AMERICAN BAR ASSOCIATION
Tort Trial and Insurance Practice Section

Spring 2021

COMMITTEE NEWS

Employee Benefits Law

Fringe Benefit Issues for Employers to Consider During and After COVID

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Mr. Block advises clients on a wide range of federal tax and ERISA matters regarding employee benefits and executive compensation. His practice encompasses qualified retirement plans, executive compensation, federal income and employment taxes, and health and welfare arrangements.

One truism of the ongoing COVID-19 pandemic is that it has fundamentally altered the way employees work. The disruption to traditional employee work schedules, coupled with the displacement caused by the pandemic, have operated in tandem to catalyze government action in the fringe benefit arena. Further, recent activity by both Congress and regulatory agencies have created planning opportunities for the well-counselled both during the COVID-19 pandemic and after it has receded. However, this recent activity also has the potential to ensnare the unsuspecting in potential tax traps.

This article seeks to provide a broad overview of the most significant changes made to the rules governing the taxation of fringe benefits in 2020, along with fringe benefit issues that have been uniquely implicated by COVID-19. Specifically, we briefly address: (1) changes to the deduction rules governing qualified transportation fringes and commuter expenses, (2) changes to the deduction rules governing the food and beverage expenses, (3) student loan relief through employer-funded educational

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In This Issue

Chair Message

David Levine
Groom Law Group Chartered
Chair, TIPS Employee Benefits Committee

David Cohen
Benetic, Inc.
Immediate Past Chair, TIPS Employee Benefits Committee

It is hard to believe that we have been dealing with a remote existence for more than a year. While we miss seeing our colleagues in person, there is light at the end of the tunnel. In the meantime, we appreciate the chance to connect via this newsletter.

The Employee Benefits Committee, working with our TIPS colleagues in the Health & Disability, Insurance Regulation, and Life Insurance Committees, successfully held our first (and we hope last for some time) virtual 47th Annual TIPS Midwinter Symposium on Health & Disability, Insurance, and Employee Benefits. We are hopeful that we will be able to meet in person in 2022, likely over MLK weekend in the Miami/Ft. Lauderdale area. Please keep an eye out for a save the date over the summer.

If you or a colleague are looking to get more involved in the Employee Benefits Committee, in addition to this newsletter the Employee Benefits Committee provides several opportunities to get your name and articles in front of your peers and potential clients, including:

- The Tort Trial & Insurance Practice Journal
- The Brief
- TortSource

If you are interested in learning more, or if you have a junior colleague who may be interested in contributing, please contact one of our publications vice-chairs, Joseph Faucher (jfaucher@truckerhuss.com) or Michelle Roberts (michelle@robertsdisability.com).

We also offer numerous opportunities to speak on a wide range of benefits-related topics. As one of six member Committees of the ABA's Joint Committee on Employee Benefits (JCEB), we can offer a wide range of speaking and discounted attendance opportunities to members with the JCEB's popular conferences and webinars. Additionally, if you have a topic you on which you would like to lead a discussion on during a periodic Committee call, please let us know. If you are interested in learning more about these speaking opportunities, please contact one of our programming vice-chairs, Denise Clark (dmclark@benefitcounsel.com) or Clarissa Kang (ckang@truckerhuss.com).

As we continue to expand ways that we interact with our members, please take the time to join our LinkedIn page. Please also confirm that your ABA membership is set up to receive Committee communications through ABAConnect. Please contact our technology vice-chair, Tim Rozelle (trozelle@kantorlaw.net), with any questions.

We appreciate your involvement in the Committee, and as always welcome any thoughts on how we can improve the experience for Committee members. We look forward to again seeing everyone in person.

David Levine
Chair, TIPS Employee Benefits Committee

David Cohen
Immediate Past Chair, TIPS Employee Benefits Committee

Connect with Employee Benefits Law

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THE BRIEF

When Does Insurance for Single-person Business Owners Become an ERISA Plan?

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Michelle represents California claimants in ERISA-governed disability and life insurance claims.

In most circumstances, claimants with denied insurance claims would prefer that state law govern the dispute rather than the Employee Retirement Income Security Act of 1974 ("ERISA"). This is especially the case if the insured's state[1] provides damages for a bad faith insurance denial. If a claim is governed by ERISA, there are no consequential, emotional distress, or punitive damages available if an insured proves a wrongful or bad faith claim denial.[2]

ERISA only comes into play if there is an ERISA plan. ERISA defines an "employee benefit plan" as "any plan, fund, or program…established or maintained by an employer…for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance…medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death …" 29 U.S.C.A. § 1002(1) (West).

It should seem straightforward that insurance policies covering business owners who are sole proprietors or the only member of a single-person corporation would not be governed by ERISA. But as demonstrated by two recent district court decisions, these disputes are not so cut and dry, at least not to the parties.

In *Juanopulos v. Salus Claims Management LLC*[3], in deciding a motion to remand the matter to Texas state court, the district court had to decide whether ERISA governs an occupational injury benefit plan that covered just the business owner. Plaintiff Juanopulos owns J&A Paint and Body Shop and alleged to be the sole proprietor and only employee. Defendant Life Insurance Company of North America (LINA) sold Plaintiff an occupational injury benefit plan for his business. The plan provides certain medical benefits for "Covered Employees" who are hurt on the job. Juanopulos filed a claim under the plan when he accidentally shot himself in the stomach while at work. He alleged that he was attempting to remove a stuck bullet from a gun he kept in his office to provide on-premises security.

Defendant Salus Claims Management LLC is a third-party administrator responsible for managing work-related injury benefit claims and Defendant Matt Reiter is a Salus employee. Reiter denied the claim on the basis that using or cleaning a gun was not within the covered scope of employment. Juanopulos unsuccessfully appealed the denial and then filed several state law claims against Defendants in Texas state court. Defendants removed based on ERISA preemption, claiming that the plan

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American Rescue Plan Saves Financially Troubled Multiemployer Pension Plans



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Mr. Kramer represents clients in ERISA and traditional labor matters, including multiemployer plan matters.

On March 11, 2021, President Biden signed the $1.9 trillion-dollar *American Rescue Plan Act of 2021* (the "Act") into law, which includes various forms of relief for financially troubled multiemployer pension plans.[1]

This relief is a culmination of years of debate in Congress and prior attempts to pass funding relief for multiemployer pension plans. The Pension Benefit Guaranty Corporation ("PBGC") has also long been reporting and warning against the pending insolvency of its multiemployer insurance program, which acts as the final safety net to cover some portion of promised retirement benefits when a multiemployer plan becomes insolvent. The PBGC has also noted that approximately one million of the more than ten million participants in multiemployer pension plans are in plans that are expected to become insolvent and unable to pay promised benefits at some point in the future. Many more are in multiemployer plans that are severely underfunded and/or making significant benefit cuts to improve their financial solvency.

It is against this background that President Biden and Congress enacted within the Act the key provisions of the "*Butch Lewis Emergency Pension Relief Act of 2021*" (the "Butch Lewis Act") that address severely underfunded multiemployer pension plans. The key provisions relating to multiemployer pension plans are summarized below.

1. Special Financial Assistance Fund.

The Act as passed will, among other things, create a "special financial assistance fund" from which the PBGC will be able to make grants to financially troubled multiemployer pension plans. This fund will be created under the Treasury Department. Notably, there is no requirement for any multiemployer pensions plans that receive this relief to repay those funds.

To be eligible for relief from the special financial assistance fund, a multiemployer pension plan must satisfy one of the following criteria:

> (A) The multiemployer pension plan is in critical and declining status in any plan year beginning in 2020 through 2022;
>
> (B) The multiemployer pension plan suspended benefits in accordance with the process set forth in the Multiemployer Pension Reform Act of 2014 ("MPRA");

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Supreme Court Gives Green Light to States to Regulate Pharmacy Benefit Managers

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Trucker Huss, APC

Ms. Kang represents plans and plan fiduciaries in ERISA litigation in district and appellate courts, including matters in which ERISA preemption is a key issue.

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Mr. Faucher has been litigating ERISA and other employee benefit cases for over thirty years, and has substantial experience litigating complex ERISA preemption issues.

As legislatures around the country continue to regulate health care within their states, courts continue to wrestle with the question of when those state laws are preempted or superseded by the Employee Retirement Income Security Act ("ERISA"). In *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474, 208 L. Ed. 2d 327 (2020) ("*Rutledge*"), the U.S. Supreme Court decided that an Arkansas state law governing prescription drug pricing for generic drugs under an ERISA health benefit plan is *not* preempted by ERISA.

Plaintiff in *Rutledge* was the Pharmaceutical Care Management Association (PCMA), a national trade association representing the eleven largest Pharmacy Benefit Managers (PBMs) in the country. PCMA challenged an Arkansas state law regulating pricing for generic drugs by PBMs. The case is significant not only in Arkansas, but nationwide, since over thirty other states have enacted laws similar to Arkansas's to control PBMs' pricing practices.

I. Role of Pharmacy Benefit Managers

PBMs act as "middlemen" between health plans and pharmacies. They process claims, calculate benefit levels, determine copayment information, make disbursements, and generate reports and data. PBMs reimburse pharmacies for prescriptions issued to participants and beneficiaries, and in turn, are reimbursed by health plans.

PBMs enter into contracts with pharmacies to create pharmacy networks. In creating these networks, PBMs select pharmacies willing to take lower reimbursements in exchange for being placed in a preferred network. When health plan participants and beneficiaries present a prescription at a pharmacy, the participant or beneficiary does not pay the full price that the pharmacist receives for the drug but instead pays a portion, or copay, and the participant's or beneficiary's health plan covers the remaining cost. PBMs gather market data to create maximum allowable cost (MAC) lists. MAC lists are used to set reimbursement rates for pharmacies filling generic prescriptions.

II. Arkansas PBM Law — Act 900

In 2015, the Arkansas state legislature adopted Act 900, Ark. Code Ann. § 17-92-507 (West) ("Act 900"), to protect pharmacies from PBMs' pricing practices that affected the profitability of pharmacies, particularly with regard to generic drugs. The state's

concern was that pharmacies, particularly rural and independent pharmacies, were at risk because the reimbursement rates set by PBMs were often too low to cover their costs. Pharmacies were therefore at risk of closing. Accordingly, Act 900:

- Required pharmacies to be reimbursed for generic drugs at a price equal to or higher than the cost invoiced for the drug by the wholesaler to the pharmacy;
- Required PBMs to update their MAC lists within at least seven days from the time there has been a certain increase in the costs of acquiring the generic drugs;
- Provided pharmacies with administrative appeal procedures that allow a pharmacy to reverse and rebill claims affected by a pharmacy's inability to procure the drug at a cost that is equal to or less than the cost on the relevant MAC list where the drug is not available "below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale"; and
- Provided a "decline-to-dispense" option for pharmacies to decline to fill a prescription where the transaction would result in the pharmacy losing money.

The case is significant not only in Arkansas, but nationwide, since over thirty other states have enacted laws similar to Arkansas's to control PBMs' pricing practices.

III. Challenges in the District Court and Circuit Court of Appeal

PCMA initially challenged Act 900 on the grounds that it is preempted by ERISA and Medicare Part D and that it violates the U.S. Constitution and the Arkansas Constitution.

On motions for summary judgment, the U.S. District Court for the Eastern District of Arkansas held that Act 900 was preempted by ERISA as applied to ERISA plans but otherwise withstood the challenges PCMA brought as to its constitutionality and preemption by Medicare Part D. PCMA appealed the ruling on the lack of preemption under Medicare Part D. The Arkansas State Attorney General appealed the ruling on ERISA preemption.

IV. Eighth Circuit Holds Arkansas Law Is Preempted

On appeal, the Eighth Circuit Court of Appeals held that Act 900 was preempted by both ERISA and Medicare Part D.

Like the District Court, the Eighth Circuit looked to its earlier ruling in *Pharm. Care Mgmt. Ass'n v. Gerhart*, 852 F.3d 722 (8th Cir. 2017), which held that an Iowa PBM law similar to Act 900 was preempted by ERISA because it had a prohibited reference to ERISA and interfered with nationally uniform plan administration. The

Iowa law required PBMs to provide information regarding their pricing methodologies to Iowa's insurance commissioner upon request. It limited the types of drugs to which a PBM could apply MAC pricing and limited the sources from which a PBM could obtain pricing information. In addition, it required PBMs to provide their pricing methodologies in their contracts with pharmacies and to provide procedures by which pharmacies could comment on and appeal MAC price lists or reimbursements. The Eighth Circuit ruled that the Iowa law had both an impermissible express reference to ERISA and an implicit reference to ERISA through regulation of PBMs who administer benefits for ERISA plans.

The Eighth Circuit held that *Gerhart* dictated the outcome in *Rutledge,* and therefore, concluded that ERISA preempted Act 900. The court held that Act 900 both relates to and has a connection with employee benefit plans and is therefore preempted. The State of Arkansas sought Supreme Court review.

V. The Supreme Court Reverses, and Holds ERISA Does Not Preempt Act 900

The Supreme Court accepted review of the Eighth Circuit's ruling that Act 900 was preempted, and heard oral argument after Justice Ginsburg had passed away, but before Justice Amy Coney Barrett was confirmed as the Court's ninth justice.

ERISA preempts state laws that "… relate to" any employee benefit plan.[1] The Supreme Court has long held that a state law relates to an ERISA plan if it has "a connection with" or "reference to" a plan.[2] In a unanimous decision (except for Justice Barrett, who took no part in the consideration of the case) issued on December 10, 2020, the Court reversed the Eighth Circuit's holding, concluding that Act 900 neither has any impermissible "connection with" ERISA plans, nor "refers to" ERISA. The Court first analyzed the "connection with" question, noting that ERISA is "… primarily concerned with preempting laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits."[3] The Court also considered whether the law "governs a central matter of plan administration or interferes with nationally uniform plan administration."[4] The Court concluded that Act 900 "is merely a form of cost regulation," and that "cost uniformity was almost certainly not an object of pre-emption."[5] Thus, the Court held that Act 900 was not preempted under the "connection with" prong of the analysis.

The Court also held that Act 900 does not "refer to" ERISA. In order for a state law to "refer to" ERISA it must "act[] immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation."[6] The Court dispensed quickly with this issue, finding that Act 900 "does not act immediately and exclusively upon ERISA plans because it applies to PBMs whether or not they

manage an ERISA plan. Indeed, the Act does not directly regulate health benefit plans at all, ERISA or otherwise. It affects plans only insofar as PBMs may pass along higher pharmacy rates to plans with which they contract.

Rutledge is but the latest in a long line of Supreme Court cases examining the concept of ERISA preemption. It will almost certainly have a significant impact on ERISA jurisprudence generally, including cases outside the PBM regulation arena. But it is certainly not going to be the final word. In a concurring opinion in *Rutledge,* Justice Clarence Thomas criticized Supreme Court jurisprudence, stating that the Court will declare as preempted "state laws based on perceived conflicts with broad federal policy objectives, legislative history, or generalized notions of congressional purposes that are not embodied within the text of federal law."[7] Justice Thomas concluded that under that "objectives and purposes" preemption approach, a state law is preempted if it has a "reference to" or "connection with" ERISA plans, and stated "… this vague test offered 'no more help than' the 'relate to' one."[8] Justice Thomas advocated for a "text-based" approach, stating, as he has in other cases, that ERISA's preemption clause should not be considered to be "sweeping" in its approach: "Congress knows how to write sweeping pre-emption statutes. But it did not do so here. Applying the statutory text, the first step is to ask whether a provision in ERISA governs the same matter as the disputed state law, and thus could replace it."[9]

Rutledge is but the latest in a long line of Supreme Court cases examining the concept of ERISA preemption.

It remains to be seen if Justice Thomas's generalized criticisms of the Supreme Court's preemption jurisprudence ever gain traction among the Court's other justices. For now, even Justice Thomas acknowledges that "the outcomes of our recent cases—if not the reasoning—are generally consistent with a text-based approach." This concession makes it somewhat unlikely that a majority of the Court's other justices will adopt Justice Thomas's preferred "text-based" approach in the face of decades of the Court's application of the somewhat amorphous "connection with" and "reference to" tests, with which the lower courts will likely continue to struggle.

Endnotes

1 29 U.S.C.A. § 1144(a) (West).
2 *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 147, 121 S. Ct. 1322, 149 L. Ed. 2d 264 (2001).
3 *Rutledge* at 480.
4 *Id.*
5 *Id.* at 481.
6 *Id.*
7 *Rutledge* at 485 (Thomas, concurring).
8 *Id.*
9 *Id.* at 484.

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Fringe... continued from page 1

assistance programs, (4) employer-provided qualified disaster relief payments, and (5) employer provided de minimis fringe benefits.

Qualified Transportation Fringes and Commuter Expense Deduction Changes

As commuting and workplace transportation slowly begin to rebound with the rollout of the COVID-19 vaccines, it is important for employers to understand the recent tax changes impacting qualified transportation fringe benefits and commuter expenses. The *Tax Cuts and Jobs Act of 2017* ("TCJA") added Code section 274(a)(4), which disallows an employer's ability to deduct the cost of certain qualified transportation fringes ("QTFs"). QTFs typically include any of the following provided by an employer to an employee: (1) transportation in a commuter highway vehicle between an employee's residence and place of employment, (2) transit pass, (3) qualified parking, and (4) qualified bicycle commuting reimbursement.

The TCJA additionally added Code section 274(l)(1), which disallows an employer's deduction for the cost of transportation, or reimbursement payments for any transportation, in connection with an employee's travel between the employee's residence and place of employment, except as necessary for ensuring the safety of the employee.

Generally, employees can receive up to $270 of QTFs provided by their employer each month tax-free. This tax-free treatment did not change (however, the TCJA has temporarily suspended the tax-free treatment of qualified bicycle commuting reimbursements until January 1, 2026). Thus, prior to the deduction disallowance, QTFs received particularly favorable tax treatment, as an employer could receive a tax deduction for providing these QTFs to employees and an employee could typically receive the benefits tax-free.

On December 16, 2020, the IRS published final regulations governing the disallowance of the employer deduction for QTFs, as well as the commuter expense deduction disallowance under Code section 274(l). The final regulations provide new guidance to assist employers in calculating nondeductible parking expenses. The final regulations also outline certain exceptions to the general rule disallowing the deduction, such as the exceptions under Code sections 274(e)(2), (e)(7), and (e)(8). Under these exceptions, if QTFs are treated as compensation to the employee, made available to the general public, or sold by the employer to the employee in a bona fide transaction for full and adequate consideration, they still may be deductible by the employer.

The final regulations also address the disallowance of the employer deduction for commuter expenses. Specifically, the regulations clarified that if the transportation is necessary for ensuring the safety of the employee (e.g., if certain unsafe conditions exist), the deduction may still be allowed. The preamble to the final regulations also clarified that the rules under Code section 274(l) disallowing the tax deduction to employers do not apply to business expenses incurred under Code section 162(a)(2) while an employee is traveling away from home. These final regulations are of particular consequence for employers whose employees have been unable to use public transportation for safety reasons, as the final regulations expanded the circumstances when the "safety of the employee" exception would apply from previous proposed regulations.

As employers continue to transition to full or partial return to work environments, employers should consider the tax implications of any reimbursements or payments for commuting or QTFs, in light of the recent guidance provided by the IRS. Engaging in such analysis now, rather than later, may significantly reduce any potential tax risk and facilitate long-term cost savings for employers.

Food and Beverage Expense Deduction Changes

The TCJA also revised the rules for deducting business expenditures for food and beverages under Code section 274(n). The rules under Code section 274(n) limit the employer's deduction for food or beverage expenses to 50% of the cost. On October 2, 2020, the IRS issued final regulations that provide guidance regarding this disallowance provision, and on December 27, 2020 Congress enacted the *Consolidated Appropriations Act,* 2021 (the "CAA"), a $2.3 trillion federal spending bill, which among other things amended these rules to potentially provide a more generous deduction to the employer.

The final regulations provide detailed guidance on the requirements for food and beverage expenses to be considered directly connected with an employer's trade or business, and thus eligible for a deduction for the employer. The regulations also provide specific examples to demonstrate how food and beverages provided to attendees at various work-related events (e.g., a business meeting or a training seminar) should be treated under the Code. The final regulations additionally confirm the applicability of certain key exceptions to the general disallowance rules (e.g., for food and beverage expenses treated as compensation to the employee).

Notable for employers to consider in 2021 is that the CAA amended Code section 274(n) to allow a 100% deduction for food and beverage expenses provided by a restaurant that are paid or incurred after December 31, 2020 and prior to

January 1, 2023. Although the IRS has yet to release guidance governing how to interpret what constitutes being "provided by a restaurant," employers that frequently incur food and beverage expenses in the ordinary course of business would be wise to discuss strategies with their counsel in order to take advantage of this beneficial change.

Student Loan Relief

Recent Congressional action has also expanded the ability of employers to provide student loan assistance to their employees. Pursuant to Code section 127(a), employees can typically exclude up to $5,250 from gross income of certain qualified educational assistance provided by their employer. Educational assistance can include items such as tuition and fee payments, books, supplies, and related items. Importantly, following the *Coronavirus Aid, Relief, and Economic Security Act,* 2019 (the "CARES Act"), effective March 27, 2020, educational assistance now also includes the principal and interest on a qualified education loan. Notably, the income exclusion for qualified education loans was set to expire on January 1, 2021; however, in the recently enacted CAA, Congress extended the exclusion until January 1, 2026. Employers looking to provide alternative benefits to attract and retain employees may be well-served to consider including this benefit for their employees (which provides a tax-free benefit for employees to help pay down student loans, while providing an employer deduction as well).

Educational assistance can include items such as tuition and fee payments, books, supplies, and related items.

Disaster Relief Payments

The pandemic has also implicated a long-standing provision of the Code, Code section 139, which excludes any "qualified disaster relief payment" from an employee's income. On March 13, 2020, the President issued an emergency declaration for the ongoing COVID-19 pandemic (which was recently extended). Accordingly, the COVID-19 pandemic became a qualified disaster for purposes of Code section 139, which the IRS highlighted in FAQs released in March 2020.

Under this broad provision, employers have been able to make certain payments on a tax-free basis to, or for the benefit of, employees during the ongoing pandemic, which also provides for an employer deduction. In particular, the provision allows employers to pay or reimburse "reasonable and necessary" personal, family, living, and other expenses incurred as a result of the COVID-19 pandemic.

The IRS has not issued specific guidance on what might constitute "reasonable and necessary" expenses in a pandemic. However, many employers, in consultation with counsel, have taken advantage of this flexible provision to provide payments to

their employees to assist with the hardships caused by the pandemic. As employers continue to deal with the ongoing pandemic, this provision provides a relatively flexible way of providing tax-efficient assistance to employees.

De Minimis Fringe Benefits

Lastly, during the pandemic, many employers have sought to provide small gifts or other benefits to their employees in order to encourage employee morale. For example, some employers have provided holiday meals, gift certificates, articles of clothing with the employer's insignia, or other similar items. Many of these benefits are governed by long-standing Code section 132(e) as "de minimis" fringe benefits. A "de minimis" fringe benefit is generally any property or service the value of which is (after taking into account the frequency with which similar fringes are provided by the employer to the employer's employees) so small as to make accounting for it unreasonable or administratively impractical. Employees can receive benefits that qualify as de minimis fringe benefits tax-free, while employers can take a deduction.

The regulations governing de minimis fringe benefits, however, provide traps for unwitting employers, potentially leading to surprise tax liability for employees receiving gifts from their well-intentioned employers, as well as potential withholding implications for the employers themselves. For example, a cash or cash equivalent benefit, such as a gift card, is not typically considered a de minimis fringe benefit, even if the same property or service acquired with the benefit would be a de minimis fringe. Therefore, such item is generally treated as taxable wages to an employee. Employers offering gift cards or other perquisites to employees should evaluate the tax treatment of such benefits with counsel to avoid any unintended income and employment taxes (and related reporting and withholding obligations and penalties).

Conclusion

The COVID-19 pandemic will likely have significant long-term ramifications on the labor market, impacting everything from the prevalence of remote work, transportation and commuting patterns, to the way in which organizations retain and reward their employees. As the labor market undergoes this transition, well-counseled employers have a unique opportunity to take advantage of these long-standing fringe benefit rules, as well as the recent fringe benefit changes to provide tax-efficient benefits to attract and retain talent employees, as well as garner significant tax savings.

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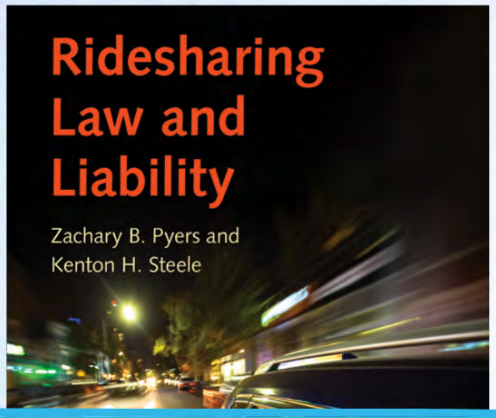

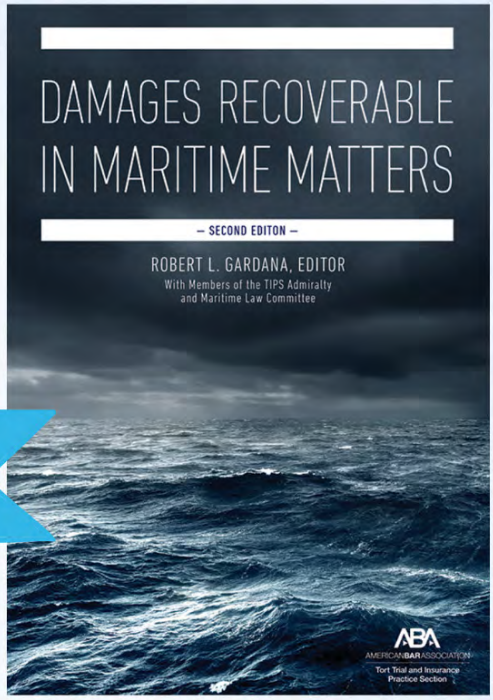

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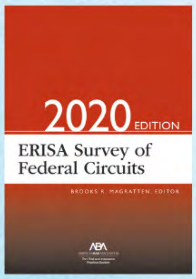

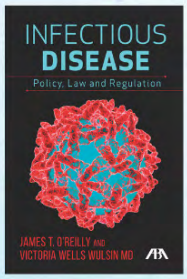

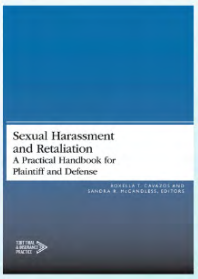

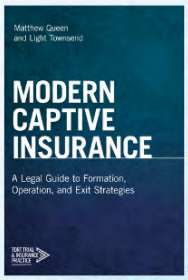

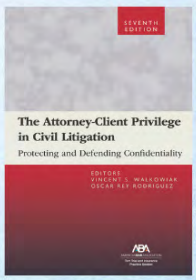

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was exclusively governed by ERISA. Juanopulos sought a remand on the basis that ERISA does not apply.

In deciding whether ERISA applies, the court noted that "the Fifth Circuit has set out three distinct inquiries that courts must resolve to determine whether a particular plan qualifies as an employee welfare benefit plan under ERISA. These are:

- *First*, whether the plan exists;
- *Second*, whether it falls within the safe-harbor provision established by the Department of Labor, which pertains to 29 C.F.R. § 2510.3-1(j); and
- *Third*, whether it satisfies the primary elements of an ERISA "'employee benefit plan'—establishment or maintenance by an employer intending to benefit employees.'"[4]

Here, the parties disputed the third area of inquiry and whether the plan covers more than just Juanopulos as an owner. The court described this dispute as in part factual—whether other employees are covered—and relates to the first area of inquiry.

As to whether the plan exists, it must be a plan that is established or maintained by an employer for the purpose of providing medical benefits to participants or their beneficiaries. The Department of Labor regulations exclude any plan under which no employees are participants covered by the plan. See 29 C.F.R. § 2510.3-3(b). The Fifth Circuit has held that "[a]n owner of a business is not considered an 'employee' for purposes of determining the existence of an ERISA plan; in other words, ERISA does not govern a plan whose *only* fully vested beneficiaries are a company's owners."[5] Because Juanopulos alleges that he is the owner and sole employee, ERISA does not govern the plan.

Fifth Circuit law makes clear that a sole proprietor is not both an employer and an employee for purposes of ERISA

Defendants raised several arguments in response. First, they argued that ERISA governs because Juanopulos was a working owner. However, Fifth Circuit law makes clear that a sole proprietor is not both an employer and an employee for purposes of ERISA.[6] A sole proprietor is not an employer because she has no employees and plans without employees are not regulated by ERISA.[7]

Second, they argued that ERISA governs the plan because it covers a class of actual or *potential* employees, not just Juanopulos. In response to this argument, the court pointed out that the DOL regulation, 29 C.F.R. § 2510.3-3(b), defines a plan as one under which employees are participants covered under the plan. Potential employees do not convert an arrangement into an ERISA plan.

Third, Defendants argued that the plan describes itself as an employee benefit plan under ERISA. The court dismissed this argument because whether an entity intended ERISA to govern is not relevant; what matters is whether the plan satisfies the statutory definition. The plan's label of an ERISA plan is contrary to law.

Lastly, the court rejected Defendants' argument that Juanopulos has not demonstrated he was the sole employee. While a witness report of the injury had a box ticked for "co-worker," Juanopulos submitted an uncontradicted affidavit that the person was not an actual employee, but an independent contractor. The court remanded the action to state court.

Another recent decision, *Steigleman v. Symetra Life Insurance Company*,[8] shows us how a business owner can inadvertently transform long-term disability ("LTD") protection into an ERISA plan after she hires employees. In 2008, Steigleman established Steigleman Insurance Agency, LLC, which she owned and operated, and worked as an agent selling Farm Bureau Financial Services insurance. As an agent, she was eligible to join "The Agents Association" ("TAA"), which "is an organization that individual agents voluntarily join and TAA then advocates on behalf of its members with Farm Bureau management." TAA had a contract with an insurance broker known as "mgc group," which created a benefits package designed specifically for TAA. The package allowed TAA members to purchase LTD insurance, among other insurance. The LTD insurance was provided by Symetra, but enrollment and premium collection were handled by mgc group.

Steigleman first purchased LTD coverage with Symetra in June 2009 and the premiums were paid by Steigleman Insurance Agency. As of 2016, her company employed two other individuals who were offered LTD coverage through the same arrangement involving TAA and mgc. They both elected the coverage and Steigleman Insurance Agency paid their entire premiums.

Steigleman eventually filed a disability claim which Symetra ultimately approved but Steigleman filed suit alleging breach of contract and the tort of bad faith based on the way Symetra handled the claim. Symetra initially admitted the state law claims were proper, but it changed its position and alleged that the claims were governed by ERISA. It moved for summary judgment on the basis that ERISA preempts the state-law claims.

On summary judgment, Symetra argued that ERISA preempts Steigelman's claims because (1) Steigleman Insurance Agency, LLC, "established and sponsored an ERISA-governed welfare benefit plan" when "[i]t purchased disability insurance" for Steigleman and her employees; and (2) TAA was an "employee organization"

that "established and sponsored an ERISA welfare benefit plan" when it offered insurance packages to its members.[9]

The court found the first argument to be dispositive and did not reach the second argument. There is no dispute that if Steigleman's disability coverage was part of an "employee benefit plan," as defined by ERISA, her state law claims cannot proceed. If a particular arrangement covers only the owner of a business, that arrangement necessarily is not an "employee benefit plan" covered by ERISA. But an arrangement *becomes* an ERISA plan if it covers working owners and their nonowner employees.

When Steigleman first purchased disability coverage from Symetra, she was the only individual covered and ERISA did not apply to her coverage at that time. But when she hired employees and provided them coverage, an ERISA plan was created. This is because the company offered its employees coverage under the policy and began paying the premiums. "From the employees' perspective, their employer had created a program, that was maintained and paid for by their employer, for the purpose of providing benefits in the event the employees became disabled."[10] Because the company paid the premiums for its employees the "safe harbor" that exempts "certain group or group-type insurance programs" from being subject to ERISA does not apply.[11] The court rejected Steigleman's argument that ERISA will never apply to a particular arrangement based on events *subsequent to* the arrangement's origins.

The court also considered whether two distinct plans were created. In other words, a non-ERISA plan for Steigleman and an ERISA plan for her employees. The court found that Ninth Circuit authority generally supportive of not bundling all plans offered by a company and calling it a single ERISA-governed plan does not help Steigleman. In *LaVenture v. Prudential Insurance Company of America*,[12] a husband and wife who were the sole shareholders of a commercial printing company purchased a health insurance policy covering only the husband and wife and then later they purchased disability insurance to cover them. One year after that, they hired their first employee and only offered the new employee health insurance, and not disability insurance. They hired more employees with the same benefit offering. Only the husband and wife were covered by the disability policy. The Ninth Circuit determined that ERISA did not apply to the disability policy because there was no evidence to establish that the disability policy and health plan were so intertwined to constitute one overall benefit plan. In other words, the offering of one welfare benefit plan governed by ERISA did not mean all benefits offered by the business became subject to ERISA. In this case, there is no evidence that Steigleman had any intent in establishing the various benefits arrangements. It did not appear that Steigleman considered ERISA at all. The court concluded that Steigleman Insurance Agency

offered a single ERISA-governed plan regarding disability benefits and the state-law claims are preempted.

Sole proprietors or single-person corporations who obtain insurance coverage through their company and want to avoid ERISA preemption should not offer the same coverage to any employees subsequently hired unless they take measures to establish a separate and distinct plan for the employees. They will also want to review the plan documents and make sure the plan does not self-identify as an ERISA plan or make employees eligible for coverage.

Endnotes

1 United Policyholders, 50 State Survey of Bad Faith Laws and Remedies (published October 23, 2014), available at https://uphelp.org/sites/default/files/publications/Final%20-%20Bad%20Faith%20Survey.pdf

2 *Aetna Health Inc. v. Davila*, 542 U.S. 200, 215, 124 S. Ct. 2488, 2499, 159 L. Ed. 2d 312 (2004) ("The limited remedies available under ERISA are an inherent part of the 'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.")

3 *Juanopulos v. Salus Claims Mgmt. LLC*, No. 4:20-CV-01394, 2021 WL 520453 (S.D. Tex. Feb. 9, 2021).

4 *Juanopulos*, 2021 WL 520453, at *3, *citing to Meredith v. Time Ins. Co.*, 980 F.2d 352, 355 (5th Cir. 1993).

5 *House v. Am. United Life Ins. Co.*, 499 F.3d 443, 450 (5th Cir. 2007).

6 *Meredith*, 980 F.2d at 356.

7 *Id.* at 358.

8 *Steigleman v. Symetra Life Ins. Co.*, No. CV-19-08060-PCT-ROS, 2021 WL 778605 (D. Ariz. Mar. 1, 2021).

9 *Id.* at 6.

10 *Id.* at 7.

11 29 C.F.R. § 2510.3-1(j).

12 *LaVenture v. Prudential Ins. Co. of Am.*, 237 F.3d 1042 (9th Cir. 2001).

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> (C) The multiemployer pension plan is certified by the plan actuary to be in critical status in any plan year beginning in 2020 through 2022, has a "modified funded percentage" (defined as the percentage equal to a fraction, the numerator of which is current value of plan assets and the denominator of which is current liabilities) of less than 40%, and has a ratio of active to inactive participants which is less than 2 to 3; or
>
> (D) The multiemployer pension plan became "insolvent" after December 16, 2014, as defined under 26 U.S.C.A. § 418E (West), has remained insolvent to date, and has not been terminated as of the date of enactment of the Act.

Under the Act, any multiemployer pension plans seeking special financial assistance must apply no later than December 31, 2025, with revised applications due no later than December 31, 2026. The Act also allows the PBGC to limit applications during the first 2 years following enactment to certain plans, such as those that are insolvent or are likely to be insolvent within 5 years.

...approximately one million of the more than ten million participants in multiemployer pension plans are in plans that are expected to become insolvent and unable to pay promised benefits...

The amount of financial assistance provided to eligible multiemployer pension plans is equal to the amount required to pay all benefits due, without reduction, due from the date of payment of the special financial assistance through the last day of the plan year ending in 2051. In addition, there is currently no stated cap on the total amount of financial assistance permitted or the procedures for approving applications. The PBGC is expected to issue additional guidance on this shortly.

The Act requires that any special financial assistance (and earnings on such amounts) be segregated from other plan assets. In addition, such funds may only be invested in investment-grade bonds or other investments as permitted by the PBGC. The PBGC also is authorized to impose additional conditions on plans receiving special financial assistance relating to increases in future accrual rates and any retroactive benefit improvements; allocation of plan assets; reductions in employer contribution rates; diversion of contributions to, and allocation of expenses to, other benefit plans; and withdrawal liability.

Any multiemployer pension plans that receive special financial assistance will be deemed to be in "critical status" until the last plan year ending in 2051, and must also reinstate any previously suspended benefits under the MPRA (either as a lump sum or in equal monthly installments). Any multiemployer pension plan accepting special financial assistance under the Butch Lewis Act will not be eligible to apply for a new suspension of benefits under the MPRA.

There is currently no provision for a tax on participating employers, or any reduction in participating employee benefits. The proposed law does provide, however, for an increase in premium rates for multiemployer plans from the currently indexed annual per participant rate (which is $31 per participant for plan years beginning in 2021) to $52 per participant for plan years beginning after December 31, 2030, with indexing for inflation tied to the Social Security Act's national wage index.

We note that earlier versions of the Act included provisions stating that any participating employer withdrawing within 15 calendar years from the effective date of the Act would not see any corresponding reduction in its withdrawal liability assessment due to the special financial assistance. The relief bill as passed, however, no longer includes these provisions, although, as stated above, the relief bill authorizes the PBGC to issue regulations relating to withdrawal liability on plans receiving special financial assistance. As passed, the Act would not otherwise change how withdrawal liability is calculated, including application of the withdrawal liability payment schedule, the 20-year cap on payments, or the mass withdrawal liability rules.

2. Temporary Funding Status Relief.

Under the Act, eligible multiemployer pension plans may elect to retain their 2019 funding status in the 2020 or 2021 plan years (known as the "designated plan year"). Any multiemployer plans in endangered or critical status in the year prior to the designated plan year would not be required to update any applicable Funding Improvement Plan, Rehabilitation Plan, or corresponding schedules, until the year following the designation year.

If a multiemployer plan is no longer considered to be in endangered or critical status as a result of an election, no further notification is required regarding its endangered or critical status, but such plan must provide notice of its election under the relief bill to its participants, beneficiaries, the PBGC, and the DOL.

3. Funding Improvement Plan and Rehabilitation Plan Relief.

Under the Act, multiemployer pension plans that are already in endangered or critical status may elect to extend any applicable Funding Improvement Plan or Rehabilitation Plan by five years for plan years beginning on or after December 31, 2019.

4. Amortization Relief

Similar to relief provided in 2008 and 2009, the Act allows multiemployer pension plans to elect to amortize investment losses (as well as losses related to Covid) for plan years ending on or after February 29, 2020 over a 30-year period (instead of 15 or less).

While there are still some questions regarding the application of its various relief provisions, the Act provides welcome relief from many of those multiemployer plans facing financial insolvency, as well as their contributing employers, participants, and beneficiaries.

Endnotes

1 https://www.congress.gov/bill/117th-congress/house-bill/1319/text

Calendar

April 13-14, 2021	**Insurance Coverage Litigation Conference** Contact: Danielle Daly - 312/988-5708	Virtual Programming
April 19, 2021	**Preemption in Aviation – Dead or Destined to Make a Comeback?** Contact: Danielle Daly - 312/988-5708	Virtual Programming
April 27-30, 2021	**TIPS 7th Annual Section Conference** Contact: Janet Hummons – 312/988-5656 Danielle Daly – 312/988-5708	Virtual Programming
May 6-8, 2021	**Fidelity & Surety Law Spring Conference** Contact: Janet Hummons – 312/988-5656 Danielle Daly – 312/988-5708	Program Cancelled
May/TBD	**Workers' Compensation** Contact: Theresa Beckom – 312/988-5672	Virtual Programing
Aug 4-10, 2021	**ABA Annual Meeting** Contact: Janet Hummons – 312/988-5656 Theresa Beckom – 312/988-5672	TBD
Sep. 18-22, 2021	**20th National Trial Academy** Contact: Janet Hummons – 312/988-5656 Danielle Daly - 312/988-5708	National Judicial College Reno, NV
October 13-16, 2021	**TIPS Annual Fall Meeting** Contact: Janet Hummons – 312/988-5656 Danielle Daly - 312/988-5708	Four Seasons Resort Dallas, TX
October 28-29, 2021	**Aviation Litigation Conference** Contact: Janet Hummons – 312/988-5656 Danielle Daly - 312/988-5708	Ritz Carlton Hotel Washington, DC
November 11-12, 2021	**FSLC & FLA Joint Fall Meeting** Contact: Janet Hummons – 312/988-5656 Danielle Daly - 312/988-5708	Westin Times Square New York, NY

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