, and any final regulation should provide an exemption so that the State may continue to regulate its AHPs to protect Washington residents and the stability of the State's insurance markets.

Discussion

I. The Proposed Commonality of Interest Requirement Under the Proposed Regulation Conflicts with the Principles and Policy Goals of ERISA, Promotes Formation of AHPs That Cannot Be Distinguished from Commercial Insurance Enterprises, and Ultimately Is Not in the Best Interest of Member Employees and Their Families.

Under the Proposed Regulation, disparate employers may form a group or association to establish an AHP solely for the purpose of sponsoring a group health plan for its member employees and their families.[1] To be treated as a single "employer" under section 3(5) of ERISA, the group or association must, among other requirements, establish that it operates in (1) the same trade, industry, line of business, or profession, or (2) the same region of one state or the same metropolitan area (even if the metropolitan area includes more than one state).[2]

Executive Order 13,813 (Oct. 12, 2017), directs the Secretary of Labor to consider proposing a new commonality of interest provision "[t]o the extent permitted by law and supported by sound policy", including consideration of ways to promote AHP formation "on the basis of common geography or industry." However, in pursuit of a more flexible test to promote AHP formation and access to health care coverage in the large group market, the Proposed Regulation would recognize a group of employers sharing only a tenuous connection, such as geographic location

[1] Proposed Regulation to be codified at 29 C.F.R. § 2510.3–5(b)(1).
[2] Proposed Regulation to be codified at 29 C.F.R. § 2510.3–5(c).

or a broadly-defined industry, as a single "employer" under ERISA—a status that has historically been conferred only on a bona fide association established for reasons other than the sole provision of health care coverage to its membership.

In light of the concerns discussed below, we respectfully request that the Secretary consider the following changes to the Proposed Regulation:

1. Restrict the provision under Proposed Regulation section 2510.3–5(c)(1) to require commonality of interest based on trade, industry, line of business, or profession;

   and

2. Eliminate the provision under Proposed Regulation section 2510.3–5(c)(2) that would permit commonality of interest solely on the basis of geography.

A. Commonality of Interest Under the Proposed Regulation

The allowance of broad geographic commonality is not supported by sound policy, and conflicts with the well-established principle under ERISA that the group maintaining an employee welfare benefit plan must be linked to the participating employees or contributing employers by common economic or representational interests unrelated to the provision of benefits.[3] The "employment-based arrangements" contemplated by ERISA's text, as acknowledged by the Notice of Proposed Rulemaking (the "Notice"),[4] stems from ERISA's purpose to protect the interests of employees, former employees, and their respective beneficiaries with respect to such plans, including but not limited to fiduciary obligations to act exclusively in the interests of these individuals.[5] The special relationship between an employee and his or her direct employer protects the employee, who can rely on his or her interests being protected when the employer or its representative provides benefits.[6] Permitting disparate employers to form an AHP based solely on geography or on their operation in an industry, no matter how broadly defined, threatens to undermine the protective nexus ERISA contemplates between the employer or group of employers with common interests sponsoring an employee welfare benefit plan and its member employees and their families.

Moreover, Congress did not intend for arrangements established to provide insurance products or services to employers and employees at large to fall under the umbrella of ERISA; such arrangements would no more be ERISA plans than any other insurance policy sold to an

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[3] *See MDPhysicians & Assocs., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 185 (5th Cir. 1992), *quoting Wis. Educ. Assoc. Ins. Trust v. Iowa State Bd.*, 804 F.2d 1059, 1063 (8th Cir. 1986); *see also* Dep't of Labor Adv. Op. 2012-04A; Exec. Order No. 13,813, Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States (Oct. 12, 2017).

[4] 83 Fed. Reg. at 617.

[5] ERISA § 2 (29 U.S.C.A. § 1001).

[6] *MDPhysicians, supra* at note 3.

employee benefit plan.[7] Recognizing this concern, the Notice proposes to impose organizational controls and governance requirements in an effort to demonstrate that these newly formed AHPs would be "genuine employment-based plans"—akin to the bona fide association plans already in existence—and not "commercial enterprises that claim to be AHPs but that are more akin to traditional insurers selling insurance in the regulated employer marketplace."[8]

However, it is not clear how such controls and requirements would ensure an AHP could effectively act in the best interest of its member employees and their families if the AHP was formed solely to purchase health care coverage and its members lack any commonality besides geography or perhaps a broadly-defined industry—or, more importantly, if its members have competing or conflicting interests for their respective workforces and benefit needs. Such an AHP would be distinguished from a commercial insurance enterprise only by its lack of an insurer or producer license, in addition to its members' singular desire to buy health care coverage in the large group market when they could not do so individually under the ACA.

Finally, the Proposed Regulation risks undermining other requirements under Title I of ERISA.[9] Specifically, the Notice states that the Proposed Regulation is intended to broaden the concept of a single "employer" solely for purposes of Title I of ERISA, and solely with respect to whether health insurance under an AHP is regulated by the ACA provisions applicable to the individual, small group, or large group market.[10] Any regulation that would make it easier for a group of employers to be treated as a single "employer" under ERISA must address the potential for such employers to rely on this status to avoid reporting and other obligations that would otherwise

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[7] H.R.Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977); *see also Wis. Educ. Assoc. Ins. Trust, supra* at note 3 (noting that a plan which is effectively an entrepreneurial venture falls outside the policy of ERISA and is not properly characterized as an employee benefit plan).
In addition, Congress has considered these issues in other insurance coverage and benefit areas, such as a "bona fide association," within Title XXVII of the Public Health Service Act ("PHSA") meaning, among other things, an association that has been formed and maintained in good faith for purposes other than obtaining insurance. PHSA § 2791(d)(3). Similarly, with respect to Voluntary Employees' Beneficiary Association, or "VEBAs," within the meaning of Internal Revenue Code section 501(c)(9), many existing AHPs use VEBAs either to purchase group insurance arrangements or fund benefits. An organization qualifies as a VEBA if it meets certain requirements and receives a determination from the Internal Revenue Service that it is so qualified. One requirement relates to "membership." Under Treasury Regulation section 1.501(c)(9)-2, membership of an organization described in section 501(c)(9) must consist of individuals who become entitled to participate by reason of their being employees and whose eligibility for membership is defined by reference to objective standards that constitute an employment-related common bond among such individuals. VEBAs have qualified under section 501(c)(9) based on the fact that membership is made up of one or more employers engaged in the same line of business in the same geographic locale. In other words, employees of one or more employers engaged in the same line of business in the same geographic locale will be considered to share an employment-related bond for purposes of an organization through which their employers provide benefits.

[8] Proposed Regulation to be codified at 29 C.F.R. § 2510.3–5(b); 83 Fed. Reg. at 623.

[9] We question, in particular, whether the Proposed Regulation would conflict with other federal laws applicable to employee welfare benefit plans, besides the potential conflicts we note in this letter with respect to ERISA Title I and the ACA.

[10] 83 Fed. Reg. at 615, n.2, and 619.

apply to each employer individually.[11] The Secretary should clarify whether the Proposed Regulation is intended to permit employers participating in such newly formed AHPs to avoid annual reporting under ERISA Title I at the employer level and, if not, confirm that such employers would continue to be treated as maintaining separate employee welfare benefit plans for annual reporting purposes.

B. Commonality of Interest Under Current Federal and State Requirements

In contrast, a bona fide association plan such as the MBA Trust, which satisfies the conditions to be a single "employer" under section 3(5) of ERISA under current federal and state requirements, is established to operate in the best interest of its member employees and their families on all fronts. Such an AHP is readily distinguishable from a commercial insurance enterprise because the association or group of employers was not established for the sole purpose to fund or purchase group health insurance coverage. A bona fide association plan can more effectively provide comprehensive advocacy and support to its membership—such as programs to assist members in hiring, training, and retaining talent; advocacy for legal, regulatory, or policy positions advancing member interests; promotion and advancement of members' strategic and business interests; and provision of comprehensive benefits packages that are not limited to health care coverage and that can be designed to address the membership's unique benefits needs. An AHP that is established out of bona fide common interests separate from a singular desire to fund or purchase group health insurance coverage is more likely to be designed and operated in the best interests of its member employees and their families.

Moreover, a bona fide association plan is less likely to maintain an AHP susceptible to fraud, mismanagement, or insolvency that could harm its members and beneficiaries. Current federal and state requirements for AHPs, including but not limited to the requirement that the group or association preexist as a bona fide association operating in the interests of its members, were imposed in response to a history of fraud, abuse, and insolvency of multiple employer welfare arrangements ("MEWAs"). The Proposed Regulation would relax such requirements, making it easier for new AHPs to form and increasing the risk of fraud and abuse.

Finally, because enrollment in group health insurance coverage (or in a self-funded AHP) is not its sole purpose for operations, a bona fide association plan is limited in its ability to restrict enrollment or benefits in an effort to discriminate against a specific individual or self-select its association risk pool. In fact, a bona fide association plan is incentivized to design its eligibility and benefits coverage to best fit its membership population, not specific individuals or groups with preferred risk profiles, and can more effectively do so when all of its members share bona fide common interests.

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[11] ERISA § 104(a) (29 U.S.C.A. § 1024(a)) (reporting on IRS Form 5500). As acknowledged in the Notice, the AHP is a type of MEWA. Generally, if a MEWA is not itself an ERISA plan, as is the case for most, each participating employer is considered to maintain a separate employee welfare benefit plan for annual reporting purposes, thus requiring each employer's plan to file an annual report absent an exemption.

II. The Concerns Raised with Respect to Adverse Selection, Market Disruption, and Discrimination Against Employers and Individuals Are Not Resolved by the Proposed Nondiscrimination Provisions, Which Conflict with Key ACA Requirements, and Are in Fact Exacerbated by the Proposed Regulation.

The Proposed Regulation would impose the following nondiscrimination requirements on AHPs: (i) prohibit conditioning employer membership on the health factor of any employee, former employee, or other beneficiary of a prospective employer member; (ii) require compliance with ACA nondiscrimination requirements under paragraphs (b) and (c) of 29 C.F.R. § 2590.702, which generally prohibit discrimination in eligibility, premiums, or contributions based on any health factor of an individual when compared to other similarly situated individuals; and (iii) prohibit treating different employer members of the group or association as distinct groups of similarly-situated individuals.[12]

Given the concerns discussed below, we respectfully request that the Secretary consider the following changes to the Proposed Regulation:

1. Eliminate the nondiscrimination provisions under Proposed Regulation section 2510.3–5(d);

   or

2. Alternatively, if Proposed Regulation section 2510.3–5(d) is finalized in its current or substantially similar form, provide an exemption from this paragraph (d) for bona fide association plans preexisting the effective date of such final regulation. As noted in Section I above, bona fide association plans established under current federal and state commonality of interest requirements are designed to ensure the protection of participants and beneficiaries, thus avoiding the risks of adverse selection, market disruption, and discrimination raised by the Proposed Regulation.

A. Conflict with ACA Nondiscrimination and Rating Requirements

Presumably, the nondiscrimination provisions under Proposed Regulation section 2510.3–5(d) were proposed primarily to address the potential for discrimination by AHPs established solely to fund or purchase group health insurance coverage for their members. However, provisions requiring compliance with paragraphs (b) and (c) of 29 C.F.R. § 2590.702 are redundant as these provisions already apply to AHPs—either directly to the group health plan or to the health insurance issuer that provides insurance coverage under that group health plan.

In addition, to the extent that Proposed Regulation section 2510.3–5(d)(4) would require an issuer to rate group health plan coverage provided through an AHP based on the overall

[12] Proposed Regulation to be codified at 29 C.F.R. § 2510.3–5(d).

experience of the entire association ("association-level rating") and would forbid setting rates for each participating employer member based on data and information specific to that employer's population ("employer-level rating"), the proposed provision conflicts with the ACA. Specifically, paragraph (c) of 29 C.F.R. § 2590.702 explicitly provides that the prohibition on requiring an individual to pay a premium or contribution greater than that required for a similarly situated individual based on a health factor is not intended to restrict the plan or issuer from setting an "aggregate amount that an employer may be charged for coverage under a group health plan."[13]

Moreover, to the extent that Proposed Regulation section 2510.3–5(d)(4) requires association-level rating for the large group market plan of an AHP that is treated as a single "employer" under ERISA, the proposed provision conflicts with the ACA rating requirements. Specifically, such community rating is required only for health insurance offered in the individual or small group markets.[14] Large fully-insured and self-funded "employers" within the meaning of section 3(5) of ERISA are not subject to this requirement, and are thus exempt from such community rating.[15] The exclusion of large group market plans from community rating requirements under the ACA was not unintentional,[16] and any regulation that would require association-level rating for large group market coverage fails to recognize this statutory exemption.[17]

B. Risk of Adverse Selection and Market Disruption

Even if the above issues with the ACA were resolved, we are concerned that the proposed nondiscrimination provisions would not effectively address the discrimination concerns raised in the Notice and that they could ultimately exacerbate such concerns due to a risk of adverse selection and market disruption.

1. Commonality of Interest Requirement

The Notice states that the nondiscrimination provisions were proposed to address the potential for adverse risk selection and resulting market disruption. However, these very risks are inherent in the Proposed Regulation and do not appear to be mitigated by the nondiscrimination

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[13] 29 C.F.R. § 2590.702(c)(2)(i) (emphasis added).
[14] 42 U.S.C.A. § 300gg.
[15] *Id.*
[16] *See* 42 U.S.C.A. § 300gg(a)(5) (providing a special rule that does not impose community rating on the large group market, but rather limits the requirements to issuers who offer coverage through public exchanges).
[17] Notably, with respect to AHPs operating in the State of Washington, it has been confirmed that AHPs are not prohibited from employer-level rating practices under the ACA, provided that such rating is not otherwise based on any health factor relating to a specific individual, and that the ACA community rating requirements do not apply to large group market plans. *In the matters of Master Builders Assoc. of King & Snohomish Ctys. & Master Builders Assoc. of King & Snohomish Ctys. Employee Benefit Grp. Ins. Trust*, Order on Cross Motions for Summary Judgment, Docket Nos. 15-0062; 15-0071; 15-0075; 15-0078; 15-0079; and 15-0084 (July 1, 2015), *available at* https://stateofreform.com/wp-content/uploads/2015/07/MBA-Trust-ruling.pdf.

provisions that have been proposed. Specifically, an AHP newly formed under the proposed commonality of interest requirement could self-select for a healthier, younger risk pool without specifically discriminating with respect to employer membership, benefits eligibility, or premiums based on any health factor of a particular individual.

For example, an AHP could be formed solely on the basis of a geographic location that is drawn to avoid areas associated with high-risk individuals or high-cost coverage within a region or metropolitan area. In fact, the Proposed Regulation recognizes this as a permissible result, in the absence of evidence that the lines were drawn to discriminate against a specific individual based on a health factor.[18] Similarly, an AHP could describe its common trade, industry, line of business, or profession so as to avoid enrollees associated with high-risk jobs or high coverage costs. In each case, the AHP would be incentivized to make coverage decisions to keep premium costs low. If the AHP is eligible to purchase in the large group market, the AHP would not be subject to and thus may not provide, in the interest of cost, ACA-required health coverage such as essential health benefits and related state benchmarking requirements.

Thus, there is a very real risk that healthier and younger individuals would flock to newly formed AHPs with the promise of cheaper coverage, with the potential of finding such coverage to be insufficient if they later experience significant health care issues. At the same time, higher-risk and higher-cost individuals who are not otherwise eligible for an employer-sponsored plan, Medicare, or Medicaid would opt for the more comprehensive ACA-required coverage in the small group and individual markets, or perhaps the more comprehensive coverage provided by preexisting bona fide association plans, creating adverse selection in those risk pools and driving up premiums. In response, preexisting bona fide association plans may be pressured into broadening their membership to compete and to mitigate the risk of adverse selection and higher health care costs, which would in turn undermine the bona fide employment interests for which the associations were established.

Note that adverse selection and disruptions are also anticipated with respect to the small group markets, individual markets and exchanges if small employers and working owners are able to leave and form single "employer" status AHPs and purchase cheaper coverage in the large group market. The potential mass exodus of small employers and individuals from these markets would create adverse selection in those risk pools, drive premiums up, and, in the worst-case scenario, eradicate the viability of such markets altogether.[19]

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[18] Proposed Regulation to be codified at 29 C.F.R. § 2510.3–5(d)(5), *Examples 5 & 6*.

[19] The American Academy of Actuaries is among the commentators on the Proposed Regulation to articulate the serious concerns that the proposed nondiscrimination provisions raise with respect to adverse selection and market disruption. *See* comment submitted by American Academy of Actuaries on February 9, 2018, *available at* https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00106.pdf; Issue Brief: Association Health Plans, American Academy of Actuaries (February 2017), *available at* https://www.actuary.org/content/association-health-plans-0. *See also,* comment submitted by Law and Policy Program Wake Forest University on February 16, 2018, *available at*

2. Association-Level Rating

To the extent the nondiscrimination provisions would require association-level rating of large group market coverage for an AHP treated as a single "employer" under ERISA, this would create similar risks of adverse selection and market disruption. While forcing blended rates across the association would reduce premiums for an employer member with high-cost or high-risk member employees, this would necessarily increase premiums for another employer member with lower-risk, healthier, or younger member employees. Under the proposed commonality of interest requirement, that lower-risk employer would be incentivized to leave the AHP to avoid the rate increases and to join another one that could provide cheaper coverage. Or, if its workforce is large enough, the employer member could forego associations altogether and instead purchase coverage from an issuer in the large group market. The threat of rate increase could cause employer members to move away from preexisting AHPs, draining the risk pools so that only high-risk member employees—and higher-cost coverage—remain.

In light of the concerns above, any regulation relating to AHP rating should be closely reviewed to determine if a new requirement of association-level rating has a greater risk of harm to small employers, member employees, and their families. The Notice states its consideration of the position that "more actuarially appropriate pricing where premiums match risk tends to lead people to buy the efficient amount of coverage, rather than underinsuring or overinsuring, and that such pricing also reduces the likelihood that insurance markets deteriorate into adverse selection spirals."[20] Rating that is tied to employer risk avoids creating the incentives noted above that would lead to adverse selection and market disruption.

3. Single "Employer" Status

The Notice also states that these nondiscrimination provisions were proposed to address the potential for discrimination among an AHP's employer membership that could undermine its treatment as a single "employer" under section 3(5) ERISA. Apparently, association-level rating is proposed based on a view that employer-level rating undermines the commonality of interest needed to establish the single "employer" status of an AHP, rendering it nearly or entirely indistinguishable from a commercial insurance enterprise.[21]

However, it is not an AHP's rating approach that threatens to undermine its single "employer" status; it is the insufficient commonality of interest preventing the members of a group or association from operating in both form and substance as a single "employer". As discussed previously, single "employer" status is undermined by the Proposed Regulation's commonality

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https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00146.pdf; comment submitted by Healthy Law Program at Kline School of Law Drexel University on February 8, 2018, *available at* https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00097.pdf.

[20] 83 Fed. Reg. at 623.

[21] *Id.*

of interest requirement, which would permit otherwise disparate employers to form an AHP solely for the purpose of providing health care coverage and based only on shared geography or a strategically-defined trade, industry, line of business, or profession. We are concerned that simply requiring such an AHP to blend its rates across the association would fail to address the lack of bona fide common interests that have been historically required to ensure an association effectively operates as a single "employer" in the best interests of its member employees and their families.

III. The Proposed Regulation Must Be Analyzed for Potential Impact on a State with Well-Established Laws and Regulations Governing Formation and Operation of AHPs, such as the State of Washington, and Any Final Regulation Should Provide an Exemption So That the State May Continue to Regulate Its AHPs to Protect Washington Residents and the Stability of the State's Insurance Markets.

We would suggest that an important aim which would serve the purposes underlying Executive Order 13813 and the Proposed Regulation is one involving deference to state laws that have an established statutory and regulatory framework to govern such matters. The Notice requests comments on the merits of ERISA preemption approaches and of using ERISA Title I to require and promote actuarial soundness, proper maintenance of reserves, adequate underwriting, and other standards to ensure AHP solvency.[22]

In this regard, the State of Washington has already established such requirements, including but not limited to requirements to operate a self-funded MEWA; requirements to qualify as a bona fide association treated as a single "employer" within the meaning of ERISA; and requirements relating to ratings practices and minimum coverage benefits.[23] The State's continued regulation of AHPs would help to ensure that such plans do not disrupt state insurance markets and would prevent such plans from committing fraudulent or abusive practices harmful to its residents, i.e., the member employees and their families. In light of these concerns, we respectfully request that the Secretary include in any final regulation on AHPs an exemption for the State of Washington, and any other state that has an established AHP market and a robust regulatory framework that already regulates that market.

Our request is analogous to the exemption from ERISA preemption provided for the Hawaii Prepaid Health Care Act ("Hawaii Act"),[24] a state law enacted in June of 1974 only a few months before ERISA was enacted. Generally, the Hawaii Act requires employers to provide comprehensive health care plans to their eligible employees working in Hawaii. The Hawaii Act went beyond the requirements of ERISA, reflecting the state's specific goal to increase access to health care coverage while also lowering costs. After the Ninth Circuit Court of Appeals ruled

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[22] 83 Fed. Reg. at 625.
[23] *See, e.g.*, Wash. Rev. Code, Ch. 48.125 (relating to self-funded MEWAs); Wash. Rev. Code § 48.44.024(2) (relating to rating practices).
[24] Haw. Rev. Stat., Ch. 393.

that the Hawaii Act was preempted under section 514 of ERISA, Congress responded by incorporating this exemption into ERISA. The exemption has enabled the State of Hawaii to continue to regulate its health care system beyond the minimum required under ERISA.

Here, we ask for a similar exemption for the State of Washington, so that the State may continue to regulate its health care system by imposing state-based requirements on AHPs as it does now. Similar to the Hawaii Act, the State of Washington's regulatory framework predates the Proposed Regulation and requires more than the minimum required under the Proposed Regulation, if finalized. The Secretary should include a provision in any final rulemaking of the Proposed Regulation that would grant such an exemption.

Conclusion

For the above reasons, the MBA Trust respectfully submits that Department of Labor Proposed Regulation Section 2510.3–5 be revised and clarified in the manner set forth above.

Respectfully submitted,

Todd Bennett,
Chair, Board of Trustees