Monday, October 25
9:00am-10:30am

106 - Benefits Law Update for the Non-Benefits Lawyer

Angela DeSilva
Associate General Counsel
Spectra Energy Corp.

Eileen Groves
Associate General Counsel
United Space Alliance, LLC

Patrick Wheeler
Senior Counsel
Kimberly-Clark Corporation

Session 106

Faculty Biographies

Angela DeSilva

Archangela M. DeSilva is associate general counsel with Spectra Energy Corp. Her responsibilities include all benefits, labor and employment law matters for all US-based Spectra business units, including counseling management regarding discrimination complaints, collective bargaining negotiations, arbitrations and employment-related litigation.

Prior to her employment with Spectra, Ms. DeSilva worked as in-house labor and employment counsel for Texaco Inc., Standard Oil Production Company and Duke Energy Corporation.

Ms. DeSilva is actively involved in ACC. She currently serves as co-chair of the webcast subcommittee of the Employment & Labor Law Committee. Previous leadership positions she has held include member, policy committee, ACC Board of Directors; chair, National Labor & Employment Law Committee; board of directors and president, ACC Houston Chapter; chair, Employment & Employee Benefits Committee, ACC Houston Chapter. Ms. DeSilva is also co-president of the ACC Houston Chapter of the Labor and Employment Relations Association (LERA). She is also a member of the ABA's Section of Labor and Employment Law and the Labor and Employment Law Sections of the State Bar of Texas and the Houston Bar Association. In addition to her professional activities, Ms. DeSilva is a member of the Advisory Board of The Women's Resource of Greater Houston.

Ms. DeSilva received a BS from Cornell University and is a graduate of Fordham University School of Law.

Eileen Groves

Eileen A. Groves is an associate general counsel of United Space Alliance, LLC ("USA") in Houston, Texas. USA is the prime contractor for NASA for human spaceflight, responsible for the day-to-day operation and management of the US Space Shuttle fleet, and is also involved in the operations of the International Space Station. Ms. Groves responsibility at USA include providing as day-to-day counsel to human resources and managers regarding labor and employment, wage & hour, OFCCP, and EEO issues and legal counsel to its benefits department regarding all USA's retirement, health and welfare plans as well.

Prior to joining USA, Ms. Groves had been a partner with Baker & Daniels in Indiana. Previously, Ms. Groves had been associate corporate labor counsel for Borden, Inc. in Columbus, Ohio where she represented Borden on labor and employment issues in both state and federal agencies and advised on all Borden's USA benefits plans as well as Borden's Canadian plans.

She was the chair of ACC National's Employment and Labor Law Committee (E&LL) in 2006-2007. The committee received the ACC Committee of the Year Award for her chairperson year. She was awarded the 2005 ACC Jonathan S. Silber Committee Member of the Year. Ms. Groves is also as a member of the board of directors of ACC's Houston Chapter.

Ms. Groves received a BA from St. John's University, New York, MA, a BA from Purdue University, Indiana and her JD from the University of Notre Dame.

Patrick Wheeler

Patrick C. Wheeler is the senior employee benefits/executive compensation counsel for Kimberly-Clark Corporation in Dallas, Texas. His responsibilities include providing employee benefits and executive compensation legal counsel to the organization as well as the Compensation Committee of the Board and managing certain other members of the legal department.

Prior to joining Kimberly-Clark, Mr. Wheeler served as a senior employee benefits/executive compensation attorney for Panhandle Eastern Corporation/Texas Eastern Corporation in Houston, Texas. Mr. Wheeler has also previously served as an employee benefits corporate attorney for McDonnell Douglas Corporation in St. Louis, Missouri and as an associate at Peper, Martin, Jensen, Maichel, and Hetlage in St. Louis, Missouri.

In addition to being a member of the Association of Corporate Counsel, Mr. Wheeler currently is a member of the Dallas Bar Association, Section of Employee Benefits/Executive Compensation, the ERISA Industry Committee, the American Bar Association, Section of Taxation Committee on Employee Benefits and Section of Labor and Employment Law, and was previously a member of the Internal Revenue Service Gulf Coast Area TE/GE Council and the Southwest Benefits Association Board.

Mr. Wheeler received his BA from Benedictine College, Atchison, Kansas and is a graduate of the University of Houston Law Center, Bates College of Law, JD.

Benefits Law Update for the Non-Benefits Lawyer

Archangela DeSilva
Eileen Groves
Patrick Wheeler

Benefits Law Update for the Non-Benefits Lawyer

- Employee Retirement Income Security Act of 1974
- Severance Pay Plans
- PPA Funding Rules
- Plan Amendment Issues
- Fiduciary Committee Structure
- ERISA Claims and Appeals
- Executive Compensation
- Worker classification
- M&A

Employee Retirement Income Security Act of 1974

Employee Retirement Income Security Act of 1974

- ERISA was added as substantive law under Title 29 of the U.S. Code, providing easy access to federal courts for participants & beneficiaries and to the DOL.
- ERISA established fiduciary standards, reporting & disclosure rules, minimum standards for participation, vesting, accruals, survivor annuities & anti-alienation rules, pre-emption from state laws.
- ERISA also amended the Internal Revenue Code (IRC) paralleling those listed above but also established limitations on benefits under defined benefit plans (DB plans) & contribution limits in Defined Contribution plans (DC plans) [eg. 401k, IRAs, 457].

ERISA

- Established Pension Benefit Guaranty Corporation (PBGC)
- Since 1974 there have been multiple changes & additions to ERISA generally included in tax legislation. Thus, you may hear ERTA, TEFRA, DEFRA, and more recently – EGTRRA & PPA.
- Determination Letters – DB & DC plans should file with the IRS for their review that your plans are in compliance with the IRC. Generally, you should file for additional review if you have made 5 or more amendments or every 5 years depending upon the final digit of your EIN.

ERISA

- EPCRS – Employee Plans Compliance Resolution System – starting in 1990 the IRS developed several programs were plans that had made errors could apply for relief & make corrections without disqualifying the plans. There are 3 distinct correction programs – Self-Correction (SCP), Voluntary Self-Correction with Service Approval (VCP) & Audit Closing Agreement Program (Audit CAP). *See Attachments*
- There are fees to apply, you will need a Determination Letter to be eligible & you will still possibly be subject to fines & excise taxes.

ERISA

- Contribution limits to DB & DC plans vary each year & these maximum limits are adjusted based upon the cost of living index. In the Attachments, are the limits for 2010 & previous years. Limits are generally announced in early December. In 2010, the max benefit limit for DB plans is $195,000 up from 2007's 180k. 401k deferrals are limited to 16,500 but those over 50 can contribute an additional 5,500 or $22,000. *See Attachments*
- This past year the IRS issued 401k Compliance Check Questionnaires to "random" plan sponsors. *See Attachments*
- This was supposedly a neutral check but we will see.

ERISA

- Additionally, you may be subject to an audit by the IRS. They will be looking at your documentation & the fees you pay your advisors. *See Attachments & Hecker v. Deere Co. 7th Cir. 2009*
- IRAs – generally distributions from qualified plans are tax-sheltered until distribution. But Roth IRA distributions are not taxable because the contributions were post-tax & the growth of these post-tax contributions are non-taxable. Effective in 2006, 401k & 403b plans were permitted to allow participants to designate some or all of their contributions as "Roth contributions".
- In 2010, normal IRAs can have all or a portion converted to Roth IRAs without the income limits & taxes deferred to 2011 & 2012.

ERISA

- 401k (or 403b) plans can permit participants to take 1 or more loans from their plans in an amount up to the greater of $50k or ½ their account balance. These loans are generally for 5 years unless they are for a primary residence & then the loan is for 10 years. If the participant defaults of the loan, the unpaid loan balance is taxable and, if under 59 ½, subject to excise tax.
- Military called up to active duty may have their loan repayments suspended during active duty & extended upon return to employment.

ERISA

- DB plans and DC plans generally sponsored by International unions are governed by the Multiemployer Pension Plan Amendments Act of 1980 (MPPAA). Contributions are generally controlled by terms of the collective bargaining agreement with the individual employer. When the MPPAA was passed, multiemployer plans were significantly unfunded.
- The MPPAA established methodology to calculate of employer's liability for withdrawing from the plan. This calculation is complex & requires detailed review of the records.

ERISA

- Under ERISA, benefits under qualified plans can not be alienated However, there are exceptions for QDROs (Qualified Domestic Relations Orders) & QMCSOS (Qualified Medical Child Support Orders). *See Attachments - Kennedy v. DuPont,* 555 U.S. ___(2009).
- Under QDROs, portions of DB & DC plans can be assigned to former spouses following divorces. QDROs should ordinarily be part of the divorce process, but under QDRO 2530.206 Regulations, QDROs can be issued after, or revised, after another dro and can be issued even after the participant's death & after the annuity has started.

ERISA

- The definition of "spouse" is generally defined by the plan document. Most plans define spouse as determined under the Defense of Marriage Act (DOMA). However, 2 district courts in Massachusetts have held this year that the DOMA is unconstitutional under equal protection principles of the Due Process Clause (*Gill v. Office of Personnel Management, DC Mass 2010)* & under Massachusetts authority to regulate marriage under the 10th Amendment (*Coakley v. US Dept of HHS, DC Mass 2010).*

Medical Plans

Patient Protection and Affordable Care Act (PPACA)[

- 2011 Provisions All Plans
- 2011Non-grandfathered plans
- Grandfathered Plans Regulations

Patient Protection and Affordable Care Act (PPACA)

2011 Provisions All Plans –

- Adult Children (Age 26)
- Preexisting conditions
- Annual & Lifetime Limits
- W-2 includes cost of health coverage
- Auto enrollment
- No rescissions except for fraud
- 90 day maximum waiting period
- Additional information.

2011Non-grandfathered plans

- Nondiscrimination 105(h) for Insured Plans
- Claims Procedures
- Preventive services coverage
- Wellness
- Cost sharing limits
- Quality of care
- Patient protections
- Additional information

Grandfathered Plans Regulations

Am I Grandfathered?

- GF even if make voluntary changes to increase benefits
- GF if conform to required legal changes
- GF if adopt voluntarily other consumer protections in PPACA
- Lose GF if significantly decrease the benefits covered on March 23, 2010
- Lose GF if materially increase cost sharing by participants in ways that might discourage covered individuals from seeking needed treatment
- Lose GF if substantially increase the cost of coverage to participants.

PPACA 2011 Provisions All Plans –

- Adult Children (Age 26)
  - GF plan may exclude if child has own employer coverage
  - Same terms of coverage, including cost for adult children
  - Opportunity to enroll and notice to employees
  - IRS Notice 2010-38 No imputed income to age 27
- Preexisting conditions
  - No preexisting conditions for enrollees under age 19
  - Extended to individuals over age 19 in 2014.

PPACA 2011 Provisions All Plans –

- Annual & Lifetime Limits (Annual limits beginning after Jan. 1, 2014)
- Auto enrollment
  - Enroll all eligible individuals in employer-sponsored medical coverage
- No rescissions except for fraud without prior notice
- 90 day maximum waiting period (Effective after Jan. 1, 2014)

PPACA 2011 Provisions All Plans –

Additional information & Notices

- GF specific disclosure w/ model language available in the IFR
- Notice of opportunity to enroll adult children
- W-2 includes cost of health coverage
- Form 1099 for all service providers above $600 per year (Eff. 1/1/2012)
- Auto enrollment adequate notice and opportunity to opt out

PPACA 2011 Provisions Non-grandfathered plans–

- Nondiscrimination 105(h) for Insured Plans
  - Most likely to impact executive health plans & severance
- Claims Procedures - Interim Final Rules issued July 22, 2010
- Preventive services coverage

PPACA 2011 Provisions Non-grandfathered plans–

Preventive services coverage

- Evidence-based as rated by the US Preventive Service Task Force
- Routine immunizations recommended by the Centers for Disease Control and Prevention
- Preventive care and screenings for infants, children, and adolescents provided for in comprehensive guidelines
- Evidence-informed preventive care and screenings for women
- When Cost Sharing Can be imposed -
  1. Where a covered preventive health service is billed separately
  2. Where a covered preventive health service is not billed separately from an office visit, and it was not the primary purpose for the office visit.

PPACA 2011 Provisions Non-grandfathered plans–

Preventive services coverage

- Wellness
- Cost sharing limits
  - Out-of-pocket maximums to the HSA-qualified high deductible plan
  - Deductible limits of $2,000/ individual coverage and $4,000/ family
  - Effective plan years after Jan. 1, 2014
- Quality of care
- Patient protections
- Additional information & Notices

Severance Pay Plans

Severance Pay Plans

- What is an ERISA Plan?
- Releases and IRC Section 409A
- ERISA 510 Issues
- Executive Compensation Vesting

Severance Pay Plans

- What is an ERISA Plan?
  - ***Fort Halifax Packing Co. v. Coyne***, 482 US 1 (1987)
    - "one-time, lump sum payment triggered by a single event requires no administrative scheme whatsoever to meet the employer's obligation."
  - ***Cassidy v Akzo Nobel Salt, Inc.***, 29 EBC 1097 (6th Cir. 2002)
    - ERISA plan because (i) required 'an ongoing administrative program to meet the employer's obligation." (ii) The degree of discretion i.e. to determine benefits must "analyze each employee's particular circumstances in light of the appropriate criteria," and (iii) "does the plan create an on-going demand on employer assets."
  - ***Crowell v. Shell Oil Co.***, 541 F.2d 295 (5th Cir. 2008)
    - Individual letter agreements which provide payments upon a change in control and which reference benefit plans to determine the amount of such payments are a "plan" within the meaning of ERISA.
  - ***Fontenot v. NL Indus., Inc.***, 953 F.2d 960 (5th Cir. 1992)
    - One-time lump sum payments triggered by a change in control are not an ERISA plan, even when such payments apply to a selected group of employees.

Severance Pay Plans

B. Releases and IRC Section 409A

- Section 409A provides that compensation which is deferred more than "short-term" is subject to taxation when earned as well as a 20% penalty
- "Short-term" deferrals permissible under Section 409A are those which are payable within 2 ½ months after the end of the calendar year in which the compensation is earned.
- IRS says that if a document provides for payment within a permissible payment period under Section 409A but also provides that such payment will be made within the permissible period only if the service provider (i.e., the employee) executes a release, then the agreement must provide for payment on the last day of the permissible period (i.e., a date certain).

Severance Pay Plans

C. ERISA 510 Issues
- Rodriguez v. Scotts Co., LLC, 2008 WL 251971(D. Mass.)
  - Employee fired for smoking could bring cause of action under ERISA §510 because the firing interfered with the former employee's right to participate in the company's employee benefit plans. The court further held that ERISA §510 does not apply where the loss of benefits is a "mere consequence" of the loss of employment but only where the loss of benefits is "a motivating factor." The court refused to dismiss the ERISA claim.

D. Executive Compensation Vesting
- "specified employees" cannot receive compensation until after the expiration of 6 months from the date of termination of employment
- Section 409A requires that the date of payment and the amount of deferral be determinable at the time the right to executive compensation vests

PPA Funding Rules

Pension Protection Act Funding Rules

- The Worker, Retiree, & Employer Recovery Act of 2008 (WRERA) contained a number of provisions, in addition to technical corrections of PPA, affecting both DB & DC plans. WRERA suspended required minimum distributions in 2009.
- Under PPA if a DB's funding level falls between 60-80% there is limitation to make lump sum distributions & there can be no amendments to increase benefits, provide new benefits, alter the benefit accrual rates or accelerate vesting.
- *See Attachments*

Pension Protection Act Funding Rules

- If a plan provides for lump sum or accelerated payments & its Adjusted Funding Target Attainment Percentage (AFTAP) is at least 60% but less than 80%, the maximum lump sum is the lesser of 50% of the benefit or 100% of PBGC maximum guaranteed benefit.
- If plan's AFTAP falls below 60% no lump sums, benefit accruals are frozen; contingent benefits are frozen; notice to participants within 30 days of benefit limitations.

Pension Protection Act Funding Rules

- Additionally, the plan actuaries certify the plan's current year AFTAP. For the first 3 months the actuary can look back to the previous year but for April thru Sept. the actuary looks to previous year minus 10%. If not certified by October the presumption is the AFTAP is less than 60%.
- Under PPA there is a required Sec. 101(f) annual funding notice to participants.
- Under the PPA DB plans were required to add 75% & 100% Joint & Survivor Annuity Options.
- There was also pension funding relief via long amortization of under funding, interest rate assumptions & mortality tables.

Plan Amendment Issues

Plan Amendment Issues

- "Serious Consideration" – exists when (1) a specific proposal is being discussed. (2) for purposes of implementation, (3) by senior management with authority to implement the change (or the plan change is considered by senior management with responsibility for benefits & who will make the recommendation to those with the authority to implement the change. *Fischer v. Philadelphia Electric Co. 96 F. 3d 1533 (3rd Cir 1996).*
- ADEA – particularly in regard to Cash Balance plans.

Plan Amendment Issues

- Scrivener's Error –
- Allowed - *Young v. Verizon's Bell Atlantic Cash Balance Plan*– 7th Cir Aug. 10, 2010 *See Attachment.*
  Mutual mistake because participants were on notice of actual intent.
- Not Allowed – need mutual mistake.
  IRS; Cross v. Noel Bragg, 4th Cir 2009; Humphrey v. United Way of Texas Gulf Coast, SD Tex 2007.

Fiduciary Committee Structure

Fiduciary Committee Structure

- Plan Expenses – reasonableness of 401k fees & expenses. *See Hecker supra.* Dismissal granted but in *Braden v. Wal-mart, 8th Cir 2009* no dismissal based upon reasonable inferences of facts alleged.
- Form 5500 reporting of fees & expenses. *See Attachment*
- Stock Drop Cases – *Moench v. Robertson, 62 F.3d 553 (3rd Cir. 1995)* continuing to hold employer stock is prudent unless it can be showed that the ERISA fiduciary could not have reasonably believed continued adherence to Plan's direction was how a prudent fiduciary should operate.
- Attorney-Client Privilege – in-house must be very careful as to who is the client.

Fiduciary Committee Structure

- SEC Release 2010-103/ Proposed Target Date Fund Rule

  - rules on Target Date Fund's disclosure to participants including a table, chart, or graph that clearly depicts the asset allocations among types of investments over the entire life of the fund. *See Attachments*
- Financial Crimes Enforcement Network proposed regulations, including final rule of April 2010 defining Mutual Funds as financial institutions. *See Attachments*

ERISA Claims and Appeals

ERISA Claims and Appeals

- *MetLife v. Glenn,* 128 S. Ct. 2343, 43 EBC 2921 (2008)
- *Conkright v. Frommert,* 130 S. Ct. 1640, 48 EBC 2569 (2010)
- *CIGNA Corp. v. Amara*, 534 F Supp 2d 288, 43 EBC 1011 (2008, DC CT) aff'd 2009 WL 3199061 *(2009, CA2) (unpublished)*
- *Kennedy v. Dupont* , 45 EBC 2249 (2009)
- *Hardt v. Reliance Standard Life Ins. Co.*, No. 09-448, 2010 U.S. LEXIS 4164 (U.S. May 24, 2010),

MetLife v. Glenn

MetLife v. Glenn, 128 S. Ct. 2343, 43 EBC 2921 (2008)

- Conflict b/c MetLife both reviews claims and pays out benefits
- *Firestone Tire and Rubber Co. v. Bruch* abuse of discretion standard applied even though conflict
- Conflict of interest a factor in determining whether an abuse of discretion
- Two-step process
  - First determine the proper weight to assign to conflict
  - Reasonableness of other factors associated w/ denial

Conkright v. Frommert

Conkright v. Frommert, 130 S. Ct. 1640, 48 EBC 2569 (2010)

- Mistake in interpretation of plan does not strip plan administrator of discretion
- If plan administrator makes mistake, and no bad faith, remand to plan administrator to reinterpret

Claims after MetLife & Conkright

- Create and maintain a separate committee or department.
- Establish proper written procedures.
- Eliminate any incentives for claims denials.
- Incentivize accuracy.
- Require well-drafted decisions

Reliance on the SPD

CIGNA Corp. v. Amara, 534 F Supp 2d 288, 43 EBC 1011 (2008, DC CT) aff'd 2009 WL 3199061 *(2009, CA2) (unpublished)* if there is an inconsistency between the SPD and the plan "likely harm" was sufficient and unlike other circuits reliance on the SPD was not required.

Post-Kennedy v. Dupont Litigation/ Administration Strategies

Does a waiver of spousal rights trump the beneficiary designation if it was not presented to the plan as a QDRO?

- A divorcing spouse can waive plan benefits through a divorce decree under state law
- Even if valid waiver the plan can follow its procedures if not provided with a QDRO
- Failure to drop ex-spouse as beneficiary followed plan but the divorce waiver did not
- Footnote suggested that estate may recover the benefits from ex-spouse since waived in divorce

Post-Kennedy v. Dupont Litigation/ Administration Strategies

- Claims review process, interpleader
- Potential plan provisions on automatic revocation

Hardt v. Reliance Standard Life Ins. Co.

Hardt v. Reliance Standard Life Ins. Co., Supreme Court rejected prevailing party rule for ERISA litigation. Factors considered:

- the degree of opposing parties' culpability or bad faith;
- ability of opposing parties to satisfy an award of attorneys' fees;
- whether an award of attorneys' fees against the opposing parties would deter other persons acting under similar circumstances;
- whether the parties requesting attorneys' fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and
- the relative merits of the parties' positions.

Executive Compensation

Executive Compensation

- 162(m)
- 409A
- Top Hat Plans
- Dodd-Frank Wall Street Reform and Consumer Protection Act

162(m)

Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010

- Pension contribution increased by "excess employee compensation"
- "Excess employee compensation" – income over $1 million & assets set aside in rabbi trust to pay deferred compensation
- Excludes as "excess employee compensation":
  - Grants after February 28, 2010 of options & RSUs w/ 5-year vesting
  - Commission based compensation
  - Certain GF nonqualified deferred compensation, RSUs, options, or SARs in effect on March 1, 2010

409A

Notice 2010-06 - Voluntarily correct document failures

- an ambiguous plan term providing for a payment "as soon as practicable" or a permissible payment event with no definition or an ambiguous definition
- an impermissible definition of separation from service, change in control event, or disability
- an impermissible payment period following a permissible payment event
- an impermissible payment event and/or payment schedule
- a failure to include the six-month delay of payment for specified employees
- an impermissible initial or subsequent deferral election provision.

Top Hat Plans

- ERISA Opinion Letter 90-14A , 05/08/1990 – Top hat group can negotiate their plan
- *Bakri v. Venture Mfg. Co.*, 473 F.3d 677 (6th Cir. 2007) “Select group" test considers:
  - The percentage of the total workforce invited to join the plan;
  - The nature of the participants' employment duties;
  - The compensation disparity between the "top hat" plan members and nonmembers; and
  - The plan language.
- *Alexander, Eben III M.D. v. Brigham & Women's Physicians Organization Inc,* - Participation was test b/c had to earn enough to be eligible to contribute

Dodd-Frank Wall Street Reform and Consumer Protection Act

- Say-on-Pay - Advisory Vote on Executive Compensation, vote frequency and Golden Parachutes
- Proxy Access
- Compensation Consultant Reforms
- Employee and Director Hedging
- Pay-for-Performance and Internal Pay Ratios Disclosure
- Claw Back Policies
- Disclosure of the Board Leadership Structures
- Prohibition on Broker Discretionary Voting
- Independent Compensation Committee Directors

Worker classification

Worker classification

A. The US Department of Labor's (DOL) FY 2011 budget request highlighted the belief that there is significant misclassification of workers by employers and the underlying assumption is that an investment of funds to the investigation and prosecution of worker misclassifications would result in significant revenues in the form of employment taxes not otherwise paid.
   - The IRS and DOL plan to undertake a joint effort to aggressively pursue the issue
   - DOL FY 2011 budget seeks to increase investigators by 10% for the purpose of pursuing worker misclassification issues
   - The Employment & Training Administration (ETA) will provide grants to states so that they can increase the focus on worker misclassification issues
   - DOL FY 2011 budget seeks to increase the number of employees in the Office of the Solicitor for the purpose of prosecuting misclassification issues

Worker classification

B. On September 18, 2009, the IRS announced that it would audit 6,000 US companies to determine they are paying required Social Security and Medicare taxes.
   - IRS says focus of audits will be whether workers are properly classified (as employees vs. independent contractors)
   - Audits will begin February 2010 over a period of 3 years and companies audited to be chosen "at random"
   - IRS plans to use these audits to develop a broader auditing program

C. S. 3254, Employee Misclassification Prevention Act (EMPA)
   1. Amends the FLSA to require employers to keep records of individuals who are paid for work as independent contractors
   2. Also requires employers to notify individuals whether they are being classified as employees or independent contractors
   3. Also penalizes employers that wrongly classify employees as contractors

Worker classification

D. H.R. 3408, Taxpayer Responsibility, Accountability and Consistency Act
   - Would effectively force employers to secure advance IRS approval for contractor classification
   - Recent legislation in Colorado, Delaware, Maryland, Nebraska, New York, Massachusetts, New Jersey

E. Vizcaino v. Microsoft Corp., 120 F.3d 1006 (9th Cir. 1997), *cert. denied*, 522 U.S. 1098 (1998)
   1. Misclassification of employees as independent contractors
   2. Company settles with IRS
   3. Common law employees are entitled to participate in Microsoft employee benefit plans, including stock option plans

Mergers & Acquisitions

Mergers & Acquisitions

A. Lessard v. Applied Risk Management, 307 F.2d 1020 (9th Cir. 2002)
- Asset purchase agreement provided that the buyer would automatically hire all of the seller's employees who were actively at work and for those who were not actively at work, the buyer agreed to hire these employees only when they were ready to return to active employment.
- Violated ADA and ERISA §510 and the agreement impermissibly discriminated against employees who were not actively at work. Both Seller and Buyer were liable.

B.Apsley v. Boeing Company and Spirit Aerosystems, Inc., 2010 US Dist. LRXIS 65837 (D. Kan.)
- distinguished *Lessard* and held that a plaintiff cannot assume that two separate actors are liable for the acts of each other based on circumstantial evidence, but must show that each action separately affected the ability to accrue benefits under the plan in which the plaintiff was a participant.

Mergers & Acquisitions

C. Halliburton Co. Benefits Comm. V. Graves, 479 F3rd 360 (5th Cir. 2007)
- held that a merger agreement clause constituted an amendment to a plan. The actions of the board of directors of the acquired company in approving the merger agreement and the chairman of the board of directors in signing the agreement were found to be sufficient to constitute an action by the corporation to amend its retiree medical program in accordance with the amendment.

D. Lillis v. AT&T Corp., No. 717-N (Del. Ch. July 20, 2007) (Lamb V.C.)
- Delaware Chancery Court, "general rule" that option plans should be read to permit cancellations. The Court departed from the general rule because the adjustment provision required that "each Participant's economic position with respect to the Award shall not, as a result of such adjustment, be worse than it had been immediately prior to such event."
- Black-Scholes value and not spread/intrinsic value kept economic position.
- Also (i) the survival of the options was fully negotiated in prior acquisition with regard to adjustment provision, (ii) AT&T previously fully conceded that the plaintiffs' position was the correct one and (iii) the options held by the directors were cashed out at their Black-Scholes value.

Mergers & Acquisitions

E. More practice pointers
- Merger agreements should specifically provide which employee benefit plans are vested and which are not
- If benefit agreements are linked to pension benefit eligibility, then such agreements will be deemed vested benefits (***Noe v. PolyOne Corp.***, 2008 WL 72369 (6th Cir. Mar. 19, 2008)
- If merger takes public company private, there is no obligation under §162(m) to file a summary compensation table for the merger year; however, there is still an obligation to file the summary compensation table with the Form 10-K for the last full year as a publicly traded company

Benefits Law Update for the Non-Benefits Lawyer

1. Employee Retirement Income Security Act of 1974

A. General Historical Outline of ERISA & its coverage
   1. PBGC – purpose & scope
   2. Multiple benefit refinements via tax legislation
   3. Determination Letter process & reason to have one
   4. EPCRS – continuing IRS assistance & fine tuning of programs to keep plans qualified.

B. Contribution Limits of DB & DC plans
   1. IRS 401 Compliance Check Questionnaires
   2. DOL Audits re fees
   3. 401k & Roth IRAs – 2010 conversion postponing taxes to 2011-12
   4. Plan Loans
   5. Military service

C. Multiemployer Pension Plans
   1. MPPAA – liability & methodology

D. QDROs
   1. Unalienability under ERISA except for QDROs & QMCSOS. Review process.
   2. Kennedy v. DuPont
   3. New Rg. 2530.206 – QDROs can be issued after or revised after another dro & can be issued after death of participant & after annuity start.

E. DOMA vs. Spouse

2. Medical Plans

A. PPACA
   1. Grandfathered Plans Regulations/ Departments of Labor, Treasury and Health & Human Services issued June 14, 2010
      a. Plans and coverage in existence on March 23, 2010 are not subject to certain health care reform provisions
      b. Coverage under an insured collectively bargained plan GF until the last CBA relating to the coverage that was in effect on March 23, 2010 terminates
      c. GF applies to both new employees and current employees who are new enrollees (and their families) who enroll in a GF plan after March 23, 2010
      d. GF lost by implementing certain participant take-aways
         i. Eliminating benefits
         ii. Increasing participants' costs over specified amount
         iii. Decreasing employer contributions by more than a specified amount
         iv. Imposing/reducing annual limits
         v. Changing insurance policies
         vi. Inappropriately transferring employees into the plan
   2. Rules that Apply to GF Plans
      a. Adult Children (Age 26)
         i. Treas. Notice 2010-38 – Clarifies tax free coverage of adult children through end of calendar year turns age 26

ii. GF plan may exclude if child has own employer coverage
iii. Same terms of coverage, including cost for adult children
iv. Opportunity to enroll and notice to employees

b. Preexisting conditions
   i. No preexisting conditions for enrollees under age 19
   ii. Extended to individuals over age 19 in 2014.

c. Annual & Lifetime Limits (Annual limits beginning after Jan. 1, 2014)

d. Auto enrollment
   i. Enroll all eligible individuals in employer-sponsored medical coverage

e. No rescissions except for fraud without prior notice

f. 90 day maximum waiting period (Effective after Jan. 1, 2014)

g. Additional information & Notices
   i. GF specific disclosure w/ model language available in the IFR
   ii. Notice of opportunity to enroll adult children
   iii. W-2 includes cost of health coverage
   iv. Form 1099 for all service providers above $600 per year (Eff. 1/1/2012)
   v. Auto enrollment adequate notice and opportunity to opt out

3. 2011 Non-grandfathered plans
   a. Nondiscrimination 105(h) for Insured Plans
      i. Most likely to impact executive health plans & severance
   b. Claims Procedures - Interim Final Rules issued July 22, 2010
   c. Preventive services coverage
      i. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services issued July 14, 2010
         1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Service Task Force ("PSTF").
         2) Routine immunizations that are currently recommended by the Centers for Disease Control and Prevention ("ACIP").
         3) Certain evidence-informed preventive care and screenings for infants, children, and adolescents provided for in comprehensive guidelines
         4) Evidence-informed preventive care and screenings for women, provided for in comprehensive guidelines supported by HRSA
         5) When Cost Sharing Can be imposed -
   d. Where a covered preventive health service is billed separately -- e.g., lab work for a cholesterol screening conducted during an office visit.
   e. Where a covered preventive health service is not billed separately from an office visit, and it was not the primary purpose for the office visit.
   f. Wellness
   g. Cost sharing limits
      i. Out-of-pocket maximums to the HSA-qualified high deductible plan
      ii. Deductible limits of $2,000/ individual coverage and $4,000/ family
      iii. Effective plan years after Jan. 1, 2014
   h. Quality of care

i. Patient protections
j. Additional information & Notices

B. Early Retiree Reinsurance Program (ERRP) – 80% of costs of claims between $15,000 and $90,000 per year HHS application http://www.hhs.gov/ociio/Documents/official-errp-program-application_.pdf

3. Severance Pay Plans

A. What is an ERISA Plan?

1. Fort Halifax Packing Co. v. Coyne, 482 US 1 (1987)
- "one-time, lump sum payment triggered by a single event requires no administrative scheme whatsoever to meet the employer's obligation."

2. Cassidy v Akzo Nobel Salt, Inc., 29 EBC 1097 (6th Cir. 2002)
- ERISA plan because (i) required 'an ongoing administrative program to meet the employer's obligation." (ii) The degree of discretion i.e. to determine benefits must "analyze each employee's particular circumstances in light of the appropriate criteria," and (iii) "does the plan create an on-going demand on employer assets."

3. Crowell v. Shell Oil Co., 541 F.2d 295 (5th Cir. 2008)
- Individual letter agreements which provide payments upon a change in control and which reference benefit plans to determine the amount of such payments are a "plan" within the meaning of ERISA.

4. Fontenotv. NL Indus., Inc., 953 F.2d 960 (5th Cir. 1992)
- One-time lump sum payments triggered by a change in control are not an ERISA plan, even when such payments apply to a selected group of employees.

B. Releases and IRC Section 409A
1. Section 409A provides that compensation which is deferred more than "short-term" is subject to taxation when earned as well as a 20% penalty
2. "Short-term" deferrals permissible under Section 409A are those which are payable within 2 ½ months after the end of the calendar year in which the compensation is earned.
3. IRS says that if a document provides for payment within a permissible payment period under Section 409A but also provides that such payment will be made within the permissible period only if the service provider (i.e., the employee) executes a release, then the agreement must provide for payment on the last day of the permissible period (i.e., a date certain).

C. ERISA 510 Issues
1. *Rodriguez v. Scotts Co., LLC*, 2008 WL 251971(D. Mass.)

- Employee fired for smoking could bring cause of action under ERISA §510 because the firing interfered with the former employee's right to participate in the company's employee benefit plans. The court further held that ERISA §510 does not apply where the loss of benefits is a "mere consequence" of the loss of employment but only where the loss of benefits is "a motivating factor." The court refused to dismiss the ERISA claim.

D. Executive Compensation Vesting
   1. "specified employees" cannot receive compensation until after the expiration of 6 months from the date of termination of employment
   2. Section 409A requires that the date of payment and the amount of deferral be determinable at the time the right to executive compensation vests

4. **PPA Funding Rules**

   A. PPA established rules re funding levels for underfunded plans (generally less than 80%) WRERA had technical corrections to PPA but also suspended the required minimum distributions for 2009.
   B. AFTAP process & Actuary certification.
   C. Sec. 101(f) Annual Funding Notices to participants
   D. Added additional S & J options & longer amortization of underfunding, regulated assumed interest rate assumptions & mortality tables.

5. **Plan Amendment Issues**

   A. Serious Consideration – if a benefit change is under serious consideration & a person who has actual knowledge is specifically asked – they must answer truthfully.
   B. ADEA – particularly issue in Cash Balance Plans which differ from traditional DBs which are career average. If there is a conversion to CB shortly before retirement age, cases alleging age discrimination.
   C. Scrivener's Error – plan writers dread! Young v. Verizon Bell – Thank you 7th Circuit!

6. **Fiduciary Committee Structure**

   A. Who & why a Fiduciary Committee? Settlor Committee.
   B. Plan Expenses – are you paying too much in fees & dismissing participant accounts? Hecker v. Deere Co.
   C. New DOL Form 5500 reporting requirements re. fees & expenses.
   D. Stock Drop Cases – Moench v. Robertson – did you hold onto the Company stock too long?
   E. Attorney- Client Privilege – In-house counsel, who is your client? Company or participant?
   F. SEC & Treasury getting into game & establishing rules for mutual funds you maybe utilizing.

7. **ERISA Claims and Appeals**

   A. Disability Claims after *MetLife v. Glenn,* 128 S. Ct. 2343, 43 EBC 2921 (2008) 128 S. Ct. 2343, 43 EBC 2921 (2008)
      1. Conflict b/c MetLife both reviews claims and pays out benefits
      2. *Firestone Tire and Rubber Co. v. Bruch* abuse of discretion standard applied even though conflict
      3. Conflict of interest a factor in determining whether an abuse of discretion
      4. Two-step process
         a. First determine the proper weight to assign to conflict
         b. Reasonableness of other factors associated w/ denial

   B. *Conkright v. Frommert,* 130 S. Ct. 1640, 48 EBC 2569 (2010)
      1. Mistake in interpretation of plan does not strip plan administrator of discretion
      2. If plan administrator makes mistake, and no bad faith, remand to plan administrator to reinterpret

   C. Safeguards to reduce the impact of conflicts
      1. Create and maintain a separate committee or department. Separate claims decisions from those who have financial responsibility for the company.
      2. Establish proper written procedures. Written guidelines and policies, which are as detailed as possible, that govern the claims determination process.
      3. Eliminate any incentives for claims denials.
      4. Incentivize accuracy.
      5. Require well-drafted decisions.

   D. *CIGNA Corp. v. Amara*, 534 F Supp 2d 288, 43 EBC 1011 (2008, DC CT) aff'd 2009 WL 3199061 *(2009, CA2) (unpublished)* if there is an inconsistency between the SPD and the plan "likely harm" was sufficient and unlike other circuits reliance on the SPD was not required.

   E. *Kennedy v. Dupont*, 45 EBC 2249 (2009)
      1. Non-QDRO divorce decree that was not presented to the plan administrator failed to waive plan benefit
      2. The court followed the plan's procedure as set forth in the plan document
         a. Claims review process & interpleader
         b. Potential plan provisions on automatic revocation

   F. PPACA Health Claims - Interim Final Rules issued July 22, 2010

   G. *Hardt v. Reliance Standard Life Ins. Co.*, No. 09-448, 2010 U.S. LEXIS 4164 (U.S. May 24, 2010), Supreme Court rejected prevailing party rule for ERISA litigation. Five factors considered:
      1. the degree of opposing parties' culpability or bad faith;
      2. ability of opposing parties to satisfy an award of attorneys' fees;
      3. whether an award of attorneys' fees against the opposing parties would deter other persons acting under similar circumstances;
      4. whether the parties requesting attorneys' fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and
      5. the relative merits of the parties' positions.

8. **Executive Compensation**

A. 162(m)
   1. 162(m) deduction reduced to $500,000 for health insurance industry
      a. Applies to *current* compensation paid after Dec. 31, 2012 & deferred compensation for services after Dec. 31, 2009
   2. Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act – Pension contribution increased by "excess employee compensation“ plus the amount of any extraordinary dividends and redemptions.
      a. 430(c)(7) defines "excess employee compensation" as income amount over $1 million & assets set aside in rabbi trust to pay deferred compensation
      b. Excludes from the definition of "excess employee compensation":
      c. Grants after February 28, 2010 of options & RSUs with at least a five-year vesting schedule
      d. Commission based compensation based on individual performance of the individual to whom such remuneration is payable
      e. Any nonqualified deferred compensation, RSUs, options, or SARs payable under a written binding contract in effect on March 1, 2010, and which is not materially modified.

B. 409A – IRS Notice 2010-6, 2010-3 IRB 275
   1. Allows correction of
      a. an ambiguous plan term providing for a payment “as soon as practicable” or a permissible payment event with no definition or an ambiguous definition
      b. an impermissible definition of separation from service, change in control event, or disability
      c. an impermissible payment period following a permissible payment event
      d. an impermissible payment event and/or payment schedule
      e. a failure to include the six-month delay of payment for specified employees
      f. an impermissible initial or subsequent deferral election provision.
   2. If corrected then won't be required to report and include as income for years prior to 2010.

C. Non-Qualified Plans – Top Hat Plans – DOL Reg. 2520.104-23
   1. ERISA Opinion Letter 90-14A , 05/08/1990 – Top hat group are those “individuals, by virtue of their position or compensation level, have the ability to affect or substantially influence, through negotiation or otherwise, the design and operation of their deferred compensation plan”
   2. *Bakri v. Venture Mfg. Co.*, 473 F.3d 677 (6th Cir. 2007)). 15% Participation Is Not a Select Group under a Top Hat Plan. Four prong "select group" test considers:

a. The percentage of the total workforce invited to join the plan;
b. The nature of the participants' employment duties;
c. The compensation disparity between the "top hat" plan members and nonmembers; and
d. The plan language.

3. *Alexander, Eben III M.D. v. Brigham & Women's Physicians Organization Inc, 513 F3d 37, 42 EBC 2554 (1st Cir. 2008)*

D. Dodd-Frank Wall Street Reform and Consumer Protection Act

1. Clawbacks -
    a. Dodd-Frank requires policy that will recapture any excess incentive based compensation that was paid to any current or former executive officer during the three-year period preceding "the date" on which the company is required to prepare an accounting restatement based on erroneous financial statements if a company is "required" to prepare an accounting restatement due to its "material noncompliance" with any financial reporting requirement under the law.
    b. Sarbanes-Oxley Act of 2002 ("SOX"), which applied to the CEO and the CFO of a public company when there was a restated financial statement "due to the material noncompliance of the issuer, as a result of misconduct, with any financial reporting requirement under the securities laws." If these circumstances exist, the CEO or CFO must repay the issuer any amounts received during the 12 months following the filing of the inaccurate financial statements that fall into one of two categories: (1) "any bonus or other incentive-based or equity-based compensation" or (2) "any profits received from the sale of securities."
    c. American Recovery and Reinvestment Act of 2009 added additional repayment rules for financial institutions receiving federal funds. The restrictions generally applied to the five highest-paid senior executive officers plus up to the next 20 highest-paid employees and required repayment of "any bonus, retention award or incentive compensation" that was based on "statements of earnings, revenues, gains, or other criteria that are later found to be materially inaccurate."
2. Independent Compensation Committee Directors –
    a. Section 952 of Dodd-Frank
3. Say-on-Pay - Advisory Vote on Executive Compensation, and frequency of advisory vote and Golden Parachutes
4. Proxy Access - SEC rules gives three-year, 3% shareholders proxy access to nominate directors & notify company at least 120 days before the anniversary of the prior year's proxy mailing.
5. Compensation Consultant consideration of independence, authority to retain, disclosure of use, and company funding
6. Employee and director hedging
7. Pay-for-performance and internal pay ratios disclosures in proxy

8. Disclosure of the Board leadership structure including the separation of the offices of Chairman and Chief Executive Officer
9. Prohibition on broker discretionary voting and increased transparency of securities ownership

9. **Worker classification**

A. The US Department of Labor's (DOL) FY 2011 budget request highlighted the belief that there is significant misclassification of workers by employers and the underlying assumption is that an investment of funds to the investigation and prosecution of worker misclassifications would result in significant revenues in the form of employment taxes not otherwise paid.
    1. The IRS and DOL plan to undertake a joint effort to aggressively pursue the issue
    2. DOL FY 2011 budget seeks to increase investigators by 10% for the purpose of pursuing worker misclassification issues
    3. The Employment & Training Administration (ETA) will provide grants to states so that they can increase the focus on worker misclassification issues
    4. DOL FY 2011 budget seeks to increase the number of employees in the Office of the Solicitor for the purpose of prosecuting misclassification issues
B. On September 18, 2009, the IRS announced that it would audit 6,000 US companies to determine they are paying required Social Security and Medicare taxes
    1. IRS says focus of audits will be whether workers are properly classified (as employees vs. independent contractors)
    2. Audits will begin February 2010 over a period of 3 years and companies audited to be chosen "at random"
    3. IRS plans to use these audits to develop a broader auditing program
C. S. 3254, Employee Misclassification Prevention Act (EMPA)
    - Amends the FLSA to require employers to keep records of individuals who are paid for work as independent contractors
    - Also requires employers to notify individuals whether they are being classified as employees or independent contractors
    - Also penalizes employers that wrongly classify employees as contractors
D. H.R. 3408, Taxpayer Responsibility, Accountability and Consistency Act
    - Would effectively force employers to secure advance IRS approval for contractor classification

    Recent legislation in Colorado, Delaware, Maryland, Nebraska, New York, Massachusetts, New Jersey
E. *Vizcaino v. Microsoft Corp.*, 120 F.3d 1006 (9th Cir. 1997), *cert. denied*, 522 U.S. 1098 (1998)
    - Misclassification of employees as independent contractors
    - Company settles with IRS

- Common law employees are entitled to participate in Microsoft employee benefit plans, including stock option plans

10. M&A

A. *Lessard v. Applied Risk Management*, 307 F.2d 1020 (9th Cir. 2002)
   - Asset purchase agreement provided that the buyer would automatically hire all of the seller's employees who were actively at work and for those who were not actively at work, the buyer agreed to hire these employees only when they were ready to return to active employment.
   - Violated ADA and ERISA §510 and the agreement impermissibly discriminated against employees who were not actively at work. Both Seller and Buyer were liable.

B. *Apsley v. Boeing Company and Spirit Aerosystems, Inc.*, 2010 US Dist. LEXIS 65837 (D. Kan.)
   - distinguished *Lessard* and held that a plaintiff cannot assume that two separate actors are liable for the acts of each other based on circumstantial evidence, but must show that each action separately affected the ability to accrue benefits under the plan in which the plaintiff was a participant.

C. *Halliburton Co. Benefits Comm. v. Graves*, 479 F3d 360 (5th Cir. 2007)
   - held that a merger agreement clause constituted an amendment to a plan. The actions of the board of directors of the acquired company in approving the merger agreement and the chairman of the board of directors in signing the agreement were found to be sufficient to constitute an action by the corporation to amend its retiree medical program in accordance with the amendment.

D. *Lillis v. AT&T Corp.*, No. 717-N (Del. Ch. July 20, 2007) (Lamb, V.C.)

   - Delaware Chancery Court, "general rule" that option plans should be read to permit cancellations. The Court departed from the general rule because the adjustment provision required that "each Participant's economic position with respect to the Award shall not, as a result of such adjustment, be worse than it had been immediately prior to such event."
   - Black-Scholes value and not spread/intrinsic value kept economic position.
   - Also (i) the survival of the options was fully negotiated in prior acquisition with regard to adjustment provision, (ii) AT&T previously fully conceded that the plaintiffs' position was the correct one and (iii) the options held by the directors were cashed out at their Black-Scholes value.

E. More practice pointers

- Merger agreements should specifically provide which employee benefit plans are vested and which are not
- If benefit agreements are linked to pension benefit eligibility, then such agreements will be deemed vested benefits (*Noe v. PolyOne Corp.*, 2008 WL 72369 (6th Cir. Mar. 19, 2008)
- If merger takes public company private, there is no obligation under §162(m) to file a summary compensation table for the merger year; however, there is still an obligation to file the summary compensation table with the Form 10-K for the last full year as a publicly traded company

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ERISA Litigation Alert

New Ruling in a Fee Case: After Trial, Defendants Win Some, Lose Some; DOL Issues Its Long Awaited Fee Disclosure Regulation; Agencies Issue Guidance on PPACA Internal Claims and Appeals and External Review Processes

07.28.10

FEATURED IN THIS EDITION

- New Ruling in a Fee Case: After Trial, Defendants Win Some, Lose Some
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New Ruling in a Fee Case: After Trial, Defendants Win Some, Lose Some

In one of the first fee cases to go to trial, the district court found that the defendants breached ERISA's prudence standard when they invested in retail share classes of three mutual funds instead of the institutional share classes of those same funds. Institutional share classes are offered to institutional investors, such as 401(k) plans, and often require a minimum investment. They usually also charge lower fees than retail share classes because the amount of assets invested is greater than that which an individual investor can usually make in a retail share class. Retail share classes may also pay higher revenue sharing fees, and, at least with respect to the three funds at issue in the case, that was true. *Tibble v. Edison International*, CV 07-5359 SVW, July 8, 2010.

Beginning in 2007, plaintiffs' class action law firms began filing lawsuits against some very large companies including Boeing, Bechtel, United Technologies, and Deere, alleging that the defendants breached ERISA's fiduciary standards of prudence and loyalty and engaged in prohibited transactions because they chose investment options for their 401(k) lineup that had higher expense ratios than equally available options with lower expense ratios. In general, these cases are collectively referred to as "fee litigation cases" or "fee cases." In *Tibble*, plaintiffs made the same basic allegations against Edison International and other 401(k) fiduciaries for selecting six mutual funds with higher expense ratios that paid more revenue sharing than other lower cost options.

In May 2009, both parties in *Tibble* filed motions for summary judgment. The *Tibble* court granted partial summary judgment for defendants on the majority of plaintiffs' claims. Siding with the defendants, the court dismissed all allegations that they engaged in prohibited transactions for including mutual funds with higher expense ratios and revenue sharing. *See Tibble v. Edison International*, 639 F. Supp.2d 1074, 1086--97 (C.D. Cal. 2009). The court reserved for trial plaintiffs' allegations that defendants violated ERISA's prudence and loyalty standards for offering the six funds as part of the 401(k) plan lineup.

No Violation of ERISA's Duty of Loyalty

ERISA requires that a fiduciary "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries." ERISA Section 404(a)(1)(A). At trial, the court found that the defendants did not violate their duty of loyalty in the process of selecting the fund classes with more revenue sharing

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fees because the defendants were not "motivated by a desire to capture revenue sharing" in making those selections. The court noted that the company's overall trend between the years 2002 to 2008, reflected a movement toward selecting funds with reduced revenue sharing. The court also found that there was no evidence that the defendants considered revenue sharing when selecting fund choices.

Defendants Violated ERISA's Prudence Standard in the Selection of Three out of the Six Funds at Issue in the Case

The court held that the record was devoid of any "credible reason why the Plan fiduciaries chose the retail share classes of the William Blair, PIMCO and MFS Total Returns funds." In essence, the court concluded that defendants failed to engage in a prudent process in selecting the higher expense ratio retail share class of the three mutual funds. With respect to the remaining three funds -- Janus Small Cap, PIMCO Capital Appreciation, and Franklin Small (-Mid) Cap funds -- all had undergone a name change after 2001. Due to the statute of limitations barring the plaintiffs from seeking remedies for any alleged harm prior to 2001, the plaintiffs alleged the name change triggered new fiduciary obligations requiring that the plan fiduciaries scrutinize these funds at the time of the name change. The court disagreed and held the plan fiduciaries had demonstrated prudent monitoring of each of these three funds and held that the plaintiffs had failed to prove that the plan fiduciaries violated ERISA. The parties have been directed to submit additional briefing to aid the court in its determination of damages.

Conclusion

As of now, the time to file an appeal for either side had not run. The case therefore may not be over. Assuming the trial court's finding of facts is correct, this case once again demonstrates the importance for fiduciaries to document the process by which they make their decisions. It is important to note that the court's decision should not be read to necessarily mean that fiduciaries cannot choose funds with higher expense ratios or that selecting retail versus institutional funds is *per se* a violation of ERISA. The court simply could not identify a procedure in which the fiduciaries had engaged to decide if the selection had been made prudently. The absence of that process is what caused the court to rule against the fiduciaries.

DOL Issues Its Long Awaited Fee Disclosure Regulation

On July 16, 2010, the United States Department of Labor ("DOL") published its long-awaited regulations on ERISA Section 408(b)(2), the statutory exemption that allows plan service providers to be compensated for their services without engaging in a prohibited transaction. The published regulation is an interim final regulation meaning that although public comments are invited, the regulations are essentially in final form, but may be modified after additional comments are received. The deadline for additional comments is August 30, 2010.

The proposed regulations were first issued in December 2007 and finalized, but not released during the Bush administration. When the Obama administration took power, these regulations were among several still under review at the Office of Management and Budget and were pulled for additional review by the new administration. The regulations were further delayed by pending federal legislation that could have had an impact on the regulations if enacted. Because it appeared that any legislation on the issue was not likely to pass anytime soon, the DOL finally released the interim final regulations. The regulations and

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attendant prohibited transaction class exemption are effective one year after the date of publication or July 16, 2011.

Background

ERISA Section 406(a) sets forth a series of prohibited transaction between a plan and a party in interest -- persons that have close relationships to a plan, *i.e.*, a fiduciary, service provider, plan sponsor, among many others. ERISA's prohibited transaction provisions are intended to be *per se* prohibited unless an exemption applies. There are many statutory and administrative exemptions. Without these exemptions, plans would literally be unable to transact any business. ERISA Section 406(a)(1)(C) prohibits the furnishing of goods, services, or facilities between a plan and a party interest. ERISA Section 408(b)(2) allows a 406(a)(1)(C) transaction to move forward if (1) the contract or arrangement between the plan and party in interest is reasonable; (2) the services are necessary for the establishment or operation of a plan, and (3) no more than reasonable compensation is paid for the services. Current regulations only provide that a contract or arrangement is reasonable if the plan is able to terminate the arrangement without penalty on a reasonably short notice. See 29 C.F.R. Section 2550.408b-2(c). The interim final regulations amend paragraph (c) of the existing regulation to add vendor disclosure requirements in order for a contract or arrangement to be deemed "reasonable."

The Regulations

In general, the interim final regulations require that "covered service providers" make certain fee disclosures in writing to the fiduciaries of a "covered plan" within certain timeframes. The regulations also clarify that, while the disclosures must be made in writing, the agreement or arrangement does not require a formal written contract as was the case under the proposed regulations.

Covered plan: A "covered plan" is a defined contribution or defined benefit plan within the meaning of ERISA that is not exempted from ERISA coverage under ERISA Section 4(b), i.e., church plan. IRAs and SEPs are not covered under the regulations, and most significantly, welfare plans are not covered either. The DOL is planning to address welfare plan fee disclosure issues in separate regulations. Also excluded are vendors providing services for less than $1,000.

Covered service providers: There are three categories of covered service providers.

Category A: Includes three sub-categories:

a. A fiduciary service provider or registered investment advisor providing services directly to the plan.
b. A fiduciary providing services to an investment contract, product, or entity that holds plan assets in which the covered plan has a direct equity investment.
c. Investment advice provided directly to the covered plan by a registered investment advisor under either the Investment Advisers Act of 1940 or state law.

Category B: Recordkeepers or brokers providing services to participant directed plans if one or more investment alternative is made available through an arrangement connected to the recordkeeper or broker.

Category C: Services for indirect compensation. This category includes, among others, any number of services such as accounting, appraisal, banking, legal, investment brokerage, or third party administration

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for which the covered service provider, an affiliate, or subcontractor reasonably expects to receive indirect compensation.

Covered service providers do not include an affiliate or subcontractor of a covered service provider.

Initial Disclosures: Includes details about the services that will be provided, the status of the provider, and compensation.

Services. The covered service provider must provide a description of the fiduciary services that it will provide.

Status. The covered service provider must provide a statement that it is a fiduciary to the plan, or expects to provide services directly to the plan under a contract or arrangement as an investment advisor registered under the 1940 Act or state law.

Compensation. The covered service provider must disclose in writing direct and indirect compensation for the services it is providing.

(1) Direct compensation is defined as compensation received directly from the covered plan, and the covered service provider must provide a written description of all direct compensation either in the aggregate or by service.

(2) Indirect compensation is defined as any compensation received from any source other than the covered plan, the plan sponsor, the covered service provider or its affiliates or subcontractors and includes, among others, any compensation paid under a 12b-1 fee or soft dollar arrangement or commissions, finder's fees, etc.

(3) The covered service provider must disclose the fees that it will pay its affiliates or subcontractors in connection with the services under its arrangement with the plan.

(4) Finally, disclosures must include any compensation for termination of the contract or arrangement.

Manner of Receipt. The regulations require that the disclosure state if the covered plan will be billed for the compensation or if the compensation will be deducted directly from the plan.

Timing of disclosures. In general, the disclosures must be made sufficiently in advance of finalizing the agreement or contract to allow the fiduciary to engage in a prudent decision with respect to the reasonableness of the fees in light of the services provided. In general, changes to the arrangement that cause a change in fees must be disclosed as soon as practicable, but in no event in less than 60 days.

Impact of the non-compliance. If a fiduciary fails to satisfy the new requirements of the 408(b)(2) regulations, the contract or arrangement with the vendor may be deemed a prohibited transaction for which correction will be necessary. A failure to satisfy the requirements will also leave plan fiduciaries more exposed for litigation alleging that the plan expenses are unreasonable and therefore the contract or arrangement prohibited. The regulations however provide two forms of potential relief for the plan fiduciaries:

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- Disclosure errors made by a covered service provider made in good faith will not automatically convert the arrangement or contract into a prohibited transaction, provided that the covered service provider corrects its omission as soon as practicable after discovering the problem, but in no event later than 60 days.
- The regulations establish a class exemption for a plan fiduciary that learns about a disclosure failure after entering into a contract or arrangement with the covered service provider.

Agencies Issue Guidance on PPACA Internal Claims and Appeals and External Review Processes

On July 22, the Departments of the Treasury ("Treasury"), Labor ("DOL") and Health and Human Services ("HHS") jointly published an interim final rule (the "IFR") implementing requirements under the Patient Protection and Affordable Care Act ("PPACA") for group health plans and health insurance issuers to establish processes for internal claims and appeals and for external reviews. The IFR, published in the Federal Register on July 23, implements section 2719 of the Public Health Service Act ("PHSA"), as enacted by PPACA, which requires group health plans and health insurance issuers offering individual and group health insurance coverage to comply with applicable state and/or federal procedures for internal and external appeals. The rules are generally effective the first plan year (policy year for individual health insurance policies) that begins on or after September 23, 2010, *i.e.*, January 1, 2011 for calendar-year plans and policies.

Points of Interest

- For internal claims and appeals, plans and insurers must follow the DOL Claims Procedure regulations set forth in 29 C.F.R. 2560.503-1 ("DOL Claims Procedure") but with certain additional requirements as set forth in the IFR.
- The IFR's additional requirements for the DOL Claims Procedure include rules that require notification of a benefit determination on an urgent claim be made within 24 hours, impose new conflicts of interest criteria for claims adjudication, and broaden the application of deemed exhaustion (see further discussion below).
- While internal appeals are pending, plans and insurers cannot reduce or terminate coverage for an ongoing course of treatment without providing advance notice and the opportunity for review.
- Existing state external review processes will be deemed in conformance with the IFR minimum requirements for a transition period -- *i.e.*, for plan years beginning before July 1, 2011.
- Self-funded plans (except for church plans and certain governmental plans), as well as issuers in states that do not have existing external review laws, must follow federal external review procedures, which will be established through future guidance.
- The federal external review process and acceptable state external review processes will include the consumer protections of the Uniform Health Carrier External Review Model Act issued by the National Association of Insurance Commissioners ("NAIC Uniform Model Act" or "Model Act").
- The rules do not apply to "grandfathered" plans. Please see our previous alert on grandfathered plans.

Definitions

The IFR applies to a plan's or issuer's internal claims and appeals and external appeals processes maintained pursuant to state or federal law. A number of definitions are set forth for these purposes. The

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04.01.03

Overview

A class action lawsuit recently filed against the Hewlett Packard Co. is a reminder that litigation alleging misclassification of employees is alive and well. Filed January 21, 2003 in Santa Clara Superior Court, the Hewlett Packard lawsuit alleges that the putative class is composed of common-law employees that have been "falsely" identified as independent contractors, and therefore wrongly deprived of participation in various employee benefit plans. [*Marks v. Hewlett Packard Company*, CV No. 814186, California Superior Court for the County of Santa Clara] The lawsuit further alleges that, although routinely working more than 40 hours per week, workers were prohibited from receiving pay for hours in excess of 40. The complaint seeks a wide range of recovery under state law including compensatory, punitive, and injunctive relief for Hewlett Packard's failure to pay the workers for all the hours they allegedly worked and for failure to allow these workers to receive company sponsored employee benefits.

A Short Trip Down Microsoft Memory Lane

The employee benefit claims in this lawsuit should inspire memories of the suit against Microsoft that, after eight years of litigation, finally settled last Spring for $97 million, $23 million of which was reserved to pay attorneys fees. [*Vizcaino v. Microsoft Corp.*, 173 F.3d 713 (9th Cir. 1999) (*Microsoft III*)] In *Microsoft III*, the Ninth Circuit ruled that as many as 15,000 temporary agency workers in certain positions were "presumptively" common law employees entitled to receive retroactive benefits offered by the company dating back to 1987. Given the potential liability that these types of lawsuits can have for employers, the Hewlett Packard suit is a good reminder to employers that now is a good time to review language in your plans and any third party agency agreements involving leased or temporary employees or independent contractors.

Predictions about the Hewlett Packard Suit

Having just been filed, it is too early to predict with certainty the outcome of the Hewlett Packard case. There are a few issues, however, that bear mentioning at this time. First, it seems likely that the suit will be removed to federal court. Although, the suit was filed in state court and does not mention the Employee Retirement Income Security Act (ERISA) of 1974, the suit should be removable because ERISA completely preempts the state law claims pertaining to employee benefit plans. The state law employment allegations, to the extent not preempted under any other federal employment law, should follow based on the district court's pendent jurisdiction.

Second, the issue that will be hotly contested is whether the plaintiff class is composed of common-law employees of Hewlett Packard or whether they are common-law employees of the third party agency who leased their services to Hewlett Packard. In *Natiowide Mut. Ins. Co. v. Darden*, the Supreme held that the common-law test applies anytime the status of a worker is at issue for the purpose of determining entitlement to benefits governed by ERISA. [*Id.*, 503 U.S. 318 (1992)] This test, the Supreme Court explained, involves analyzing at least 13-factors that have been developed by the courts over time

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including “the hiring party’s right to control the manner and means by which the product is accomplished.” [*Id.* 503 U.S. at 323-24]

Assuming the case progresses and is not dismissed or settled early, another issue that is likely to be litigated involves whether irrespective of the plaintiffs’ employee status, do they nonetheless fall within an identifiable class of employees excluded from participating in the employee benefit plans at issue in the case. There are currently few restraints on plan design. ERISA limits exclusions from pension plans based on age and length of service and annual service hours, but beyond these restrictions, there is nothing in the statute that would prevent an employer from excluding a class of workers from its plan.

Any provision in a plan excluding a class of employees should be unambiguous. For example, assume an entire group of workers is excluded from participating in a plan because they are classified as “independent contractors.” Later, as a result of an IRS audit or a participant challenge, it is determined that the workers meet the common-law definition of employee. The plan from which the workers were excluded has language stating that all employees of the sponsoring employer are eligible to participate in the plan. What is the result? It will likely depend on how well crafted the governing plan documents are. After the Microsoft decision, it has become common to include language in plan documents expressly stating that a group excluded from receiving benefits on the basis of independent contractor or leased employee status will not be eligible to receive benefits even if the group is subsequently deemed to be the common law employee of the plan sponsors.

Three Steps To Avoid Liability

1. Make sure that the plan document includes language conferring the maximum degree of deference on the plan administrator to interpret the terms of the plan.

2. Make certain that the plan has clearly excluded those categories of employees that should be excluded based on the company’s plan design and that it has been amended to protect against a Microsoft-type finding. Sample language for a plan might read as follows:

   Reclassification: This subsection applies to any individual classified by the Employer as a leased employee, independent contractor, or coming within another non-employee or ineligible designation. If any such individual is thereafter required by the Internal Revenue Service, Department of Labor or other governmental agency, or by any court or other tribunal to be classified as an Employee, such individual shall not be eligible to participate in this Program unless and until the time he or she is expressly designated by the Plan Administrator as an eligible Employee. Such designation shall only provide for eligibility prospectively from the time it is made, even if the decision or requirement applies retroactively.

3. If your company outsources any functions and those workers are on company premises, examine the relationship to ensure that the recipient of the services is not exercising greater control over the workers than is necessary. To the extent possible, the agency (not the recipient of services) should, for example, have the obligations to hire or fire the individual, pay wages, instruct or train, evaluate performance, issue employment manuals, provide health insurance and pension benefits, etc.

Conclusion

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Because employee status can be a hotly contested point, it is probably impossible for employers to eliminate all exposure arising from Microsoft-type allegations. There is much that an employer can do to improve its chances of prevailing such a lawsuit. The Hewlett Packard lawsuit serves as a reminder that now is a good time to review practices and documents governing these issues.

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IRS Announces 2010 Retirement Plan and Inflation-Adjusted Benefits

The Internal Revenue Service has announced cost-of-living adjustments applicable to dollar limitations for retirement plans and inflation-adjusted limits for other benefits for 2010. Almost all of the limitations have remained the same as the 2009 limits.

	2009 Limits	2010 Limits
401(k)/403(b) Contributions	$16,500	$16,500
457(b) Limit	$16,500	$16,500
Catch-up Contributions	$5,500	$5,500
Compensation Limit**	$245,000	$245,000
Highly Compensated Employees**	$110,000	$110,000
Key Employee Officer Compensation**	$160,000	$160,000
Maximum Annual Benefit Defined Benefit Plan**	$195,000	$195,000
Maximum Annual Contribution Defined Contribution Plan**	$49,000	$49,000
ESOP Limits	$195,000	$195,000
Dollar limit for determining lengthening of 5-year period*		
Dollar amount for determining max. amount subject to 5-year distribution*	$985,000	$985,000
Maximum SIMPLE contribution	$11,500	$11,500
FICA Wage Base ***	$106,800	$106,800
Qualified Transportation Fringe Benefits-Code § 132		
Monthly limit for transportation in a commuter highway vehicle or transit pass	$120 (increased to $230 by the stimulus bill)	$230
Monthly limit for qualified parking	$230	$230
Monthly limit for bicycle commuters	$20	Not yet released
Adoption Assistance Programs		
Maximum excludable from employee gross income	$12,150	$12,170
Exclusion phased out with modified gross income (starting at–ending at)	$182,150–222,180	$182,520–222,520

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2009 Forecast Alert

01.23.09

FEATURED IN THIS EDITION

- Qualified Plans
- Health & Welfare
- Exec Comp
- Payroll Tax & Fringe Benefits

Benefits professionals can expect to be busy in 2009, and it will be important for them to keep their eye on the ball with so many developments taking place. To aid our clients and friends in this process, we have summarized below some of the developments we are expecting to require attention in 2009. These are broken down by four areas retirement plans, health and welfare plans, executive compensation, and payroll tax and fringe benefits.

Qualified Plans

Gary Quintiere, Elizabeth Drake, Mindy Leeds, Garrett Fenton

Don't think that passage of the Pension Protection Act in 2006 marked the beginning of a hiatus in pension regulations. Sponsors and administrators of tax-qualified retirement plans should expect having to contend with continued compliance requirements and legislative/regulatory initiatives that may well be both very broad and technical at the same time. Greater compliance complexity inevitably leads to plan design and operational errors which, in turn, create circumstances that are ripe for litigation.

Compliance Issues

Plan Amendment Requirements

In 2009, plan sponsors will need to amend their plans to reflect the final regulations under Internal Revenue Code section 415 and to comply with the Pension Protection Act of 2006 ("PPA"). The 415 amendments generally need to be made by the due date of the sponsor's 2008 tax return, while PPA amendments are generally required by the end of 2009. Among the required PPA amendments are those dealing with interest rate assumptions and mortality tables, accelerated vesting for defined contribution and cash balance/hybrid plans, and qualified optional survivor annuities. Because plans were required to comply with many of these changes in 2008, sponsors will need to ensure that the amendments accurately reflect the plan's past administration.

Plan Design Decisions

The Worker, Retiree, and Employer Recovery Act of 2008 ("WRERA"), signed into law on December 23, 2008, contains a number of provisions in addition to PPA technical corrections affecting both defined

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benefit and defined contribution plans. For example, due to the recent downturn in the financial markets, WRERA allows defined contribution plans to suspend required minimum distributions for 2009. Plan sponsors will need to quickly decide if they want to suspend these distributions and if so, update their communications to participants and beneficiaries.

Plan sponsors should also be alert to design decisions that will likely be required in 2009 as the IRS finalizes its regulations regarding automatic enrollments in 401(k) plans and issues guidance relating to the Heroes Earnings Assistance and Relief Tax Act of 2008.

Form 5500 Fee Disclosures

This year, new disclosure requirements on the Form 5500, Schedule C, will become effective. Beginning with the 2009 Form 5500 (filed in 2010), all direct and indirect compensation paid to service providers, as well as compensation paid to service providers by certain third-parties, must be reported. There is no limit on the number of service providers for whom reporting is required, although an exception exists for providers who receive less than $5,000. The definition of service provider and the types of indirect compensation that must be reported is broad, and the onus is on plan administrators to obtain this information and include it on Schedule C. Therefore, plan administrators who have not already done so will need to work with their service providers and ensure that this information will be provided in sufficient time to file the 2009 Form 5500.

Legislation and Regulations

Defined Benefit Plan Funding

WRERA has been billed, in large part, as providing relief from what would otherwise be unanticipated and prohibitive funding requirements for defined benefit plans. While welcome, the consensus is that further relief is necessary to avoid the funding nightmare that has been exacerbated by the economic downturn and restricted cash flow many businesses are now facing. We expect to see large-scale efforts, some of which are already underway, to persuade Congress to enact further pension funding relief as it considers broader economic stimulus proposals.

On the IRS's agenda for defined benefit plans are final regulations under Code section 430, regarding PPA funding requirements, as well as the funding-based restrictions on benefits and benefit accruals under Code section 436. We also expect the IRS to continue to devote attention to the benefit accrual rules as they apply to hybrid plans and so-called "greater of" benefit formulas.

Defined Contribution Plans and Retirement Security

As the baby-boomer generation reaches retirement, retirement security is likely to be a front-burner item for the 111th Congress. Potential legislative changes may include, for example, income guarantees, annuitization options, and other features intended to strengthen the retirement benefits of defined contribution/401(k) plans while allowing them to maintain characteristics that distinguish them from defined benefit plans.

The IRS will also devote considerable attention to defined contribution plans in 2009, according to officials with the Office of Employee Plans. As noted, regulations on automatic enrollment 401(k) plans, as well as diversification rules for employer stock plans, are likely to be finalized in the coming year. The IRS is also

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expected to issue further guidance, including an updated "Special Tax Notice," in response to the many changes relating to direct rollovers and distribution notices and elections.

Fee Disclosure Initiatives

Service providers and plan sponsors had been anticipating DOL final regulations requiring certain disclosures from service providers to plan fiduciaries. These regulations have now been delayed due to concerns from OMB regarding the cost of implementing the rules. It is unclear whether DOL will seek to have the OMB under President Obama's administration approve the regulations or whether they will be withdrawn completely. If they are withdrawn, legislation seems highly likely as Congress is also concerned about ensuring that service providers are providing adequate information regarding direct and indirect fees, services, and conflicts of interest.

Litigation

Given the recent turmoil in the financial markets, we anticipate a new wave of litigation alleging breaches of fiduciary duty and testing the limits of ERISA section 404(c) protections for participant-directed plans. This will involve not only investments in company stock, but also challenges to investing in financially distressed companies. Plaintiffs' lawyers have already targeted giants such as Lehman Brothers, Bear Stearns, AIG and Wachovia. Thus, it is critical that plan sponsors and fiduciaries review their ERISA section 404(c) compliance, if applicable, and establish and follow a formal plan governance program in order to protect themselves against any future challenges.

Health & Welfare

Susan Relland

Health and welfare plan sponsors and service providers are likely to have a busy year. Specifically there are already a number of plan changes that sponsors will need to make before 2010, there are several significant regulations expected to be issued in 2009, and comprehensive health reform is likely to be a topic of serious discussion and debate on Capitol Hill for the first time in 15 years.

Compliance Issues

Mental Health Parity Act

Almost all health plan benefits will need to be revised to comply with the greatly expanded Mental Health Parity Act requirements that were passed as part of the Emergency Economic Stabilization Act of 2008. The changes are effective for plan years beginning after October 3, 2009 (with special effective date rules for collectively bargained plans). While some employers have reported that their plans are already in compliance, this is unlikely to be true for the majority of health plans. As a general rule, mental health benefits, and now substance use disorder benefits, must be offered under the same terms as apply to medical or surgical benefits (e.g., the same co-payments, coinsurance, deductibles, out-of-pocket maximums, in and out-of-network benefits, etc.). In addition, plans may not have any separate cost-

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Split-Dollar Life Insurance and 409A, ESOP Dividends, Disaster Relief, Health Legislation, Termination of Employment for Smoking

07.08.08

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Exec Comp: Amending Split-Dollar Life Insurance Arrangements May Avoid Section 409A Treatment

Tony Provenzano & Adrian Morchower

Employers should review their split-dollar life insurance arrangements ("SDAs") to determine whether such arrangements are subject to, or comply with, Code Section 409A. In reviewing such arrangements, the important first step is understanding which SDAs could be subject to Section 409A. IRS Notice 2007-34 breaks down the various types of SDAs and describes which SDAs are generally exempt from Section 409A. For example, SDAs that provide only death benefits are excluded from coverage under Section 409A. In addition, SDAs treated as loans under Treas. Reg. Sec. 1.7872-15 or treated as loan arrangements under prior guidance (guidance before 2003) generally will not be subject to Section 409A unless the loans are waived, cancelled, or forgiven. However, Notice 2007-34 provides that Section 409A may apply to any SDA, including those entered into before September 18, 2003 (when the split-dollar regulations were issued), if any benefits under the policy were not "earned and vested" as of December 31, 2004 and if the arrangements provide deferred compensation.

If an SDA is subject to Code Section 409A, the next and more difficult step is determining what amendments are required to comply with Section 409A. Generally, the amended SDA should limit distributions to those events permitted under Section 409A (termination of employment, death, disability, change in control, hardship or stated time). For purposes of an SDA, a distribution would generally occur when the SDA is "rolled out" (when the value of the arrangement is transferred to the employee free of any residual claim of the employer). Notice 2007-34 did provide some relief, however, with respect to certain grandfathered SDAs. In the event the SDA currently receives favorable tax treatment because it was entered into prior to September 18, 2003 and therefore not subject to the split-dollar regulations (under Treas. Reg. Sec. 1.61-22), an amendment to the SDA to comply with Section 409A will generally not cause the SDA to lose such favorable tax treatment under the split-dollar rules.

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Qualified Plans: New Reporting Requirements for Section 404(k) ESOP Dividends

Fred Oliphant & Veronica Rouse

The IRS recently announced changes in the reporting requirements of dividends paid by a C corporation to an Employee Stock Ownership Plan ("ESOP), which is later distributed in cash to participants and their beneficiaries within ninety days after the close of the plan year in which the dividend was paid, generally known as a Code Section 404(k) dividend.

Section 404(k) of the Code provides that a C corporation is allowed a deduction for applicable dividends made in cash to an ESOP sponsored by the corporation or a related corporation under Code Section 409(l)(4). Generally, whether initiated by the corporation or by an election from a participant or beneficiary, Section 404(k) dividends take two forms: (1) the corporation pays a dividend directly to the ESOP participant or beneficiary; or (2) the corporation pays the dividend to the ESOP and then it is distributed by the ESOP in cash to participants or their beneficiaries within 90 days after the close of the plan year. Section 404(k) dividends are not subject to the 10% penalty on early plan distributions under Code Section 72(t), are not eligible for rollover treatment under Section 402(c)(4), are not taken into account when determining compliance under Section 401(a)(9), and are not subject to withholding under Section 3405(e).

In Announcement 2008-56, the IRS requires that cash dividends distributed on or after January 1, 2009 from the corporation to the ESOP and subsequently to the participant or beneficiary be reported on Form 1099-R. In the past, pursuant to Announcement 85-168, these cash dividends were reported on Form 1099-DIV. The Form 1099-R applicable to this new reporting requirement will include a box 7, which will indicate the special tax treatment and rollover restrictions mentioned above. Additional distributions made in the same taxable year are required to be reported on a separate Form 1099-R.

Dividends paid directly to ESOP participants and beneficiaries will continue to be reported on Form 1099-DIV, and Announcement 85-168 is revoked.

Fringe Benefits & Payroll Tax: Tax-Effective Disaster Relief -- Direct Employer Payments to Employees

Lee Spence

In the aftermath of the severe flooding that has recently devastated many areas of the Midwest (and other parts of the country) that have been declared by the President to be federal disaster areas, employers in or close to those areas are looking for ways to help employees who have suffered resulting losses and expenses. There is a tax-effective way to provide such help: by making direct payments to the employees.

Qualifying Payments are Excludible from the Employee's Income

Code Section 139 allows individuals to exclude from gross income (as well as from payroll taxation if they are employees, and self-employment taxes if they are independent contractors), any "qualified disaster relief payment." As indicated in the legislative history, qualifying payments come from *any source*, to

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reimburse or pay reasonable and necessary personal, family, living, or funeral expenses. The payments also may be provided to reimburse or pay reasonable and necessary expenses for the individual's repair or rehabilitation of a personal residence or for the repair or replacement of the residence's contents, to the extent attributable to the qualified disaster.

In Rev. Rul. 2003-12, 2003-1 C.B. 283, the IRS confirmed that Code Section 139 allows employees to exclude from gross income (and for payroll tax purposes) qualifying payments received directly from their employers. Specifically, *Situation 3* of the ruling concludes that grants for medical, temporary housing, and transportation expenses made to employees by an employer, following a flood in a flood area that is a "presidentially declared disaster area," are excludable under Section 139, provided the expenses are not compensated for by insurance or other sources. The employer in *Situation 3* does not require employees to provide proof of actual expenses to receive a grant payment; however, according to the facts of the ruling (but with no explanation of any details), the employer's program contains requirements in the program documents that ensure that the grant amounts are reasonably expected to be commensurate with the amount of unreimbursed reasonable and necessary medical, temporary housing, and transportation expenses the employees incur as a result of the flood. The grants approved in Situation 3 are available to all employees without regard to length or type of service and are not intended to provide relief for all flood-related losses or to reimburse the cost of nonessential, luxury, or decorative items and services. The ruling concludes that the employees may exclude these payments from gross income (and for payroll tax purposes) under Section 139.

Payments are Deductible by the Employer

The legislative history of Code Section 139 confirms that the employees' ability to exclude qualifying disaster relief payments from gross income does not affect the employer's entitlement to deduct the payments as a business expense. The long-standing position of the IRS is that an employer may deduct "amounts expended by way of rehabilitation of employees for injuries and damages sustained in a major disaster." Rev. Rul. 131, 1953-2 C.B. 112, modified by Rev. Rul. 2003-12, *supra.*

There are indeed other techniques that employers can use to provide disaster relief. But they are generally more complicated and time-consuming to put in place than the expedient of making qualifying direct payments to affected employees, and we will address those other techniques on another occasion.

Health & Welfare: Legislative Activity Affecting Employer Plans

Susan Relland

The U.S. Congress is either considering or has recently passed a number of bills likely to affect employers. On May 22, President Bush signed the Genetic Information Nondiscrimination Act of 2008 ("GINA"). Title I of the Act prohibits health plans from restricting enrollment or setting premiums based on genetic information, or requiring or requesting genetic testing; and the Act adds civil penalties under ERISA for violations of the rules. Title II prohibits employers from using genetic information to discriminate in hiring or other employment opportunities; and remedies under the Civil Rights Act would apply to violations, including compensatory and punitive damages. The full scope and application of the Act are somewhat unclear; however many employers are concerned about how the rules will affect health plan administration and the ability to ask for information in connection with wellness programs. Hopefully

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Department of Labor regulations, which the Act requires to be issued, will provide helpful clarification, but the timeline for issuing guidance has yet to be determined.

An expanded mental health parity bill (H.R. 1424) may be signed into law later this year. The House and Senate are working to reconcile a few conflicting provisions and secure funding for the bill. The legislation would require full parity between all provisions relating to mental health and medical/ surgical benefits in an employer's health plan (*i.e., copays*, coinsurance, day/ visit limits, deductibles, out-of-network coverage, and annual/lifetime limits on benefits would have to be no less generous for mental health benefits than for medical/ surgical benefits.) Current law only requires plans to have annual or lifetime limits on benefits that are no more restrictive for mental health benefits than they are for medical/ surgical benefits. If enacted, the bill would likely require almost all plan sponsors to revise the benefits they currently offer under
their plans.

On June 25, the House of Representatives overwhelmingly approved H.R. 3195, the ADA Amendments Act of 2008. The bill would ease the definition of disability to those that "materially restrict" a major life activity and would allow for a wider scope of physical and mental disabilities to be covered under the ADA. In addition, the bill would require employers to review their disability plans to accommodate the greater number of possibly qualifying claims. The outlook in the Senate is still unclear. As a general matter, short and long-term disability plans and long-term care insurance are receiving increased focus by politicians. Members of Congress have also discussed and/or introduced proposals affecting COBRA, FMLA, ERISA preemption, and Medicare Advantage plans that coordinate with employer-sponsored retiree health plans.

ERISA Litigation: ERISA Claim Regarding Termination for Smoking

Susan Relland

A United States District Court of the District of Massachusetts has ruled that a plaintiff who was terminated from employment because he was a smoker could proceed with a claim under Section 510 of ERISA against the employer. See *Rodrigues v. Scotts Company*, LLC, 2008 WL 251971 (D. Mass.). In an effort to "save money on medical insurance costs and to promote healthy lifestyles among its employees," The Scotts Company, Inc. ("Scotts") adopted a policy "prohibiting smoking of tobacco products by its employees at any time and at any place, whether or not in the workplace or during work hours." Shortly after Mr. Rodrigues was hired, Scotts required him to submit a urine sample to test for the presence of nicotine. Upon receiving a positive result, Scotts fired Rodrigues.

Rodrigues filed suit claiming that Scotts' decision to fire him was (i) an invasion of privacy under Massachusetts state law, (ii) an act of wrongful termination, (iii) a violation his civil rights under Massachusetts state law, and (iv) unlawful discrimination under Section 510 of ERISA. In considering Scotts' motion to dismiss the action, the Massachusetts district court granted the defendant's motion to dismiss the plaintiff's wrongful termination and civil rights violation claims. However, the court ruled that Rodrigues could proceed with his invasion of privacy and ERISA claims.

Section 510 of ERISA generally prohibits taking an employment action with the specific intent of interfering with one's benefits under ERISA (e.g., eligibility to participate in an ERISA plan). Rodrigues's claim under Section 510 of ERISA is that in terminating his short-lived employment because he was a

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smoker, Scotts interfered with the attainment of a right to which he would have become entitled -- namely, participation in the Scotts employee benefits plan -- if he had remained employed. Scotts moved for dismissal of the ERISA claim, arguing that (i) Section 510 of ERISA applies only to employment actions taken against existing employees and not to hiring decisions (Scotts claimed the decision to terminate Rodrigues was a hiring decision because his employment offer was conditional on being a non-smoker) and (ii) even if Rodrigues were considered an employee, excluding him from participation in the benefits plan because of his smoking behavior (rather than because he was making or expected to make a claim for benefits) does not violate ERISA. In noting that "Section 510 does not apply to those instances where the loss of benefits was a mere consequence of, but not a motivating factor behind, a termination of employment," the district court ruled that the resolution of the plaintiff's ERISA claim may depend on what facts the plaintiff may ultimately prove and that the plaintiff could therefore proceed with the claim.

Employers considering a no-smoking policy for after-work hours will want to monitor this case as it progresses.

For further information, please contact any of the following lawyers:

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Fiduciary Issues

U.S. Supreme Court Finds Conflict of Interest, Adds New Wrinkle to Benefit Claims Review

This column takes a look at a recent Supreme Court case, MetLife v. Glenn. MetLife *does not appear to have significantly changed the standard of review set in* Firestone v. Bruch *nearly twenty years ago. It does nothing to mitigate the uncertainty in the benefits claims determination process. The greater change for employers may be the impact on how they organize their claims administration departments, such as using TPAs that are not payors to decide claims.*

By Tess J. Ferrera

Tess J. Ferrera, Esq., is a partner with Thompson Hine, LLC in Washington, D.C., and a senior editor of the *Journal of Pension Benefits*.

On June 19, 2008, the United States Supreme Court announced a decision that does nothing to introduce more certainty and predictability into the benefit claims determination process. [*Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2243, 2008 WL 2444796 (June 19, 2008)]

It is common practice for the administrator of a welfare plan, be it the employer or insurance company, to both decide whether an employee is entitled to a benefit and to fund the payment of that benefit. In *MetLife v. Glenn,* a divided Court held that: (1) an ERISA administrator that both decides and pays claims operates under a conflict of interest; and, (2) the conflict of interest must be considered in determining whether the plan administrator abused its discretion in denying the claim. This decision resolves a split among the Circuits that had developed after the Supreme Court's 1989 decision in *Firestone Tire & Rubber Co. v. Bruch*. [489 U.S. 101 (1989)]

Factual Background

MetLife was the plan administrator and insurer of the long-term disability plan for Sears, Roebuck & Company. As such, MetLife decides whether a benefit should be paid and funds valid benefits claims. Wanda Glenn, a Sears employee, was diagnosed with a heart condition. In June 2000, she applied for disability benefits under the Sears disability plan. MetLife determined she was eligible for 24 months of coverage under the plan. After the initial 24-month period, Glenn had to meet a stricter standard to qualify for extended plan benefits. On this second round of review, MetLife determined that she was not eligible for more benefits under the plan terms. After exhausting her administrative remedies, Glenn sought judicial review of MetLife's denial. The District Court denied relief. On appeal, the Sixth Circuit reversed the lower court, finding that MetLife had operated under a "conflict of interest," because it both decided eligibility for benefits and funded benefits.

The Supreme Court's Decision and Analysis

In *Firestone*, the Supreme Court, nearly twenty years ago, addressed the standard of review in the claims determination context. The Court established four principles for determining the appropriate standard of judicial review. First, courts should be "guided by principles of trust law," and a plan administrator should be analogized to the trustee of a common-law trust and the benefit decision a fiduciary act. [*Id.* at 111–113] Second, trust law requires that the decision be reviewed *de novo*, unless the plan provides to the contrary. [*Id.* at 115] Third, where the plan gives the administrator discretionary authority to determine eligibility for benefits, "trust principles make a deferential standard of review appropriate." [*Id.* at 111] Fourth, the principle most relevant to *MetLife*, if "a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.'" [*Id.* at 115 (*quoting* Restatement § 187, Comment d)]

Firestone did not elaborate on the circumstances that might give rise to a conflict of interest, and as Chief

Justice Roberts and Justice Scalia point out in their respective concurring and dissenting opinions, that statement in *Firestone* was pure *dictum*. Nonetheless, much law has been made based on that *dictum*, and the circuits have split on whether the obligation to pay a claim by the same person who decides the claim creates the kind of conflict of interest to which *Firestone* referred. Although divided on *how* to weigh the conflict, the Court, even the dissenting Justices, unanimously agreed that a conflict exists under these circumstances. Justice Breyer wrote the *MetLife* five-justice majority opinion; Chief Justice Roberts concurred in the judgment, but wrote a separate opinion; Justice Kennedy concurred in part and dissented in part; and Justice Scalia wrote a dissent in which Justice Thomas joined.

Although the question presented to the Court was whether an insurance company that both decides and funds claims operates under a conflict of interest, in an uninvited comment, the majority stated that the conflict of interest is especially clear in self-insured plans where the employer both funds the plan and evaluates benefits claims. In those cases, the Court reasoned that "every dollar provided in benefits is a dollar spent by…the employer; and every dollar saved…is a dollar in [the employer's] pocket." [Slip op. at 5, *quoting Bruch v. Firestone Tire & Rubber Co.,* 828 F.2d 134, 144 (3d Cir. 1987)] The Court finding the conflict "less clear" where the plan administrator is not the employer itself, but a professional insurance company, nevertheless held that, for ERISA purposes, a conflict exists.

In deciding the "how" part of the question presented, the majority did not disturb the *Firestone* premise: a conflicted administrator is still entitled to a deferential standard of review, but the conflict must be weighed as a "factor in determining whether there is an abuse of discretion." [Slip op. at 9, *quoting Firestone*, 489 U.S. at 115 (*quoting* Restatement § 187, Comment d)] The majority declined to provide any framework for or guidance as to how the conflict might be considered, noting that:

> [b]enefits decisions arise in too many contexts, concern too many circumstances, and can relate in too many different ways to conflicts—which themselves vary in kind and in degree of seriousness—for us to come up with a one-size-fits-all procedural system that is likely to promote fair and accurate review. Indeed, special procedural rules would create further complexity, adding time and expense to a process that may already be too costly for many of those who seek redress.

[Slip op. at 10] This portion of the opinion came under attack by the concurring and dissenting Justices.

Chief Justice Roberts, concurring in part and in the judgment, argued that the conflict should be considered "only where there is evidence that the benefits denial was motivated or affected by the administrator's conflict." [Roberts, C.J. (Concurring slip op. at 1)] In essence, Roberts opined, an administrator's potential interest to save money, standing alone, should not trigger more exacting judicial scrutiny. Moreover, without some constraint in the application, "the majority's approach…invites the substitution of judicial discretion for the discretion of the plan administrator." [*Id.* at 2–3] "The end result[,]" Chief Justice Roberts predicted, will be "to increase the level of scrutiny in every case in which there is a conflict…[,] thereby undermining the deference owed to plan administrators when the plan vests discretion in them." [*Id.* at 1]

The dissenting opinion by Justices Scalia and Thomas reiterates Roberts' concern that the majority's approach undermines the deference typically due a plan administrator that has the type of discretion described in *Firestone*, and pronounced the majority's "totality-of-the-circumstances" approach "nothing but *de novo* review in sheep's clothing." [Scalia, J. (Dissenting slip op. at 1, 5)] The dissent notes that under trust law, "a fiduciary with a conflict does not abuse its discretion unless the conflict *actually* and *improperly motivates* the decision." [*Id.* at 2]

Undeterred by the criticism, the majority noted that courts are no strangers to the kind of case-by-case review required by its decision, whereby courts must apply the weight of any given factor to the specifics of a particular case. By way of example, the Court noted that the conflict of interest "should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including…where an insurance company administrator has a history of biased claims administration." [Slip op. at 11] At the other end of the spectrum, the Court suggested that the conflict

> should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decisionmaking irrespective of whom the inaccuracy benefits. (*Id.*)

The majority's approach seems to counsel more in favor of reforming organizational structures to minimize the inherent conflict of interest where the administrator both decides and funds the benefits, rather than providing guidance for balancing the factors that might lead to more judicial consistency in the benefit claims arena.

Did *MetLife* Change the Rules?

MetLife does not appear to have significantly changed the standard of review set in *Firestone* nearly twenty years ago. In affirming the Sixth Circuit's approach, *MetLife* leaves its approach, and that of many courts that have treated a structural conflict as a factor to consider in evaluating whether a benefits claim denial is arbitrary, unchanged. The biggest change likely will be felt in those Circuits (the First, Second, and Seventh) that did not apply a heightened standard of scrutiny where the only argument in favor of a heightened level of review was the presence of a structural conflict. Historically, one of the most significant battles in benefits litigation has been about the applicable standard of review. *Metlife* simply establishes that a structural conflict is the type of conflict that was envisioned in *Firestone*. Participants still have to prove that the conflict played a role in the benefits denial in order to have an administrator's denial of a benefits claim reversed.

The greater change may be the impact on how companies organize their claims administration departments. Taking a cue from Justice Breyer, employers may want to review how their benefits claims decision-making is currently structured and to take a few preliminary steps to minimize (perhaps to the vanishing point) the structural conflict of interest. These active steps could include measures such as using third-party administrators ("TPAs") that are not the payor to decide claims, evaluating the TPA's performance based on reversals of denials by courts, and building firewalls between those who pay the claims and those who decide whether a benefit is valid under the terms of the plan or insurance policy. ■

FIDUCIARY ISSUES

Seventh Circuit Affirms Dismissal of First Fee Case to Reach an Appellate Court; Second Circuit Follows Suit

Hecker v. Deere & Co. is the first 401(k) excessive fee case to reach a court of appeals and only one of four excessive fee cases involving a 401(k) plan that have been entirely dismissed because a district court found that plaintiffs failed to state a cognizable claim under the Employee Retirement Income Security Act ("ERISA") of 1974. This case should provide some comfort to sponsors that reside in states under the jurisdiction of the Seventh Circuit.

BY TESS FERRERA

Tess Ferrera, Esq. is a partner with Thompson Hine, LLC in Washington, D.C., and a senior editor of the *Journal of Pension Benefits.*

In a complete victory for Defendants accused of breaching their fiduciary duties to participants of a 401(k) plan for paying excessive fees to the investment advisor and trustee of a plan, the Seventh Circuit in Hecker v. Deere & Co., 556 F.3d 575 (7th Cir. Feb. 12, 2009), affirmed a lower court decision tossing the complaint out on a motion to dismiss. *Deere* is the first 401(k) excessive fee case to reach a court of appeals and only one of four excessive fee cases involving a 401(k) plan that have been entirely dismissed because a court found that plaintiffs failed to state a cognizable claim under the Employee Retirement Income Security Act ("ERISA") of 1974. [Young v. General Motors Investment Management Corp., 08-1532-cv (2d Cir. 2009) (summary order affirming district court's dismissal on other grounds); Braden v. Wal-Mart Stores, Inc., 590 F. Supp. 2d 1159 (S.D. Mo. 2008) appeal pending; Columbia v. Fidelity Management Trust Co., 2008 WL 4457861 (D. Mass. Sept. 30, 2008).] *Deere* case should provide some comfort to sponsors that reside in states under the jurisdiction of the Seventh Circuit.

The *Deere* Facts and Allegations

Deere sponsors two 401(k) Plans (the "Plans"). In 1990, Deere engaged Fidelity Management Trust Company ("Fidelity Trust") to serve as trustee to both Plans. Under its arrangement with Deere, Fidelity Trust agreed to provide investment advice to Deere regarding the menu of investment options for the Plans, to administer participant accounts, and to provide record keeping services to the Plans. Each of the Plans included 23 different Fidelity mutual funds, two investment funds managed by Fidelity Trust, a company stock fund, and an open brokerage window called BrokerageLink. BrokerageLink gives participants access to 2,500 investment options managed by companies other than Fidelity Trust. Fidelity Management & Research Co. ("Fidelity Research") is an advisor to the Fidelity mutual funds offered to participants through the Deere Plans. Deere and the two Fidelity entities were all named defendants in the complaint.

As is typical in these arrangements, each mutual fund charges an asset-based fee, which in this case was paid to Fidelity Research for providing investment advice to the funds. Fidelity Research, in turn, shared a portion of its revenue with Fidelity Trust as compensation for the services it agreed to provide the Fund, rather than charge Deere or the Plan directly for its services. All mutual funds are not structured to include revenue sharing arrangements and those that do typically have higher expense ratios. The services that are paid through revenue sharing arrangements, however, are necessary services to proper administration of plans and would have to be paid for directly by the plan or its sponsor, if not paid indirectly through revenue sharing arrangements.

At the heart of Plaintiffs' complaint is that, by including investment options in its 401(k) Plans that charged an additional amount for revenue sharing, participants paid excessive fees, and because the participants did not know about these revenue sharing arrangements, there was an "impermissible lack

of transparency in the fee structure." According to Plaintiffs, Deere breached its fiduciary duties to the Plans and engaged in nonexempt prohibited transactions because the Fidelity entities were paid excessive compensation. Plaintiffs alleged that Fidelity entities were functional fiduciaries under a variety of theories and had co-fiduciary liability with Deere for the alleged losses to the Plan. Plaintiffs alleged that the losses to the Plan were the lost earnings resulting from the payment of excessive fees to Fidelity Research.

The District Court's Ruling

The district court dismissed the case for the following reasons. Noting that there currently is no statutory or regulatory requirement to disclose revenue sharing arrangements, the court concluded that Deere had complied with all applicable statutory disclosure requirements. In support of its position, the court also noted that the Department of Labor is considering proposals to amend existing regulations, which would, among other things, require disclosure of revenue sharing arrangements, demonstrating that there is no current disclosure requirement. The court concluded that Deere had met whatever obligations existed to make sure that participants understood the actual expenses paid to fund managers.

With respect to the allegation that Deere and Fidelity Trust breached their fiduciary duties by selecting Plan investment options with unreasonably high fees, the court concluded that the defendants satisfied the necessary requirements to use ERISA § 404(c) as an affirmative defense. The court did not think it was necessary to evaluate whether the fees paid to Fidelity Research were actually excessive. The court ruled that, because BrokerageLink gave participants 2,500 additional funds with a wide range of expense ratios (.07% to just over 1%) from which to select for investments, and because these funds were offered to the public at large, the expense ratios necessarily were set against the backdrop of market competition. In general, the test for determining whether compensation is reasonable is based on examining the going rate for similar services in a specific geographic region. Thus, the court implicitly concluded that, irrespective of whether the fees paid to the Fidelity Research managed funds were excessive or not, participants had a wide choice of funds from which to choose, any number of which had lower expense ratios. The court concluded therefore that any losses participants suffered as a result of investing in the Fidelity funds were losses attributable to participants exercising control over their investments within the meaning of ERISA § 404(c).

The district court held that since Deere had not breached any fiduciary duties to the Plans, Fidelity could not have co-fiduciary liability whether or not it was a fiduciary to the Plans, a question the court did not reach.

The Seventh Circuit affirmed, but on slightly different grounds.

The Seventh Circuit Decision

The Fidelity Entities Are Not Fiduciaries

The Court started by deciding the question left unanswered by the district court: Were Fidelity Trust and Fidelity Research functional fiduciaries to the Plans? The court had no trouble finding that neither functioned as a fiduciary to the Plans. It held that Fidelity Trust did not have the power to actually select the menu of investment options for the Plan, concluding that the Trust Agreement gave that power exclusively to Deere: "The fact that Deere may have discussed this decision, or negotiated about it, with Fidelity Trust does not mean that Fidelity Trust had discretion to select the funds for the Plans." The Court also distinguished its decision from Haddock v. Nationwide Fin. Servs. [419 F. Supp. 2d 156 (D. Conn. 2006)]. In *Nationwide*, the court noted, the financial institution had authority to delete and substitute mutual funds from a plan without seeking approval from the named fiduciary.

The Court resoundingly rejected Plaintiffs' assertion that either Fidelity Trust or Fidelity Research were fiduciaries because they exercised discretion over plan assets by determining how much revenue Fidelity Research would share with Fidelity Trust. Mutual fund assets, the Court noted, are not Plan assets. ERISA does not define the term, "plan asset," but the statute does define specific instances when an asset will not be deemed a plan asset for ERISA purposes. ERISA § 401(b)(1) provides:

> [i]n the case of a plan which invests in any security issued by a [mutual fund], the assets of such plan shall be deemed to include such security but shall not, solely by reason of such investment, be deemed to include any assets of such [mutual fund].

This latter point has thus far eluded at least two other district courts that have, at least at an early

stage, refused to hold that mutual fund assets are statutorily exempt from being a "plan" asset, and therefore have thus far refused to find that compensation paid out of mutual fund assets under a revenue sharing arrangement cannot, as a matter of law, be deemed an exercise of discretion under ERISA. [*See* Haddock v. Nationwide Fin. Servs., 419 F. Supp. 2d 156 (D. Conn. 2006) and Charter v. John Hancock Life Ins. Co., 534 F. Supp. 2d 168 (D. Mass. 2007).]

The Court, therefore, held that Plaintiffs had failed to state a claim against the Fidelity entities on the grounds that neither were fiduciaries to the Plans under any theory relevant to the facts of the case.

Deere Gets Off, Too

The Seventh Circuit summarized Plaintiffs' allegations against Deere as breach of fiduciary duty for (1) failing to disclose the revenue sharing arrangement between the two Fidelity entities, and (2) agreeing to limit the investment options to Fidelity Research funds, leading to investment options with excessively high fees. Affirming the district court, the Seventh Circuit rejected that Deere had any duty to disclose the revenue sharing arranging, and held that the critical information—disclosure of the total fees imposed on the various funds—was indisputably provided to the participants. It also noted, like the district court, that participants were free to select funds with lower expense ratios through BrokerageLink.

Finding that there is "no statute or regulation prohibiting a fiduciary from selecting funds from one management company," the Seventh Circuit also rejected Plaintiffs second theory of liability against Deere. In *dicta* (a court musing outside the scope of its holding), the Seventh Circuit questioned whether selecting the menu of options was a fiduciary act at all. The Court thought that selecting the menu mix was more akin to a settlor act of plan design than a fiduciary act administering a plan. On the assumption that it was a fiduciary act, the Court held that there was no breach of fiduciary duty for selecting a menu of funds from one management company.

More on the Section 404(c) Defense

The Seventh Circuit's primary holding in *Deere* is that the Fidelity entities do not serve as fiduciaries to the Deere Plans and therefore, as a matter of law, they cannot have fiduciary or co-fiduciary liability for any alleged breach. With respect to Deere, the Court held that Deere had prudently discharged all its fiduciary duties, as currently understood. In the alternative or as a supplemental reason for finding no breach of fiduciary duty, the Court stated that even if it had underestimated Deere's fiduciary responsibilities, the district court's ruling had to be affirmed if § 404(c) was available as an affirmative defense, the primary basis of the district court's opinion. The Court concluded that it was available and therefore affirmed the district court's ruling on this basis, too.

As *JPB* readers know, ERISA § 404(c) modifies the normally applicable fiduciary rules when a plan allows a participant or beneficiary to "exercise control over the assets in his account" [ERISA § 404(c)(1)]. The DOL has issued regulations on what it means for a participant to "exercise control over the assets in his account." The Court noted that some of those criteria included that a participant must:

1. Have the right to exercise independent control over the assets in his/her account and in fact exercise that control;
2. Be able to choose from a broad range of risk investment alternatives, not to number less than three;
3. Be able to give instructions with respect to those options at least once every three months; and
4. Be given sufficient information to make informed decisions.

The Court noted that nothing in the regulations requires that plans offer only cost-free investment vehicles and that the regulations permit the imposition of reasonable expenses, provided the proper procedures are in place to inform participants of expenses their individual accounts incur. Finally, the Court noted that the regulations will not apply if the plan fiduciary has concealed material nonpublic facts regarding the investment.

The Court stated Plaintiffs have focused on defendants' failure to disclose nonpublic material information, revenue-sharing arrangements, and decisions to offer only Fidelity Research mutual funds were unhelpful to determining whether § 404(c) applied. The Court thought the central question was "whether the alleged misconduct—the imprudent selection of mutual funds with excessively high fees—falls within the safe harbor." Affirming the district court's reasoning, the Seventh Circuit concluded that § 404(c) had been satisfied in this case, because even if it was assumed that the Fidelity funds charged excessive fees, the total fees charged by each plan was disclosed and participants could invest in one of 2,500 other funds, some of which had lower fees. At bottom, the Court

ruled that participants controlled how much fees they paid because they controlled the investments they made in their individual accounts. Like the district court, the Seventh Circuit ruled that, to the extent participants experienced any loss in their accounts, it was based on their selection of investment choices. Therefore, neither Deere nor Fidelity, assuming Fidelity could be deemed a fiduciary, could be responsible for those losses under § 404(c).

Conclusion

Since *Deere* was decided, the Second Circuit summarily affirmed a district court dismissal of a fee case on grounds different than the district court's decision [Young v. General Motors Investment Management Corp., 08-1532-cv (2d. Cir. 2009)]. The district court had dismissed the case because it concluded that Plaintiffs' claims were time-barred under ERISA's statute of limitations provision. The Second Circuit reviewed the case on the merits, not just on procedural grounds, and concluded that the complaint failed to state a claim upon which relief could be granted. The Second Circuit noted that with respect to plaintiffs' claim that the plan fiduciaries violated ERISA's diversification provision, plaintiffs complained only of certain investments. The court noted that ERISA's diversification provision contemplates a claim when the plan is undiversified as a whole, and that therefore the complaint's focus on a few individual funds was insufficient to withstand a motion to dismiss. With respect to Plaintiffs' excessive fee claim, the Second Circuit looked for guidance from cases deciding the question in the analogous context of the Investment Company Act. Noting that to establish a valid excessive fee claim in this Circuit, a plaintiff must show that the advisor manager's is so disproportionately large that it bears no reasonable relationship to the services provided. The Second Circuit dismissed the case because plaintiffs' had plead no facts in support of that standard. The *WalMart* case is on appeal. The district court in that case simply threw the case out because it did not think Plaintiffs' factual allegations were sufficient to support their claims.

These are four cases dismissed at a very early stage in the litigation proceedings; two affirmed on appeal. Many others, over 20, have survived dismissal at the motion to dismiss stage. Survival at the earliest stage in litigation is more common than not. Still these cases demonstrate the difficulties these cases present for plaintiffs. The Second Circuit's adoption of the ICI's test in the ERISA context is not all that different from the market test routinely applied in the ERISA context to determine what is reasonable compensation. Better regulation in this area is needed to protect from what may inevitably be confusing and contradictory court decisions in this most important arena. ■

I

111TH CONGRESS
1ST SESSION

H. R. 3408

To amend the Internal Revenue Code of 1986 to modify the rules relating to the treatment of individuals as independent contractors or employees, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 30, 2009

Mr. MCDERMOTT (for himself, Mr. NEAL of Massachusetts, and Mr. TIERNEY) introduced the following bill; which was referred to the Committee on Ways and Means

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A BILL

To amend the Internal Revenue Code of 1986 to modify the rules relating to the treatment of individuals as independent contractors or employees, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Taxpayer Responsibility, Accountability, and Consistency Act of 2009''.

SEC. 2. INFORMATION REPORTING FOR PAYMENTS TO CORPORATIONS.

(a) IN GENERAL.—Section 6041 of the Internal Revenue Code of 1986 (relating to information at source) is amended by adding at the end the following new subsection:

''(h) PAYMENTS TO CORPORATIONS.—

''(1) IN GENERAL.—Notwithstanding any regulations prescribed by the Secretary before the date of the enactment of this subsection, subsection (a) shall apply to payments made to a corporation.

''(2) EXCEPTION.—Paragraph (1) shall not apply to payments made to a hospital or extended care facility described in section 501(c)(3) which is exempt from taxation under section 501(a) or to a hospital or extended care facility owned and operated by the United States, a State, the District of Columbia, a possession of the United States, or a political subdivision, agency or instrumentality of any of the foregoing.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made more than 1 year after the date of the enactment of this Act.

SEC. 3. DETERMINATION OF ELIGIBILITY FOR SAFE HARBOR TREATMENT OF INDIVIDUALS AS NON-EMPLOYEES FOR PURPOSES OF EMPLOYMENT TAXES.

(a) IN GENERAL.—Chapter 25 of the Internal Revenue Code of 1986 (relating to general provisions relating to employment taxes) is amended by adding at the end the following new section:

"SEC. 3511. SAFE HARBOR.

"(a) TERMINATION OF CERTAIN EMPLOYMENT TAX LIABILITY.—

"(1) IN GENERAL.—If—

"(A) for purposes of employment taxes, the taxpayer did not treat an individual as an employee for any period, and

"(B) in the case of periods after December 31, 1978, all Federal tax returns (including information returns) required to be filed by the taxpayer with respect to such individual for such period are filed on a basis consistent with the taxpayer's treatment of such individual as not being an employee,

then, for purposes of applying such taxes for such period with respect to the taxpayer, the individual shall be deemed not to be an employee unless the taxpayer had no reasonable basis for not treating

such individual as an employee. This paragraph shall not apply with respect to an individual for any periods beginning after the date of notice of a determination that such individual should be treated as an employee of the taxpayer.

''(2) STATUTORY STANDARDS FOR SATISFYING THE REQUIREMENTS OF PARAGRAPH (1).—For purposes of paragraph (1), a taxpayer shall be treated as having a reasonable basis for not treating an individual as an employee only if—

''(A) the taxpayer's treatment of such individual was in reasonable reliance on—

''(i) a written determination issued to the taxpayer addressing the employment status of such individual or another individual holding a substantially similar position with the taxpayer, or

''(ii) a concluded examination (for employment tax purposes) of whether such individual (or another individual holding a substantially similar position) should be treated as an employee of the taxpayer, with respect to which there was no determination that such individual (or another individual holding a substantially similar

position) should be treated as an employee, and

''(B) the taxpayer (or a predecessor) has not treated any other individual holding a substantially similar position as an employee for purposes of employment taxes for any period beginning after December 31, 1977.

''(b) DEFINITIONS.—For purposes of this section—

''(1) EMPLOYMENT TAX.—The term 'employment tax' means any tax imposed by this subtitle.

''(2) EMPLOYMENT STATUS.—The term 'employment status' means the status of an individual, under the usual common law rules applicable in determining the employer-employee relationship, as an employee or as an independent contractor (or other individual who is not an employee).

''(c) SPECIAL RULES FOR APPLICATION OF SECTION.—

''(1) NOTICE OF AVAILABILITY OF SECTION.—An officer or employee of the Internal Revenue Service shall, before or at the commencement of any examination relating to the employment status of one or more individuals who perform services for the taxpayer, provide the taxpayer with a written notice of the provisions of this section.

"(2) RULES RELATING TO STATUTORY STANDARDS.—For purposes of subsection (a)(2), with respect to any period beginning after the date of the enactment of this paragraph, a taxpayer may not rely on an examination commenced, or a written determination issued, if—

"(A) the controlling facts and circumstances that formed the basis of a determination of employment status have changed or were misrepresented by the taxpayer, or

"(B) the Secretary subsequently issues contrary guidance relating to the determination of employment status that has bearing on the facts and circumstances that formed the basis of a determination of employment status.

"(3) SUBSTANTIALLY SIMILAR POSITION.—For purposes of this section, the determination as to whether an individual holds a position substantially similar to a position held by another individual shall be made by the Secretary in a manner consistent with the Fair Labor Standards Act of 1938.

"(d) BURDEN OF PROOF.—A taxpayer must establish entitlement to relief under this section by a preponderance of the evidence.

"(e) PETITIONS FOR REVIEW OF STATUS.—

''(1) IN GENERAL.—Under procedures established by the Secretary not later than 1 year after the date of the enactment of this section, any individual who performs services for a taxpayer may petition (either personally or through a designated representative or attorney) for a determination of the individual's status for employment tax purposes.

''(2) ADMINISTRATIVE PROCEDURES.—The procedures established under paragraph (1) shall provide for—

''(A) a determination of status not later than 90 days after the filing of the petition with respect to employment in any industry (such as the construction industry) in which employment is transient, casual, or seasonal, and

''(B) an administrative appeal of any determination that an individual is not an employee of the taxpayer.

''(3) DUTY TO SEEK SERVICE PROVIDER INFORMATION.—In the case of a request by a taxpayer for a determination of an individual's status for employment tax purposes, the Secretary shall, to the extent practicable—

''(A) seek to obtain from such individual information relating to the individual's performance of services for the taxpayer, and

''(B) provide written notice to the individual detailing any written determination of the individual's status for employment tax purposes.

''(f) RESULTS OF MISCLASSIFICATION DETERMINATIONS.—In any case in which the Secretary determines that a taxpayer has misclassified an individual as not an employee for employment tax purposes, the Secretary shall inform the Secretary of Labor about such misclassification and notify the individual of any eligibility for the refund of self-employment taxes under chapter 2.

''(g) REGULATIONS.—The Secretary shall, not later than 1 year after the date of the enactment of this section, prescribe such regulations as may be necessary and appropriate to carry out the purposes of this section.''.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 7436(a) of such Code is amendment by striking ''section 530 of the Revenue Act of 1978'' and inserting ''section 3511''.

(2) The table of sections for chapter 25 of such Code is amended by adding at the end the following new item:

''Sec. 3511. Safe harbor.''.

(c) TERMINATION OF SECTION 530 OF THE REVENUE ACT OF 1978.—Section 530 of the Revenue Act of 1978 shall not apply to services rendered more than 1 year after the date of the enactment of this Act.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services rendered more than 1 year after the date of the enactment of this Act.

SEC. 4. ANNUAL REPORTS ON WORKER MISCLASSIFICATION.

The Secretary of the Treasury shall issue an annual report on worker misclassification. Such report shall include the following:

(1) Information on the number and type of enforcement actions against, and examinations of, employers who have misclassified workers.

(2) Relief obtained as a result of such actions against, and examinations of, employers who have misclassified workers.

(3) An overall estimate of the number of employers misclassifying workers, the number of workers affected, and the industries involved.

(4) The impact of such misclassification on the Federal tax system.

(5) Information on the outcomes of the petitions filed under section 3511(e) of the Internal Revenue Code of 1986.

SEC. 5. INCREASE IN INFORMATION RETURN PENALTIES.

(a) FAILURE TO FILE CORRECT INFORMATION RETURNS.—

(1) IN GENERAL.—Section 6721(a)(1) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''$50'' and inserting ''$250'', and

(B) by striking ''$250,000'' and inserting ''$3,000,000''.

(2) REDUCTION WHERE CORRECTION IN SPECIFIED PERIOD.—

(A) CORRECTION WITHIN 30 DAYS.—Section 6721(b)(1) of such Code is amended—

(i) by striking ''$15'' and inserting ''$50'',

(ii) by striking ''$50'' and inserting ''$250'', and

(iii) by striking ''$75,000'' and inserting ''$500,000''.

(B) FAILURES CORRECTED ON OR BEFORE AUGUST 1.—Section 6721(b)(2) of such Code is amended—

(i) by striking ''$30'' and inserting ''$100'',

(ii) by striking ''$50'' and inserting ''$250'', and

(iii) by striking ''$150,000'' and inserting ''$1,500,000''.

(3) LOWER LIMITATION FOR PERSONS WITH GROSS RECEIPTS OF NOT MORE THAN $5,000,000.—Section 6721(d)(1) of such Code is amended—

(A) in subparagraph (A)—

(i) by striking ''$100,000'' and inserting ''$1,000,000'', and

(ii) by striking ''$250,000'' and inserting ''$3,000,000'',

(B) in subparagraph (B)—

(i) by striking ''$25,000'' and inserting ''$175,000'', and

(ii) by striking ''$75,000'' and inserting ''$500,000'', and

(C) in subparagraph (C)—

(i) by striking ''$50,000'' and inserting ''$500,000'', and

(ii) by striking ''$150,000'' and inserting ''$1,500,000''.

(4) PENALTY IN CASE OF INTENTIONAL DISREGARD.—Section 6721(e) of such Code is amended—

(A) by striking ''$100'' in paragraph (2) and inserting ''$500'', and

(B) by striking ''$250,000'' in paragraph (3)(A) and inserting ''$3,000,000''.

(b) FAILURE TO FURNISH CORRECT PAYEE STATEMENTS.—

(1) IN GENERAL.—Section 6722(a) of such Code is amended—

(A) by striking ''$50'' and inserting ''$250'', and

(B) by striking ''$100,000'' and inserting ''$1,000,000''.

(2) PENALTY IN CASE OF INTENTIONAL DISREGARD.—Section 6722(c) of such Code is amended—

(A) by striking ''$100'' in paragraph (1) and inserting ''$500'', and

(B) by striking ''$100,000'' in paragraph (2)(A) and inserting ''$1,000,000''.

(c) FAILURE TO COMPLY WITH OTHER INFORMATION REPORTING REQUIREMENTS.—Section 6723 of such Code is amended—

(1) by striking ''$50'' and inserting ''$250'', and

(2) by striking ''$100,000'' and inserting ''$1,000,000''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to information returns required to be filed after December 31, 2009.

○

II

111TH CONGRESS
2D SESSION

S. 3254

To amend the Fair Labor Standards Act of 1938 to require persons to keep records of non-employees who perform labor or services for remuneration and to provide a special penalty for persons who misclassify employees as non-employees, and for other purposes.

IN THE SENATE OF THE UNITED STATES

APRIL 22, 2010

Mr. BROWN of Ohio (for himself, Mr. HARKIN, Mr. DURBIN, Mrs. MURRAY, Mr. CASEY, and Mr. MERKLEY) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To amend the Fair Labor Standards Act of 1938 to require persons to keep records of non-employees who perform labor or services for remuneration and to provide a special penalty for persons who misclassify employees as non-employees, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Employee Misclassification Prevention Act''.

SEC. 2. CLASSIFICATION OF EMPLOYEES AND NON-EMPLOYEES.

(a) RECORDKEEPING AND NOTICE REQUIREMENTS.—Section 11(c) of the Fair Labor Standards Act of 1938 (29 U.S.C. 211(c)) is amended—

(1) by striking ''(c) Every employer subject to any provision of this Act or of any order issued under this Act'' and inserting the following:

''(c) RECORDKEEPING AND NOTICE REQUIREMENTS.—

''(1) IN GENERAL.—Every person subject to any provision of this Act or of any order issued under this Act'';

(2) by striking ''of the persons employed by him'' and inserting the following: ''of—

''(A) each individual employed by such person'';

(3) by striking ''employment maintained by him, and shall'' and inserting the following: ''employment;

''(B) subject to paragraph (2), each individual—

''(i) who is not an employee within the meaning given the term in section 3(e) (referred to in this subsection as a 'non-employee');

"(ii) whom the person has engaged, in the course of the person's trade or business, for the performance of labor or services; and

"(iii)(I) with respect to whom the person is required to file an information return under section 6041A(a) of the Internal Revenue Code of 1986; or

"(II) who is providing labor or services to the person through an entity that is a trust, estate, partnership, association, company, or corporation (as such terms are used in section 7701(a)(1) of the Internal Revenue Code of 1986) if—

"(aa) such individual has an ownership interest in the entity;

"(bb) creation or maintenance of such entity is a condition for the provision of such labor or services to the person; and

"(cc) the person would be required to file an information return for the entity under section 6041A(a) of the Internal Revenue Code of 1986 if the entity were an individual; and

"(C) the remuneration and hours relating to the performance of labor or services by each individual described in subparagraph (B); and

"(D) the notices required under paragraph (5),

and shall"; and

(4) by adding at the end the following:

"(2) RECORDKEEPING LIMITATION.—A person otherwise subject to the requirements of paragraph (1) shall have no responsibility for making, keeping, or preserving records, including the records described in such paragraph and paragraph (4), concerning the employees of any individual described in paragraph (1)(B) or the non-employees with whom such individual has engaged for the performance of labor or services for such person, unless such records are provided during the course of the trade or business to the person.

"(3) PRESUMPTION.—

"(A) IN GENERAL.—For purposes of this Act and the regulations or orders issued under this Act, an individual who is employed, or who is remunerated for the performance of labor or services, by a person, shall be presumed to be an employee of the person if—

"(i) the person has not made, kept, and preserved records in accordance with subparagraphs (B) and (C) of paragraph (1) regarding the individual; or

"(ii) the person has not provided the individual with the notice required under paragraph (5).

"(B) REBUTTAL.—The presumption under subparagraph (A) shall be rebutted only through the presentation of clear and convincing evidence that an individual described in such subparagraph is not an employee (within the meaning of section 3(e)) of the person.

"(4) ACCURATE CLASSIFICATION.—An accurate classification of the status of each individual described in paragraph (1) as either an employee (within the meaning of section 3(e)) of the person maintaining the records or a non-employee of such person shall be included within the records under this subsection.

"(5) NOTICE.—

"(A) IN GENERAL.—Every person subject to any provision of this Act or of any order issued under this Act shall provide the notice described in subparagraph (C) to each employee

of the person and each individual classified by the person as a non-employee under paragraph (1)(B).

"(B) TIMING OF NOTICE.—

"(i) IN GENERAL.—Such notice shall be provided, at a minimum, not later than 6 months after the date of enactment of the Employee Misclassification Prevention Act, and thereafter—

"(I) for new employees, upon employment; and

"(II) for new non-employees who are classified under paragraph (1)(B), upon commencement of the labor or services described in such paragraph.

"(ii) CHANGE IN STATUS.—Each person required to provide notice under subparagraph (A) to an individual shall also provide such notice to such individual upon changing such individual's status as an employee or non-employee under paragraph (1).

"(C) CONTENTS OF NOTICE.—The notice required under this paragraph shall be in writing and shall—

"(i) inform the individual of the individual's classification, by the person submitting the notice, as an employee or a non-employee under paragraph (1);

"(ii) include a statement directing such individual to a Department of Labor Web site established for the purpose of providing further information about the rights of employees under the law;

"(iii) include the address and telephone number for the applicable local office of the United States Department of Labor;

"(iv) include for each individual classified as a non-employee under paragraph (1)(B) by the person submitting the notice, the following statement: 'Your rights to wage, hour, and other labor protections depend upon your proper classification as an employee or non-employee. If you have any questions or concerns about how you have been classified or suspect that you may have been misclassified, contact the U.S. Department of Labor.'; and

"(v) include such additional information as the Secretary shall prescribe by regulation.".

(b) SPECIAL PROHIBITED ACTS.—Section 15(a) of the Fair Labor Standards Act of 1938 (29 U.S.C. 215(a)) is amended—

(1) by striking paragraph (3) and inserting the following:

"(3) to discharge or in any other manner discriminate against any individual (including an employee) because such individual has—

"(A) opposed any practice, or filed a petition or complaint or instituted or caused to be instituted any proceeding—

"(i) under or related to this Act (including concerning an individual's status as an employee or non-employee for purposes of this Act); or

"(ii) concerning an individual's status as an employee or non-employee for employment tax purposes within the meaning of subtitle C of the Internal Revenue Code of 1986;

"(B) testified or is about to testify in any proceeding described in subparagraph (A); or

''(C) served, or is about to serve, on an industry committee;'';

(2) in paragraph (5), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(6) to fail to accurately classify an individual as an employee.''.

(c) SPECIAL PENALTY FOR CERTAIN MISCLASSIFICATION, RECORDKEEPING, AND NOTICE VIOLATIONS.—Section 16 of the Fair Labor Standards Act of 1938 (29 U.S.C. 216) is amended—

(1) in subsection (b)—

(A) in the sixth sentence, by striking ''any employee'' each place the term occurs and inserting ''any employee or individual'';

(B) in the fourth sentence, by striking ''employee'' and inserting ''employee or individual'';

(C) in the third sentence—

(i) by striking ''either of the preceding sentences'' and inserting ''any of the preceding sentences'';

(ii) by striking ''one or more employees'' and inserting ''one or more employees or individuals''; and

(iii) by striking ''other employees'' and inserting ''other employees or individuals, respectively,''; and

(D) by inserting after the first sentence the following: ''Such liquidated damages are doubled (subject to section 11 of the Portal-to-Portal Pay Act of 1947 (29 U.S.C. 260)) where, in addition to violating the provisions of section 6 or 7, the employer has violated the provisions of section 15(a)(6) with respect to such employee or employees.''; and

(2) in subsection (e), by striking paragraph (2) and inserting the following:

''(2) Any person who violates section 6, 7, 11(c), or 15(a)(6) shall be subject to a civil penalty, for each employee or other individual who was the subject of such a violation, in an amount—

''(A) not to exceed $1,100; or

''(B) in the case of a person who has repeatedly or willfully committed such violation, not to exceed $5,000.''.

(d) EMPLOYEE RIGHTS WEB SITE.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Labor shall establish, for purposes of sec-

tion 11(c)(5)(C)(ii) of the Fair Labor Standards Act of 1938 (as added by this Act), a single web page on the Department of Labor Web site that summarizes in plain language the rights of employees as described in the amendments made by subsection (a) and other information considered appropriate by the Secretary, including appropriate links to additional information on the Department of Labor Web site or other Federal agency Web sites. In addition, such web page—

(A) shall include a statement explaining that employees may have additional or greater rights under State or local laws and how employees may obtain additional information about their rights under State or local laws;

(B) shall be made available in English and any other languages that the Secretary determines to be prevalent among individuals likely to access the web page; and

(C) may provide a link to permit individuals to file complaints online.

(2) COORDINATION WITH OTHER FEDERAL WEB SITES.—The Secretary shall coordinate with other relevant Federal agencies in order to provide information similar to the information described in para-

graph (1) (or a link to the Department of Labor web page required by this subsection) on the Web sites of such other agencies.

SEC. 3. MISCLASSIFICATION OF EMPLOYEES FOR UNEMPLOYMENT COMPENSATION PURPOSES.

(a) IN GENERAL.—Section 303(a) of the Social Security Act (42 U.S.C. 503(a)) is amended—

(1) in paragraph (10), by striking the period and inserting ''; and''; and

(2) by adding after paragraph (10) the following:

''(11)(A) Such auditing and investigative procedures as may be necessary to identify employers that have not registered under the State law or that are paying unreported wages, where these actions or omissions by the employers have the effect of excluding employees from unemployment compensation coverage; and

''(B) The making of quarterly reports to the Secretary of Labor (in such form as the Secretary of Labor may require) describing the results of the procedures under subparagraph (A); and

''(12) The establishment of administrative penalties for misclassifying employees, or paying unreported wages to employees without proper record-

keeping, for unemployment compensation purposes.''.

(b) REVIEW OF AUDITING PROGRAMS.—The Secretary of Labor shall include, in the Department of Labor's system for measuring States' performance in conducting unemployment compensation tax audits, a specific measure of their effectiveness in identifying the underreporting of wages and the underpayment of unemployment compensation contributions (including their effectiveness in identifying instances of such underreporting or underpayments despite the absence of cancelled checks, original time sheets, or other similar documentation).

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) shall take effect 12 months after the date of the enactment of this Act.

(2) EXCEPTION.—If the Secretary of Labor finds that legislation is necessary in order for the unemployment compensation law of a State to comply with the amendments made by subsection (a), such amendments shall not apply with respect to such law until the later of—

(A) the day after the close of the first regular session of the legislature of such State

which begins after the date of the enactment of this Act; or

(B) 12 months after the date of the enactment of this Act.

(d) DEFINITION OF STATE.—For purposes of this section, the term ''State'' has the meaning given such term by section 3306(j) of the Internal Revenue Code of 1986.

SEC. 4. DEPARTMENT OF LABOR COORDINATION, REFERRAL, AND REGULATIONS.

(a) COORDINATION AND REFERRAL.—Notwithstanding any other provision of law, any office, administration, or division of the Department of Labor that, while in the performance of its official duties, obtains information regarding the misclassification by a person subject to the provisions of the Fair Labor Standards Act of 1938 (29 U.S.C. 201 et seq.) or any order issued under such Act of any individual regarding whether such individual is an employee or a non-employee contracted for the performance of labor or services for purposes of section 6 or 7 of such Act (29 U.S.C. 206, 207) or in records required under section 11(c) of such Act (29 U.S.C. 211(c)), shall report such information to the Wage and Hour Division of the Department. The Wage and Hour Division may re-

port such information to the Internal Revenue Service as the Division considers appropriate.

(b) REGULATIONS.—The Secretary of Labor shall promulgate regulations to carry out this Act and the amendments made by this Act.

SEC. 5. TARGETED AUDITS.

The audits of employers subject to the Fair Labor Standards Act of 1938 (29 U.S.C. 201 et seq.) that are conducted by the Wage and Hour Division of the Department of Labor shall include certain industries with frequent incidence of misclassifying employees as non-employees, as determined by the Secretary of Labor.

○

Epidemiology & Statistics Unit, Research and Scientific Affairs, January 2009.

10. Mannino, D. M. et al., "Surveillance for Asthma—United States, 1980–1999," *Morbidity and Mortality Weekly Report*, 51(SS01):1–13, March 29, 2002.

11. Analysis completed by FDA based on information provided by IMS Health, IMS National Sales Perspective (TM), 2009, extracted September 2009. These data can be purchased from IMS Health. Please send all inquiries to: IMS Health, Attn: Brian Palumbo, Account Manager, 660 West Germantown Pike, Plymouth Meeting, PA 19462.

12. Rozek, R. P., and E. R. Bishko, "Economic Issues Raised in the FDA's Proposed Rule on Removing the Essential-Use Designation for Albuterol MDIs," National Economic Research Associates, August 13, 2004 (FDA Docket No. 2003P–0029/C25).

13. Hendeles, L. G, L. Colice, and R. J. Meyer, "Withdrawal of Albuterol Inhalers Containing Chlorofluorocarbon Propellants," *New England Journal of Medicine*, 356:1344–1351, March 29, 2007.

14. Goldman, D. P. et al., "Pharmacy Benefits and the Use of Drugs by the Chronically Ill," *The Journal of the American Medical Association*, 291:2344–2350, May 19, 2004.

15. DeNavas-Walt, C., B. D. Proctor, and J. C. Smith, U.S. Census Bureau, Current Population Reports, P60–236(RV), Income, Poverty, and Health Insurance Coverage in the United States: 2008, Table 7, p. 21, 2009.

List of Subjects in 21 CFR Part 2

Administrative practice and procedure, Cosmetics, Drugs, Foods.

■ Therefore, under the Federal Food, Drug, and Cosmetic Act and the Clean Air Act and under authority delegated to the Commissioner of Food and Drugs, after consultation with the Administrator of the Environmental Protection Agency, 21 CFR part 2 is amended as follows:

PART 2—GENERAL ADMINISTRATIVE RULINGS AND DECISIONS

■ 1. The authority citation for 21 CFR part 2 continues to read as follows:

Authority: 15 U.S.C. 402, 409; 21 U.S.C. 321, 331, 335, 342, 343, 346a, 348, 351, 352, 355, 360b, 361, 362, 371, 372, 374; 42 U.S.C. 7671 *et seq.*

§ 2.125 [Amended]

■ 2. Effective June 14, 2010, in § 2.125, remove and reserve paragraphs (e)(2)(iii) and (e)(4)(vii).

§ 2.125 [Amended]

■ 3. Effective December 31, 2010, in § 2.125, remove and reserve paragraphs (e)(1)(v) and (e)(4)(iv).

§ 2.125 [Amended]

■ 4. Effective June 30, 2011, in § 2.125, remove and reserve paragraph (e)(1)(iii).

§ 2.125 [Amended]

■ 5. Effective December 31, 2013, in § 2.125, remove and reserve paragraphs (e)(2)(iv) and (e)(4)(viii).

Dated: April 8, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–8467 Filed 4–13–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF THE TREASURY

31 CFR Part 103

RIN 1506–AA93

Financial Crimes Enforcement Network; Amendment to the Bank Secrecy Act Regulations; Defining Mutual Funds as Financial Institutions.

AGENCY: Financial Crimes Enforcement Network ("FinCEN"), Treasury.

ACTION: Final rule.

SUMMARY: FinCEN is issuing this final rule to include mutual funds within the general definition of "financial institution" in regulations implementing the Bank Secrecy Act ("BSA"). The final rule subjects mutual funds to rules under the BSA on the filing of Currency Transaction Reports ("CTRs") and on the creation, retention, and transmittal of records or information for transmittals of funds. Additionally, the final rule amends the definition of mutual fund in the rule requiring mutual funds to establish anti-money laundering ("AML") programs. The amendment harmonizes the definition of mutual fund in the AML program rule with the definitions found in the other BSA rules to which mutual funds are subject. Finally, the final rule amends the rule that delegates authority to examine institutions for compliance with the BSA. The amendment makes it clear that FinCEN has not delegated to the Internal Revenue Service the authority to examine mutual funds for compliance with the BSA, but rather to the U.S. Securities and Exchange Commission ("SEC") as the federal functional regulator of mutual funds.

DATES: Effective Date: This rule is effective May 14, 2010.

Compliance Date: Mutual funds must comply with 31 CFR 103.33 by January 10, 2011. The compliance date for all other aspects of this rulemaking is the same as the effective date.

FOR FURTHER INFORMATION CONTACT: The FinCEN regulatory helpline at (800) 949–2732 and select Option 6.

SUPPLEMENTARY INFORMATION:

I. Background

A. Statutory Provisions.

The Bank Secrecy Act, Public Law 91–508, codified as amended at 12 U.S.C. 1829b, 12 U.S.C. 1951–1959, and 31 U.S.C. 5311–5314; 5316–5332, authorizes the Secretary of the Treasury ("Secretary") to issue regulations requiring financial institutions to keep records and file reports that are determined to have a high degree of usefulness in criminal, tax, and regulatory investigations or proceedings, or in the conduct of intelligence or counter-intelligence activities, including analysis, to protect against international terrorism, and to implement anti-money laundering programs and compliance procedures.[1] Regulations implementing the BSA appear at 31 CFR part 103. The authority of the Secretary to administer the BSA has been delegated to the Director of FinCEN.

The definition of "financial institution" in the BSA includes investment companies.[2] The Investment Company Act of 1940, codified at 15 U.S.C. 80a–1 *et seq.* (the "Investment Company Act"), defines "investment company"[3] and subjects investment companies to regulation by the SEC.

B. Overview of Current Regulatory Provisions.

Regulations implementing the BSA currently apply only to investment companies that are "open-end companies," as the term is defined in the Investment Company Act. More commonly known as mutual funds, open-end companies are the predominant type of investment company. Open-end companies are management companies that offer or have outstanding securities that are redeemable at net asset value.[4]

Although FinCEN has issued individual rules that apply to mutual funds,[5] FinCEN has not included

[1] Language expanding the scope of the BSA was added by the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001 ("USA PATRIOT Act"), Public Law 107–56.

[2] 31 U.S.C. 5312(a)(2)(I).

[3] *See* 15 U.S.C. 80a–3.

[4] 15 U.S.C. 80a–4; 15 U.S.C. 80a–3(a)(1); 15 U.S.C. 80a–2(a)(32). Face-amount certificate companies and unit investment trusts are excluded from the definition of "management company." 15 U.S.C. 80a–4(3).

[5] *Anti-Money Laundering Programs for Mutual Funds*, 67 FR 21117 (April 29, 2002); *Customer Identification Programs for Mutual Funds*, 68 FR 25131 (May 9, 2003); *Amendment to the Bank Secrecy Act Regulations—Requirement That Mutual Funds Report Suspicious Activity*, 71 FR 26213 (May 4, 2006); *Anti-Money Laundering Programs; Special Due Diligence Programs for Certain Foreign Accounts*, 71 FR 496 (Jan. 4, 2006); *Anti-Money*

Continued

FIDUCIARY ISSUES

Department of Labor: New Disclosures Requirements

The steady movement away from defined benefit plans toward participant-directed defined contribution plans has generated lots of debate for years over whether participants have sufficient information to make informed investment choices. The debate has centered around both how to deliver investment advice without a plan sponsor exposing itself to additional fiduciary liability and, more recently, how to disclose the true cost of those investment choices so participants are able to make more informed choices.

BY TESS J. FERRERA

Tess J. Ferrera, Esq., is a partner with Thompson Hine, LLC, in Washington, DC, and a senior editor of the *Journal of Pension Benefits.*

On July 23, 2008, the United States Department of Labor (DOL) issued proposed regulations that would require additional plan-related disclosures to participants. This is the third of three sets of regulations the DOL has issued on investment and fee-related disclosures. On November 16, 2007, the DOL issued its first set of regulations, requiring additional investment fee related disclosures on the Schedule C to the Form 5500. [72 *Fed. Reg.* 64710] On December 13, 2007, the DOL issued its second set of proposed regulations that will amend a key statutory exemption (ERISA Section 408(b)(2)) for service provider-related prohibited transactions and also issued a proposed administrative prohibited transaction class exemption that would cover plan administrators in the event that a service provider fails to disclose the requisite information to exempt the transaction from prohibited status. [72 *Fed. Reg.* 70988]

This article summarizes the new requirements beginning with the Schedule C requirements and ending with the most recently issued participant disclosure proposed regulations.

1. Final Rules to Form 5500 Schedule C

The proposed Form 5500 regulations amend several schedules, but for purposes of this article the focus is exclusively on the amendments to the Schedule C to the Form 5500. Schedule C generally must be filed by large plans to report service provider compensation of more than $5,000. The amendments do not affect the large plan application or the $5,000 threshold. The key goal of the amendments is to require more transparency of service provider compensation, including indirect compensation which may have gone unreported in the past.

The Schedule C now consists of three parts. Part I requires, subject to an alternative reporting option, the identification of each person who was paid, directly or indirectly, $5,000 or more in total compensation, *i.e.*, money or anything of value, for services to a plan. The final Schedule C requires that direct compensation be reported on a separate line item from indirect compensation paid from sources other than the plan. In addition, the codes identifying the sources of payment have been expanded to better reflect the variety of sources from which indirect compensation may be paid. The final Schedule C includes an alternative form of filing for those service providers whose only source of indirect compensation is limited to "eligible indirect compensation" (certain specified types of common investment-related fees), provided that certain written disclosures are furnished to the plan administrator, pertaining to amount of compensation, the services provided, and the parties paying for the compensation. The written disclosures may be provided electronically.

Part II of the new Schedule C requires plan administrators to identify each service provider that failed or refused to provide the information necessary to complete Part I. Part III is the same as the current Part II, requiring termination information on plan accountants and enrolled actuaries.

On July 26, 2008, the DOL released Frequently Asked Questions About the 2009 Form 5500 Schedule C and also announced a one-year compliance delay with the new disclosure requirements, provided that plan administrators obtain a statement from the service providers that, in spite of good faith efforts

to make necessary systems change to comply with the new regulations, it was unable to complete the changes. For a copy of the DOL's July 24, 2008 FAQs on Schedule C go to *http://www. dol.gov/ebsa/ faqs/faq_ scheduleC.html.*

2. Proposed Regulations Amending Requirements for the Application of ERISA Section 408(b)(2) Exemption

ERISA Section 406(a) sets forth a series of prohibited transaction between a plan and persons who have close relationships to the plan, referred to as parties in interest. The transactions set forth in ERISA Section 406(a) are intended to be *per se* prohibited unless an exemption applies. There are many exemptions, both statutory and administrative. Without these exemptions, plans literally would be unable to transact any business. ERISA Section 406(a)(1)(C) generally prohibits the furnishing of goods, services, or facilities between a plan and a party in interest. Without an exemption, this provision would render all services between a plan and a service provider prohibited because virtually all service providers to a plan are defined parties in interest to a plan. [*See* ERISA § 3(14)(B).] ERISA Section 408(b)(2) exempts a transaction otherwise prohibited by ERISA Section 406(a)(1)(C) if the contract or arrangement between the plan and party in interest is reasonable, the services are necessary for the establishment or operation of a plan, and no more than reasonable compensation is paid for the services. Existing DOL regulations shed some light on all three requirements. [*See* 29 C.F.R. § 2550.408b-2.] The proposed amendments intend to clarify the meaning of "reasonable" contract or arrangement.

> Currently, the regulations state only that a contract or arrangement is reasonable if the plan is able to terminate the arrangement without penalty and on reasonably short notice. [*See* 29 C.F.R. § 2550.408b-2(c).] The proposed regulation adds a new paragraph to the existing regulations that generally requires that, in order to be reasonable, any contract or arrangement between an employee benefit plan and certain service providers must require the service provider to disclose the compensation it will receive, directly or indirectly, and any conflicts of interest that may arise in connection with its services to the plan. The regulation is striking because it shifts the disclosure burden to the service provider irrespective of whether or not the service provider is a fiduciary to the plan.

Understanding that not all service providers are equal, the regulations are limited to three broad categories of service providers:

1. A fiduciary either within the meaning of ERISA or under the Investment Advisers Act of 1940;
2. A service provider that provides any one or more of the following services to the plan pursuant to the contract or arrangement: banking, consulting, custodial, insurance, investment advisory, investment management, recordkeeping, securities, or other investment brokerage, or third-party administration; or
3. A service provider who receives or may receive indirect compensation or fees in connection with providing any one or more of the following services to the plan: accounting, actuarial, appraisal, auditing, legal, or valuation.

In other words and by way of example, a plan's printer may be omitted from the new requirements.

Under the proposed revisions to the regulations, no contract or arrangement will be considered reasonable unless:

1. The contract or arrangement is in writing;
2. The service provider must disclose in writing to the appropriate fiduciary all compensation direct and indirect that it will receive for the services that it is providing;
3. Compensation or fees include money or other thing of monetary value received or to be received directly from the plan or plan sponsor, or indirectly to the service provider or its affiliate from any other source in connection with the services to be provided;
4. If the services are bundled, only the service provider providing the bundled services must make the disclosures. The service provider shall not be required to disclose the allocation of its fees to affiliates, subcontractors, or other parties, unless any one of these other entities is receiving compensation for additional unrelated services;
5. A description of the manner of receipt of the fees or compensation, *i.e.*, bill the plan, or deduct directly from plan accounts;
6. Whether the service provider will provide services as a fiduciary;
7. Whether the service provider expects to acquire a financial or other interest in, any transaction to be entered by the plan in connection with the contract or arrangement;

8. Whether the service provider or affiliate has any material financial, referral, or other relationship or arrangement with a money manager, broker, client of the service provider, other service provider to the plan or any other entity that might create a conflict in performing services under the contract or arrangement;
9. Whether the service provider will be able to affect its own compensation without prior approval of another fiduciary, *i.e.*, performance-based compensation;
10. Disclosures of material changes related to compensation and fee disclosures no later than 30 days from the date on which the service provider acquires knowledge of those changes; and
11. The terms of the contract shall include a requirement that the service provider must disclose all compensation.

Another important point on the issue of fees and compensation is that they may be expressed in terms of a monetary amount, formula, percentage of the plan's assets, or per capita charge for each participant or beneficiary. Whatever form is used, the goal is to ensure that the responsible fiduciary have sufficient information by which to evaluate the reasonableness of the fees. Thus, there is lots of flexibility on how fees and compensation can be paid, provided that the resulting payments are reasonable and the fiduciary understands what is being paid.

This proposal has generated a lot of comments and on April 1, 2008, the DOL held a public hearing to dialogue with the regulated community on these new and very critical regulations. Highlights of those comments follow.

America's Health Insurance Plan (AHIP), a national association representing about 1,300 health plans, advocated that, in their current form, the regulations should be withdrawn and revised to more accurately reflect the specific needs of health and welfare plans. In support of their position, AHIP made two general points. First, AHIP stated that it did not believe that disclosure deficiencies existed in the health and welfare context. It advocated that plan fiduciaries already receive or can request from their service providers a comprehensive list of information related to cost and quality of services. Second, AHIP asserted that additional disclosure requirements would serve only to increase costs on health plans and service providers while failing to provide any additional material information.

The Investment Company Institute (ICI), the national association of US investment companies, generally supported the need for additional disclosures and urged the DOL to retain two key features of the proposed regulations. First, ICI stated that the regulations' new requirement imposing disclosure of direct and indirect compensation, *i.e.*, service fees, 12b-1 fees, sub-transfer agent fees, was laudable and filled an important gap in the existing regulations. Second, it urged the DOL to retain the rule that when bundled services are priced as a package, the service provider need not disclose how it allocates those fees among its other service providers.

At the hearing, ICI also highlighted two areas where it believed the regulations needed clarification. First, ICI noted that the DOL needed to make clear that the regulations did not turn service providers to mutual funds into service providers to plans. ICI explained that mutual funds have "dozens—sometimes hundreds—of service providers, none of whom has any idea about the extent to which particular employee benefit plans are invested in the mutual fund." If the regulations are understood to convert these service providers to plan service providers, the implications are exponential in that ERISA's prohibited transaction provision might be triggered. Servicing plans would thus, at a minimum, become very costly, not to mention complicated. Moreover, as ICI notes, the information that plan fiduciaries would have to review would likewise increase exponentially and quite likely would lead to information overload, overwhelming (and likely confusing) plan fiduciaries.

ICI next suggested that the DOL should "scale back" the broad sweep of the disclosures regarding conflicts of interest. ICI explained that, as currently proposed, the rule would seem to require that a service provider disclose *anyone* with whom it *may* have a conflict rather than focus on instances where a potential conflict actually might exist. In its view, the purpose of the proposal was already achieved by the requirement to disclose direct and indirect compensation and the requirement to disclose compensation earned from affiliates. Anything more, in ICI's view, would simply be redundant.

The DOL is likely to make some changes to the final regulations in response to the public comments, but more disclosure is unquestioningly the wave of the future.

3. Fiduciary Requirements for Disclosure in Participant-Directed Account Plans

The final of the three sets of disclosure regulations is aimed at improving fee information directly

to participants. One welcomed change is that the regulations replace the confusing participant disclosure provisions in the Section 404(c) regulations, which, among other things, required dissemination of the prospectus for each investment a participant selected, a costly and mostly futile exercise since most participants do not read prospectuses.

The proposed regulation is being issued under ERISA Section 404(a), ERISA's prudence and loyalty provisions, with conforming amendments to the Section 404(c) regulations. Under the regulations, plan fiduciaries must comply with these new disclosure requirements as a matter of discharging their fiduciary obligations to plan participants. In general, the regulations provide that plan fiduciaries must ensure that participants and beneficiaries, on a regular and periodic basis, are made aware of their rights and responsibilities with respect to their investment selections and provided with sufficient information regarding designated investment alternatives available under the plan, including plan fees and expenses so that they can make informed investment decisions.

The disclosures are broken down into two categories: plan-related information and investment-related information. The plan-related disclosures consist of three sub-categories: (1) general plan information; (2) administrative expense information; and (3) individual expense information.

Plan-Related Disclosures

General Disclosure Requirements

These disclosures must be made to an individual on or before the date he or she becomes eligible to be a participant or beneficiary under the plan and at least annually thereafter. The general plan disclosures may be made in the plan's summary plan description and include information on the following issues:

- An explanation of how participants may give investment instructions;
- An explanation of limitations pertaining to giving investment instructions, including restrictions on transfer to or from a designated investment alternative;
- An explanation about the exercise of voting, tender, and similar rights related to investments;
- A description of the designated investment alternatives; and
- An identification of any designated investment managers to whom participants and beneficiaries may give investment directions.

In addition, participants and beneficiaries must receive a description of any material changes to the required information not later than 30 days after the date of the adoption of such changes.

Administrative Expenses

On or before the date of eligibility, and at least annually thereafter, a fiduciary must provide participants and beneficiaries with an explanation of any fees and expenses for plan administration, *e.g.*, legal, accounting, recordkeeping, that are not included in investment-related expenses and that may be charged against the plan as a whole. Fiduciaries must also provide information on the basis upon which such charges will be allocated to, or affect the individual account balances of participants. This information may be provided in the plan's summary plan description. In addition to these general disclosures, the proposal also requires that, at least quarterly, participants be furnished with statements of the dollar amounts actually charged during the preceding quarter and a general description of the services provided for those fees.

Individual Expenses

On or before the date of eligibility, and at least annually thereafter, a fiduciary must disclose to individual participants the charges assessed on an individual-by-individual, rather than plan-wide, basis. These include, for example, expenses related to qualified domestic relations orders, a participant loan, or investment advice services. On a quarterly basis, the proposal also requires that participants be furnished statements of the dollar amounts actually charged during the preceding quarter and general description of the services provided for those fees.

Investment-Related Disclosures

Investment-related disclosures are divided into two categories: automatic disclosures and disclosure based on participant request. On or before the date of eligibility, and at least annually thereafter, fiduciary must automatically disclose to participants:

1. Information identifying the designated investment alternatives;
2. Performance data;
3. Benchmarks; and
4. Fees and expenses.

Identifying, Performance, and Benchmark Disclosures

Identifying information must include:

1. The name of the designated investment alternative;
2. An Internet Web site that supplements the designated investment alternative with information about the investment's issuer or provider, principal strategies and attendant risks, the assets in the portfolio, turnover, and performance and related fees;
3. The category of the investment, *e.g.*, money market, stocks, large or small cap funds; and
4. The type of management utilized, *e.g.*, passively or actively managed.

Performance disclosures for investment alternatives whose returns are not fixed include information on the average annual total return of he investment for the following periods, if available, one-year, five-year and ten-year, measured as of the end of the applicable calendar year. The statement must also indicate that an investment's past performance is not necessarily an indication of future performance. The name and returns of an appropriate broad-based securities market index over the same periods comparable to the performance data must also be provided. The comparable benchmarks come from unaffiliated investment providers.

Investment-Related Fee and Expense Disclosures

For investment alternatives with respect to which the returns are not fixed, the following disclosures are required:

- The amount and description of each shareholder-type fee, such as sales loads, sales charges, deferred sales charges, redemption fees, surrender charges, exchange fees, account fees, purchase fees, and mortality and expense fees;
- The total annual operating expenses of the investment expressed as a percentage; and
- A statement indicating that fees and expenses are only one of several factors that participants should consider when making investment decisions.

The information described above must be provided in a chart or similar comparative format designed to facilitate a comparison of costs for each designated investment alternative.

Information Provided Upon request

Fiduciaries must provide the following information upon request:

- Copies of the prospectuses;
- Copies of financial statements or reports of the investment alternatives to the extent such materials are provided to the plans;
- Statement of the value of a share or unit of each designated investment alternative as well as the valuation date; and
- List of assets comprising the portfolio.

Under the regulations, these disclosures may be provided through the plan's summary plan description or some other more appropriate form provided that the disclosures are made in a manner calculated to be understood by the average participant. The comment period was still open as of the writing of this article.

Summary

Irrespective of how the two proposed regulations get modified when finalized, the future is more transparency and disclosure. All service provider contracts will have to be reviewed to ensure compliance with the new Section 408(b)(2) regulations and all participant communications will also need to be reviewed. Complying with these new disclosures will add costs to administering plans, but the alternative of falling behind on these new rules when final will be more costly if the DOL finds a violation. ■

Internal Revenue Code

I. § 3509 Determination of employer's liability for certain employment taxes.

(a) In general.
If any employer fails to deduct and withhold any tax under chapter 24 or subchapter A of chapter 21 with respect to any employee by reason of treating such employee as not being an employee for purposes of such chapter or subchapter, the amount of the employer's liability for—

(1) Withholding taxes.
Tax under chapter 24 for such year with respect to such employee shall be determined as if the amount required to be deducted and withheld were equal to 1.5 percent of the wages (as defined in section 3401) paid to such employee.

(2) Employee social security tax.
Taxes under subchapter A of chapter 21 with respect to such employee shall be determined as if the taxes imposed under such subchapter were 20 percent of the amount imposed under such subchapter without regard to this subparagraph.

(b) Employer's liability increased where employer disregards reporting requirements.

(1) In general.
In the case of an employer who fails to meet the applicable requirements of section 6041(a) , 6041A , or 6051 with respect to any employee, unless such failure is due to reasonable cause and not willful neglect, subsection (a) shall be applied with respect to such employee

(A) by substituting "3 percent" for "1.5 percent" in paragraph (1) ; and

(B) by substituting "40 percent" for "20 percent" in paragraph (2) .

(2) Applicable requirements.
For purposes of paragraph (1) , the term "applicable requirements" means the requirements described in paragraph (1) which would be applicable consistent with the employer's treatment of the employee as not being an employee for purposes of chapter 24 or subchapter A of chapter 21.

(c) Section not to apply in cases of intentional disregard.
This section shall not apply to the determination of the employer's liability for tax under chapter 24 or subchapter A of chapter 21 if such liability is due to the employer's intentional disregard of the requirement to deduct and withhold such tax.

(d) Special rules.
For purposes of this section —

(1) Determination of liability.
If the amount of any liability for tax is determined under this section —

(A) the employee's liability for tax shall not be affected by the assessment or collection of the tax so determined,

(B) the employer shall not be entitled to recover from the employee any tax so determined, and

(C) sections 3402(d) and section 6521 shall not apply.

(2) Section not to apply where employer deducts wage but not social security taxes.
This section shall not apply to any employer with respect to any wages if—

(A) the employer deducted and withheld any amount of the tax imposed by chapter 24 on such wages, but

(B) failed to deduct and withhold the amount of the tax imposed by subchapter A of chapter 21 with respect to such wages.

(3) Section not to apply to certain statutory employees.
This section shall not apply to any tax under subchapter A of chapter 21 with respect to an individual described in subsection (d)(3) of section 3121 (without regard to whether such individual is described in paragraph (1) or (2) of such subsection).

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Qualified Plans: 2009 Compliance Issues Related to Pension Funding

Elizabeth Drake, Veronica Rouse, Garrett Fenton

Companies with defined benefit plans are facing two relatively new compliance issues -- an ERISA disclosure and a new tax-qualification requirement -- in the early part of 2009. ERISA requires companies with calendar-year plans to distribute a detailed funding notice to participants and beneficiaries by April 30, 2009. The tax-qualification rules restrict lump sums and other "accelerated" payments, plan amendments, and possibly, benefit accruals under plans that are not fully funded in accordance with the pension protection act requirements. Both the funding notice and the funding-based limits involve highly technical and nuanced concepts for which there is very little guidance. Companies must nonetheless make decisions and communicate with participants in a relatively short timeframe, and need to prepare for the inquiries that will inevitably arise.

New ERISA Participant Notice Requires Detailed Funding-Related Disclosures

ERISA Section 101(f) requires plan administrators to distribute a funding notice within 120 days after the close of each plan year (special timing rules apply to small plans) beginning after December 31, 2007. This means that for calendar-year plans, a funding notice must be provided by April 30, 2009 for the 2008 plan year.

In an ideal world, the Department of Labor ("DOL") would have issued final regulations with respect to the notice requirement before plans were required to distribute the notice. To date, the only guidance is a series of Q&A's in Field Assistance Bulletin 2009-01, which includes model notices. While helpful, the FAB highlights some of challenges companies face in order to comply with the new notice requirement.

The annual funding notice must disclose, among other things, information about the plan's funded status for the two previous plan years, the value of the plan's assets and liabilities, the number of plan participants, statements of the plan's funding and investment policies, and an explanation of any amendment or scheduled benefit increase or reduction, or other known event taking effect for the current year and having a material effect on plan liabilities or assets. At first glance, some of this information may appear to be straightforward, but this is not necessarily the case. Because many of the funding concepts are new, the FAB directs plans to provide certain information in accordance with proposed IRS funding regulations (for which there are a number of unresolved questions) and DOL enforcement policies "pending further guidance."

ERISA requires the notice to be written in a manner that can be understood by the average plan participant. The FAB contains model notices for single-employer and multiemployer plans. Plan administrators are not required to use the model notice, but the DOL will treat the notice requirement as satisfied if the administrator has complied with the guidance in the FAB and generally acted in good-faith. The FAB does not explicitly allow plan administrators to modify the model notice, but it does allow administrators to add any information they believe to be necessary or helpful to understanding the required information.

The funding notice must be provided to each participant and beneficiary, each labor organization representing plan participants, each contributing employer (in the case of multiemployer plan), and the PBGC. A plan administrator that fails to provide the annual funding notice to a participant or beneficiary may be liable for a penalty of up to $100 a day from the time of the failure and for such other relief as a court may deem proper.

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Funding-Based Limits Present Implementation Challenges

When the PPA's funding-based limits became effective in 2008, few would have anticipated the number of plans likely to become subject to those limitations in 2009. As a result of the economic downturn, large numbers of plans must now cope with these limitations and do so without the benefit of final regulations. While plans can rely on the proposed regulations, they are highly technical and leave a number of unanswered questions.

As background, if a plan provides for the payment of lump sums or certain other "accelerated" benefits, and its adjusted funding target attainment percentage ("AFTAP") is at least 60% but less than 80%, the maximum lump sum that can be paid to a participant is generally the lesser of (1) 50% of the benefit, or (2) 100% of the present value of the PBGC maximum guaranteed benefit for that year. If a benefit payment is restricted by this rule, proposed regulations generally require the plan to allow affected participants to elect to either defer the payment or bifurcate the payment based on the unrestricted and restricted portions (*e.g.*, payment of 50% as a lump sum and 50% as an annuity). Benefits with a present value of $5,000 or less are exempt from these restrictions. If a plan's AFTAP is less than 60%, the plan may not pay any lump sums and must freeze benefit accruals.

In addition to the benefit restrictions, a plan is generally prohibited from implementing any amendment that has the effect of increasing plan liabilities (*e.g.*, by increasing benefits or establishing new benefits) during any year in which its AFTAP, counting the cost of the amendment, is less than 80%. Benefits payable solely because of a plant shutdown or other unpredictable contingent event are prohibited in any year that the plan's AFTAP is less than 60%, counting the cost of those benefits.

Until the plan's actuary certifies the current year's AFTAP, certain presumptions apply for purposes of determining whether the funding-based limits apply. For the first three months of 2009, calendar-year plans can look back to their 2008 certified AFTAP. From April 1 through September 30, the plan's presumed AFTAP is equal to the 2008 certified AFTAP minus 10%. If the current year's AFTAP is not certified by October 1, the plan is presumed to have an AFTAP of less than 60%. Therefore, if a plan with a 2008 certified AFTAP of less than 90% is unable to obtain a 2009 certified AFTAP by April 1, the plan may be subject to at least partial restrictions on accelerated payments starting April 1, 2009.

The proposed regulations offer several ways to avoid the benefit restrictions. These rules are highly technical and require actuarial analysis to determine when to use credit balances, the proper amount to contribute or provide for security for a particular purpose, and the consequences of such decisions.

Companies with plans that were funded at the lower percentages last year may have already developed strategies to deal with this year's funding-based limits, but the end-of-year downturn in the markets may cause many other plans, unexpectedly, to be subject to at least the partial restrictions on accelerated payments. Companies should plan now whether they will take steps to avoid these restrictions or, in the alternative, how the restrictions will be communicated to participants.

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Avoid 162(m) Deduction Disallowance; Increased Employment Tax Audits; 2010 COLAs; COBRA Subsidy Audits Begin; Excise Tax on High Cost Health Plans

10.27.09

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Executive Compensation: Last Chance to Fix Bonus Plans and Severance/Employment Agreements

Anne Batter

For those companies who have not yet revised their bonus plans or severance/employment agreements to comply with the IRS interpretation of Internal Revenue Code (Code) section 162(m) in Rev. Rul. 2008-13, 2008-10 IRB 518, now would be the time to do that in order to avoid a deduction disallowance for the 2010 annual bonus (and for long-term bonuses with a performance period beginning January 1, 2010). For taxpayers with calendar year performance periods, the grandfather provisions in Rev. Rul. 2008-13 generally will only protect annual bonuses through the 2009 performance period. Bonus plans and severance/employment agreements impacting the bonus paid for the 2010 performance period generally will need to be compliant with Rev. Rul. 2008-13 in order to avoid deduction disallowance under Code section 162(m). The same is true for long-term bonuses with performance periods beginning after January 1, 2009.

As background, Rev. Rul. 2008-13 sets forth the IRS's position that a bonus program does not meet the requirements for deductibility as performance-based compensation exempt from section 162(m) if the plan and/or other arrangements provide for payment of a bonus without regard to attainment of performance goals on the employer's involuntary termination of the employee without cause, or the employee's termination for good reason or by retirement. Thus, for example, under the ruling, if a performance plan (or a separate severance or employment agreement) contains a provision specifying that the target level bonus will be paid upon the executive's involuntary termination, or termination for good reason, or retirement, whether or not the performance goals are met, then all payments under the performance plan, even those that are made upon meeting the performance goal, will be treated as failing the Code section 162(m) exception.

Thus, the ruling applies a strict interpretation of Treas. Reg. § 1.162-27(e)(2)(v), so that a plan can only be assured continued exemption from Code section 162(m) as qualified performance-based

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compensation if the plan and associated arrangements provide for payment of a target bonus without regard to attainment of goals only on death, disability, or change in control. As has always been the case, bonus payments actually made without regard to attainment of goals in these circumstances (i.e., death, disability, or change in control) are non-deductible but the inclusion of provisions for such payments will not disqualify the entire plan from satisfying the section 162(m) exception for performance-based compensation.

This new strict interpretation of the Code section 162(m) regulations was first announced in PLR 200804004 (January 25, 2008), which signaled the IRS's disagreement with its prior ruling position in PLR 200613012 (March 31, 2006) and PLR 199949014 (December 10, 1999). Due to taxpayers' vocal concerns regarding the financial accounting consequences of this new position, the IRS issued Rev. Rul. 2008-13 and made it prospective in effect.

Rev. Rul. 2008-13 was made effective prospectively for plans and arrangements that otherwise satisfy the rules for performance-based compensation exempt from Code section 162(m) and contain payments terms similar to those in the ruling. Thus, the ruling does not apply to bonus programs for (i) performance periods beginning on or before January 1, 2009, and (ii) compensation paid under employment contracts in effect on February 21, 2008. Although the wording of Rev. Rul. 2008-13 is not as clear as it could be, it would appear the IRS meant to grandfather contracts in effect as of February 21, 2008, only for the stated term thereof, but not where the employment contract has been extended or renewed since February 21, 2008, even under a provision for automatic renewal.

To the extent not covered by the grandfather rule for employment contracts in effect on February 21, 2008, the last performance period that is grandfathered for annual bonus plans is the 2009 calendar year performance period. Consequently, in such a case, the grandfather will not apply to the 2010 performance period and the plan and other arrangements (such as associated employment agreements and severance plans) need to be revised to comply with Rev. Rul. 2008-13 in order to be assured a deduction for the 2010 bonus (and bonuses relating to longer periods beginning January 1, 2010).

Note that companies need to review, not only their annual bonus plans and long-term performance-based compensation programs, but also any severance or employment agreements that might separately provide whether a bonus (or a bonus substitute) is paid in the year of termination. How the severance programs and employment agreements can be designed such that they do not clearly make up for the target bonus that cannot be paid on termination pursuant to Rev. Rul. 2008-13 is an open issue that must be given serious consideration.

Fringe Benefits and Payroll Tax: IRS to Increase Employment Tax Audits

Thomas Cryan, Jr.

Earlier this year, we alerted our clients that the IRS has been conducting its largest hiring initiative in decades. We suspected, based on both statements from the IRS and because employment taxes are "recession proof," i.e. taxes that can be collected even when a company is in a net operating loss position, that a primary focus of this increase in manpower would be employment taxes. A recent announcement from the IRS has confirmed this.

On September 18, 2009, the IRS announced that it will audit 6,000 U.S. companies to determine whether

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they pay all their required employment taxes to fund Social Security and Medicare benefits. The IRS indicated that the primary focus of these examinations will be worker classification (i.e., whether service providers are being properly classified as independent contractors) and the tax treatment of fringe benefits. John Tuzynski, chief of employment tax operations at the IRS, also noted that the IRS will focus in particular on fringe benefits such as company cars and the personal use of corporate-owned vacation property. The audits will occur over a three-year period, beginning in February 2010, and the companies will be chosen at random. These examinations will enable the IRS to collect data to identify additional issues and to prepare a broader national audit program.

The IRS will consider a taxpayer's prior efforts to correct plan issues or withholding procedures in assessing whether penalties are appropriate for back years. Therefore, we strongly recommend that our clients take steps now to comply with IRS requirements *prior* to the IRS discovering the issue on audit. We have been working with our clients to conduct internal audits of both their plans and withholding procedures in an effort to both discover and correct any plan or procedure deficiencies. Please let us know if we can be of assistance.

There are two additional developments on the audit front. First, taxpayers have reported that the IRS has begun auditing (i) Code section 409A compliance and (ii) claims for the COBRA subsidy (see article below). Second, taxpayers also have reported that their audit teams have indicated that the returns of corporate officers will be reviewed in conjunctions with the corporate income tax return audit as part of the Global High Wealth Industry initiative within LMSB. This initiative will be described in more detail in a separate, upcoming alert. In summary, a new industry, the Global High Wealth Industry, has been added to LMSB and we expect this could result in more sophisticated audits of corporate officers' tax returns as well as better coordination of the examination of the corporate return and the individual officers' returns.

Qualified Plans: IRS Releases COLA-Adjusted Amounts for 2010

Elizabeth Drake, Garrett Fenton

On October 15, the IRS released the 2010 annual cost-of-living adjustments (COLAs) to qualified plan limitations. There had been some speculation that at least some of the COLA-adjusted amounts could actually decrease from their 2009 levels, since the relevant cost-of-living index had declined from a year ago. But the IRS interpreted the Internal Revenue Code's COLA provisions to prevent a year-to-year reduction in the relevant limitations, and thus maintained the amounts at their 2009 levels:

Limitation	Amount for 2010
Code section 402(g) elective deferral limit	$16,500
Code section 415(b) dollar limitation for defined benefit plans	$195,000
Code section 415(c) annual additions limit for defined contribution plans	$49,000
Code section 401(a)(17) compensation limit	$245,000
Code section 416(i) key employee officer compensation	$160,000
Code section 409(o) threshold ESOP account balance subject to a five-year distribution period	$985,000

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Code section 409(o) threshold ESOP account balance for a one-year extension	$195,000
Code section 414(q) "highly compensated employee" compensation threshold	$110,000
Code section 414(v) catch-up contribution limit	$5,500

The 2010 Social Security taxable wage base is also unchanged from its 2009 level of $106,800.

Health and Welfare: IRS Rapidly Begins COBRA Subsidy Audits

Michael Lloyd

When Congress provided a 65% subsidy for involuntarily terminated workers in the American Recovery and Reinvestment Act of 2009, many questioned whether the IRS could adequately ensure compliance of claims for the subsidy. M&C has learned that the IRS has already begun audits of employers and insurers claiming the subsidy on their 2009 Forms 941 (Employer Quarterly Federal Tax Return). The IRS information document request asks for the identity of all individuals represented on line 12b of the Form 941, each individual's request for the COBRA subsidy, and a copy of the insurance premium invoice to the employer with proof that the employee paid the premium. Although IRS guidance instructs employers/ insurers to maintain this information in their files **[IR-2009-15, Feb. 26, 2009]**, the speed with which the IRS has initiated enforcement action (6 months) is surprising. Employers and insurers should make sure that they have their COBRA subsidy documentation in order.

Health and Welfare: Senate Finance Committee Proposes Excise Tax on High Cost Health Plans

Susan Relland, Garrett Fenton

On October 13, the Senate Finance Committee voted to approve its version of the health reform bill, which includes as its primary funding source a controversial excise tax on high cost health plans. The funding provisions included in the eventual Senate health reform bill will likely be based in large part on the Finance Committee's provisions. Thus, employers, insurers, and plan administrators should be aware of the excise tax, as well as how it could potentially affect them in the near future.

The proposal calls for the imposition of a 40% non-deductible excise tax, beginning in 2013, imposed on the excess of the aggregate value of employer-sponsored health coverage over a threshold amount. The "value" of coverage provided under a self-funded plan is determined based on COBRA premiums. In calculating the value of retiree coverage, pre-65 and post-65 retiree plans may be combined at the employer's election.

The threshold amount is generally $8,000 for individual coverage and $21,000 for family coverage (although several Senators are interested in increasing those amounts). For retirees over age 55 and individuals in high-risk professions, however, the thresholds are $9,850 and $26,000, respectively. A three year transition rule would implement higher thresholds in the 17 states with the most expensive health care as of the end of 2012, as determined each year. The thresholds are indexed to CPI-U + 1%,

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which is usually a much lower rate than actual medical cost inflation. Thus, an increasing number of plans will likely begin to exceed the relevant thresholds over time.

Employer and employee contributions made on a pre-tax or after-tax basis are taken into account in determining the value of coverage for purposes of the excise tax. In addition, the threshold includes all contributions to medical, dental, vision, health Flexible Spending Arrangements (FSAs), Health Reimbursement Arrangements (HRAs), and Health Savings Accounts (HSAs) (if made by the employer or the employee through a cafeteria plan) for the year. All long-term care and disability benefits, as well as indemnity and specified-disease insurance purchased with after-tax contributions, are excluded from the value of coverage for purposes of the excise tax.

The excise tax will be imposed upon the insurance company in the case of an insured plan, and the plan administrator in the case of a self-funded plan. The tax will be allocated to the insurers and administrators in proportion to the value of the health plans. An employer will need to calculate the total value of health coverage on a per-employee basis, determine the allocation of the tax for each plan, and report the resulting amount to each insurer and plan administrator, and to the Secretary of Treasury, in accordance with regulations. The employer will be subject to a penalty for underreporting, although the penalty may be waived if the employer can show that the failure was due to reasonable cause and not willful neglect.

Several revisions to the excise tax provisions have been suggested, and could be made before the full Senate votes on its health reform bill. For example, the bill could index the thresholds to a higher percentage (e.g., CPI-U + 3%, or CPI-medical) that more accurately reflects medical cost inflation; exempt retiree medical coverage and employee-pay-all plans; carve out employee after-tax (and even pre-tax) contributions; increase the threshold for family coverage from $21,000 to, for example, $25,000; maintain the increased thresholds under the transition rule for high-cost states indefinitely; or eliminate the threshold completely and, instead, beginning with the value of coverage provided in 2013, impose an excise tax on plans that increase at a rate greater than medical inflation for the year. It remains to be seen which, if any, of these suggestions will garner enough support to be either included in the final Senate health reform bill or adopted as part of a conference to reconcile House and Senate-passed versions of health reform.

For Additional Information

For additional information, please contact any of the following attorneys in our ERISA/ Employee Benefits practice:

Anne Batter, abatter@milchev.com, 202-626-1473

Thomas Cryan, Jr., tcryan@milchev.com, 202-626-1482

Elizabeth Drake, edrake@milchev.com, 202-626-5838

Garrett Fenton, gfenton@milchev.com, 202-626-5562

Michael Lloyd, mlloyd@milchev.com, 202-626-1589

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IRS 401(k) Compliance Check Questionnaire; Application of Section 162(m) in Acquisition Context; HIRE Act Social Security Exemption; Guidance on Grandfathered Health Plans

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- Qualified Plans: IRS 401(k) Compliance Check Questionnaire Goes Beyond Just the Facts
- Executive Compensation: IRS Changes Position on Application of Section 162(m) in Acquisition Context
- Employment Taxes: HIRE Act Social Security Exemption Available on Forms 941 for Second Quarter of 2010
- Health & Welfare: Guidance on Grandfathered Health Plans: "If you like your coverage, you can keep it." Really?

Qualified Plans: IRS 401(k) Compliance Check Questionnaire Goes Beyond Just the Facts

Elizabeth Drake and Adrian Morchower

The IRS is conducting a compliance check of 401(k) plans that involves a comprehensive look into approximately 1,200 plans selected at random from plans that filed a Form 5500 for the 2007 plan year. The 401(k) compliance check is designed to determine (1) potential compliance issues, (2) any plan operational issues, and (3) additional education and outreach guidance that may be helpful for the IRS to provide to plan sponsors top improve compliance. The IRS notes that a previous study indicated that 401(k) plans are by far the most non-compliant plan type in the retirement plan universe.

A sponsor whose 401(k) plan is selected for the compliance check is provided with an online 401(k) Compliance Check Questionnaire (Form 14146) and is requested to submit the electronically completed Questionnaire within 90 days from the date of the accompanying IRS letter. The Questionnaire contains a wide variety of questions within the following categories:

- Demographics
- 401(k) plan participation
- Employer and employee contributions
- Top-heavy and nondiscrimination rules
- Distributions and plan loans
- Other plan operations
- Automatic contribution arrangements
- Designated Roth features
- IRS voluntary compliance programs
- Plan administration

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Most of the questions request factual information regarding the sponsor's 401(k) plan. Some questions, however, require information regarding the existence of other plans, including the number of the sponsor's nonqualified deferred compensation arrangements, which could involve certain compensation arrangements that are imbedded in various employment contracts. In addition, the Questionnaire asks for an opinion regarding the importance of various factors, including recent financial conditions, on participation in, and operations of, the 401(k) plan.

The IRS states that its contact with a sponsor regarding the Questionnaire is a compliance check, which is not an audit or investigation under Code section 7605(b), an audit under section 530 of the Revenue act of 1978, or a review of an organizations books and records. In its letter accompanying the Questionnaire, the IRS states that failure to respond or to provide complete information will result in further action which could include a full examination of the 401(k) plan. In Publication 3114, the IRS states that a person may refuse to participate in a compliance check without penalty and states further that the IRS has the option of opening a formal investigation, whether or not the business owner agrees to participate in a compliance check.

The paper copy of the Questionnaire circulated by the IRS does not require a signature or verification that the Questionnaire is completed under penalties of perjury, but it does require information about the position of the person or persons who completed the Questionnaire. Nonetheless, we highly recommend a legal review of the completed Questionnaire, not just because of the scope of information provided, but because certain multiple choice questions, if answered accurately, may indicate a plan qualification failure.

For those interested in reviewing the Questionnaire, a copy can be found at http://www.irs.gov/retirement/article/0,,id=223440,00.html.

Executive Compensation: IRS Changes Position on Application of Section 162(m) in Acquisition Context

Anne Batter

A relatively recent development in the IRS' interpretation of section 162(m) has received little attention, notwithstanding that it will often result in an additional deduction disallowance when a public company is acquired. The issue has to do with the application of section 162(m) to the year before a public company is acquired.

In the past, the IRS had concluded that a company was not a "publicly-held corporation" and, consequently, was not subject to deduction disallowance under Code section 162(m), not just for the *short* year ending with the acquisition, but also for the last *full* fiscal year before it was acquired in cases where the merger occurred prior to the deadline for the company filing an SEC proxy statement for that year. In such a case where the merger occurred before the proxy would be filed, there would be no summary compensation table filed with the proxy for the last full fiscal year (because no such proxy was filed) and there generally (at least in past years) would not be a summary compensation table filed elsewhere. Companies in this situation had obtained favorable private rulings from the IRS that they were not public for the last full fiscal year before a merger after representing that they would not be required to file a summary compensation table with the proxy statement or a Form 10-K for either the last full or the

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IRS 401(k) Compliance Check Questionnaire; Application of Section 162(m) in Acquisition Context; HIRE Act Social Security Exemption; Guidance on Grandfathered Health Plans

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FEATURED IN THIS EDITION

Qualified Plans: IRS 401(k) Compliance Check Questionnaire Goes Beyond Just the Facts

Elizabeth Drake and Adrian Morchower

The IRS is conducting a compliance check of 401(k) plans that involves a comprehensive look into approximately 1,200 plans selected at random from plans that filed a Form 5500 for the 2007 plan year. The 401(k) compliance check is designed to determine (1) potential compliance issues, (2) any plan operational issues, and (3) additional education and outreach guidance that may be helpful for the IRS to provide to plan sponsors top improve compliance. The IRS notes that a previous study indicated that 401(k) plans are by far the most non-compliant plan type in the retirement plan universe.

A sponsor whose 401(k) plan is selected for the compliance check is provided with an online 401(k) Compliance Check Questionnaire (Form 14146) and is requested to submit the electronically completed Questionnaire within 90 days from the date of the accompanying IRS letter. The Questionnaire contains a wide variety of questions within the following categories:

- Demographics
- 401(k) plan participation
- Employer and employee contributions
- Top-heavy and nondiscrimination rules
- Distributions and plan loans
- Other plan operations
- Automatic contribution arrangements
- Designated Roth features
- IRS voluntary compliance programs
- Plan administration

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Most of the questions request factual information regarding the sponsor's 401(k) plan. Some questions, however, require information regarding the existence of other plans, including the number of the sponsor's nonqualified deferred compensation arrangements, which could involve certain compensation arrangements that are imbedded in various employment contracts. In addition, the Questionnaire asks for an opinion regarding the importance of various factors, including recent financial conditions, on participation in, and operations of, the 401(k) plan.

The IRS states that its contact with a sponsor regarding the Questionnaire is a compliance check, which is not an audit or investigation under Code section 7605(b), an audit under section 530 of the Revenue act of 1978, or a review of an organizations books and records. In its letter accompanying the Questionnaire, the IRS states that failure to respond or to provide complete information will result in further action which could include a full examination of the 401(k) plan. In Publication 3114, the IRS states that a person may refuse to participate in a compliance check without penalty and states further that the IRS has the option of opening a formal investigation, whether or not the business owner agrees to participate in a compliance check.

The paper copy of the Questionnaire circulated by the IRS does not require a signature or verification that the Questionnaire is completed under penalties of perjury, but it does require information about the position of the person or persons who completed the Questionnaire. Nonetheless, we highly recommend a legal review of the completed Questionnaire, not just because of the scope of information provided, but because certain multiple choice questions, if answered accurately, may indicate a plan qualification failure.

For those interested in reviewing the Questionnaire, a copy can be found at http://www.irs.gov/retirement/article/0,,id=223440,00.html.

Executive Compensation: IRS Changes Position on Application of Section 162(m) in Acquisition Context

Anne Batter

A relatively recent development in the IRS' interpretation of section 162(m) has received little attention, notwithstanding that it will often result in an additional deduction disallowance when a public company is acquired. The issue has to do with the application of section 162(m) to the year before a public company is acquired.

In the past, the IRS had concluded that a company was not a "publicly-held corporation" and, consequently, was not subject to deduction disallowance under Code section 162(m), not just for the *short* year ending with the acquisition, but also for the last *full* fiscal year before it was acquired in cases where the merger occurred prior to the deadline for the company filing an SEC proxy statement for that year. In such a case where the merger occurred before the proxy would be filed, there would be no summary compensation table filed with the proxy for the last full fiscal year (because no such proxy was filed) and there generally (at least in past years) would not be a summary compensation table filed elsewhere. Companies in this situation had obtained favorable private rulings from the IRS that they were not public for the last full fiscal year before a merger after representing that they would not be required to file a summary compensation table with the proxy statement or a Form 10-K for either the last full or the

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short-year before the merger. See e.g., PLR 200519035 (May 13, 2005); PLR 200519-34 (May 13, 2005); PLR 200519033 (May 13, 2005); PLR 200419013 (May 7, 2004).

The IRS has more recently changed the position outlined in these PLRs with respect to the last full year before the merger, while continuing to issue PLRs concluding that a company is not a public company subject to Code section 162(m) for the short-year before the merger. In CCA 200923030 (June 5, 2009), the IRS explained that, even in the case of a merger that occurs before the proxy statement is filed, the SEC rules require the filing of a summary compensation table with the Form 10-K covering the company's last full year. Apparently, however, the SEC does not always enforce this filing requirement, presumably because the acquired company will be wholly-owned by the new parent company, rather than by the public, by the time the Form 10-K would be required to be filed. Because the filing is nonetheless required by SEC rules, the IRS in CCA 200923030 concluded that, under the definition of publicly held corporation in Reg. § 1.162-27(c)(1)(i)(A), a company is public for the last full year before such a merger because it is "required to be registered under section 12 of the Exchange Act." This is true, even if it does not actually file a Form 10-K containing a summary compensation table for its final full year.

Notwithstanding its change in position with regard to the last full fiscal year before a merger, the IRS has maintained its position that a company is not a public company for the short fiscal year ending with a merger. In private rulings post-dating CCA 200923030, acquired company taxpayers have represented that they were not required to disclose under the securities rules for the full year in which the merger occurred or for the short-year ending with the merger. See PLRs 200951006 (December 18, 2009); PLR 200945010 (November 6, 2009); PLR 200916012 (April 17, 2009). On the basis of these representations, the IRS has concluded that the merged company is not a public company for section 162(m) purposes for the year of the merger (including for the short-year ending with the merger). This makes sense because the merged company would begin filing for that year for SEC purposes with the new parent company and the status as a public company for section 162(m) purposes should depend on the new parent company status for that year.

In summary, beginning with CCA 200923030, the IRS position is that a public company remains subject to Code section 162(m) for the last full fiscal year before it is acquired, but does not remain subject to Code section 162(m) for the short-year ending with the merger.

Employment Taxes: HIRE Act Social Security Exemption Available on Forms 941 for Second Quarter of 2010

Marianna Dyson and Tom Cryan

The HIRE Act (P.L. 111-147) includes two provisions that encourage employers to hire workers who have been previously unemployed or underemployed. The incentives are in the form of a Social Security tax exemption for the employer-half of the Social Security tax (6.2 percent) and a new-hire retention tax credit that gives employers the lesser of $1,000 or 6.2 percent of wages paid during the pervious year if the employee remains employed for a full year. The first of these two benefits, the Social Security tax exemption, can be claimed on the employer's Form 941, beginning in the second quarter of 2010.

The Social Security tax exemption applies to all "qualified employees" hired after February 3, 2010 and before January 1, 2011, and applies to the employer-half of Social Security taxes *paid* from March 19, 2010 through December 31, 2010. A "qualified employee" is any individual who has been unemployed, or

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employed less than 40 hours during the 60-day period ending on the date the employment begins. The statute specifically uses the term "employed" when describing this 60-day period, and therefore, services as an independent contractor during this period should not disqualify a new hire from qualifying for the exemption.

The IRS has released new Form W-11, Hiring Incentives to Restore Employment (HIRE) Act Employee Affidavit, to assist employers in tracking and documenting eligible employees. Since the hiring period eligibility for the FICA tax credit pre-dates the enactment of the statute and the release of this form, employers have an incentive to verify if employees hired during the early part of the qualifying period are "qualified employees," and if so, require them to sign Form W-11. Although the IRS website FAQs on the Hire Act warn that the exemption will not apply to "wages paid to an employee who is hired to replace an existing worker," the FAQs provide that this limitation does not apply if the employee terminated employment voluntarily, was terminated for cause, or terminated because of lack of work. In addition, an individual who has not previously worked, such as a recent graduate, also qualifies for the exemption. Accordingly, there are few instances in which the Social Security exemption would not apply to a new hire that otherwise meets the definition of a "qualified employee," provided the employer did not terminate an employee for the purpose of hiring an employee to take advantage of the incentives.

Please let us know if you have any questions regarding the new Social Security tax exemption or retention credit.

Health & Welfare: Guidance on Grandfathered Health Plans: "If you like your coverage, you can keep it." Really?

Tess Ferrera and Garrett Fenton

The Patient Protection and Affordable Care Act ("PPACA"), Section 1251, as amended by section 2301(a) of the Health Care and Education Reconciliation Act of 2010 ("HCERA"), provides that certain group health plans and health insurance coverage in place as of March 23, 2010 are exempt, or "grandfathered," from several market reform provisions in subtitles A and C of Title I of PPACA. On June 14, 2010, the Departments of the Treasury, Labor ("DOL"), and Health and Human Services ("HHS") released an Interim Final Rule on grandfathered health plans (the "IFR"), which was published in the Federal Register on June 17, 2010. The IFR has the same practical effect as final regulations, but the public still has an opportunity to weigh in with comments. The comment period for the IFR closes on August 16, 2010.

The regulations define a grandfathered plan as a group health plan, or group or individual health insurance coverage, in which at least one person was enrolled on March 23, 2010 *and* at least one person (not necessarily the same person) has been enrolled at all times since March 23, 2010. The IFR provides guidance on the very important question of how to maintain grandfather status, by describing the type of activity that will cause a plan to cease to be grandfathered.

PPACA Provisions That Do Not Apply To Grandfathered Plans

Many of PPACA's "market reform" provisions are not effective until the first plan year (policy year in the individual market) beginning in 2014. Some are effective for the first plan or policy year beginning on or after September 23, 2010, six months after PPACA was enacted. Grandfathered plans are exempt from

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some, but not all, of these new market reform requirements. Listed below are the relevant market reform sections of the Public Health Service Act ("PHSA"), enacted under PPACA, that do not apply to a grandfathered plan, including a notation regarding each provision's general effective date and applicability to insured only, versus insured and self-funded, plans:

- 2701: Premium rating standards (plan/policy years beginning in 2014) (insured plans)
- 2702: Guaranteed availability of coverage (plan/policy years beginning in 2014) (insured plans)
- 2703: Guaranteed renewability (plan/policy years beginning in 2014) (insured plans)
- 2705: Prohibited discrimination based on health status (plan/policy years beginning in 2014) (insured and self-funded plans)
- 2706: Prohibited discrimination against health care providers (plan/policy years beginning in 2014) (insured and self-funded plans)
- 2707: Comprehensive health insurance coverage (for the individual and small group markets) (plan/policy years beginning in 2014) (insured and self-funded plans)
- 2709: Coverage for individuals participating in clinical trials (plan/policy years beginning in 2014) (insured and self-funded plans)[1]
- 2713: Preventive coverage without cost-sharing (plan/policy years beginning on or after September 23, 2010) (insured and self-funded plans)
- 2715A: Provision of additional information (plan/policy years beginning on or after September 23, 2010, but likely delayed in connection with the establishment of the exchanges) (insured and self-funded plans)
- 2716: Prohibited discrimination by insured plans in favor of highly compensated employees (plan/policy years beginning on or after September 23, 2010) (insured plans)
- 2717: Ensuring quality of care (plan/policy years beginning on or after September 23, 2010, but likely delayed pending guidance on reporting requirements, which must be issued by March 23, 2012) (insured and self-funded plans)
- 2719: Appeals process (plan/policy years beginning on or after September 23, 2010) (insured and self-funded plans)
- 2719A: Patient protections (plan/policy years beginning on or after September 23, 2010) (insured and self-funded plans)

PPACA Provisions That Apply To Grandfathered Plans

Listed below are the relevant market reform sections of the PHSA, enacted under PPACA, that still apply to grandfathered plans:

- 2704: Prohibition on pre-existing condition exclusions (plan/policy years beginning in 2014, but plan/policy years beginning on or after September 23, 2010 for individuals under age 19) (insured and self-funded plans)[2]
- 2708: Prohibition on excessive waiting periods (plan/policy years beginning in 2014) (insured and self-funded plans)
- 2711: Prohibition on lifetime and annual limits (insured and self-funded)
    - Lifetime limits: The prohibition applies to all grandfathered plans (plan/policy years beginning on or after September 23, 2010)
    - Annual limits: The prohibition applies to grandfathered group coverage (plan/policy years beginning on or after September 23, 2010, with restricted annual limits permissible before plan/policy years beginning in 2014), but not grandfathered individual coverage
- 2712: Prohibition on rescissions (plan/policy years beginning on or after September 23, 2010) (insured and self-funded plans)

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- 2714: Extension of dependent child coverage to age 26 (plan/policy years beginning on or after September 23, 2010) (insured and self-funded plans)[3]
- 2715: Uniform explanation of coverage documents (plan/policy years beginning on or after September 23, 2010, but likely delayed pending the issuance of guidance) (insured and self-funded plans)
- 2718: Medical loss ratio (plan/policy years beginning on or after September 23, 2010) (insured plans)

Activity That Can Cause a Loss of Grandfather Status

The IFR discusses a number of actions that can lead to a loss of grandfather status. Three general observations can be gleaned from the IFR in this regard: (1) the agencies appear to have approached the question of losing grandfather status subjectively, asking whether a participant would perceive a real change in his or her benefits when examining a particular activity; (2) a decrease in benefits or increase in cost to participants that is more than insignificant will often result in a loss of grandfather status; and (3) grandfather status will be very difficult to maintain.

The following actions, among others, will lead to a loss of grandfather status.

- Eliminating all or substantially all benefits to diagnose or treat a particular condition
- Eliminating benefits for any necessary element to diagnose or treat a condition
- Any increase in a percentage cost-sharing requirement, such as a deductible or out-of-pocket limit
- Any increase in fixed amount cost-sharing (other than a copayment) that exceeds the "maximum percentage increase"
- An increase in a fixed-amount copayment that is higher than (1) $5 adjusted for medical inflation, or (2) a percentage that exceeds the "maximum percentage increase"
- Decreasing the employer contribution rate toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5% below the rate that was in effect as of March 23, 2010
- Adding an overall annual dollar limit to a plan or coverage that had no annual or lifetime dollar limits on March 23, 2010
- Adding an annual limit to a plan or coverage that had a lifetime limit (but no annual limit) that is lower than the lifetime limit that was in effect on March 23, 2010
- Decreasing the annual limit for a plan or coverage below the annual limit (if any) in effect on March 23, 2010
- Changing insurance policies

PPACA also includes anti-abuse provisions which, if violated, will cause a loss of grandfather status. Generally, moving employees to other plans will not cause a loss of grandfather status, unless the reason for the moving around is to evade the health reform requirements. If employees are transferred from a plan they were covered under on March 23, 2010 to a receiving plan which, if it was treated as an amendment to the transferor plan, would cause the transferor plan to lose its grandfather status, then the receiving plan will cease to be grandfathered. Similarly, if the principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered plan, the plan will lose grandfather status.

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The list of activity described in the regulations that can cause a loss of grandfather status involve routine annual or more frequent occurrences in most welfare plans, which is why, unless significant changes are made to the IFR, no one expects grandfathered plans to last very long.

Other Notable Points

1. **Administrative Requirements**. Grandfathered plans must comply with specific disclosure requirements to participants and beneficiaries that clearly inform them that the plan is grandfathered and not subject to many of the new PPACA requirements. In this regard, the IFR provides model language that may be modified in future guidance.

Plans and/or insurers must maintain records documenting the terms of the relevant plan or insurance coverage in effect on March 23, 2010, and any other necessary documentation to ensure that they can prove their grandfather status. Those records must be available to the agencies, participants, and beneficiaries upon request.

2. **Special Rules for Collectively Bargained Plans**. Coverage under an insured collectively bargained plan is grandfathered *at least* until the last CBA relating to the coverage that was in effect on March 23, 2010 terminates. Only fully-insured collectively bargained plans are eligible for this special grandfather status. The same PPACA exemptions apply to an insured, collectively bargained plan under the special grandfather status as apply to all other "regular" grandfathered plans.

3. **Transitional Issues**. Changes to the terms of a plan or coverage are *deemed* effective as of March 23, 2010 (even if they are not effective until later), and will not cause a loss of grandfather status, provided certain specified actions were taken on or before March 23, 2010. Namely, the changes must be made pursuant to a legally binding contract entered into on or before March 23, 2010, a filing with a state insurance department on or before March 23, 2010, or written amendments to a plan that were adopted on or before March 23, 2010.

The IFR also provides for a grace period to revoke or modify changes made to the terms of a plan or coverage after March 23 and before June 14, 2010, if the revocation or modification is done by the first day of the first plan year beginning on or after September 23, 2010. The agencies may also take into account any good-faith attempt, before June 14, 2010 (the date the IFR was initially made public), to comply with a reasonable interpretation of the grandfather statute -- despite the plan or coverage technically running afoul of the grandfather requirements -- provided that the IFR's parameters are only modestly exceeded.

4. **Retiree-Only and HIPAA-Excepted Benefit Exemptions**. The preamble to the IFR confirms that the agencies interpret the exemptions for retiree-only health plans and limited, "HIPAA-excepted" benefits from many of the requirements imposed upon group health plans (including the new PPACA market reform provisions) as continuing to apply. Before the IFR was issued, there had been a question as to whether these exemptions -- which had previously been contained in the Internal Revenue Code, ERISA, and Public Health Service Act ("PHSA"), and were deleted or largely eliminated from the PHSA (but not the Internal Revenue Code or ERISA) by PPACA -- ceased to exist under a technical reading of the statute.

The preamble to the IFR acknowledges that the exemptions were deleted from the PHSA, and therefore a technical argument could be made that they do not apply to health insurance policies and non-federal governmental plans (which are subject to the PHSA). However, the preamble states that HHS will

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effectively treat the exemptions as not having been deleted from the PHSA. We caution, however, that individual states -- not HHS -- generally have primary enforcement authority with regard to the PHSA. In addition, the states generally have the authority to impose stricter requirements, as long as they do not "prevent" the application of a standard contained in the PHSA. Therefore, although HHS is encouraging states to interpret the retiree-only and HIPAA-excepted benefit exemptions as effectively continuing to exist under the PHSA, there is no guarantee that each state will actually do so.

[1] There are now technically two sections 2709; one is former section 2713 (relating to disclosure of information), which still applies to grandfathered (insured) plans.
[2] Grandfathered individual insurance coverage is exempt from this requirement.
[3] For grandfathered group coverage, for plan years beginning before 2014, the mandate does not apply with respect to dependent children eligible for other employer-sponsored coverage (other than through their parents' employers).

For more information, please contact:

Elizabeth Drake, edrake@milchev.com, 202-626-5838

Adrian Morchower, amorchower@milchev.com, 202-626-5940

Anne Batter, abatter@milchev.com, 202-626-1473

Marianna Dyson, mdyson@milchev.com, 202-626-5867

Tom Cryan, tcryan@milchev.com, 202-626-1482

Tess Ferrera, tferrera@milchev.com, 202-626-1470

Garrett Fenton, gfenton@milchev.com, 202-626-5562

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Executive Compensation: Last Chance to Fix Bonus Plans and Severance/Employment Agreements

Anne Batter

For those companies who have not yet revised their bonus plans or severance/employment agreements to comply with the IRS interpretation of Internal Revenue Code (Code) section 162(m) in Rev. Rul. 2008-13, 2008-10 IRB 518, now would be the time to do that in order to avoid a deduction disallowance for the 2010 annual bonus (and for long-term bonuses with a performance period beginning January 1, 2010). For taxpayers with calendar year performance periods, the grandfather provisions in Rev. Rul. 2008-13 generally will only protect annual bonuses through the 2009 performance period. Bonus plans and severance/employment agreements impacting the bonus paid for the 2010 performance period generally will need to be compliant with Rev. Rul. 2008-13 in order to avoid deduction disallowance under Code section 162(m). The same is true for long-term bonuses with performance periods beginning after January 1, 2009.

As background, Rev. Rul. 2008-13 sets forth the IRS's position that a bonus program does not meet the requirements for deductibility as performance-based compensation exempt from section 162(m) if the plan and/or other arrangements provide for payment of a bonus without regard to attainment of performance goals on the employer's involuntary termination of the employee without cause, or the employee's termination for good reason or by retirement. Thus, for example, under the ruling, if a performance plan (or a separate severance or employment agreement) contains a provision specifying that the target level bonus will be paid upon the executive's involuntary termination, or termination for good reason, or retirement, whether or not the performance goals are met, then all payments under the performance plan, even those that are made upon meeting the performance goal, will be treated as failing the Code section 162(m) exception.

Thus, the ruling applies a strict interpretation of Treas. Reg. § 1.162-27(e)(2)(v), so that a plan can only be assured continued exemption from Code section 162(m) as qualified performance-based

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compensation if the plan and associated arrangements provide for payment of a target bonus without regard to attainment of goals only on death, disability, or change in control. As has always been the case, bonus payments actually made without regard to attainment of goals in these circumstances (i.e., death, disability, or change in control) are non-deductible but the inclusion of provisions for such payments will not disqualify the entire plan from satisfying the section 162(m) exception for performance-based compensation.

This new strict interpretation of the Code section 162(m) regulations was first announced in PLR 200804004 (January 25, 2008), which signaled the IRS's disagreement with its prior ruling position in PLR 200613012 (March 31, 2006) and PLR 199949014 (December 10, 1999). Due to taxpayers' vocal concerns regarding the financial accounting consequences of this new position, the IRS issued Rev. Rul. 2008-13 and made it prospective in effect.

Rev. Rul. 2008-13 was made effective prospectively for plans and arrangements that otherwise satisfy the rules for performance-based compensation exempt from Code section 162(m) and contain payments terms similar to those in the ruling. Thus, the ruling does not apply to bonus programs for (i) performance periods beginning on or before January 1, 2009, and (ii) compensation paid under employment contracts in effect on February 21, 2008. Although the wording of Rev. Rul. 2008-13 is not as clear as it could be, it would appear the IRS meant to grandfather contracts in effect as of February 21, 2008, only for the stated term thereof, but not where the employment contract has been extended or renewed since February 21, 2008, even under a provision for automatic renewal.

To the extent not covered by the grandfather rule for employment contracts in effect on February 21, 2008, the last performance period that is grandfathered for annual bonus plans is the 2009 calendar year performance period. Consequently, in such a case, the grandfather will not apply to the 2010 performance period and the plan and other arrangements (such as associated employment agreements and severance plans) need to be revised to comply with Rev. Rul. 2008-13 in order to be assured a deduction for the 2010 bonus (and bonuses relating to longer periods beginning January 1, 2010).

Note that companies need to review, not only their annual bonus plans and long-term performance-based compensation programs, but also any severance or employment agreements that might separately provide whether a bonus (or a bonus substitute) is paid in the year of termination. How the severance programs and employment agreements can be designed such that they do not clearly make up for the target bonus that cannot be paid on termination pursuant to Rev. Rul. 2008-13 is an open issue that must be given serious consideration.

Fringe Benefits and Payroll Tax: IRS to Increase Employment Tax Audits

Thomas Cryan, Jr.

Earlier this year, we alerted our clients that the IRS has been conducting its largest hiring initiative in decades. We suspected, based on both statements from the IRS and because employment taxes are "recession proof," i.e. taxes that can be collected even when a company is in a net operating loss position, that a primary focus of this increase in manpower would be employment taxes. A recent announcement from the IRS has confirmed this.

On September 18, 2009, the IRS announced that it will audit 6,000 U.S. companies to determine whether

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they pay all their required employment taxes to fund Social Security and Medicare benefits. The IRS indicated that the primary focus of these examinations will be worker classification (i.e., whether service providers are being properly classified as independent contractors) and the tax treatment of fringe benefits. John Tuzynski, chief of employment tax operations at the IRS, also noted that the IRS will focus in particular on fringe benefits such as company cars and the personal use of corporate-owned vacation property. The audits will occur over a three-year period, beginning in February 2010, and the companies will be chosen at random. These examinations will enable the IRS to collect data to identify additional issues and to prepare a broader national audit program.

The IRS will consider a taxpayer's prior efforts to correct plan issues or withholding procedures in assessing whether penalties are appropriate for back years. Therefore, we strongly recommend that our clients take steps now to comply with IRS requirements *prior* to the IRS discovering the issue on audit. We have been working with our clients to conduct internal audits of both their plans and withholding procedures in an effort to both discover and correct any plan or procedure deficiencies. Please let us know if we can be of assistance.

There are two additional developments on the audit front. First, taxpayers have reported that the IRS has begun auditing (i) Code section 409A compliance and (ii) claims for the COBRA subsidy (see article below). Second, taxpayers also have reported that their audit teams have indicated that the returns of corporate officers will be reviewed in conjunctions with the corporate income tax return audit as part of the Global High Wealth Industry initiative within LMSB. This initiative will be described in more detail in a separate, upcoming alert. In summary, a new industry, the Global High Wealth Industry, has been added to LMSB and we expect this could result in more sophisticated audits of corporate officers' tax returns as well as better coordination of the examination of the corporate return and the individual officers' returns.

Qualified Plans: IRS Releases COLA-Adjusted Amounts for 2010

Elizabeth Drake, Garrett Fenton

On October 15, the IRS released the 2010 annual cost-of-living adjustments (COLAs) to qualified plan limitations. There had been some speculation that at least some of the COLA-adjusted amounts could actually decrease from their 2009 levels, since the relevant cost-of-living index had declined from a year ago. But the IRS interpreted the Internal Revenue Code's COLA provisions to prevent a year-to-year reduction in the relevant limitations, and thus maintained the amounts at their 2009 levels:

Limitation	Amount for 2010
Code section 402(g) elective deferral limit	$16,500
Code section 415(b) dollar limitation for defined benefit plans	$195,000
Code section 415(c) annual additions limit for defined contribution plans	$49,000
Code section 401(a)(17) compensation limit	$245,000
Code section 416(i) key employee officer compensation	$160,000
Code section 409(o) threshold ESOP account balance subject to a five-year distribution period	$985,000

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Code section 409(o) threshold ESOP account balance for a one-year extension	$195,000
Code section 414(q) "highly compensated employee" compensation threshold	$110,000
Code section 414(v) catch-up contribution limit	$5,500

The 2010 Social Security taxable wage base is also unchanged from its 2009 level of $106,800.

Health and Welfare: IRS Rapidly Begins COBRA Subsidy Audits

Michael Lloyd

When Congress provided a 65% subsidy for involuntarily terminated workers in the American Recovery and Reinvestment Act of 2009, many questioned whether the IRS could adequately ensure compliance of claims for the subsidy. M&C has learned that the IRS has already begun audits of employers and insurers claiming the subsidy on their 2009 Forms 941 (Employer Quarterly Federal Tax Return). The IRS information document request asks for the identity of all individuals represented on line 12b of the Form 941, each individual's request for the COBRA subsidy, and a copy of the insurance premium invoice to the employer with proof that the employee paid the premium. Although IRS guidance instructs employers/ insurers to maintain this information in their files **[IR-2009-15, Feb. 26, 2009]**, the speed with which the IRS has initiated enforcement action (6 months) is surprising. Employers and insurers should make sure that they have their COBRA subsidy documentation in order.

Health and Welfare: Senate Finance Committee Proposes Excise Tax on High Cost Health Plans

Susan Relland, Garrett Fenton

On October 13, the Senate Finance Committee voted to approve its version of the health reform bill, which includes as its primary funding source a controversial excise tax on high cost health plans. The funding provisions included in the eventual Senate health reform bill will likely be based in large part on the Finance Committee's provisions. Thus, employers, insurers, and plan administrators should be aware of the excise tax, as well as how it could potentially affect them in the near future.

The proposal calls for the imposition of a 40% non-deductible excise tax, beginning in 2013, imposed on the excess of the aggregate value of employer-sponsored health coverage over a threshold amount. The "value" of coverage provided under a self-funded plan is determined based on COBRA premiums. In calculating the value of retiree coverage, pre-65 and post-65 retiree plans may be combined at the employer's election.

The threshold amount is generally $8,000 for individual coverage and $21,000 for family coverage (although several Senators are interested in increasing those amounts). For retirees over age 55 and individuals in high-risk professions, however, the thresholds are $9,850 and $26,000, respectively. A three year transition rule would implement higher thresholds in the 17 states with the most expensive health care as of the end of 2012, as determined each year. The thresholds are indexed to CPI-U + 1%,

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which is usually a much lower rate than actual medical cost inflation. Thus, an increasing number of plans will likely begin to exceed the relevant thresholds over time.

Employer and employee contributions made on a pre-tax or after-tax basis are taken into account in determining the value of coverage for purposes of the excise tax. In addition, the threshold includes all contributions to medical, dental, vision, health Flexible Spending Arrangements (FSAs), Health Reimbursement Arrangements (HRAs), and Health Savings Accounts (HSAs) (if made by the employer or the employee through a cafeteria plan) for the year. All long-term care and disability benefits, as well as indemnity and specified-disease insurance purchased with after-tax contributions, are excluded from the value of coverage for purposes of the excise tax.

The excise tax will be imposed upon the insurance company in the case of an insured plan, and the plan administrator in the case of a self-funded plan. The tax will be allocated to the insurers and administrators in proportion to the value of the health plans. An employer will need to calculate the total value of health coverage on a per-employee basis, determine the allocation of the tax for each plan, and report the resulting amount to each insurer and plan administrator, and to the Secretary of Treasury, in accordance with regulations. The employer will be subject to a penalty for underreporting, although the penalty may be waived if the employer can show that the failure was due to reasonable cause and not willful neglect.

Several revisions to the excise tax provisions have been suggested, and could be made before the full Senate votes on its health reform bill. For example, the bill could index the thresholds to a higher percentage (e.g., CPI-U + 3%, or CPI-medical) that more accurately reflects medical cost inflation; exempt retiree medical coverage and employee-pay-all plans; carve out employee after-tax (and even pre-tax) contributions; increase the threshold for family coverage from $21,000 to, for example, $25,000; maintain the increased thresholds under the transition rule for high-cost states indefinitely; or eliminate the threshold completely and, instead, beginning with the value of coverage provided in 2013, impose an excise tax on plans that increase at a rate greater than medical inflation for the year. It remains to be seen which, if any, of these suggestions will garner enough support to be either included in the final Senate health reform bill or adopted as part of a conference to reconcile House and Senate-passed versions of health reform.

For Additional Information

For additional information, please contact any of the following attorneys in our ERISA/ Employee Benefits practice:

Anne Batter, abatter@milchev.com, 202-626-1473

Thomas Cryan, Jr., tcryan@milchev.com, 202-626-1482

Elizabeth Drake, edrake@milchev.com, 202-626-5838

Garrett Fenton, gfenton@milchev.com, 202-626-5562

Michael Lloyd, mlloyd@milchev.com, 202-626-1589

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655 Fifteenth Street, N.W., Suite 900 • Washington, D.C. 20005-5701 • 202-626-5800 • 202-626-5801 FAX • millerchevalier.com

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Qualified Plans: IRS Refines its Fix-It Program – The Employee Plan Compliance Resolution System (EPCRS) – in Revenue Procedure 2008-50

Fred Oliphant and Barbara Graham

In Revenue Procedure 2008-50, the IRS has issued its latest enhancement to its correction programs for qualified plans that allow plan sponsors to correct plan failures without the plan losing its qualification status. The three components of EPCRS have not changed: (1) the Self-Correction Program (SCP); (2) the Voluntary Correction Program (VCP), and (3) the Audit Closing Agreement Program (Audit CAP), but the Revenue Procedure makes a number of modifications to those programs, which are briefly highlighted below.

The new Revenue Procedure will allow streamlined VCP submissions for certain common plan failures, provided the submissions follow the formats provided in the Revenue Procedure without modifications. The failures covered by the new streamlined submission procedure include the failure to administer plan loans in accordance with Internal Revenue Code (Code) section 72(p)(2) and also the failure to adopt timely discretionary amendments to implement optional law changes specified in the Revenue Procedure, for example, the optional good faith EGTRRA amendment to allow catch-up contributions.

In addition to streamlining the application and reducing the fee in some instances for plan loan failures, the new Revenue Procedure will allow corrections for such failures even if the plan document does not provide that the loans must comply with Code section 72(p)(2). One advantage of submitting plan loan failures under VCP is that if the correction requires the reporting of a deemed distribution to the participant on a Form 1099-R, the plan sponsor may request that the deemed distribution to the participant be reported on the 1099-R for the year of correction rather than the year of failure. Note, however, the plan sponsor must now specifically request this relief in the VCP submission. (This relief is not available under SCP or Audit CAP). It bears keeping in mind that for plan loan failures to be eligible for VCP, the failure must not simply be due to an individual employee's failure, such as failure to repay on time, but must represent a systematic failure of some kind on the part of the plan sponsor.

Often a correction method involves making an earnings adjustment to a corrective distribution or contribution. In the new Revenue Procedure the IRS is now allowing the use of the Department of Labor's Voluntary Fiduciary Correction Program (VFCP) Online Calculator to determine this earnings adjustment. The plan sponsor must show, however, it is not feasible to make a reasonable estimate of what the actual investment results would have been.

This Revenue Procedure provides some clarification on when a determination letter should or should not be submitted in the context of a VCP submission or correction under Audit CAP where a plan amendment is part of the correction. The rules are complex but in general whether such an application is required will depend upon the type of plan amendment and whether the VCP submission or correction under Audit CAP occurs in an on-cycle or off-cycle year. An on-cycle year refers to the last 12 months of the plan's remedial amendment cycle. For example, if a plan sponsor files a VCP submission during an off-cycle year for failure to adopt timely an amendment to allow catch-up contributions, then the VCP submission should not include a determination letter application. The compliance statement issued by the IRS in the VCP process will treat the amendment as timely made but the plan sponsor will still need to submit the amendment along with the compliance statement with a determination letter application in the plan's on-cycle year. Certain other nonamender failures require a determination letter application even during an off-cycle year.

655 Fifteenth Street, N.W., Suite 900 • Washington, D.C. 20005-5701 • 202-626-5800 • 202-626-5801 FAX • millerchevalier.com

Grandfathered Health Plan Guidance Under PPACA

Fred Oliphant
Tess Ferrera
Garrett Fenton
Josephine Harriott

June 21, 2010

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Agenda

- Grandfathered Plan Rules
  - Introduction
  - What's at stake - scope of exemption for grandfathered plans and policies
  - Definition of grandfathered plan
  - Application to new employees, enrollees
  - Administrative requirements
  - Special rules for collectively bargained plans
  - Maintaining grandfather status
  - Transition issues
- Clarification of status of retiree-only and HIPAA-excepted plan exemptions
- Other considerations
- Next steps for employers/insurers

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Introduction

- Treasury, DOL, and HHS released Interim Final Rule (IFR) on grandfathered health plans June 14; published in the Federal Register June 17
  - IFR -- Same practical effect as final regulations, but opportunity for public comments (due by August 16) before final regulations issued
- IFR implements section 1251 of the Patient Protection and Affordable Care Act ("PPACA"), as amended by section 2301(a) of the Health Care and Education Reconciliation Act ("HCERA")
- PPACA section 1251 provides that certain group health plans and coverage in existence on March 23, 2010 are not subject to certain health care reform provisions
  - "If you like your coverage, you can keep it"

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Introduction

- General Rule: A group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010 is exempt from several market reform provisions in subtitles A and C of Title I of PPACA
- Duration theoretically indefinite, but intent is to provide temporary exemptions to gradually ease transition into all reforms before 2014 (when exchanges are operational)
  - Likely shorter duration for individual and small group coverage, due to more frequent changes in carriers, coverage, etc.
- Maintaining grandfather – IFR focuses on changes that reduce benefits, shift costs to participants, or change carriers

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What's at Stake – Scope of Exemption

- Partial relief from some (but not all) PPACA market reforms in PHSA Title XXVIII, primarily sections 2701-2719A
  - Incorporated by reference into ERISA (section 715) and IRC (section 9815)
- Grandfathered plans' exemptions from several provisions
  - 2701: Premium rating standards (January 1, 2014) (insured plans)
  - 2702: Guaranteed availability of coverage (January 1, 2014) (insured plans)
  - 2703: Guaranteed renewability (January 1, 2014) (insured plans)
  - 2705: Prohibited discrimination based on health status (January 1, 2014) (insured and self-funded plans)
  - 2706: Prohibited discrimination against health care providers (January 1, 2014) (insured and self-funded plans)
  - 2707: Comprehensive health insurance coverage (for the individual and small group markets) (January 1, 2014) (insured and self-funded plans)

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What's at Stake – Scope of Exemption (Cont.)

- Grandfathered plans' exemptions from new PHSA provisions (cont.)
  - 2709: Coverage for individuals participating in clinical trials (January 1, 2014) (insured and self-funded plans)
    - Note: There are now technically two sections 2709; one is former section 2713 (relating to disclosure of information), which still applies to grandfathered (insured) plans
  - 2713: Preventive coverage without cost-sharing (September 23, 2010) (insured and self-funded plans)
  - 2715A: Provision of additional information (September 23, 2010, but likely delayed in connection with establishment of exchanges) (insured and self-funded plans)
  - 2716: Prohibited discrimination by insured plans in favor of highly compensated employees (HCEs) (September 23, 2010) (insured plans)

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What's at Stake – Scope of Exemption (Cont.)

- Grandfathered plans' exemptions from new PHSA provisions (cont.)
  - 2717: Ensuring quality of care (September 23, 2010, but likely delayed pending guidance on reporting requirements which must be issued by March 23, 2012) (insured and self-funded plans)
  - 2719: Appeals process (September 23, 2010) (insured and self-funded plans)
  - 2719A: Patient protections (September 23, 2010) (insured and self-funded plans)

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What's at Stake – Scope of Exemption (Cont.)

- Grandfathered plans are still subject to some of the new PHSA provisions
  - 2708: Prohibition on excessive waiting periods (January 1, 2014) (insured and self-funded plans)
  - 2712: Prohibition on rescissions (September 23, 2010) (insured and self-funded plans)
  - 2714: Extension of dependent child coverage to age 26 (September 23, 2010) (insured and self-funded plans)
    - Note: For grandfathered group coverage, for plan years beginning before 2014, the mandate does not apply to dependent children eligible for other employer-sponsored coverage (other than through their parents' employers)
  - 2715: Uniform explanation of coverage documents (September 23, 2010, but likely delayed pending guidance)
  - 2718: Medical loss ratio (September 23, 2010) (insured plans)

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What's at Stake – Scope of Exemption (Cont.)

- Special rules for certain PHSA provisions
  - 2704: No pre-existing condition exclusions
    - Only grandfathered individual insurance coverage is exempt
    - Provision generally applies to group coverage (insured and self-funded) for plan years beginning in 2014 (September 23, 2010 for individuals under 19)
  - 2711: Prohibition on lifetime and annual limits (insured and self-funded)
    - Lifetime limits: Prohibition applies to all grandfathered plans (September 23, 2010)
    - Annual limits: Prohibition applies to grandfathered group coverage (September 23, 2010, with restricted annual limits permissible before 2014), but not grandfathered individual coverage
      - Awaiting guidance on restricted annual limits permissible for plan years beginning before 2014

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What's at Stake – Scope of Exemption (Cont.)

- Grandfathered plans must also comply with pre-PPACA law, to the extent not supplanted by applicable PPACA provisions
  - Example: Grandfathered plans are exempt from new PHSA section 2702 (guaranteed availability) but are still subject to pre-PPACA guaranteed availability rules for the small group market (former section 2711)

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Definition of a Grandfathered Plan

- To take advantage of the grandfather, a plan or policy must be
  - a group health plan
  - group health insurance coverage or
  - individual insurance coverage
- *under which*
  - an individual was enrolled on March 23, 2010 *and*
  - at least one person (not necessarily the same person) has been continuously covered by plan or group health insurance coverage since March 23, 2010
    - ❖No need to "track" individual enrollees

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Definition of a Grandfathered Plan (Cont.)

- Grandfather status
  - applies separately to each benefit package offered under a grandfathered group health plan or health insurance coverage
  - applies to family members who enroll after March 23, 2010 if the covered individual was enrolled in grandfathered coverage on March 23, 2010

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Application to New Employees, Enrollees

- Grandfather applies to both new employees and current employees who are new enrollees (and their families) who enroll in a grandfathered plan after March 23, 2010

but

- Grandfather status can be lost if employees are moved among or between plans for purposes of evading the statute

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Application to New Employees, Enrollees (Cont.)

- Grandfather status can be lost under "anti-abuse" rules
  - If the principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered plan

or

  - If employees are transferred from a plan they were covered under on March 23, 2010 to a receiving plan which, if it was treated as an amendment to the transferor plan, would cause the transferor plan to lose its grandfather status
    - Does not apply to transfers for bona fide employment-based reason (but change in the terms or cost of coverage not treated as bona fide reason)

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Administrative Requirements

- Grandfathered plans/coverage must comply with specific disclosure requirements to participants and beneficiaries
  - Model language available in the IFR, but may be modified in future guidance
- Must maintain records documenting terms of plan/ coverage in effect on March 23, 2010, and any necessary substantiating documentation
  - Must make these records and documentation available to the agencies, participants, or beneficiaries upon request

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Special Rules for Collectively Bargained Plans

- "Special grandfather" for insured collectively bargained plans, in addition to general grandfather
  - No special grandfather for self-funded plans
- Coverage under an insured collectively bargained plan is grandfathered at least until the last CBA relating to the coverage that was in effect on March 23, 2010 terminates
  - Adoption of PPACA compliance amendments is not treated as terminating the CBA
- Not totally exempt from PPACA reforms – must still comply with PPACA provisions applicable to grandfathered plans

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Special Rules for Collectively Bargained Plans (Cont.)

- After the last CBA relating to coverage in effect on March 23, 2010 terminates, general grandfather rules apply
  - Compare coverage at that time with coverage that was in effect on March 23, 2010
  - Note: Change in insurance carriers since March 23, 2010, alone, will not cause loss of grandfather unless the change occurs after the last CBA relating to coverage terminates

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Special Rules for Collectively Bargained Plans (Cont.)

- Summary
  - Non-collectively bargained plan
    - Only general grandfather can apply
  - Self-funded collectively bargained plan
    - Only general grandfather can apply
      - Changes made after March 23, 2010 can cause loss of grandfather, even if last CBA relating to coverage in effect on March 23, 2010 has not yet terminated
  - Insured collectively bargained plan
    - Special grandfather applies until last CBA relating to coverage in effect on March 23, 2010 terminates
    - General grandfather can apply thereafter
  - All three remain subject to health reform provisions that apply to grandfathered plans, as of the same effective dates

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Maintaining Grandfather Status

- Grandfather can be lost by implementing certain participant take-aways
  - Eliminating benefits
  - Increasing participants' costs over specified amount
  - Decreasing employer contributions by more than a specified amount
  - Imposing/reducing annual limits

Note: other actions that cause loss of grandfather

  - Changing insurance policies
  - Inappropriately transferring employees into the plan

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Maintaining Grandfather Status (Cont.)

- Plan changes that can end grandfather (benefit reduction)
  - Eliminating all or substantially all benefits to diagnose or treat a particular condition
  - Eliminating benefits for any necessary element to diagnose or treat a condition

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Maintaining Grandfather Status (Cont.)

- Important definitions/concepts for measuring increases in participant costs and decreases in employer contributions
  - "Maximum percentage increase" – medical inflation rate plus 15%. Medical inflation is the increase since March 2010 in the overall medical care component of the CPI-U (unadjusted)
    - Published by the Bureau of Labor Statistics
  - "Contribution rate" -
    - Amount of contributions by employer or employee organization compared to total cost of coverage
    - The formula used to make contributions based on factors such as hours worked or product output

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Maintaining Grandfather Status (Cont.)

- Plan changes that can end grandfather (increasing participant cost)
  - Any increase in a percentage of cost-sharing (such as coinsurance)
  - Any increase in fixed amount cost-sharing other than a copayment (such as a deductible or out-of-pocket limit) that exceeds the "maximum percentage increase"
  - An increase in a fixed-amount copayment that is higher than
    - $5 adjusted for medical inflation *or*
    - A percentage that exceeds the "maximum percentage increase"

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Maintaining Grandfather Status (Cont.)

- Plan changes that can end grandfather (decreasing employer contribution)
  - Decreasing the "contribution rate" toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5% below the contribution rate for the coverage period that includes March 23, 2010
  - Decreasing the formula-based "contribution rate" for any tier of coverage for any class of individuals by more than 5% below the coverage rate in effect on March 23, 2010

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Maintaining Grandfather Status (Cont.)

- Plan changes that can end grandfather (imposing/ reducing annual limit)
  - Adding an overall annual dollar limit to a plan that had no annual or lifetime dollar limits on March 23, 2010
  - Adding an annual limit (to a plan that had lifetime but no annual limits) with a lower dollar value than the lifetime limit in effect on March 23, 2010
  - Decreasing the dollar value of the annual limit for a plan or coverage below the value on March 23, 2010

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Maintaining Grandfather Status (Cont.)

- Grandfather generally will not be lost solely by reason of
  - Increasing premiums
  - Changing third party administrators
  - Amending the plan to comply with federal or state legal requirements
  - Amending the plan to enhance benefits
- But can lose grandfather status if collateral consequences of such actions run afoul of grandfather maintenance rules

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Transitional Issues

- Changes to terms of plans/coverage are deemed effective March 23, 2010 (even if not effective until later), and will not cause a loss of grandfather, provided certain specified actions were taken on or before March 23, 2010
- Grace period to revoke or modify changes made to terms of plan/coverage after March 23 and before June 14, 2010 if done by first plan year beginning on or after September 23, 2010 (agencies may also take into account good-faith attempt to comply where changes "modestly" exceed IFR parameters)

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Clarification of Status of Retiree-Only and HIPAA-Excepted Plan Exemptions

- Exemptions formerly in parallel IRC, ERISA and PHSA sections
  - Retiree-only: PPACA deleted PHSA exemption
  - HIPAA-excepted benefits: PPACA amendments can be read to eliminate exemption with respect to several PHSA provisions
  - No direct changes made to IRC and ERISA exemptions
- PPACA "conforming amendments" to ERISA and IRC incorporate by reference the new/amended sections of PHSA, and provide that those sections expressly supersede conflicting IRC and ERISA provisions

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Clarification of Status of Retiree-Only and HIPAA-Excepted Plan Exemptions (Cont.)

- Preamble to IFR: Continued presence of these exemptions in IRC and ERISA does not conflict with absence of parallel exemption in PHSA
  - ERISA and IRC retiree-only and HIPAA-excepted benefit plan exemptions still apply
  - Even though exemptions are no longer in PHSA, HHS will not enforce relevant HIPAA and PPACA provisions against retiree-only or HIPAA-excepted benefit plans
    - States have primary authority to enforce PHSA against insurers, but HHS "encouraging" states to continue to recognize exemptions, and will not cite states for failing to substantially enforce PHSA provisions if they do so
    - States can still impose stricter standards than PHSA

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Other Considerations

- Grandfather does not exempt employers or insurance companies from any provisions outside Subtitles A and C of Title I of PPACA, including:
  - "Free rider" penalties and "free choice" vouchers
  - Annual comparative effectiveness research fees
  - Annual fees on health insurance companies
  - Cap on permitted salary reduction contributions to FSAs
  - Restrictions on pre-tax reimbursements from FSAs/HRAs/HSAs
  - Excise tax on high-cost ("Cadillac") coverage
  - $500,000 limitation on deductibility of compensation for health insurance industry
  - Mandatory auto-enrollment provisions
  - New employer 1099 and W-2 reporting requirements
- Separate rating for grandfathered versus non-grandfathered plans

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Next Steps

- Group health plans and insurers must weigh the options to determine if it makes sense to maintain grandfathered status
  - Various costs of grandfathering
    - Restrictions on changes in coverage terms
    - Administrative requirements
    - Compliance with many PPACA provisions (and pre-PPACA law) regardless of grandfather
  - Projected costs of grandfathering could change -- IFR on grandfathering may be modified in the future
  - Employee/customer relations issues

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Next Steps (Cont.)

- Additional guidance expected in the near future
  - Medical loss ratio provisions
  - Prohibited annual and lifetime limits; permitted "restricted" annual limits
  - Prohibition on pre-existing condition exclusions for individuals under age 19
  - Prohibited rescissions
  - Mandated preventive coverage without cost-sharing
  - Prohibited discrimination in favor of HCEs for insured plans
  - Uniform explanation of coverage documents

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Contact Information

For additional information, please contact:

Fred Oliphant
(202) 626-5834
coliphant@milchev.com

Tess Ferrera
(202) 626-1470
tferrera@milchev.com

Garrett Fenton
(202) 626-5562
gfenton@milchev.com

Josephine Harriott
(202) 626-1496
jharriott@milchev.com

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Updated 2010-03-30

Key Issues for Large Employer Health Plan Sponsors
From Senate-Passed Bill (H.R. 3590) as Revised

	Senate Bill (H.R. 3590) as passed by Senate on Dec. 31, 2009	Reconciliation Bill (H.R. 4872) as passed by Senate on March 25, 2010
Employer Fees		
• Free Rider penalty (which is not deductible by employers) o If no coverage offered, and at least one full-time employee (30+ hours per week, assessed on a monthly basis) receives a tax credit to buy insurance through the Exchange, penalty is $750* X total number of full-time employees* o Applies to employers with over 50 full-time employees*, no exemption for seasonal workers o If coverage offered to an individual with family income up to 400% of FPL but *either* the actuarial value is less than 60% or any employee's required premium is greater than 9.8%* of income (thus entitling the employee to a tax credit), penalty is *lesser of:* ▪ $750* X total number of full-time employees, or ▪ $3,000 X number of employees receiving the tax credit	• Sec. 1513; MA Sec. 10106(f) (See also new Code Section 36B for 60% and 9.8% requirements) • Effective beginning 2014	• Sec. 1003 (see also Sec. 1001 amendment to Code Section 36B) • Increases $750 penalty to $2,000 • Part-time employees (on a full-time equivalent basis) are included when determining if an employer has 50 employees • When calculating tax due, subtract first 30 full-time employees • 9.8% premium threshold reduced to 9.5%
• Wyden free choice vouchers o An employer that provides and contributes to health coverage for employees must provide free choice vouchers to each employee who is required to contribute between 8% and 9.8%* of the employee's household income toward the cost of coverage, if such employee's household income is <400% FPL and the employee does not enroll in a health plan sponsored by the employer o 8% and 9.8% are to be indexed to the rate of premium growth o Employees may use the vouchers to purchase coverage through	• MA Sec. 10108 • Effective beginning Jan. 1, 2014	• Note: 9.8% is not reduced to 9.5% to coordinate with the Free Rider penalty, but the Joint Committee on Taxation's summary of the bill indicates the appropriate threshold is 9.5%

* = Provision is modified by Reconciliation Bill
Code = Internal Revenue Code
CPI = Consumer Price Index
DOE = Date of Enactment
FPL = Federal Poverty Level
MA = Manager's Amendment released on Dec. 19, 2009 (passed with Senate bill on Dec. 31, 2009)
PHSA = Public Health Service Act
TBD = To be determined

	Senate Bill (H.R. 3590) as passed by Senate on Dec. 31, 2009	Reconciliation Bill (H.R. 4872) as passed by Senate on March 25, 2010
the Exchange and employers will pay amounts directly to the Exchange o If the cost of the Exchange coverage costs less than the voucher, the difference will be paid to the employee o The amount of the voucher must be equal to the amount the employer would have provided toward such employee's coverage (individual vs. family based on the coverage the employee elects through the Exchange) with respect to the plan to which the employer pays the largest portion of the cost o The cost of the plan is to be determined under rules similar to COBRA, except that they will be adjusted for age and category of enrollment (e.g., employee-only, employee+1, family) in accordance with regulations to be established o Amounts paid toward the cost of coverage under the Exchange are excluded from the employee's income and the employer receives a tax deduction for the amount of the voucher o No free rider penalty will be imposed with respect to employees who receive vouchers		
• Per participant fee on employer plan-sponsors for comparative effectiveness research o $1 per participant for the first plan year ending after 9/30/2012 (2012 for calendar year plans); $2 per participant for the following year; multiply by "national health expenditures" through 2019 (fee sunsets after 2019)	• Sec. 6301 • Effective beginning first plan year ending after Sept. 30, 2012	
• The Secretary of Labor must study and report to Congress on whether the employees fees and assessments would result in a reduction in employee wages o Determination is based on Bureau of Labor Statistics National Compensation Survey	• Sec. 1513(c) • Report due date is unclear	
Group Health Plan Mandates		
• $600 non-deductible penalty per full-time employee in a 60-90 day waiting period*	• Sec. 1513; MA Sec. 10106(e) • Effective beginning Jan. 1, 2014	• Sec. 1003 • Eliminates these penalties
• Prohibits waiting periods greater than 90 days	• Sec. 1201 (adds PHSA Sec. 2708) • Effective plan years beginning on or after Jan. 1,	• Sec. 2301 • Eliminates grandfather

	Senate Bill (H.R. 3590) as passed by Senate on Dec. 31, 2009	Reconciliation Bill (H.R. 4872) as passed by Senate on March 25, 2010
	2014, but grandfather applies*	
• Must cover unmarried* adult children to age 26	• Sec. 1001(adds PHSA Sec. 2714) • Effective plan years beginning 6 months after DOE, but grandfather applies*	• Sec. 2301; tax treatment in Sec. 1004(d) • No grandfather beginning in 2014; prior to 2014, grandfather applies but must cover adult children who are not eligible for other employer-sponsored coverage • Must cover any children up to age 26, even if married • Extends income tax exclusion for coverage for adult children who have not turned 27 as of the end of the year
• Imposes restrictions on lifetime and annual limits	• Sec. 1001 (adds PHSA Sec. 2711); MA Sec. 10101(a) • No lifetime limits beginning the plan year that begins 6 months after DOE • No annual limits for plan years beginning on or after Jan 1, 2014 • Restrictions on annual limits (TBD by regulations) effective for plan years beginning prior to Jan. 1, 2014 • Grandfather applies to restrictions on both lifetime and annual limits*	• Sec. 2301 • Eliminates grandfather for both lifetime and annual limits
• May not limit coverage for preexisting conditions	• Sec. 1201 (adds PHSA Sec. 2704); MA Sec. 10103(e) • Generally effective beginning in 2014 • For children under age 19, effective plan years beginning 6 months after DOE	• Sec. 2301 • Eliminates grandfather for both limits

	Senate Bill (H.R. 3590) as passed by Senate on Dec. 31, 2009	Reconciliation Bill (H.R. 4872) as passed by Senate on March 25, 2010
	• Grandfather applies to both limits*	
• Must limit cost sharing to the out-of-pocket maximum for HSA-qualified high deductible health plans	• Sec. 1201 (adds PHSA Sec. 2707(b)); see also Sec. 1302(c)(1) • Effective plan years beginning on or after Jan. 1, 2014, but grandfather applies	
• Deductibles may not exceed $2,000 for individual coverage or $4,000 for family coverage • May be increased by the maximum reimbursement available from a health FSA • Amounts are indexed to inflation of average health premiums	• Sec. 1201 (adds PHSA Sec. 2707(b)); see also Sec. 1302(c)(2) • Effective plan years beginning on or after Jan. 1, 2014, but grandfather applies	
• Must provide preventive care without cost sharing, and cover certain child preventive services as recommended by U.S. Preventive Service Task Force, CDC, and the Health Resources and Services Administration	• Sec. 1001(adds PHSA Sec. 2713) • Effective plan years beginning 6 months after DOE, but grandfather applies	
• Must cover clinical trials for life-threatening diseases (for benefits that would otherwise be covered and subject to the plan's restrictions on out-of-network providers)	• MA Sec. 10103(c) • Effective plan years beginning on our after Jan. 1, 2014, but grandfather applies	
• Group health plan must implement an effective internal appeals process; provide notice to participants of available internal and external appeals processes and the availability of any applicable office of health insurance consumer assistance or ombudsman established under the bill to assist such enrollees with the appeals processes; and allow participants to review their files, present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process • Self-funded group health plans must implement an external review process in accordance minimum standards to be created by the Secretary • Insured plans will have to satisfy external review requirements mandated by the state, which will be binding, or by the Secretary, but only if the state doesn't have procedures	• MA Sec. 10101(g) • Effective plan years beginning 6 months after DOE, but grandfather applies	

	Senate Bill (H.R. 3590) as passed by Senate on Dec. 31, 2009	Reconciliation Bill (H.R. 4872) as passed by Senate on March 25, 2010
• Requires that a plan enrollee be allowed to select their primary care provider, or pediatrician in the case of a child, from any available participating primary care provider • Precludes the need for prior authorization or increased cost-sharing for emergency services, whether provided by in-network or out-of-network providers • Plans are precluded from requiring authorization or referral to Ob-Gyn	• MA Sec. 10101(h) • Effective plan years beginning 6 months after DOE	
• Prohibits rescission of group health plan coverage without prior notice	• Sec. 1001(adds PHSA Sec. 2712) • Effective plan years beginning 6 months after DOE, but grandfather applies*	• Sec. 2301 • Eliminates grandfather
• Grandfather: o Grandfather available for individuals enrolled in a plan on DOE, subsequently-enrolled family members, and new hires o Applies to coverage mandates, but not free rider o Unclear what would cause grandfather to end o Collectively bargained plans are grandfathered until the date on which the last of the collective bargaining agreements relating to the grandfathered coverage in effect on DOE terminates	• Sec. 1251	
Other Provisions Impacting Plan Design		
• FSA contributions are capped at $2,500, indexed to CPI	• Sec. 9005; MA Sec. 10902 • Effective taxable years beginning after Dec. 31, 2010*	• Sec. 1403 • Effective taxable years beginning after Dec. 31, 2012
• Prohibits pre-tax reimbursement of non-prescribed over-the-counter drugs from FSAs, HRAs, HSAs	• Sec. 9003 • Effective taxable years beginning after Dec. 31, 2010	
• Codifies HIPAA wellness rules and increases 20% incentive cap to 30% with Secretary discretion to increase to 50%	• Sec. 1201(adds PHSA Sec. 2705) • Effective plan years beginning on or after Jan. 1, 2014	
• Wellness programs may not require the disclosure or collection of any information relating to presence of firearms, and may not base	• MA Sec. 10101(e) • Effective plan years	

	Senate Bill (H.R. 3590) as passed by Senate on Dec. 31, 2009	Reconciliation Bill (H.R. 4872) as passed by Senate on March 25, 2010
premiums, discounts, rebates, or rewards on the basis of firearm or ammunition ownership	beginning 6 months after DOE	
• Code Section 105(h) nondiscrimination rules that apply to self-funded plans will apply to insured plans as well	• MA Sec. 10101(d) (adds PHSA Sec. 2716) • Effective plan years beginning 6 months after DOE, but grandfather applies	
• Temporary reinsurance program for employers providing health coverage to retirees over age 55 who are not eligible for Medicare. o Reimburses employers for 80% of claims between $15,000 - 90,000 (indexed for inflation) o Ends on January 1, 2014	• Sec. 1102 • Effective within 90 days of DOE	
• Increases the adoption assistance exclusion ($12,170 for 2009) by $1,000	• MA Sec. 10909 • Effective taxable years beginning after Dec. 31, 2009	
• Clarifies that rating requirements do not apply to self-funded plans	• MA Sec. 10103	
Revenue Provisions		
• Excise tax on high-cost plans o 40% nondeductible tax o Applies to insurance company or administrator (or employer that makes HSA or MSA contributions); expected to be passed directly to employers o The threshold is $8,500* for individual coverage, $23,000* for family coverage; thresholds for retirees over age 55 and individuals in high-risk professions are $9,850* for individual coverage, $26,000* for family coverage o Annual threshold amounts and tax are calculated monthly o Includes employer and employee contributions made on a pre-tax or after-tax basis o Includes all health coverage (e.g., medical, dental*, vision*, FSA, HRA, HSA, on-site clinics; appears that wellness programs that qualify as ERISA health plans are included); accident, disability, long-term care, and after-tax indemnity or specified disease coverage are excluded o Indexed to CPI-U + 1%* o Applies to active and retired participants*; employer has the	• Sec. 9001; MA Sec. 10901 • Effective beginning with taxable years beginning after Dec. 31, 2012*	• Sec. 1401 • Effective taxable years beginning after Dec. 31, 2017 • Increases the threshold from $8,500 to $10,200 for individual coverage, from $23,000 to $27,500 for family coverage; increases threshold for individuals in high-risk professions from $9,850 to $11,850 for individual coverage, from $26,000 to $30,950 for family coverage • To the degree that health costs rise unexpectedly quickly between now and 2018, the initial threshold would be adjusted upwards automatically. • Includes an adjustment for plans

	Senate Bill (H.R. 3590) as passed by Senate on Dec. 31, 2009	Reconciliation Bill (H.R. 4872) as passed by Senate on March 25, 2010
option to combine pre-65 and post-65 retirees groups when calculating "value" o Employer must calculate value of coverage on an individual basis and report to insurance companies/Treasury, subject to mandatory failure-to-report penalties o 3-year transition for the 17 highest-cost states, to be determined each year*		that have higher than average costs due to the age or gender of their workers • Excludes dental and vision • Indexes thresholds to CPI-U+1% in 2019 and to CPI-U beginning in 2020 • Clarifies excise tax applies to former employees, surviving spouses, and other primary insured individuals • Eliminates transition for high cost states
• Tax on health insurance industry o Annual fee imposed on companies that insure U.S. health risk, prorated by market share o Fees are $2* billion in 2011 phased up to $10* billion in 2017 o May apply to reinsurance (disability, long-term care, accident, specified disease, and hospital indemnity are exempt) o Fees associated with coverage for individuals who are U.S. citizens, U.S. residents, or located in the U.S. are all taken into account	• Sec. 9010; MA Sec. 10905(b) • Effective beginning Jan. 1, 2011	• Sec. 1406 • Effective beginning Jan. 1, 2014) • The fees are increased to $8 billion in 2014 and are phased up to $14.3 billion in 2018, and indexed to the annual amount of premium growth in subsequent years • VEBAs established by non-employers are exempt
• Caps deductibility of compensation under Code Section 162(m) to $500,000 for the health insurance industry	• Sec. 9014 • Applies to current compensation paid during taxable years beginning after Dec. 31, 2012, and to deferred compensation for services performed in taxable years beginning after Dec. 31, 2009	
• Increases excise tax for nonqualified HSA withdrawals from 10% to 20%, and for Archer MSA withdrawals from 15% to 20%	• Sec. 9004 • Effective for distributions made after Dec. 31, 2010	
• Additional 0.9% Medicare tax for employees (not employers) on wages over $200,000 ($250,000 for joint filers), for a total of 2.35%	• Sec. 9015; MA Sec. 10906 • Effective beginning Jan. 1,	• Sec. 1402 • Adds 3.8% tax on unearned

	Senate Bill (H.R. 3590) as passed by Senate on Dec. 31, 2009	Reconciliation Bill (H.R. 4872) as passed by Senate on March 25, 2010
	2013	income (e.g., from interest, dividends, annuities, royalties, and rents) with respect to those with income over $200,000 ($250,000 for joint filers)
Medicare-Related Provisions		
• Eliminates the employer's deduction for the amount of the Medicare Part D retiree drug subsidy (*i.e.*, the employer's allowable deduction for retiree prescription drug expenses must be reduced by the amount of the tax-free subsidy payment received)	• Sec. 9012 • Effective taxable years beginning after Dec. 31, 2010*	• Sec. 1407 • Effective taxable years beginning after Dec. 31, 2012
• Establishes an Independent Payment Advisory Board • Binding Medicare Recommendations: o Board must make recommendations to Congress to reduce Medicare spending and improve quality o If Medicare costs projected to be unsustainable (unless growth is below the targeted growth rate), and Congress does not pass alternative act that achieves same level of savings, recommendations automatically take effect o Proposals do not have to consider the cost-shifting or other impact on employer-sponsored plans • Non-binding Private Sector Recommendations: o The Board must make annual recommendations to the President, Congress, and private entities on actions they can take to improve quality and constrain the rate of cost growth in the private sector • Binding Recommendations Regarding Overall Health Spending: o Beginning in 2020, the Board must make binding biennial recommendations to Congress if the growth in overall health spending exceeds growth in Medicare spending o Such recommendations would focus on slowing overall health spending while maintaining or enhancing beneficiary access to quality care under Medicare	• Sec. 3403; MA Sec. 10320 • Varying effective dates beginning in 2014	
• States required to provide premium assistance and wrap-around benefits to any Medicaid beneficiary who is offered employer-sponsored insurance, if it is cost-effective for the state to do so (slight expansion of CHIPRA)	• Sec. 2003 • Effective beginning Jan. 1, 2014	

	Senate Bill (H.R. 3590) as passed by Senate on Dec. 31, 2009	Reconciliation Bill (H.R. 4872) as passed by Senate on March 25, 2010
• Shrinks* the Part D donut hole, which may reduce cost for employer plans that wrap around Medicare or increase the amount of the retiree drug subsidy employers receive	• Sec. 3315 • Effective beginning 2010	• Sec. 1101 • Eliminates donut hole by 2020
• Expands Recovery Audit Contractor program to collect Medicare Secondary Payer claims to Parts C and D	• Sec. 6411 • No later than Dec. 31, 2011	
New Coverage Options and Individual Mandate		
• States must establish Exchanges to offer private insurance choices to individuals and small business; federal government to establish minimum requirements o States may allow employers with more than 100 employees to purchase coverage through the Exchanges beginning Jan. 1, 2017	• Title I, Subtitle D • Funding available to the states within 1 year after DOE • Exchanges must begin offering coverage by Jan. 1, 2014	
• States can apply for HHS or Treasury waiver (up to 5 years) of health plan requirements, exchanges, cost-sharing, tax credit, and individual and employer provisions	• Sec. 1332 • Effective plan years beginning on or after Jan. 1, 2017	
• If employer offers coverage, any employee may opt out and enroll in Exchange	• Sec. 1513	
• Loans and grants are available to establish non-profit, member-run, health insurance co-ops • A public option is not included	• Sec. 1322 • Loans and grants awarded by July 1, 2013	
• All individuals must obtain qualifying coverage or pay a penalty o Penalty is the greater of $95 in 2014, $495* in 2015 and $750* in 2016, or up to 2%* of income by 2016, up to a cap of the national average bronze plan premium o Penalties are 50% for children up to a cap of $2,250* for the entire family o After 2016, index to CPI • Premium tax credits are available to individuals with family income up to 400% of FPL	• Sec. 1501 (Code Sec. 5000A); MA Sec. 10106(b) • Effective beginning Jan. 1, 2014	• Sec. 1002 • Decreases penalties to $325 in 2015 and $695 in 2016, up to a maximum of $2,085 or 2.5% of income by 2016
• Individuals with coverage through any employer plans offered in the small or large group markets in a State will satisfy the individual mandate - no minimum coverage requirements	• Sec. 1501 (Code Sec. 5000A)	

	Senate Bill (H.R. 3590) as passed by Senate on Dec. 31, 2009	Reconciliation Bill (H.R. 4872) as passed by Senate on March 25, 2010
Administrative Requirements		
• Employers must automatically enroll all eligible individuals in employer-sponsored coverage o Employer must provide adequate notice and opportunity to opt out	• Sec. 1511 • Effective date unclear	
• Creates government-run voluntary long-term care program (CLASS Act) o Employers are expected to automatically enroll employees and facilitate payroll deductions o Employers may choose not to participate	• Sec. 8002 • Effective beginning Jan. 1, 2011	
• Must provide 1099 for all corporate service providers receiving more than $600 per year for services or property o Currently only applies to non-corporate service providers	• Sec. 9006 • Effective beginning Jan. 1, 2012	
• New employer reporting requirement to enforce individual mandate o Must report whether employees were offered coverage, length of waiting period, lowest cost option, actuarial value, etc. o Secretary has the authority to review for accuracy, particularly the amount of the large employer's share of the total allowed costs under the plan (presumably for purpose of determining whether the plan had an actuarial value of more or less than 60%)	• Sec. 1514; MA Sec. 10106(g) • Effective beginning Jan. 1, 2014	
• New employer W-2 reporting of the value of coverage provided by the employer	• Sec. 9002 • Effective taxable years beginning after Dec. 31, 2010	
• Plans must use government-developed uniform explanation of coverage documents	• Sec. 1001 (adds PHSA Sec. 2715); MA Sec. 10103(d) • Models to be developed within 1 year of DOE • Employers must begin notifying employees within 2 years of DOE	
• New employer notice requirements informing employees of the following: o Information about the state Exchanges o If plan's share of total allowed costs of benefits is less than 60% o Availability of a tax credit o Availability of free choice vouchers	• Sec. 1512; MA Sec. 10108 • Notice must be provided by March 1, 2013, or upon subsequent hire	

	Senate Bill (H.R. 3590) as passed by Senate on Dec. 31, 2009	Reconciliation Bill (H.R. 4872) as passed by Senate on March 25, 2010
• Group health plans will be required to provide the following transparency disclosures: o Claims payment policies and practices o Periodic financial disclosures; data on enrollment, disenrollment, the number of claims that are denied, and rating practices o Information on cost-sharing and payments with respect to any out-of-network coverage o Information on enrollee and participant rights under the bill o Other information required by the DOL/HHS • Information must be provided to HHS and the public	• MA Sec. 10101(c) (adds PHSA Sec. 2715A); see also PHSA Sec. 1311(e)(3) as added by MA • Effective plan year beginning 6 months after DOE	
• HHS must conduct a study of the group health plan markets to compare characteristics of employers, plan benefits, financial solvency, etc. and determine the extent to which insurance market reforms are likely to cause adverse selection in the large group market or encourage small and midsize employers to self-insure • HHS and DOL are to collect information on the following: o The extent to which self-insured group health plans can offer less costly coverage and, if so, whether lower costs are due to more efficient plan administration and lower overhead or to the denial of claims and the offering very limited benefit packages o Claim denial rates, plan benefit fluctuations (to evaluate the extent that plans scale back health benefits during economic downturns), and the impact of the limited recourse options on consumers o Any potential conflict of interest as it relates to the health care needs of self-insured enrollees and self-insured employer's financial contribution or profit margin, and the impact of such conflict on administration of the health plan The study may require collection of information from employers	• MA Sec. 10103(f) (adds PHSA Secs. 1253 and 1254) • Report due within 1 year of DOE	
• GAO must conduct a study of the incidence of benefit denials by group health plans o GAO shall consider samples of data concerning denials of coverage and the reasons for such denials, and will include data concerning denials that are subsequently approved • The study may require collection of information from employers	• MA Sec. 10107(adds PHSA Sec. 1562) • Report due within 1 year of DOE	

	Senate Bill (H.R. 3590) as passed by Senate on Dec. 31, 2009	Reconciliation Bill (H.R. 4872) as passed by Senate on March 25, 2010
Other Key Provisions		

• Medical liability reform
  ○ States will be eligible for grants to test alternatives to civil tort litigation that emphasize patient safety, disclosure of health care errors, and early resolution of disputes
  ○ Patients will be able to opt-out of these alternatives at any time Alternatives will be evaluated to determine their effectiveness
	• MA Sec. 10607
	• $5 million of appropriations are authorized beginning Oct. 1, 2010	

• Several provisions use COBRA rates as a proxy for "value of employer coverage" • Requires HHS to develop a methodology to measure health plan value	• E.g., Sec. 9001 (excise tax); 9002 (W-2 reporting); MA Sec. 10329 • Due within 18 months of DOE	
• Includes several provisions to develop a national quality improvement strategy including developing quality measures involving input from multiple stakeholders, reporting on quality measures under federal health programs, and implementing value-based purchasing in Medicare, and encouraging the development of new patient care models	• Title III, Subtitle A	

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Employee Benefits Alert

New Guidance Issued Under Health Care Reform Legislation

07.16.10

FEATURED IN THIS EDITION

- Agencies Issue Guidance on Required Coverage for Preventive Health Care without Cost-Sharing
- More Guidance: Agencies Issue Rules on Preexisting Condition Exclusions, Lifetime and Annual Limits, Recissions, and Patient Protections

Agencies Issue Guidance on Required Coverage for Preventive Health Care without Cost-Sharing

On July 14, the Departments of the Treasury ("Treasury"), Labor ("DOL") and Health and Human Services ("HHS") jointly issued an interim final rule (the "IFR") implementing the requirement under the Patient Protection and Affordable Care Act ("PPACA") that group health plans and health insurance issuers provide coverage for preventive health services without cost-sharing. This latest installment in the "initial wave" of agency guidance under the health care reform legislation was accompanied by a White House conference call on the evening of July 14, in which senior officials fielded a variety of questions about the new rules. The IFR is expected to be published in the Federal Register some time during the week of July 19.

The IFR implements section 2713 of the Public Health Service Act ("PHSA"), as enacted by PPACA, which requires group health plans and health insurance issuers offering individual and group health insurance coverage to, at a minimum, provide coverage -- without imposing any cost-sharing requirements -- for certain categories of "preventive health services." This requirement is generally effective with respect to the first plan year (policy year for individual health insurance policies) that begins on or after September 23, 2010, i.e., January 1, 2011 for calendar-year plans and policies. It does not apply to "grandfathered" plans, however. Please see our previous alert on grandfathered plans, in the July 8, 2010 Focus On Employee Benefits.

Scope of Covered Preventive Health Services

There are four categories of items and services that qualify as "preventive," for which coverage must be provided without cost-sharing, namely:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Service Task Force ("PSTF"). Examples include certain specified types of screenings for high blood pressure, cholesterol, colorectal cancer, and diabetes, as well as counseling for tobacco use, alcohol misuse, and obesity. The full list of these items is available at http://www.healthcare.gov/center/regulations/prevention/taskforce.html.

2. Routine immunizations for children, adolescents, and adults that are currently recommended for a specific individual by the Advisory Committee on Immunization Practices of the Centers for Disease

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Control and Prevention ("ACIP"). These immunizations are broken out into four schedules, based on a person's age, and can be found at http://www.healthcare.gov/center/regulations/prevention/recommendations.html.

3. Evidence-informed preventive care and screenings for infants, children, and adolescents provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"). These guidelines are published in two charts: (1) the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, available at http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf, and (2) the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, available at http://www.hrsa.gov/heritabledisorderscommittee/SACHDNC.pdf. The guidelines included in the second chart went into effect on May 21, 2010, and therefore, plans and issuers are not required to provide coverage without cost-sharing for the services described therein until the first plan year that begins on or after May 21, 2011 (see "Timing to Provide Coverage for Preventive Services" below).

4. Evidence-informed preventive care and screenings for women, provided for in comprehensive guidelines supported by HRSA (and not otherwise addressed in the PSTF's recommendations under #1, above). These guidelines are currently being developed, and HHS expects to issue them by August 1, 2011.

If a recommendation or guideline for a preventive health service in one of these four categories does not specify the frequency, method, treatment, or setting in which the item or service must be provided, the plan or insurer may use "reasonable medical management techniques" to apply any coverage limitations to that item or service. In addition, a plan or health insurance coverage may impose cost-sharing requirements with respect to any coverage provided for preventive health services not contained in one of the four categories described above.

Out-of-Network Preventive Health Services

One of the major open issues that had been surrounding these provisions since the enactment of PPACA was whether (and the extent to which) a plan or insurance coverage with a network of providers would need to cover preventive health services obtained from out-of-network providers. The IFR clarifies that a plan or insurer need not provide any coverage for such out-of-network items and services. If the plan or insurer does provide coverage for out-of-network preventive health services, it may impose cost-sharing requirements with respect to those services.

Cost-Sharing with respect to Office Visits and Treatment

The IFR provides helpful guidance regarding situations in which cost-sharing requirements -- including copayments, deductibles, and coinsurance -- may and may not be imposed for covered preventive health services provided during an office visit. The following three scenarios are described:

1. Where a covered preventive health service is billed separately -- e.g., lab work for a cholesterol screening conducted during an office visit, if the office visit is not, itself, for preventive health services and the lab work is billed separately -- the plan or insurer may impose cost-sharing requirements for the office visit (but not for the preventive health service).

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2. Where a covered preventive health service is not billed separately from an office visit, and the primary purpose for the office visit was to obtain the preventive health service, the plan or insurer may not impose cost-sharing requirements with respect to the office visit.

3. Where a covered preventive health service is not billed separately from an office visit, but the preventive health service was not "the primary purpose" for the office visit, then the plan or insurer may impose cost-sharing requirements with respect to the office visit (including the preventive health service).

In addition, the IFR provides an example that clarifies that a plan or insurer may impose cost-sharing requirements for any "treatment" that results from a preventive health service, such as a screening, provided that the treatment, itself, is not a covered preventive health service.

Timing to Provide Coverage for Preventive Health Services

The Federal government maintains updated lists and charts describing all of the applicable recommendations and guidelines that qualify as "preventive" health services, as well information regarding the date that each such item and service became effective, at http://www.healthcare.gov/center/regulations/prevention/recommendations.html.

Group health plans and health insurers must provide coverage, without imposing cost-sharing requirements, for each applicable item and service specified in these lists and charts, for plan years that begin on or after the later of (1) September 23, 2010, or (2) one year after the recommendation or guideline relating to the specific item or service becomes effective. For example, certain screenings for depression in adolescents have been PSTF-recommended preventive health services (with an A or B rating) since March 30, 2009, and therefore must be covered without cost-sharing for the first plan year beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar-year plans). Screenings and counseling for childhood obesity, on the other hand, have only been PSTF-recommended preventive health services (with an A or B rating) since January 31, 2010, and therefore do not need to be covered without cost-sharing until the first plan year beginning on or after January 31, 2011 (i.e., January 1, 2012 for calendar-year plans).

The IFR clarifies that a plan or insurer need not continue to provide coverage for any preventive health services that have been removed from the applicable lists and charts. Please note, however, that certain other legal requirements may apply if a plan or insurer drops or modifies coverage (or cost-sharing requirements) for a formerly-listed preventive health service. For example, such a coverage or cost-sharing modification may constitute a "material modification" under PHSA section 2715(d)(4), for which 60 days advance notice must be provided to enrollees.

Plans should visit the government's website provided above, at least once per year, to determine which additional preventive health services must be covered without cost-sharing for the following plan year, and which services are no longer required to be covered without cost-sharing. Insurers having policies with plan (policy) years starting at different times throughout the year may need to review the website on a more frequent basis.

More Guidance: Agencies Issue Rules on Preexisting Condition Exclusions, Lifetime and Annual Limits, Recissions, and Patient Protections

On June 28, 2010, the Departments of the Treasury, DOL and HHS (collectively "the agencies") published interim final regulations ("IFR") on several more provisions under PPACA, as amended by the

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Heath Care and Education Reconciliation Act of 2010 ("HCERA"). 75 Fed. Reg. 37188 (June 28, 2010). The new rules provide guidance on PPACA's amendments to the PHSA relating to preexisting condition exclusions, lifetime and annual limits, rescissions and other patient protections relating to choice of providers and emergency care.

The following provides a brief summary of the regulations.

PHSA section 2704 - Prohibition on Preexisting Condition Exclusions

PHSA section 2704 prohibits group health plans -- self-funded and fully-insured -- or health care policies (in the case of individual coverage) from imposing preexisting condition exclusions for plan or policy years beginning on or after January 1, 2014. Two exceptions apply: (1) For enrollees who are under 19 years of age, the prohibition on preexisting condition exclusions is effective for plan or policy years beginning on or after September 23, 2010, and (2) the prohibition does not apply to grandfathered individual policies. Grandfathered group health plans that are fully insured or self-funded must comply with this provision.

PHSA section 2704 amends the HIPAA rules relating to preexisting conditions, which generally define a preexisting condition exclusion as a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. Under the amended definition, a preexisting condition includes not just an exclusion of coverage for a specific benefit, but a complete exclusion from a group health plan or coverage (i.e., a denial of coverage), if the exclusion is based on a preexisting condition. Until 2014, when the provision is fully effective, the current HIPAA rules continue in force.

The IFR does not preclude a plan from excluding from coverage a particular benefit if the exclusion applies regardless of when the condition arose relative to the effective date of coverage.

PHSA section 2711 - Lifetime and Annual Limits

PHSA section 2711 generally prohibits a group health plan and health policy (in the case of individual coverage) from imposing lifetime or annual limits on the dollar value of "essential health benefits" for plan or policy years beginning on or after September 23, 2010, although "restricted annual limits" may be imposed for plan years beginning on or after January 1, 2014. The restriction on lifetime limits applies to all group health plans and health policies whether or not the plans or policies qualify as grandfathered. The restriction on annual limits applies to all group health plans, including grandfathered plans, and new or non-grandfathered individual health insurance policies. The restriction on annual limits does not apply to grandfathered individual health insurance policies, however.

The IFR addresses limits on the "dollar value" of benefits. The IFR does not address non-dollar utilization limits, so that pending further clarification, it appears that plans may still limit, for example, the number of visits a participant may make to a doctor's office, or generally other non-dollar utilization limits.

PPACA allows the Secretary to permit "restricted annual limits" on essential benefits prior to January 1, 2014. The IFR adopts a three-year phased in approach to restricted annual limits, under which annual limits on the dollar value of essential benefits may not be less than the following amounts:

- $750,000 for plan or policy years beginning on or after September 23, 2010, but before September 23, 2011;

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- $1.25 million for plan or policy years beginning on or after September 23, 2011, but before September 23, 2012;
- $2 million for plan or policy years beginning on or after September 23, 2012, but before September 23, 2014.

The restricted annual limits are minimums and plans are free to adopt higher annual limits or eliminate annual limits prior to January 1, 2014.

The regulations do not define "essential health benefits," but until further guidance is issued, an essential benefit includes the following benefits as listed in PPACA section 1302(b):

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

Until further guidance is released, the agencies will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefit."

Annual or lifetime limit restrictions do not apply to health FSAs, MSAs, HSAs or HRAs integrated with a group health plan that otherwise complies with the annual and lifetime limit prohibition. They also do not apply to retiree-only HRAs, though the status of stand-alone HRAs is unclear. The agencies are requesting comments on the application of section 2711 to stand-alone HRAs that are not retiree-only.

Certain benefit plans, including limited benefit plans such as mini-meds, can seek a waiver if compliance with the regulations will result in a significant decrease in access to benefits or a significant increase in premiums. HHS intends to issue future guidance regarding the scope and process for applying for a waiver.

Group health plans and issuers must notify individuals that have reached lifetime limits and are otherwise still eligible to participate in the group health plan or other coverage on the effective date of the regulations that the lifetime limit no longer applies.

PHSA Section 2712 - Prohibition on Rescission

PHSA section 2712 provides that a group health plan or health policy (in the case of individual coverage) cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. Where permissible, rescissions can only occur if the participant or group is given 30-days notice. These rules apply to all rescissions in the group health plan, whether insured or self-funded, and to coverage in the individual market.

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The regulations build on already-existing HIPAA protections regarding cancellations of coverage, which allow cancellations of coverage for specific enumerated reasons such as non-payment of premiums, fraud or intentional misrepresentation of material fact, or withdrawal of a product or withdrawal of an issuer from the market.

The regulations define "rescission" to mean retroactive cancellation, and not prospective cancellations, since other rules and guidance exists to address prospective cancellations. Moreover, the regulations only set a floor, and more protective State or local laws are not preempted. Cancellations with a retroactive effect for failure to pay premiums also do not fall within the definition of "rescission."

PHSA Section 2719(A) - Patient Protection of Provider Choice and Emergency Services

A. Choice of Health Care Professional.

PHSA section 2719(A) sets forth three new provisions relating to choice of professional health care provider that apply only to plans or health insurance coverage that has a network of providers. None of these provisions apply to grandfather plans.

Primary Care Provider: In the case of a plan or other arrangement that requires that a participant or policy holder choose a primary care physician, the covered person must be allowed to choose from any participating provider that is available to accept the participant, beneficiary, or enrollee.

Pediatrician: If the plan requires the designation of a primary care provider for a child, the plan or issuer must permit the designation of a physician (allopathic or osteopathic) who specializes in pediatrics if the provider is in the network and is available to accept the child. All other terms of the plan or policy apply including any exclusions with respect to pediatric coverage.

OB/GYN: If the plan provides coverage for obstetrical or gynecological care and requires the designation of a primary care provider, the plan or issuer cannot require preauthorization before a woman seeks services in this area from an in-network OB/GYN provider.

Notice Requirements: The plans or health insurance issuer must provide a notice informing the participant or enrollee of the terms of coverage complying with these regulations.

B. Emergency Services.

A group health plan -- insured or self-funded -- or health insurance coverage that provides benefits for services in the emergency department of a hospital must not require a covered individual to obtain prior authorization for emergency services, even if the emergency services are provided out of network. The plan or policy cannot impose cost-sharing or co-payment requirements for out of network services that exceed cost-sharing or co-payment requirements if the services had been provided in network, though the individual may be required to pay any balance remaining after the plan or policy has paid.

The IFR provides three methods for calculating payments for out of network providers. Plans must pay the greatest of:

- The negotiated in-network rate (if there is more than one negotiated rate for the service, the median of those amounts);

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- The amount calculated using the same method the plan generally uses for out of network services, such as usual, customary and reasonable amount, unreduced by any out-of-network cost sharing; or
- The amount payable under Medicare, excluding any in-network copayment or coinsurance.

Plans may impose cost-sharing other than copayments and coinsurance, such as deductible or out-of-pocket maximums that generally apply to out of network services.

An emergency service means a medical screening examination that is within the capability of a hospital emergency department, including ancillary services routinely available in hospital emergency departments to evaluate an emergency condition, and further examination and treatment necessary to stabilize the patient, as required under section 1867 of the Social Security Act. The definition of "emergency conditions" is based on the prudent man standard and the EMTALA provisions in section 1867(e)(1)(A) of the Social Security Act.

For more information, please contact:

Fred Oliphant, foliphant@milchev.com, 202-626-5834

Tess Ferrera, tferrera@milchev.com, 202-626-1470

Anthony Shelley, ashelley@milchev.com, 202-626-5924

Garrett Fenton, gfenton@milchev.com, 202-626-5562

Josephine Harriott, jharriott@milchev.com, 202-626-1496

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401(k) Fiduciary Suit, Top Hat Select Group, PPA Distributions, Supplemental Health, Fringe Benefits or Non-Employee Directors

03.24.08

FEATURED IN THIS EDITION

ERISA Litigation: 401(k) Plan Fiduciaries May Be Sued by Participants for Individual Losses

Alan Horowitz & Josephine Harriott

The U.S. Supreme Court, in a unanimous decision in *Larue v. Dewolff, Boberg & Assoc. Inc.* issued on February 20, 2008, found that ERISA allows participants in 401(k) and other defined contribution plans to sue plan fiduciaries to recover for losses to their individual accounts when the losses result from breaches of duties, responsibilities, or obligations. This decision is significant in recognizing the existence of an individual right to sue for monetary relief under ERISA § 502(a)(2) and in distinguishing between defined contribution and defined benefit plans for ERISA purposes.

Under the Dewolff 401(k) plan, participants could choose how their plan contributions would be invested. Mr. Larue alleged that during 2001 and 2002, he made certain elections that DeWolff failed to carry out, which resulted in a $150,000 depletion of his interest in the plan. He sued, claiming that DeWolff had breached its fiduciary duty and seeking relief under ERISA §§ 409(a) and 502(a)(2) for the $150,000 value his account lost. ERISA § 409(a) makes fiduciaries liable for losses to the plan caused by breach of fiduciary duty and requires the lost profits to be restored to the plan. ERISA § 502(a)(2) allows a plan participant to sue to recover benefits, enforce rights under the plan, or clarify rights to future benefits.

In 1985, the Supreme Court had held that ERISA does not authorize a participant in a defined benefit ERISA disability plan to sue for individual damages caused by a delay in processing her claim when the fiduciary breach did not harm the plan itself. See *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 132 (1985). That decision was understood by many, including the Fourth Circuit in Larue, to foreclose a participant's ability to sue for individual damages under ERISA. In ruling that a fiduciary breach that injures the individual accounts that distinguish a defined contribution plan is actionable under ERISA § 502(a)(2), even if the breach does not threaten the solvency of the entire plan, the Court in Larue shows that participants can sue for monetary relief in certain circumstances.

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Exec Comp: Deferred Compensation Plan with 15% Participation Is Not a Select Group Under a Top Hat Plan

Gary Quintiere & Veronica Rouse

Plan sponsors should carefully review the participants of any deferred compensation plan that is intended to serve as a "top hat" plan, as the Sixth Circuit is taking a stricter view of these plans. Generally, a "top hat" plan is characterized as one in which participants are able to direct or control negotiations with the employer regarding the design and operation of the deferred compensation plan such that the substantive rights and protections of ERISA are not necessary.

Earlier this year, a district court in the Sixth Circuit ruled that regardless of the fact that certain plan participants generated a threshold of gross commissions totaling $275,000 in order to be eligible for the plan, the plan was not a "top hat" plan because the percentage of the total workforce invited to join the plan was 30% even though the actual participation in the plan was around 15%. (*Daft v. Advest, Inc.,* No. 5:06 Civ. 1876 (N.D. Ohio January 18, 2008)). Although the court acknowledged there was no bright line test, it is obvious that percentages considered low in practice may not seem so in litigation.

Further, this case signals that the "select group" test used by the court may be more heavily considered than the "highly compensated" or "management" designations placed on most "top hat" participants. Although these employees made $275,000 or more in commissions, the court accused Advest of not providing enough information to convince the court that the plan participants' base compensation was not relatively low. The court rendered its ruling based on the possibility that these participants would not be considered highly compensated and probably not considered management. Ultimately, during the court's deliberations, the "bargaining power" element of a "top hat" plan took a back seat to the "select group" test requirements.

Including participants who do not have the ability to influence the design and operation of their deferred compensation plan may jeopardize the plan's characterization as a "top hat" plan. In a Sixth Circuit Court ruling last year that reversed a district court, the plan at issuailed to withstand scrutiny under the four-prong "select group" test (Bakri v. Venture Mfg. Co., 473 F.3d 677 (6th Cir. 2007)). That test requires a deferred compensation plan to consider the following:

1. The percentage of the total workforce invited to join the plan;

2. The nature of the participants' employment duties;

3. The compensation disparity between the "top hat" plan members and nonmembers; and

4. The plan language.

Thus, the Sixth Circuit makes it clear: you cannot buoy base compensation with bonuses or commissions to create a top hat plan, and you must evaluate the percentage of the workforce eligible to join the plan -- not just the actual percentage of participants in the plan.

There are only a small number of decided "top hat" cases on record, but this may be a growing area of litigation. A lack of definitive guidance in this area as to how much workforce coverage is too much and which factors are the most important makes cases such as these even more noteworthy.

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Qualified Plans: IRS Provides Guidance on Distribution-Related Provisions of Pension Protection Act

Fred Oliphant & Veronica Rouse

The IRS recently released Notice 2008-30, in which it addressed a number of distribution-related provisions of Pension Protection Act of 2006 (PPA 2006) that are effective in 2008. The following are a few of the highlights from the Notice:

Rules Governing Rollovers to Roth IRAs

PPA 2006 amended the definition of a qualified rollover contribution to a Roth IRA under Code Section 408A to include (i) rollovers from qualified plan distributions via a trustee-to-trustee transfer or a rollover within 60 days of distribution and (ii) rollovers from annuity plans and governmental plans, provided the participant meets certain income limitations. The Notice clarifies that qualified rollover contributions from an eligible retirement plan other than a Roth IRA are exempt from additional tax under Section 72(t) unless the amounts are distributed from the Roth IRA within five years. The Notice also clarifies that plans must permit a participant to elect a direct rollover to a Roth IRA unless the transaction qualifies for the exceptions for small amounts and multiple distributions under Treas. Reg. § 1.401(a)(31)-1. The Notice further provides that plan administrators do not need to certify the eligibility of the rollover to a Roth IRA and ineligible rollover amounts may be recharacterized pursuant to Section 408(A)(d)(6). The Notice also discusses the withholding requirements that apply to an eligible rollover distribution to a Roth IRA, and rollovers by non-spouse beneficiaries.

Complying with the New Qualified Optional Survivor Annuity Requirement

PPA 2006 amended Section 417 to require plans subject to Section 401(a)(11) to offer participants a specified optional form of benefit as an alternative to the Qualified Joint and Survivor Annuity (QJSA). The optional form of benefit is the Qualified Optional Survivor Annuity (QOSA), which is an annuity for the life of a participant with a survivor annuity for the life of the participant's spouse that is equato a specified applicable percentage of the amount of the annuity that is payable during the joint lives of the participant and the spouse and that is the actuarial equivalent of a single life annuity for the life of the participant. The specified applicable percentage of spousal coverage for a QOSA depends on the level of spousal coverage under the QJSA. If the QJSA spousal coverage is less than 75%, then the QOSA percentage must be 75%, and if the QJSA spousal coverage is equal to, or greater than, 75%, the QOSA percentage is 50%.

The Notice provides that if the plan is already providing an option that meets the QOSA requirements, the plan does not need to be amended to designate such an option as a QOSA nor does the administration of the plan need to be amended to designate the optional form as a QOSA. The Notice also describes how to satisfy the requirement of a written explanation of the terms and conditions of a QOSA by following Treas. Reg. § 1.417(a)(3)-1.

The Notice clarifies that under Section 417, a participant who waives the QJSA may elect the QOSA during the applicable election period, and spousal consent is not required to elect the QOSA as a form of distribution pursuant to Treas. Reg. § 1.401(a)-20, Q&A-16, unless the QOSA is not at least actuarially equivalent to the QJSA. In regards to pre-retirement survivor annuities, the Notice indicates that a plan

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offering a pre-retirement survivor annuity does not also have to offer a pre-retirement annuity based on a QOSA.

Transition to New Applicable Mortality Table and Applicable Interest Rate

Section 417(e)(3), which provides rules for the determination of the present value of benefits for purposes of Section 417(e)requires that the present value not be less than the present value calculated using the applicable mortality table and the applicable interest rate as defined under Section 417(e)(3)(B) and (C). For plan years beginning on or after January 1, 2008, there are new requirements for the applicable interest rate and applicable mortality table (PPA factors), which replace those previously applicable (GATT factors). (See Rev. Rul. 2007-67 for additional guidance regarding this change.) Many plan sponsors have been interested in cushioning the transition to PPA factors by providing participants with the better of the two sets of factors for a limited period. There have been outstanding issues with such approach, though, which the Notice now addresses.

The Notice clarifies that for a limited period (generally through the 2009 plan year) a plan will not fail to satisfy the requirement that a QJSA for a married participant be at least as valuable as any other form of benefit payable under the plan at the same time merely because the amount payable under an option subject to Section 417(e)(3) is based on the PPA factors or the GATT factors, whichever is more favorable. The Notice also provides that the Section 411(d)(6) cutback relief in PPA Section 1107 will apply to such provisions, but indicates that such cutback relief only applies to the first amendment which implements the PPA factors (disregarding amendments adopted on or before June 30, 2008).

Complying with the Requirement of Distributing Gap-Period Earnings

The Notice clarifies that plans submitted during Cycles B and C of the determination letter review process are required to provide for the inclusion of gap-period earnings when distributing excess deferrals. (See Rev. Proc. 2007-44 for more information.) Furthermore, interim plan amendments are not required to be adopted until the last day of the first plan year beginning on or after January 1, 2009. Although the interim plan amendment requirement has been delayed, plans are required to include gap-period earnings in the distribution of excess deferrals attributable to tax years beginning on or after January 1, 2007.

Health & Welfare: Treasury Department Issues Guidance on Supplemental Health Insurance

Susan Relland & Patricia Szoeke

The Treasury Department recently issued Notice 2008-23 providing guidance on when supplemental health insurance would be treated as an excepted benefit under HIPAA (and therefore not subject to HIPAA's portability and nondiscrimination rules). HIPAA imposes rules regarding limitations on preexisting condition exclusions, issuance of certificates of creditable coverage, special enrollment rights, and discrimination on the basis of any health factor. These provisions, however, do not apply to certain excepted benefits, one category of which is supplemental excepted benefits.

Notice 2008-23 provides a safe harbor under which supplemental health insurance coverage that meets the following criteria will qualify as an excepted benefit under HIPAA:

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- The coverage is provided through a policy, certificate, or contract of insurance separate from the primary coverage under the plan;
- The supplemental policy, certificate, or contract of insurance was issued by an entity that does not provide the primary coverage under the plan (for this purpose, entities that are part of the same controlled group of corporation or under common control, within the meaning of Code Section 52(a) or (b) are considered a single entity);
- The supplemental policy, certificate, or contract of insurance is specifically designed to fill gaps in primary coverage (e.g., coinsurance, deductibles) but does not include a policy, certificate, or contract of insurance that becomes secondary or supplemental only under a coordination-of-benefits provision;
- The cost of coverage under the supplemental policy, certificate, or contract of insurance may not exceed 15% of the cost of primary coverage (with cost being determined in the same manner as the applicable premium is calculated under a COBRA continuation provision); and
- The supplemental policy, certificate, or contract of insurance that is group health insurance coverage is not different among individuals in eligibility, benefits, or premiums based on any factor of an individual (or any dependent of the individual).

Supplemental health insurance coverage not meeting these criteria is subject to further examination as to whether it qualifies as "similar supplemental coverage to coverage under a group health plan" and therefore subject to the portability and nondiscrimination requirements. As the Departments of Treasury, Labor, and Health and Human Services have joint jurisdiction over HIPAA, all three agencies are developing similar notices (see DOL Field Assistance Bulletin 2007-4) and expect this safe harbor to be incorporated as a requirement (as opposed to a safe harbor) in a future proposed rulemaking.

Payroll Tax & Fringe Benefits

Fred Oliphant & Patricia Szoeke

Code Section 132 provides the framework for the tax treatment of some of the most common types of fringe benefits provided by employers. However, whether non-employee directors are eligible to receive such benefits on a non-taxable basis depends on the type of fringe benefit being provided.

Generally, the most common type of fringe benefits employers provide on a non-taxable basis are no-additional-cost services, qualified employee discounts, working condition fringes, and de minimis fringes. Section 132 provides that these fringe benefits may be provided on a non-taxable basis only to "employees" of the employer. However, the definition of "employee" in the fringe benefit regulations differs in the scope of its coverage, depending on the type of fringe benefit.

Under one definition of "employee," non-employee directors are not eligible to receive a no-additional-cost service or a qualified employee discount on a non-taxable basis. See Treas. Reg. § 1.132-1(b)(1). However, applying a different definition of "employee," the regulations provide that an employer may provide a working condition fringe or a de minimis fringe to a non-employee director on a non-taxable basis. See Treas. Reg. § 1.132-1(b)(2) and (4).

For further information, please contact any of the following lawyers:

Alan Horowitz, ahorowitz@milchev.com, 202-626-5839

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Health Reform Teleconference Part VI

April 1, 2010

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Agenda

- New coverage options and individual mandate
- Employer fees
- Group health plan mandates
- Other provisions impacting plan design
- Revenue provisions
- Administrative requirements

- Questions: EB@milchev.com

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New Coverage Options

- States must establish Exchanges to offer private insurance choices by Jan. 1, 2014
  - Individuals who are offered employer-sponsored coverage may opt out and enroll in an Exchange
  - States may allow large employers (100+ employees) to purchase coverage through the Exchanges beginning Jan. 1, 2017
- Loans and grants are available to establish non-profit, member-run health insurance co-ops
- A public option was not included

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Individual Mandate

- Must obtain acceptable coverage beginning Jan. 1, 2014, or pay annual excise tax
  - Penalty is greater of $95 in 2014 (phased up to $695 in 2016) or 2.5% of income, up to cap of the national average bronze plan premium
  - Penalties are 50% for children up to a cap of $2,085 per family
  - Amount are indexed to CPI
- Any employer-sponsored group health plan coverage will satisfy the individual mandate – no minimum coverage requirements

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Employer Fees

- No strict mandate to provide coverage, but free rider penalties beginning in 2014
  - If no coverage offered, and at least one full-time employee (30+ hours per week) receives a tax credit to buy insurance through an Exchange, penalty is $2,000 X total number of full-time employees (after subtracting first 30 employees)
  - If coverage offered, but ***either*** the actuarial value is less than 60% or any employee's required premium is greater than 9.5% of income (thus entitling the employee with family income of <400% FPL to a tax credit), penalty is *lesser of:*
    - $2,000 X total number of full-time employees, or
    - $3,000 X number of employees receiving the tax credit
  - No exclusion for seasonal workers

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Employer Fees (cont'd)

- Free choice vouchers
  - An employer that provides and contributes to health coverage for employees must provide free choice vouchers to each employee who:
    - Is required to contribute between 8% and 9.8% (9.5%?) of employee's family income toward the cost of coverage (indexed to rate of premium growth),
    - Employee's family income is <400% FPL, and
    - Employee does not enroll in a health plan sponsored by the employer
  - Employees may use vouchers to purchase coverage through an Exchange (and may keep any extra)

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Employer Fees (cont'd)

- Free choice vouchers (cont'd)
  - Amount of the voucher is equal to the amount the employer would have provided toward such employee's coverage (individual vs. family based on the coverage the employee elects through the Exchange) with respect to the plan to which the employer pays the largest portion of the cost
  - Amounts are excluded from the employee's income and the employer receives a tax deduction
  - No free rider penalties are imposed for employees who receive vouchers
  - Appears to apply to full and part-time employees
  - Employers have many open questions about vouchers

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Employer Fees (cont'd)

- Comparative effectiveness research fee - employer must pay:
  - $1 per plan participant for the first plan year ending after Sept. 30, 2012
  - $2 per participant for the following year
  - Indexed to the cost of "national health expenditures" through 2019
  - Fee sunsets after 2019

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Group Health Plan Mandates

- Prohibits waiting periods greater than 90 days
  - Effective plan years beginning on or after Jan. 1, 2014
  - No grandfather
- Must cover adult children (unmarried or married) to age 26 (benefit is excluded from employee's income)
  - All plans must comply beginning in 2014
  - Prior to 2014, grandfather applies but must cover adult children who are not eligible for other employer-sponsored coverage

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Group Health Plan Mandates (cont'd)

- Prohibits lifetime limits on benefits
  - Effective plan years beginning after Sept. 23, 2010
  - No grandfather
- Restricts annual limits on benefits
  - Prohibits annual limits for all plans for plan years beginning on or after Jan. 1, 2014
  - Restrictions on annual limits (to be established by regulations) effective for earlier plan years
  - No grandfather

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Group Health Plan Mandates (cont'd)

- Limits cost-sharing to the HSA-qualified high deductible health plan out-of-pocket maximums
  - Effective plan years beginning on or after Jan. 1, 2014
  - Grandfather applies
- Imposes deductible limits of $2,000 for individual coverage and $4,000 for family coverage
  - May be increased by maximum health FSA contributions
  - Effective plan years beginning on or after Jan. 1, 2014
  - Grandfather applies

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Group Health Plan Mandates (cont'd)

- Prohibits plans from limiting coverage for preexisting conditions
  - Effective for all plans beginning Jan. 1, 2014
  - For children under age 19, effective for plan years beginning after Sept. 23, 2010
  - No grandfather
- Requires plans to cover preventive care services recommended by U.S. Preventive Service Task Force without any cost sharing (e.g., copays, deductibles)
  - Effective for plan years beginning after Sept. 23, 2010
  - Grandfather applies

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Group Health Plan Mandates (cont'd)

- Must cover clinical trials for life-threatening diseases (subject to the plan's normal restrictions on benefits and out-of-network providers)
  - Effective for plan years beginning after Sept. 23, 2010
  - Grandfather applies
- Must comply with new internal and external appeals standards to be established by regulations
  - Effective for plan years beginning after Sept. 23, 2010
  - Grandfather applies

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Group Health Plan Mandates (cont'd)

- Prohibits rescission of group health plan coverage without prior notice
  - Effective for plan years beginning after Sept. 23, 2010
  - No grandfather
- Grandfather for coverage mandates available for individuals enrolled in the plan on March 23, 2010, subsequently enrolled family members, and new hires
  - Collectively bargained plans are grandfathered until the date on which the last agreement relating to the grandfathered coverage terminates
  - Unclear what causes grandfather for other plans to end

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Other Provisions Impacting Plan Design

- Health FSA contributions are capped at $2,500, indexed to CPI
  - Effective taxable years beginning after Dec. 31, 2012
- Prohibits pre-tax reimbursement of non-prescribed over-the-counter drugs from FSAs, HRAs, HSAs
  - Effective Jan. 1, 2011
- Codifies HIPAA wellness rules and increases 20% incentive cap to 30% with Secretary discretion to increase to 50%
  - Effective plan years beginning on or after Jan. 1, 2014

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Other Provisions Impacting Plan Design (cont'd)

- Temporary reinsurance program for employers providing coverage to retirees over age 55 who are not eligible for Medicare
  - Reimburses employers for 80% of claims between $15,000 and $90,000 (indexed for inflation)
  - Effective within 90 days of date of enactment
  - Ends on Jan. 1, 2014
- Eliminates the employer's deduction for the amount of the Medicare Part D retiree drug subsidy
  - Effective Jan. 1, 2013
  - Immediate FAS 106 accounting impact

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Other Provisions Impacting Plan Design (cont'd)

- Code Section 105(h) nondiscrimination rules that apply to self-funded group health plans will apply to insured plans as well
  - Most likely to impact executive health plans
  - Effective plan years beginning after Sept. 23, 2010
  - Grandfather applies

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Revenue Provisions

- Excise tax on high cost plans
  - Beginning Jan. 1, 2018, 40% non-deductible excise tax imposed on insurer or TPA if the aggregate value of employer-sponsored health coverage exceeds a threshold amount:
    - Generally: $10,200 (individual coverage) / $27,500 (family coverage)
    - Retirees over age 55 and individuals in high-risk professions: $11,850 (individual coverage) / $30,950 (family coverage)
    - Adjustments to thresholds are available for plans that have higher-than-average costs due to age or gender of their workers

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Revenue Provisions (cont'd)

- Excise tax on high cost plans (cont'd)
  - Adjustments to thresholds
    - If health costs increase more than expected between now and 2018, thresholds will be automatically increased
    - Thresholds are indexed to CPI-U + 1% in 2019 and to CPI-U thereafter
    - No transitional adjustment will be made for high-cost states

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Revenue Provisions (cont'd)

- Excise tax on high cost plans (cont'd)
  - Coverage subject to excise tax
    - Includes employee/employer, pre-tax/after-tax contributions
    - Includes contributions to medical, health FSAs, HRAs, HSAs, and on-site clinics/ wellness plans that are ERISA plans
    - Does not include dental, vision, accident, disability, long-term care, and after-tax indemnity or specified disease coverage

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Revenue Provisions (cont'd)

- Excise tax on high cost plans (cont'd)
  - Cost of coverage
    - The value of the coverage is the COBRA premium
    - The value of coverage for pre-65 and post-65 retirees may be combined at the employer's discretion
    - Expect new Treasury guidance on how to calculate COBRA premiums

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Revenue Provisions (cont'd)

- Code section 162(m) executive compensation deduction cap reduced to $500,000 for health insurance industry
  - Applies to *current* compensation paid during taxable years beginning after Dec. 31, 2012
  - Applies to *deferred* compensation for services performed in taxable years beginning after Dec. 31, 2009
- Annual health industry fees based on market share
  - Applies to health insurance premiums (not TPA fees)
  - Fees are $8 billion in 2014, phased up to $14.3 in 2018
- Increases excise tax for non-qualified HSA withdrawals from 10% to 20% for distributions after Dec. 31, 2010

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Revenue Provisions (cont'd)

- Medicare taxes
  - Additional 0.9% Medicare tax for employees (not employers) on wages over $200,000 ($250,000 for joint filers) – total of 2.35%
  - New 3.8% tax on unearned income (e.g., from interest, dividends, annuities, royalties, and rents) with respect to those with income over $200,000 ($250,000 for joint filers)
  - Effective Jan. 1, 2013

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Administrative Requirements

- Automatic enrollment
  - Employers must automatically enroll all eligible individuals in employer-sponsored medical coverage
    - Employer must provide adequate notice and opportunity to opt out
    - Effective date unclear
  - Employers are expected to automatically enroll employees in, and facilitate payroll deductions for, new government-run voluntary long-term care program
    - Employers may choose not to participate
    - Program takes effect Jan. 1, 2011

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Administrative Requirements (cont'd)

- Reporting requirements
  - Must report value of employer-provided health insurance coverage on Form W-2
    - Effective Jan. 1, 2011
  - Must provide Form 1099 for all corporate service providers receiving more than $600 per year for services or property
    - Currently limited to non-corporate service providers
    - Effective Jan. 1, 2012

Administrative Requirements (cont'd)

- Reporting requirements (cont'd)
  - Individual mandate requires self-insured employers to report coverage information to IRS and to covered individuals
    - Effective Jan. 1, 2014
  - Excise tax on high cost plans requires employers to calculate and report amount subject to excise tax allocable to insurers/plan administrators (subject to underreporting penalty equal to tax not paid, plus interest)
    - Effective Jan. 1, 2018

Administrative Requirements (cont'd)

- Notice and disclosure requirements
  - Must make transparency disclosures to HHS and the public for plan years beginning after Sept. 23, 2010
  - Must use government-developed uniform explanation of coverage documents by Sept. 2012
  - Must inform employees of the following (by March 31, 2013 or upon subsequent new hire):
    - Information about state Exchanges
    - If a plan's share of total allowed costs of benefits is less than 60%
    - Availability of a premium assistance tax credit
    - Availability of free choice vouchers

Next Steps – Congressional and Regulatory

- Likely to be a technical corrections bill
- Agencies are required to issue a significant amount of guidance over the next several years
  - Are expected to answer many open questions for employer plan sponsors
  - Recent agency guidance for GINA and mental health parity has not been favorable for employers
  - Employers should consider actively participating in regulatory process
- Note about proposed DOL guidance defining what constitutes an ERISA group health plan

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Next Steps – Initial Compliance and Planning

- Now:
  - Account for changes to Medicare retiree drug subsidy
  - Take advantage of reinsurance program for early retiree costs
- For plan year beginning after Sept. 23, 2010:
  - Determine which plans qualify for the grandfather
  - Revise plan design for coverage mandates that are not grandfathered and amend plan documents
  - Amend plan documents to prohibit reimbursement of non-prescribed over-the-counter drugs

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Next Steps – Initial Compliance and Planning (cont'd)

- For plan year beginning after Sept. 23, 2010 (cont'd):
  - Revise internal and external appeals processes in accordance with guidance to be issued
  - Watch for guidance to prepare for:
    - Transparency disclosures
    - Automatic enrollment requirements
    - 2011 W-2 reporting
- Begin considering long-term strategy for plan sponsorship

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Questions?

For more information, please contact either of the following:

Fred Oliphant	(202) 626-5834	foliphant@milchev.com
Susan Relland	(202) 626-1486	srelland@milchev.com

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SECURITIES AND EXCHANGE COMMISSION

17 CFR Parts 230 and 270

[Release Nos. 33-9126; 34-62300; IC-29301; File No. S7-12-10]

RIN 3235-AK50

INVESTMENT COMPANY ADVERTISING: TARGET DATE RETIREMENT FUND NAMES AND MARKETING

AGENCY: Securities and Exchange Commission.

ACTION: Proposed rule.

SUMMARY: The Securities and Exchange Commission is proposing amendments to rule 482 under the Securities Act of 1933 and rule 34b-1 under the Investment Company Act of 1940 that, if adopted, would require a target date retirement fund that includes the target date in its name to disclose the fund's asset allocation at the target date immediately adjacent to the first use of the fund's name in marketing materials. The Commission is also proposing amendments to rule 482 and rule 34b-1 that, if adopted, would require marketing materials for target date retirement funds to include a table, chart, or graph depicting the fund's asset allocation over time, together with a statement that would highlight the fund's final asset allocation. In addition, the Commission is proposing to amend rule 482 and rule 34b-1 to require a statement in marketing materials to the effect that a target date retirement fund should not be selected based solely on age or retirement date, is not a guaranteed investment, and the stated asset allocations may be subject to change. Finally, the Commission is proposing amendments to rule 156 under the Securities Act that, if adopted, would provide additional guidance regarding statements in marketing materials for target date retirement funds and other investment companies that could be misleading. The amendments are intended to provide enhanced

information to investors concerning target date retirement funds and reduce the potential for investors to be confused or misled regarding these and other investment companies.

DATES: Comments should be received on or before August 23, 2010.

ADDRESSES: Comments may be submitted by any of the following methods:

Electronic comments:

- Use the Commission's Internet comment form (http://www.sec.gov/rules/proposed.shtml);
- Send an e-mail to rule-comments@sec.gov. Please include File Number S7-12-10 on the subject line; or
- Use the Federal eRulemaking Portal (http://www.regulations.gov). Follow the instructions for submitting comments.

Paper comments:

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE, Washington, DC 20549-1090.

All submissions should refer to File Number S7-12-10. This file number should be included on the subject line if e-mail is used. To help us process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (http://www.sec.gov/rules/proposed.shtml). Comments are also available for Web site viewing and copying in the Commission's Public Reference Room, 100 F Street, NE, Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. All comments received will be posted without change; we do not edit personal

Commission is proposing amendments to rule 34b-1 pursuant to authority set forth in Sections 34(b) and 38(a) of the Investment Company Act [15 U.S.C. 80a-33(b) and 80a-37(a)].

List of Subjects

17 CFR Part 230

Advertising, Investment companies, Reporting and recordkeeping requirements, Securities.

17 CFR Part 270

Investment companies, Reporting and recordkeeping requirements, Securities.

TEXT OF PROPOSED RULE AMENDMENTS

For the reasons set out in the preamble, the Commission proposes to amend Title 17, Chapter II, of the Code of Federal Regulations as follows.

PART 230 – GENERAL RULES AND REGULATIONS, SECURITIES ACT OF 1933

1. The authority citation for Part 230 continues to read in part as follows:

Authority: 15 U.S.C. 77b, 77c, 77d, 77f, 77g, 77h, 77j, 77r, 77s, 77z-3, 77sss, 78c, 78d, 78j, 78l, 78m, 78n, 78o, 78t, 78w, 78ll(d), 78mm, 80a–8, 80a–24, 80a–28, 80a–29, 80a–30, and 80a–37, unless otherwise noted.

* * * * *

2. Section 230.156 is amended by adding paragraph (b)(4) to read as follows:

§ 230.156 Investment company sales literature.

* * * * *

(b) * * *

(4) A statement suggesting that securities of an investment company are an appropriate investment could be misleading because of:

(i) The emphasis it places on a single factor (such as an investor's age or tax bracket) as the basis for determining that the investment is appropriate; or

(ii) Representations, whether express or implied, that investing in the securities is a simple investment plan or requires little or no monitoring by the investor.

* * * * *

3. Section 230.482 is amended by:

a. Redesignating paragraphs (b)(5) and (b)(6) as paragraphs (b)(6) and (b)(7);

b. Adding new paragraph (b)(5);

c. In newly redesignated paragraph (b)(6), revising the first and second references "paragraphs (b)(1) through (b)(4)" to read "paragraphs (b)(1) through (b)(4) and paragraph (b)(5)(ii)";

d. In newly redesignated paragraph (b)(6), revising the third reference "paragraphs (b)(1) through (b)(4)" to read "paragraphs (b)(1) through (b)(4) and paragraphs (b)(5)(ii) and (v)"; and

e. Revising the phrase "NASD Regulation, Inc." in the note to paragraph (h) to read "Financial Industry Regulatory Authority, Inc."

The addition reads as follows:

§ 230.482 Advertising by an investment company as satisfying requirements of Section 10.

* * * * *

(b) * * *

(5) Target date funds.

(i) Definitions. For purposes of this section:

(A) Target Date Fund means an investment company that has an investment objective or strategy of providing varying degrees of long-term appreciation and capital preservation through a mix of equity and fixed income exposures that changes over time based on an investor's age, target retirement date, or life expectancy.

(B) Target Date means any date, including a year, that is used in the name of a Target Date Fund or, if no date is used in the name of a Target Date Fund, the date described in the fund's prospectus as the approximate date that an investor is expected to retire or cease purchasing shares of the fund.

(C) Landing Point means the first date, including a year, at which the asset allocation of a Target Date Fund reaches its final asset allocation among types of investments.

(ii) An advertisement that places a more than insubstantial focus on one or more Target Date Funds must include a statement that:

(A) Advises an investor to consider, in addition to age or retirement date, other factors, including the investor's risk tolerance, personal circumstances, and complete financial situation;

(B) Advises an investor that an investment in the Target Date Fund(s) is not guaranteed and that it is possible to lose money by investing in the Target Date Fund(s), including at and after the Target Date; and

(C) Unless disclosed pursuant to paragraph (b)(5)(iv)(C) of this section, advises an investor whether, and the extent to which, the intended percentage allocations

of the Target Date Fund(s) among types of investments may be modified without a shareholder vote.

(iii) An advertisement that places a more than insubstantial focus on one or more Target Date Funds, and that uses the name of a Target Date Fund that includes a date, including a year, must disclose the percentage allocations of the Target Date Fund among types of investments (e.g., equity securities, fixed income securities, and cash and cash equivalents) as follows: (1) an advertisement that is submitted for publication or use prior to the date that is included in the name must disclose the Target Date Fund's intended asset allocation at the date that is included in the name and must clearly indicate that the percentage allocations are as of the date in the name; and (2) an advertisement that is submitted for publication or use on or after the date that is included in the name must disclose the Target Date Fund's actual asset allocation as of the most recent calendar quarter ended prior to the submission of the advertisement for publication or use and must clearly indicate that the percentage allocations are as of that date. This information must appear immediately adjacent to (or, in a radio or television advertisement, immediately following) the first use of the Target Date Fund's name in the advertisement and must be presented in a manner reasonably calculated to draw investor attention to the information.

(iv) A print advertisement or an advertisement delivered through an electronic medium that places a more than insubstantial focus on one or more Target Date Funds must include a prominent table, chart, or graph clearly depicting the percentage allocations of the Target Date Fund(s) among types of investments (e.g., equity securities, fixed income securities, and cash and cash equivalents) over the entire life of the Target

Date Fund(s) at identified periodic intervals that are no longer than five years in duration and at the inception of the Target Date Fund(s), the Target Date, the Landing Point, and, in the case of an advertisement that relates to a single Target Date Fund, as of the most recent calendar quarter ended prior to the submission of the advertisement for publication. If the advertisement relates to a single Target Date Fund, the table, chart, or graph must clearly depict the actual percentage allocations among types of investments from the inception of the Target Date Fund through the most recent calendar quarter ended prior to the submission of the advertisement for publication, clearly depict the future intended percentage allocations among types of investments, and identify the periodic intervals and other required points using specific dates (which may include years, such as 2015 or 2020). If the advertisement relates to multiple Target Date Funds with different Target Dates that all have the same pattern of asset allocations, the advertisement may include separate presentations for each Target Date Fund that meet the requirements of the preceding sentence or may include a single table, chart, or graph that clearly depicts the intended percentage allocations of the Target Date Funds among types of investments and identifies the periodic intervals and other required points using numbers of years before and after the Target Date. If the advertisement (1) relates to a single Target Date Fund and is submitted for publication prior to the Landing Point; or (2) relates to multiple Target Date Funds with different Target Dates that all have the same pattern of asset allocations, the table, chart, or graph must be immediately preceded by a statement explaining the table, chart, or graph that includes the following information:

(A) The asset allocation changes over time;

(B) The Landing Point (or in the case of a table, chart, or graph for multiple Target Date Funds, the number of years after the Target Date at which the Landing Point will be reached); an explanation that the asset allocation becomes fixed at the Landing Point; and the intended percentage allocations among types of investments (e.g., equity securities, fixed income securities, and cash and cash equivalents) at the Landing Point; and

(C) Whether, and the extent to which, the intended percentage allocations among types of investments may be modified without a shareholder vote.

(v) A radio or television advertisement that is submitted for use prior to the Landing Point and that places a more than insubstantial focus on one or more Target Date Funds, and that uses the name of a Target Date Fund that includes a date (including a year), must include a statement that includes the Landing Point, an explanation that the asset allocation becomes fixed at the Landing Point, and the intended percentage allocations of the fund among types of investments (e.g., equity securities, fixed income securities, and cash and cash equivalents) at the Landing Point.

* * * * *

PART 270 - RULES AND REGULATIONS, INVESTMENT COMPANY ACT OF 1940

4. The authority citation for Part 270 continues to read in part as follows:

Authority: 15 U.S.C. 80a-1 et seq., 80a-34(d), 80a-37, and 80a-39, unless otherwise noted.

* * * * *

5. Section 270.34b-1 is amended by:

a. Removing the language "paragraphs (a) and (b) of" in the introductory text and the note to introductory text;

b. Revising the references "paragraph (b)(5) of § 230.482 of this chapter" in paragraph (a) and paragraph (b)(1)(i) to read "paragraph (b)(6) of § 230.482 of this chapter";

c. Revising the heading to the note following paragraph (b) to read "Note to paragraph (b)"; and

d. Adding paragraph (c) at the end thereof.

The addition reads as follows:

§ 270.34b-1 Sales literature deemed to be misleading.

* * * * *

(c) Sales literature that places a more than insubstantial focus on one or more Target Date Funds (as defined in paragraph (b)(5)(i)(A) of § 230.482 of this chapter) must contain the information required by paragraphs (b)(5)(ii), (iii), and (iv) of § 230.482 of this chapter, presented in the manner required by those paragraphs and by paragraph (b)(6) of § 230.482 of this chapter.

By the Commission.

Elizabeth M. Murphy
Secretary

Dated: June 16, 2010

SUPREME COURT OF THE UNITED STATES

No. 07–636

KARI E. KENNEDY, EXECUTRIX OF THE ESTATE OF WILLIAM PATRICK KENNEDY, DECEASED, PETITIONER *v.* PLAN ADMINISTRATOR FOR DUPONT SAVINGS AND INVESTMENT PLAN ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

[January 26, 2009]

JUSTICE SOUTER delivered the opinion of the Court.

The Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, 29 U. S. C. §1001 *et seq.*, generally obligates administrators to manage ERISA plans "in accordance with the documents and instruments governing" them. §1104(a)(1)(D). At a more specific level, the Act requires covered pension benefit plans to "provide that benefits . . . under the plan may not be assigned or alienated," §1056(d)(1), but this bar does not apply to qualified domestic relations orders (QDROs), §1056(d)(3). The question here is whether the terms of the limitation on assignment or alienation invalidated the act of a divorced spouse, the designated beneficiary under her ex-husband's ERISA pension plan, who purported to waive her entitlement by a federal common law waiver embodied in a divorce decree that was not a QDRO. We hold that such a waiver is not rendered invalid by the text of the antialienation provision, but that the plan administrator properly disregarded the waiver owing to its conflict with the designation made by the former husband in accordance with

plan documents.

I

The decedent, William Kennedy, worked for E. I. DuPont de Nemours & Company and was a participant in its savings and investment plan (SIP), with power both to "designate any beneficiary or beneficiaries . . . to receive all or part" of the funds upon his death, and to "replace or revoke such designation." App. 48. The plan requires "[a]ll authorizations, designations and requests concerning the Plan [to] be made by employees in the manner prescribed by the [plan administrator]," *id.*, at 52, and provides forms for designating or changing a beneficiary, *id.*, at 34, 56–57. If at the time the participant dies "no surviving spouse exists and no beneficiary designation is in effect, distribution shall be made to, or in accordance with the directions of, the executor or administrator of the decedent's estate." *Id.*, at 48.

The SIP is an ERISA "'employee pension benefit plan,'" 497 F. 3d 426, 427 (CA5 2007); 29 U. S. C. §1002(2), and the parties do not dispute that the plan satisfies ERISA's antialienation provision, §1056(d)(1), which requires it to "provide that benefits provided under the plan may not be assigned or alienated."[1] The plan does, however, permit a beneficiary to submit a "qualified disclaimer" of benefits as defined under the Tax Code, see 26 U. S. C. §2518, which has the effect of switching the beneficiary to an "alternate . . . determined according to a valid beneficiary designa-

[1]The plan states that "[e]xcept as provided by Section 401(a)(13) of the [Internal Revenue] Code, no assignment of the rights or interests of account holders under this Plan will be permitted or recognized, nor shall such rights or interests be subject to attachment or other legal processes for debts." App. 50–51. Title 26 U. S. C. §401(a)(13)(A), in language substantially tracking the text of §1056(d)(1), provides that "[a] trust shall not constitute a qualified trust under this section unless the plan of which such trust is a part provides that benefits provided under the plan may not be assigned or alienated."

tion made by the deceased." Supp. Record 86–87 (Exh. 15).

In 1971, William married Liv Kennedy, and, in 1974, he signed a form designating her to take benefits under the SIP, but naming no contingent beneficiary to take if she disclaimed her interest. 497 F. 3d, at 427. William and Liv divorced in 1994, subject to a decree that Liv "is . . . divested of all right, title, interest, and claim in and to . . . [a]ny and all sums . . . the proceeds [from], and any other rights related to any . . . retirement plan, pension plan, or like benefit program existing by reason of [William's] past or present or future employment." App. to Pet. for Cert. 64–65. William did not, however, execute any documents removing Liv as the SIP beneficiary, 497 F. 3d, at 428, even though he did execute a new beneficiary-designation form naming his daughter, Kari Kennedy, as the beneficiary under DuPont's Pension and Retirement Plan, also governed by ERISA.

On William's death in 2001, petitioner Kari Kennedy was named executrix and asked DuPont to distribute the SIP funds to William's Estate. *Ibid.* DuPont, instead, relied on William's designation form and paid the balance of some $400,000 to Liv. *Ibid.* The Estate then sued respondents DuPont and the SIP plan administrator (together, DuPont), claiming that the divorce decree amounted to a waiver of the SIP benefits on Liv's part, and that DuPont had violated ERISA by paying the benefits to William's designee.[2]

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[2]The Estate now says that William's beneficiary-designation form for the Pension and Retirement Plan applied to the SIP as well, but the form on its face applies only to DuPont's "Pension and Retirement Plan." App. 62. In the District Court, in fact, the Estate stipulated that William "never executed any forms or documents to remove or replace Liv Kennedy as his sole beneficiary under either the SIP or [a plan that merged into the SIP]." *Id.*, at 28. In any event, the Estate did not raise this argument in the Court of Appeals, and we will not

So far as it matters here, the District Court entered summary judgment for the Estate, to which it ordered DuPont to pay the value of the SIP benefits. The court relied on Fifth Circuit precedent establishing that a beneficiary can waive his rights to the proceeds of an ERISA plan "'provided that the waiver is explicit, voluntary, and made in good faith.'" App. to Pet. for Cert. 38 (quoting *Manning* v. *Hayes*, 212 F. 3d 866, 874 (CA5 2000)).

The Fifth Circuit nonetheless reversed, distinguishing prior decisions enforcing federal common law waivers of ERISA benefits because they involved life-insurance policies, which are considered "'welfare plan[s]'" under ERISA and consequently free of the antialienation provision. 497 F. 3d, at 429. The Court of Appeals held that Liv's waiver constituted an assignment or alienation of her interest in the SIP benefits to the Estate, and so could not be honored. *Id.*, at 430. The court relied heavily on the ERISA provision for bypassing the antialienation provision when a marriage breaks up: under 29 U. S. C. §1056(d)(3),[3] a court order that satisfies certain statutory requirements is known as a qualified domestic relations order, which is exempt from the bar on assignment or alienation. Because the Kennedys' divorce decree was not a QDRO, the Fifth Circuit reasoned that it could not give effect to Liv's waiver incorporated in it, given that "ERISA provides a specific mechanism—the QDRO—for addressing the elimination of a spouse's interest in plan benefits, but that mechanism is *not* invoked." 497 F. 3d, at 431.

We granted certiorari to resolve a split among the

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address it in the first instance. See *Taylor* v. *Freeland & Kronz*, 503 U. S. 638, 645–646 (1992).

[3]Section 1056(d)(3)(A) provides that the antialienation provision "shall apply to the creation, assignment, or recognition of a right to any benefit payable with respect to a participant pursuant to a domestic relations order, except that paragraph (1) shall not apply if the order is determined to be a qualified domestic relations order."

Courts of Appeals and State Supreme Courts over a divorced spouse's ability to waive pension plan benefits through a divorce decree not amounting to a QDRO.[4] 552 U. S. ___ (2008). We subsequently realized that this case implicates the further split over whether a beneficiary's federal common law waiver of plan benefits is effective where that waiver is inconsistent with plan documents,[5] and after oral argument we invited supplemental briefing on that latter issue, upon which the disposition of this case ultimately turns. We now affirm, albeit on reasoning different from the Fifth Circuit's rationale.

II

A

By its terms, the antialienation provision, §1056(d)(1), requires a plan to provide expressly that benefits be neither "assigned" nor "alienated," the operative verbs having histories of legal meaning: to "assign" is "[t]o transfer; as to assign property, or some interest therein," Black's Law Dictionary 152 (4th rev. ed. 1968), and to "alienate" is "[t]o convey; to transfer the title to property," *id.*, at 96. We think it fair to say that Liv did not assign or alienate anything to William or to the Estate later standing in his

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[4] Compare *Altobelli* v. *IBM Corp.*, 77 F. 3d 78 (CA4 1996) (federal common law waiver in divorce decree does not conflict with antialienation provision); *Fox Valley & Vicinity Constr. Workers Pension Fund* v. *Brown*, 897 F. 2d 275 (CA7 1990) (en banc) (same); *Keen* v. *Weaver*, 121 S. W. 3d 721 (Tex. 2003) (same), with *McGowan* v. *NJR Serv. Corp.*, 423 F. 3d 241 (CA3 2005) (federal common law waiver in divorce decree barred by antialienation provision).

[5] Compare *Altobelli*, *supra* (federal common law waiver controls); *Mohamed* v. *Kerr*, 53 F. 3d 911 (CA8 1995) (same); *Brandon* v. *Travelers Ins. Co.*, 18 F. 3d 1321 (CA5 1994) (same); *Fox Valley*, 897 F. 2d 275 (same); *Strong* v. *Omaha Constr. Industry Pension Plan*, 270 Neb. 1, 701 N. W. 2d 320 (2005) (same); *Keen*, *supra* (same), with *Metropolitan Life Ins. Co.* v. *Marsh*, 119 F. 3d 415 (CA6 1997) (plan documents control); *Krishna* v. *Colgate Palmolive Co.*, 7 F. 3d 11 (CA2 1993) (same).

shoes.

The Fifth Circuit saw the waiver as an assignment or alienation to the Estate, thinking that Liv's waiver transferred the SIP benefits to whoever would be next in line; without a designated contingent beneficiary, the Estate would take them. The court found support in the applicable Treasury Department regulation that defines "assignment" and "alienation" to include

> "[a]ny direct or indirect arrangement (whether revocable or irrevocable) whereby a party acquires from a participant or beneficiary a right or interest enforceable against the plan in, or to, all or any part of a plan benefit payment which is, or may become, payable to the participant or beneficiary." 26 CFR §1.401(a)–13(c)(1)(ii) (2008).

See *Boggs* v. *Boggs*, 520 U. S. 833, 851–852 (1997) (relying upon the regulation to interpret the meaning of "assignment" and "alienation" in §1056(d)(1)). The Circuit treated Liv's waiver as an "'indirect arrangement'" whereby the Estate gained an "'interest enforceable against the plan.'" 497 F. 3d, at 430.

Casting the alienation net this far, though, raises questions that leave one in doubt. Although it is possible to speak of the waiver as an "arrangement" having the indirect effect of a transfer to the next possible beneficiary, it would be odd usage to speak of an estate as the transferee of its own decedent's property, just as it would be to speak of the decedent in his lifetime as his own transferee. And treating the estate or even the ultimate estate beneficiary as the assignee or transferee would be strange under the terms of the regulation: it would be hard to say the estate or future beneficiary "acquires" a right or interest when at the time of the waiver there was no estate and the beneficiary of a future estate might be anyone's guess. If there were a contingent beneficiary (or the participant made a

subsequent designation) the estate would get no interest; as for an estate beneficiary, the identity could ultimately turn on the law of intestacy applied to facts as yet unknown, or on the contents of the participant's subsequent will, or simply on the participant's future exercise of (or failure to invoke) the power to designate a new beneficiary directly under the terms of the plan. Thus, if such a waiver created an "arrangement" assigning or transferring anything under the statute, the assignor would be blindfolded, operating, at best, on the fringe of what "assignment" or "alienation" normally suggests.

The questionability of this broad reading is confirmed by exceptions to it that are apparent right off the bat. Take the case of a surviving spouse's interest in pension benefits, for example. Depending on the circumstances, a surviving spouse has a right to a survivor's annuity or to a lump-sum payment on the death of the participant, unless the spouse has waived the right and the participant has eliminated the survivor annuity benefit or designated a different beneficiary. See *Boggs*, *supra,* at 843; 29 U. S. C. §§1055(a), (b)(1)(C), (c)(2). This waiver by a spouse is plainly not barred by the antialienation provision. Likewise, DuPont concedes that a qualified disclaimer under the Tax Code, which allows a party to refuse an interest in property and thereby eliminate federal tax, would not violate the antialienation provision. See Brief for Respondents 21–23; 26 U. S. C. §2518. In each example, though, we fail to see how these waivers would be permissible under the Fifth Circuit's reading of the statute and regulation.

Our doubts, and the exceptions that call the Fifth Circuit's reading into question, point us toward authority we have drawn on before, the law of trusts that "serves as ERISA's backdrop." *Beck* v. *PACE Int'l Union*, 551 U. S. 96, 101 (2007). We explained before that §1056(d)(1) is much like a spendthrift trust provision barring assign-

ment or alienation of a benefit, see *Boggs*, *supra,* at 852, and the cognate trust law is highly suggestive here. Although the beneficiary of a spendthrift trust traditionally lacked the means to transfer his beneficial interest to anyone else, he did have the power to disclaim prior to accepting it, so long as the disclaimer made no attempt to direct the interest to a beneficiary in his stead. See 2 Restatement (Third) of Trusts §58(1), Comment *c,* p. 359 (2001) ("A designated beneficiary of a spendthrift trust is not required to accept or retain an interest prescribed by the terms of the trust. . . . On the other hand, a purported disclaimer by which the beneficiary attempts to direct who is to receive the interest is a precluded transfer"); E. Griswold, Spendthrift Trusts §524, p. 603 (2d ed. 1947) ("The American cases, though not entirely clear, generally take the view that the interest under a spendthrift trust may be disclaimed"); *Roseberry* v. *Moncure*, 245 Va. 436, 439, 429 S. E. 2d 4, 6 (1993) ("'If a trust is created without notice to the beneficiary or the beneficiary has not accepted the beneficial interest under the trust, he can disclaim'" (quoting 1 A. Scott & W. Fratcher, Law of Trusts §36.1, p. 389 (4th ed. 1987) (hereinafter Fratcher))).

We do not mean that the whole law of spendthrift trusts and disclaimers turns up in §1056(d)(1), but the general principle that a designated spendthrift can disclaim his trust interest magnifies the improbability that a statute written with an eye on the old law would effectively force a beneficiary to take an interest willy-nilly. Common sense and common law both say that "[t]he law certainly is not so absurd as to force a man to take an estate against his will." *Townson* v. *Tickell*, 3 Barn. & Ald. 31, 36, 106 Eng. Rep. 575, 576–577 (K. B. 1819).[6]

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[6]DuPont argues that Liv's waiver would have been an invalid disclaimer at common law because it was given for consideration in the divorce settlement. But the authorities DuPont cites fail to support the

The Treasury is certainly comfortable with the state of the old law, for the way it reads its own regulation "no party 'acquires from' a beneficiary a 'right or interest enforceable against the plan' pursuant to a beneficiary's waiver of rights where the beneficiary does not attempt to direct her interest in pension benefits to another person." Brief for United States as *Amicus Curiae* 18. And, being neither "plainly erroneous [n]or inconsistent with the regulation," the Treasury Department's interpretation of its regulation is controlling. *Auer* v. *Robbins*, 519 U. S. 452, 461 (1997).[7]

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proposition that a beneficiary's otherwise valid disclaimer was invalid at common law because she received consideration. See *Roseberry* v. *Moncure*, 245 Va., at 439, 429 S. E. 2d, at 6; *Smith* v. *Bank of Del.*, 43 Del. Ch. 124, 126–127, 219 A. 2d 576, 577 (1966); *Preminger* v. *Union Bank & Trust Co.*, 54 Mich. App. 361, 368–369, 220 N. W. 2d 795, 798–799 (1974); 4 Fratcher §337.1 (4th ed. 1989); 1 Restatement (Second) of Trusts §36, Comment *c* (1957). It is true that the receipt of consideration prevents a beneficiary from making a qualified disclaimer for gift tax purposes, see 26 CFR §25.2518–2 (2008), and there is common law authority for the proposition that a renunciation by a devisee is ineffective against existing creditors if "it is shown that those who would take such property on renunciation had agreed to pay to the devisee something of value in consideration of such renunciation." 6 W. Bowe & D. Parker, Page on Law of Wills §49.5, p. 48 (2005); see also *Schoonover* v. *Osborne*, 193 Iowa 474, 478–479, 187 N. W. 20, 22 (1922). But at common law the receipt of consideration did not necessarily render a disclaimer invalid. See *Commerce Trust Co.* v. *Fast*, 396 S. W. 2d 683, 686–687 (Mo. 1965); *Central Nat. Bank* v. *Eells*, 5 Ohio Misc. 187, 189–192, 215 N. E. 2d 77, 80–81 (Ohio Prob. Ct. 1965); *In re Wimperis* [1914] 1 Ch. 502, 508–510; see also *In re Estate of Baird*, 131 Wash. 2d 514, 519, n. 5, 933 P. 2d 1031, 1034, n. 5 (1997). In any event, our point is not that Liv's waiver was a valid disclaimer at common law: only that reading the terms of 29 U. S. C. §1056(d)(1) to bar all non-QDRO waivers is unsound in light of background common law principles.

[7] It is true that the Government's position regarding the applicability of the antialienation provision to a waiver has fluctuated. The Labor Department previously took the position that "application of such a federal common-law waiver rule to pension plans would conflict with ERISA's anti-alienation provision." Brief for Secretary of Labor as

The Fifth Circuit found "significant support" for its contrary holding in the QDRO subsections, reasoning that "[i]n the marital-dissolution context, the QDRO provisions supply the *sole* exception to the anti-alienation provision," 497 F. 3d, at 430, a point that echoes in DuPont's argument here. But the negative implication of the QDRO language is not that simple. If a QDRO provided a way for a former spouse like Liv merely to waive benefits, this would be powerful evidence that the antialienation provision was meant to deny any effect to a waiver within a divorce decree but not a QDRO, else there would have been no need for the QDRO exception. But this is not so, and DuPont's argument rests on a false premise. In fact, a beneficiary seeking only to relinquish her right to benefits cannot do this by a QDRO, for a QDRO by definition requires that it be the "creat[ion] or recogni[tion of] the existence of an alternate payee's right to, or assign[ment] to an alternate payee [of] the right to, receive all or a portion of the benefits payable with respect to a participant under a plan." 29 U. S. C. §1056(d)(3)(B)(i)(I). There is no QDRO for a simple waiver; there must be some succeeding designation of an alternate payee.[8] Not being a

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Amicus Curiae 16 in *Keen* v. *Weaver*, No. 01–0447 (Tex. 2003). And it likewise asserted that "waiver of pension benefits is generally impermissible under [§1056(d)(1)]." Brief for Secretary of Labor as *Amicus Curiae* 5 in *In re Estate of Egelhoff*, No. 67626–7 (Wash. 2001). The Labor Department has reconsidered that view and has now taken the Treasury's position. Brief for United States as *Amicus Curiae* 20, n. 6. But "the change in interpretation alone presents no separate ground for disregarding the [Treasury's and the Labor] Department's present interpretation." *Long Island Care at Home, Ltd.* v. *Coke*, 551 U. S. 158, 171 (2007). Nor does the fact that the interpretation is stated in a legal brief make it unworthy of deference, as "[t]here is simply no reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question." *Auer*, 519 U. S., at 462.

[8]Even if one understands Liv's waiver to have resulted somehow in her interest reverting to William, he does not qualify as an "alternate

mechanism for simply renouncing a claim to benefits, then, the QDRO provisions shed no light on whether a beneficiary may waive by a non-QDRO.

In sum, Liv did not attempt to direct her interest in the SIP benefits to the Estate or any other potential beneficiary, and accordingly we think that the better view is that her waiver did not constitute an assignment or alienation rendered void under the terms of §1056(d)(1).

B

DuPont has three other reasons for saying that Liv's waiver was barred by ERISA. They are unavailing.

First, it argues that even if the waiver is not an assignment or alienation barred under the terms of §1056(d)(1), §1056(d)(3)(A) still prohibits it, in providing that §1056(d)(1) "shall apply to the creation, assignment, or recognition of a right to any benefit payable with respect to a participant pursuant to a domestic relations order [that is not a QDRO]." At the very least, DuPont reasons, Liv's waiver included a "recognition" of William's rights with respect to the SIP benefits. But DuPont overlooks the point that when subsection (d)(3)(A) provides that the bar to assignments or alienations extends to non-QDRO domestic relations orders, it does nothing to expand the scope of prohibited assignment and alienation under subsection (d)(1). Whether Liv's action is seen as a waiver or as a domestic relations order that incorporated a waiver, subsection (d)(1) does not cover it and §1056(d)(3)(A) does not independently bar it.

Second, DuPont relies upon §1056(d)(3)(H)(iii)(II), providing that if a domestic relations order is not a QDRO,

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payee," which is defined by statute as "any spouse, former spouse, child, or other dependent of a participant who is recognized by a domestic relations order as having a right to receive all, or a portion of, the benefits payable under a plan with respect to such participant." 29 U. S. C. §1056(d)(3)(K).

"the plan administrator shall pay the segregated amounts (including any interest thereon) to the person or persons who would have been entitled to such amounts if there had been no order." According to DuPont, because the divorce decree was not a QDRO this provision calls for paying benefits as if there had been no order. But DuPont has wrenched this language out of its setting, reading clause (iii) of subparagraph (H) as if there were no clause (i):

> "During any period in which the issue of whether a domestic relations order is a qualified domestic relations order is being determined . . . the plan administrator shall separately account for the amounts (hereinafter in this subparagraph referred to as the 'segregated amounts') which would have been payable to the alternate payee during such period if the order had been determined to be a qualified domestic relations order." §1056(d)(3)(H)(i).

Thus it is clear that subparagraph (H) speaks of a domestic relations order that distributes certain benefits (the "segregated amounts") to an alternate payee, when the question for the plan administrator is whether the order is effective as a QDRO. That is the circumstance in which, for want of a QDRO, clause (iii) tells the plan administrator not to pay the alternate, but to distribute the segregated amounts as if there had been no order. Clause (iii) does not, as DuPont suggests, state a general rule that a non-QDRO domestic relations order is a nullity in any proceeding that would affect the determination of a beneficiary. And of course clause (iii) says nothing here at all; the divorce decree names no alternate payee, and there are consequently no "segregated amounts."

Third, DuPont claims that a plan cannot recognize a waiver of benefits in a non-QDRO divorce decree because ERISA preempts "any and all State laws insofar as they

may now or hereafter relate to any employee benefit plan," with "State law" being defined to include "decisions" or "other State action having the effect of law."[9] §§1144(a), (c)(1). DuPont says that Liv's waiver, expressed in a state-court decision and related to an employee benefit plan, is thus preempted. But recognizing a waiver in a divorce decree would not be giving effect to state law; the argument is that the waiver should be treated as a creature of federal common law, in which case its setting in a state divorce decree would be only happenstance. A court would merely be applying federal law to a document that might also have independent significance under state law. See, *e.g.*, *Melton* v. *Melton*, 324 F. 3d 941, 945–946 (CA7 2003); *Clift* v. *Clift*, 210 F. 3d 268, 271–272 (CA5 2000); *Lyman Lumber Co.* v. *Hill*, 877 F. 2d 692, 693–694 (CA8 1989).

III

The waiver's escape from inevitable nullity under the express terms of the antialienation clause does not, however, control the decision of this case, and the question remains whether the plan administrator was required to honor Liv's waiver with the consequence of distributing the SIP balance to the Estate.[10] We hold that it was not,

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[9] This preemption provision does not apply to QDROs. See §1144(b)(7).

[10] Despite our following answer to the question here, our conclusion that §1056(d)(1) does not make a nullity of a waiver leaves open any questions about a waiver's effect in circumstances in which it is consistent with plan documents. Nor do we express any view as to whether the Estate could have brought an action in state or federal court against Liv to obtain the benefits after they were distributed. Compare *Boggs* v. *Boggs*, 520 U. S. 833, 853 (1997) ("If state law is not preempted, the diversion of retirement benefits will occur regardless of whether the interest in the pension plan is enforced against the plan or the recipient of the pension benefit"), with *Sweebe* v. *Sweebe*, 474 Mich. 151, 156–159, 712 N. W. 2d 708, 712–713 (2006) (distinguishing *Boggs* and holding that "while a plan administrator must pay benefits to the named beneficiary as required by ERISA," after the benefits are dis-

and that the plan administrator did its statutory ERISA duty by paying the benefits to Liv in conformity with the plan documents.

ERISA requires "[e]very employee benefit plan [to] be established and maintained pursuant to a written instrument," 29 U. S. C. §1102(a)(1), "specify[ing] the basis on which payments are made to and from the plan," §1102(b)(4). The plan administrator is obliged to act "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [Title I] and [Title IV] of [ERISA]," §1104(a)(1)(D), and the Act provides no exemption from this duty when it comes time to pay benefits. On the contrary, §1132(a)(1)(B) (which the Estate happens to invoke against DuPont here) reinforces the directive, with its provision that a participant or beneficiary may bring a cause of action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."

The Estate's claim therefore stands or falls by "the terms of the plan," §1132(a)(1)(B), a straightforward rule of hewing to the directives of the plan documents that lets employers "'establish a uniform administrative scheme, [with] a set of standard procedures to guide processing of claims and disbursement of benefits.'"[11] *Egelhoff* v. *Egel-*

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tributed "the consensual terms of a prior contractual agreement may prevent the named beneficiary from retaining those proceeds"); *Pardee* v. *Pardee*, 2005 OK CIV APP. 27, ¶¶20, 27, 112 P. 3d 308, 313–314, 315–316 (2004) (distinguishing *Boggs* and holding that ERISA did not preempt enforcement of allocation of ERISA benefits in state-court divorce decree as "the pension plan funds were no longer entitled to ERISA protection once the plan funds were distributed").

[11] We express no view regarding the ability of a participant or beneficiary to bring a cause of action under 29 U. S. C. §1132(a)(1)(B) where the terms of the plan fail to conform to the requirements of ERISA and the party seeks to recover under the terms of the statute.

hoff, 532 U. S. 141, 148 (2001) (quoting *Fort Halifax Packing Co.* v. *Coyne*, 482 U. S. 1, 9 (1987)); see also *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U. S. 73, 83 (1995) (ERISA's statutory scheme "is built around reliance on the face of written plan documents"). The point is that by giving a plan participant a clear set of instructions for making his own instructions clear, ERISA forecloses any justification for enquiries into nice expressions of intent, in favor of the virtues of adhering to an uncomplicated rule: "simple administration, avoid[ing] double liability, and ensur[ing] that beneficiaries get what's coming quickly, without the folderol essential under less-certain rules." *Fox Valley & Vicinity Const. Workers Pension Fund* v. *Brown*, 897 F. 2d 275, 283 (CA7 1990) (Easterbrook, J., dissenting).

And the cost of less certain rules would be too plain. Plan administrators would be forced "to examine a multitude of external documents that might purport to affect the dispensation of benefits," *Altobelli* v. *IBM Corp.*, 77 F. 3d 78, 82–83 (CA4 1996) (Wilkinson, C. J., dissenting), and be drawn into litigation like this over the meaning and enforceability of purported waivers. The Estate's suggestion that a plan administrator could resolve these sorts of disputes through interpleader actions merely restates the problem with the Estate's position: it would destroy a plan administrator's ability to look at the plan documents and records conforming to them to get clear distribution instructions, without going into court.

The Estate of course is right that this guarantee of simplicity is not absolute. The very enforceability of QDROs means that sometimes a plan administrator must look for the beneficiaries outside plan documents notwithstanding §1104(a)(1)(D); §1056(d)(3)(J) provides that a "person who is an alternate payee under a [QDRO] shall be considered for purposes of any provision of [ERISA] a beneficiary under the plan." But this in effect means that

a plan administrator who enforces a QDRO must be said to enforce plan documents, not ignore them. In any case, a QDRO enquiry is relatively discrete, given the specific and objective criteria for a domestic relations order that qualifies as a QDRO,[12] see §§1056(d)(3)(C), (D), requirements that amount to a statutory checklist working to "spare [an administrator] from litigation-fomenting ambiguities," *Metropolitan Life Ins. Co.* v. *Wheaton*, 42 F. 3d 1080, 1084 (CA7 1994). This is a far cry from asking a plan administrator to figure out whether a claimed federal common law waiver was knowing and voluntary, whether its language addressed the particular benefits at issue, and so forth, on into factually complex and subjective determinations. See, *e.g., Altobelli, supra,* at 83 (Wilkinson, C. J., dissenting) ("[W]aiver provisions are often sweeping in their terms, leaving their precise effect on plan benefits unclear"); *Mohamed* v. *Kerr*, 53 F. 3d 911, 915 (CA8 1995) (making "fact-driven determination" that marriage termination agreement constituted a valid waiver under federal common law).

These are good and sufficient reasons for holding the line, just as we have done in cases of state laws that might

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[12] To qualify as a QDRO, a divorce decree must "clearly specif[y]" the name and last known mailing address of the participant and the name and mailing address of each alternate payee covered by the order; the amount or percentage of the participant's benefits to be paid by the plan to each such alternate payee or the manner in which such amount or percentage is to be determined; the number of payments or period to which the order applies; and each plan to which such order applies. §1056(d)(3)(C). A domestic relations order cannot qualify as a QDRO if it requires a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan; requires the plan to provide increased benefits; or requires the payment of benefits to an alternate payee that are required to be paid to another alternate payee under another order previously determined to be a QDRO. §1056(d)(3)(D). A plan is required to establish written procedures for determining whether a domestic relations order is a QDRO. §1056(d)(3)(G)(ii).

blur the bright-line requirement to follow plan documents in distributing benefits. Two recent preemption cases are instructive here. *Boggs* v. *Boggs*, 520 U. S. 833, held that ERISA preempted a state law permitting the testamentary transfer of a nonparticipant spouse's community property interest in undistributed pension plan benefits. We rejected the entreaty to create "through case law . . . a new class of persons for whom plan assets are to be held and administered," explaining that "[t]he statute is not amenable to this sweeping extratextual extension." *Id.*, at 850. And in *Egelhoff* we held that ERISA preempted a state law providing that the designation of a spouse as the beneficiary of a nonprobate asset is revoked automatically upon divorce. 532 U. S., at 143. We said the law was at fault for standing in the way of making payments "simply by identifying the beneficiary specified by the plan documents," *id.*, at 148, and thus for purporting to "undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators," *id.*, at 149–150 (quoting *Ingersoll-Rand Co.* v. *McClendon*, 498 U. S. 133, 142 (1990)); see *Egelhoff*, *supra*, at 147, n. 1 (identifying "the conflict between the plan documents (which require making payments to the named beneficiary) and the statute (which requires making payments to someone else)").

What goes for inconsistent state law goes for a federal common law of waiver that might obscure a plan administrator's duty to act "in accordance with the documents and instruments." See *Mertens* v. *Hewitt Associates*, 508 U. S. 248, 259 (1993) ("The authority of courts to develop a 'federal common law' under ERISA . . . is not the authority to revise the text of the statute"). And this case does as well as any other in pointing out the wisdom of protecting the plan documents rule. Under the terms of the SIP Liv was William's designated beneficiary. The plan provided an easy way for William to change the designation, but for

whatever reason he did not. The plan provided a way to disclaim an interest in the SIP account, but Liv did not purport to follow it.[13] The plan administrator therefore did exactly what §1104(a)(1)(D) required: "the documents control, and those name [the ex-wife]." *McMillan* v. *Parrott*, 913 F. 2d 310, 312 (CA6 1990).

It is no answer, as the Estate argues, that William's beneficiary-designation form should not control because it is not one of the "documents and instruments governing the plan" under §1104(a)(1)(D) and was not treated as a plan document by the plan administrator. That is beside the point. It is uncontested that the SIP and the summary plan description are "documents and instruments governing the plan." See *Curtiss-Wright Corp.*, 514 U. S., at 84 (explaining that 29 U. S. C. §§1024(b)(2) and (b)(4) require a plan administrator to make available the "governing plan documents"). Those documents provide that the plan administrator will pay benefits to a participant's designated beneficiary, with designations and changes to be made in a particular way. William's designation of Liv as his beneficiary was made in the way required; Liv's waiver was not.[14]

IV

Although Liv's waiver was not rendered a nullity by the terms of §1056, the plan administrator properly distrib-

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[13] The Estate does not contend that Liv's waiver was a valid disclaimer under the terms of the plan. We do not address a situation in which the plan documents provide no means for a beneficiary to renounce an interest in benefits.

[14] The Estate also contends that requiring a plan administrator to distribute benefits in conformity with plan documents will allow a beneficiary who murders a participant to obtain benefits under the terms of the plan. The "slayer" case is not before us, and we do not address it. See *Egelhoff* v. *Egelhoff*, 532 U. S. 141, 152 (2001) (declining to decide whether ERISA preempts state statutes forbidding a murdering heir from receiving property as a result of the killing).

uted the SIP benefits to Liv in accordance with the plan documents. The judgment of the Court of Appeals is affirmed on the latter ground.

It is so ordered.

In the

United States Court of Appeals

For the Seventh Circuit

Nos. 09-3872 & 09-3965

CYNTHIA N. YOUNG, on behalf of
herself and others similarly situated,

Plaintiff-Appellant/
Cross-Appellee,

v.

VERIZON'S BELL ATLANTIC CASH
BALANCE PLAN, et al.,

Defendants-Appellees/
Cross-Appellants.

Appeals from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 05 C 07314—Morton Denlow, *Magistrate Judge.*

ARGUED JUNE 1, 2010—DECIDED AUGUST 10, 2010

Before BAUER, FLAUM, and TINDER, *Circuit Judges.*

TINDER, *Circuit Judge.* "People make mistakes. Even administrators of ERISA plans." *Conkright v. Frommert,* 130 S. Ct. 1640, 1644 (2010). This introduction was fitting

in *Conkright*, which dealt with a single honest mistake in the interpretation of an ERISA plan. It is perhaps an understatement in this case, which involves a devastating drafting error in the multi-billion-dollar plan administered by Verizon Communications, Inc. ("Verizon").

Verizon's pension plan contains erroneous language that, if enforced literally, would give Verizon pensioners like plaintiff Cynthia Young greater benefits than they expected. Young nonetheless seeks these additional benefits based on ERISA's strict rules for enforcing plan terms as written. Although Young raises some forceful arguments, we conclude that ERISA's rules are not so strict as to deny an employer equitable relief from the type of "scrivener's error" that occurred here. We will accordingly affirm the district court's judgment granting Verizon equitable reformation of its plan to correct the scrivener's error.

I. Background

A. Bell Atlantic's Pension Plans

Bell Atlantic, the predecessor of Verizon, operated the Bell Atlantic Management Pension Plan ("BAMPP") until 1996. The BAMPP expressed an employee's retirement benefit as a defined annuity, but employees also had the option of receiving a lump sum if they retired during specified "cashout windows." For certain employees who retired during the 1994-1995 cashout window, the BAMPP provided a lump sum equal to the "actuarial equivalent present value" of the employee's pension

benefit, but calculated using an enhanced discount rate. Specifically, section 4.19 of the BAMPP required the use of a discount rate of "120% of the applicable . . . PBGC [Public Benefit Guarantee Corporation] interest rate in effect" at the time of severance.

In 1996, Bell Atlantic adopted the Bell Atlantic Cash Balance Plan to replace the BAMPP. The new Plan expressed an employee's benefit as a cash balance that grew steadily with the employee's age and years of service. Under the Cash Balance Plan, employees still had the option of receiving their retirement benefit as either an annuity or a lump sum.

Key to this transition to the Cash Balance Plan was converting the value of employees' benefits under the old BAMPP to cash balances under the new Plan. The Plan used "transition factors," a series of multipliers that increased with employees' age and years of service, to make the conversion. The Plan language describing this conversion is critical, so we reproduce it in some detail (the emphasis is ours):

> 16.5 Opening Balance
>
> . . . .
>
> 16.5.1 Pension Conversions as of the Transition Date
>
> *Where a present value must be determined under this Section 16.4* [sic, should read "Section 16.5"], *the present value shall be determined as follows: (a) using the PBGC interest rates which were in effect for September of 1995* . . . .

> 16.5.1(a) 1995 Active Participants and 1995 Former Active Participants
>
> . . . the opening balance of the Participant's Cash Balance Account on January 1, 1996 shall be the amount described in subsection (1) or (2) below, as applicable:
>
> > 16.5.1(a)(1) If Eligible for Service Pension
> >
> > . . . .
> >
> > 16.5.1(a)(2) Not Eligible for Service Pension
> >
> > In the case of a Participant who is not eligible for a Service Pension under the 1995 BAMPP Plan as of the Transition Date, the amount described in this paragraph (2) is *the product of multiplying* (A) *the Participant's applicable Transition Factor described in Table 1 of this Section, times* (B) *the lump-sum cashout value of the Accrued Benefit payable at age 65 under the 1995 BAMPP Plan,* determined as if the Participant had a Severance From Service Date on December 31, 1995, based on Compensation paid through December 31, 1995, *multiplied by the applicable transition factor described in Table 1 of this Section. . . .*

B. Young's Administrative Claim

Cynthia Young worked for Bell Atlantic from 1965 to 1997. When the Cash Balance Plan took effect in 1996,

Young was not eligible for a service pension under the BAMPP—that is, her age and service level did not qualify her for full retirement benefits—so her opening cash balance was calculated using § 16.5.1(a)(2), for a resulting balance of $240,127. By the time Young retired in 1997, her cash balance had grown to the point that she received a lump-sum benefit of $286,095.

Several years later, in 2004, Young filed a claim with the Claims Review Unit of Verizon (which by then had taken over Plan administration as Bell Atlantic's successor). Young claimed that Bell Atlantic made two errors in calculating her opening cash balance, and hence her ultimate pension benefit, under the Cash Balance Plan. First, Young read the language of § 16.5.1(a)(2) to require that the "applicable transition factor" be multiplied twice to convert her lump-sum cashout under the BAMPP to her opening cash balance under the new Plan. Bell Atlantic, however, multiplied the transition factor only once when making the conversion. Second, Young claimed that Bell Atlantic improperly applied the 120% PBGC discount rate used in the 1995 BAMPP to determine the "lump-sum cashout value" under § 16.5.1(a)(2). Young contended that Bell Atlantic should have used a discount rate of simply 100% of the PBGC rate.

Verizon's Claims Review Unit denied Young's claims, and on appeal, Verizon's Claims Review Committee affirmed. The Committee concluded that the intended meaning of § 16.5.1(a)(2) was to use only a single transition factor to calculate opening cash balances; the

section's second reference to the "applicable transition factor" was a drafting mistake. As for Young's discount rate claim, the Committee concluded that § 16.5.1(a)(2) incorporated the 120% PBGC rate used in the 1995 BAMPP by referring to "the lump-sum cashout value . . . under the 1995 BAMPP Plan."

C. Young's Federal Court Class Action

In 2005, Young brought a federal court action under ERISA § 502(a), 29 U.S.C. § 1132(a), against Verizon and its Cash Balance Plan (collectively "Verizon"). Young asserted the same claims she raised in Verizon's administrative process, arguing that Verizon improperly applied only a single transition factor and the 120% PBGC discount rate to calculate her opening cash balance. The parties agreed to treat the case as a class action, and the district court certified a class of some 14,000 Bell Atlantic/Verizon pensioners similarly situated to Young.

Young's class action presented the district court, acting through Magistrate Judge Denlow, with a challenge. The court was confronted with a convoluted ERISA plan that seemed to contain a costly drafting error, but an uncertain state of law on the scope of the court's review of such an error. So the court decided to bifurcate the trial into two phases and apply alternative standards of review. In the first phase, the court assumed that it was limited to examining the administrative record and reviewing the Verizon Review Committee's denial of benefits under a deferential standard. (The Cash Balance Plan granted Verizon, as plan administrator, broad dis-

cretion to interpret the Plan, so judicial review was constrained to an "arbitrary and capricious" standard. *Black v. Long Term Disability Ins.*, 582 F.3d 738, 743-44 (7th Cir. 2009).) Under this standard, the district court upheld the Committee's denial of Young's discount rate claim. Conversely, on Young's transition factor claim, the court concluded that the Committee abused its discretion in unilaterally disregarding the second reference to the transition factor in § 16.5.1(a)(2) as a drafting mistake. If Verizon wished to avoid that mistake, it would have to seek a court order for equitable reformation of the Plan.

Taking the district court's cue, Verizon counterclaimed for equitable reformation of the Plan to remove the second transition factor in § 16.5.1(a)(2) as a "scrivener's error." The court took up Verizon's counterclaim in the second phase of the trial, in which the court conducted a de novo review of the Plan and allowed the parties to introduce extrinsic evidence on the intended meaning of § 16.5.1(a)(2). And that evidence overwhelmingly showed that the inclusion of the second transition factor was indeed a scrivener's error.

The drafting history of the 1996 Plan revealed how the second, erroneous transition factor came to be. Six drafts of the Plan were prepared prior to the final version. The first three drafts were prepared by Mercer Human Resources Consulting, an outside firm hired by Bell Atlantic, and contained no mention of a second transition factor. It was not until one of Bell Atlantic's in-house attorneys, Barry Peters, took over drafting responsibility that the second transition factor appeared. In working on the

fourth draft, Peters restructured the conversion formula under § 16.5.1(a)(2) into a more readable "A times B" format, but in doing so, neglected to delete a trailing clause from the previous draft that referred to "the applicable Transition Factor." Testifying in the district court, Peters admitted that he made this mistake in failing to delete the trailing clause in § 16.5.1(a)(2), thereby duplicating the transition factor. Peters's mistake survived unnoticed in the fifth, sixth, and final drafts of the Plan.

In addition to the drafting history, the correspondence between Bell Atlantic and plan participants showed an expectation that only a single transition factor would be used to calculate opening cash balances. In October 1995, Bell Atlantic sent participants a brochure entitled, "Introducing Your Cash Balance Plan," which clearly depicted opening cash balances as the product of an employee's lump-sum value under the 1995 BAMPP and a single transition factor. In November 1995, Bell Atlantic sent participants personalized statements of their estimated opening account balances, which also illustrated the use of a single transition factor. Following the implementation of the Plan, Bell Atlantic sent participants personalized statements of their actual opening balances, and thereafter quarterly cash balance statements, which, again, reflected the use of only one transition factor. Notably, though, these Plan-related communications contained "plan trumps" provisions cautioning that, in the event of discrepancies between those communications and the Plan, the Plan would govern.

Also convincing was the course of dealing between Bell Atlantic/Verizon and plan participants. Bell Atlantic consistently calculated opening cash balances using a single transition factor and paid benefits accordingly. Taking Young's case as an example, her transition factor was 2.659. The estimated opening balance statement that Young received illustrated the multiplication of this 2.659 transition factor by her BAMPP lump-sum cashout value of $90,027, for an estimated opening balance of $90,027 × 2.659 = $239,381. The actual opening balance statement that Young received in 1996 applied the same, single-transition-factor formula to slightly different numbers: $90,307 × 2.659 = $240,127. Prior to Young's lawsuit, no employee complained that opening balances should have been increased by an additional transition factor. For her part, Young admitted that she never relied on the transition factor language in § 16.5.1(a)(2) prior to this litigation.

Based on this evidence of the intended meaning of the Plan, the district court found that the second transition factor in § 16.5.1(a)(2) was a scrivener's error and granted Verizon's counterclaim for equitable reformation. The court also resolved a host of other arguments raised by the parties, many of which we discuss below. But suffice it to say, the district court's treatment of the issues presented by this case was exhaustive. Over the course of a four-year, multi-phase litigation, the court built a complete record, fully explored alternative bases of decision, and sharply honed the issues for appellate review. These commendable efforts by the district court, as well as the fine advocacy by both sides, have

greatly assisted this court in deciding this complex ERISA case.

II. Analysis

A. Statute of Limitations

Before reaching the merits, we must address each side's argument that the other's claims are barred by the statute of limitations. ERISA does not provide a limitations period for actions brought under § 502, 29 U.S.C. § 1132, so we borrow the most analogous statute of limitations from state law. *Berger v. AXA Network LLC*, 459 F.3d 804, 808 (7th Cir. 2006). We do not automatically borrow the forum state's limitations period; if another state has a significant connection to the dispute and its limitations period is more consistent with federal ERISA policies, that state's limitations period should apply. *Id.* at 813. For actions such as this one to enforce ERISA plans under § 502(a), we have previously borrowed state limitations periods for suits on written contracts. *Leister v. Dovetail, Inc.*, 546 F.3d 875, 880-81 (7th Cir. 2008); *Daill v. Sheet Metal Workers' Local 73 Pension Fund*, 100 F.3d 62, 65 (7th Cir. 1996).

The parties agree that Pennsylvania's four-year statute of limitations for breach of contract actions, 42 Pa. Cons. Stat. § 5525, should apply to this ERISA case. Pennsylvania has the most significant connection to this dispute, since Bell Atlantic was headquartered and drafted the Cash Balance Plan there. Also, more class members currently live in Pennsylvania than any other state, and while a

few class members live in the forum state of Illinois, Young has never lived or worked there. We further note that the Plan contains a choice of law provision stating that Pennsylvania law will fill any gaps left by federal ERISA law. *See Berger*, 459 F.3d at 813-14 (considering choice of law clause as a non-controlling but relevant factor in selecting a limitations period).

The real point of contention is the accrual date of the parties' claims, that is, when Pennsylvania's four-year limitations period started to run. Although federal courts borrow state limitations periods for certain ERISA claims, the accrual of those claims is governed by federal common law. *Daill*, 100 F.3d at 65.

Beginning with Young's ERISA claim, we have held that a claim to recover benefits under § 502(a) accrues "upon a clear and unequivocal repudiation of rights under the pension plan which has been made known to the beneficiary." *Id.* at 66. In this case, Young did not receive a clear repudiation of her claim for additional benefits until 2005, when Verizon's Review Committee resolved her administrative appeal. (Actually, the Committee denied Young's claim with respect to the discount rate issue in 2005 but took until 2007 to deny her claim with respect to the transition factor issue. Since it is obvious that Young's entire federal court action, filed in 2005, would be timely using a 2005 accrual date, this distinction is immaterial.) Prior to denying Young's administrative claim, Verizon did not inform Young that it rejected her interpretation of the Plan calling for two transition factors and a 100% PBGC dis-

count rate. *Cf. id.* at 66 (claim accrued upon correspondence from plan disagreeing with participant's understanding of benefits).

Verizon argues that Young's claim accrued in February 1998, when she received her lump-sum benefit computed under Verizon's interpretation of the Cash Balance Plan. At that time, however, the parties' dispute over the correct interpretation of the Plan had not developed. And nothing suggests that the $286,095 payment that Young received should have been a red flag that she was underpaid. *Cf. Redmon v. Sud-Chemie Inc. Ret. Plan for Union Employees*, 547 F.3d 531, 539 (6th Cir. 2008) (finding a clear repudiation when the plan stopped making payments entirely, but not earlier when the payment amount was merely inconsistent with the plaintiff's understanding of benefits). The 1998 payment that Young received was not so inconsistent with her current claim for additional benefits as to serve as a clear repudiation.

Moving to Verizon's counterclaim, Seventh Circuit precedent provides less guidance on the accrual of a claim for equitable reformation under ERISA § 502(a)—understandably so, since the cognizance of such a claim is an issue of first impression for this court. The general federal common law rule is that an ERISA claim accrues when the plaintiff knows or should know of conduct that interferes with the plaintiff's ERISA rights. *See Berger*, 459 F.3d at 815-16 (accrual when beneficiaries learned of change in employer's method for determining benefit eligibility); *Teumer v. Gen.*

Motors Corp., 34 F.3d 542, 550 (7th Cir. 1994) ("Once an unlawful action is taken, a claim accrues when the putative plaintiff discovers the *injury* that results."). Applying this rule to Verizon's reformation action, we consider when Verizon should have known that the scrivener's error in the Cash Balance Plan, if left unreformed, would impede its rights under the Plan.

The district court found, and Verizon does not dispute, that Verizon's predecessor Bell Atlantic learned of the scrivener's error in 1997. Indeed, Bell Atlantic removed the second, erroneous transition factor from the 1998 plan that it adopted to replace the 1997 version of the Cash Balance Plan. Still, we conclude that this 1997 discovery did not give Verizon notice of the need to reform the scrivener's error, given a course of dealing consistent with Verizon's interpretation of the Plan.

Verizon always treated the Plan's second transition factor as a drafting mistake, and through correspondence with plan participants, it communicated that only a single transition factor would be used to calculate opening cash balances. Verizon consistently paid benefits using this formula, and prior to Young's administrative claim, no employee communicated a contrary understanding that Plan benefits should be calculated using two transition factors. *Cf. Tolle v. Carroll Touch, Inc.*, 977 F.2d 1129, 1141 (7th Cir. 1992) (employee's ERISA unlawful discharge claim accrued when employer communicated discharge decision); *Bowes v. Travelers Ins. Co.*, 173 F. Supp. 2d 342, 346 (E.D. Pa. 2001) (applying Pennsylvania law, claim for reformation of written con-

tract accrued when conflicting oral statements underlying the dispute were made). Under these circumstances, although Verizon discovered the drafting mistake in 1997, it did not then know that this mistake would give rise to a controversy requiring it to raise an equitable reformation claim. *See Int'l Union v. Murata Erie N. Am., Inc.*, 980 F.2d 889, 901 (3d Cir. 1992) (ERISA claim did not accrue when plan sponsor amended plan absent evidence that participants knew of any potential controversy over amended language). Instead, it was not before Young put the transition factor language at issue in her 2005 federal court action that Verizon's counterclaim for equitable reformation accrued.

None of the parties' claims accrued before 2005 when Young brought her federal court ERISA action, so these claims are timely under the applicable Pennsylvania four-year limitations period. We may proceed to the merits of Verizon's claim for equitable reformation and Young's claim for additional benefits under ERISA § 502(a).

B. Equitable Reformation Due to Scrivener's Error

ERISA is a comprehensive statute designed to uniformly regulate employee benefit plans. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). To achieve uniformity, ERISA contains numerous requirements for adopting and administering plans. Plans must be "established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). The plan terms must be communicated to participants through an easily understood "summary plan description," as well as a "summary of any material

modification" to the plan. *Id.* § 1022(a). These ERISA-required writings are given primary effect and strictly enforced, and plan administrators must adhere to "the bright-line requirement to follow plan documents in distributing benefits." *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865, 876 (2009).

While ERISA's strict requirements "ensure[ ] fair and prompt enforcement of rights under a plan," Congress was careful not to make those requirements so onerous "that administrative costs, or litigation expenses, unduly discourage employers from offering plans in the first place." *Conkright v. Frommert*, 130 S. Ct. 1640, 1649 (2010) (quotations omitted). So ERISA also allows some flexibility in plan administration and enforcement to achieve fair, equitable results. In particular, employers may grant plan administrators broad discretion in interpreting plan terms. *Id.* "Deference promotes efficiency by encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation." *Id.*

Another ERISA provision that promotes equitable plan enforcement—and the statute important here—is § 502(a)(3), which allows a plan participant, beneficiary, or fiduciary to bring a civil action for "appropriate equitable relief." 29 U.S.C. § 1132(a)(3)(B). The Supreme Court has explained that the statute authorizes "those categories of relief that were *typically* available in equity" during the days when common law courts were divided as courts of law or of equity. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993); *see also Kenseth v. Dean*

Health Plan, Inc., No. 08-3219, 2010 WL 2557767, at *24 (7th Cir. June 28, 2010) (describing categories of equitable relief available under 29 U.S.C. § 1132(a)(3)). The issue in this case, then, is whether Verizon's claim for equitable reformation of its Cash Balance Plan is the type of equitable relief authorized by § 502(a)(3).

We have never considered whether § 502(a)(3) authorizes equitable reformation of an ERISA plan due to a scrivener's error, but our case law addressing the related problem of ambiguous plan language suggests that such relief may be appropriate.

In *Mathews v. Sears Pension Plan*, 144 F.3d 461 (7th Cir. 1998), we put the parties' reasonable expectations ahead of the literal text of an ERISA plan. Although the plain language of the plan suggested a benefits formula more favorable to employees, the employer offered objective, extrinsic evidence showing an "extrinsic ambiguity" in this language. *Id.* at 466-67. The summary plan documents and the parties' course of dealing were consistent with the employer's reading of the plan, so we declined to adopt the employees' contrary reading under "rigid and archaic" rules of contract interpretation. *Id.* at 469.

We reached a different result in *Grun v. Pneumo Abex Corp.*, 163 F.3d 411, 420-21 (7th Cir. 1998), refusing to set aside unambiguous plan language based on an employer's claim of "mutual mistake." Still, we acknowledged that such relief would be available in "the rare case where literal application of a text would lead to absurd results or thwart the obvious intentions of its

drafters." *Id.* at 420 (quotation omitted). Reformation was inappropriate in *Grun* because the employee relied on the literal plan language to predict his right to severance compensation. *Id.* at 421; *cf. Mathews*, 144 F.3d at 469 (noting absence of claim that any beneficiary actually relied on plan language).

Other circuits have directly addressed claims for equitable reformation of an ERISA plan. Using reasoning similar to that in *Mathews* and *Grun*, these courts have either concluded that ERISA authorizes such relief or does not foreclose the possibility.

Verizon's strongest case is *Int'l Union v. Murata Erie N. Am., Inc.*, 980 F.2d 889, 907 (3d Cir. 1992), in which the Third Circuit recognized an employer's § 502(a)(3) claim to correct a "scrivener's error" in a plan provision on the distribution of excess funds. The court found equitable reformation appropriate because holding the employer to the scrivener's error would produce "what is admittedly a 'windfall'"—"an excess remaining in the Plans" that the plaintiffs could not have reasonably expected. *Id.* The Eighth Circuit applied a similar rationale in *Wilson v. Moog Auto., Inc. Pension Plan*, 193 F.3d 1004, 1008-10 (8th Cir. 1999), to conclude that an ERISA plan's failure to provide a minimum age for retirement benefits was a reformable mistake. Reformation was possible because extrinsic evidence showed that none of the plaintiffs actually relied on the erroneous plan language or believed that they would be eligible for early retirement. *Id.* at 1009-10.

The Ninth Circuit distinguished *Murata* in *Cinelli v. Sec. Pac. Corp.*, 61 F.3d 1437, 1444-45 (9th Cir. 1995), rejecting

an employee's claim that the absence of a plan provision entitling him to vested life insurance benefits was a mistake. Although reformation of a scrivener's error was appropriate in *Murata* to avoid a "windfall" and uphold employees' reasonable expectations of benefits, those factors were lacking in *Cinelli*. *Id.* at 1445. Likewise, in *Blackshear v. Reliance Standard Life Ins. Co.*, 509 F.3d 634, 643-44 (4th Cir. 2007), *abrogated on other grounds as stated in Williams v. Metro. Life Ins. Co.*, Nos. 09-1025 & 09-1568, 2010 WL 2599676, at *5 (4th Cir. June 30, 2010), the Fourth Circuit declined to equitably reform an ERISA plan under the circumstances, where the plan language was clear and neither the summary plan description nor other plan documents supported the employer's claim of a scrivener's error.

From this authority, we conclude that ERISA § 502(a)(3) authorizes equitable reformation of a plan that is shown, by clear and convincing evidence, to contain a scrivener's error that does not reflect participants' reasonable expectations of benefits. Though complex in design, ERISA maintains the basic goal of "protecting employees' justified expectations of receiving the benefits their employers promise them." *Cent. Laborers' Pension Fund v. Heinz*, 541 U.S. 739, 743 (2004). It would thwart this goal to enforce erroneous plan terms contrary to those expectations, even if doing so would increase employees' benefits. The "appropriate equitable relief" authorized by § 502(a)(3) allows a court to reform an ERISA plan to avoid such an unfair result. *See Cent. Pa. Teamsters Pension Fund v. McCormick Dray Line, Inc.*, 85 F.3d 1098, 1105 n.2 (3d Cir. 1996) ("[I]n circumstances where a court can

establish that no plan participants were likely to have relied upon the scrivener's error in question . . . allowing reformation of the scrivener's error does not thwart ERISA's statutory purpose . . . ."); *Murata*, 980 F.2d at 907 ("[T]he alleged error relates to what is admittedly a 'windfall' . . . that neither side could have reasonably expected."); *cf. Mathews*, 144 F.3d at 469 ("We cannot see how ERISA beneficiaries or anyone else . . . would be benefited by the adoption of principles of contractual interpretation so rigid and archaic as to permit the class to reap the pure windfall here sought to the potential prejudice of other beneficiaries.").

We acknowledge, like the Third Circuit in *Murata*, 980 F.2d at 907, that equitable reformation of an ERISA plan creates some tension with the "written instrument" requirement of 29 U.S.C. § 1102(a)(1), also known as the "plan documents rule," *Kennedy*, 129 S. Ct. at 877. This rule ensures "that every employee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan," *Murata*, 980 F.2d at 907, without complicated "enquiries into nice expressions of intent" behind plan language, *Kennedy*, 129 S. Ct. at 875. Young cautions that allowing equitable reformation of ERISA plans will undermine the efficient, easily enforceable plan documents rule and encourage protracted, discovery-intensive litigation over the intended meaning of a plan.

Even so, since we interpret § 502(a)(3) to authorize the equitable reformation claim asserted here, we cannot simply reject such a claim based on the added litigation

burden that it might represent. Moreover, we see little difference between the intent-based inquiry that took place in this reformation case and what must occur in the related case of an ambiguous ERISA plan. In each case, the court must look beyond the plan document to extrinsic evidence to determine the parties' understanding of the plan. *See Mathews*, 144 F.3d at 467. We do not think that the availability or scope of this judicial inquiry should turn on whether the error in an ERISA plan is deemed an "ambiguity" or a "scrivener's error." Drafting mistakes in ERISA plans may take many forms; some involve language that is ambiguous on its face while others, like the mistake here, involve language that is not intrinsically ambiguous but still misstates participants' benefits. It would not further the purposes of ERISA to allow courts to correct one type of mistake but not the other.

Also, other limitations on the equitable reformation claim that we recognize under § 502(a)(3) will mitigate its impact on the plan documents rule. Only those who can marshal "clear and convincing" evidence that plan language is contrary to the parties' expectations will have a viable claim. *Murata*, 980 F.2d at 908. This standard of proof is rigorous, requiring evidence that is "clear, precise, convincing and of the most satisfactory character that a mistake has occurred and that the mistake does not reflect the intent of the parties." *Id.* at 907 (quotation omitted); *accord Blackshear*, 509 F.3d at 642. The evidence also must be "objective" and not dependent "on the credibility of testimony (oral or written) of an interested party." *Mathews*, 144 F.3d at 467. These high

standards of proof should deter an employer from seeking to reform plan language simply because it has proven unfavorable.

In this case, though, we agree with the district court that Verizon presented enough objective, convincing evidence to show that the second reference to the transition factor in § 16.5.1(a)(2) of the Cash Balance Plan was a scrivener's error inconsistent with participants' expected benefits.

The drafting history left little doubt that the second transition factor in § 16.5.1(a)(2) was a mistake. It first appeared in the fourth draft of the Plan, the first draft prepared by Bell Atlantic attorney Barry Peters. This draft reformatted the multiplication formula in § 16.5.1(a)(2), but in doing so, failed to omit the prior draft's trailing clause that referred to the transition factor, thereby duplicating the transition factor. We need not rely on Peters's arguably self-serving testimony to conclude that this botched reformatting led to the second transition factor; so much is clear by comparing the fourth draft with the prior version. And given the absence of any evidence contemporaneous to the fourth draft suggesting that Bell Atlantic was reworking the Plan to increase benefits, it is evident that duplicating the transition factor was a drafting mistake.

The communications and course of dealing between Bell Atlantic/Verizon and plan participants further illustrate that the parties intended a single-transition-factor formula. Young and other participants received a Plan brochure that described their opening cash balances

as the product of their lump-sum values under the 1995 BAMPP and a single transition factor. Although the brochure did not explicitly state that a "single" transition factor would be used, the formula depicted in the brochure makes clear that only one multiplier would apply. That was confirmed in the personalized statements sent to participants of their estimated and actual opening cash balances, which reported values based on the use of a single transition factor. By way of illustration, Young received an estimated opening balance statement that reported her transition factor of 2.659 and her BAMPP lump-sum cashout value of $90,027, for an estimated opening balance of $239,381. Her actual opening balance reported in a later statement, $240,127, was calculated similarly. If a second 2.659 transition factor were applied to these figures, Young's estimated and actual opening balances would have been $636,514 and $638,498, respectively. Bell Atlantic/Verizon never squared transition factors in this manner but instead calculated benefits using only a single transition factor, consistent with the Plan communications. Prior to Young's claim, no employee complained that cash balances should have been increased by an additional transition factor.

Granted, many of the Plan communications, including the Plan brochure and opening balance statements, are less compelling because they contain what Young describes as "plan trumps" provisions, which stated that the communications were subordinate to any contrary language in the Plan. As Young points out, were the situation reversed and the employee-favorable language

contained in a Plan communication rather than the Plan itself, Verizon no doubt would contend that these plan trumps provisions barred Young from relying on the communication. *See Kolentus v. Avco Corp.*, 798 F.2d 949, 958 (7th Cir. 1986) ("[W]hen the summary booklet expressly states that it is merely an outline of the pension plan and that the formal text of the plan governs in the event a question arises, the plaintiffs cannot rely on the general statements of the booklet but must look to the plan itself."). Young's point is well-taken, but we cannot agree that the mere existence of plan trumps provisions precludes Verizon from reforming the Plan consistent with Plan communications. At issue is whether Verizon has established by clear and convincing evidence that the intended meaning of § 16.5.1(a)(2) was to apply only a single transition factor to calculate opening cash balances. Verizon may include all the Plan communications describing a single-transition-factor formula as part of that evidence, even though they contain plan trumps provisions.

Based on this evidence of the intended meaning of the Plan, the district court correctly found that the second transition factor in § 16.5.1(a)(2) was a scrivener's error inconsistent with plan participants' expected benefits. Under these circumstances, equitable reformation of the Plan to remove the error is appropriate.

We close our discussion of Verizon's reformation claim by considering additional defenses to equitable relief. Because Verizon's claim is one for "appropriate equitable relief" under ERISA § 502(a)(3)(B), 29 U.S.C.

§ 1132(a)(3)(B), it is subject to the traditional equitable defenses at common law, provided that they are not inconsistent with ERISA.

Young raises the defense of "good faith" and "fair dealing," under which a contracting party may be precluded from reforming a mistake caused by the party's own "gross" negligence. Restatement (Second) of Contracts § 157 & cmt. a (1981). As the district court put it, Bell Atlantic/Verizon's failure to prevent the drafting mistake in § 16.5.1(a)(2) was "profound" negligence. Bell Atlantic charged a single in-house attorney, Barry Peters, with revising a critical provision of a multi-billion-dollar pension plan, apparently without critical review by another ERISA expert. It is baffling that a major corporation would not invest greater resources to ensure accuracy in the drafting of such an important document. Still, we cannot agree with Young that this institutional failure showed a lack of good faith. Verizon never misrepresented its intended meaning of the Cash Balance Plan, and indeed, based on the extrinsic evidence examined above, it made great efforts to accurately communicate how participants' benefits would be calculated. *Cf. id.* cmt. a, illustration 2 (misrepresentation that party verified bid for accuracy was failure to act in good faith).

For similar reasons, we do not accept Young's "unclean hands" defense, under which "equitable relief will be refused if it would give the plaintiff a wrongful gain." *Scheiber v. Dolby Labs., Inc.*, 293 F.3d 1014, 1021 (7th Cir. 2002). A plaintiff who acts unfairly, deceitfully, or in bad

faith may not through equity seek to gain from that transgression. *See Packers Trading Co. v. Commodity Futures Trading Comm'n*, 972 F.2d 144, 148-49 (7th Cir. 1992). Verizon made a mistake, and a big one at that, in drafting the Cash Balance Plan, but Verizon did not attempt to deceive plan participants regarding their benefit rights under the intended meaning of § 16.5.1(a)(2). *Cf. id.* (barring relief for a plaintiff who concealed his knowledge of the defendant's mistake and then attempted to recover based on that mistake). On the contrary, Verizon's Plan administration and communications reflected its consistent view that opening cash balances would be calculated using only a single transition factor.

Finally, Young raises the equitable defense of laches, or unreasonable delay, by Verizon in seeking equitable reformation. Laches means "culpable delay in suing" and may apply if the plaintiff commits an unreasonable, prejudicial delay in bringing the suit. *Teamsters & Employers Welfare Trust of Ill. v. Gorman Bros. Ready Mix*, 283 F.3d 877, 880 (7th Cir. 2002). For reasons explained above in our discussion of the statute of limitations, Verizon did not unreasonably delay in bringing its equitable reformation claim. Although Verizon learned of the scrivener's error in the Cash Balance Plan in 1997, at that time it had no reason to believe that this error would lead to a benefits dispute. Instead, the parties' correspondence and course of dealing were consistent with Verizon's understanding that only a single transition factor would be used to calculate benefits. By 1998, Verizon had corrected the Plan to reflect this understanding, and

no employee communicated a contrary interpretation before Young brought her administrative claim in 2004. Since this course of conduct reinforced Verizon's interpretation of the Cash Balance Plan, Verizon did not "sleep on [its] rights," *Hot Wax, Inc. v. Turtle Wax, Inc.*, 191 F.3d 813, 820 (7th Cir. 1999), by not bringing an equitable reformation claim before Young's lawsuit.

In sum, no equitable defenses bar Verizon's equitable reformation claim under ERISA § 502(a)(3), and the district court properly granted that claim to remove the scrivener's error from the Cash Balance Plan.

C. Discount Rate for Opening Cash Balances

In addition to her argument regarding the second transition factor in § 16.5.1(a)(2), Young claimed that Verizon improperly applied the enhanced, 120% PBGC discount rate used in the 1995 BAMPP to calculate her opening balance under the Cash Balance Plan. Verizon's Review Committee denied Young's discount rate claim, and because the Plan grants the administrator broad discretion to interpret Plan provisions, we review the Committee's decision for an abuse of discretion. *See Black v. Long Term Disability Ins.*, 582 F.3d 738, 744 (7th Cir. 2009).

The interpretation of ERISA plans is governed by federal common law, which draws on general principles of contract interpretation to the extent they are consistent with ERISA. *Mathews*, 144 F.3d at 465. Under these principles, contract language is given its plain and ordi-

nary meaning. *Pitcher v. Principal Mut. Life Ins. Co.*, 93 F.3d 407, 411 (7th Cir. 1996). Contracts must be read as a whole, and the meaning of separate provisions should be considered in light of one another and the context of the entire agreement. *Taracorp, Inc. v. NL Indus., Inc.*, 73 F.3d 738, 745 (7th Cir. 1996). Contract interpretations should, to the extent possible, give effect to all language without rendering any term superfluous, *id.* at 746, but if both a general and a specific provision apply to the subject at hand, the specific provision controls, *Medcom Holding Co. v. Baxter Travenol Labs., Inc.*, 984 F.2d 223, 227 (7th Cir. 1993).

The use of a discount rate to calculate opening balances under the Cash Balance Plan occurs by operation of § 16.5.1(a)(2). That section defines opening cash balances as the product of two variables (assuming, of course, one ignores the second "transition factor" that we have disregarded as a scrivener's error): "(A) the Participant's applicable Transition Factor described in Table 1 of this Section, *times* (B) the lump-sum cashout value of the Accrued Benefit payable at age 65 under the 1995 BAMPP Plan . . . ." Under § 4.19 of the BAMPP, which was attached to the Cash Balance Plan as an appendix, lump-sum payments for employees who retired during the 1994-1995 cashout window were calculated using a discount rate of 120% of "the applicable PBGC interest rate."

Reading the language of § 16.5.1(a)(2) in the context of the entire Cash Balance Plan—including the attached 1995 BAMPP—the best interpretation is one that applies the

120% PBGC discount rate used in the 1995 BAMPP to calculate opening cash balances. The plain meaning of the "(B)" variable in § 16.5.1(a)(2)—"the lump-sum cashout value . . . payable . . . under the 1995 BAMPP Plan"—is the lump-sum value *as calculated* under the 1995 BAMPP. Since the BAMPP used a 120% PBGC discount rate, that same methodology carries over to calculating opening balances under the Cash Balance Plan.

Young points to the umbrella section 16.5.1, which provides that any "present value" that "must be determined under this Section 16.[5] shall be determined . . . using the PBGC interest rates which were in effect for September of 1995." Young would apply this present value definition, which uses a discount rate of simply 100% of the PBGC rate, to determine the "lump-sum cashout value" in § 16.5.1(a)(2). Young's interpretation ignores the explicit reference in § 16.5.1(a)(2) to the cashout value "under the 1995 BAMPP Plan." Because § 16.5.1(a)(2) specifically uses the 1995 BAMPP formula for discounting lump-sum values, the more general present value formula in § 16.5.1 does not apply to that section.

We also disagree with Young that incorporating the 1995 BAMPP, 120% PBGC formula into § 16.5.1(a)(2) in this manner renders the 100% PBGC formula in § 16.5.1 superfluous. The latter formula applies broadly to calculate present values under "this Section 16.[5]." Notably, unlike § 16.5.1(a), provisions in § 16.5.2(a) use the "present value" term defined in § 16.5.1 to determine opening cash balances for employees covered by those sections.

So it harmonizes all the language in § 16.5 to give effect to the 120% PBGC rate incorporated into § 16.5.1(a)(2) for that specific provision, while giving effect to the general 100% PBGC rate for other provisions in § 16.5.

The most reasonable reading of § 16.5.1(a)(2) is one that applies the 120% PBGC discount rate to calculate opening cash balances. At the very least, Verizon's Review Committee did not abuse its discretion in adopting this interpretation.

III. Conclusion

ERISA's rules for written plans are strictly enforced, but they are not so strict as to prevent equitable reformation of a plan that is shown, by clear and convincing evidence, to contain a scrivener's error that is inconsistent with participants' expected benefits.

AFFIRMED.

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WORKER CLASSIFICATION: IMPACT ON EMPLOYEE BENEFITS

Miller & Chevalier Worker Classification Seminar
March 4, 2008

Fred Oliphant
Elizabeth F. Drake

I. EMPLOYEE BENEFIT PLAN CONSEQUENCES FOR WORKER CLASSIFICATION

A. Classification for Employees for Benefits and Qualified Plans

1. The Code definitions of "employee," by their terms, are limited to the employment tax provisions. Tax-qualified retirement and profit-sharing plans are subject to the "exclusive benefit" rule of Code § 401(a)(2), which limits participation in such plans to the participating employer's "employees." Note that an independent contractor can establish a qualified retirement plan for him or herself and cannot participate in the plan of a service recipient. Code § 401(c).

2. Other tax-preferences in the Code are also limited to "employees," such as group term life insurance under Code § 79, exclusions for sick and accident coverage under Code §§ 105 and 106; cafeteria plans under Code § 125, a legal assistance plan under Code § 127; and a dependent care assistance program under Code § 129.

3. In *Nationwide Mutual Ins. Co. v. Darden*, 503 U.S. 318 (1992), the Supreme Court held that for purposes of ERISA an "employee" is defined using the common-law standard. The opinion cites Rev. Rul. 87-41 as an example of the factors taken into account under the common law.

4. Consistent with *Darden*, the IRS takes the view that the same common law test specified under Code § 3121(d)(2) applies for other purposes under the Code, including employee benefit plan provisions. *See e.g.*, PLR 9546018 (Aug. 18, 1995).

   a. Thus, the IRS position is that the same services cannot give rise to an employee-employer relationship for one purpose under the Code as well as an independent contractor relationship for another purpose under the Code.

   b. This reading of *Darden* is the basis for the IRS entering into closing agreements and providing other relief for businesses who provided tax-qualified benefits to workers who were later determined to be independent contractors. *See, e.g.,* P.L.R. 9546018 (Aug. 18, 1995); Press Release, 98 TNT 178-23, Doc. 98-28069 (announcing

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an agreement to preserve qualification of retirement plans for insurance agents).

5. Some uncertainty regarding the classification of individuals for employee benefit plan purposes has been raised by *Ware v. United States*, 67 F.3d 574 (6th Cir. 1995). The 6th Circuit upheld a district court's determination that an individual was an independent contractor, but stated in *dicta* that the application of the common law test for classifying workers might differ depending on the context and as an example stated that "control and supervision" may be less important in analyzing the classification of a worker for employee benefit plan purposes. In addition, the decision in the 9th Circuit opinion in *Vizcaino v. Microsoft* suggests that both a leasing firm and a service recipient could be the employer for purposes of a qualified plan.

6. There are special rules for determining whether "leased employees" are treated as employees for purposes of employee benefit plans. In general, a leased employee must be counted as an employee of the service recipient for purposes of determining whether a retirement plan meets the qualification requirements, as well as for other employee benefit plans, including cafeteria plans, group term life insurance, and fringe benefits.

7. A leased employee is a worker (i) whose services are provided to the recipient on a substantially full-time basis for at least one year (ii) under a contract with a third-party organization and (iii) under the primary direction and control of the service recipient. Code § 414(n). Note that the standard under (iii) was changed, effective in 1997, by the Small Business Job Protection Act of 1996. Under prior law, the standard was whether the work was "historically performed" by employees. The change in the definition is considered to be a narrowing of the leased employee definition.

II. THE CONSEQUENCES OF WORKER CLASSIFICATION DECISIONS IN EMPLOYEE BENEFIT PLANS

A. Background

1. Workers who are reclassified as common-law employees and who are covered under the terms of an employee benefit plan have a contractual right to benefits, which is protected under the Employee Retirement Income Security Act.

2. Accrual of benefits for reclassified employees who are covered under the terms of a qualified plan could raise plan qualification issues if benefits are not provided because the plan must be administered consistent with its written terms. *See* Reg. § 401-1(a)(2) (requirement that plan be a "definite written program").

3. Plan qualification issues also could arise even if the reclassified workers are not covered under the terms of the plan but their reclassification causes the plan to fail to meet the nondiscriminatory coverage rules. *See e.g., Kenney v. Comm'r*, 70 T.C.M. (CCH) 614 (1995), in which a retirement plan was disqualified because it failed to benefit a sufficient number of nonhighly compensated employees as a result of misclassification

4. In a series of cases, workers who have been treated as independent contractors or as employees of another entity (*e.g.*, leased workers) have sued for retroactive coverage under employee benefit plans after being reclassified as common-law employees. These cases are discussed below.

B. **Exclusion of Non-Employees**

1. The exclusive benefit rule generally prohibits a tax-qualified plan from covering a worker who is not an employee of the employer.

   a. In *Professional & Executive Leasing, Inc. v. Commissioner*, 862 F.2d 751 (9th Cir. 1988), *aff'g* 89 T.C. 225 (1987), a plan covering non-employees was disqualified on the basis that the plan was not established for the exclusive benefit of employees.

   b. There have been a number of cases addressing whether an individual who covered himself under a tax-qualified plan sponsored by the individual in the capacity as a self-employed individual was entitled to deduct contributions to the plan.

      i. In these cases, the IRS argued that the individual could not sponsor a tax-qualified plan because he was an employee of another entity, and not self-employed. *See, e.g., Jacobs v. Commissioner*, T.C. Memo 1993-570, 66 T.C.M. (CCH) 1470(1993), as amended 94 T.N.T. 10-7 (1994); *Reece v. Commissioner*, T.C. Memo 1992-335, 63 T.C.M. (CCH) 3129 (1992); *Herman v. Commissioner*, T.C. Memo 1986-590, 52 T.C.M. (CCH) 1194 (1986); *Bilenas v. Commissioner*, T.C. Memo 1983-661, 47 T.C.M. (CCH) 217 (1983); *Pulver v. Commissioner*, T.C. Memo 1982-437, 44 T.C.M. (CCH) 644 (1982); and *Azad v. United States*, 388 F.2d 74 (8th Cir. 1968), *aff'g* 277 F. Supp. 258 (D.C. Minn. 1966).

   c. It is not necessary that a plan's eligibility provisions expressly state that independent contractors are excluded if it is otherwise clear that only employees are covered. However, a plan's eligibility provisions need to be carefully drafted to avoid complications that could arise if individuals whom the sponsor classifies as non-employees are reclassified as employees.

C. **Exclusion of Employees including Reclassified Workers**

1. An employer is not required to provide benefits under the plan to all its employees. Instead, within certain parameters discussed below, an employer is permitted to select which individuals it wishes to cover under its plan. *See Bronk v. Mountain States Tel. and Tel., Inc.*, 140 F.3d 1335 (10th Cir. 1998); *Central States, Southeast and Southwest Areas Pension Fund v. Hartlage Truck Serv. Inc.*, 991 F.2d 1357 (7th Cir. 1993); *Abraham v. Exxon Corp.*, 85 F.3d 1126, 1130 (5th Cir. 1996); *Clark v. E. I. DuPont De Nemours & Co., Inc.*, No. 95-2845, 1997 U.S. App. LEXIS 321 (4th Cir. Jan. 9, 1997), *cert. denied*, 117 S. Ct. 2425 (1997). *See also Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) ("ERISA does not . . . proscribe discrimination in the provisions of employee benefits.").

2. The minimum participation rules under Code § 410(a) provide that, in general, a tax-qualified plan may not require, as a condition of participation, that an employee complete more than one year of service or attain an age greater than 21.

   a. The minimum participation rules are slightly different as applied to tax-exempt educational institutions and where the plan provides for immediate vesting after two years. *See* Code §§ 410(a)(1)(B)(i), (ii); *see also* ERISA § 202(a).

   b. The minimum participation standards were designed "to ensure that employee pension expectations are not defeated" by shifting age or service length requirements. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510 n.5 (1981).

   c. Code § 410(a) only precludes an employer from excluding an employee on the basis of the employee's age or service. Treas. Reg. § 1.410(a)-3(d) ("Section 410(a) [does] not preclude a plan from establishing conditions, other than conditions relating to age or service, which must be satisfied by plan participants"). Accordingly, an exclusion based on a factor other than age or service is permissible under Code § 410(a). *But see Renda v. Adam Meldrum & Anderson Co.*, 806 F. Supp. 1071 (W.D.N.Y. 1992) (discussed *infra*); *Crouch v. Mo-Kan Iron Workers Welfare Fund*, 740 F.2d 805 (10th Cir. 1984).

   d. However, the regulations under Code § 410(a) state, "[P]lan provisions may be treated as imposing age or service requirements even though the provisions do not specifically refer to age or service. Plan provisions which have the effect of requiring an age or service requirement with the employer or employers maintaining the plan will be treated as if they imposed an age or service requirement." Treas. Reg. § 1.410(a)-3(e). *See also* Preamble to

T.D. 7508, 1975 TM LEXIS 46; QAB FY-2006 No. 3 (discussed *infra)*.

i. Example: Corporation A is divided into two divisions. In order to work in Division 2, an employee must first have been employed in Division 1 for five years. A plan provision which required Division 2 employment for participation will be treated as a service requirement because such a provision has the effect of requiring 5 years of service. Treas. Reg. § 1.410(a)-3(e)(2)(Ex. 1).

ii. Example: A plan which requires one year of service as a condition of participation excludes a part-time or seasonal employee if his customary employment is for not more than 20 hours per week or five months in any plan year. The plan does not qualify because the provision could result in the exclusion, by reason of a minimum service requirement, of an employee who has completed one year of service. The plan would not qualify even though, after excluding all such employees, the plan satisfied the coverage requirements of § 410(b). Treas. Reg. § 1.410(a)-3(e)(2)(Ex. 3). See also IRS Ann. 75-110, 1975 IRB LEXIS 32, *17 (1975).

iii. Example: Employer A establishes a plan which covers employees after they retire and does not cover current employees unless they retire. Any employee who works past age 60 is treated as retired. The plan fails to satisfy the requirements of § 410(a) because the plan imposes a minimum age and service requirement in excess of that allowed by this section. Treas. Reg. § 1.410(a)-3(e)(2)(Ex. 4).

e. The distinction between eligibility categories based on job classification and those based on a service or age consideration is not always straightforward. From a practical standpoint, it may be difficult to determine solely from the plan's terms whether an exclusion is based on the nature of the employees' work, which would be permissible, or the employee's length of service, which would violate Code § 410(a).

i. For example, the regulations provide an example where eligibility is based on whether the individual is employed at Division 1 or Division 2. The relevant plan only covered employees employed at Division 2. On its face, this seems to be a classification based on a factor other than age or service. However, the regulations state that the classification is a disguised service requirement because an employee can only work at Division 2 after completing five years of employment with the employer.

ii. One way to interpret this example is to assume that the distinction between Division 1 and Division 2 has no business significance. Under that interpretation, the only characteristic shared by the excluded employees in Division 1 is their status as employees who have been with the employer less than five years. Thus, the "divisions" were not true job or business classifications, but merely disguised service classifications.

iii. Query: Would the conclusion be different if there were some business reason for the classification? How strong must the business justification be?

f. The difficulty in determining whether a classification is a disguised age or service requirement is illustrated by a case where a court considered whether the exclusion of all "casual workers" was permissible. *See Central States v. Hartlage Truck Servs., Inc.*, 991 F.2d 1357 (7th Cir. 1993).

i. Casual workers were those employees who only worked as needed or to fill in for other employees who were on leave for vacation, sickness, or disability.

ii. The excluded casual worker argued that the exclusion of "casual" employees was an impermissible exclusion based on service because it excluded employees who worked intermittent or irregular schedules, but who nevertheless could perform one year of service.

iii. The court upheld the exclusion, concluding that "casual" describes the nature of the work being performed, *i.e.*, those with irregular job assignments or duties.

D. In addition to the 410(a) participation rules, a number of other tax qualification rules turn on the number of employees of the employer. These include the § 410(b) coverage rules, § 401(a)(4) nondiscrimination rules, and the § 416 top-heavy requirements.

III. THE CASE LAW: RECLASSIFIED WORKERS CLAIMING EMPLOYEE BENEFITS

A. Microsoft—Workers Prevail Based on Plan Language

1. The litigation against Microsoft and its employee benefit plans illustrates the legal issues and potential liabilities associated with misclassification of contingent workers. This litigation has produced three separate opinions from the 9th Circuit Court of Appeals. *Vizcaino v. Microsoft*, 97 F.3d 1187 (9th Cir. 1996), 105 F.3d 1334 (9th Cir. 1997), *reh'ing en banc* 120 F.3d 1006 (9th Cir. 1997); *Microsoft Corp. v. Vizcaino*, U.S. Sup. Ct. No. 97-

854 (review denied 1/26/98) (rejection of company's request that 9th Circuit's decision on the issue of workers' eligibility to participate in ESPP be reversed or remanded); 173 F.3d 713 (1999) (leased employees allowed to participate in ESPP).

2. In *Vizcaino v. Microsoft,* 97 F.3d 1187 (9th Cir. 1996) *(Vizcaino I),* the U.S. Court of Appeals for the Ninth Circuit reversed the district court and held that workers were entitled to retroactive benefits under the Microsoft qualified savings plan and the employee stock purchase plan, notwithstanding that the terms of the workers written contracts stated that the workers would receive no benefits.

3. Microsoft did not contest the workers' status as common-law employees, but argued that the employees were not entitled to benefits under the savings plan because it covered only the employees on the "U.S. payroll." Microsoft argued that this language precluded the workers' claims because they were not treated as employees for payroll purposes and, instead, were paid like any other vendor to the company.

4. The 9th Circuit did not give deference to the plan administrator's interpretation of the plan language and, instead, reviewed the case *de novo*. The standard of review is significant because it allowed the court to substitute its interpretation of the plan rather than review the plan administrator's interpretation under an arbitrary and capricious standard.

5. With respect to the employee stock purchase plan, Microsoft argued that the terms of the workers' agreements precluded their being covered under the plan. The court, however, determined that the plan incorporated the provisions of Code § 423, which generally requires that all common-law employees be covered by the plan (except for certain short service employees).

6. On rehearing, *en banc*, the 9th Circuit once again reversed the district court's decision in favor of Microsoft. *Vizcaino v. Microsoft Corp.*, No. C93-178D, 120 F.3d 1006 (9th Cir. 1997), *cert. denied*, 118 S. Ct. 899 (1998) ("*Vizcaino II*"). The court again found that the reclassified workers were covered under the ESPP. However, it remanded the case so that the plan administrator could make a determination as to whether the reclassified workers were covered under the terms of the Savings Plan.

    a. The court made the interesting observation: "We could decide that Microsoft knew that the Workers were employees, but chose to paste the independent contractor label upon them after making a rather amazing series of decisions to violate the law. Or we could decide that Microsoft mistakenly thought that the Workers were independent contractors and that all else simply seemed to flow from that status."

b. This statement sheds light on why the court did not embrace the argument that Microsoft meant to exclude the workers; if it accepted Microsoft's argument at face value, the court viewed that it would follow that Microsoft was acting in bad faith. Microsoft seemed to be in a catch-22 situation.

c. *Vizcaino II* is helpful to employers to the extent that it reaffirms the plan administrator's exclusive role in interpreting the terms of a qualified plan (provided the plan grants him such discretion).

d. *Vizcaino II* is not helpful to employers, however, to the extent that it gives no weight to the terms of the employment contracts.

7. In *Vizcaino III*, 173 F.3d 713 (9th Cir. 1999), *cert. denied* 528 U.S. 1105), the 9th Circuit reversed the district court's decision on remand and introduced even more uncertainty into the area of worker classification whenever services are provided to a service recipient by employees of a leasing organization.

   a. The court adopted the premise that a worker in a three-party arrangement can have two masters by misapplying several old employment tax revenue rulings. The court failed to consider the only recent guidance on worker classification issued by the IRS, which specifically concluded that incorporation of a worker (*e.g.*, where the worker is "employed" by a personal service corporation) is deemed to be a generally accepted indicator that the worker is an employee of that corporation, not of the entity receiving the worker's services. *See* IRS Training Materials at 2-23. In addition, the IRS Training Materials conceded that in a close case, the designation of the worker's status in a written contract (*e.g.*, as an employee of the service recipient, of himself, or of another corporation) "is an effective way to resolve the [status] issue…in close cases." IRS Training Materials at 2-22. In essence, the court ignored the contractual agreement of the parties, and retroactively granted the leased employees the best of all possible worlds — *i.e.*, retention of their contractually agreed-upon cash wages (which were higher than the wages that they would have earned as employees of Microsoft), retention of the benefits of coverage by the leasing company's plans, and retroactive reward of all the benefits of coverage by Microsoft's SPP and ESPP plans as well.

   b. The court in *Vizcaino III* also ignored the fact that Code § 414(n) does not require that the workers be provided benefits by both the leasing company and by the service recipient. Instead, § 414(n) simply provides, in any case where a service-recipient leases employees from another employer, the service-recipient, in testing its own benefits plans for possible discrimination, must count certain long-service leased employee as "recipients of zero benefits" from the service-recipient. Thus, if a service-recipient hires too many leased employees, and

retains their services for over a year, that practice may cause discrimination testing problems for the service recipient.

c. The 9th Circuit likewise failed to understand that Code § 414(n), by its terms, applies solely in cases where the "leased workers" are in fact the employees of the leasing company, and not the common-law employees of the client company. If this prerequisite is not met, the leased employee should be treated as an employee of the service-recipient, and not as an employee of the leasing company. In short, the statute is constructed to require a choice between employers, not the potential receipt of two sets of benefits from dual employers. Thus, the initial critical determination in any leased employee benefits case must be a determination of whether the leased employee is the employee of the leasing organization (and subject to the reach of Code § 414(n)) or the employee of the client company (and potentially entitled to benefits as a common-law employee). *See, e.g., Burrey v. Pacific Gas & Electric Co.,* 159 F.3d 388 (9th Cir. 1998) (discussed *infra*).

d. The court also cited several IRS rulings in support of this dual-employer proposition. All of the rulings pertain to the issue of employment tax liabilities, rather than benefits' coverage. For example, Rev. Rul. 66-162, 1966-1 C.B. 234, concluded that clerks of a concessionaire in a department store were employees of both the concessionaire and the department store for employment tax purposes. That ruling did not address employee benefits, and (even more critically) it did not deal with a case where the parties had contractually agreed that only one company would be the "employer" of the worker.

e. Finally, the court in *Vizcaino III* relied on Rev. Ruls. 87-41, 1987-1 C.B. 296, and 75-41, 1975-1 C.B. 323, to conclude that the workers at issue had dual employers. Neither of these rulings, however, addressed whether the workers could be the employees of *both* an employment agency and the client. In fact, Rev. Rul. 87-41 makes it clear that the ruling has *no application to the service recipient* in a three-party arrangement—the real crux of the ruling being the employment tax liability of a leasing organization under a 1986 amendment to § 530 of the Revenue Act of 1978 which provides special relief to employers if they mistakenly treat their employees as independent contractors. Likewise, Rev. Rul. 75-41 does not conclude that works of a leasing organization are the employees of both the recipient of the services and the leasing organization. To the contrary, the ruling concludes that the workers entered into contracts with the leasing organization which gave the latter the right to control and direct the performance of their services as the employer.

B. **Exxon, Dupont and Capital Cities: Employers Prevail Based on Plan Language and Contract Analysis**

1. In *Abraham v. Exxon Corp.,* 85 F.3d 1126 (5th Cir. 1996), the 5th Circuit held that workers who were reclassified as employees were not entitled to retroactive benefits.

2. Like Microsoft, Exxon conceded the workers' status as common-law employees. In contrast to Microsoft, Exxon successfully argued that the language of the Exxon plan specifically excluded "leased employees." Thus, under the terms of Exxon's plan, the court held that the workers were not entitled to benefits even though they were deemed to be Exxon's employees under the common-law definition.

3. The Exxon court specifically noted that ERISA and the Code do not require coverage of all common-law employees. The court rejected the plaintiffs' argument that the prohibition on service-related participation requirements under ERISA and the Code precludes employers from excluding workers on account of their status as "leased" or "contract" employees. *See* ERISA § 202; Code § 410(a).

4. In *Clark v. Dupont*, 105 F.3d 646 (4th Cir. 1997), the 4th Circuit issued an unpublished opinion following the *Exxon* analysis with respect to leased employees who were excluded under the terms of Dupont's employee benefit plans.

5. Employment (contractor) agreements played a significant role in the case of *Capital Cities/ABC, Inc. v. Ratcliff*, 141 F.3d 1405 (10th Cir.), *cert. denied*, 1998 U.S. LEXIS 5658 (1998) involving workers who sold newspapers ("carriers"). The carriers had signed employment agreements whereby they agreed to the status of independent contractors, ineligible for benefits from the employer. In 1991, the IRS began auditing the employer's newspaper delivery system and determined that the carriers were employees. The carriers then sued for benefits under the employer's benefit plans. The plans included two welfare plans, a defined contribution plan and a defined benefit plan. The court held that the carriers were not entitled to benefits on the basis that "the Agreements constitute a mutual understanding that the carriers would not receive benefits under the . . . plans."

   a. Interestingly, the court noted that the employment agreements were not waivers. This approach was necessary because the carriers signed the agreements before the benefits were even offered and, therefore, the agreements could not be "knowing and voluntary."

   b. With regard to the defined contribution plan, the court noted that the eligibility provisions expressly excluded anyone "hired by the Company pursuant to an employment agreement . . . if such

agreement provides that such individual shall not be eligible to participate."

c. With regard to the defined benefit plan, the court also noted that the plan's eligibility provisions excluded these workers, although the basis for this conclusion seems forced.

d. The carriers argued that the eligibility provisions of the employee benefit plans should be interpreted independent of the employment agreements. The court rejected this argument, stating, "Finally, in determining the language and intent of all four plans, we cannot ignore the fact that the carriers had signed the Agreements, which specifically provided that they would receive no benefits. It defies common sense to think that the Star would simultaneously enter into explicit agreements . . . EXCLUDING the carriers from participation in the Plans, while maintaining and administering Plans which INCLUDE the carriers."

6. In *Trombetta v. Cragin Fed. Bank for Sav. Employee Stock Ownership Plan*, 102 F.3d 1435 (7th Cir. 1996), independent loan originators sued the bank they worked with for benefits, claiming that they were employees. One of several factors the plan administrator relied on in denying the workers benefits was the fact that they had signed employment agreements stating that they were independent contractors. The court determined that the plan administrator's decision was not arbitrary or capricious.

7. *Boren v. Southwestern Bell Tel. Co.*, 933 F.2d 891 (10th Cir. 1991), involved a worker who had signed annual employment agreements with an alleged employer from 1952 - 1955 and from 1959 until 1980. The contracts after 1967 stated that Mr. Boren was an independent contractor. Mr. Boren attempted to argue that, despite this agreement, the employer was contractually obligated to provide him benefits pursuant to its tax-qualified benefit plans because Mr. Boren was an employee and the plans purported to offer benefits to employees. The court did not accept Mr. Boren's argument that the pension plan should be construed independent of the employee agreements. The court did not engage in an analysis of whether Mr. Boren was an employee, holding that "the service contracts define the relationship of Mr. Boren and Southwestern Bell and determine their rights inter se." *Boren*, 933 F.2d at 894. *See Board of Trade v. Hammond Elevator Co.*, 198 U.S. 424, 437 (1905) (rights between parties may be fixed by contract). *But see Daughtrey v. Honeywell, Inc.*, 3 F.3d 1488 (11th Cir. 1993) (where the appellate court reversed and remanded the district court's holding that a worker was not an employee because she had signed an employment agreement which stated that she was an independent contractor).

C. **Renda: Employers Precluded from Drafting Plan Language to Exclude Workers**

1. In *Renda v. Adam Meldrum & Anderson Co.*, 806 F. Supp. 1071 (W.D.N.Y. 1992), a district court adopted the interpretation of ERISA § 202 and Code § 410(a) that was rejected in *Exxon* and *Dupont*. The court held that the employer could not exclude common-law employees from participation in a qualified plan based on their status (no permissible exclusion for common-law employee treated as leased employee). The analysis in *Renda* conflicts with the controlling Treasury regulation providing that a plan cannot condition participation on an employee's age or time of service beyond the statutory limits, but that a plan may contain other limitations on participation, such as an exclusion based on job classification. *See* Treas. Reg. § 1.410(a)-3(d).

2. *Renda* is a minority position and the conclusion is based on the inaccurate interpretation that employers are legally precluded under the Code and ERISA from excluding the class of employees from participation in their plans. Subsequent cases in the 2nd Circuit, 5th Circuit, and 10th Circuit have criticized the decision in *Renda* and have not followed its reasoning. *See Montesano v. Xerox Corp. Retirement Income Guarantee Plan*, 117 F. Supp. 2d 147 (D. Conn. 2000); *Abraham v. Exxon Corp.,* 85 F.3d 1126 (5th Cir. 1996); *Bronk v. Mountain States Tel. and Tel., Inc.*, 140 F.3d 1335 (10th Cir. 1998).

D. **Recent Developments**

1. Interpretation of Plan Language

a. The court in *Belluarado v. Cox Enterprises Inc. Pension Plan*, 157 Fed. Appx. 823 (6th Cir. 2005) upheld the denial of benefits to two newspaper carriers who had signed independent contractor agreements. In denying the benefits, the plan's administrator relied on the company's unwritten personnel policies, which provided that commissioned newspaper carriers were ineligible to participate in the plan. The court held that reliance on such a policy was not arbitrary and capricious.

b. In *Kolling v. American Power Conversion Corp.*, 347 F.3d 11 (1st Cir. 2003), the court upheld the denial of benefits to an independent consultant despite the ambiguous plan language that defined an "employee" as "an employee of the employer." The court noted that the company acted reasonably in interpreting the term "employee" to include only those workers who received IRS Form W-2s. *See also Machlachlan v. ExxonMobil Corp*., 350 F.3d 472 (5th Cir. 2003) *cert. denied* (2004) (finding that the administrator reasonably interpreted the plan language to exclude plaintiffs from receiving plan benefits); *see also Pearson v. AT&T Pension Benefit Plan*, 2007 U.S. Dist.

LEXIS 76448 (N.D. Ill. 2007) (employee of third party staffing agency not eligible for benefits where plan language excluded temporary and contract workers regardless of their status as a common-law employee).

c. In *Law v. Northwest Natural Gas Co*., 2007 U.S. Dist. LEXIS 32973 (D. Ore. 2007), the court held that even if the workers could prove they were common-law employees, they were nonetheless ineligible for benefits under the benefit plans. Prior to 2004, the plans excluded individuals whose compensation was in the form of a "fee under contract." In 2004, the plans were amended to limit participation to individuals classified by the company as common-law employees and whose compensation was reported by the company on Form W-2. The court upheld the plan administrator's determination that under both the pre-2004 and post-2004 plans, the plaintiffs were not eligible for benefits because they did not qualify under the plan's terms. The court also rejected the plaintiffs' allegation that the 2004 plan amendment amounted to an impermissible exclusion based on length of service. The plaintiffs argued that at the time of the amendment, the company knew (among other things) that the plaintiffs would be reaching retirement age and that it would be the subject of an IRS audit regarding the plaintiffs' independent contractor status. Noting that the amendment did not change the plaintiffs' status under the plans, the court held that the amendment clarified eligibility criteria and contained nothing that would violate ERISA's prohibition on excluding employees based on years of service.

d. In *Martin v. Public Service Electric & Gas Co.,* 2007 U.S. Dist. LEXIS 1852 (D.N.J. 2007), the court upheld the denial of benefits to three individuals who claimed they were improperly classified as independent contractors. The company expressly excluded independent contractors from its benefit plan. The court held that even if the workers were deemed common-law employees, they would nonetheless be ineligible to receive benefits under the company's plan. *See also Central Pennsylvania Teamsters Pension Fund v. Power Packaging Inc.*, 151 Fed. Appx. 145 (3d. Cir. 2005) (*unpublished*) (employer properly excluded leased employees who were not "on the payroll" as was required in the bargaining agreements).

e. The court in *Schultz v. Stoner*, 308 F. Supp. 2d 289 (S.D.N.Y. 2004) held that a plan's formal documents, and not the summary plan description ("SPD"), controlled whether certain workers were eligible for employee benefits. The plan administrator, in its denial of benefits, had relied on SPD language that limited the plan's participation in contrast with the broader, more generic language of the plan's formal documents.

f. In a departure from the cases discussed above, the court in *In re FedEx Ground Package System Inc. Employment Practices Litigation*, 2007 U.S. Dist. LEXIS 76798 (N.D. Ind. 2007) gave no deference to plan language that excluded package drivers classification by FedEx as independent contractor, "regardless of whether such individuals are subsequently reclassified by a court . . . as common law employees." The court explained that if the drivers are common law employees, they can't be independent contractors, despite FedEx classifying them as such. Thus, the court said, if the drivers show they are common law employees, they would be eligible for benefits. The court noted that allowing an employer to define eligibility through exclusionary language that denies coverage based solely on the employer's classification of workers as independent contracts, regardless of the relationship, runs counter to *Darden*.

2. Issues Particular to Leased Employees

a. In *Burrey v. Pacific Gas & Electric Co.,* 159 F.3d 388 (9th Cir. 1998) district, the plan provided that "leased employees," which it defined by referencing Code § 414(n), were not eligible to participate in the plan. In reversing the lower court's grant of summary judgment in favor of the employer, the 9th Circuit noted that the plan's reference to Code § 414(n) did not result in the exclusion of all leased employees from participation, as the reference to Code § 414(n) did not address lease employees who would also meet the definition of a common-law employee. On remand, the court held that the plaintiffs were not common-law employees under the thirteen factor *Darden* test pursuant to Code § 414(n). In denying common-law employee status, the court relied on the fact that the plaintiffs were treated as employees of the staffing agency for tax purposes and received benefits from the agency rather than defendant. *Burrey v. Pacific Gas & Electric Co.*, 1999 U.S. Dist. LEXIS 22619 (N.D. Cal. 1999).

b. In *Wolf v. Coca-Cola Co.,* 200 F.3d 1337 (11th Cir. 2000), the plan excluded "leased employees," but defined leased employees as "individuals who perform services for the Company under an agreement with a leasing organization." The plaintiff argued that she was a common-law employee, and therefore, under the analysis in *Vizcaino II* and *Burrey*, Coca-Cola was required to cover her under its employee benefit plans. The 11th Circuit disagreed, explaining reasoning that in *Vizcaino II* and *Burrey*, the relevant plan language indicated that common-law employees were covered. Thus, if a worker was found to be a common-law employee, he or she would become eligible for plan benefits. In contrast, the eligibility language in the Coca-Cola plan did not automatically cover all common-law employees, and therefore, even if the plaintiff was a common-law employee, she would not be eligible for benefits unless she was also found to have satisfied the plan's eligibility requirements.

3. Issues Particular to Temporary or Seasonal Employees

   a. In *Epright v. Environmental Resources Management, Inc. Health & Welfare Plan,* 81 F.3d 335 (3d Cir. 1996), the 3rd Circuit held that a temporary employee could not be excluded from participation if he otherwise satisfies the plan's stated eligibility criteria. Neither the plan nor any employee communication specifically addressed temporary workers. However, the plan stated that active employees (defined as working more than 30 hours/week) were eligible. The plaintiff, although classified as a temporary worker, had worked in excess of 30 hours/week during his entire tenure with the company.

   b. In *Cerra v. Harvey,* 279 F. Supp. 2d 778 (S.D. W. Va. 2003), the court did not permit the employer to exclude an employee from plan eligibility solely by defining his position as part-time if he otherwise satisfies the plan's eligibility requirements. The plaintiff was originally hired as a part-time employee, intending to work 20 hours/week. However, due to the demands of his position, he routinely worked between 160-200 hours/month. The plan language at issue provided that "full-time employees" were eligible to participate.

   c. The IRS issued QAB FY-2006 No. 3 to address the issue of whether exclusion of part-time or seasonal employees imposed an indirect service requirement on plan participation that *could* exceed one year of service (and therefore result in a violation of Code § 410(a)). The IRS noted that worker classification (*e.g.*, seasonal, part-time, temporary, etc.) should be closely scrutinized to determine if a plan is imposing a direct or indirect service requirement.

4. Issues Particular to Professional Employer Organizations ("PEOs")

   a. There are no clear guidelines regarding the provision of benefits under the Code of ERISA. Because of the exclusive benefit rule, PEOs that offer employee benefits must either (1) claim a "co-employment" relationship with the recipient company, or (2) establish their benefit plans as multiple employer plans.

   b. In Revenue Procedure 2002-21, 2002-1 CB 911 (4/24/2002), the IRS provides a limited form of relief from disqualification for defined contribution plans established by PEOs prior to May 13, 2002, for the benefit of a recipient company's existing workforce. Rev. Proc. 2002-21 provides PEOs that maintain defined contribution plans for "worksite employees" with the option of either converting the PEO retirement plan to a multiple employer plan or terminating the plan in order to avoid plan disqualification for a violation of the exclusive benefit rule. The Rev. Proc. also provides the recipient company an

opportunity to choose whether and how the PEO's decision to terminate the plan or establish a multiple employer plan should be implemented with respect to its own workers.

c. In Revenue Procedure 2003-86, 2003-2 CB 1211, the IRS provided PEOs with a transition period under Rev. Proc. 2002-21.

5. ERISA § 510 Claims

a. ERISA § 510 makes it unlawful to discharge a plan participate for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan.

b. In *Berger v. AXA Network, LLC,* 2003 U.S. Dist LEXIS 11555 (N.D. Ill. July 7, 2003), the court recognized that a claim for violation of ERISA § 510 existed where insurance agents claimed they were allegedly reclassified from "statutory employee" to "self-employed" for the purpose of interfering with the attainment of rights under the defendant insurer's benefit plans. However, the 7th Circuit subsequently affirmed the district court's granting of summary judgment on the ERISA claim in favor of the employer, stating that the individuals were independent contractors both before and after the claim. See *Berger v. AXA Network LLC*, 459 F.3d 804, (7th Cir. 2006). See also, *Seaman v. Arvida Realty Sales,* 985 F.2d 543 (11th Cir. 1993) (an actionable claim exists under ERISA § 510 where an individual's employment is terminated due to her refusal to be reclassified from an employee to an independent contractor, and such termination results in the loss of unvested health benefits and participation in the company's 401(k) plan); *Gitlitz v. Compagnie Nationale Air France,* 129 F.3d 554 (11th Cir. 1997), *rehearing denied*, 141 F.3d 1191 (11th Cir. 1998) (plaintiffs, who were salaried workers whose positions were eliminated but who were given the opportunity to perform similar tasks as independent contractors, had created an issue of fact as to whether their reclassification was with the intent of interfering with their benefits under ERISA).

c. However, in *Schwartz v. Independence Blue Cross,* 299 F. Supp. 2d 441 (E.D. Pa. 2003), the court dismissed the plaintiff's claim that a company interfered with his right to benefits in violation of ERISA § 510 by "misclassifying" him as a leased employee. In stating that "[n]o cause of action for 'misclassification' of an employee will lie under ERISA," the court found that allegedly unlawful misclassification of the plaintiffs as nonemployees or purported refusal to rehire former employees did not constitute a violation under ERISA § 510's antidiscrimination provision even if that refusal is based on the employer's desire to avoid creating future pension liability disproportionately greater than that incurred if it hired new employees without past service or pension credit. *See also Millsap v. McDonnell Douglas Corp.,* 162 F. Supp. 2d 1262 (N.D. Okla. 2001), *reversed on other grounds,* 368 F.3d 1246 (10th Cir. 2004), where the court held that ERISA § 510 requires evidence that the employer's desire to block attainment of benefits rights was a determinative factor in the employee's discharge.

WORKER CLASSIFICATION: IMPACT ON EMPLOYEE BENEFITS

Miller & Chevalier Worker Classification Seminar
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Fred Oliphant
Elizabeth F. Drake

I. EMPLOYEE BENEFIT PLAN CONSEQUENCES FOR WORKER CLASSIFICATION

A. Classification for Employees for Benefits and Qualified Plans

1. The Code definitions of "employee," by their terms, are limited to the employment tax provisions. Tax-qualified retirement and profit-sharing plans are subject to the "exclusive benefit" rule of Code § 401(a)(2), which limits participation in such plans to the participating employer's "employees." Note that an independent contractor can establish a qualified retirement plan for him or herself and cannot participate in the plan of a service recipient. Code § 401(c).

2. Other tax-preferences in the Code are also limited to "employees," such as group term life insurance under Code § 79, exclusions for sick and accident coverage under Code §§ 105 and 106; cafeteria plans under Code § 125, a legal assistance plan under Code § 127; and a dependent care assistance program under Code § 129.

3. In *Nationwide Mutual Ins. Co. v. Darden*, 503 U.S. 318 (1992), the Supreme Court held that for purposes of ERISA an "employee" is defined using the common-law standard. The opinion cites Rev. Rul. 87-41 as an example of the factors taken into account under the common law.

4. Consistent with *Darden*, the IRS takes the view that the same common law test specified under Code § 3121(d)(2) applies for other purposes under the Code, including employee benefit plan provisions. *See e.g.*, PLR 9546018 (Aug. 18, 1995).

   a. Thus, the IRS position is that the same services cannot give rise to an employee-employer relationship for one purpose under the Code as well as an independent contractor relationship for another purpose under the Code.

   b. This reading of *Darden* is the basis for the IRS entering into closing agreements and providing other relief for businesses who provided tax-qualified benefits to workers who were later determined to be independent contractors. *See, e.g.,* P.L.R. 9546018 (Aug. 18, 1995); Press Release, 98 TNT 178-23, Doc. 98-28069 (announcing

an agreement to preserve qualification of retirement plans for insurance agents).

5. Some uncertainty regarding the classification of individuals for employee benefit plan purposes has been raised by *Ware v. United States*, 67 F.3d 574 (6th Cir. 1995). The 6th Circuit upheld a district court's determination that an individual was an independent contractor, but stated in *dicta* that the application of the common law test for classifying workers might differ depending on the context and as an example stated that "control and supervision" may be less important in analyzing the classification of a worker for employee benefit plan purposes. In addition, the decision in the 9th Circuit opinion in *Vizcaino v. Microsoft* suggests that both a leasing firm and a service recipient could be the employer for purposes of a qualified plan.

6. There are special rules for determining whether "leased employees" are treated as employees for purposes of employee benefit plans. In general, a leased employee must be counted as an employee of the service recipient for purposes of determining whether a retirement plan meets the qualification requirements, as well as for other employee benefit plans, including cafeteria plans, group term life insurance, and fringe benefits.

7. A leased employee is a worker (i) whose services are provided to the recipient on a substantially full-time basis for at least one year (ii) under a contract with a third-party organization and (iii) under the primary direction and control of the service recipient. Code § 414(n). Note that the standard under (iii) was changed, effective in 1997, by the Small Business Job Protection Act of 1996. Under prior law, the standard was whether the work was "historically performed" by employees. The change in the definition is considered to be a narrowing of the leased employee definition.

II. THE CONSEQUENCES OF WORKER CLASSIFICATION DECISIONS IN EMPLOYEE BENEFIT PLANS

A. Background

1. Workers who are reclassified as common-law employees and who are covered under the terms of an employee benefit plan have a contractual right to benefits, which is protected under the Employee Retirement Income Security Act.

2. Accrual of benefits for reclassified employees who are covered under the terms of a qualified plan could raise plan qualification issues if benefits are not provided because the plan must be administered consistent with its written terms. *See* Reg. § 401-1(a)(2) (requirement that plan be a "definite written program").

3. Plan qualification issues also could arise even if the reclassified workers are not covered under the terms of the plan but their reclassification causes the plan to fail to meet the nondiscriminatory coverage rules. *See e.g., Kenney v. Comm'r*, 70 T.C.M. (CCH) 614 (1995), in which a retirement plan was disqualified because it failed to benefit a sufficient number of nonhighly compensated employees as a result of misclassification

4. In a series of cases, workers who have been treated as independent contractors or as employees of another entity (*e.g.*, leased workers) have sued for retroactive coverage under employee benefit plans after being reclassified as common-law employees. These cases are discussed below.

B. **Exclusion of Non-Employees**

1. The exclusive benefit rule generally prohibits a tax-qualified plan from covering a worker who is not an employee of the employer.

   a. In *Professional & Executive Leasing, Inc. v. Commissioner*, 862 F.2d 751 (9th Cir. 1988), *aff'g* 89 T.C. 225 (1987), a plan covering non-employees was disqualified on the basis that the plan was not established for the exclusive benefit of employees.

   b. There have been a number of cases addressing whether an individual who covered himself under a tax-qualified plan sponsored by the individual in the capacity as a self-employed individual was entitled to deduct contributions to the plan.

      i. In these cases, the IRS argued that the individual could not sponsor a tax-qualified plan because he was an employee of another entity, and not self-employed. *See, e.g., Jacobs v. Commissioner*, T.C. Memo 1993-570, 66 T.C.M. (CCH) 1470(1993), as amended 94 T.N.T. 10-7 (1994); *Reece v. Commissioner*, T.C. Memo 1992-335, 63 T.C.M. (CCH) 3129 (1992); *Herman v. Commissioner*, T.C. Memo 1986-590, 52 T.C.M. (CCH) 1194 (1986); *Bilenas v. Commissioner*, T.C. Memo 1983-661, 47 T.C.M. (CCH) 217 (1983); *Pulver v. Commissioner*, T.C. Memo 1982-437, 44 T.C.M. (CCH) 644 (1982); and *Azad v. United States*, 388 F.2d 74 (8th Cir. 1968), *aff'g* 277 F. Supp. 258 (D.C. Minn. 1966).

   c. It is not necessary that a plan's eligibility provisions expressly state that independent contractors are excluded if it is otherwise clear that only employees are covered. However, a plan's eligibility provisions need to be carefully drafted to avoid complications that could arise if individuals whom the sponsor classifies as non-employees are reclassified as employees.

C. **Exclusion of Employees including Reclassified Workers**

1. An employer is not required to provide benefits under the plan to all its employees. Instead, within certain parameters discussed below, an employer is permitted to select which individuals it wishes to cover under its plan. *See Bronk v. Mountain States Tel. and Tel., Inc.*, 140 F.3d 1335 (10th Cir. 1998); *Central States, Southeast and Southwest Areas Pension Fund v. Hartlage Truck Serv. Inc.*, 991 F.2d 1357 (7th Cir. 1993); *Abraham v. Exxon Corp.*, 85 F.3d 1126, 1130 (5th Cir. 1996); *Clark v. E. I. DuPont De Nemours & Co., Inc.*, No. 95-2845, 1997 U.S. App. LEXIS 321 (4th Cir. Jan. 9, 1997), *cert. denied*, 117 S. Ct. 2425 (1997). *See also Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) ("ERISA does not . . . proscribe discrimination in the provisions of employee benefits.").

2. The minimum participation rules under Code § 410(a) provide that, in general, a tax-qualified plan may not require, as a condition of participation, that an employee complete more than one year of service or attain an age greater than 21.

   a. The minimum participation rules are slightly different as applied to tax-exempt educational institutions and where the plan provides for immediate vesting after two years. *See* Code §§ 410(a)(1)(B)(i), (ii); *see also* ERISA § 202(a).

   b. The minimum participation standards were designed "to ensure that employee pension expectations are not defeated" by shifting age or service length requirements. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510 n.5 (1981).

   c. Code § 410(a) only precludes an employer from excluding an employee on the basis of the employee's age or service. Treas. Reg. § 1.410(a)-3(d) ("Section 410(a) [does] not preclude a plan from establishing conditions, other than conditions relating to age or service, which must be satisfied by plan participants"). Accordingly, an exclusion based on a factor other than age or service is permissible under Code § 410(a). *But see Renda v. Adam Meldrum & Anderson Co.*, 806 F. Supp. 1071 (W.D.N.Y. 1992) (discussed *infra*); *Crouch v. Mo-Kan Iron Workers Welfare Fund*, 740 F.2d 805 (10th Cir. 1984).

   d. However, the regulations under Code § 410(a) state, "[P]lan provisions may be treated as imposing age or service requirements even though the provisions do not specifically refer to age or service. Plan provisions which have the effect of requiring an age or service requirement with the employer or employers maintaining the plan will be treated as if they imposed an age or service requirement." Treas. Reg. § 1.410(a)-3(e). *See also* Preamble to

T.D. 7508, 1975 TM LEXIS 46; QAB FY-2006 No. 3 (discussed *infra)*.

i. Example: Corporation A is divided into two divisions. In order to work in Division 2, an employee must first have been employed in Division 1 for five years. A plan provision which required Division 2 employment for participation will be treated as a service requirement because such a provision has the effect of requiring 5 years of service. Treas. Reg. § 1.410(a)-3(e)(2)(Ex. 1).

ii. Example: A plan which requires one year of service as a condition of participation excludes a part-time or seasonal employee if his customary employment is for not more than 20 hours per week or five months in any plan year. The plan does not qualify because the provision could result in the exclusion, by reason of a minimum service requirement, of an employee who has completed one year of service. The plan would not qualify even though, after excluding all such employees, the plan satisfied the coverage requirements of § 410(b). Treas. Reg. § 1.410(a)-3(e)(2)(Ex. 3). See also IRS Ann. 75-110, 1975 IRB LEXIS 32, *17 (1975).

iii. Example: Employer A establishes a plan which covers employees after they retire and does not cover current employees unless they retire. Any employee who works past age 60 is treated as retired. The plan fails to satisfy the requirements of § 410(a) because the plan imposes a minimum age and service requirement in excess of that allowed by this section. Treas. Reg. § 1.410(a)-3(e)(2)(Ex. 4).

e. The distinction between eligibility categories based on job classification and those based on a service or age consideration is not always straightforward. From a practical standpoint, it may be difficult to determine solely from the plan's terms whether an exclusion is based on the nature of the employees' work, which would be permissible, or the employee's length of service, which would violate Code § 410(a).

i. For example, the regulations provide an example where eligibility is based on whether the individual is employed at Division 1 or Division 2. The relevant plan only covered employees employed at Division 2. On its face, this seems to be a classification based on a factor other than age or service. However, the regulations state that the classification is a disguised service requirement because an employee can only work at Division 2 after completing five years of employment with the employer.

ii. One way to interpret this example is to assume that the distinction between Division 1 and Division 2 has no business significance. Under that interpretation, the only characteristic shared by the excluded employees in Division 1 is their status as employees who have been with the employer less than five years. Thus, the "divisions" were not true job or business classifications, but merely disguised service classifications.

iii. Query: Would the conclusion be different if there were some business reason for the classification? How strong must the business justification be?

f. The difficulty in determining whether a classification is a disguised age or service requirement is illustrated by a case where a court considered whether the exclusion of all "casual workers" was permissible. *See Central States v. Hartlage Truck Servs., Inc.*, 991 F.2d 1357 (7th Cir. 1993).

i. Casual workers were those employees who only worked as needed or to fill in for other employees who were on leave for vacation, sickness, or disability.

ii. The excluded casual worker argued that the exclusion of "casual" employees was an impermissible exclusion based on service because it excluded employees who worked intermittent or irregular schedules, but who nevertheless could perform one year of service.

iii. The court upheld the exclusion, concluding that "casual" describes the nature of the work being performed, *i.e.*, those with irregular job assignments or duties.

D. In addition to the 410(a) participation rules, a number of other tax qualification rules turn on the number of employees of the employer. These include the § 410(b) coverage rules, § 401(a)(4) nondiscrimination rules, and the § 416 top-heavy requirements.

III. THE CASE LAW: RECLASSIFIED WORKERS CLAIMING EMPLOYEE BENEFITS

A. Microsoft—Workers Prevail Based on Plan Language

1. The litigation against Microsoft and its employee benefit plans illustrates the legal issues and potential liabilities associated with misclassification of contingent workers. This litigation has produced three separate opinions from the 9th Circuit Court of Appeals. *Vizcaino v. Microsoft*, 97 F.3d 1187 (9th Cir. 1996), 105 F.3d 1334 (9th Cir. 1997), *reh'ing en banc* 120 F.3d 1006 (9th Cir. 1997); *Microsoft Corp. v. Vizcaino*, U.S. Sup. Ct. No. 97-

854 (review denied 1/26/98) (rejection of company's request that 9th Circuit's decision on the issue of workers' eligibility to participate in ESPP be reversed or remanded); 173 F.3d 713 (1999) (leased employees allowed to participate in ESPP).

2. In *Vizcaino v. Microsoft,* 97 F.3d 1187 (9th Cir. 1996) *(Vizcaino I),* the U.S. Court of Appeals for the Ninth Circuit reversed the district court and held that workers were entitled to retroactive benefits under the Microsoft qualified savings plan and the employee stock purchase plan, notwithstanding that the terms of the workers written contracts stated that the workers would receive no benefits.

3. Microsoft did not contest the workers' status as common-law employees, but argued that the employees were not entitled to benefits under the savings plan because it covered only the employees on the "U.S. payroll." Microsoft argued that this language precluded the workers' claims because they were not treated as employees for payroll purposes and, instead, were paid like any other vendor to the company.

4. The 9th Circuit did not give deference to the plan administrator's interpretation of the plan language and, instead, reviewed the case *de novo*. The standard of review is significant because it allowed the court to substitute its interpretation of the plan rather than review the plan administrator's interpretation under an arbitrary and capricious standard.

5. With respect to the employee stock purchase plan, Microsoft argued that the terms of the workers' agreements precluded their being covered under the plan. The court, however, determined that the plan incorporated the provisions of Code § 423, which generally requires that all common-law employees be covered by the plan (except for certain short service employees).

6. On rehearing, *en banc*, the 9th Circuit once again reversed the district court's decision in favor of Microsoft. *Vizcaino v. Microsoft Corp.*, No. C93-178D, 120 F.3d 1006 (9th Cir. 1997), *cert. denied*, 118 S. Ct. 899 (1998) ("*Vizcaino II*"). The court again found that the reclassified workers were covered under the ESPP. However, it remanded the case so that the plan administrator could make a determination as to whether the reclassified workers were covered under the terms of the Savings Plan.

    a. The court made the interesting observation: "We could decide that Microsoft knew that the Workers were employees, but chose to paste the independent contractor label upon them after making a rather amazing series of decisions to violate the law. Or we could decide that Microsoft mistakenly thought that the Workers were independent contractors and that all else simply seemed to flow from that status."

b. This statement sheds light on why the court did not embrace the argument that Microsoft meant to exclude the workers; if it accepted Microsoft's argument at face value, the court viewed that it would follow that Microsoft was acting in bad faith. Microsoft seemed to be in a catch-22 situation.

c. *Vizcaino II* is helpful to employers to the extent that it reaffirms the plan administrator's exclusive role in interpreting the terms of a qualified plan (provided the plan grants him such discretion).

d. *Vizcaino II* is not helpful to employers, however, to the extent that it gives no weight to the terms of the employment contracts.

7. In *Vizcaino III*, 173 F.3d 713 (9th Cir. 1999), *cert. denied* 528 U.S. 1105), the 9th Circuit reversed the district court's decision on remand and introduced even more uncertainty into the area of worker classification whenever services are provided to a service recipient by employees of a leasing organization.

   a. The court adopted the premise that a worker in a three-party arrangement can have two masters by misapplying several old employment tax revenue rulings. The court failed to consider the only recent guidance on worker classification issued by the IRS, which specifically concluded that incorporation of a worker (*e.g.*, where the worker is "employed" by a personal service corporation) is deemed to be a generally accepted indicator that the worker is an employee of that corporation, not of the entity receiving the worker's services. *See* IRS Training Materials at 2-23. In addition, the IRS Training Materials conceded that in a close case, the designation of the worker's status in a written contract (*e.g.*, as an employee of the service recipient, of himself, or of another corporation) "is an effective way to resolve the [status] issue…in close cases." IRS Training Materials at 2-22. In essence, the court ignored the contractual agreement of the parties, and retroactively granted the leased employees the best of all possible worlds — *i.e.*, retention of their contractually agreed-upon cash wages (which were higher than the wages that they would have earned as employees of Microsoft), retention of the benefits of coverage by the leasing company's plans, and retroactive reward of all the benefits of coverage by Microsoft's SPP and ESPP plans as well.

   b. The court in *Vizcaino III* also ignored the fact that Code § 414(n) does not require that the workers be provided benefits by both the leasing company and by the service recipient. Instead, § 414(n) simply provides, in any case where a service-recipient leases employees from another employer, the service-recipient, in testing its own benefits plans for possible discrimination, must count certain long-service leased employee as "recipients of zero benefits" from the service-recipient. Thus, if a service-recipient hires too many leased employees, and

retains their services for over a year, that practice may cause discrimination testing problems for the service recipient.

c. The 9th Circuit likewise failed to understand that Code § 414(n), by its terms, applies solely in cases where the "leased workers" are in fact the employees of the leasing company, and not the common-law employees of the client company. If this prerequisite is not met, the leased employee should be treated as an employee of the service-recipient, and not as an employee of the leasing company. In short, the statute is constructed to require a choice between employers, not the potential receipt of two sets of benefits from dual employers. Thus, the initial critical determination in any leased employee benefits case must be a determination of whether the leased employee is the employee of the leasing organization (and subject to the reach of Code § 414(n)) or the employee of the client company (and potentially entitled to benefits as a common-law employee). *See, e.g., Burrey v. Pacific Gas & Electric Co.,* 159 F.3d 388 (9th Cir. 1998) (discussed *infra*).

d. The court also cited several IRS rulings in support of this dual-employer proposition. All of the rulings pertain to the issue of employment tax liabilities, rather than benefits' coverage. For example, Rev. Rul. 66-162, 1966-1 C.B. 234, concluded that clerks of a concessionaire in a department store were employees of both the concessionaire and the department store for employment tax purposes. That ruling did not address employee benefits, and (even more critically) it did not deal with a case where the parties had contractually agreed that only one company would be the "employer" of the worker.

e. Finally, the court in *Vizcaino III* relied on Rev. Ruls. 87-41, 1987-1 C.B. 296, and 75-41, 1975-1 C.B. 323, to conclude that the workers at issue had dual employers. Neither of these rulings, however, addressed whether the workers could be the employees of *both* an employment agency and the client. In fact, Rev. Rul. 87-41 makes it clear that the ruling has *no application to the service recipient* in a three-party arrangement—the real crux of the ruling being the employment tax liability of a leasing organization under a 1986 amendment to § 530 of the Revenue Act of 1978 which provides special relief to employers if they mistakenly treat their employees as independent contractors. Likewise, Rev. Rul. 75-41 does not conclude that works of a leasing organization are the employees of both the recipient of the services and the leasing organization. To the contrary, the ruling concludes that the workers entered into contracts with the leasing organization which gave the latter the right to control and direct the performance of their services as the employer.

B. **Exxon, Dupont and Capital Cities: Employers Prevail Based on Plan Language and Contract Analysis**

1. In *Abraham v. Exxon Corp.,* 85 F.3d 1126 (5th Cir. 1996), the 5th Circuit held that workers who were reclassified as employees were not entitled to retroactive benefits.

2. Like Microsoft, Exxon conceded the workers' status as common-law employees. In contrast to Microsoft, Exxon successfully argued that the language of the Exxon plan specifically excluded "leased employees." Thus, under the terms of Exxon's plan, the court held that the workers were not entitled to benefits even though they were deemed to be Exxon's employees under the common-law definition.

3. The Exxon court specifically noted that ERISA and the Code do not require coverage of all common-law employees. The court rejected the plaintiffs' argument that the prohibition on service-related participation requirements under ERISA and the Code precludes employers from excluding workers on account of their status as "leased" or "contract" employees. *See* ERISA § 202; Code § 410(a).

4. In *Clark v. Dupont*, 105 F.3d 646 (4th Cir. 1997), the 4th Circuit issued an unpublished opinion following the *Exxon* analysis with respect to leased employees who were excluded under the terms of Dupont's employee benefit plans.

5. Employment (contractor) agreements played a significant role in the case of *Capital Cities/ABC, Inc. v. Ratcliff*, 141 F.3d 1405 (10th Cir.), *cert. denied*, 1998 U.S. LEXIS 5658 (1998) involving workers who sold newspapers ("carriers"). The carriers had signed employment agreements whereby they agreed to the status of independent contractors, ineligible for benefits from the employer. In 1991, the IRS began auditing the employer's newspaper delivery system and determined that the carriers were employees. The carriers then sued for benefits under the employer's benefit plans. The plans included two welfare plans, a defined contribution plan and a defined benefit plan. The court held that the carriers were not entitled to benefits on the basis that "the Agreements constitute a mutual understanding that the carriers would not receive benefits under the . . . plans."

   a. Interestingly, the court noted that the employment agreements were not waivers. This approach was necessary because the carriers signed the agreements before the benefits were even offered and, therefore, the agreements could not be "knowing and voluntary."

   b. With regard to the defined contribution plan, the court noted that the eligibility provisions expressly excluded anyone "hired by the Company pursuant to an employment agreement . . . if such

agreement provides that such individual shall not be eligible to participate."

c. With regard to the defined benefit plan, the court also noted that the plan's eligibility provisions excluded these workers, although the basis for this conclusion seems forced.

d. The carriers argued that the eligibility provisions of the employee benefit plans should be interpreted independent of the employment agreements. The court rejected this argument, stating, "Finally, in determining the language and intent of all four plans, we cannot ignore the fact that the carriers had signed the Agreements, which specifically provided that they would receive no benefits. It defies common sense to think that the Star would simultaneously enter into explicit agreements . . . EXCLUDING the carriers from participation in the Plans, while maintaining and administering Plans which INCLUDE the carriers."

6. In *Trombetta v. Cragin Fed. Bank for Sav. Employee Stock Ownership Plan*, 102 F.3d 1435 (7th Cir. 1996), independent loan originators sued the bank they worked with for benefits, claiming that they were employees. One of several factors the plan administrator relied on in denying the workers benefits was the fact that they had signed employment agreements stating that they were independent contractors. The court determined that the plan administrator's decision was not arbitrary or capricious.

7. *Boren v. Southwestern Bell Tel. Co.*, 933 F.2d 891 (10th Cir. 1991), involved a worker who had signed annual employment agreements with an alleged employer from 1952 - 1955 and from 1959 until 1980. The contracts after 1967 stated that Mr. Boren was an independent contractor. Mr. Boren attempted to argue that, despite this agreement, the employer was contractually obligated to provide him benefits pursuant to its tax-qualified benefit plans because Mr. Boren was an employee and the plans purported to offer benefits to employees. The court did not accept Mr. Boren's argument that the pension plan should be construed independent of the employee agreements. The court did not engage in an analysis of whether Mr. Boren was an employee, holding that "the service contracts define the relationship of Mr. Boren and Southwestern Bell and determine their rights inter se." *Boren*, 933 F.2d at 894. *See Board of Trade v. Hammond Elevator Co.*, 198 U.S. 424, 437 (1905) (rights between parties may be fixed by contract). *But see Daughtrey v. Honeywell, Inc.*, 3 F.3d 1488 (11th Cir. 1993) (where the appellate court reversed and remanded the district court's holding that a worker was not an employee because she had signed an employment agreement which stated that she was an independent contractor).

C. **Renda: Employers Precluded from Drafting Plan Language to Exclude Workers**

1. In *Renda v. Adam Meldrum & Anderson Co.*, 806 F. Supp. 1071 (W.D.N.Y. 1992), a district court adopted the interpretation of ERISA § 202 and Code § 410(a) that was rejected in *Exxon* and *Dupont*. The court held that the employer could not exclude common-law employees from participation in a qualified plan based on their status (no permissible exclusion for common-law employee treated as leased employee). The analysis in *Renda* conflicts with the controlling Treasury regulation providing that a plan cannot condition participation on an employee's age or time of service beyond the statutory limits, but that a plan may contain other limitations on participation, such as an exclusion based on job classification. *See* Treas. Reg. § 1.410(a)-3(d).

2. *Renda* is a minority position and the conclusion is based on the inaccurate interpretation that employers are legally precluded under the Code and ERISA from excluding the class of employees from participation in their plans. Subsequent cases in the 2nd Circuit, 5th Circuit, and 10th Circuit have criticized the decision in *Renda* and have not followed its reasoning. *See Montesano v. Xerox Corp. Retirement Income Guarantee Plan*, 117 F. Supp. 2d 147 (D. Conn. 2000); *Abraham v. Exxon Corp.,* 85 F.3d 1126 (5th Cir. 1996); *Bronk v. Mountain States Tel. and Tel., Inc.*, 140 F.3d 1335 (10th Cir. 1998).

D. **Recent Developments**

1. Interpretation of Plan Language

a. The court in *Belluarado v. Cox Enterprises Inc. Pension Plan*, 157 Fed. Appx. 823 (6th Cir. 2005) upheld the denial of benefits to two newspaper carriers who had signed independent contractor agreements. In denying the benefits, the plan's administrator relied on the company's unwritten personnel policies, which provided that commissioned newspaper carriers were ineligible to participate in the plan. The court held that reliance on such a policy was not arbitrary and capricious.

b. In *Kolling v. American Power Conversion Corp.*, 347 F.3d 11 (1st Cir. 2003), the court upheld the denial of benefits to an independent consultant despite the ambiguous plan language that defined an "employee" as "an employee of the employer." The court noted that the company acted reasonably in interpreting the term "employee" to include only those workers who received IRS Form W-2s. *See also Machlachlan v. ExxonMobil Corp*., 350 F.3d 472 (5th Cir. 2003) *cert. denied* (2004) (finding that the administrator reasonably interpreted the plan language to exclude plaintiffs from receiving plan benefits); *see also Pearson v. AT&T Pension Benefit Plan*, 2007 U.S. Dist.

LEXIS 76448 (N.D. Ill. 2007) (employee of third party staffing agency not eligible for benefits where plan language excluded temporary and contract workers regardless of their status as a common-law employee).

c. In *Law v. Northwest Natural Gas Co*., 2007 U.S. Dist. LEXIS 32973 (D. Ore. 2007), the court held that even if the workers could prove they were common-law employees, they were nonetheless ineligible for benefits under the benefit plans. Prior to 2004, the plans excluded individuals whose compensation was in the form of a "fee under contract." In 2004, the plans were amended to limit participation to individuals classified by the company as common-law employees and whose compensation was reported by the company on Form W-2. The court upheld the plan administrator's determination that under both the pre-2004 and post-2004 plans, the plaintiffs were not eligible for benefits because they did not qualify under the plan's terms. The court also rejected the plaintiffs' allegation that the 2004 plan amendment amounted to an impermissible exclusion based on length of service. The plaintiffs argued that at the time of the amendment, the company knew (among other things) that the plaintiffs would be reaching retirement age and that it would be the subject of an IRS audit regarding the plaintiffs' independent contractor status. Noting that the amendment did not change the plaintiffs' status under the plans, the court held that the amendment clarified eligibility criteria and contained nothing that would violate ERISA's prohibition on excluding employees based on years of service.

d. In *Martin v. Public Service Electric & Gas Co.,* 2007 U.S. Dist. LEXIS 1852 (D.N.J. 2007), the court upheld the denial of benefits to three individuals who claimed they were improperly classified as independent contractors. The company expressly excluded independent contractors from its benefit plan. The court held that even if the workers were deemed common-law employees, they would nonetheless be ineligible to receive benefits under the company's plan. *See also Central Pennsylvania Teamsters Pension Fund v. Power Packaging Inc.*, 151 Fed. Appx. 145 (3d. Cir. 2005) (*unpublished*) (employer properly excluded leased employees who were not "on the payroll" as was required in the bargaining agreements).

e. The court in *Schultz v. Stoner*, 308 F. Supp. 2d 289 (S.D.N.Y. 2004) held that a plan's formal documents, and not the summary plan description ("SPD"), controlled whether certain workers were eligible for employee benefits. The plan administrator, in its denial of benefits, had relied on SPD language that limited the plan's participation in contrast with the broader, more generic language of the plan's formal documents.

f. In a departure from the cases discussed above, the court in *In re FedEx Ground Package System Inc. Employment Practices Litigation*, 2007 U.S. Dist. LEXIS 76798 (N.D. Ind. 2007) gave no deference to plan language that excluded package drivers classification by FedEx as independent contractor, "regardless of whether such individuals are subsequently reclassified by a court . . . as common law employees." The court explained that if the drivers are common law employees, they can't be independent contractors, despite FedEx classifying them as such. Thus, the court said, if the drivers show they are common law employees, they would be eligible for benefits. The court noted that allowing an employer to define eligibility through exclusionary language that denies coverage based solely on the employer's classification of workers as independent contracts, regardless of the relationship, runs counter to *Darden*.

2. Issues Particular to Leased Employees

a. In *Burrey v. Pacific Gas & Electric Co.,* 159 F.3d 388 (9th Cir. 1998) district, the plan provided that "leased employees," which it defined by referencing Code § 414(n), were not eligible to participate in the plan. In reversing the lower court's grant of summary judgment in favor of the employer, the 9th Circuit noted that the plan's reference to Code § 414(n) did not result in the exclusion of all leased employees from participation, as the reference to Code § 414(n) did not address lease employees who would also meet the definition of a common-law employee. On remand, the court held that the plaintiffs were not common-law employees under the thirteen factor *Darden* test pursuant to Code § 414(n). In denying common-law employee status, the court relied on the fact that the plaintiffs were treated as employees of the staffing agency for tax purposes and received benefits from the agency rather than defendant. *Burrey v. Pacific Gas & Electric Co.*, 1999 U.S. Dist. LEXIS 22619 (N.D. Cal. 1999).

b. In *Wolf v. Coca-Cola Co.,* 200 F.3d 1337 (11th Cir. 2000), the plan excluded "leased employees," but defined leased employees as "individuals who perform services for the Company under an agreement with a leasing organization." The plaintiff argued that she was a common-law employee, and therefore, under the analysis in *Vizcaino II* and *Burrey*, Coca-Cola was required to cover her under its employee benefit plans. The 11th Circuit disagreed, explaining reasoning that in *Vizcaino II* and *Burrey*, the relevant plan language indicated that common-law employees were covered. Thus, if a worker was found to be a common-law employee, he or she would become eligible for plan benefits. In contrast, the eligibility language in the Coca-Cola plan did not automatically cover all common-law employees, and therefore, even if the plaintiff was a common-law employee, she would not be eligible for benefits unless she was also found to have satisfied the plan's eligibility requirements.

3. Issues Particular to Temporary or Seasonal Employees

   a. In *Epright v. Environmental Resources Management, Inc. Health & Welfare Plan,* 81 F.3d 335 (3d Cir. 1996), the 3rd Circuit held that a temporary employee could not be excluded from participation if he otherwise satisfies the plan's stated eligibility criteria. Neither the plan nor any employee communication specifically addressed temporary workers. However, the plan stated that active employees (defined as working more than 30 hours/week) were eligible. The plaintiff, although classified as a temporary worker, had worked in excess of 30 hours/week during his entire tenure with the company.

   b. In *Cerra v. Harvey,* 279 F. Supp. 2d 778 (S.D. W. Va. 2003), the court did not permit the employer to exclude an employee from plan eligibility solely by defining his position as part-time if he otherwise satisfies the plan's eligibility requirements. The plaintiff was originally hired as a part-time employee, intending to work 20 hours/week. However, due to the demands of his position, he routinely worked between 160-200 hours/month. The plan language at issue provided that "full-time employees" were eligible to participate.

   c. The IRS issued QAB FY-2006 No. 3 to address the issue of whether exclusion of part-time or seasonal employees imposed an indirect service requirement on plan participation that *could* exceed one year of service (and therefore result in a violation of Code § 410(a)). The IRS noted that worker classification (*e.g.*, seasonal, part-time, temporary, etc.) should be closely scrutinized to determine if a plan is imposing a direct or indirect service requirement.

4. Issues Particular to Professional Employer Organizations ("PEOs")

   a. There are no clear guidelines regarding the provision of benefits under the Code of ERISA. Because of the exclusive benefit rule, PEOs that offer employee benefits must either (1) claim a "co-employment" relationship with the recipient company, or (2) establish their benefit plans as multiple employer plans.

   b. In Revenue Procedure 2002-21, 2002-1 CB 911 (4/24/2002), the IRS provides a limited form of relief from disqualification for defined contribution plans established by PEOs prior to May 13, 2002, for the benefit of a recipient company's existing workforce. Rev. Proc. 2002-21 provides PEOs that maintain defined contribution plans for "worksite employees" with the option of either converting the PEO retirement plan to a multiple employer plan or terminating the plan in order to avoid plan disqualification for a violation of the exclusive benefit rule. The Rev. Proc. also provides the recipient company an

opportunity to choose whether and how the PEO's decision to terminate the plan or establish a multiple employer plan should be implemented with respect to its own workers.

c. In Revenue Procedure 2003-86, 2003-2 CB 1211, the IRS provided PEOs with a transition period under Rev. Proc. 2002-21.

5. ERISA § 510 Claims

a. ERISA § 510 makes it unlawful to discharge a plan participate for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan.

b. In *Berger v. AXA Network, LLC,* 2003 U.S. Dist LEXIS 11555 (N.D. Ill. July 7, 2003), the court recognized that a claim for violation of ERISA § 510 existed where insurance agents claimed they were allegedly reclassified from "statutory employee" to "self-employed" for the purpose of interfering with the attainment of rights under the defendant insurer's benefit plans. However, the 7th Circuit subsequently affirmed the district court's granting of summary judgment on the ERISA claim in favor of the employer, stating that the individuals were independent contractors both before and after the claim. See *Berger v. AXA Network LLC*, 459 F.3d 804, (7th Cir. 2006). See also, *Seaman v. Arvida Realty Sales,* 985 F.2d 543 (11th Cir. 1993) (an actionable claim exists under ERISA § 510 where an individual's employment is terminated due to her refusal to be reclassified from an employee to an independent contractor, and such termination results in the loss of unvested health benefits and participation in the company's 401(k) plan); *Gitlitz v. Compagnie Nationale Air France,* 129 F.3d 554 (11th Cir. 1997), *rehearing denied*, 141 F.3d 1191 (11th Cir. 1998) (plaintiffs, who were salaried workers whose positions were eliminated but who were given the opportunity to perform similar tasks as independent contractors, had created an issue of fact as to whether their reclassification was with the intent of interfering with their benefits under ERISA).

c. However, in *Schwartz v. Independence Blue Cross,* 299 F. Supp. 2d 441 (E.D. Pa. 2003), the court dismissed the plaintiff's claim that a company interfered with his right to benefits in violation of ERISA § 510 by "misclassifying" him as a leased employee. In stating that "[n]o cause of action for 'misclassification' of an employee will lie under ERISA," the court found that allegedly unlawful misclassification of the plaintiffs as nonemployees or purported refusal to rehire former employees did not constitute a violation under ERISA § 510's antidiscrimination provision even if that refusal is based on the employer's desire to avoid creating future pension liability disproportionately greater than that incurred if it hired new employees without past service or pension credit. *See also Millsap v. McDonnell Douglas Corp.,* 162 F. Supp. 2d 1262 (N.D. Okla. 2001), *reversed on other grounds,* 368 F.3d 1246 (10th Cir. 2004), where the court held that ERISA § 510 requires evidence that the employer's desire to block attainment of benefits rights was a determinative factor in the employee's discharge.

WORKER CLASSIFICATION
ADMINISTRATIVE AND LEGISLATIVE INITIATIVES
March 4, 2008

Employee Benefits and Employment Tax Group
Miller & Chevalier Chartered

I. Administrative Initiatives - What's New At IRS

A. Worker Classification - Primary Focus of Employment Tax Compliance Resources in FY 08

1. Forms SS-8

2. Internal Databases

3. State Referrals

B. Recent IRS Initiatives - Tax Gap Motivated - Referenced in "Reducing the Federal Tax Gap - A Report on Improving Voluntary Compliance" (Internal Revenue Service, U.S. Department of Treasury, August 2, 2007)

1. Questionable Employment Tax Practice ("QETP") Initiative - Partnership with Department of Labor ("DOL"), National Association of State Workforce Agencies, Federation of Tax Administrators, and State Workforce Agencies to provide a collaborative national approach to combat employment schemes.

a. Exchange Agreements or MOUs between IRS and States

(1) Sharing of Tax and Audit Information

(2) Side by Side Examinations

b. Recent Deliverable - Report of the Joint Enforcement Task Force on Employee Misclassification (New York State Department of Labor)

(1) Established September 5, 2007

(2) Coordinating compliance efforts of six New York State Agencies

(3) Interacts with both IRS and DOL in connection with QETP

(4) For 4th Quarter 2007 - Extent of misclassification uncovered was 254% greater than numbers reported to the federal government (10,486 misclassified workers reported to DOL) compared to 35,410 uncovered.

2. State Reverse File Matching Initiative ("SRFMI")

a. Matches IRS master file extracts received through the Government Liaison Data Exchange Program against State master files

b. Identify differences in Federal and State reporting

c. Goal - Engage all 50 States in SRFMI

3. Improve FED/FED program by facilitating and expanding partnerships with other federal agencies

C. Guidance/Forms

1. Proposed Regs. Sections 6205 and 6413 - Interest Free Adjustment Process

a. Adjustments no longer allowed on current return (i.e., Form 941c)

b. Separately filed return to make adjustments

c. Interest-free adjustment treatment will continue to apply where employer failed to file return for a return period solely because the employer failed to treat any individuals as employees (misclassifications)

d. Effective date - publication of final regulations

e. Comment period ends March 27, 2008; hearing scheduled for April 17, 2008

f. IRS expects to finalize regulations soon thereafter

2. Form 8819

a. For use by employees who failed to withhold Social Security and Medicare taxes to report and pay their share of these taxes

b. Applies to Section 530 employers

c. Workers who believe that they are misclassified

D. Whistleblower Legislation - Potential Impact

E. Treasury Inspector General for Tax Administration Annual Audit Plan FY 08 "Misclassification of Employees as Independent Contractors"

1. Commenced 2007 - Work In Progress

2. Audit Objective - Evaluate the Actions the IRS Has Taken to Address the Misclassification of Employees as Independent Contractors

II. Legislative Initiatives

A. Current Legislative Environment

1. Democratic control of both the House and Senate

2. PAYGO rules in effect

a. New spending or tax cuts may not add to the federal deficit (i.e., increases in spending and reductions in taxes must be "paid for" by spending cuts or tax increases)

b. Tax agenda is dictated by "revenue raisers"

3. Legislative priorities

a. Extending current law ("extenders" package, AMT relief, pending expiration of Bush tax cuts)

b. Addressing noncompliance (the "tax gap")

B. Congressional Focus on the "Tax Gap"

1. Annual amount of noncompliance due to underreporting, underpayment and nonfiling

2. Difference between what taxpayers should have paid and what they actually paid on a timely basis

3. Estimated to be $345B gross ($290B net after enforcement and late payments)

a. 71% = Individual income tax

b. 9% = Corporate income tax

c. 20% = Non-income taxes (employment, estate and excise taxes)

4. Viewed as a source of revenue to fund legislative priorities

C. Committee on Ways and Means Subcommittee Hearing (May 2007)

1. GAO estimate that misclassification of workers reduces federal revenues by up to $4.7B annually

2. Panelists focused on loss of revenue associated with misclassification, impact on misclassified employees, potential for abuse by employers and the need for legislative changes to avoid such misclassification

3. Criticism of the safe harbor contained in Section 530 of the Revenue Act of 1978

4. The Joint Committee on Taxation released a comprehensive pamphlet in connection with the hearing. Joint Committee on Taxation, *Present Law and Background Relating to Worker Classification for Federal Tax Purposes* (JCX-26-07), May 7, 2007.

5. March 2007 Committee on Education and Labor Subcommittee Hearing focused on similar issues

D. Senate Report to Financial Services and General Government Appropriations Bill (July 2007)

1. Report contains language urging the IRS to provide increased enforcement in industries where the misclassification of employees is widespread. S. Rep. No. 129, 110th Cong., 1st Sess. 28 (2007) ("The Committee is concerned with the misclassification of workers as independent contractors, who file using IRS Form 1099. Many of these workers should be correctly classified as employees and should file using W–2 forms. This misclassification leads to the underreporting and underpayment of employment and payroll taxes by employers and individuals, which accounts for a substantial portion of the gross tax gap. Therefore, the Committee strongly urges the IRS to provide increased tax enforcement in industries where misclassification of employees is widespread.").

E. Introduction of the Independent Contractor Proper Classification Act of 2007 (September 2007)

1. S. 2044, the Independent Contractor Proper Classification Act of 2007, was introduced on by four Democratic senators (Obama, Durbin, Kennedy and Murray).

2. Characterizes Section 530 as a "tax loophole" and the bill as one that will "help close the tax gap, ensure benefits from workers, [and] restore [a] fair playing field for employers."

F. Blackwater Investigation (October 2007)

1. Blackwater is a private firm that provides security services to the U.S. government in Iraq and Afghanistan. The company has been subject to a large degree of criticism and Congressional scrutiny.

2. As a result of this criticism and scrutiny, one issue that was raised was Blackwater's classification of armed guards as independent contractors rather than employees. Politically, the issue has been characterized as an issue of "significant tax evasion" allowing Blackwater to avoid "paying millions of dollars in Social Security, Medicare, unemployment and related taxes for which it is legally responsible."

3. Subject of inquiry by Rep. Waxman (House Oversight) and Sen. Kerry (Senate Finance).

4. Senators Obama and Durbin have requested a Treasury investigation and also have used Blackwater as evidence in support of the need to enact the Independent Contractor Proper Classification Act of 2007.

G. Announcement of FedEx Assessment (December 2007)

1. In an SEC filing, FedEx announced it expected the IRS to assess $319M in taxes and penalties because of a dispute regarding worker classification of owner-operators who provide pickup and delivery services.

WORKER CLASSIFICATION
FEDERAL TAX ISSUES
March 4, 2008

Employee Benefits and Employment Tax Group
Miller & Chevalier Chartered

I. DETERMINING WORKER STATUS FOR FEDERAL EMPLOYMENT TAX PURPOSES.

A. Introduction.

The classification of workers as employees or independent contractors has long been a contentious issue between taxpayers and the Internal Revenue Service, and it is heating up again.

For example, on December 21, 2007, FedEx Corporation disclosed in its Form 10-Q filing with the Securities Exchange Commission (attached) that it is a defendant in numerous class action lawsuits and state administrative proceedings involving the treatment of its owner-operator drivers. Moreover, the company disclosed that an IRS worker classification examination of calendar year 2002 had tentatively concluded that the owner-operators of FedEx Ground should be reclassified as employees, which could result in an assessment of $319 million for that year, including interest and penalties.

Historically, proper classification has been significant under federal tax laws because of the substantial penalties for failure to properly withhold, deposit and report employment taxes (i.e., income tax withholding, Federal Insurance Contributions Act ("FICA") and Federal Unemployment Tax Act ("FUTA") taxes). In addition, worker misclassification is perceived as being at the core of the current tax gap, because "there is revenue loss associated with lower compliance rates of independent contractors and service recipients compared to the compliance rates of employees and their employers."[1] Consistent with that concern, senior managers within the IRS employment tax function have been publicly warning taxpayers that one of the agency's top compliance initiatives is worker classification.[2] In late 2007, the IRS released a fact sheet to help business owners in properly classifying workers as part of the educational series on the tax gap[3] and entered into a memorandum of

[1] Joint Committee on Taxation, *Present Law and Background Relating to the Worker Classification for Federal Tax Purposes*, (JCX-26-07), May 7, 2007.

[2] "IRS Examining Employment Tax Compliance, Official Says," 2008 TNT 14-3 (Doc. 2008-1217, January 22, 2008).

[3] IRS Fact Sheet 2007-27 (attached).

655 FIFTEENTH STREET, NW, SUITE 900
WASHINGTON, DC 20005

understanding with 29 states to share information on employment tax practices. Consequently, taxpayers would be well advised to review their working relationships with service providers and reacquaint themselves with the tools available for determining correct status and getting disputes resolved.

Businesses must not only support their classification of workers against IRS challenges, they must be prepared to counter a more direct threat originating from the workers themselves. More and more, workers are challenging their worker status in private law suits for employee benefits. At the same time, businesses are continuing to outsource workers or to adopt flexible or variable staffing models, which means that the legal and economic consequences of misclassifying workers have become more significant.

1. Red Flags that Could Give Rise to an IRS Worker Classification Examination.

- The service recipient treats workers performing similar services differently, i.e., some as employees and others as independent contractors even though they provide similar services.
- An independent contractor was previously treated by the service recipient as an employee for performing similar services.
- An independent contractor receives "employee" benefits, such as health care.
- A state tax authority or another federal agency has reclassified an independent contractor as an employee.
- The worker has not filed federal tax returns consistent with the position that he/she is a sole proprietor or providing services as an employee of a corporation.

B. Common Law Employees or Independent Contractors?

1. The Internal Revenue Code defines an "employee" for purposes of Federal Insurance Contributions Act ("FICA") and Federal Unemployment Tax Act ("FUTA") taxes as "any individual, who under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee." Internal Revenue Code ("Code") §§ 3121(d)(2), 3306(i).

2. The Employment Tax Regulations describe the common law test as follows:

> [G]enerally, the relationship of employer and employee exists when the person or persons for whom the services are performed have the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which that result is accomplished.

> That is, an employee is subject to the will and control of the employer not only as to what shall be done but as to how it shall be done.

Treas. Reg. §§ 31.3121(d)-1(c), 31.3306(i)-1(b). *See also Nationwide Mutual Insurance Co. v. Darden*, 503 U.S. 318 (1992) and *Weber v. Commissioner*, 103 T.C. 378 (1994), *aff'd* 60 F.3d 1104 (4th Cir. 1995) (service recipient's right to direct and control a worker not only as to the result to be accomplished, but also the means and manner by which the result is accomplished, even if that right remains unexercised).

- There is no statutory definition of employee for income tax withholding purposes. The regulations provide, however, that the same common-law test applies. *See* Treas. Reg. § 31.3401(c)-1(b).

3. Because the application of the common law test requires consideration of all of the facts and circumstances related to "control," it has long been criticized as being indeterminate, with the result that it is difficult for both taxpayers and the IRS to apply the test with any certainty.

- Rev. Rul. 87-41, 1987-1 C.B. 296 (attached), is a compendium of 20 factors that the IRS takes into account law in determining whether there is an employment relationship under the common law.

4. IRS Training Materials on Worker Classification.

In 1996, the IRS issued Training Materials for its agents on worker classification, which simplifies the determination of worker classification by emphasizing that there should not be a mechanical application of the 20-factor test set forth in Rev. Rul. 87-41. In addition, agents are advised to consider the impact of changes in the economy and the laws when considering the classification of workers as employees or independent contractors. *See* "Independent Contractor or Employee? Training Materials," Training 3320-102 (Rev. 10-96, TPDS 84238I) (attached); *see also* Internal Revenue Manual ("IRM") § 4.23.5.1, *et seq.*[4] The Training Materials also provide guidance to agents as to the application of the special relief provision for businesses under Section 530 of the Revenue Act of 1978. (*See* the discussion of Section 530 below in section IV.B.).

- The Training Materials do not constitute legal guidance, but they provide insight into current IRS views on worker classification.

- In lieu of the "20 factors," the Training Materials direct examiners to review three broader aspects of a business worker relationship:

[4] The Training Materials, in toto, were not incorporated into the IRM. Therefore, it may be helpful to review the final version of the Training Materials, which were included as a Special Supplement (Report No. 43) to BNA's Daily Tax Report (March 5, 1997).

Behavioral Control, Financial Control, and a catch-all referred to as Relationship of the Parties.

- Behavioral Control: looks to the right of the business to control the behavior of a worker. Evidence of behavioral control includes both instructions and training.

- Financial Control: looks to the right of the business to direct and control the means and details of the business aspects of how a worker provides services. This is not a simple question of economic dependence of the worker on the business, but more a question of the degree to which the business has taken over the worker's opportunity for profit and loss. Relevant factors include (1) significant worker investment; (2) unreimbursed expenses; (3) services available to the relevant market; (4) method of payment; and (5) opportunity for profit and loss.

- The Relationship of the Parties: a "catch all" category that takes into account the objective evidence of how the parties intended to treat their relationship. These factors include how the relationship is described in any contract; whether Form W-2 or 1099 was filed; whether the worker was incorporated; whether the worker was included in an employee benefits program; the permanency or indefinite nature of the business-worker relationship; the extent to which the services performed by the worker are a key aspect of the regular business of the company.

- Observation. Even though the Training Materials assert that the factors can be divided into three categories, an evaluation of which factors are the most relevant for determining a particular worker's status does not fall out so conveniently. As pointed out in the Training Materials, "control is a matter of degree" and the factors must be weighed to determine the extent, if any, of the business's right to direct and control. In other words, the relevant evidentiary facts must be selected and weighed.

5. No Ruling Position.

The IRS will not issue a ruling for the purpose of determining prospective employment status of a worker, although it will issue a ruling with regard to prior employment status under its SS-8 program. Rev. Proc. 2008-1, § 3.01(66), 2008-1 I.R.B. 110.

6. Case Law Developments Focusing on Risk of Loss.

In a series of cases involving insurance agents, the workers' risk of loss through unreimbursed business expenses were compelling factors in determining that the workers were independent contractors, notwithstanding the insurance company's treatment of these workers as employees. *See Butts*

v. Commissioner, T.C. Memo 1993-478, *aff'd per curiam*, 49 F.3d 713 (11th Cir. 1995); *Smithwick v. Commissioner*, 66 T.C.M. (CCH) 1545 (1993), *aff'd*, 49 F.3d 713 (11th Cir. 1995); *Mosteirin v. Commissioner*, 70 T.C.M. (CCH) 305 (1995*); Lozon v. Commissioner*, 73 T.C.M. (CCH) 2914 (1997).

C. Special Categories of Workers Outside the Common Law Test -- Officers.

1. A corporate officer is considered to be the employee for purposes of FICA, FUTA, and federal income tax withholding, unless –

- The officer does not perform any services, or performs only minor services (as judged by the relative burden, frequency, duration, and necessity of the services); *and*

- The officer is not entitled to receive, directly or indirectly, any remuneration. *See* Code §§ 3121(d)(1), 3306(i), 3401(c).

2. A director of a corporation is not an employee for purposes of services performed as a director.

See Western Management, Inc. v. Commissioner, 97 AFTR 2d-1949 (9th Cir. 2006).

D. Other Special Categories.

1. Statutory Employees. Four occupational groups (who are independent contractors under the common law) qualify as "statutory employees": (a) agent-drivers or commission-drivers, (b) full-time life insurance salespersons, (c) home workers, and (d) traveling or city salespersons. Code § 3121(d)(3). A worker who is otherwise classifiable as a common law employee cannot be a statutory employee. Workers in these groups are considered employees for FICA tax, and in some instances for FUTA tax, but never for federal income tax withholding purposes. *See also* Rev. Rul. 90-93, 1990-2 C.B. 331 (full-time life insurance salesmen treated as statutory employees for FICA purposes are not employees for purposes of Code §§ 62 and 67).

2. State and Local Government Employees. State and local government employees are statutory employees for FICA tax purposes if they are covered by an agreement under section 218 of the Social Security Act. Code § 3121(d)(4). State and local government employees are also employees for FICA tax purposes if they are employees under the common law standard.

3. Statutory non-employees. Certain categories of workers are, by statute, independent contractors solely for FICA, FUTA or federal income tax withholding purposes.

- Qualifying real estate agents and direct sellers are statutory non-employees under Code § 3508.

- Code § 3506 provides rules for companion sitters to qualify as statutory non-employees.

E. Application of the Common Law to Three-Party Arrangements.

1. Three-party arrangements involve workers who are hired by one firm to perform services for another firm (the service recipient). In these cases, the question usually is not whether the worker is an employee or an independent contractor but which entity -- the firm providing the worker or the service recipient is the employer.

2. Three-party arrangements typically involve a professional staffing firm, but may also arise in the context of employees who are "seconded" to a joint venture or to another domestic or foreign affiliate of a business. (*See* detailed discussion in section V., below.)

3. The application of the common-law standard in this context raises special questions, however, given that, by necessity, both the service recipient and the firm providing the workers will be giving direction to the worker.

4. Thus, in a three-party arrangement, the focus is necessarily on distinguishing the kind of direction and control that both the service recipient and the staffing firm may provide to the worker.

5. Rev. Rul. 75-41, 1975-1 C.B. 323, addresses the standards for making determinations in three-party arrangements.

- In the ruling, the staffing firm recruited the worker, determined the worker's skills and qualifications, paid the wages to the worker, provided the worker with employee benefits, and "instruct[ed] the individual as to his work hours and the nature of his duties, based on the [service recipient's] request."

- On these facts, the ruling holds that the staffing firm's ultimate ability to hire or discharge the worker is indicative of its role as the employer.

6. As a practical matter, the IRS National Office interprets Rev. Rul. 75-41 narrowly. The IRS is precluded under Section 530 (see discussion below in section IV.B.) from revoking the ruling or otherwise modifying its analysis.

7. Consistent with a narrow reading of Rev. Rul. 75-41, the IRS has adopted a "no-rule" position for three-party arrangements in which (1) "a professional staffing corporation (loan-out corporation)" hires an employee of the "subscriber" (i.e., the service recipient) and then assigns that worker back to the subscriber, or (2) a loan-out corporation assigns a worker to a subscriber for one year or longer. *See* Rev. Proc. 2008-3, § 3.02(7), 2008-1 I.R.B. 110.

- Identifying the employer in a three-party arrangement was also an issue in the *Vizcaino v. Microsoft* litigation.

8. *See* additional discussion of leasing arrangements and loan-out entities in V. and VI., below.

F. Dual Status Workers.

1. A worker who performs two separate functions for a business can be classified as an employee with respect to one function and as an independent contractor with respect to the other. *See* PLR 199914044 (4/9/99).

2. In Rev. Rul. 58-505, 1958-2 C.B. 729, officers of a corporations who also sold insurance on behalf of that corporation were classified as employees for the former function and independent contractors for the latter function. *See also Pulver v. Commissioner*, 44 T.C.M. 644 (1982).

G. Joint Employment.

1. In Rev. Rul. 66-162, 1966-1 C.B. 234, the IRS summarily concluded that clerks of a concessionaire in a department store were employees of both the concessionaire and the department store for employment tax purposes.

2. Curiously, the IRS has not routinely relied on this old ruling to assert joint employment. The Court of Appeals for the 9th Circuit, however, cited the ruling in the most recent round in the *Vizcaino v. Microsoft* litigation.

II. EMPLOYMENT TAX CONSEQUENCES OF WORKER CLASSIFICATION.

A. Obligation to Withhold Employment Taxes.

1. An employer is required to withhold from "wages" paid to an employee and remit the amount to the government –

- federal income taxes. Code §§ 3101, 3402.
- Federal Insurance Contribution Act (FICA) taxes:
  - Social Security (OASDI) taxes at a rate of 6.2% on wages up to the applicable annual wage base (e.g., $94,200, $97,500, and $102,000 for 2006, 2007, and 2008, respectively) and
  - Medicare taxes at a rate of 1.45%.
- The term "wages" is generally defined for both FICA and income tax withholding purposes as compensation for services provided as an employee. However, there are specific exceptions for both FICA and income tax withholding purposes, which do not necessarily overlap. *See* Code §§ 3121(a), 3401(a).

- If the employer fails to properly withhold and remit either the employee's share of FICA or income taxes, it can be held liable for payment of the taxes. Code §§ 3102(a), 3403. This is known as "secondary liability."

- In addition to the withheld amounts, employers are required to pay matching amounts of both portions of FICA taxes (Code § 3111) and taxes up to the applicable annual wage base, which is currently $7,000 a year. Code § 3301.

2. Disputes with workers over the obligation to withhold can arise. In *Ford v. Troyer*, 25 F. Supp. 2d 723 (E.D. La. 1998), the U.S. District Court, while acknowledging a split in the federal courts on the issue, held that a worker who has been misclassified as an independent contractor has standing to sue the company and seek a court to compel the company to comply with its FICA and FUTA tax obligations with respect to the compensation the company had paid the worker (because those taxes benefit the worker). The court determined that a similar right does not exist with respect to the federal income taxes that should have been withheld. *See also Sanchez v. Overmyer*, 845 F. Supp. 1178 (N.D. Ohio 1993); *compare Estate of Suskovich v. Anthem Health Plans of Virginia, Inc.,* 2007 U.S. Dist. LEXIS 91556 (S.D. Ind. 2007) (denial of estate's assertion that service recipients improperly treated decedent as independent contractor and therefore it should have been indemnified for benefits and underwithheld employment taxes).

B. Statutory Relief Provision for Employment Taxes.

1. Code § 3509 provides a special rule to determine an employer's liability solely for the *employee's* portion of the FICA tax and income tax withholding where such taxes were not deducted and withheld because the worker was erroneously treated as an independent contractor.

2. Generally, as long as the employer completed required information returns (Forms 1099-MISC) consistent with treating the worker as an independent contractor, the employer will be required to pay a tax of 1.5% of wages as the income tax withholding amount and 20% of the *employee's* portion of the FICA tax. Code § 3509(a).

- If the required Forms 1099-MISC were not completed, the employer will be required to pay 3% of wages as the income tax withholding amount and 40% of the employee's portion of the FICA tax. Code § 3509(b).

3. If Code § 3509 applies, the employer will still be required to pay the full amount of the *employer's* portion of the FICA tax and the full amount of FUTA tax owed. Also, the employer also cannot take any credit under Code §§ 3402(d) (abatement of income taxes) and 6521 (mitigation of FICA taxes) for employee-paid taxes to offset the liabilities imposed by section 3509. Code § 3509(d)(1)(C).

4. Code § 3509 also does not apply: (1) to cases where the employer intentionally disregarded the requirement to deduct and withhold taxes (Code § 3509(c)); (2) in situations where the employer deducted income taxes, but failed to deduct FICA taxes (Code § 3509(d)(2)); (3) to statutory employees (Code § 3509(d)(3)); or (4) to FUTA taxes (Code § 3509(a)).

C. Statutory Employer Liability.

1. A party that is not the common law employer of a worker may nonetheless be the "employer" for income tax withholding purposes if that party has control over the payment of the wages. Code § 3401(d)(1).

2. The Supreme Court has interpreted the statutory employer concept to apply to both FICA (at least with respect to the employee's share) and FUTA taxes, as well as income tax withholding obligations, although the statute is arguably limited by its terms to only income tax withholding. *Otte v. United States*, 419 U.S. 43 (1974); *Consolidated Flooring Services v. United States,* 42 Fed. Cl. 878 (1999). *But see* TAM 199918056 (statutory employer liability held to apply for income tax withholding purposes, but not for determination of the amount of the liability for FICA and FUTA taxes, since Code § 3401(d)(1) does not apply for purposes of determining what constitutes "wages;" therefore, separate annual wage bases apply to wages paid on behalf of each client company).

3. Three-party arrangements may raise statutory employer questions.

- In the view of most taxpayers, Code § 3401(d) provides that there can be only one party responsible for withholding – either the common law employer or, if the common law employer is not in control of the wages, then the person who is in control of the wages.

- This view is supported by *General Motors Corp. v. United States*, 91-1 USTC ¶ 50,032 (E.D. Mich 1990). *See also* PLR 9825009 (6/19/98), in which the IRS relied on Code § 3401(d)(1) to conclude that an agency that referred nurses to clients was liable for employment taxes on compensation received by the nurses, based on determinations that (1) the nurses were common law employees of the agency's clients, and (2) the referral agency retained "control of the payment" of compensation to the nurses.

- *See* also GCM 38441 (7/11/80); *Winstead v. United States*, 109 F.3d 989 (4th Cir. 1997); Chief Counsel Advice 200017041 (3/31/00); CCA 200019009 (2/7/00); and FSA 200023006 (2/2/00).

4. Nonetheless, the IRS has taken the position in certain circumstances that there is joint liability between a service recipient and another party, such as a staffing firm.

- In cases involving three-party arrangements, the IRS has argued that the service recipient is also in control of the wages because the staffing company's payment of the wages is linked, and in some cases dependent upon, a payment from the service recipient to the leasing company. *See, e.g., In re Professional Security Services, Inc.*, 94-1 USTC ¶ 50,148 (Bankr. M.D. Fla. 1993).

III. NEW IRS ENFORCEMENT INITIATIVES -- "CONNECTING THE DOTS?"

A. The Questionable Employment Tax Practice Initiative -- Teaming with the States.

In November 2007, the IRS announced its nationwide program to facilitate cooperation and information sharing between the IRS and state workforce agencies.

1. The QTEP initiative is a collaboration with the states to identify employment tax schemes and illegal practices and to increase voluntary compliance with employment tax rules and regulations. *See* IRS Fact Sheet 2007-25 (November 6, 2007) (attached).

2. In addition to the IRS and the Department of Labor, the initiative was spearheaded by the National Association of State Workforce Agencies, the Federation of Tax Administrators and the state workforce agencies of California, Michigan, New Jersey, New York and North Carolina. A memorandum of understanding ("MOU") was developed and at least 29 states, to date, have signed it.

3. The MOU permits the IRS and the states to exchange audit reports and audit plans, and to participate in side-by-side examinations, when appropriate. It also provides, for the first time, a centralized and uniform mechanism for IRS and state employment tax data exchanges.

4. A QTEP oversight team, consisting of representatives from each participating agency, oversees all program activities. Moreover, the members of the oversight team will meet regularly to discuss issues of concern and make recommendations for improvements in partnership activities. The team will strive to create uniform processes, "draft and promote legislative changes in an effort to achieve nationwide standardization and to create a level playing field for all employers."

B. New IRS Form 8919, "Uncollected Social Security and Medicare Tax on Wages" -- Teaming with the Workers.

Historically, misclassified workers have been required to use Form 4137 ("Social Security and Medicare Tax on Unreported Tip Income") to report their share of FICA taxes, generally when the service recipient was granted Section 530 relief. In December 2007, the IRS released new Form 8919 (attached) to be used by employees (beginning with tax year 2007) to report their share of FICA taxes when

they have been misclassified for a variety of reasons. This form is likely to serve as a powerful lead for IRS employment tax examiners, in that it should be used by workers in a variety of situations where the IRS has not yet made a determination or conducted an examination. Specifically, the worker must meet one of the following criteria indicating that he performed services as an employee:

- the worker has filed Form SS-8, Determination of Worker Status for Purposes of Federal Employment Taxes and Income Tax Withholding, and received a determination letter from the IRS stating they are an employee of the firm;
- the worker has been designated as a Section 530 employee by their employer or by the IRS prior to January 1, 1997;
- the worker has received other correspondence from the IRS that states they are an employee;
- the worker was previously treated as an employee by the firm and they are performing services in a similar capacity and under similar direction and control;
- the worker's co-workers are performing similar services under similar direction and control and are treated as employees;
- the worker's co-workers are performing similar services under similar direction and control and filed Form SS-8 for the firm and received a determination that they were employees; or
- the worker has filed Form SS-8 with the IRS and has not yet received a reply.

IV. RESOLVING WORKER STATUS FOR EMPLOYMENT TAX PURPOSES.

A. Form SS-8 Determinations on Workers' Status.

1. A worker can get a ruling from the IRS on his worker classification status by completing Form SS-8 ("Determination of Employee Work Status for Purposes of Federal Employment Taxes and Income Tax Withholding"). In theory, a ruling can be applied to a class of workers whose employment status is in question if the form is completed for one person who is representative of the class. If a worker submits a Form SS-8 request, the "Firm" will be asked to fill out the form, so that the IRS will have input from both the worker and the service recipient.

- Usually, the IRS determination of worker status under the SS-8 program is redacted when released, although the determination issued to Blackwater Security Consulting LLC was made public and provides a good example of how the process works. 204 DTR (October 23, 2007).

2. The IRS centralized the Form SS-8 ruling process to two locations in the United States. Employers residing in the eastern half of the U.S. are instructed to file with the SS-8 Determinations Board in Newport, VT, whereas employers in the western half must file in Austin, TX. Unfortunately, as part of this centralization of the process, the IRS National Office distanced itself from its historical participation in the ruling process when cases became too complex for the IRS Districts to handle. Currently, if an employer receives an adverse ruling from the SS-8 Determinations Branch, the only remedy is to ask for a branch supervisor's review. If the ruling is not reissued, no other remedy of review exists. Since an adverse ruling does not rise to the level of an "actual controversy," there is no mechanism for taking the matter to IRS Appeals for reconsideration.

3. Even though an examination has not occurred, the IRS has now developed a procedure whereby it will issue a notice to the "employer" inquiring as to why amended employment tax returns have not been filed to reflect the Form SS-8 determination, if the "employer" has not reported adjustments consistent with the Form SS-8 determination. The letter specifically asks the employer to provide specific information regarding: (1) the filing of returns to reflect adjustments consistent with the Form SS-8 determination; (2) the taxpayer's position with respect to Section 530 relief if amended returns were not filed; or (3) the taxpayer's reasons for disagreeing with the SS-8 determination. In other words, the IRS is looking to the taxpayer to assist it in determining whether to open an examination.

B. Section 530 Relief.

1. In 1978, Congress enacted Section 530 of the Revenue Act of 1978 as an interim measure. Pub. L. No. 95-600, as amended. This off-code provision, which was ultimately made permanent, was intended to protect businesses that acted reasonably in treating workers as independent contractors from adverse employment tax consequences, even though the workers might in fact turn out to be common law employees. Since the enactment of the Small Business Job Protection Act of 1996, § 1122 of Pub. L. No. 104-188, analysis under Section 530 must be the first step in any inquiry regarding whether workers should be classified as employees or independent contractors for federal employment tax purposes. Thus, the IRS must make a Section 530 analysis regardless of whether the business requests it and provide the business with a plain language summary of Section 530 (*i.e.,* Pub. 1976) at the start of any examination of worker classification. IRS Training Materials at 1-4.

2. Scope of Section 530 Relief. Section 530 shields the business from employment tax liability arising from misclassification of the worker; it does not convert the status of the worker in question from employee to independent contractor. Section 530 relief does not extend to the worker as taxpayer. Workers who are in fact employees may suffer adverse tax consequences because of limitations on their deducting unreimbursed business

expenses and on their ability to participate in their own retirement plans. *Id.* at 1-5.

3. Limitations on IRS Pronouncements. Section 530 generally precludes the IRS from promulgating any regulations or revenue rulings on individuals' employment status. Private letter rulings are still issued. *Id.* at 1-4.

4. Requirements of Section 530. A business need not concede or agree to the determination that the workers are employees in order for Section 530 relief to be applicable. But in order to qualify for Section 530 protection, a business must meet both (a) a consistency test and (b) a reasonable basis test, and the workers in question must be within the scope of the Section 530 provisions, as discussed below. *Id.* at 1-5.

5. The Consistency Test. The consistency test includes both (1) a reporting consistency test, and (2) a substantive consistency test.

- Reporting Consistency. A business must have "timely filed" any required Forms 1099-MISC with respect to the worker for the period in question, on a basis consistent with the business's treatment of the worker as not being an employee. A failure to file the required Forms 1099-MISC in one year will not preclude Section 530 relief for other years in which forms were filed. Businesses that mistakenly, in good faith, file the wrong type of Form 1099 do not lose Section 530 eligibility. *Id.* at 1-6 to 1-8; *see also* Rev. Proc. 85-18, 1985-1 C.B. 518.

  - Note: In a recent decision, *Medical Emergency Care Associates, S.C. v. Commissioner,* 120 T.C. No. 15, the Tax Court rejected Rev. Proc. 85-18's requirement of "timely filing" of Forms 1099-MISC and held that Section 530 was still available to the taxpayer, even though the Forms 1099-MISC were filed late.

  - Substantive Consistency. A business, as well as its predecessor entities (if any), must *not* have treated the worker in question, or any other worker holding a "substantially similar position," as an employee at any time after December 31, 1977. *Id.* at 1-9.

    - A "substantially similar position" is one in which the job functions, duties, and responsibilities of the workers are substantially similar, and where the control and supervision of those duties and responsibilities are substantially similar. This is a factual determination. *Id*.

    - Withholding federal income tax or FICA tax, or filing a Form 940, 941, 942, 943, or W-2, with respect to a worker is inconsistent with classification as an independent contractor. Filing a delinquent or amended employment tax return is not inconsistent if filing results from IRS compliance procedures, but is

inconsistent if the tax period was for a period following the period under audit. *Id*. at 1-10.

- Only federal tax treatment as an employee, and neither state nor local tax treatment, is relevant to this determination. *Id*. at 1-11.

- If a business treated the workers in question as independent contractors in an earlier year, but then treated them as employees in later years, the later treatment will not disqualify the business from Section 530 relief for the earlier year. *Id*. at 1-12.

- The fact that a single worker performs services in two separate capacities, and is treated as an employee in one, and an independent contractor in the other, will not necessarily disqualify a business from Section 530 relief for its treatment of the worker in the capacity as independent contractor. *Id*.

6. The Reasonable Basis Test.

This test requires that the business demonstrate some reasonable basis for its treatment of the worker in question as an independent contractor. A business may show such reasonable basis by showing that it reasonably relied on either a prior audit, judicial precedent, industry practice, or some other reasonable basis. *Id.* at 1-15 to 1-16. The legislative history behind Section 530 indicates Congress's intent that the reasonable basis requirement be construed liberally in favor of taxpayers. *Id.* at 1-16.

- Burden of Proof. As is generally true in tax matters, the business has the initial burden of proof in demonstrating a reasonable basis. The burden of proof under Section 530 shifts to the IRS, however, if both (1) the business establishes a "prima facie" case that it was reasonable not to treat an individual as an employee, i.e., the business presents evidence that will allow it to prevail unless the government presents other evidence that contradicts and overcomes the business's evidence; and (2) the business has fully cooperated with any "reasonable" IRS requests for relevant information, i.e., where compliance is not impracticable given the costs and circumstances. The shift in burden of proof applies to both portions of the consistency test, as well as to the safe havens of judicial precedent, prior audit, and industry practice, but not to the determination of any other reasonable basis. *Id.* at 1-17 to 1-18.

- Proving Reasonable Basis.

  - The Prior Audit Safe Haven. A business is treated as having reasonable basis if it relied on a prior audit as the basis for classifying the workers in question as independent contractors. *Id*. at 1-19.

- If the prior audit began before January 1, 1997, then the audit need not have been an audit for employment tax purposes in order to constitute a reasonable basis. But if the prior audit began after December 31, 1996, the audit must have specifically included an examination for employment tax purposes of the status of the class of workers presently at issue, or of a substantially similar class of workers. *Id*. at 1-19. In either case, the business can establish existence and knowledge of the audit by furnishing a copy of correspondence connected with the audit. But note that the prior audit can be reasonably relied upon for Section 530 relief only for periods after the audit took place. *Id*. at 1-22.

- The prior audit safe haven does not apply if the relationship between the business and the workers presently in question is substantially different from that which existed at the time of the audit. *Id*. at 1-19.

- The prior audit safe haven is limited to past audits conducted on the business itself, and not, for example, on a parent corporation. *Id*. at 1-20.

- Audits conducted by agencies other than the IRS will not qualify a business for relief based upon the prior audit safe haven. *Id*. at 1-24.

- The Judicial Precedent Safe Haven. To obtain Section 530 relief under this safe haven, a business must demonstrate reasonable reliance in its worker classification on federal judicial precedent, a published ruling (i.e., a revenue ruling), technical advice relating to that business, or a private letter ruling to that business. *Id*. at 1-24.

- The Industry Practice Safe Haven. To obtain Section 530 relief under this safe haven, a business must demonstrate reasonable reliance in its worker classification on a long-standing practice of a significant segment of the industry in which the workers in question are engaged. *Id*. at 1-26.

  - An "industry" is defined as the businesses located in the same geographic or metropolitan area that compete for the same customers. The relevant geographic area may be a single county or the entire United States, depending on the scope of relevant market competition. *Id*.

  - An industry practice is "long-standing" if it had been in continuance for at least 10 years at the time that the business began relying upon it, although a shorter period may qualify depending on the facts and circumstances. An industry practice

will not be disqualified merely because the practice or the industry came into existence after 1978. *Id*. at 1-27.

- A segment of the industry is "significant" if it includes 25 % or more of the relevant industry (determined without taking the business itself into account), although a lower percentage may be a significant segment depending on the facts and circumstances. *Id*. at 1-28.

- The business must make a reasonable showing of the industry practice at the time it began to treat the workers as independent contractors, must show that it relied on such practice, and that its reliance on the industry practice was reasonable. Relevant information in this regard includes formal surveys of industry practice, regardless of when made. Whether reliance on an industry practice is reasonable will depend on the extent of the business's knowledge of industry practice, as well as on the source of the information from which this knowledge was derived. The business's mistaken, but good faith, belief concerning industry practice does not qualify it for relief under this safe haven. *Id*. at 1-29 to 1-31.

- Other Reasonable Basis. A business that fails to meet any of the above safe havens may still be entitled to relief if it can demonstrate that it relied on some other reasonable basis for not treating a worker as an employee. *Id*. at 1-32.

  - Reliance on the advice of an attorney or accountant may constitute a reasonable basis. At a minimum, the business should establish that it reasonably believed that the attorney or accountant was familiar with business tax issues, through either education or experience, and that the advice was based on sufficient relevant facts furnished by the business to the advisor. *Id*.

  - Prior state or federal administrative determinations may or may not constitute a reasonable basis, depending on whether the determination used the same common law rules that apply for federal employment tax purposes. *Id*. at 1-33.

  - A prior audit of the predecessor entity of a business may qualify for relief if there was merely a change in form of the business. The same holds for a private letter ruling or technical advice memorandum issued to the predecessor entity. *Id*. at 1-34.

  - Neither cost considerations nor demands by workers for classification as independent contractors constitute reasonable basis. *Id*. at 1-35.

7. Worker Coverage.

Certain categories of workers are outside the scope of Section 530 protection.

- Workers Covered by Section 530. The legislative history indicates that Section 530 only applies to common law employees, but section 3.09 of Rev. Proc. 85-18 provides that Section 530 also applies to all workers classified as employees under Code section 3121(d) (including statutory employees). *Id.* at 1-36.

- Workers Not Covered by Section 530. Section 530 relief does not apply with respect to a worker who, pursuant to an arrangement between the business and a third party, provides services for the third party as an engineer, designer, drafter, computer programmer, systems analyst, or other similarly skilled worker engaged in a similar line of work. This provision does not change the status of a worker from independent contractor to employee, and it applies only to remuneration paid and services rendered after December 31, 1986. *Id.* at 1-38.

8. Recent legislation proposing to curtail application of Section 530.

The GAO estimates that the misclassification of workers can reduce federal revenues by up to $4.7 billion annually. With the increased emphasis on closing the tax gap and, in particular, the effect that worker misclassification has on the underreporting of income, it is interesting that eleven years after Section 530 was liberalized by the Small Business Job Protection Act of 1996, Senators Obama, Durbin, Kennedy and Murray have introduced the "Independent Contractor Proper Classification Act of 2007" (S. 2044) aimed at closing a "loophole" the allows some firms to "cheat" workers out of money, benefits, and worker protections. It will be interesting to see how this proposal holds up in the face of small business interests.

C. Classification Settlement Program.

If a business is not eligible for Section 530 relief and the IRS believes the business may have improperly treated a worker as an independent contractor rather than an employee, the IRS will determine if the business is eligible for a settlement offer under the Classification Settlement Program ("CSP").

1. The CSP on worker classification issues was initially implemented in March 1996 on a two-year trial basis. In Notice 98-21 (Apr. 2, 1998), the Service announced that the program was being extended indefinitely. Although there has been no indication that the CSP is under review, it will be interesting to see if the current focus on worker classification as a significant contributor to the tax gap will cause the IRS to examine the policy behind a program that is perceived by some as an incentive to delay treating workers as employees until the IRS actually conducts an examination.

2. The goal of the CSP is to resolve worker classification issues as early in the administrative process as possible and to ensure that the taxpayer relief provisions under Section 530 of the Revenue Act of 1978 are properly applied.

3. Under CSP, if certain requirements are satisfied, the IRS will offer businesses under audit a settlement using standard closing agreements.

4. A taxpayer's participation in the CSP is voluntary, and a CSP offer may be accepted at any time during the examination process, including during IRS appeals.

5. A taxpayer that declines the CSP settlement offer retains all rights to administrative appeal that exist under the IRS' procedures and all existing rights to judicial review.

6. The CSP program covers only employment tax issues.

7. The CSP settlement offers are structured as follows:

- If a business meets the Section 530 reporting consistency requirements, but either clearly does not meet the Section 530 substantive consistency requirement, or clearly cannot meet the reasonable basis test, the IRS examiner will offer a settlement equal to the employment taxes for one year under examination, computed under Code § 3509 rates, if applicable.

- If the business meets the reporting consistency requirements and has a "colorable argument" that it meets the substantive consistency requirement and the reasonable basis test under Section 530, the IRS will offer a settlement equal to 25% of the FICA tax and income tax withholding liability for one year under examination, computed under Code § 3509, if applicable, plus the full FUTA tax for that year.

- It should be noted that CSP only permits either a 25% settlement or a 100% settlement based on the most recent audit year. An IRS agent is not permitted to negotiate a settlement between those amounts. In exchange for the settlement, the business must agree to classify its workers as employees in the future, beginning with the first calendar quarter following the date of the CSP agreement. Importantly, the settlement, which is calculated on the assessment employment tax liability for the most recent calendar year under audit, covers not only all the years currently under audit but also any intervening years.

8. A few significant problems have arisen under the CSP:

- IRS examiners may be less willing to consider the merits of a worker classification dispute in borderline cases and, thus, may use CSP as a means to avoid engaging in a difficult legal analysis.

- The IRS does not require employers to issue Forms W-2 recharacterizing the amounts previously reported as income on Forms 1099-MISC. CSP procedures do, however, instruct IRS examiners to tell employers to notify workers of the reclassification. This may give workers an incentive to sue for past benefits or to claim unemployment benefits under state law.

- Consistent with Section 530, CSP does not extend to technical services firms covered by Section 1706 of the 1986 Tax Reform Act (i.e., Section 530(d) of the Revenue Act of 1978, as amended). It is not clear how CSP applies when a technical services firm has a colorable argument that a class of workers is not covered by Section 1706, because the workers are not "engineers, designers, drafters, computer programmers, systems analysts, or other similarly skilled workers in a similar line of work."

- When workers perform the same or similar duties, but their relationships with the employer are different, it is not clear how CSP applies to these different classes of workers.

- CSP also requires the examiner to determine whether the case meets the criteria to be referred to the employee plans division of the IRS. Under Code § 401(a)(2), a qualified plan's assets must be held for the exclusive benefit of employees and their beneficiaries. If a plan covers purported employees who are reclassified as independent contractors, the plan is in violation of this "exclusive benefit" rule. Although the IRS has expressed concern about the ramifications of worker reclassification on employers' pension plans, it has decided not to pursue a follow-up program that would have dealt with the pension plan consequences and would have provided a structured settlement program for those problems as well.

D. Appeals Dispute Resolution Procedures

1. The Internal Revenue Service Restructuring and Reform Act of 1998, Pub. L. No. 105-206, § 3465, codified in Code § 7123 the authority of the IRS to provide procedures for early referrals to Appeals and for mediation and binding arbitration of disputes, including those involving employment tax issues. H.R. Rep. No. 105-599, at 291 (1998).

2. The IRS procedures for early referral in employment tax cases are set forth in Rev. Proc. 99-28, 1999-29 I.R.B. 109. Employment tax issues that are appropriate for early referral include those that, if resolved, can be expected to result in a quicker resolution of the entire case, such as: worker classification issues, including whether a worker is an employee or independent contractor under the common law; whether a worker is a statutory employee or statutory non-employee; and whether Section 530 of the Revenue Act of 1978 applies.

3. The procedures for mediation are set forth in Rev. Proc. 2002-44, 2002 I.R.B. 10.

4. Fast Track Mediation and Fast Track Settlement programs are also available for employment tax disputes. *See* Rev. Proc. 2003-40, 2003-25 I.R.B. 1044; and Rev. Proc. 2003-41, 2003-25 I.R.B. 1047.

E. Tax Court Jurisdiction in Worker Classification Disputes

1. Code § 7436, which gives the Tax Court authority to review certain types of worker classification issues, was added by the Taxpayer Relief Act of 1997, Pub. L. No. 105-34, § 1454(a) and was amended by the Community Renewal Tax Relief Act of 2000, Pub. L. No. 106-554, § 314(f), retroactive to the effective date of section 7436(a).

- Prior to its enactment, a taxpayer was only able to litigate employment tax disputes in refund forums – either in U.S. District Court or the U.S. Court of Federal Claims. Thus, the taxpayer had to first pay the tax in dispute (or a divisible portion thereof), and then sue for a refund.

2. Code § 7436 gives the Tax Court authority to review two types of determinations that may be made by the IRS during the examination of a taxpayer: (a) whether a person is an employee for purposes of Subtitle C (employment taxes); or (b) whether a taxpayer is not entitled to relief under Section 530(a) of the Revenue Act of 1978.

- A pleading may be filed in Tax Court only by the person for whom services are performed. Code § 7436(b). Therefore, a worker cannot seek Tax Court review under this provision.

- The Tax Court can only review determinations that are made by the IRS as part of an examination. Therefore, the Tax Court cannot review IRS determinations set forth in private letter rulings or in Forms SS-8.

- The Tax Court does not have jurisdiction to review other employment tax issues under this provision, nor does it have jurisdiction to review issues not arising under Subtitle C, such as the classification of individuals for pension plan coverage or the proper treatment of individual income tax deductions.

3. Code § 7436(b)(3) provides that if the taxpayer changes its treatment of a worker for employment tax purposes during the pendency of a proceeding under this section, that fact shall not be taken into account in the Tax Court's determination.

4. A "Notice of Determination" issued by the IRS is a prerequisite for Tax Court jurisdiction in worker classification cases. *See* IRS Notice 98-43.

5. The taxpayer must file a petition in the Tax Court within 90 days after the IRS mails its Notice of Determination to the taxpayer by certified or registered mail. Code § 7436(b)(2). This time cannot be extended.

6. Cases docketed in the Tax Court will be referred to the IRS Appeals Division for consideration of settlement unless the Notice of Determination was issued by IRS Appeals. Cases in which IRS Appeals issued the Notice of Determination may be referred to Appeals unless IRS District Counsel determines there is little likelihood that a settlement of all or part of the case can be achieved in a reasonable period of time. Notice 98-43.

7. Proceedings under Code § 7436 may be conducted under the Tax Court's simplified procedures for small tax cases under Code § 7463 if the employment tax in dispute is $50,000 or less for each quarter involved. A decision entered under the small case procedures will not be reviewable by any other court and will not be treated as precedent for any other case not involving the same taxpayer and the same determinations. Code § 7436(c)(2).

8. Code § 7436(d)(1) provides that the suspension of the limitations period for assessment in Code § 6503(a) applies in the same manner as if a Notice of Deficiency had been issued.

9. Restrictions on assessment under Code § 6213 of the Code apply in the same manner as if a Notice of Deficiency had been issued. Code § 7436(d)(1).

10. Determinations made by the Tax Court in cases under this provision (other than cases under the small case procedures of Code § 7436(c)) shall have the force and effect of a decision of the Tax Court and shall be reviewable as such. Code § 7436(a).

11. In *Henry Randolph Consulting v. Comm'r*, 112 T.C. 1 (1999), the Tax Court concluded that its 1997 statutory grant of jurisdiction under Code § 7436 did not give it the authority to determine the amount of a taxpayer's employment tax liability resulting from the IRS's worker classification determination. However, as noted above, section 7436(a) was technically corrected (retroactively) to give the Tax Court jurisdiction to determine the proper amount of employment taxes. *See also Ewens and Miller, Inc. v. Commissioner,* 117 T.C. 263 (2001); and *Evans Publishing, Inc. v. Commissioner,* 119 T.C. 242 (2002).

12. In *Charlotte's Office Boutique, Inc. v. Commissioner*, 425 F.3d 1203 (9th Cir. 2005), the U.S. Court of Appeals for the Ninth Circuit agreed with the Tax Court's determination that it retained jurisdiction under section 7436(a) to review worker classification of solely owned corporation's owner and resulting employment taxes, even though the owner's status as an employee in the earlier years had been conceded.

V. PROLIFERATION OF LEASED AND CONTINGENT WORKER ARRANGEMENTS.

A. Background.

1. Partly as a result of the IRS's audit program forcing businesses to reclassify "independent contractors" as employees, companies have developed creative solutions to hiring workers who are not their employees. This class of contingent workers is generally described as workers who are not part of the employer's regular work force, but are hired to meet certain needs. Leased employees form one type of the contingent workforce. Other types of contingent workers include: part-time, casual, per diem, shared and temporary employees, as well as independent contractors or consultants. These workers' "employers" also go by a variety of names, ranging from "leasing organization," "PC", "loan-out," "seconder org," to "PEO." None of these terms is defined in the Internal Revenue Code, except "leased employees." (*See* Code § 414(n)). Unfortunately, although these three-party arrangements have proliferated exponentially in recent years to meet changing demands for products and services, the IRS has been very slow in issuing guidance on the subject. In April, 1993, it withdrew proposed regulations under Code § 414(n). 58 Fed. Reg. 25556 (4/27/93). It has made no commitment since that time to issue regulations or other guidance to taxpayers on employee leasing arrangements.

2. Technical Advice Memorandum ("TAM") 199918056 (11/12/98) held that merely paying wages to another company's employees did <u>not</u> transform the wage-payer into the common law employer of the workers, but did transform the wage-payer into the employer under Code § 3401(d)(1) for income tax withholding purposes only. This TAM was interpreted by some as a sign that the IRS might be ready to issue formal warnings to leasing companies and PEOs that merely paying wages and claiming the title of "employer" does not cause the true employer to lose that status. Curiously, IRS representatives have downplayed the potential significance of this TAM, indicating that it involved "special facts."

3. In 2000, the U.S. General Accounting office submitted a report to Senators Kennedy and Torricelli concerning contingent worker arrangements in the United States. *Contingent Workers: Incomes and Benefits Lag Behind Those of Rest of Workforce*, GAO/HEHS-00-76 (June 2000).

B. Examples of Leasing/Staffing Arrangements.

1. The term "leasing/staffing arrangement" has evolved over the years to refer to many different relationship structures. Some of the more common structures are described below. These structures range from the traditional concept of providing full-time, part-time or temporary workers to a recipient organization to providing entire departmental or organizational functions to the recipient organization.

- Traditional leasing arrangement: it is typical in a traditional leasing arrangement that all or substantially all of an employer organization's employees (or sometimes a discrete facility, business line or site) are transferred to the payroll of an employee leasing firm ("leasing firm"). This is often referred to as the "fire-hire," because the common law employer fires its rank-and-file employees and the leasing firm hires the employees to perform the same services for the employer organization. The employer organization ("recipient organization" or "service recipient") then leases the workers back from the leasing firm.

- Temporary staffing agency: a temporary staffing agency usually provides the agency's common law employees to perform temporary, short-term duties for the recipient organization.

- Long-term temporary assignment: a temporary help firm provides employees to supplement the service recipient's work force on an ongoing basis, typically to work on special projects. The overall size of the temporary work force at any given time depends on the work demands, thus the core work force remains very stable.

- "Master vendor" arrangement: a large consumer of temporary help firms hires one staffing firm (the "master vendor") to supply all needed temporary employees, consolidate billing and invoicing and streamline administration. Generally, the master vendor assigns an onsite supervisor to work on the recipient organization's premises to coordinate all job orders, train new temporary workers, oversee scheduling, complete reports regarding temporary worker usage and perform other administrative tasks. The master vendor may even engage staffing firm subcontractors ("secondary suppliers") to assist it in meeting the recipient organization's supplemental staffing needs.

- Contract technical worker arrangement: highly-skilled technical workers, usually professionals, are supplied for long-term projects under contract between the service recipient and a technical services firm.

- Outsourcing: outsourcing is a staffing arrangement whereby an independent company with expertise in operating a specific function contracts to take full operational responsibility for performing that function, rather than just supply personnel. Typical outsource functions include security, janitorial services, landscaping and cafeteria food services and, even more recently, the corporate tax department (!).

- Professional employer organization: a professional employer organization ("PEO") is a third-party employee leasing agency that, in essence, becomes the "worksite employer's" human resources department, e.g., pays the workers' wages, pays employment taxes

with respect to these wages and retains authority for hiring and firing. A PEO arrangement is often established by the common law employer (i.e., the worksite employer) that wants to "source" its own employees to the PEO. After the employees are transferred to the "employ" of the PEO, they continue to perform the same duties for the worksite employer.

2. IRS Views of Many Leasing Arrangements.

- The IRS has always been troubled by the issues created in conjunction with leasing arrangements. Even though the proposed employee leasing regulations were withdrawn by the IRS in 1993, IRS examination at one point initiated a market segment study of the "employee leasing" industry to determine whether, in certain types of arrangements involving leasing firms, the leasing firm was properly regarded as the "common law" employer for purposes of employment taxes and employee benefit plans. The study recommended that leased employees performing services for the client companies should have been treated as regular employees of those companies, rather than the leasing organizations that hired them. IRS examination submitted a report to the Office of the Chief Counsel on its study, but no action was ever taken. (*See*, however, TAM 199918056 (11/12/98) (which concluded that a company "paying wages" was not the common law employer, but was the employer under Code § 3401(d)(1) for income tax withholding purposes only).

3. Transition problems.

- A leasing firm and client company that enter into a leasing arrangement must be very careful to consider the ramifications of the change and all the legal obligations that can be triggered. This is particularly the case in a situation in which the workers formerly employed by the client company are being hired by the firm and assigned back to fill the same job positions. All the formalities of a transfer of the employees from the client company to the leasing firm must be observed.

- The change of employment must be clearly communicated to all of the affected employees, who must be formally laid off by the client firm and hired by the leasing firm. All normal hiring procedures must be observed, i.e., acquisition of new Forms W-4 from the employees and restart of FICA taxes on wages paid to the employees by the leasing firm.

- Questions can arise regarding post-employment fringe benefits. The best example would be whether or not the transferred employees are entitled to severance pay under the client company's severance policy, because they have in fact severed their employment relationship. In *Blau v. Del Monte Corp.*, 748 F.2d ((9th Cir. 1984),

cert. denied 474 U.S. 865 (1985), Del Monte sold its subsidiary, Granny Goose, to a purchaser. None of the employees lost their jobs, but because the employees were no longer employed by Del Monte, the court held that the employees were entitled to severance pay under the terms of Del Monte's severance plan.

- Affected employees may also claim entitlement to other post-employment rights, such as COBRA health benefits or distributions from individual retirement accounts, profit sharing, stock purchase, and other benefit plans maintained by the client company.

VI. LOAN-OUT ENTITIES USED TO PROVIDE PERSONAL SERVICES.

A. Background.

1. Since the late 1990s, there has been an increase in the use of personal service corporations, including "loan-out" entities structured as single-member limited liability companies ("LLCs"). The concept of using a loan-out entity to provide personal services, particularly professional services, is certainly not a new one. Moreover, the IRS has attacked this form of entity over the years, and Congress has attempted to impose limitations through legislation. This area of tax law is so confusing that it has left service-recipients in the precarious position of having to determine whether to recognize loan-outs as entities distinct from their shareholder-employees or to force these service-providers to accept direct employment with the service-recipients. If a service-recipient respects the loan-out entity and it is subsequently determined by the IRS that the service-recipient should not have done so, significant retroactive Federal employment tax consequences could result.

2. The IRS currently has no active initiatives directing its agents to examine the use of personal-service loan-outs structured as LLCs by their sole owners.

B. The "Check-the-Box" Regulations.

1. In December 1996, the IRS simplified the tax treatment of LLCs by issuing new regulations under section 7701, known as the "check-the-box" regulations, because taxpayers are permitted to make elections regarding the tax classification of the entity. Under these regulations, a domestic, multi-member, non-publicly traded LLC is taxed as a partnership, unless it elects to be taxed as an association, resulting in corporate tax treatment.

2. A single-member LLC that does not elect to be classified as an association is "disregarded as an entity separate from its owner" for federal income tax purposes. *See* Treas. Reg. § 301.7701-3(b)(1). If an entity is so disregarded, "its activities are treated in the same manner as a sole proprietorship, branch, or division of the owner." Treas. Reg. § 301.7701-2(a). In other words, if the sole owner is an individual, the disregarded entity is treated like a sole

proprietorship for income tax purposes. This means that an LLC owned entirely by an individual will not have a tax identity separate from its owner.

3. Both single-member and multi-member LLCs electing to be taxed as corporations may elect either S or C corporation status.

4. The entity classification elections must be made on Form 8832, "Entity Classification Election."

5. The recipient of any personal services has the burden of determining whether the service-provider is an employee or independent contractor under the common law.

C. Unincorporated LLCs.

1. In the case of an unincorporated LLC owned by an individual performing personal services, the service recipient is faced with having to determine whether or not the individual is in fact its employee.

2. Although the final regulations pertaining to the employment tax treatment of disregarded entities (72 Fed. Reg. 45891 (Aug. 16, 2007)) provide that an individual owner of a disregarded entity continues to be treated as self-employed for purposes of Self-Employed Contributions Act ("SECA") taxes and therefore should not be treated as an employee of the disregarded entity for employment tax purposes, these regulations do not preclude the IRS from recharacterizing the payments to the individual for personal services as "wages" paid by the service recipient. In other words, the IRS could take the position that the service recipient was a common law employee. Employment taxes would be retroactively assessed on the payments made to the LLC for the service provider's services and penalties would be imposed.

3. Even though a multiple-member LLC by definition is not a disregarded entity, the IRS may examine the LLC's ownership interests to determine whether ownership of members other than that of the service provider is sufficient for purposes of sustaining the LLC's treatment as a partnership and whether the facts and circumstances support the assertion that the multiple-member LLC has a legitimate business purpose.

D. Procedures for Determining an LLC's Status and How to Treat It.

1. Prior to the performance of services, the service-recipient may want to consider asking for the following documentation—

- a Form W-9 ("Request for Taxpayer Identification Number and Certification");
- even if the Form W-9 verifies that the LLC is a corporation, a copy of the corporate resolution or other documentation indicating the LLC's corporate status; and

- a copy of Form 8832, which is the form used to elect entity classification. This form should provide both the service provider's Social Security number ("SSN") and the LLC's taxpayer identification numbers.

2. The service-recipient should also confirm that the service provider's relationship to his unincorporated LLC is that of an employee and that the requisite payroll taxes will be withheld and paid on any compensation paid by the LLC to him for services. A copy of the employment contract between the loan-out and the service provider could assist the service-recipient in determining whether there is a meaningful business relationship between the two (and that the payroll tax rules are being complied with) or whether the corporation is simply an alter ego.

3. The service-recipient may want to include the appropriate indemnification language in the services agreement with the LLC in the event the payments to the LLC are retroactively recharacterized by the IRS as wages subject to payroll taxation.

4. The service-recipient should also consider obtaining a separate written guarantee from the service provider that he will be personally responsible for indemnifying the service recipient for any employment tax liability arising out of an IRS examination and that he will sign a Form 4669 after the appropriate annual income tax returns are filed by either the corporation or the individual. (Forms 4669 will assist the service-recipient in obtaining abatement from any asserted liabilities for failure to withhold income taxes, if the IRS subsequently deems the service-recipient to be the common law employer or the "statutory" employer under section 3401(d)(1) of the Code.)

5. The service recipient should consider reporting all the payments made to the LLC on Forms 1099-MISC, even though the LLC is a C or S corporation and may be considered exempt under information reporting rules. *See* Treas. Reg. §§ 1.6041-3(p)(1) and 1.6049-4(c)(1)(ii)(A); *and also* Prop. Treas. Reg. § 1.6045-5(d)(1).

VII. SUGGESTIONS FOR MINIMIZING WORKER CLASSIFICATION PROBLEMS.

- Review all worker contracts to clarify worker status; follow common law test carefully.
- Watch out for situations in which the worker's status switches from that of an employee to an independent contractor or in which the job functions are similar for workers with different worker classifications.
- Review all plans' coverage provisions.

- Be on the alert for "Form SS-8" requests filed by workers, who are or were classified as independent contractors.
- Monitor IRS changes in its worker "Classification Settlement Program" ("CSP") and announcements on its ongoing study of employee leasing issues.
- Consider carefully benefits and risks of any CSP settlements, and do not issue retroactive Forms W-2, if any CSP settlements are entered into with the IRS.
- Be on the alert for contingent worker arrangements.
- Scrutinize arrangements with LLCs.
- Be aware that the states may have more vigorous enforcement programs than the IRS.

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