EMPLOYEE BENEFITS GUIDANCE ISSUED IN 2018

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A. TREASURY AND IRS GUIDANCE

1. Treasury and IRS Temporary and Final Regulations


83 Fed. Reg. 11876 (March 19, 2018) contains final rules that increase various civil monetary penalties (CMPs) under laws administered by the Treasury Department.

T.D. 9835, 83 Fed. Reg. 34469 (July 20, 2018), finalizes with minor changes the proposed regulations issued in 2017 (REG-131643-15, 82 Fed. Reg. 5477 (Jan. 18, 2017)) reversing the IRS’s long-standing position and allowing employer contributions to a plan to qualify as QMACs or QNECs if they satisfy applicable nonforfeitability and distribution requirements at the time they are allocated to participants’ accounts, rather than when they are contributed to the plan. The final regulations are effective July 20, 2018, but “taxpayers may apply [them] to earlier periods.”


2. IRS Revenue Rulings

Rev. Rul. 2018-4, 2018-4 I.R.B. 304, contains covered compensation tables for the 2018 plan year that have been revised to reflect a revision to the taxable wage base for 2018 that was announced by the Social Security Administration in November 2017.

Rev. Rul. 2018-10, 2018-16 I.R.B. 477, provides applicable terminal charge and SIFL mileage rates to be used in determining the value of noncommercial flights taken on employer-provided aircraft from January 1, 2018, through June 30, 2018.
Rev. Rul. 2018-17, 2018-25 I.R.B. 753, concludes that interests in an IRA that are paid to a state unclaimed property fund are nonperiodic distributions that are subject to 10% federal income tax withholding under Code § 3405(b)(1) and must be reported to the IRS on Form 1099-R under Code § 408(i) and Treas. Reg. § 1.408-7(a). The ruling does not take effect until the earlier of January 1, 2019, or the date it becomes reasonably practicable for the trustee or custodian to comply. It is not clear what right an IRA owner who discovers that the IRA has been escheated and reclaims it from the state will have to avoid the early application of income tax on the IRA distribution, or the additional income tax on early distributions under Code § 72(t) if the escheat occurred before the owner reached age 59½. It also is not clear whether the IRS is correct to treat escheatment as a distribution. An August 27, 2018, comment letter from Lisa J. Bleier at SIFMA and Tamara Salmon at the ICI explains that compliance with Rev. Rul. 2018-17 would require the holder to liquidate some of the securities in the IRA to satisfy the withholding requirement, but “this very likely would run afoul of federal securities laws that . . . generally preclude holders of securities accounts from liquidating a customer’s securities . . . without either prior authorization from the owner or pursuant to a court order,” and that this is not a concern regarding escheatment itself because “when an IRA is deemed abandoned, the entirety of the account (i.e., the securities therein) is transferred to the state [and] held in trust by the state for the owner for a period of time.” They describe SIFMA and the ICI as part of the “Holders Coalition, which represents the interests of . . . institutions and firms that maintain IRAs and assist holders of these in complying with the states’ laws.”


Rev. Rul. 2018-26, 2018-40 I.R.B. 520, provides applicable terminal charge and SIFL mileage rates to be used in determining the value of noncommercial flights taken on employer-provided aircraft from July 1, 2018, through December 31, 2018.

3. IRS Revenue Procedures

Rev. Proc. 2018-1, 2018-1 I.R.B. 6, contains revised procedures for issuing letter rulings and information letters issued by the Associate Chief Counsel (Tax Exempt and Government Entities), and revised procedures for DLs issued by the Tax Exempt and Government Entities Division.

Rev. Proc. 2018-3, 2018-1 I.R.B. 130, contains a revised list of areas under the jurisdiction of the Associate Chief Counsel (Tax Exempt and Government Entities) relating to issues on which the IRS will not (or ordinarily will not) issue advance rulings or DLs. One new issue is whether income accruing to a trust relating to or associated with a qualified retirement plan can be excluded from gross income under Code § 115.

Rev. Proc. 2018-4, 2018-1 I.R.B. 146, contains revised procedures for issuing DLs on qualified plans issued by the Commissioner, Tax Exempt and Government Entities Division, Employee Plans Rulings and Agreements Office, and the user fees associated with advice requested from the Employee Plans Rulings and Agreements Office, including user fees for advice under the EPCRS, which have been “simplified.”
Rev. Proc. 2018-18, 2018-10 I.R.B. 392, modified some inflation-adjusted items for 2018 to reflect changes to the indexing methodology made by the TCJA. These include the limit on the small employer health insurance credit in Code § 45R, the exclusion limit for adoption assistance Code § 137, the deductible and OOP limits for “high deductible health plans” for MSAs in Code § 220, the minimum dollar penalties for failure to file tax returns in Code § 6651, the penalties for failure to file information returns and provide copies to individuals in Code §§ 6652, 6721 and 6722, and the annual contribution limits and the deductible and OOP limits for “high deductible health plans” for HSAs in Code § 223. It reduced the 2018 limit for HSAs from $6,900 to $6,850.

Rev. Proc. 2018-19, 2018-14 I.R.B. 466, modifies Rev. Proc. 2018-4, 2018-1 I.R.B. 146, to reduce the user fee for submitting a determination letter request from $3,000 to $2,300. It says that taxpayers who paid the $3,000 user fee will receive a $700 refund. The increase had been heavily criticized.


Rev. Proc. 2018-25, 2018-18 I.R.B. 543, provides inflation-adjusted tables showing depreciation limitations and lease inclusion amounts under Code § 280F for passenger automobiles first placed in service (or first leased) in calendar year 2018. The tables reflect the changes made to Code §§ 168(k) and 280F by the TCJA.

Rev. Proc. 2018-27, 2018-20 I.R.B. 591, allows taxpayers who contributed the full $6,900 that was allowed to be contributed to an HSA for 2018 under prior law – before the limit was reduced to $6,850 by Rev. Proc. 2018-18, 2018-10 I.R.B. 392, to reflect changes to the indexing methodology made by the TCJA – to continue to treat the 2018 limit as $6,900. It also allows taxpayers who already received a corrective distribution from an HSA to treat the distribution as a mistake and repay the HSA without any tax or reporting consequences.


Rev. Proc. 2018-30, 2018-21 I.R.B. 622, announces the 2019 inflation-adjusted amounts for HSAs under Code § 223(g). The annual contribution limit will be $3,500 for an individual with self-only coverage under an HDHP and $7,000 for an individual with family coverage under an HDHP. An HDHP will be a health plan with an annual deductible of at least $1,350 for self-only coverage or $2,700 for family coverage, and annual OOPs that do not exceed $6,750 for self-only coverage or $13,500 for family coverage.


Rev. Proc. 2018-43, 2018-36 I.R.B. 425, provides the 2018 monthly national average premium for qualified health plans that have a bronze level of coverage for taxpayers to use in determining their maximum individual shared responsibility payment under Code § 5000A(c)(1)(B) and Treas. Reg. § 1.5000A-4.


Rev. Proc. 2018-57, 2018-49 I.R.B. 827, provides inflation-adjusted limits for 2019 for, among other things, the annual limitation on salary reduction contributions to health FSAs (increasing to $2,700), the monthly limitation for qualified transportation fringe benefit and qualified parking (increasing to $265), the minimum and maximum deductibles and maximum OOP for high-deductible health plans used in conjunction with MSAs, the foreign earned income exclusion amount (increasing to $105,900), and the Code §§ 6721 and 6722 dollar penalties (remaining at $270 each). The annual penalty for not maintaining minimum essential health coverage was reduced to $0 by the TCJA.

Rev. Proc. 2019-1, 2019-1 I.R.B. 1, contains revised procedures for issuing letter rulings and information letters issued by the Associate Chief Counsel (Employee Benefits, Exempt Organizations, and Employment Taxes), and revised procedures for DLs issued by the Tax Exempt and Government Entities Division.

Rev. Proc. 2019-3, 2019-1 I.R.B. 130, contains a revised list of areas under the jurisdiction of the Associate Chief Counsel (Employee Benefits, Exempt Organizations, and Employment Taxes) relating to issues on which the IRS will not (or ordinarily will not) issue advance rulings or DLs.


4. IRS Notices

Notice 2018-11, 2018-11 I.R.B. 425, contains updated IRS weighted average interest rates, yield curves, and segment rates used for funding and other purposes.

Notice 2018-14, 2018-7 I.R.B. 353, makes additional changes to the withholding rules to reflect the TCJA. The notice (1) extends the effective period of existing Forms W-4 claiming an exemption from withholding until February 28, 2018, (2) allows employees to claim exemption from withholding after that date using the 2017 Form W-4 until 30 days after the 2018 Form W-4 is released by using one of several different specified methods, (3) allows employees to delay
giving their employers new Forms W-4 until 30 days after the 2018 Form W-4 is released, and
does not require them to do so at all for 2018 if they have a reduction in the number of withhold-
ing allowances due solely to the changes made by the TCJA, (4) requires employers paying
supplemental wages to implement the 22% rate as soon as possible, but not later than February
15, 2018, and (5) provides that employers that withhold at a higher rate before that date may, but
are not required to, correct the over-withholding under the normal rules applicable to corrections
of over-withholding.

Notice 2018-16, 2018-10 I.R.B. 390, contains updated IRS weighted average interest rates, yield
curves, and segment rates used for funding and other purposes.

Notice 2018-18, 2018-12 I.R.B. 443, announces that the Treasury Department and the IRS
“intend to issue regulations providing guidance on the application of section 1061,” and “The
regulations will provide that the term “corporation” in section 1061(c)(4)(A) [which exempts
from the rule any interest in a partnership directly or indirectly held by a “corporation”] does not
include an S corporation.” It does not include any analysis to support this conclusion.

Notice 2018-12, 2018-12 I.R.B. 441, announced that “[b]enefits for male sterilization or male
contraceptives are not preventive care under the SSA, and no applicable guidance issued by the
Treasury Department and the IRS provides for the treatment of these benefits as preventive care
within the meaning of section 223(c)(2)(C). Accordingly, under current guidance, a health plan
that provides benefits for male sterilization or male contraceptives before satisfying the mini-
mum deductible for an HDHP under section 223(c)(2)(A) does not constitute an HDHP, regard-
less of whether the coverage of such benefits is required by state law.” The position in the notice
is effective in 2020, apparently even in states that do not require HDHPs to offer male steriliza-
tion or male contraceptives.

Notice 2018-22, 2018-14 I.R.B. 464, contains updated IRS weighted average interest rates, yield
curves, and segment rates used for funding and other purposes.

Notice 2018-24, 2018-17 I.R.B. 507, requests comments on “specific types of plans for which
the Treasury Department and the IRS should consider accepting determination letter applications
during calendar year 2019 in circumstances other than for initial qualification and qualification
upon plan termination.” It says that, consistent with Rev. Proc. 2016-37, 2016-29 I.R.B. 136,
§ 4.03(3), more consideration will be given where there are “significant law changes, new
approaches to plan design, and the inability of certain types of plans to convert to pre-approved
plan documents,” and consistent with this comments “should not merely state the type of plan,
but should also specify the issues applicable to that type of plan that would justify review of that
particular plan type under the determination letter program.”

Notice 2018-27, 2018-20 I.R.B. 580, allows a small employer that is eligible for the premium tax
credit under Code § 45R but has a principal business address in a county in which a QHP will
not be available through a SHOP Exchange during 2016 to calculate the credit by treating
whatever health insurance coverage the employer provides for 2017 and later plan years as
qualifying for the credit, as long as the coverage meets certain requirements. Notice 2014-6,
Notice 2015-8 and Notice 2014-6 provided similar relief for prior years for small employers
located in counties in Iowa, Washington and Wisconsin.
Notice 2018-33, 2018-17 I.R.B. 508, announces the limitations on housing expenses eligible for exclusion under Code § 911 for specific locations (in lieu of the otherwise applicable limitation of $31,230) for 2018. The original notice incorrectly calculated the general exclusion amount. This amount was corrected by Notice 2018-44, 2018-21 I.R.B. 611.

Notice 2018-34, 2018-19 I.R.B. 549, contains updated IRS weighted average interest rates, yield curves, and segment rates used for funding and other purposes.


Notice 2018-42, 2018-24 I.R.B. 750, describes several modifications to Notice 2018-3, 2018-2 I.R.B. 285, necessitated by the TCJA. It explains that, because of the suspension of miscellaneous itemized deductions by TCJA § 11045, the business standard mileage rate in Notice 2018-3 cannot be used to claim an itemized deduction for unreimbursed employee travel expenses under Code § 67 during the suspension period. (However, it notes that the rate can continue to be used to claim a deduction from AGI for travel expenses of certain employees (military reservists, state or local government officials paid on a fee basis, and certain performing artists) under Code § 62(a)(2).) It also explains that, because of the suspension of moving expense deductions by TCJA § 11049 (except for certain members of the military), the standard mileage rate in Notice 2018-3 cannot be used to claim a moving expense deduction under Code § 217 during the suspension period. Finally, it explains that, because of the increase in the depreciation limitations for passenger automobiles by TCJA § 13202, the maximum standard automobile cost that may be used in computing the allowance under a fixed and variable rate (“FAVR”) plan is now $50,000 for both passenger automobiles and trucks and vans placed in service after December 31, 2017.


Notice 2018-55, 2018-26 I.R.B. 773, provides guidance on new Code § 4968. Code § 4968 was added by TCJA § 13701. It imposes a 1.4% excise tax on “the net investment income [an applicable educational institution] for the taxable year” and “appl[ies] to taxable years beginning after December 31, 2017.” The guidance relates to the calculation of the institution’s basis for purposes of determining gain or loss, and the netting of capital gains and losses. It analogizes to existing guidance under Code § 4940(c), which is referenced in Code § 4968. Among other things, it states that Treasury and the IRS intend to propose regulations stating that the basis of “property held by an applicable educational institution on December 31, 2017, . . . shall be deemed to be not less than the fair market value of such property on December 31, 2017, plus or minus all adjustments after December 31, 2017, and before the date of disposition.” This might provide a clue to the way Treasury and the IRS will interpret the effective date of Code § 4960, which also “appl[ies] to taxable years beginning after December 31, 2017.”

Notice 2018-56, 2018-27 I.R.B. 3, contains updated IRS weighted average interest rates, yield curves, and segment rates used for funding and other purposes.
Notice 2018-65, 2018-35 I.R.B. 350, contains updated IRS weighted average interest rates, yield curves, and segment rates used for funding and other purposes.

Notice 2018-67, 2018-36 I.R.B. 409, outlines general concepts for identifying separate trades or businesses for purposes of Code § 512(a)(6), which was added by TCJA § 13702, and allows interim reliance on a reasonable, good-faith standard. It also says that “any amount included in UBTI under § 512(a)(7) is not subject to § 512(a)(6).” It also allows organizations to treat partnership interests as a single trade or business if the organization (and its disqualified persons, supporting organizations, and controlled entities) either (1) directly holds no more than 2% of the profits and capital of the partnership or (2) directly holds no more than 20% of the capital of the partnership and lacks “control or influence” over the partnership.

Notice 2018-68, 2018-36 I.R.B. 418, provides guidance on the changes made by TCJA § 13601 to the definition of “covered employee” in Code § 162(m)(3), and the grandfather rule in TCJA § 13601(e)(2). It also asks for comments on a number of other issues. Margaret and Martha are preparing a client alert.


Notice 2018-70, 2018-38 I.R.B. 441, announces that the Treasury Department and IRS intend to propose regulations to “clarify” that the temporary reduction of the exemption amount in Code § 151(d) by Code § 151(d)(5)(A), which was added by TCJA § 11041(a)(2), does not apply to the gross income limitation in the definition of “qualifying relative” in Code § 152(d)(1)(B). Code § 151(d)(5)(B) is not broad enough by its terms to achieve this, which has led to uncertainty over the availability of the new $500 tax credit in Code § 24(h) and the scope of other provisions that rely on the definition of “qualifying relative.”

Notice 2018-73, 2018-40 I.R.B. 526, contains updated IRS weighted average interest rates, yield curves, and segment rates used for funding and other purposes.

Notice 2018-74, 2018-40 I.R.B. 529, modifies the safe harbor Code § 402(f) explanations in Notice 2014-74, 2014-50 I.R.B. 937, to reflect (1) TCJA § 13613, which modified the qualified plan loan offset rules, (2) Rev. Proc. 2016-47, 2016-37 I.R.B. 346, which allowed a taxpayer to self-certify eligibility for a waiver of the 60-day deadline for completing a rollover, (3) MAP-21 § 100121, which added an exception from Code § 72(t) for federal retirees participating in phased retirement, and (4) DPSERA § 2, which added an exception from Code § 72(t) for certain federal public safety officers. It contains two new model safe harbor explanations as well as instructions on how to amend the existing safe harbor explanations in Notice 2014-74.

Notice 2018-71, 2018-41 I.R.B. 548, provides guidance on the paid family and medical leave tax credit in Code § 45S, which was added by TCJA § 13403. Among other things, it provides that (1) neither the employer nor the leave has to be subject to the FMLA, (2) a “part-time” employee is an employee who is customarily employed for fewer than 30 hours per week, (3) for 2018, a written leave policy will be considered to have been in place as of the effective date of the policy.
if it is adopted on or before December 31, 2018, and the employer brings its leave practices into compliance with the terms of the policy for the entire period covered by the policy, and (4) paid leave provided under an STD program (whether insured or self-insured) can be characterized as paid family and medical leave. However, the notice provides no guidance on meaning of “wages normally paid” (used to determine the minimum payments while on leave).

Notice 2018-75, 2018-41 I.R.B. 556, provides that TCJA § 11048, which amended Code § 132(g) to eliminate, temporarily, the exclusion for qualified moving expense reimbursements, applies only to payments or reimbursements for expenses incurred in connection with moves that occurred after December 31, 2017. Presumably the same rule applies to TCJA § 11049, which added a new Code § 217(k) to eliminate, temporarily, the individual deduction for moving expenses. It is not clear what this means for moves that began in 2017 and ended in 2018.

Notice 2018-76, 2018-42 I.R.B. 599, provides guidance on TCJA § 13304(b), which repealed the exception in Code § 274(n)(2) to the 50% disallowance rule for food or beverages that are de minimis fringes described in Code § 132(e) and eliminated the reference in Code § 274(n)(1) to entertainment expenses (which are now completely nondeductible even if they are directly related to the active conduct of a trade or business, unless another exception applies). The notice states that Treasury and the IRS “intend to publish proposed regulations under § 274 clarifying when business meal expenses are nondeductible entertainment expenses and when they are 50 percent deductible expenses,” and that, until the proposed regulations are effective, taxpayers may deduct 50% percent of an otherwise allowable business meal expense, i.e., treat it as a non-entertainment expense, if (1) the expense is an ordinary and necessary expense under Code § 162(a), (2) the expense is not lavish or extravagant under the circumstances, (3) the taxpayer, or an employee of the taxpayer, is present at the furnishing of the food or beverages, (4) the food and beverages are provided to a current or potential business customer, client, consultant, or similar business contact, and (5) in the case of food and beverages provided during or at an entertainment activity (such as a sporting event), the food and beverages are purchased separately from the entertainment, or the cost of the food and beverages is stated separately from the cost of the entertainment on one or more bills, invoices, or receipts. Commenters have criticized the Notice as disregarding the long history of treating even business-related meals with clients and customers as entertainment under Code § 274.

Notice 2018-77, 2018-42 I.R.B. 601, provides the special per diem rates effective October 1, 2018, for taxpayers to use in substantiating the amount of ordinary and necessary business expenses incurred while traveling away from home, specifically (1) the special transportation industry meal and incidental expenses (M&IE) rates, (2) the rate for the incidental expenses only deduction, and (3) the rates and list of high-cost localities for purposes of the high-low substantiation method.

Notice 2018-81, 2018-43 I.R.B. 666, provides guidance on how a church or convention or association of churches that has made an election under the first sentence of Code § 414(c)(2)(C) to be aggregated with an organization with which the church or association is associated, or an employer that has made an election under the first sentence of Code § 414(c)(2)(D) to treat churches separately from entities that are not churches, subsequently revokes the election under the last sentence of each provision. The notice states that all that is required is for “the entity authorized to revoke the election [to] provide a copy of the revocation upon request by the IRS.”
Notice 2018-82, 2018-44 I.R.B 718, contains updated IRS weighted average interest rates, yield curves, and segment rates used for funding and other purposes.


Notice 2018-85, 2018-48 I.R.B. 788, announces that the per capita PCORI fee imposed by Code §§ 4375 and 4376 for policy years and plan years that end on or after October 1, 2018, and before October 1, 2019, will be $2.45 (up from $2.39).

Notice 2018-86, 2018-50 I.R.B. 982, contains updated IRS weighted average interest rates, yield curves, and segment rates used for funding and other purposes.

Notice 2018-88, 2018-49 I.R.B. 817, is a follow-on to 83 Fed. Reg. 54420 (Oct. 29, 2018), which contained proposed rules that would allow HRAs (and other specified “account-based group health plans”) to be integrated with individual health insurance coverage, and thus satisfy PHSA §§ 2711 and 2713, if certain requirements were satisfied, and that would provide rules for determining whether such an HRA was affordable and provided minimum value for purposes of Code § 36B. The Notice states that those proposed regulations “raise issues under the Code, in particular concerning the application of section 4980H (the employer shared responsibility provisions) and section 105(h) (addressing discriminatory self-insured group health plans). This notice is intended to initiate and inform the process of developing guidance that addresses these issues, and requests comments on potential approaches developed by the Treasury Department and the IRS.” Specifically, it states that Treasury and the IRS anticipate providing guidance:

- Allowing an ALE to determine the affordability of an HRA integrated with individual health insurance coverage (referred to as an “individual coverage HRA”) for Code § 4980H purposes by reference to the lowest cost silver-level Exchange coverage for the rating area in which the employee’s primary site of employment was located (rather than the employee’s place of residence).
- Allowing an ALE to determine the affordability of an individual coverage HRA that has a calendar year plan year by reference to the cost of the plan used to determine affordability (referred to as the “applicable affordability plan”) for the prior calendar year.
- Allowing an ALE to assume that the cost of the applicable affordability plan for the first month of the plan year would remain the same throughout the year.
- Allowing an ALE to report an employee’s required contribution determined under the safe harbors in this notice, if applicable, rather than the employee’s required contribution calculated under the proposed regulations under Code § 36B.
- Allowing an ALE to use the existing Form W–2 wages safe harbor, rate of pay safe harbor, and federal poverty line safe harbor in the regulations under Code § 4980H to determine the affordability of an individual coverage HRA.
- Treating an individual coverage HRAs as satisfying the requirement in Treas. Reg. § 1.105-11(c)(3)(i) that any maximum limit attributable to employer contributions must be uniform for all participants, if the HRAs provide the same maximum dollar amount to all employees who are members of a particular class of employees.
- Requiring individual coverage HRAs to be offered on the same terms to all employees who are members of the same class of employees, subject to an exception where “the
price of an individual health insurance coverage policy in the relevant individual insurance market [increases] based on the ages of the employees who are members of that class of employees.”

**Notice 2018-89.** 2018-49 I.R.B. 826, states that (i) the IRS will not assert that cash payments made by an employer to a charitable organization in exchange for vacation, sick, or personal leave that an employee elects to forgo constitute gross income or wages, or that the opportunity to make such an election results in constructive receipt of gross income or wages, if the payments are made to the charitable organization for the relief of victims of Hurricane Michael and are paid before January 1, 2020, (ii) the employee may not claim a charitable contribution deduction under Code § 170 with respect to the value of the forgone leave, and (iii) the IRS will not assert that payments made under such a program are deductible by the employer solely under Code § 170 rather than Code § 162.

**Notice 2018-90.** 2018-49 I.R.B. 826, delays the effective date of Rev. Rul. 2018-17, 2018-25 I.R.B. 753, from (1) the earlier of January 1, 2019, or the date it becomes reasonably practicable for the trustee or custodian to comply, to (2) the earlier of January 1, 2020, or the date it becomes reasonably practicable for the trustee or custodian to comply.


**Notice 2018-92.** 2018-51 I.R.B. 1038, provides additional guidance on the changes to the withholding rules being made by the IRS to reflect the TCJA. Among other things, the notice (1) extends until April 30, 2019, the suspension (in Notice 2018-14, 2018-7 I.R.B. 353) of the requirement for employees to give their employers new Forms W-4 if they have a reduction in the number of withholding allowances due solely to the changes made by the TCJA, (2) extends through 2019 the default rule that when employees fail to furnish Forms W-4 they will be treated as single with zero withholding allowances, despite the TCJA’s repeal of Code § 3401(e), (3) allows employees to take any expected Code § 199A deductions into account in determining whether they are entitled to additional withholding allowances until further guidance under Code § 3402(m) is issued, (4) allows employees to use the online withholding calculator or Publication 505 in lieu of the worksheets to Form W-4 to determine the amount to enter on line 5 or 6 of Form W-4, and (5) extends through 2019 the rule (in Notice 2018-14) that withholding under Code § 3405 where no withholding certificate is in effect is based on treating the payee as a married individual claiming three withholding allowances.

**Notice 2018-94.** 2018-51 I.R.B. 1042, extends the deadline for furnishing 2018 Forms 1095-C and 1095-B to employees from January 31, 2019, to March 4, 2019, but not for filing these forms with IRS. It tells individuals that, because of the delay, they “may rely on other information received from their employer or other coverage provider for purposes of filing their returns, including determining eligibility for the premium tax credit under section 36B and confirming that they had minimum essential coverage for purposes of sections 36B and 5000A.” It also provides relief from penalties under Code §§ 6721-6722 for failing to file and furnish accurate information returns and statements for 2018 under Code §§ 6055-6056 to reporting entities that made good-faith efforts to comply with the information-reporting requirements. The relief is the same as the relief provided for 2017 in Notice 2018-6, 2018-3 I.R.B. 300, and similar relief
provided in prior years, except that it extends the deadline for more than 30 days because March 2, 2019, is a Saturday.

**Notice 2018-95**, 2018-52 I.R.B. 1058, provides transition relief from the so-called “once-in-always-in” rule in Treas. Reg. § 1.403(b)-5(b)(4)(iii)(B), which prohibits part-time or temporary employees from being excluded under the universal availability rule unless they worked fewer than 1,000 hours in each preceding plan year (not just the most recent one). The notice calls this the once-in-always-in or “OIAI” rule. Many taxpayers complained to the IRS that they did not have enough notice of this requirement. Among other things, the notice provides that:

- During the “relief period” (which ended December 31, 2018, for calendar-year plans) a plan will not be treated as failing to satisfy the requirements for excluding part-time employees merely because it was not operated in compliance with the OIAI rule.
- An individually designed plan that has not consistently been operated in compliance with the OIAI rule will have to be amended to highlight the OIAI rule explicitly (rather than simply tracking the language in the regulation) by March 31, 2020 (the end of the remedial amendment period in Rev. Proc. 2013-22), but if it does so it will not be treated as having a failure to follow the plan terms.
- A plan will not be treated as failing to satisfy the requirements for excluding part-time employees if it applies the OIAI rule as if it first became effective January 1, 2018. Also, the plan will not have to be amended to reflect the use of this “fresh-start opportunity.”

**Notice 2018-97**, 2018-52 I.R.B. 1062, provides guidance to taxpayers on Code § 83(i), which was added by TCJA § 13603. Among other things, the notice requires stock subject to that section to be deposited into an escrow arrangement, and notes that “this has the effect of allowing a corporation to preclude its employees from making section 83(i) elections by declining to establish an escrow arrangement consistent with the terms outlined above.” It also indicates that an employer that does not intend to establish such an escrow will satisfy the notice requirement in Code § 83(i)(6) if it states in the stock option or RSU grant agreement that no election under Code § 83(i) will be available with respect to stock received upon the exercise of the stock option or settlement of the RSU.

**Notice 2018-99**, 2018-52 I.R.B. 1067, provides interim guidance for taxable organizations to determine the amount of deductions for parking expenses that are disallowed by Code § 274(a)(4), which was by TCJA § 13304, and for tax-exempt organizations to determine the corresponding parking-related increase in the amount of their UBTI under Code § 512(a)(7), which was added by TCJA § 13703. Among other things:

- It says that, based on the exception in Code § 274(e)(2) for expenses that are treated as compensation, the cost of a qualified transportation fringe is not subject to Code § 274(a)(4) “to the extent that the fair market value” of the qualified transportation fringe exceeds the Code § 132(f)(2) limit and is treated as compensation. The ABA Tax Section comments asked for confirmation that Code § 274(e)(2) would have this effect when applying Code § 512(a)(7). However, they also asked for Code § 274(a)(4) to be applied to the value rather than the cost of qualified transportation fringes (at least when applying Code § 512(a)(7)), which the notice specifically rejects, and also for employers to be allowed to include the value of otherwise-excludable qualified transportation fringes in
employees’ incomes in order to apply Code § 274(e)(2) to the entire amount of the fringes rather than just the nonexcludable amount, which the notice does not address. The notice does not explain how this partial exclusion works when the value of the qualified transportation fringe is not the same as its cost, e.g., whether it is applied pro rata.

• It says that, based on the exception in Code § 274(e)(7), the cost of parking that is available to the general public (including customers, clients, visitors, delivery persons, patients, students, and church members) is not subject to Code § 274(a)(4). It also provides rules for determining the extent to which this exception applies when the parking also is available to employees, and gives taxpayers until March 31, 2019, to change parking arrangements and signs to reduce the number of spots reserved for employees in order to apply these rules, retroactive to January 1, 2018.

• It says that a deduction for depreciation on a parking structure owned by a taxpayer is not a parking expense for purposes of Code § 274(a)(4), based on W.L. Schautz Co. v. United States, 567 F.2d 373 (Ct. Cl. 1977), and other authorities. The ABA Tax Section comments asked for confirmation of this.

• It says that the provision of qualified transportation fringes to which Code § 512(a)(7) applies is not itself an unrelated trade or business. The ABA Tax Section comments asked for confirmation of this.

• It says that on-premises athletic facilities are not subject to Code § 512(a)(7) even though they are specifically mentioned in that section, because deductions for such facilities are not disallowed by Code § 274(a)(4). The ABA Tax Section comments asked for confirmation of this.

Notice 2018-100, 2018-52 I.R.B. 1074, waives any addition to tax under Code § 6655(e) for an underpayment of estimated UBIT due on or before December 17, 2018, by a tax-exempt organization that was not required to file Form 990-T for the preceding taxable year, to the extent that the underpayment resulted from Code § 512(a)(7). Code § 512(a)(7) was added by TCJA § 13703 and increases the UBTI of a tax-exempt organization by the amount of the deductions for qualified transportation fringes that would be disallowed by Code § 274(a)(4), which was added by TCJA § 13304, if the organization were subject to tax. The ABA Tax Section comments recommended relief not only from that addition to tax but also from any underpayment, accuracy-related, or other applicable penalties attributable to that section until guidance was issued and in effect.

Notice 2019-2, 2019-2 I.R.B. 281, announces the optional standard mileage rates for operating an automobile during 2018 for business (58¢/mile, up from 54.5¢/mile in 2018), charitable (14¢/mile, same as in 2018), and medical or moving (20¢/mile, up from 18¢/mile in 2018) purposes. (However, it notes that the TCJA suspended deductions for miscellaneous itemized deductions and moving expenses through 2025, with only limited exceptions, as a result of which relatively few taxpayers will benefit from the increases.) It also contains the maximum standard automobile cost that may be used in computing the allowance under a fixed and variable rate (“FAVR”) plan.

Notice 2019-3, 2019-3 I.R.B. 350, contains updated IRS weighted average interest rates, yield curves, and segment rates used for funding and other purposes.
Notice 2019-5, 2019-2 I.R.B. 283, provides that, consistent with the CCIIO memorandum dated September 12, 2018, entitled Guidance on Claiming a Hardship Exemption through the Internal Revenue Service (IRS), “all hardship exemptions available under 45 CFR 155.605(d)(1) may be claimed by a qualifying individual (or the taxpayer who may claim a qualifying individual as a dependent) on a Federal income tax return for the 2018 tax year without obtaining a hardship exemption certification from the Marketplace.”

Notice 2019-8, 2019-3 I.R.B. 354, announces that the maximum value of vehicles first made available to employees for personal use in 2018 that are eligible for the (i) vehicle cents-per-mile valuation rule and (ii) the fleet-average valuation rule is $50,000 for passenger automobiles, trucks and vans (significantly higher than in 2017 because of the amendments to Code § 280F made by TCJA § 13202).

Notice 2019-9, 2019-4 I.R.B. ___, provides interim guidance on the excise tax imposed by Code § 4960, as added by TCJA § 13602, on “excess remuneration” and “excess parachute payments” paid by “applicable tax-exempt organizations” (“ATEOs”) to “covered employees.” Among other things:

- It does not grandfather any existing arrangements, but does treat remuneration that was vested in a year before the effective date, or vested in a year before an individual became a covered employee, as having been paid in that year and thus exempt from Code § 4960. The ABA Tax Section comments requested this approach.
- It allows tax-exempt organizations to take positions based on reasonable, consistent, good-faith interpretations of Code § 4960 until future guidance (which is expected to be in the form of a proposed regulation) is issued, and says that the positions in the Notice are deemed to be based on reasonable, good faith interpretations. It does not rule out other reasonable, good faith interpretations, but identifies four positions that it considers the only reasonable, good faith interpretations – including determining an ATEO’s five highest compensated employees on a group basis when it is part of a group of related ATEOs – apparently even for periods before the Notice was issued. The ABA Tax Section comments requested this approach, but without any rule treating certain positions as mandatory.
- It says that public universities with Code § 501(c)(3) determination letters are ATEOs, but allows them to relinquish their letters voluntarily.
- It determines “excess remuneration” and “excess parachute payments,” and identifies “covered employees,” based on amounts paid during the calendar year ending with or within the employer’s taxable year. The ABA Tax Section comments requested this approach in the interests of administrability and convenience, but requested that it be optional rather than mandatory.
- It does not treat remuneration as “paid” when it vests only in the case of amounts actually subject to Code § 457(f). Thus, it applies Code § 4960 to short-term deferrals, severance pay, accrued earnings, church plan deferrals, and other amounts when they accrue and vest rather than when they are paid, even though they are not included in income or wages at that time. This will the application of Code § 4960 less predictable, and will require ATEOs to keep new records that are not based on their payroll systems in order to apply it correctly. The ABA Tax Section comments requested that such treatment be limited to amounts actually subject to Code § 457(f).
• It does not provide guidance on the meaning of “predecessor,” but instead asks for comments on this issue. The ABA Tax Section comments contained two recommendations relating to the meaning of “predecessor.”

• It determines an ATEO’s five highest compensated employees by ranking its common-law employees by compensation, using the same definition of “remuneration” as is used for other purposes under Code § 4960. The ABA Tax Section comments requested this approach, but also requested that parachute payments be excluded.

• It determines an ATEO’s five highest compensated employees separately for each ATEO even when the ATEO is part of a group of ATEOs that are related organizations under Code § 4960. The ABA Tax Section comments requested that in such a situation the five highest compensated employees, and their “excess remuneration,” be determined on a group basis, in part to avoid double-taxation of that remuneration. The Notice would avoid double-taxation using a different rule.

• It defines “control” for purposes of the related-organization rules using rules that are very similar to the rules applied for Form 990 reporting purposes, including the constructive ownership rules of Code § 318. The ABA Tax Section comments requested that “control” be determined using the rules under Code § 414(b) and (c) applying a 50% rather than an 80% threshold, in part because not all tax-exempt organizations file Form 990.

• It defines “medical services” as the direct performance of services that relate to the diagnosis, cure, mitigation, treatment, or prevention of disease or that are for the purpose of affecting a structure or function of the body, including for this purpose documenting the care and condition of a patient and accompanying another professional as a supervisor while that professional performs medical services, but not including managing an organization’s operations even if it is a hospital. It also allows an ATEO to make a reasonable, good faith allocation between remuneration for medical services and other services, and asks for comments on how this allocation should be made.

• It says that a payment is “contingent on an employee’s separation from employment,” and thus can be a “parachute payment” for purposes of Code § 4960, only if the facts and circumstances indicate that the employer would not make the payment in the absence of an involuntary separation from employment. The ABA Tax Section comments requested a similar rule.

• It generally defines “separation from employment” the same way as “separation from service” in Code § 409A, except that it treats a bona fide change from employee to independent contractor status as a separation from employment. The ABA Tax Section comments requested that the definition of “severance from employment” in Code § 457 be used, instead, because it is familiar to many tax-exempt organizations.

• It says that the imposition of the Code § 4960 excise tax is not determinative of whether an ATEO has paid more than reasonable compensation to a covered employee for purposes of Code § 4941 or 4958. The ABA Tax Section comments asked for confirmation of this.

5. IRS Announcements

Ann. 2018-05, 2018-13 I.R.B. 461, announced that on March 30 or shortly thereafter the IRS will issue opinion letters for preapproved M&P and VS DB plans that were modified to conform
to Notice 2012-76, 2012-52 I.R.B. 775, and that have already submitted amendments, and that
the IRS will accept new applications for those from May 1, 2018, through April 30, 2020.

Ann. 2018-12, 2018-30 I.R.B. 232, announces that there were no articles submitted for publication
in 2018-30 I.R.B.

6. **Treasury and IRS Proposed Regulations and Requests for Comments**

REG-132197-17, 83 Fed. Reg. 6806 (Feb. 15, 2018), contains proposed regulations that would
remove “298 regulations that are no longer necessary because they do not have any current or
future applicability under the Internal Revenue Code,” i.e., deadwood. A high percentage of
these are in the employee benefits area.

Notice, 83 Fed. Reg. 15095 (April 9, 2018), contains a Treasury Department proposal to elimi-
nate the regulation authorizing the TARP Executive Compensation Office, which no longer has
any employees anyway.

REG-107892-18, 83 Fed. Reg. 40884 (Aug. 16, 2018), contains proposed regulations on the
deduction available under Code § 199A, which was added by TCJA § 11011. Among other
things, they would:

- **Rely on the Code § 162 standard for determining whether an activity is a “trade or busi-
ness,” except that they would exclude the trade or business of performing services as an
employee, as required by the statute. The regulations seem to assume, but do not say ex-
plicitly, that a trade or business cannot include multiple individuals or entities, and thus
that any combining of individuals or entities must be done under the aggregation rule de-
scribed below. Contrary to some speculation, they do not seem to require the individual
who ultimately takes the deduction to be engaged in the trade or business actively or di-
rectly; thus, for example, a purely passive limited partner seems to be entitled to take the
deduction with respect to any Code § 704(a) amounts that are allocated to him or her.
However, in addition to carving guaranteed payments for services out of “qualified busi-
ness income” (“QBI”), as required by the statute, they would carve out guaranteed pay-
ments for capital because they are “are determined without regard to the income of the
partnership.”**

- **Provide helpful guidance on the meaning of a “specified service trade or business” (**“SSTB”),
for which the deduction is phased out if the taxpayer’s income exceeds certain thresholds. Surprisingly,
they would exclude banking from the definition of “financial services” and services provided by real estate
and insurance agents and brokers from the definition of “brokerage services.” They would provide that the field of “health” includes
only services performed directly for a “patient,” and the field of “consulting” does not in-
clude consulting services that are embedded in, or ancillary to, the sale of goods if there
is no separate payment for the services. Importantly, and also surprisingly, they would
limit a “trade or business where the principal asset of the trade or business is the reputa-
tion or skill of one or more of its employees or owners” to (1) receiving fees, compensa-
tion, or other income for endorsing products or services, (2) licensing or receiving fees,
compensation or other income for the use of an individual’s image, likeness, name, signa-
ture, voice, trademark, or any other symbols associated with the individual’s identity, or**
(3) receiving fees, compensation, or other income for appearing at an event or on radio, television, or another media format. Because capital gains are completely excluded from QBI by statute, while fees from managing the portfolio of a fund is merely an SSTB, in some situations it might be better for the manager of a fund to receive fees rather than carried interests (and the associated share of fund capital gains). (Query whether the fund or the manager can elect to treat the capital gains as ordinary income under Code § 475.)

- Create a de minimis rule under which an otherwise qualifying trade or business (1) with no more than $25 million of gross receipts will not be treated as an SSTB if less than 10% of its gross receipts are derived from an SSTB, and (2) with more than $25 million of gross receipts will not be treated as an SSTB if less than 5% of its gross receipts are derived from an SSTB.

- Provide that the deduction will not reduce net earnings from self-employment or income subject to the net investment income tax. However, it is unclear whether, in calculating “qualified business income” (“QBI”), the deductions for health insurance premiums, pension contributions, and one-half of self-employment taxes will be taken into account.

- Consistent with previous public statements, limit the exclusion from QBI for “reasonable compensation” to S corporations. The preamble makes the bizarre argument that extending the concept to partnership allocations, regardless of whether they are guaranteed, “would violate the principle set forth in Rev. Rul. 69-184, 1969-1, C.B. 256, that a partner of a partnership cannot be an employee of the partnership.” If the argument is that it would violate that principle because the concept applies only to employees, then that appears to assume the conclusion rather than make any actual new argument.

- Change the language of the exclusions in the statute for “reasonable compensation paid to the taxpayer,” “any guaranteed payment described in [Code § 707(c)] paid to a partner,” and, “any payment described in [Code § 707(a)] to a partner” to “[r]easonable compensation received by a shareholder from an S corporation,” “[a]ny guaranteed payment described in [Code §] 707(c) received by a partner,” and “[a]ny payment described in [Code §] 707(a) received by a partner.” It is not clear how these standards apply to amounts that are accrued but not paid, or never are accrued or paid. Perhaps in the first case amounts that are accrued are supposed to reduce the business’s QBI. The preamble seems to address the second case by saying that, at least in the context of an S corporation, “[b]ecause the trade or business of performing services as an employee is not a qualified trade or business under [Code §] 199A(d)(1)(B) . . . even if an S corporation fails to pay a reasonable wage to its shareholder-employees, the shareholder-employees are nonetheless prevented from including an amount equal to reasonable compensation in QBI.” Although the preamble refers to any “failure to pay” reasonable compensation, it is clear from the rest of the discussion as well as the way the IRS has applied the reasonable compensation rule that it applies only if the S corporation makes other distributions that it characterizes as (untaxed) dividends rather than compensation; thus it would appear that an S corporation can treat all of its retained earnings as QBI even if eventually some will have to be distributed as compensation.

- Allow wages to count towards the W-2 wage limit only if they are paid to a common law employee within the meaning of Code § 3121(d)(1) and (2) (thus excluding statutory employees) for employment by the individual taxpayer or pass-through entity owned “directly or indirectly” by the individual taxpayer (“RPE”), and are properly reported to the SSA within 60 days after the due date of the Form W-2, and allow wages paid by third-
party payors (such as PEOs) to count towards the W-2 wage limit, in the same way as the regulations under old Code § 199, as long as the wages are for common law employees of the taxpayer or RPE.

• Allow trades or businesses to be aggregated if (1) none of the businesses is an SSTB, (2) the same owners own “directly or indirectly” at least 50% of the businesses, and (3) the businesses either (a) provide services or products that are customarily offered together, (b) share facilities or significant business functions, or (c) operate in coordination with, or reliance on, each other. The use of the phrase “directly or indirectly” here and in the definition of an RPE suggests that tiered partnerships are, in effect, aggregated automatically at the individual level, which seems consistent the statement in the preamble that aggregation in a tiered partnership situation is permitted only at the level of the individual taxpayer, because that is where the deduction is taken.

• Create a rebuttable presumption that an employee who becomes an independent contractor while providing substantially the same services, directly or indirectly, to a former employer remain an employee for purposes of Code § 199A.

REG-107892-18 was accompanied by FAQs, and by Notice 2018-64, 2018-35 I.R.B. 347, which contains a draft revenue procedure that would provide three different methods for calculating “wages” for purposes of Code § 199A from an employee’s Form W-2: the “unmodified Box 1 method,” the “modified Box 1 method,” and the “tracking wages method.”

REG-118826-16, 83 Fed. Reg. 52726 (Oct. 17, 2018), contains proposed revisions to Treas. Reg. §§ 301.6721-1, 301.6722-1 and 301.6724-1 that would (1) provide guidance on and implement the de minimis safe harbor election rules in Code §§ 6721(c)(3)(B) and 6722(c)(3)(B), which were added by PATH Act § 202, and (2) update penalty amounts and references to specific information reporting obligations in the existing regulations. The proposed regulations would allow a payee to make the election not to have the de minimis rule apply as late as October 15 of the year the erroneous information return was received, and provide that it would remain in effect for all subsequent years until revoked by the payee. They would allow the payee may make the election by email or telephone if the payor provided a valid notification to the payee describing the reasonable alternative manner. They would provide that a payor had reasonable cause for a de minimis error even if an election was made as long as it issued a corrected information return within 30 days after the election. Some of these issues were addressed previously in Notice 2017-9, 2017-4 I.R.B. 542. Except for the last rule, which would be effective for information returns required to be provided on or after January 1, 2017, the regulations generally would be effective for returns required to be provided on or after January 1 of the year after they are published in final form.

REG-107163-18, 83 Fed. Reg. 55653 (Nov. 7, 2018), would amend Treas. Reg. §§ 53.6011-1 and 53.6071-1 to (1) provide that persons (including governmental entities) that are liable for section 4960 excise taxes are required to file a return on Form 4720, and (2) require the Form 4720 to be filed by the 15th day of the fifth month after the end of the person’s taxable year during which the excise tax liability was incurred.

REG-107813-18, 83 Fed. Reg. 56763 (Nov. 14, 2018), contains proposed regulations that would:
• Revise Treas. Reg. § 1.401(k)-1(d)(1) to implement the rule in Code § 401(k)(2)(B)(i)(V), as added by PPA § 827 and revised by HEART Act § 107(a), permitting a reservist called to active duty after September 11, 2001, to take an in-service distribution from a Code § 401(k) plan;

• Revise Treas. Reg. § 1.401(k)-1(d)(3) to implement the rule in Code § 401(k)(14), as added by BBA 2018 § 41114, permitting hardship distributions to include QNECs and QMACs as well as elective contributions, and earnings on all three kinds of contributions;

• Revise Treas. Reg. § 1.401(k)-1(d)(3) to implement PPA § 826, which directed Treasury to modify the regulations to permit a Code § 401(k) plan to treat a participant’s beneficiary the same as his or her spouse or dependent in determining whether the participant has incurred a hardship;

• Revise Treas. Reg. § 1.401(k)-1(d)(3) to specify that the temporary change to the personal casualty loss deduction rule in Code § 165(h)(5) made by TCJA § 11044, which excludes losses not attributable to a federally declared disaster as defined in Code § 165(i)(5), does not apply in determining whether a participant has incurred a hardship, and to include losses attributable to such a federally declared disaster only if the participant’s principal residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance with respect to the disaster;

• Revise Treas. Reg. § 1.401(k)-1(d)(3) to collapse the existing general and safe harbor rules for determining whether a distribution is necessary to satisfy an immediate and heavy financial need into a single rule that would require the participant to have obtained all other currently available distributions under the plan and all other plans of deferred compensation maintained by the employer, and to represent that he or she “has insufficient cash or other liquid assets to satisfy the need” (According to the regulations, “[t]he plan administrator may rely on the employee’s representation unless the plan administrator has actual knowledge to the contrary.” Unlike the existing rules, this would eliminate any requirement to obtain loans from or suspend participation in the plan or other plans of the employer. Unlike the existing general rule, this would eliminate any requirement to obtain commercial loans and would ignore other “reasonably available resources” that are not either cash or liquid assets. However, it would allow the plan sponsor to impose additional conditions, other than a suspension requirement. The lack of a plan loan requirement and the prohibition against any suspension requirement would reflect BBA 2018 § 41113.; and

• Make the above changes to Treas. Reg. § 1.401(k)-1(d)(3) generally effective for distributions in plan years beginning after December 31, 2018, but (i) make the requirement of an employee representation and the prohibition against any suspension requirement effective for distributions on or after January 1, 2020, (ii) allow the prohibition against any suspension requirement to be made effective for plan years beginning after December 31, 2018, even if the distribution was made in a prior plan year, and (iii) allow the changes relating to federally declared disasters to be made effective as early as January 1, 2018.

The preamble states that the proposed rules “generally apply to section 403(b) plans” because of the cross-reference in the Code § 403(b) regulations to the Code § 401(k) requirements, but that, since BBA 2018 § 41114 did not amend Code § 403(b), “income attributable to section 403(b)
elective deferrals continues to be ineligible for distribution on account of hardship.” It also states that plan amendments will be required once the regulations are finalized and that all amendments relating to the final regulations will have the same amendment deadline. The changes appear to render most recent IRS substantiation guidelines relating to hardship distributions, namely Memorandum from Thomas J. Petit, Acting Director, EP Examinations, to Employee Plans (EP) Examinations Employees, Substantiation Guidelines for Safe-Harbor Hardship Distributions from Section 403(b) Plans (March 7, 2017), and Memorandum from Thomas J. Petit, Acting Director, EP Examinations, to Employee Plans (EP) Examinations Employees, Substantiation Guidelines for Safe-Harbor Hardship Distributions from Section 401(k) Plans (Feb. 23, 2017). REG-122898-17, 83 Fed. Reg. 58202 (Nov. 19, 2018), would increase the applicable fees and make other changes to the regulations relating to enrolled agents and enrolled retirement plan agents in 26 C.F.R. Part 300.

7. Other Treasury and IRS Guidance

**FSA 20171202F** (Jan. 13, 2017) addressed the tax consequences under Code §§ 61 and 132 of a fringe benefit program where a company allowed its employees to designate a limited number of individuals, without regard to their relationship to the employee, to rent property at a discount.

**CCA 201752008** (April 24, 2017) required a tax-exempt hospital corporation and a health insurance provider that were part of the same controlled group to aggregate amounts paid to the same employee when applying the Code § 162(m)(6) deduction limits.


**PLR 201803007** (Oct. 20, 2017) applied the IRS’s long-standing methodology and Advocate Health Care Network v. Stapleton, 137 S. Ct. 1652 (2017), to conclude that a DB plan, a DC plan and a 403(b) plan for employees of a hospital controlled by a religious order are “church plans” under Code § 414(e).

In a January 23, 2018, speech at a New York State Bar Association Tax Section meeting, Bryan Rimmke, an attorney-adviser in the Treasury Department’s Office of Tax Policy, and Clifford Warren, special counsel in the IRS Office of Chief Counsel (Passthroughs and Special Industries), stated that Code § 199A (the 20% deduction for qualified business income) is a high-priority area for guidance, but not Code § 1061 (the three-year holding period for carried interest treatment) because it applies to a smaller group of taxpayers. At the same meeting, Bill Paul said Code § 162(m) is on the list of issues the IRS plans to address. In a January 25, 2018, speech at a DC Bar Community of Taxation event, Thomas West, Treasury Tax Legislative Counsel, stated that the Treasury Department will release an updated priority guidance plan in the coming weeks that will reflect TCJA implementation projects, and that taxpayers can expect to see projects involving Code § 199A on it.

On January 23, 2018, the IRS posted **FAQs** to its web site relating to TCJA § 13611, which prohibits a taxpayer who has made a Roth IRA conversion from undoing that transaction and treating it as a contribution to a traditional IRA instead. They state that the new rule will not
apply to a Roth IRA conversion made in 2017 if the recharacterization is made by October 15, 2018.

Notice, 83 Fed. Reg. 3463 (Jan. 25, 2018), announces that an application from The Board of Trustees of the Ironworkers Local Union No. 16 Pension Fund (Ironworkers 16 Pension Fund) to reduce benefits under the MPRA has been published on the Treasury Web site, and that comments on the application are requested from interested parties.

On January 29, 2018, the IRS released the 2018 version of Publication 15 (Circular E).

News Release IR-2018-19 (Feb. 6, 2018) notes that the TCJA did not affect how cost-of-living increases are calculated for purposes of most of the dollar limits for retirement plans, and therefore that no changes in those dollar limits for 2018, which were announced in Notice 2017-64, 2017-45 I.R.B. 486, are needed. It notes that, while the TCJA did affect how cost-of-living increases are calculated for purposes of some IRA limits, after taking the rounding rules into account no changes in those dollar limits are needed, either.

ILM 201805001 (Oct. 26, 2017) concluded that a consultant who provided clients with a study which incorrectly reclassified property in order to accelerate or “front-load” depreciation deductions during the first 5 years the property was placed in service, thereby creating larger tax losses for his clients was liable for a Code § 6701 penalty for aiding and abetting understatements of tax liability because he “knew or had reason to believe that his clients, both individual and corporate taxpayers, would use the [study] as guidance in claiming depreciation deductions on returns, a material matter under the internal revenue laws, and that the [study] would (if so used) result in understatements of tax liability of other persons.” It noted that “[t]he legislative history to section 6701 states that the penalty was intended to apply as a civil counterpart to the criminal penalty on aiding or assisting in the preparation or presentation of false or fraudulent returns or other documents.”

On February 7, 2018, the IRS and Treasury Department released the Second Quarter Update to the Department of the Treasury 2017-2018 Priority Guidance Plan. It includes several new employee benefits projects relating to the TCJA, including (1) guidance on issues relating to the family and medical leave credit under Code § 45S, (2) guidance under Code § 162(m) relating to the effective date provisions, (3) “[c]omputational, definitional, and anti-avoidance guidance under new [Code] § 199A,” (4) guidance relating to withholding under Code §§ 3402 and 3405 and optional flat rate withholding, and (5) “[g]uidance on certain issues relating to the excise tax on excess remuneration paid by ‘applicable tax-exempt organizations’ under [Code] § 4960.”

In a February 9, 2018, speech at the ABA Tax Section Midyear Meeting, Dana Trier, at that point still Treasury Department Deputy Assistant Secretary for Tax Policy, stated that based on conversations with congressional staffers who worked on Code § 199A he and Tax Legislative Counsel Thomas West had no plans to apply the reasonable compensation exclusion to qualified business income to entities other than S corporations, even though the language could be interpreted to apply to Code § 707(c) guaranteed payments and Code § 707(a) non-partner payments.
The White House delivered its FY 2019 budget to Congress on February 12, 2018. It does not propose any significant tax law amendments, and there is not expected to be any Treasury Department “greenbook” this year as a result.

A letter from Republican members of the House Oversight and Government Reform committee to Acting IRS Commissioner David Kautter (Feb. 20, 2018) asks the Treasury Department to provide any legal analyses that justify the IRS’s classification of regulations and justify their exemption from the usual review. Similarly, a letter from Representatives Ron Johnson and James Lankford to Acting IRS Commissioner David Kautter (Feb. 13, 2018) “strongly urge[s] you to reconsider the IRS’s decision to exempt itself from assessing the economic impact of its regulations” as required by the Regulatory Flexibility Act by treating most of its regulations as interpretive regulations, the impact of which is inherently part of the impact of the underlying statute. (The Regulatory Flexibility Act (1980), as amended by the Small Business Regulatory Enforcement Fairness Act (1996), requires an agency to prepare an analysis of the economic impact of a rule on small entities unless it certifies that the rule does not have a “significant economic impact.” However, this requirement applies only to the extent that the rule imposes a collection of information requirement in the case of an interpretative rule involving the Internal Revenue Code. It also provides for review by Congress and prohibits any “major” rule from going into effect until that review is complete. Executive Order 12291 (Feb. 17, 1981) went further and required an agency to prepare a “regulatory impact analysis” of any “major rule,” and required OMB review of such a rule. Executive Order 12291 was replaced by Executive Order 12866 (Sept. 30, 1993), which required each agency to determine whether a rule was a “significant regulatory action” (similar to a “major rule” in Executive Order 12291), and required OMB to be notified about all planned rulemaking but required OMB review only of rules that the agency or the OMB determined to be “significant regulatory actions.” Memorandum of Agreement - Treasury and OMB Implementation of Executive Order 12291 (April 29, 1983) waived the review requirement under Executive Order 12291 except for “legislative” regulations that are “major,” and allowed Treasury to determine which regulations are “major.” Similarly, Treasury and the IRS have long taken the position that most tax regulations are exempt from the APA’s notice and comment requirements as interpretive regulations, although that position has been questioned, see Altera v. Commissioner, 145 T.C. 91 (2015), and it is in tension with their position – confirmed in Mayo Foundation for Medical Education & Research v. United States, 562 U.S. 44 (2011) – that most tax regulations, even those promulgated under Code § 7805, carry the “force of law” for purposes of Chevron deference.)

CCA 20180202017530746 (Feb. 2, 2018) concluded that Code § 6521 allowed an employer to offset SECA taxes paid by workers it misclassified as nonemployees against the employees’ share of FICA that the employer was required to withhold and pay to the IRS, where Code § 3509 did not apply because of “evidence of intentional disregard” and the statute of limitations on SECA tax refunds had run, despite the rather lack of an express provision allowing this like Code § 3102(f)(3) (relating to a failure to deduct and withhold Additional Medicare tax).

Memorandum from Sean E. O’Reilly, Acting Director, EP Examinations, to Employee Plans (EP) Examinations Employees, Missing Participants and Beneficiaries and Required Minimum Distributions – 403(b) Plans (Feb. 23, 2018), directs EP examiners not to challenge a Code § 403(b) plan as failing to satisfy the required minimum distribution (RMD) rules as long as the plan (1) searched for alternative contact information in plan, plan sponsor and publicly-available
records for directories, (2) used a commercial locator service, credit reporting agency or a proprietary internet search tool for locating individuals, and (3) sent mail via the United States Postal Service to the last known mailing address and attempted contact “through appropriate means for any address or contact information,” which includes email addresses and telephone numbers. The directive will be incorporated into IRM 4.72.13. An identical directive was issued on October 19, 2017, for qualified plans.

**News Release IR-2018-36** (Feb. 28, 2018) announces that the IRS has released an updated “Withholding Calculator” on IRS.gov and a new version of Form W-4 to reflect the tax changes in the TCJA.

In a March 9, 2018, speech at the Federal Bar Association Section on Taxation conference, Adrienne M. Mikolashek, an attorney in the Office of Chief Counsel (Passthroughs and Special Industries), stated that the IRS is considering how to treat a pass-through entity that operates its business out of one partnership and pays employers out of another entity for purposes of the Form W-2 wage limit on the deduction under new Code § 199A.

In a March 9, 2018, speech at the Federal Bar Association Section on Taxation conference, Kyle Brown, division counsel, Tax-Exempt and Government Entities Division, stated that the IRS is considering whether to permit DL applications for large DB plans, plans involved in certain types of M&A transactions, and possibly others, but before doing so “will put out an official request for comments”.

**CCA 201810007** (Nov. 28, 2017) concluded that tax preparation services provided as part of a tax equalization program for expats are not working condition fringes because an expat could have deducted the expense incurred in providing the benefit only under Code § 212(3), and not Code § 162.

**CCA 201810008** (Feb. 7, 2018) concluded that a floor-offset arrangement under which the DB plan benefits are offset only for NHCEs (1) does not satisfy the conditions for combined testing on the basis of equivalent benefits under Treas. Reg. § 1.401(a)(4)-9(b)(2)(v) because, after taking the offset into account, the combined plan is not primarily DB in character and does not consist of broadly available separate plans, and (2) does not satisfy Code § 401(a)(26) because, after taking the offset into account, the NHCEs do not accrue meaningful benefits under the DB plan, and the offset must be taken into account despite the special rule in Treas. Reg. § 1.401(a)(26)-5(a)(2)(iii) for floor offsets because “the effect of an offset that does not apply fully to all participants is identical to the effect of an offset that applies uniformly to reduce benefits under the defined benefit plan by non-uniform benefits in the offsetting plan.”

**PLR 201811008** (Dec. 14, 2017) applied the IRS’s long-standing methodology and Advocate Health Care Network v. Stapleton, 137 S. Ct. 1652 (2017), to conclude that a DB plan for employees of a social service agency controlled by a church are “church plans” under Code § 414(e).

In a March 23, 2018, speech at the Washington Non-Profit Legal & Tax Conference, Janine Cook, IRS Deputy Associate Chief Counsel (Tax-Exempt and Government Entities), stated that Publication 15-B makes clear that “if an employer effectively wants to give more cash to their
employees so that they can pay for their parking or metro on a pretax basis, that is still a qualified transportation fringe benefit, it is not additional compensation.”

PMTA 2018-009 (Nov. 13, 2017) concluded that the IRS was not required to issue Letter 3523, “Notice of Employment Tax Determination under IRC § 7436,” after an employment tax audit of a foreign corporation in which the corporation argued that it had no income tax withholding obligation with respect to amounts paid to certain NRAs because it was not engaged in a trade or business within the United States. The IRS reasoned that “This argument is not based on a position that the NRAs are not employees. Thus, there is no actual controversy over the worker classification of the NRAs. Rather, the foreign corporation’s disagreement is premised on the position that the NRAs are employees, but that because the employees worked for a foreign corporation while temporarily in the United States and were compensated less than a threshold amount the foreign corporation did not have a trade or business within the United States. Essentially, the foreign corporation is arguing that the exception from the definition of ‘wages’ in section 3401(a)(6) is applicable.”

On April 9, 2018, the IRS posted FAQs to its web site on the new paid family and medical leave tax credit in Code § 45S, which was added by TCJA § 13403. They provide no guidance beyond a restatement of the language in the statute itself and a description of the guidance the IRS intends to provide.


• The 1993 Memorandum waived the review requirement under EO 12291 for any regulation that is not both “legislative” and “major,” and allowed Treasury to determine which regulations are “major.” It also specifically waived the review requirement for any revenue ruling or revenue procedure. EO 12291 was replaced by EO 12866 (Sept. 30, 1993), which requires each agency to determine whether a rule is a “significant regulatory action.” A “significant regulatory action” is any “regulatory action” that among other things is “likely to result in a rule” that may “[c]reate a serious inconsistency or otherwise interfere with an action taken or planned by another agency”; “[r]aise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in this Executive order”; or “[h]ave an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities.”

• The 2018 Memorandum applies the review requirement under EO 12291 only to a “regulatory action (as defined by Executive Order 12866)” under Title 26 that is “likely to result in a rule that may (a) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (b) raise novel legal or policy issues, such as by prescribing a rule of conduct backed by an assessable payment; or (c) have an annual non-revenue effect on the economy of $100 million or more, measured against a no-
action baseline” (emphasis added). It does not specifically exempt revenue rulings or revenue procedures.

There is some ambiguity as to whether sub-regulatory guidance is covered by the 2018 Memorandum. It refers only to a “regulatory action (as defined by Executive Order 12866),” but an OIRA memorandum on EO 13771, Reducing Regulation and Controlling Regulatory Costs (Jan. 30, 2017), implied that a “significant regulatory action” as defined in EO 12866 also includes “[a] significant guidance document,” even though that is a separate category of guidance once covered by EO 12866.


In a May 11, 2018, speech at the ABA Tax Section May Meeting, Audrey Ellis, attorney-adviser, Treasury Office of Tax Legislative Counsel, stated that Treasury does not intend to apply the reasonable compensation exclusion to qualified business income to entities other than S corporations. She said “I don’t think that we’re intending to create a new rule where you have to have reasonable compensation in a partnership,” because “we think the reasonable compensation language was directed at S corporations.”

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In a June 6, 2018, speech at the Texas Federal Tax Institute, Troy Caldron, a supervisory special agent in the IRS Criminal Investigation (CI) division, said that the IRS has increased its emphasis on criminal employment tax enforcement over the past few years, and listed some of the factors that might elevate a case to CI, but also said that a “nearly surefire” way to avoid criminal prosecution is for the taxpayer to start making payments before the case is referred to CI.


PLR 201826009 (April 2, 2018) concluded that a DB plan established by a church’s residential addiction treatment center and administered by a committee formed by the center, was a church plan under Code § 414(e), and that it had not made an election under Code § 410(d) because it
never filed a formal election meeting the requirements of Treas. Reg. § 1.410(d)-1, even though it had in the past “voluntarily operated [the plan] in compliance with standards of [ERISA], including filing Form 5500 for the plan, paying premiums to the Pension Benefit Guaranty Corporation, and updating and amending the plan on a continuous basis.”

PLR 201827002 (March 16, 2018) is a reminder that Treas. Reg. § 301.7701-4(c)(1), which the IRS applies outside the qualified plan area, provides that an “investment trust” will not be classified as a trust if there is a power under the trust agreement to vary the investment of the certificate holders.

PMTA 2018-015 (June 25, 2018) advised that when an employer is found to have provided $10,000 in taxable fringe benefits to an employee in 2016, but not withheld any income or FICA taxes from the benefits or other wages paid to the employee, (1) because it is in satisfaction of the employer’s own liability under Code § 3403 the payment of the income taxes by the employer in 2018 will not result in additional income or wages to the employee in 2016 (and the employee will get no credit for the income taxes under Code § 31 because the income taxes were not tax actually withheld in 2016), but (2) because the employee FICA taxes are ultimately the employee’s liability under Code § 3101, Treas. Reg. § 31.3102-1(d) and Rev. Rul. 86-111, 1986-2 C.B. 176, the payment of the employee FICA taxes by the employer in 2018 will not result in additional income or wages to the employee only if the employer deducts the employee FICA taxes from other remuneration paid to the employee or otherwise collects the amount from the employee in accordance with Code § 6205 and Treas. Reg. § 31.6205-1(d)(1). It also stated that “[t]o the extent GCM 39577 (February 21, 1986) indicates that the employer’s payment of its income tax withholding liability under section 3403 in a subsequent calendar year is additional compensation to the employee, it is in error.”

PLR 201831006 (May 3, 2018) concluded that an offer to allow active employees currently accruing benefits under the employer’s DB plan to cease accruing benefits under [the DB plan] and receive future accruals solely under the employer’s DC plan did not establish an impermissible CODA. The IRS explained that “Because there are no pre-tax contributions to [the DB plan] and because employees currently participate in [the DC plan], neither choice being offered in this one-time election causes any amount to be provided to the employee in the form of cash or some other taxable benefit not currently available.”

Delegation Order 30-1 (Rev. 3) (July 26, 2018) delegates the authority to prescribe the extent to which letter rulings and determination letters are applied without retroactive effect down to the Director, Employee Plans Rulings and Agreements (EP R&A) and the Director, EP Examinations. (Previously it was delegated to the Deputy Division Counsel, Tax Exempt and Government Entities.)

PLR 201833012 (May 22, 2018), which was issued to Abbot Labs, involved an amendment to a 401(k) plan to provide that (1) an employee who made a student loan repayment (SLR) equal to at least 2% of compensation would receive an “SLR nonelective contribution” equal to 5% of compensation (but apparently no matching contribution even if the employee made an elective contribution); while (2) an employee who made a student loan repayment equal to less than 2% of compensation but did make an elective contribution would receive a matching contribution equal to 5% of compensation. The IRS concluded that the SLR nonelective contributions would
not violate the contingent benefit rule because they “are conditioned on whether an employee makes a student loan repayment during a pay period and are not conditioned (directly or indirectly) on the employee making elective contributions under a cash or deferred arrangement,” and “because an employee who makes student loan repayments and thereby receives SLR nonelective contributions is still permitted to make elective contributions, the SLR nonelective contribution is not conditioned (directly or indirectly) on the employee electing to have the employer make or not make contributions under the arrangement in lieu of receiving cash.”

INFO 2018-0013 (June 21, 2018) notes that “Notice 2015-87 [Q&A-10] clarifies that in the case of employees under a SCA, the choice of a cash-out payment will generally not require the employer to pay a greater share of the cost of the health coverage in order for the coverage to be considered affordable.”

A letter to Steven Mnuchin and David Kautter from the Republican members of the Senate Finance Committee dated August 16, 2018, notes that TCJA § 13307, which denies a deduction for any settlement or payment related to sexual harassment or sexual abuse if such settlement or payment is subject to a nondisclosure agreement or attorney’s fees related to such a settlement or payment “arguably prohibits the recipient of any payment from deducting legal fees incurred in pursuing sexual harassment cases, because such legal fees are ‘related to’ a settlement or payment that is subject to a NDA,” but that “Congressional intent was that these attorney’s fees would not be subject to this rule.” It urges that “any guidance that is issued related to [that section] and the Internal Revenue Service’s enforcement of them reflects the Congress’ intent.” The letter addresses two other provisions, as well, and says that “[w]hile this letter focuses on these three important provisions, we are continuing a thorough review of [the TCJA] to identify other instances in which the language as enacted may require regulatory guidance or technical corrections to reflect the intent of the Congress. After this review, we intend to introduce technical corrections legislation to address any items identified in the on-going review.”

On August 17, 2018, the IRS and Treasury Department released the Fourth Quarter Update to the Department of the Treasury 2017-2018 Priority Guidance Plan. It includes several new employee benefits projects relating to the TCJA, including guidance on Code §§ 162(m) and 4960.

On July 3, 2018, the IRS posted an International Practice Unit to its website on determining an individual’s residency for tax treaty purposes.

PLR 201835011 (June 6, 2018) notifies a trust that it does not qualify for tax-exempt status under Code § 501(c)(9). The attached adverse determination letter explains that it violates Treas. Reg. §§ 1.501(c)(9)-1 and 1.501(c)(9)-2(a)(1) because “[y]ou will provide benefits to any employers for all industries in your state that has executed an adoption agreement and has 50 employees or less. Therefore, membership is not defined by a common employer. You are also not covered under a collective bargaining unit agreement, not a member of a labor union or not a member of one of more locals of a national or international labor union. Your employers are not required to be in the same line of business even though they are in the same geographic locale.” It explains that the trust violates Treas. Reg. § 1.501(c)(9)-5(a) because “you do not maintain records indicating the amounts contributed by each member and contributing employer and the amount and type of benefits paid by the organization to or on behalf of each member.”
On September 7, 2018, the IRS released draft instructions for the 2018 Form 990, including discussions of Code §§ 512(a)(6), 512(a)(7) and 4960.

PLR 201837004 (June 5, 2018) concluded that, for purposes of determining the concentration of ownership under the pension-held REIT rules, the tax classification and the concentration of ownership in a REIT held by a Rev. Rul. 81-100 group trust should be determined by evaluating the interests equitably held for each participating entity separately, in part because, “[p]ursuant to Revenue Ruling 2011-1, the tax exempt status of a group trust is derivative of the tax exempt status of its participants.” PLR 201650003 (Aug. 26, 2016) and PLR 201650002 (Aug. 26, 2016) came to the same conclusion.

On September 21, 2018, the IRS announced on its web site that if a taxpayer files any Forms 1099-MISC that report both non-employee compensation and other income required to be reported on Form 1099-MISC after January 31, 2019 (the due date for Forms 1099-MISC that report non-employee compensation), in a single transmission (i.e., on paper with a single Form 1096 or electronically through FIRE with a single payer “A” record), “the IRS will treat every form in the single transmission as if it is subject to the [Code §] 6721 penalty for failure to file by January 31, 2019.” Therefore, to limit penalties, a taxpayer that files any Forms 1099-MISC that report non-employee compensation after January 31, 2019, should file them in a separate transmission. The web site previously recommended this approach for 2017 but warned that it would become mandatory in 2018.

In a September 27, 2018, speech to the National Association of Stock Plan Professionals, Stephen Tackney, Deputy Associate Chief Counsel (Employee Benefits), IRS Office of Associate Chief Counsel (Tax-Exempt and Government Entities), stated that one of the biggest questions the IRS has been getting from employers about new Code § 83(i) is how to avoid it. Veena Murthy said in April that the provision wasn’t intended to be mandatory, but, according to Tackney, the IRS isn’t ready to make that determination.

On October 24, 2018, the Information Reporting Program Advisory Committee (IRPAC) released its 2018 Report, which is an annual report that includes recommendations on a wide range of information reporting issues. Among other things, it recommends that the IRS waive penalties for taxpayer under-withholding for 2018, and extend the good-faith relief from penalties under Code §§ 6721 and 6722 for failing to file and furnish accurate information returns and statements under Code §§ 6055 and 6056 (see Notice 2018-6, 2018-3 I.R.B. 300) to returns and statements for 2018.

PLR 201844005 (July 16, 2018) concluded that “for purposes of computing UBTI and the set-aside under [Code §] 512(a)(3)(E)(i), the applicable account limit under [Code §] 419A(c)(6) may be computed by including insurance premiums for medical benefits as qualified direct costs.” It contrasted other provisions, such as Code § 419(c)(5)(B)(ii), that “include specific language excluding insurance premiums,” with Code § 419A(c)(6), which “refers to ‘qualified direct costs’ with no such exclusionary language.”

AM 2018-004 (Nov. 23, 2018) advises Kyle Brown, the Division Counsel (Tax Exempt & Government Entities) that (1) whether an employer has a substantial non-compensatory business reason for furnishing on-premises meals to its employees within the meaning of Treas. Reg.
§ 1.119-1(a)(2)(i) should be determined based on Commissioner v. Kowalski, 434 U.S. 77 (1977), as clarified by Boyd Gaming Corp. v. Commissioner, 177 F.3d 1096 (9th Cir. 1999), acq., 1999-35 I.R.B. 314, which together require that the meals be provided in order for the employee to properly discharge his or her duties, and that the enactment of Code 119(b)(2) has no effect on this analysis; (2) the IRS’s acquiescence in “Boyd Gaming does not preclude the IRS from determining whether an employer actually follows and enforces its stated business policies and practices, and whether these policies and practices, and the needs and concerns they address, necessitate the provision of meals so that there is a substantial noncompensatory business reason for furnishing meals to employees”; and (3) employers should be required to substantiate their business reasons by, for example, “provid[ing] additional information that demonstrates that employees indeed have shortened meal periods, employees are aware of the shortened meal period requirement, which the employer meaningfully enforces, and that these shortened meal periods are linked to the nature of the employer’s business.” It added that “self-imposed limitations on meal periods on the part of employees (such as claims that employees take short meal periods due to the expectations of ‘corporate culture’) do not qualify as a situation in which an employer’s business requires a shortened meal period.” The AM appears to be targeted at companies like Google that provide elaborate on-premises meals for their employees. It explains that “the IRS has encountered a pattern of cases in which employers furnish meals to employees and do not include the value of these meals in the employees’ income, claiming that the meals are excluded from income under section 119 of the Code” and

The employers in these cases proffer a variety of business reasons for furnishing meals to their employees and claim that such reasons are substantial noncompensatory business reasons. For example, many employers claim that innovation and collaboration are a key aspect of their company’s business model and culture, and the meals the employer provides facilitate employee innovation, collaboration, and productivity. Many also claim that meals are provided to enable employees to work long days and overtime. Some claim that meals are provided to promote a healthier workforce, because the furnished meals are healthier than the meal options the employees might otherwise consume off the premises. Certain employers claim that meals are provided to discourage employees from jeopardizing trade secrets by encouraging them to remain on business premises for meals, rather than leave the premises and possibly discuss sensitive information during meals in public places.

PLR 201538022 (June 16, 2015) concluded that the exemption from the excise tax on reversions from qualified plans in Code § 4980(c)(1)(A) applied to an employer that was, at all times, tax-exempt under Code § 501(c)(3), and had never been subject to UBIT.


PLR 201850011 (Sept. 14, 2018) concluded that an acquired company satisfied the “administrative scrutiny” requirement in the SLOB regulations under Code § 414(r)(2) where, among other
things, it “provides unique products and services . . . that are distinct from the products and services provided by [the acquiror],” and “[s]ince the acquisition, [it] has continued to operate autonomously and has been led by substantially the same leadership team as before the acquisition.”


**B. DOL GUIDANCE**

1. **DOL Temporary and Final Regulations**

83 Fed. Reg. 28912 (June 21, 2018) contains the final version of the regulation on association health plans (AHPs) that DOL proposed earlier in the year (83 Fed. Reg. 614 (Jan. 5, 2018)). The release of the final regulation was accompanied by FAQs and a press release. It retains many of the key provisions of the proposed regulation, but makes several significant additions and changes. In particular:

- It makes new 29 C.F.R. § 2510.3-5 a safe harbor for an association to act as the “employer” with respect to the plan for purposes of ERISA § 3(5), and specifically states that “This section does not invalidate any existing advisory opinions, or preclude future advisory opinions, from the Department under [ERISA § 3(5)] that address other circumstances in which the Department will view a person as able to act directly or indirectly in the interest of direct employers in sponsoring an employee welfare benefit plan that is a group health plan.” The preamble notes that “[t]herefore, AHPs established under pre-rule guidance will retain the same flexibility as in the past to condition individual employer members’ premiums on their respective employees’ health status, to the extent permissible under the current HIPAA nondiscrimination rules based on the facts and circumstances of the particular situation.”

- It allows the association to have the offering of the AHP as its “primary purpose,” as long as it has at least one other “substantial business purpose” unrelated to that, and provides that this requirement is satisfied if the association “would be a viable entity in the absence of sponsoring [the AHP].”

- It extends the requirement that the association not be owned or controlled by a health insurance issuer to include a subsidiary or affiliate of a health insurance issuer.

- It adds three examples of when distinctions between types of employees and employers will not violate the requirement not to discriminate with respect to benefits or contributions based on a health factor, including agriculture and industry subsectors, occupations as cashier, stockers or sales associates, and part-time versus full-time status.

- It eliminates the requirement that a “working owner” not be eligible to participate in a subsidized group health plan maintained by another employer of the owner or the own-
er’s spouse, and reduces the work requirement from 30 hours per week or 120 hours per month to 20 hours per week or 80 hours per month.

- It adds a severability provision stating that if any provisions in the regulation are found to be invalid or stayed pending further agency action, the remaining portions of the rule will remain operative.

- It phases in the regulation’s effective date, so that it applies (1) on September 1, 2018, for fully insured AHPs, (2) on January 1, 2019, for non-fully insured AHPs that were in existence on June 21, 2018, and (3) on April 1, 2019, for non-fully insured AHPs formed after June 21, 2018.

The preamble rejects the criticism that the regulation “conflicts with the text of the ACA by allowing small employers and individuals, who are not subject to the employer shared responsibility provisions under section 4980H of the Code and who were supposed to be purchasing insurance coverage that is subject to the essential health benefits (‘EHB’) requirements, to band together to obtain health insurance that does not comply with all the ACA insurance rules applicable to small group market insurance.” However it does not dispute that the regulation makes this easier, explaining that the regulation “is intended to facilitate the creation and maintenance of AHPs to offer more affordable health insurance to small businesses, including working owners.”

The regulation slightly revises the requirement that the activities of the association be “controlled by its employer members,” and that employer members that participate in the AHP “control the plan.” The preamble states that the revised text “is intended to better align the control test . . . with the Department’s pre-rule guidance under ERISA section 3(5), including the requirement that control exist in form and substance.” It goes on to explain that:

the Department will consider all relevant facts and circumstances in determining whether the functions and activities of the group or association are sufficiently controlled by its employer members, and whether the employer members who participate in the group or association’s group health plan sufficiently control the group health plan. In the Department’s view, the following factors, although not exclusive, are particularly relevant for this analysis: 1) whether employer members regularly nominate and elect directors, officers, trustees, or other similar persons that constitute the governing body or authority of the employer group or association and plan; 2) whether employer members have authority to remove any such director, officer, trustee, or other similar person with or without cause; and 3) whether employer members that participate in the plan have the authority and opportunity to approve or veto decisions or activities which relate to the formation, design, amendment, and termination of the plan, for example, material amendments to the plan, including changes in coverage, benefits, and premiums. The Department ordinarily will consider sufficient control to be established if these three conditions are met.

Presumably, because it is intended to align with the DOL’s pre-rule guidance, this summary also applies to AHPs that do not rely on the regulation.
The preamble rejects the criticism that the regulation impermissibly allows a plan with no common law employees (i.e., that covers only working owners) to be treated as an employee benefit plan under ERISA and a group health plan under the ACA. It claims that Nationwide Mutual Insurance Co. v. Darden, 503 U.S. 318 (1992) (holding that when Congress uses “employee” in a statute without including a helpful definition of the term, it should be presumed to have intended to refer to “the conventional master-servant relationship as understood by common-law agency doctrine”), does not prohibit treating a working owner as an employee under ERISA because “[t]he Darden Court did not address the validity of an agency rule promulgated after notice and comment defining ‘employer’ or ‘employee’ under ERISA.” It states that 29 C.F.R. § 2510.3-3 (excluding “plans without employees” from ERISA) does not prohibit covering a plan with no common law employees under ERISA, and also cites Yates v. Hendon, 541 U.S. 1 (2004), in support of the result, even though Yates states that “[p]lans that cover only sole owners or partners and their spouses, [29 C.F.R. § 2510.3-3] instructs, fall outside Title I’s domain. Plans covering working owners and their nonowner employees, on the other hand, fall entirely within ERISA’s compass.” The potential vulnerability of this portion of the regulation might have inspired the new severability provision: in explaining that provision, the preamble notes that, “[f]or example, a ruling by a federal court that the ‘working owners’ provision in section 2510.3-5(e) is void will not impact the ability of an employer group or association to meet the ‘commonality of interest’ requirement in section 2510.3-5(c) by being located in the same geographic locale.”

The preamble acknowledges that the regulation “does not modify or otherwise limit existing State authority as established under section 514 of ERISA” to regulate AHPs. However, it warns somewhat ominously that “ERISA section 514(b)(6) provides a potential future mechanism for preempting state insurance laws that go too far in regulating non-fully-insured AHPs in ways that interfere with the important policy goals advanced by this final rule.”

2. DOL Advisory Opinions

DOL Adv. Op. 2018-01A (Nov. 5, 2018) concluded that Retirement Clearinghouse, LLC is a fiduciary with respect to certain aspects of its administration of the RCH Auto Portability Program, a program “designed to help employees who may have multiple job changes over their career consolidate small accounts held in a prior employer’s individual account plan and rollover IRA into a new employer’s 401(k) or other defined contribution individual account plan.”

3. DOL Proposed Regulations and Requests for Comments

83 Fed. Reg. 614 (Jan. 5, 2018) contains a proposed regulation that would add a new 29 C.F.R. § 2510.3-5 and make a related amendment to 29 C.F.R. § 2510.3-3(c). New 29 C.F.R. § 2510.3-5 would define “a bona fide group or association of employers” that qualifies as an “employer” within the meaning of ERISA § 3(5) and thus is “capable of establishing a group health plan that is an employee welfare benefit plan,” i.e., a single plan rather than a collection of separate plans. The regulation would expand that definition consistent with Executive Order 13813, Promoting Healthcare Choice and Competition Across the United States, 82 Fed. Reg. 48385 (Oct. 17, 2017), which instructed the DOL to “consider proposing regulations or revising guidance, consistent with law, to expand access to health coverage by allowing more employers to form AHPs [i.e., association health plans],” including by “expanding the conditions that satisfy the
commonality-of-interest requirements under current Department of Labor advisory opinions.” In particular, in a significant departure from prior DOL guidance, it would allow the association to exist for the sole purpose of sponsoring a group health plan for its employer members, and expand “commonality of interest” to include employers that are (1) in the same trade, industry, line of business, or profession or (2) have a principal place of business within a region that does not exceed the boundaries of the same State or the same metropolitan area, such as the New York City and Washington, D.C. metropolitan areas. According to the preamble, other restrictions in the proposed regulation are expected to be enough to prevent it from extending to “commercial-insurance-type arrangements that lack the requisite connection to the employment relationship.” It would prohibit the association from conditioning membership of an employer based on any health factors of the employer’s employees or former employees, and would prohibit employees or former employees of different employer members from being treated as “distinct groups of similarly-situated individuals” for purposes of applying the nondiscrimination requirements under ERISA § 702. It would require each employer member participating in the plan to be a “person acting directly as an employer of one or more employees” participating in the plan, but it would treat a “working owner” of a trade or business to be treated as an employee for this purpose. A “working owner” would be a sole proprietor or partner who, among other things (1) is earning wages or self-employment income from the trade or business and (2) either works at least 30 hours per week or 120 hours per month providing personal services to the trade or business, or has earned income from the trade or business that at least equals the working owner’s cost of coverage under the plan. The preamble states that therefore a plan could be “comprised of only working owners,” although it is not clear whether the DOL believes that such a plan would be subject to ERISA. The preamble states that these requirements were included because, without them, “the regulation could effectively eliminate the statutory distinction between offering and maintaining employment-based ERISA-covered plans, on the one hand, and the mere marketing of insurance to individuals outside the employment context, on the other.” The regulation also would require the association to meet certain organizational requirements, which the preamble says “largely duplicate conditions in the Department’s existing sub-regulatory guidance under ERISA section 3(5),” including that “the establishment and maintenance of the group health plan, are controlled by its employer members, either directly or indirectly through the regular nomination and election of directors, officers, or other similar representatives that control the group or association and the establishment and maintenance of the plan.” The regulation would apply solely to association health plans (AHPs), and the preamble states that it does not apply “in any context other than as applied to an employer group or association sponsoring an AHP.” Citing 2011 CMS guidance, the preamble states that if an association qualifies as an “employer” under the regulation, then whether the coverage it offers is subject to the small group market or the large group market rules in the PHSA added by HIPAA and the ACA is determined at the association rather than the employer level, i.e., based on the number of employees employed by all of the employers participating in the association. Therefore, coverage offered by an association that qualifies under the regulation would be likely to be subject to the less restrictive large group market rules. AHPs would continue to be MEWAs, but if they were fully insured they would be subject to limited state regulation under ERISA § 514(b)(6)(A)(i).

83 Fed. Reg. 53534 (Oct. 23, 2018) contains a proposed regulation that would add a new 29 C.F.R. § 2510.3-55 and make a related amendment to 29 C.F.R. § 2510.3-3(c). New 29 C.F.R. § 2510.3-55 would define “a bona fide group or association of employers” that “may act as an
‘employer’ within the meaning of section 3(5) of [ERISA] in sponsoring a multiple employer defined contribution pension plan,” i.e., maintain a single DC plan rather than a collection of separate DC plans. The regulation would expand the definition consistent with Executive Order 13847, Strengthening Retirement Security in America (Aug. 31, 2018), 83 Fed. Reg. 45321 (Sept. 6, 2018), which instructed the DOL to “examine policies that would . . . clarify and expand the circumstances under which United States employers, especially small and mid-sized businesses, may sponsor or adopt a MEP as a workplace retirement option for their employees, subject to appropriate safeguards.” (Although the regulation actually was in final form by the time the Executive Order was issued.) In a significant departure from prior DOL guidance, it would allow the association to exist for the “primary purpose” of providing a MEP coverage to its members and their employees, as long as it had “at least one substantial business purpose” unrelated to providing the MEP; this could be satisfied by showing that the association “would be a viable entity in the absence of sponsoring an employee benefit plan.” It also would expand “commonality of interest” to include employers that are (1) in the same trade, industry, line of business, or profession or (2) have a principal place of business within a region that does not exceed the boundaries of a single state or metropolitan area, such as the New York City or Washington, D.C. metropolitan area. It would require each employer member participating in the plan to be a “person acting directly as an employer of one or more employees” participating in the plan, but it would allow a “working owner” of a trade or business to be treated as an employee for this purpose. A “working owner” would be a sole proprietor or partner who, among other things (1) is earning wages or self-employment income from the trade or business and (2) either works at least 20 hours per week or 80 hours per month providing personal services to the trade or business, or has earned income from the trade or business that at least equals the working owner’s cost of coverage under “any group health plan sponsored by the group or association in which the individual is participating or is eligible to participate.” (The drafters might have meant the cost of coverage under the MEP.) The regulation would require the association to meet certain organizational requirements, which are meant to duplicate conditions in the DOL’s existing guidance. Also would allow a “bona fide PEO” to maintain a MEP as long as certain requirements were satisfied; fewer requirements would have to be satisfied if the PEO was a “certified professional employer organization” meeting the requirements of Code § 7705(a). The regulation would “replace and supersede criteria in prior subregulatory guidance.” However, it would apply only to DC plans because, according to the preamble, DB plans “raise different policy considerations,” and sponsorship of MEPs is trending away from DB plans anyway. The regulation would not cover “corporate MEPs” or “open MEPs,” but the preamble invites comments on whether the DOL should address them “by regulation or otherwise.”

4. Other DOL Guidance

EBSA News Release (Jan. 5, 2018) announces that the DOL is sticking with its 90-day delay – from January 1, 2018, through April 1, 2018 – of the applicability date of the final regulations (81 Fed. Reg. 92316 (Dec. 19, 2016)) containing new requirements for processing disability claims modeled after the procedural protections for health care claimants in the ACA. The delay through April 1, 2018, is at 82 Fed. Reg. 56560 (Nov. 29, 2017).

On January 5, 2017, the Wage and Hour Division of the DOL issued a news release stating that “On Dec. 19, 2017, the U.S. Court of Appeals for the Ninth Circuit [in Benjamin v. B & H
On January 8, 2018, the Wage and Hour Division of the DOL reissued 17 opinion letters on various FLSA issues that were issued by acting Wage and Hour Division Administrator Pas- santino in January 2009, at the end of the George W. Bush administration, but withdrawn on March 2, 2009, at the beginning of the Obama administration.

In January 2018 the DOL Wage and Hour Division added a note at the end of Fact Sheet #17B: Exemption for Executive Employees Under the Fair Labor Standards Act (FLSA) stating that it is undertaking rulemaking to revise its overtime rules. Those rules were amended by the Obama Administration to include a requirement that management employees be paid at least $100,000 per year, see 81 Fed. Reg. 32391 (May 23, 2016), but a nationwide injunction prohibiting the enforcement of those amendments was issued in Nevada v. United States Department of Labor, 218 F. Supp. 3d 520 (E.D. Tex., Nov. 22, 2016), which the DOL is appealing. The Fact Sheet states that “Until the Department issues its final rule, it will enforce the part 541 regulations in effect on November 30, 2016, including the $455 per week standard salary level.”

Notice, 83 Fed. Reg. 12596 (March 22, 2018), notifies interested persons of the pendency of Application No. D-11949, which would allow certain affiliates of BNP Paribas to continue to act as QPAMs under PTCE 84-14 for a one-year period notwithstanding BNP Paribas USA’s expected criminal conviction for misconduct relating to its FX operations.

On April 23, 2018, the DOL issued lengthy and significant set of proposed FAQs (labeled Part 39) on MHPAEA implementation. Among other things:

- Q&A-2 concludes that the MHPAEA prohibits a plan from denying all claims for ABA therapy under the rationale that the treatment is experimental or investigative, where the plan document say that both medical/surgical and MH/SUD services will be denied as experimental only “when no professionally recognized treatment guidelines define clinically appropriate standards of care for the condition, and fewer than two randomized controlled trials are available to support the treatment’s use with respect to the condition,” and “[m]ore than one professionally recognized treatment guideline and more than two controlled randomized trials support the use of Applied Behavioral Analysis (ABA) therapy to treat certain children with Autism Spectrum Disorder.”

- Q&A-3 concludes that the MHPAEA prohibits a plan from denying all benefits for MH/SUD treatment that have a rating of “C” or below in the Hayes Medical Technology Directory, where the plan document says that both medical/surgical and MH/SUD services will be denied as experimental or investigative only if they have a rating below “B”
in the Hayes Medical Technology Directory, and “the plan reviews and covers certain treatments for medical/surgical [but not MH/SUD] conditions that have a rating of ‘C’ on a treatment-by-treatment basis.”

- Q&A-4 concludes that the MHPAEA prohibits a plan from setting the dosage limit for buprenorphine to treat opioid use disorder below what professionally-recognized treatment guidelines generally recommend, while not setting the dosage limit for medical/surgical benefits below that level. It explains that the deviation might be acceptable if it is based on recommendations from a Pharmacy and Therapeutics (P&T) committee, but in that case “this deviation should be evaluated for compliance with MHPAEA’s NQTL requirements (for instance, by determining (1) whether the expertise of the members of the P&T committee in MH/SUD conditions is comparable to their expertise in medical/surgical conditions, and (2) by determining the whether the committees’ evaluation of nationally-recognized treatment guidelines in setting dosage limits for medications for both MH/SUD and medical/surgical conditions is comparable).”

- Q&A-5 concludes that the MHPAEA does not prohibit a plan from having a general exclusion for items and services to treat bipolar disorder, including prescription drugs, because “[a]n exclusion of all benefits for a particular condition or disorder . . . is not a treatment limitation for purposes of the definition of ‘treatment limitations’ in the MHPAEA regulations.”

They were accompanied by (1) the DOL’s 2018 Report to Congress entitled Pathway to Full Parity, (2) a FY 2017 MHPAEA Enforcement Fact Sheet, (3) a 2018 MHPAEA Self-Compliance Tool, (4) a Revised Draft MHPAEA Disclosure Template, and (5) an HHS Action Plan.

Field Assistance Bulletin 2018-01 (April 23, 2018) states that “provides guidance to [EBSA’s] national and regional offices to assist in addressing questions they may receive from plan fiduciaries and other interested stakeholders about Interpretive Bulletin 2016-01 (relating to the exercise of shareholder rights and written statements of investment policy), and Interpretive Bulletin 2015-01 (relating to ‘economically targeted investments’ (ETIs)).” Regarding Interpretive Bulletin 2015-01, it warns against “too readily treat[ing] ESG factors as economically relevant to the particular investment choices at issue when making a decision,” and said that while “a prudently selected, well managed, and properly diversified ESG-themed investment alternative [may] be added to the available investment options on a 401(k) plan platform” even if it might not be justified on purely economic grounds, “[n]othing in the QDIA regulation suggests that fiduciaries should choose QDIAs based on collateral public policy goals.” Regarding Interpretive Bulletin 2016-01, it states that investment policy statements need not contain guidelines on ESG investments and that, if they do, fiduciaries need not follow them if they are not consistent with ERISA. It also warns against “routinely incur[ring] significant expenses to engage in direct negotiations with the board or management of publicly held companies with respect to which the plan is just one of many investors . . . [or] fund[ing] advocacy, press, or mailing campaigns on shareholder resolutions, call[ing] special shareholder meetings, or initi- at[ing] or actively sponsor[ing] proxy fights on environmental or social issues relating to such companies.” One commenter noted that “[t]he way they distinguish between investment options in the guidance is overly simplistic” because “ESG factors for many investors are considered important financial considerations.” Another noted that “FAB 2018-01 would have been shorter
and had fewer questionable interpretations of what was intended by prior DOL guidance had it indicated that it had changed its position on these issues.”

Brief for the Secretary of Labor as amicus curiae in Rudel v. Hawaii Management Alliance Assoc., No. 17-17395 (9th Cir., filed April 16, 2018), urges the Ninth Circuit to affirm the lower court’s decision that while Hawaii state subrogation law was completely preempted, providing the court with jurisdiction, it was saved from express preemption as a law regulating insurance and, under Unum Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999), served as the rule of decision in the case, effectively becoming terms of plan.

Field Assistance Bulletin 2018-02 (May 7, 2018) extends the temporary enforcement policy announced in Field Assistance Bulletin 2017-02 (May 22, 2017) for the DOL fiduciary rule “until after regulations or exemptions or other administrative guidance has been issued” to reflect U.S. Chamber of Commerce v. DOL, 885 F.3d 360 (5th Cir. 2018). It notes that “The Treasury Department and the IRS have confirmed that, for purposes of applying IRS Announcement 2017-4, this FAB 2018-02 constitutes ‘other subsequent related enforcement guidance’.”

A BLS news release dated June 7, 2018, reported that “[u]sing three different measures, contingent workers accounted for 1.3 percent to 3.8 percent of total employment in May 2017,” and that “[i]n February 2005, the last time the survey was conducted, all three measures were higher, ranging from 1.8 percent to 4.1 percent of employment.” It also reported that in May 2017 “there were 10.6 million independent contractors (6.9 percent of total employment), 2.6 million on-call workers (1.7 percent of total employment), 1.4 million temporary help agency workers (0.9 percent of total employment), and 933,000 workers provided by contract firms (0.6 percent of total employment),” and that “[c]ompared with February 2005 (the last time the survey was conducted), the proportion of the employed who were independent contractors was lower in May 2017, while the proportions employed in the other three alternative arrangements were little different.” These findings (particularly the reduction in the percentages) are at odds with those in a 2016 study by economists Larry Katz of Harvard and Alan Krueger of Princeton.

Field Assistance Bulletin 2018-04 (July 13, 2018) provides guidance for agents to use in determining whether home care providers, such as nurses and health aides, are employees for purposes of FLSA of home care “registries,” which connect them with people who need their services. It states that “WHD will consider the totality of the circumstances to evaluate whether an employment relationship exists between a registry and a caregiver.”


The DOL has posted new model notices that employers can provide to satisfy FLSA § 18B, as added by the ACA, to its web site.

On August 28, 2018, the Wage and Hour Division of the DOL issued six opinion letters on various FLSA and FMLA issues, including whether FMLA leave may be taken for donating an
organ (yes) and whether employees need to be compensated for time spent on “wellness activities” (no).

EBSA News Release (Nov. 15, 2018) announces the release of advance informational copies of the 2018 Form 5500 and summarizes the key changes from the 2017 form.

C. PBGC GUIDANCE

1. PBGC Temporary and Final Regulations

83 Fed. Reg. 1555 (Jan. 12, 2018) contains final rules that increase various civil monetary penalties (CMPs) under laws administered by the PBGC.

83 Fed. Reg. 46642 (Sept. 14, 2018), contains a final regulation implementing MPRA § 121, which gave the PBGC express authority to promote and facilitate merger of multiemployer plans if the action is in the interests of participants and beneficiaries of at least one of the plans and is not detrimental to any of the participants and beneficiaries involved. PBGC adopted a few changes in the final regulation in response to comments, but the regulation is substantially similar to what was proposed in 2016 (81 Fed. Reg. 36229 (June 6, 2016)), except that it does not include the proposed changes related to plan solvency.

83 Fed. Reg. 49799 (Oct. 10, 2018), finalizes with only one substantive change the proposed regulations issued earlier this year (83 Fed. Reg. 9716 (March 7, 2018)) amending the PBGC’s benefit payment regulation by replacing the guarantee limitations applicable to “substantial owners” with a new limitation applicable to “majority owners” to reflect statutory changes made by PPA 2006, and making other related changes.

2. PBGC Proposed Regulations and Requests for Comments

83 Fed. Reg. 9716 (March 7, 2018), contains proposed regulations that would amend the PBGC’s benefit payment regulation by replacing the guarantee limitations applicable to “substantial owners” with a new limitation applicable to “majority owners,” to reflect statutory changes made by PPA 2006.

83 Fed. Reg. 32815 (July 16, 2018) contains a PBGC proposed rule that would amend 29 C.F.R. §§ 4041A.2, 4041A.11-4041A.12, 4041A.23-4041A.25, 4245.1-4245.8, 4281.2-4281.3, 4281.11, 4281.13, and 4281.43-4281.47, and remove and reserve 29 C.F.R. § 4281.14, to allow smaller plans terminated by mass withdrawal to perform actuarial valuations less frequently and remove certain notice requirements for insolvent plans.

3. Other PBGC Guidance

Notice, 83 Fed. Reg. 14524 (April 4, 2018), contains a PBGC policy statement describing the process it uses to review a multiemployer plan’s proposal to adopt alternative payment amounts and terms and conditions to satisfy withdrawal liability under ERISA § 4224, and the information the PBGC finds helpful in doing so. It notes that “[a]lthough not required, plan trustees have sought assurance from PBGC that such alternative terms and conditions under section 4224 of ERISA are consistent with Title IV.”
Notice, 83 Fed. Reg. 26312 (June 6, 2018), announces that the PBGC has received a request from Marlins Holdings LLC for an exemption from the bond/escrow and contract requirements of ERISA § 4204 that otherwise would have to be met in order to avoid withdrawal liability under the Major League Baseball Players Benefit Plan on account of its purchase of the Miami Marlins from Miami Marlins, L.P., and asks for comments on the submission.

83 Fed. Reg. 30991 (June 2, 2018) contains a Disaster Relief Announcement stating that the PBGC will henceforth tie its disaster relief directly to any relief issued by the IRS, eliminating any need for the PBGC to issue separate announcements, subject to certain exceptions listed in the Announcement.

Notice, 83 Fed. Reg. 55915 (Nov. 8, 2018), announces that the PBGC has approved a request from Marlins Holdings LLC for an exemption from the bond/escrow and contract requirements of ERISA § 4204 that otherwise would have to be met in order to avoid withdrawal liability under the Major League Baseball Players Benefit Plan on account of its purchase of the Miami Marlins from Miami Marlins, L.P.

Notice, 83 Fed. Reg. 62629 (Dec. 4, 2018), states that the PBGC intends to request OMB approval of a form and instructions to be used when submitting a coverage determination request. It notes that coverage determinations are most often requested for church plans (ERISA § 4021(b)(3)), plans exclusively for substantial owners (ERISA § 4021(b)(9)), plans covering no more than 25 active participants (ERISA § 4021(b)(13)), and Puerto Rico plans (ERISA § 1022(i)(1)), and that the form would highlight these types of plans.

83 Fed. Reg. 67073 (Dec. 28, 2018) contains final rules that increase various civil monetary penalties (CMPs) under laws administered by the PBGC.

D. SEC, FASB AND SECURITIES EXCHANGE GUIDANCE

1. SEC, FASB, ISS and Securities Exchange Temporary and Final Rules

SEC Release No. IA-4839, Exemptions From Investment Adviser Registration for Advisers to Small Business Investment Companies, 83 Fed. Reg. 1396 (Jan. 11, 2018), implements a provision of the FAST Act which amended the exemption from investment adviser registration for any adviser solely to “private funds” with less than $150 million in assets under management by excluding the assets of SBICs when calculating “private fund assets” towards the $150 million limit.

83 Fed. Reg. 1396 (Jan. 26, 2018) contains final rules that increase various civil monetary penalties (CMPs) under laws administered by the SEC.

FASB Accounting Standards Update (ASU) No. 2018-07, Compensation—Stock Compensation (Topic 718): Improvements to Nonemployee Share-Based Payment Accounting (July 2018), expands the scope of FASB Accounting Standards Codification (ASC) Topic 718 (Topic 718) to include stock compensation granted to nonemployees. For public companies, ASU 2018-07 is effective for annual reporting periods beginning after December 15, 2018, and interim periods within that fiscal year (that is, 2019 financial statements for calendar year companies). For nonpublic companies, ASU 2018-07 is effective for annual reporting periods beginning after
December 15, 2019 (that is, 2020 financial statements for calendar year companies), and interim periods within fiscal years beginning after December 15, 2020 (that is, 2021 quarterly statements for calendar year companies). Early adoption is permitted, but no earlier than a company’s adoption of ASC Topic 606. FASB Accounting Standards Update (ASU) No. 2018-09, Codification Improvements (July 2018), also explains that differences between tax deductions for share-based payment arrangements and expenses recorded in financial statements are recognized in the period in which the amount of the tax deduction is determined.

83 Fed. Reg. 34940 (July 24, 2018), contains an amendment to 15 C.F.R. § 230.701 to reflect the Economic Growth, Regulatory Relief, and Consumer Protection Act, which directed the SEC to increase, from $5 million to $10 million, the amount of securities that a company can issue to employees and other service providers in reliance on Rule 701 in any consecutive 12-month period without triggering enhanced disclosure obligations. The preamble says that the rule is effective July 23, 2018. However, it also says the rule is “effective immediately upon publication in the Federal Register,” which was one day later.

2.SEC, FASB, ISS and Securities Exchange Proposed Rules and Requests for Comments

On April 18, 2018, the SEC adopted several proposed rules which would partially take the place of the DOL fiduciary rule. They were published in May in the Federal Register:

• Rel. 34-83062, Regulation Best Interest, 83 Fed. Reg. 21574 (May 9, 2018), would add a new 17 C.F.R. § 240.15l-1 and revise 17 C.F.R. §§ 240.17a-3 and 240.17a-4 establishing a standard of conduct for broker-dealers and natural persons who are associated persons of a broker-dealer when making a recommendation of any securities transaction or investment strategy involving securities to a retail customer. The regulation would not include a fiduciary standard for brokers, or define what “best interest” is with regard to the standards brokers must uphold when selling products and services to customers.

• IA-4889, Proposed Commission Interpretation Regarding Standard of Conduct for Investment Advisers; Request for Comment on Enhancing Investment Adviser Regulation, 83 Fed. Reg. 21203 (May 9, 2018), contains a proposed interpretation of the standard of conduct for advisers under the Investment Advisers Act of 1940.

• Rel. 34-83063 and IA-4888, Required Disclosures in Retail Communications and Restrictions on the Use of Certain Names or Titles, 83 Fed. Reg. 21416 (May 9, 2018), would add or revise various regulations to require registered investment advisers and registered broker-dealers to provide a brief relationship summary to retail investors to inform them about the relationships and services the firm offers, the standard of conduct and the fees and costs associated with those services, specified conflicts of interest, and whether the firm and its financial professionals currently have reportable legal or disciplinary events.
3. Other SEC, FASB, ISS and Securities Exchange Guidance

In Rels. Nos. 83581 and 3947, and File No. 3-18570 (July 2, 2018), the SEC accepted an offer from Dow Chemical Company to settle a cease-and-desist order relating to Dow’s failure to report approximately $3 million in executive perquisites consisting of “personal use of Dow aircraft and other expenses” in its proxies. Among other things, Dow agreed to pay a civil money penalty of $1.75 million. The order noted that under Release Nos. 33-8732A & 34-54302A, 71 Fed. Reg. 53158 (Sept. 8, 2006), an item escapes treatment as a perquisite or personal benefit only if it is “integrated and directly related to the performance of the executive’s duties,” but “Dow incorrectly applied a standard whereby a business purpose related to the executive’s job was sufficient to determine that a benefit would not be a perquisite that required disclosure,” which was a standard the SEC “considered, but ultimately decided not to adopt,” in those releases.

SEC Release No. 33-10521, 83 Fed. Reg. 34958 (July 24, 2018), contains a concept release soliciting comments on “possible ways to modernize [Rule 701] and the relationship between it and Form S-8, consistent with investor protection.”

On November 21, 2018, ISS released a preliminary set of FAQs relating to compensation matters for shareholder meetings occurring on or after February 1, 2019.

E. LEGISLATION

President Trump signed H.R. 195 into law on January 23, 2018, as Pub. L. No. 115-120. Section 4002 amends ACA § 9001 to delay the effective date of the Cadillac tax imposed by Code § 4980I for two years, to years beginning after December 31, 2021. Section 4003 amends ACA § 9010 to suspend the health insurance provider fee imposed by that section in 2019. The JCT scored the Cadillac tax delay as costing $14.8 billion over 10 years and the health insurance provider fee suspension as costing $12.7 billion.

President Trump signed H.R.1892, the Bipartisan Budget Act of 2018 (“BBA 2018”), into law on February 9, 2018, as Pub. L. No. 115-123.

- Section 20102 provides relief for individuals impacted by the 2017 California wildfires. It exempts a distribution of up to $100,000 that is made between October 8, 2017, and January 1, 2019, to a participant who lives in a California wildfire disaster area from the 10% tax imposed by Code § 72(t), and allows the distribution to be included in income ratably over a three-year period or, alternatively, recontributed to the plan and treated as an eligible rollover contribution. It also allows a withdrawal to purchase a home in a California wildfire disaster area to be recontributed to the plan and treated as an eligible rollover contribution, and increases the maximum amount of a plan loan for a participant who lives in such an area to $100,000 and allows loan repayments to be delayed for a one-year period.

- Sections 30421-24 create a bipartisan joint select committee to address solvency issues for multiemployer plans and the PBGC, require it to provide legislative language by No-
November 30, 2018, and provide special streamlined procedures for approving that legislation.

- Section 41109 exempts colleges and universities that charge no tuition from the excise tax on investment income that was added by TCJA § 13701, which was included in the TCJA by Senate Minority Leader McConnell (R-Ky) but deleted at the last minute because it violated the Byrd rule.

- Section 41104 allows an amount paid from a retirement plan under an improper levy by the IRS in tax years beginning after December 31, 2017, to be recontributed to the plan and treated as an eligible rollover contribution. Plans are not required to be amended to allow such recontributions.

- Section 41106 requires the IRS to create a Form 1040SR for individuals over age 65 that will be similar to Form 1040EZ but will be available even if the individuals receive certain income, including distributions from qualified plans.

- Section 41113 directs the IRS to eliminate, by February 9, 2019, the regulations requiring a participant who receives a hardship withdrawal to be suspended from making elective contributions for six months under certain circumstances.

- Section 41114 adds a new Code § 401(k)(14) allowing hardship distributions to include elective deferrals (plus earnings) to profit sharing or stock bonus plans, qualified matching contributions (plus earnings) and qualified nonelective contributions (plus earnings), and providing that a distribution will not be treated as not being on account of hardship merely because the participant has not obtained a loan available under the plan.

President Trump signed H.R. 1625, the Consolidated Appropriations Act, 2018, into law on March 23, 2018, as Pub. L. No. 115-141. Among other things:

- Section 101 of Division T (Revenue Provisions) of the Act amends Code § 199A as it relates to cooperatives.

- Section 101(a) of Title I (Tax Technical Corrections) of Division U (also called the “Tax Technical Corrections Act of 2018”) of the Act makes a technical change to Code § 132(f)(6)(A).

- Section 401(a) of Title IV (Clerical Corrections and Deadwood) of Division U makes technical changes to Code §§ 105(h)(7)(B); 125(e)(2); 132(c)(4); 219(f)(1) and (g)(8); 223(c)(2)(C) and (d)(2)(A); 401(a)(2), (a)(15), (a)(32)(A) and (c)(2)(A)(iii); 402(i); 404A(c)(4)(B); 408(a)(1) and (m)(3)(B); 408A(d)(3)(B) and (e)(2)(B); 409(n)(1)(A)(i); 409A(b)(3)(B)(i); 411(a)(4)(A); 412(c)(1)(A), (c)(4)(B) and (c)(7)(B)(iii); 413(b)(6); 414(I)(2)(G), (u)(6), (x)(1), (y)(1)(C)(i) and 414(y)(2); 418E(d)(1) and (e)(1)(A); 419A(c)(6)(B); 420(c)(1)(A); 424(g); 430(c)(7)(E)(v)(II) and (h)(2)(F); 431(d)(2)(B)(i); 432(b)(3)(A)(i), (b)(3)(B), (b)(3)(D)(iv), (e)(8)(C)(iii), (f)(3) and (g)(1); 433(c)(5)(C)(ii)(II); 457(f)(4)(C)(i); 457A(d)(4); 529(c)(6) and (e)(3)(A); 529A(d)(4) and (e)(4); 3101(a); 3111(e)(5)(B); 3121(b)(5)(B)(i)(V) and (b)(5)(H)(i); 3304(a)(4)(G)(ii); 3306(b)(5)(F) and (c)(19); 3306(u) and (v); 3309(d); 3401(a); 4971(b), (c)(3), (f) and (g)(4)(C)(ii); 4975(d)(3), (d)(17), (d)(21), (f)(8)(C)(iv)(II), (f)(8)(F)(i)(I) and
(f)(8)(F)(i)(V); 4980B(f)(1) and (f)(5)(C)(iii); 4980I(b)(3)(C)(iv) and (b)(3)(C)(v); and 6039(d)(2).

- Section 401(b) of Title IV makes further technical changes to Code §§ 411(a)(3)(F)(i); 415(g); 419(e)(3)(A); and 419A(g)(1) and (g)(2).

President Trump signed S. 2155, the Economic Growth, Regulatory Relief, and Consumer Protection Act, into law on May 24, 2018, as Pub. L. No. 115-174. Among other things, it directs the SEC to increase, from $5 million to $10 million, the amount of securities that a company can issue to employees and other service providers in reliance on Rule 701 of the Securities Act in any consecutive 12-month period without triggering enhanced disclosure obligations.

President Trump signed H.R. 6, The Support for Patients and Communities Act, into law on October 24, 2018, as Pub. L. No. 115-271. Section 4002 extends the Medicare secondary payer mandatory reporting provisions in SSA § 1862(b)(7)(A) (added by MMSEA § 111) after 2019 to situations where the group health plan is a primary payer with respect to prescription drug coverage under Part D. Section 4003 creates a new exception from the individual mandate penalty in Code § 5000A (even though that penalty is now $0) for “a member of a religious sect or division thereof which is not described in [Code §] 1402(g)(1), who relies solely on a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with the religious beliefs of the individual.”

Staff of the Joint Committee on Tax’n, 109th Cong., General Explanation of Public Law 115-97 (Comm. Print 2018) (JCS-1-18), is the JCT staff’s “Blue Book” for the TCJA. Among other things:

- It confirms that “[n]otwithstanding the temporary repeal of miscellaneous itemized deductions [by TCJA § 11046], working condition fringes continue to be excluded under section 132(d).”

- It takes a narrower view than the IRS and Treasury Department in Notice 2018-76, 2018-42 I.R.B. 599, on the disallowance of deductions by Code § 274, as amended by TCJA § 13304, for business meals consumed during entertainment events for entertainment expenses, stating that “[w]hen a meal is included in an activity or event with a client that primarily constitutes entertainment, the provision disallows the deduction for the entire activity or event including the meal. For example, food or beverages consumed during a theatre or sporting event would be nondeductible under this rule because the activity or event is primarily entertainment.”

- It agrees with the IRS and Treasury Department in Notice 2018-99, 2018-52 I.R.B. 1067, that (1) the disallowance of deductions and related inclusion in UBTI under Code § 512(a)(7), as added by TCJA § 13703, for qualified transportation fringes relates to the cost of providing the fringes rather than the value of the fringes, (2) the exception in Code § 274(e)(2) for expenses treated as compensation applies to qualified transportation fringes, and (3) on-premises athletic facilities are not subject to Code § 512(a)(7) even though they are specifically mentioned in that section, but disagrees with Notice 2018-99 in stating that the costs of a parking facility include depreciation. However, it also notes that “[a] technical correction may be needed to reflect [the drafters’] intent” that “[t]he determination of unrelated business taxable income associated with providing qualified
transportation fringes, including parking facilities used in connection with qualified parking, [should] be consistent with the determination of the deduction disallowance under section 274.”

• It states that the disallowance of deductions for any settlement or payment related to sexual harassment or sexual abuse under by Code § 162, as amended by TCJA § 13307, does not apply to attorney’s fees “incurred by the beneficiary of the settlement or recipient of the payment,” but acknowledges that “[a] technical correction may be necessary to reflect this intent.”

• It states that the definition of a related person for purposes of the definition of an “applicable partnership interest” in Code § 1061(c)(1), as added by TCJA § 13309, “means a related person within the meaning of section 267(b) or 707(b),” but acknowledges that “[a] technical correction may be necessary to reflect this intent.”

• It states that the compensation used for purposes of determining who is a “covered employee” for purposes of Code § 4960, as added by TCJA § 13602, (1) “is intended to be expansive to most accurately determine the five highest compensated employees, and includes compensation from disregarded entities,” as well as “compensation directly or indirectly paid to an employee by any related person or governmental entity,” and that it (2) does not include “remuneration paid to a licensed medical professional that is directly related to the performance of medical or veterinary services,” and therefore does not include remuneration for “services that are not direct medical services (such as teaching, research, or acting as dean, officer, or board member of a hospital).”

• It states that Code § 4960 applies to state colleges and universities, but acknowledges that “[a] technical correction may be necessary to reflect this intent.” It also states that Code § 4960 applies to short-term deferrals of compensation when they vest rather than when they are paid and implies that the same rule applies to earnings on deferred compensation.

• It states that “[a] technical correction may be necessary to reflect that the related organization rules also apply to excess parachute payments and for purposes of determining covered employees.” It also states that “[p]arachute payments include amounts contingent on separation from employment from severance and deferred compensation plans (including supplemental executive retirement plans), and do not exclude bona fide severance or separation pay plans under section 457(f) or section 409A.”

• It appears to go further than the IRS and Treasury Department in Notice 2018-67, 2018-36 I.R.B. 409, in stating that “it is intended that the Secretary consider whether it would be appropriate in certain cases to permit an organization that maintains an investment portfolio to treat multiple investment activities as one unrelated trade or business” for purposes of Code § 512(a)(6), as added by TCJA § 13702.

United States v. Woods, 571 U.S. 31, 48 (2013), states that “the Blue Book, like a law review article, may be relevant to the extent it is persuasive.”

On January 2, 2019, outgoing Chairman Kevin Brady of the Ways and Means Committee released a discussion draft of the “Tax Technical and Clerical Corrections Act,” which would make technical corrections to the TCJA, including several employee benefit provisions. On the same day, the JCT issued its “Technical Explanation of the House Ways and Means Committee Chairman’s Discussion Draft of the ‘Tax Technical and Clerical Corrections Act’” (JCX-1-19).
F. LITIGATION

Owens v. W. & S. Life Ins. Co., 717 F. App’x 412 (5th Cir., Jan. 4, 2018), held that the plaintiffs violated the forfeiture provision of the retirement plan by engaging in employment competitive with Western & Southern’s business, and therefore were not entitled to the plan’s post-retirement benefits. It held that the plaintiffs were judicially estopped from arguing that the plan is not a top hat plan.

Allied Constr. Indus. v. City of Cincinnati, 879 F.3d 215 (6th Cir. Jan. 4, 2018), reversed the district court’s decision that three city ordinance provisions concerning bidder specifications for certain city projects were preempted by ERISA. It explained that the city was acting as a market participant in enacting the ordinances, and therefore these provisions are not preempted by ERISA.

On January 12, 2018, the Supreme Court granted certiorari in Wisconsin Central Ltd. v. United States, 856 F.3d 490 (7th Cir. 2017), which held that “compensation” subject to tax under RRTA includes gains from the exercise of nonqualified stock options because stock options are a form of cash.

Keel v. Commissioner, 115 T.C.M. (CCH) 1011(Jan. 16, 2018), unsurprisingly concluded that, because cancellation of indebtedness income is part of AGI, it must be included when calculating household income for purposes of the premium assistance tax credit in Code § 36B.

AARP v. EEOC, No. 1:16-cv-02113 (D.D.C., Jan. 19, 2018), vacated the portion of the court’s December order requiring the EEOC to propose new wellness regulations by August 30, 2018, but left in place the portion vacating the existing regulations on January 1, 2019.

Valencia v. North Star Gas Lt. Co., 291 F.3d 1155 (S.D. Cal., Jan. 23, 2018), dismissed Peoplease LLC, a payroll company, from a proposed class action alleging that one of its client companies denied workers overtime in violation of the FLSA and similar California law. It explained that the employees had not alleged facts sufficient to show that Peoplease was their employer under those laws, in that they did not allege that Peoplease could fire them, supervised their work or set their pay.

N.Y. & Presbyterian Hosp. v. United States, 881 F.3d 877 (Fed. Cir., Jan. 31, 2018), concluded that Code § 3102(b), which provides that “[e]very employer required so to deduct the [employee share of FICA] tax shall be liable for the payment of such tax, and shall be indemnified against the claims and demands of any person for the amount of any such payment made by such employer,” entitled the hospital to be reimbursed by the IRS for the cost of settling a suit brought by former medical residents attempting to get refunds for FICA tax withheld from their paychecks. The suit was settled after the district court denied the hospital’s motion to dismiss in Childers v. N.Y. & Presbyterian Hosp., 36 F. Supp. 3d 292 (S.D.N.Y. 2014). The settlement agreement self-servingly characterized the payment as “a refund for the amount of FICA taxes previously withheld by the Hospital,” even though the court denied the motion to dismiss largely because it asserted claims of fraud, breach of fiduciary duty, negligence, breach of contract and unjust enrichment which “do not arise out of the Hospital’s collection of taxes.” There was a forceful dissent.
Southpaw Credit Opportunity Master Fund, L.P. v. Roma Restaurant Holdings, Inc., 2018 WL 658734 (Del. Ch., Feb. 1, 2018), concluded that restricted stock issued to employees could not be counted in a vote on the composition of the company’s board, because the stock had been issued before the employees executed joinder forms as required by the company’s Stockholders’ Agreement.

United States v. Askins & Miller Orthopaedics, P.A., 2018 WL 740991 (M.D. Fla., Feb. 6, 2018), appeal dismissed, 2018 WL 3361601 (11th Cir., June 19, 2018), denied requests by the government for alternative injunctions against an employer from which the IRS had difficulty collecting employment taxes. One version of the injunction would have required the employer and its members “to comply with their employment tax obligations.” The other version would have required them, more specifically, to “pay over to the IRS all income and Federal Insurance Contributions Act (‘FICA’) taxes withheld from employees and Askins & Miller’s own share of FICA taxes.” Regarding the first version, the court said that “this Circuit has repeatedly ‘questioned the enforceability of obey-the-law injunctions’ in the context of securities cases and others . . . because they lack specificity and deprive defendants of the procedural protections that would ordinarily accompany a future charge,” and that therefore this version “would be unenforceable.” Regarding the second version, the court said that “while the United States makes much of its inability to collect from Defendants, that does not constitute irreparable injury under Circuit precedent or Florida law,” because “The test of the inadequacy of a remedy at law is whether a judgment could be obtained, not whether, once obtained it will be collectible [citation omitted].” By contrast, United States v. Best Rate Tree & Landscaping Inc., No. 3:17-cv-00226 (W.D.N.C., Feb. 21, 2018), granted a request by the government for an injunction against a company and its owner from which the IRS also had difficulty collecting employment taxes. The injunction required the employer to:

“1) Timely pay to the [IRS] all employment and unemployment taxes, and make all federal tax deposits as required by Law;

“2) Provide proof to the [IRS], no later than the 20th of each month that the required income and employment taxes were paid to the [IRS];

“3) Timely pay outstanding federal employment and unemployment tax liabilities due on each return required to be filed;

“4) Retain the services of an independent accountant to prepare the company’s employment and unemployment tax returns and ensure the timely filing of those returns and payment of taxes owed;

“5) Refrain from assigning any property or making any disbursements until all income and employment taxes required to be withheld from its employees’ wages are paid; and

“6) Give written notification of any future employment tax conduct with respect to any new or presently-owned interest, including notifying the Revenue Officer of any new businesses that they may come to own, manage, or work for.”

It also provided that any failure to comply “shall be deemed in contempt of this Court and may subject the Defendants to sanctions including monetary penalties and/or incarceration.” The
court explained that “[t]he United States lacks an adequate remedy at law because the Defendants have evaded the United States’ previous collection efforts” and “will suffer irreparable harm without an injunction because the Defendants’ ever-increasing federal tax liabilities of approximately $173,000 may never be collected.”

Franchina v. Providence Fire Department, No. 16-2401 (1st Cir. Jan. 25, 2018), declined to revisit Higgins v. New Balance Athletic Shoe, Inc., 194 F.3d 252 (1st Cir. 1999), “a nearly twenty year-old case in which we concluded that Title VII does not proscribe harassment based solely on one’s sexual orientation.” However, it concluded that Higgins does not “foreclose[] a plaintiff in our Circuit from bringing sex-plus claims under Title VII where, in addition to the sex-based charge, the ‘plus’ factor is the plaintiff’s status as a gay or lesbian individual.” Citing Hively v. Ivy Tech Community College of Indiana, 853 F.3d 339 (7th Cir. 2017), it also noted that “the tide may be turning when it comes to Title VII’s protections.”

CNH Industrial N.V. v. Reese, No. 17–515 (Feb. 20, 2018) (per curiam), reiterated the Supreme Court’s rejection of the Yard-Man presumption and conclusion in M & G Polymers USA, LLC v. Tackett, 135 S. Ct. 926 (2015), that ordinary contract principles should be applied in interpreting collective bargaining agreements. It agreed with the dissent that the lower court’s analysis was “Yard-Man re-born, re-built, and re-purposed for new adventures.”

Payne v. Unisys Corp., No. 0:18-cv-00493 (D. Minn., complaint filed Feb. 20, 2018), is a lawsuit claiming that Unisys discriminatorily denied an employee and her transgender partner coverage for sex reassignment treatments under its company medical plan. The complaint was filed on her behalf by Gender Justice. Similar complaints have been filed by the ACLU and other groups. At the time, the Unisys plan had an express “categorical exclusion” of gender-transition-related care.

Usenko v. SunEdison Semiconductor LLC, 2018 WL 999982 (E.D. Mo., Feb. 21, 2018), dismissed, for failure to state a claim, a class action brought by participants in a defined contribution plan alleging that the fiduciaries of the plan violated their fiduciary duties by allowing participants to continue to invest in former parent company stock despite knowing, through public information, that the stock was an imprudent investment. It said “the Court agrees with those federal courts that have found that Dudenhoef er forecloses breach of prudence claims based on public information "irrespective of whether such claims are characterized as based on alleged overvaluation or alleged riskiness of a stock."

Wheaton College v. Azar, No. 13-8910 (N.D. Ill., Feb. 22, 2018), issued a permanent injunction agreed to by the parties prohibiting the government from enforcing the contraceptive mandate – apparently even the watered-down one that applies to religious organizations – against the college on the basis that it violated RFRA.

Zarda v. Altitude Express, Inc., 883 F.3d 100 (2d Cir., Feb. 26, 2018), joined the Seventh Circuit (Hively v. Ivy Tech Community College of Indiana, 853 F.3d 339 (7th Cir. 2017)) in holding that “sexual orientation discrimination is a form of sex discrimination” under Title VII. A petition for certiorari was filed on May 29, 2018.
Public Citizen Inc. v. Trump, 297 F. Supp. 3d 6 (D.D.C., Feb. 26, 2018), dismissed a lawsuit brought by Public Citizen, Inc., the NRDC and the CWA against President Trump’s executive order requiring agencies to eliminate two regulations for every new one they issue, based on lack of standing. The court explained that “[w]ith respect to foregone or weakened regulatory actions, plaintiffs have not alleged or otherwise proffered any facts identifying specific regulatory initiatives that have been, or are likely to be, discarded or weakened as a result of the executive order.”

New Mexico Health Connections v. HHS, 312 F. Supp. 3d 1164 (D.N.M., Feb. 28, 2018), rejected a portion of the methodology in the regulations implementing the permanent risk adjustment program in ACA § 1343 as “arbitrary and capricious, because the administrative record indicates that HHS assumed, erroneously, that the ACA requires risk adjustment to be budget neutral, and all of HHS’ reasons for using the statewide average premium rely on that budget neutrality assumption.” The rejection was based on the APA, which allows a court to “hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.”

Martinez v. Superior Healthplan, Inc., 2018 WL 771360 (W.D. Tex., Jan. 23, 2018), agreed that employees who signed agreements acknowledging that they were independent contractors were not eligible for benefits under a health plan even though they later were determined to be employees, because “In this Plan the employer excluded individuals who may even later be determined to be common law employees. Although this may appear unfair, ERISA allows this practice.”

Laborers’ Pension Fund v. Miscevic, 880 F.3d 927 (7th Cir., Jan. 29, 2018), cert. denied, 138 S. Ct. (2018), agreed with the district courts that have held, after Egelhoff v. Egelhoff, 532 U.S. 141 (2001), that “ERISA does not preempt slayer statutes.” The court reasoned that “[s]layer laws are an aspect of family law, a traditional area of state regulation,” but also seemed influenced (as other courts have been) by the uniformity of the statutes, noting that “we disagree with the conclusion that state slayer statutes interfere with the nationally uniform plan administration.”

Santomenno v. Transamerica Life Ins. Co., 883 F.3d 833 (9th Cir., Feb. 23, 2018), concluded that a TPA was not an ERISA fiduciary when it negotiated its own compensation with a prospective customer because it “plainly did not exercise discretionary control over the plan, possess authority over its assets, render investment advice, nor have any discretionary authority in the administration of the plan” at that time,” and “any other outcome would lead to absurd results.” Paying itself the amount of the agreed upon fees also was allowed because “when a service provider’s definitively calculable and nondiscretionary compensation is clearly set forth in a contract with the fiduciary-employer, collection of fees out of plan funds in strict adherence to that contractual term is not a breach of the provider’s fiduciary duty.”

In Ariana M. v. Humana Health Plan of Texas, 884 F.3d 246 (5th Cir., March 1, 2018) (en banc), the Fifth Circuit rejected its holding in Pierre v. Connecticut General Life Ins. Co., 932 F.2d 1552, 1562 (5th Cir. 1991), and agreed with the majority of other circuits by adopting a de novo standard for reviewing factual determinations by benefit plan administrators where the plan does not delegate them discretion to make those determinations. After a review of the case law, it
explained that “[c]onsidering these cases and without having to endorse all the critiques other circuits have made of Pierre, on balance we conclude that they warrant changing course and adopting the majority approach – an approach the federal and Texas governments also support. We are also influenced by ERISA’s strong interest in uniformity.”

EEOC v. R.G. & G.R. Harris Funeral Homes, Inc., 884 F.3d 560 (6th Cir., March 7, 2018), concluded that (1) a funeral home violated Title VII when it terminated an employee who decided to have sex reassignment surgery and, in connection with that, needed to “live and work full-time as a woman for one year,” which would have violated the funeral home’s sex-specific dress code, and (2) RFRA did not prevent Title VII from being enforced against the funeral home because, among other things, “a religious claimant cannot rely on customers’ presumed biases to establish a substantial burden under RFRA,” and “simply permitting Stephens to wear attire that reflects a conception of gender that is at odds with Rost’s religious beliefs is not a substantial burden under RFRA.” The court also concluded that (3) the ministerial exception did not apply to the funeral home because it was not a “religious institution.” The court relied in part on the analyses in appeals court decisions like Zarda v. Altitude Express, Inc., 883 F.3d 100 (2d Cir. 2018), which concluded that Title VII prohibits discrimination on the basis of sexual orientation, but is the first appeals court to decide that Title VII prohibits discrimination on the basis of gender identity. A petition for certiorari was filed on July 20, 2018. On October 24, 2018, the Department of Justice, ostensibly on behalf of the EEOC, submitted a brief that disagreed with the holding in the case but also urged the Supreme Court to address the issue in Zarda first, because it “implicates a much deeper and more entrenched circuit conflict on a similarly important and recurring question that nearly every circuit has addressed.”

Simmons v. Service Credit Union, 2018 WL 1251628 (D.N.H., March 12, 2018), concluded that an employment agreement with a former CEO to provide him with post-retirement medical coverage was an employee benefit plan under Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982), and Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987). It rejected the argument that an agreement that covered only one employee could not be an employee benefit plan under ERISA, and said that, because the plan covered the CEO and his spouse, regardless of where they lived, “a failure to treat SCU’s agreement as an ERISA employee benefit plan would leave both SCU and Simmons exposed to the threat of ‘conflicting and inconsistent state and local regulation,’ a problem that ERISA was expressly enacted to address.”

Market Synergy Group, Inc. v. United States Department of Labor, 885 F.3d 676 (10th Cir., March 13, 2018), unanimously upheld the district court’s decision in Market Synergy Group, Inc. v. United States Department of Labor, 2017 WL 661592 (D. Kan., Feb. 17, 2017), that the DOL did not violate the Administrative Procedures Act or the Regulatory Flexibility Act by amending and partially revoking PTCE 84-24 as it applies to fixed indexed annuity sales as part of its fiduciary rule. But soon after that U.S. Chamber of Commerce v. DOL, 885 F.3d 360 (5th Cir., March 15, 2018), concluded in a split decision that the DOL exceeded its regulatory authority in issuing the fiduciary rule itself. It reasoned that the “text and structure of [ERISA] unambiguously forecloses [the DOL]’s statutory interpretation” of “investment advice for a fee” in the fiduciary rule, because there is a “settled principle of interpretation,” which applies in this case, that “Congress intends to incorporate the well-settled meaning of the common-law terms it uses,” and “the touchstone of common law fiduciary status [is] the parties’ underlying relationship of trust and confidence.” Furthermore, “[e]ven if the common law presumption did not apply, the
Fiduciary Rule contradicts the text of the ‘investment advice fiduciary’ provision and contemporaneous understandings of its language.” Finally, even assuming that the statute is ambiguous enough to reach step 2 of a Chevron analysis, the DOL’s interpretation is unreasonable because “the text here does not compel departing from the common law (but actually embraces it), and . . . the Fiduciary Rule suffers from its own conflicts with the statutory text,” and “DOL’s turnaround from its previous regulation that upheld the common law understanding of fiduciary relationships alone gives us reason to withhold approval or at least deference for the Rule.”

Then on March 23, 2018, NAFA and the DOL filed a joint stipulation with the D.C. Circuit agreeing to the voluntary dismissal of NAFA’s appeal of National Association of Fixed Annuities v. Perez, 219 F. Supp. 3d 10 (D.D.C., Nov. 4, 2016), which granted summary judgment to the DOL in a narrowly focused challenge to the fiduciary rule. The DOL allowed the May 7 deadline for requesting en banc review of the Fifth Circuit decision to pass. It still has until June 13 to seek certiorari in the Supreme Court, but has shown no inclination to do so. The Fifth Circuit explained in Harmon v. Thornburgh, 878 F.2d 484, 495 n.21 (D.C. Cir. 1989), that “[w]hen a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated – not that their application to the individual petitions is proscribed.”

Harmon v. FMC Corp., 2018 WL 1366621 (E.D. Pa., March 16, 2018), dismissed, for failure to state a claim, a class action brought by participants in a 401(k) plan alleging that the fiduciaries of the plan violated their fiduciary duties by offering as an investment option the Sequoia Fund, a nondiversified fund which invested heavily in Valeant Pharmaceuticals stock. It noted that “§ 404(c) and the corresponding regulations allow plans to include undiversified investment options as long as the plans are diversified as a whole.”

On March 19, 2018, the Supreme Court invited the solicitor general to file a brief expressing the government’s views on which party in a fiduciary breach lawsuit has the burden of showing loss-causation, in connection with a petition for certiorari in Pioneer Centres Holding Co. Stock Ownership Plan v. Alerus Financial, N.A., 138 S. Ct. 1317 (March 19, 2018). The Sixth, Ninth, Tenth and Eleventh Circuits have ruled that the plaintiff must prove each element of the claim, including showing that the alleged breach caused a loss. The Fourth, Fifth and Eighth Circuits have ruled that the burden of demonstrating a lack of causation falls to the defendant after a valid case for fiduciary breach has been made.

Scott v. Aon Hewitt Financial Advisors, LLC, 2018 WL 1384300 (N.D. Ill., March 19, 2018), dismissed, for failure to state a claim, an action brought by participants in Caterpillar Inc.’s 401(k) plan alleging that Financial Engines Inc. “kicked back” a portion of its fees to Aon Hewitt Financial Advisors and Hewitt Associates that were unrelated to any substantial functions performed by either Hewitt entity, because the court concluded that neither entity was an ERISA fiduciary. The court explained that the plaintiffs had not alleged that Hewitt Associates “provided individualized investment advice to the Plan on a regular basis pursuant to a mutual agreement that its advice would serve as a primary basis for the Plan’s investment decisions,” and had made “no attempt to explain how Hewitt’s arms’ length negotiations with Financial Engines to
provide data transmission and technological services to Financial Engines under a separate contract constitutes an exercise of discretionary authority over the Plan or Plan assets.” It explained that, while Aon Hewitt Financial Advisors was a fiduciary or the purpose of providing investment advice to plan participants, “that does not make [it] a fiduciary for all purposes,” and that “it is well-established that a service provider who negotiates its own compensation with a plan fiduciary at arm’s length is not a fiduciary for that purpose.”

Jahangirian v. Commissioner, T.C. Summ. Op. 2018-14 (March 20, 2018), sustained the IRS’s determination that an individual’s “tax home” was in Oklahoma where he was working rather than in California where his family lived. The court cited its own test on when employment away from a taxpayer’s abode is “indefinite” rather than “temporary,” and ultimately relied on the Ninth Circuit’s “somewhat different test” (because that’s where the appeal would lie), but interestingly never cited any IRS guidance.

Atlantic Plastic & Hand Surgery, PA v. Anthem Blue Cross Life & Health Ins. Co., 2018 WL 1420496 (D.N.J., March 22, 2018), and Orthopedics & Sports Medicine v. Anthem Blue Cross Life & Health Ins. Co., 2018 WL 1440325 (D.N.J., March 22, 2018), both concluded that a provider was not entitled to claim benefits based on an assignment from the participant from a plan that contained a clear anti-assignment clause, but that the participant had standing to pursue the claim himself because he remained personally responsible for the outstanding medical charges. Regarding the first point, Atlantic Plastic said “although the Third Circuit has not addressed the enforceability of anti-assignment provisions contained in ERISA-governed employee benefit plans, the consensus from other courts of appeals that have considered that issue is that unambiguous anti-assignment provisions are enforceable,” and that “[c]onsistent with those decisions, courts within this District routinely enforce unambiguous anti-assignment provisions contained in ERISA-governed plans.” Regarding the second point, Atlantic Plastic said that where it is alleged that a participant “remains indebted to the Provider Plaintiffs for a greater amount than she would have had Defendants properly paid the asserted benefits[, s]uch allegations are sufficient to create an injury-in-fact, and accordingly establish Article III standing.”

Gaskill v. Life Ins. Co. of North America, 2018 WL 1455863 (E.D. Mo., March 23, 2018), dismissed, for failure to state a claim, a lawsuit against Cigna for penalties for failure to produce Plan documents, because the employer – not Cigna – was “specifically designated in the Plan documents as the ‘Plan Administrator’.” It added that the de facto plan administrator doctrine is “unavailing under our cases” (citing Brown v. J.B. Hunt Transportation Services, Inc., 586 F.3d 1079, 1088 (8th Cir. 2009)).

Barchock v. CVS Health Corp., 886 F.3d 43 (1st Cir., March 23, 2018), agreed with the district court that fiduciaries of a 401(k) plan did not violate their fiduciary duties under ERISA by including a stable value fund heavily invested in cash and cash-equivalents, where the fund performed within its own stated, conservative objectives.

Davita Inc. v. St. Joseph’s/Candler Health System, Inc., 2018 WL 1513317 (S.D. Ga., March 27, 2018), concluded that a health care provider’s lawsuit against an employer that maintained a health plan for failure to pay its contractually agreed-upon fees was not completely preempted by ERISA and thus could be remanded to a state court. It noted that “[t]he services Plaintiff pro-
vides to Defendant’s insureds, along with the fee schedule for those services, are governed by a contractual agreement between Plaintiff and Defendant.” It seemed to view the possibility that the provider had received an assignment from the participant, and thus could have proceeded under ERISA, as irrelevant: “The Eleventh Circuit Court of Appeals has recognized that a healthcare provider may end up with either an assigned ERISA claim and an independent state law claim, or both. [citation omitted] Under these circumstances, an assignment of benefits is irrelevant if the healthcare provider has alleged only an independent state law claim. [citation omitted] As a result, a party may not invoke this Court’s federal question jurisdiction where a healthcare provider has alleged only an independent state law claim.”

Munnelly v. Fordham University Faculty & Administration HMO Ins. Plan, 316 F. Supp. 3d 714 (S.D.N.Y., March 30, 2018), agreed with the plaintiffs that “Empire’s exclusion of residential treatment services from coverage of mental health benefits under the Plan violates the [MHPAEA].” It explained that “the [MHPAEA] expressly prohibits treatment limitations on mental health benefits that are ‘more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits,’ as well as ‘separate treatment limitations that are applicable only with respect to mental health . . . benefits’.” It rejected the idea that these were permitted by the interim final regulations, noting that the preamble to those regulations stated that “[t]he Interim Final Rules ‘do not address the scope of services issue’.”

Moura v. Kaiser Foundation Health Plan, 2018 WL 1569812 (N.D. Cal., March 30, 2018), concluded that a plaintiff whose initial lawsuit for benefits for the treatment of anorexia nervosa under ERISA § 503(a)(1)(B) was denied for failing to allege that he had exhausted his administrative remedies, but then was allowed to amend his lawsuit to allege that “Kaiser’s pattern and practice of treatment for eating disorders violates [the fiduciary requirements of] ERISA and the California and Federal Health Parity Acts,” did not have to allege that he had exhausted his administrative remedies for that claim because “[a]lthough as general rule a plan participant must exhaust such remedies prior to filing a legal action, ‘exhaustion of internal dispute procedures is not required where the issue is whether a violation of the terms of the statute has occurred. [citation omitted] Accordingly, where, as in this case, ‘the participant’s claim rests on an allegation of breach of fiduciary duty, the exhaustion requirement is inapplicable’.” It is not clear why Kaiser did not argue that his fiduciary breach claim was essentially just another claim for benefits.

Encino Motorcars LLC v. Navarro, 138 S. Ct. 1134 (U.S., April 2, 2018), concluded that auto service advisers are not covered by the FLSA because of the exception in the FLSA for “any salesman, partsman or mechanic primarily engaged in selling or servicing automobiles.”

Sherman v. Commissioner, T.C. Summ. Op. 2018-14 (April 2, 2018), followed Peterson v. Commissioner, T.C. Memo. 2013-271, aff’d in part, dismissed in part, 827 F.3d 968 (11th Cir. 2016), to conclude that post-retirement payments received by a former national sales director for Mary Kay cosmetics were subject to self-employment tax. The Tax Court noted that “[a]lthough the opinion of the Court of Appeals was divided, both the majority and the dissent agreed that payments under the Family Security Program are subject to self-employment tax.”

Carlson v. Northrop Grumman Corp., 2018 WL 1586241 (N.D. Ill., April 2, 2018), concluded that a plan administrator was entitled to Firestone deference in interpreting a severance plan
where the severance plan was a “Component Plan” of a wrap plan, and the wrap plan document granted discretionary authority to make eligibility determinations and interpret the plan’s terms to the plan administrator, even though the SPD for the severance plan stated that it was the official plan document, and it was adopted after the wrap plan.

**Wengert v. Rajendran**, 886 F.3d 725 (8th Cir., April 3, 2018), concluded that a participant’s surviving spouse, who was his beneficiary under the terms of an ESOP, but whom he was in the process of divorcing, had no claim to benefits under the ESOP when he died, because he requested a lump-sum distribution of his accrued benefit to a personal trust two days before he died, and the plan administrator wired the funds the same day, leaving no benefits for her to claim.

**Boden v. St. Elizabeth Medical Center, Inc.**, 2018 WL 1629866 (E.D. Ky., April 4, 2018), concluded that participants who alleged that St. Elizabeth and the pension plan committee wrongly treated a plan as a church plan, and demanded under ERISA § 502(a)(2) and (a)(3) that St. Elizabeth “bring the Plan into compliance with ERISA,” “make the Plan whole for past contributions that should have been made pursuant to [the minimum funding rules of] ERISA,” and “fund the Plan in accordance with the Plan Document,” did not have to show they had individual injuries in order to have Article III standing because, citing *Loren v. Blue Cross & Blue Shield of Michigan*, 505 F.3d 598 (6th Cir. 2007), and *Soehnlen v. Fleet Owners Ins. Fund*, 844 F.3d 576 (6th Cir. 2016), “when bringing an action to recover on behalf of a plan under ERISA § 502(a)(2), a plaintiff with statutory standing must also show constitutional standing, but need not show individualized injury.” The court refused to follow *Lee v. Verizon Communications, Inc.*, 837 F.3d 523 (5th Cir. 2016), where the Fifth Circuit held that the named plaintiff lacked Article III standing to assert a claim under ERISA § 502(a)(2) because he had not alleged “an injury in fact sufficient to support constitutional standing” by alleging “injury against [his] individual[ ] benefit payments, rather than injury to the plan as a whole.” This conclusion is troubling because it suggests that – even outside the church plan context – individual participants in a DB plan can bring claims against plan sponsors for inadequately funding the plan, at least if that results in noncompliance with ERISA’s funding rules. *Loren* also has an interesting discussion of when multiple plans exist under ERISA, which says “Given HIPPA’s default rule that all medical benefits offered by an employer are generally considered to be part of one ERISA health plan, and the fact that if an employer intends to create multiple plans it has the ability to do so by filing multiple plan documents, we start with the strong presumption that the filing of only one ERISA plan document indicates that the employer intended to create only one ERISA plan.

*** We conclude that Defendant has not overcome the presumption that the employee health benefits offered by an employer constitute a single ERISA plan. In order to defeat this presumption, [the employers] must show, through the plan documents, that such benefits are provided and operated under separate plans. The most obvious first step in this regard would be to register multiple ERISA plans by filing multiple plan documents.”

**In re Parrish**, 583 B.R. 873 (Bankr. E.D.N.C., April 6, 2018), concluded that the excise tax imposed by Code § 5000A for violating the individual mandate is a penalty and not a tax for purposes of 11 U.S.C. § 507(a) and is not entitled to priority status in bankruptcy.

**Fernandez v. Franklin Resources, Inc.**, 2018 WL 1697089 (N.D. Cal., April 6, 2018), concluded that a class-action lawsuit alleging that the Franklin Templeton and the Administrative and Investment Committees for the Franklin Templeton 401(k) Retirement Pan breached their
fiduciary duties by offering under-performing mutual funds managed by Franklin Templeton and charging excessive administrative fees could not be dismissed merely because the lead plaintiff signed a severance agreement that released all claims against Franklin Templeton, because “In Bowles [v. Reade, 198 F.3d 752 (9th Cir. 1999),] the Ninth Circuit held that a plan participant cannot settle, without the plan’s consent, a § 502(a)(2) breach of fiduciary duty claim seeking ‘a return to [the plan] and all participants of all losses incurred and any profits gained from the alleged breach of fiduciary duty.’ [citation omitted] Because Plaintiff seeks to bring the same type of claim to restore value to the Plan, she could not have released the claim (or agreed not to bring a lawsuit asserting that claim) without the consent of the Plan.” The court concluded that LaRue v. DeWolff, Boberg & Assocs., Inc., 552 U.S. 248 (2008), did not require a different result, because “[i]t holding that, in the defined contribution context, § 502(a)(2) permits individual claims, does not mean that all § 502(a)(2) claims must be individual. A plaintiff may still bring a § 502(a)(2) claim on behalf of a plan, even if the plan is a defined contribution plan.”

Duggan v. Towne Properties Group Health Plan, 2018 WL 1696802 (S.D. Ohio, April 6, 2018), amended and superseded, 2018 WL 1696802 (S.D. Ohio, April 6, 2018), concluded that a TPA that performed only ministerial duties and was not designated as the plan administrator or a fiduciary was not liable for failing to provide plan documents to participants under ERISA § 502.

Stein v. Atlas Industries Inc., 730 F. App’x 313 (6th Cir., April 9, 2018), affirmed the district court’s grant of summary judgment to an employer on a FMLA retaliation claim, but reversed its grant of summary judgment on a related ERISA § 510 interference claim.

Teufel v. Northern Trust Co., 887 F.3d 799 (7th Cir., April 11, 2018), cert. denied, 139 S. Ct. 271 (2018), concluded that Northern Trust did not violate ERISA § 204’s anti-cutback rules by changing the accrual formula in its pension plan prospectively, including with respect to future salary increases. The court noted that “Teufel wants us to treat the expectation of future salary increases as an ‘accrued benefit’.”

United States v. Forbush-Moss PSC, 2018 WL 1802451 (W.D. Ky., April 13, 2018), granted a request by the government for an injunction against a law firm from which the IRS had difficulty collecting employment taxes. Authority for the injunction was based on Code § 7402(a).

IHC Health Servs., Inc. v. JetBlue Airways Corp., 2018 WL 1801921 (D. Utah, April 13, 2018), concluded that the employer had to pay an out-of-network Utah medical center 80% of the amount it actually billed for emergency medical services, not 80% of competitive fees in the geographic area, even though the latter was how the plan was administered by Anthem, because there was nothing in the record that supported the latter approach.

Feather v. SSM Health Care Corp., No. 4:16-cv-01669-HEA (E.D. Mo., April 23, 2018), concluded that the ERISA church plan exemption was constitutional under the First Amendment.

Eden Surgical Ctr. v. Cognizant Technology Solutions Corp., 720 F. App’x 862 (9th Cir., April 26, 2018), concluded that “[b]ecause the [plan’s] anti-assignment provision is valid and enforceable, Eden lacks derivative standing to sue” the plan for benefits based on an assignment of a participant’s benefit claim even though “Aetna incorrectly advised Eden regarding the applicable
reimbursement rate; and . . . mistakenly told Eden that the benefit plan did not contain an anti-
assignment provision.”

Bakery & Confectionary Union & Industry International Pension Fund v. Just Born II, Inc., 888 F.3d 696 (4th Cir., April 26, 2018), concluded that the maker of Peeps was liable for contributions under a multiemployer plan’s rehabilitation plans after its CBA expired because ERISA § 305 extends liability to any employer that was a “bargaining party” “with respect to” a CBA even after the CBA’s provisions lapse, if they lapse while the plan is still in critical status. The court distinguished Trustees of Local 138 Pension Trust Fund v. F.W. Honerkamp Co., 692 F.3d 127 (2d Cir. 2012), because that decision did not provide that an employer could implement a proposal to remain in the fund under different rules than provided for in the rehabilitation plan. It explained that “[o]ur interpretation of the Provision in no way limits the application of other ERISA provisions governing when and how an employer may withdraw partially or completely from an ERISA-qualified plan. [citations omitted] Instead, our decision centers on what is required of employers who have not sought to withdraw, and who instead remain participants in the plan by virtue of an expired collective bargaining agreement.”

Girardot v. The Chemours Co., 731 Fed.Appx. 108 (3d Cir., April 30, 2018), concluded that a voluntary separation plan that gave participants a lump sum severance benefit based on their base pay and years of service, a lump sum equal to the cost of three months of COBRA medical coverage, and a prorated portion of their bonuses, “is generally akin to a Fort Halifax plan and does not involve a new or ongoing administrative scheme” and therefore “is not subject to ERISA.” It noted that “Chemours did not express an intention to provide regular and long-term benefits.” It rejected the employees’ argument that “Chemours’ individualized determinations of the employees’ eligibility to participate in the VSP – which involved denying VSP applications of those employees that the Company needed to retain for business reasons” created an ongoing administrative scheme.

Dynamex Operations West Inc. v. Superior Court of Los Angeles County, 4 Cal. 5th 903, 416 P.3d 1 (April 30, 2018), reh’g denied (June 20, 2018), adopted the Industrial Welfare Commission’s broad definition of employment, which includes both a common-law definition and a “suffer or permit to work” definition as alternatives, for wage and hour law purposes, consistent with Martinez v. Combs, 49 Cal. 4th 35, 64, 109 Cal. Rptr.3d 514, 231 P.3d 259 (2010) (which nevertheless focused on the common-law alternative), rejected the idea that the only applicable definition was the multi-factor “control test” in S.G. Borello & Sons Inc. v. Department of Industrial Rel., 48 Cal. 3d 341 (1989), and concluded that the “ABC” test (which presumes a worker to be an employee unless three requirements are met) should be used when applying the “suffer or permit to work” definition. The New Jersey Supreme Court reached a very similar conclusion in Hargrove v. Sleepy’s, LLC, 220 N.J. 289, 106 A.3d 449 (2015).

McKennon v. Meadowvale Dairy Employee Benefit Plan, 2018 WL 2090190 (N.D. Iowa, May 4, 2018), rejected a motion to dismiss a claim by a hospital for $760,000 in medical bills incurred by an undocumented alien.

Schweitzer v. Investment Committee of Phillips 66 Savings Plan, 312 F. Supp. 3d 608 (S.D. Tex., May 9, 2018), dismissed, for failure to state a claim, a class action brought by participants in a Phillips 66 Co. 401(k) plan alleging that the fiduciaries of the plans violated their fiduciary
duties by continuing to offer ConocoPhillips stock after Phillips 66 Co. became a separate company, even though ConocoPhillips stock ceased to be an “employer security” as a result, and therefore no longer was exempt from the diversification requirement, because the Phillips 66 Co. participants were free to trade their ConocoPhillips stock for other plan investments, and the investment in ConocoPhillips stock was not imprudent based on Fifth Third Bancorp v. Dudenhoeffer, 134 S. Ct. 2459 (2014). An appeal was filed on June 12, 2018.

Guinn v. General Motors LLC, 2018 WL 2149267 (N.D. Ohio, May 10, 2018), concluded that the nephew of a deceased participant in a life insurance plan was not entitled to benefits because he was never properly designated as a beneficiary. The court noted that “there is a recognized split among the federal circuits regarding the way in which a beneficiary is determined,” with some applying a “substantial compliance” doctrine, the Sixth Circuit follow a “bright line” rule instead, and therefore “we determine the insured’s intent by the designation on file at the time of the insured’s death.”

BNSF Railway Co. v. Loos, 138 S. Ct. 1988 (May 14, 2018), granted certiorari in Loos v. BNSF Railway Co., 865 F.3d 1106 (8th Cir. 2017), which concluded that although damages for lost wages are a form of money remuneration paid to an individual, they are included in RRTA wages only if they are paid for actual services rendered as an employee, not for time lost. One other court has come to the same conclusion under FICA, see Newhouse v. McCormick & Co., 157 F.3d 582 (8th Cir. 1998), but it is considered the minority view. The Court heard oral arguments on November 6, 2018.

Facebook Inc. v. Internal Revenue Service, 2018 WL 2215743 (N.D. Cal., May 14, 2018), concluded that (1) the Taxpayer Bill of Rights (“TBOR”), codified by the PATH Act, did not entitle Facebook to review by the Appeals Office, and (2) the IRS’s denial of access to the Appeals Office, and its issuance of Rev. Proc. 2016-22, 2016-15 I.R.B. 577, which says that some cases docketed in the Tax Court will not be referred to the Appeals if referral isn’t in the “interest of sound tax administration,” were not arbitrary and capricious under the APA. Patrick J. Smith of Ivins, Phillips & Barker said that, in his view, the lack of guidelines on the “interest of sound tax administration” standard invoked by Rev. Proc. 2016-22 makes the denial a violation of the APA’s arbitrary and capricious standard.

American Orthopedic & Sports Medicine v. Independence Blue Cross Blue Shield, 890 F.3d 445 (3d Cir., May 16, 2018), concluded that a health provider could not sue a plan for benefits based on an assignment of a participant’s benefit claim where the plan contained a valid anti-assignment provision. The Third Circuit had not previously ruled on this issue. It explained that, while

neither ERISA’s text nor policy point decidedly in one direction, persuasive authority from our Sister Circuits does. In thoughtful and reasoned decisions, every Circuit to have considered the arguments presented by Appellant has rejected them, ultimately concluding that nothing in ERISA forecloses plan administrators from freely negotiating anti-assignment clauses, among other terms.

Appeals Courts in all but four Circuits have now held that anti-assignment provisions in health insurance plans governed by ERISA are enforceable. Even in the Fourth, Sixth, Seventh, and
D.C. Circuits, where there is no binding Appeals Court decision, several District Courts have found that such provisions are enforceable.

Kinra v. Chicago Bridge & Iron Co., 2018 WL 2371030 (S.D.N.Y., May 24, 2018), dismissed, for failure to state a claim, a class action brought by participants in company-sponsored savings and 401(k) plans alleging that the fiduciaries of the plans violated their fiduciary duties by continuing to offer company stock as an investment option even though they allegedly “knew or should have known that [Company Stock] was artificially inflated as a result of construction delays and cost overruns on . . . the Nuclear Projects.” The court explained that the complaint “fails to plead facts showing that a reasonable fiduciary could not conclude that freezing Company Stock purchases would not have been more harmful to the Fund than helpful,” and therefore failed to satisfy the Supreme Court’s pleading standards in Fifth Third Bancorp v. Dudenhoeffer, 134 S. Ct. 2459 (2014). It explained that “if the Plans had made public that they were halting all investments in Company Stock, this course of action would be tantamount to early disclosure, . . . with the attendant concerns about causing a drop in the stock price that would devalue the Plans’ current investments in the stock.” Also, “if the Plans hid the fact that it was ignoring Participants’ investment directives and ‘diverting’ their contributions without authorization to securities investments other than the Company Stock Fund, it seems inevitable that such action would run afoul of the Plan Documents and be unlawful with respect to the Participants [and] likely violate the securities’ laws proscription against the purchase or sale of securities based on nonpublic information. This is typical of many recent decisions.

Eagle Force Holdings, LLC v. Campbell, No. 399, 2017 (Del., May 24, 2018), stated in a footnote that “[w]e acknowledge the debate over whether a party can recover on a breach of warranty claim where the parties know that, at signing, certain of them were not true. [citation omitted] Campbell argues that reliance is required, but we have not yet resolved this interesting question. [citation omitted] And we observe that a majority of states have followed the New York Court of Appeals’ decision in CBS Inc. v. Ziff-Davis Publishing Co., 75 N.Y.2d 496, 554 N.Y.S.2d 449, 553 N.E.2d 997 (1990), which holds that traditional reliance is not required to recover for breach of an express warranty: the only ‘reliance’ required is that the express warranty is part of the bargain between the parties.”

Divane v. Northwestern University, 2018 WL 2388118 (N.D. Ill., May 25, 2018), dismissed claims that Northwestern, which acted as the plan administrator for two section 403(b) plans, and the members of the Investment Committee for the plans, breached their fiduciary duties by offering certain high-fee and poorly performing investment options and offering too many investment options in the plan, as well as a claim that Northwestern failed to monitor the other fiduciaries, and a prohibited transaction claim. Sweda v. University of Pennsylvania, 2017 WL 4179752 (E.D. Pa., Sept. 21, 2017), dismissed similar claims against the University of Pennsylvania.

Fiedziuszko v. Commissioner, T.C. Memo. 2018-75 (May 31, 2018), concluded that an aerospace engineer who provided consulting services to Space Systems Loral through a temporary employment agency used by Loral to hire consultants was a statutory employee under Code § 3121(d)(3)(C) (home workers) rather than a common law employee in 2012 and therefore he was entitled to deduct self-employed health insurance expenses on line 29 of his Form 1040 and deduct business expenses on Schedule C (although the Tax Court agreed with the IRS that they
should be denied for lack of substantiation). The Tax Court noted that “[w]hile his Form W-2 for 2012 did not indicate that he was a statutory employee, we believe this to be a mistake. Mr. Fiedziuszko’s Form W-2 for 2011 indicated that he was a statutory employee.” The only basis it cited for treating him as a home worker, besides his treatment as a statutory employee in 2011, was that he “worked primarily from his home office rather than Loral’s offices and produced reports and patents according to his assignments from Loral.” That is a surprisingly low barrier to treatment as a home worker, and is reminiscent of VanZant v. Commissioner, T.C. Summ. Op. No. 2007-195 (Nov. 19, 2007). It is not clear why the Tax Court (and the parties themselves) focused on his status as a statutory employee at all, since FICA taxes were not at issue and the Tax Court also concluded that he was not a common law employee (using the seven factors it applied in decisions like Ewens & Miller, Inc. v. Commissioner, 117 T.C. 263, 270 (2001)), which should have been enough to entitle him to deduct his self-employed health insurance and business expenses. Perhaps that means that the Tax Court’s conclusion is mere dictum.

Heavenly Hana LLC v. Hotel Union & Hotel Industry of Hawaii Pension Plan, 891 F.3d 839 (9th Cir., May 31, 2018), adopted a constructive notice standard and concluded that an LLC owned by a private equity group which purchased a hotel and related assets was liable for the MPPAA withdrawal liability that was triggered by the sale even though the purchasers lacked actual notice of the withdrawal liability. According to the court, “[c]onstructive notice would only exist when three conditions are met: (1) the purchaser qualifies as a successor; (2) the relevant pension plan is underfunded; and (3) a purchaser using reasonable care or diligence would have discovered the withdrawal liability. Additionally, successor liability would only be imposed when it is fair to do so.” The court explained that “congressional purpose, the liberal remedial construction of the MPPAA adopted in previous cases, the adoption of a constructive notice standard in other contexts, and the practical realities of asset purchases all support a conclusion that constructive notice of withdrawal liability is sufficient to trigger successor withdrawal liability under the MPPAA.”

Miller v. Olsen, 724 F. App’x 625 (9th Cir., May 31, 2018), affirmed the District Court’s conclusion that the Euterpe Employee Equity Growth Plan (EGP) was not subject to ERISA because “[t]he ‘primary purpose’ of the EGP is not to provide retirement benefits or deferred income, but rather to encourage longevity and provide increased compensation to select Euterpe employees.” The plan allowed the board to grant phantom ownership interests in Somerset, a company whose sole asset was a building that it purchased, to employees selected by the board. The interests vested when a participant reached age 62, but benefits could be withdrawn early subject to penalties. The court noted that in Rich v. Shrader, 823 F.3d 1205, 1210 (9th Cir. 2016), “[w]e recently explained that whether or not the primary purpose of a plan is to provide deferred compensation or retirement income is the ‘paramount consideration’ in determining whether a compensation plan qualifies as an employee pension benefit plan under ERISA.”

Cognetta v. Bonavita, 330 F. Supp. 3d 797 (E.D.N.Y., June 7, 2018), concluded that a self-funded health plan was entitled to an equitable lien over the prospective monetary damages awarded to a plan beneficiary who was severely injured in a car accident. The court concluded that an anti-subrogation provision in New York’s insurance law was preempted by ERISA. It rejected the defendants’ argument that the requested relief was legal rather than equitable because they did not currently possess the funds sought by the plan, explaining that the fiduciaries of the plan “ultimately seek ‘particular funds’ that are likely to come into defendants’ possession.
in light of the state court’s finding of liability in defendants’ favor.” It also rejected the defendants’ argument that the plan was silent or ambiguous on the issues of subrogation or reimbursement, and thus the make-whole doctrine should be applied as a matter of contract interpretation based on US Airways, Inc. v. McCutchen, 569 U.S. 88 (2013), because the “plain language” of the plan’s SPD (which the court described as “its operative document”) and the subrogation agreement “indicates that the Plan has first priority over defendants’ recovery, whether that recovery fully or partially covers defendants’ expenses.”

A letter to speaker Paul Ryan from Attorney General Jeff Sessions dated June 7, 2018, states that DOJ, with the approval of President Trump, “will not defend the constitutionality of [Code §] 5000A(a)” in Texas v. United States, No. 4:18-cv-00167-O (N.D. Tex.), the suit filed by 20 Republican state Attorneys General on February 26, 2018, “and will argue that certain provisions of the Affordable Care Act (ACA) are inseverable from that provision.” NFIB v. Sebelius, 132 S. Ct. 2566 (2012), upheld the constitutionality of Code § 5000A on the basis that it was a tax. The complaint argues that “because the tax penalty provision in the ACA no longer raises any revenue” starting in 2019, when the TCJA reduces the penalty to zero, “the Supreme Court’s avoidance reading is no longer possible.” It goes on to argue that “[o]nce the heart of the ACA – the individual mandate – is declared unconstitutional, the remainder of the ACA must also fall.” However, the letter states that the DOJ instead will follow the Obama Administration’s position in NFIB that Code § 5000A is severable from the all of the ACA’s provisions except the guaranteed issue (PHSA § 2702) and community rating (PHSA § 2701) provisions. On May 16, 2018, the court granted a request by 17 Democratic state Attorneys General to intervene in the case and defend the constitutionality of Code § 5000A and the rest of the ACA.

Pharmaceutical Care Management Association v. Rutledge, 891 F.3d 1109 (8th Cir. 2018), concluded that ERISA preempted an Arkansas law that, among other things, mandated that pharmacies be reimbursed for generic drugs at a price equal to or higher than the pharmacies’ cost for the drug based on the invoice from the wholesaler, and contained a “decline-to-dispense” option for pharmacies that will lose money on a transaction, even though – unlike the Iowa law at issue in Pharmaceutical Care Management Association v. Gerhart, 852 F.3d 722 (8th Cir. 2017) – it did not make explicit reference to ERISA, because – like the Iowa law – it made implicit reference to ERISA.

Sveen v. Melin, 138 S. Ct. 1815 (U.S., June 11, 2018), concluded that a Minnesota law passed in 2002, specifying that when one spouse designates the other as his or her life-insurance beneficiary, that designation is automatically revoked if the couple divorces, did not violate the Contracts Clause of the Constitution even though it applied to policies in effect before the law was enacted.

Hart Interior Design LLC 401(k) Profit Sharing Plan v. Recorp Investments Inc., 2018 WL 1961643 (D. Ariz., April 26, 2018), concluded that an LLC formed by an individual to own land on which water wells might be drilled, in which the plan held a 28% interest, was not a REOC because the only development performed with respect to the property was two water wells drilled several years before the relevant testing period. But the court concluded that there was a triable issue of fact as to whether the entity that managed the LLC, which previously was owned by the individual, and a bank that lent money to the individual and obtained an interest in the LLC and ownership of the management entity as part of a judgment against him, were fiduciaries of the
plan by virtue of exercising control over the plan’s assets in the LLC, and that by attempting to collect suspects management fees and other debts from the LLC and withholding material information about them were in breach of their fiduciary duties to the plan.

**Epic Systems Corp. v. Lewis, 138 S. Ct. 1612 (May 21, 2018), reversed, 5-4, Lewis v. Epic Systems Corp., 823 F.3d 1147 (7th Cir. 2016),** which concluded that arbitration agreements that contain class action waivers violate the NLRA. The majority opinion by Justice Gorsuch explained that the FAA “instructed federal courts to enforce arbitration agreements according to their terms—including terms providing for individualized proceedings.” It rejected the employees’ argument that the FAA was overridden (based on its savings clause) by the policies of the NLRA, specifically NLRA § 7, which guarantees workers “the right to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection.” It reasoned that “Section 7 focuses on the right to organize unions and bargain collectively. It may permit unions to bargain to prohibit arbitration. [citations omitted] But it does not express approval or disapproval of arbitration. It does not mention class or collective action procedures. It does not even hint at a wish to displace the Arbitration Act—let alone accomplish that much clearly and manifestly, as our precedents demand.” The minority opinion by Justice Ginsburg argued that the majority’s conclusions were inconsistent with “the NLRA’s text, history, purposes, and longstanding construction.” It said that “[b]ecause I would hold that employees’ § 7 rights include the right to pursue collective litigation regarding their wages and hours, I would further hold that the employer-dictated collective-litigation stoppers, i.e., ‘waivers,’ are unlawful.” It predicted that “[t]he inevitable result of today’s decision will be the underenforcement of federal and state statutes designed to advance the well-being of vulnerable workers.” Based on this decision, **Cowabunga, Inc. v. NLRB, 893 F.3d 1286 (11th Cir., June 26, 2018), and Everglades College, Inc. v. NLRB, 893 F.3d 1290 (11th Cir., June 26, 2018), both reversed the NLRB’s previous conclusions that the employers had violated the NLRA by maintaining and enforcing employment agreements requiring that employment disputes be resolved through individualized arbitration.**

**Stolebarger v. The Prudential Ins. Co. of America, 2018 WL 2287672 (N.D. Cal., May 18, 2018), concluded that a claim for LTD benefits under a policy purchased through Bryan Cave had to be brought under ERISA (and that his state-law claim was completely preempted), because the LTD policy did not fit within the safe harbor in 29 C.F.R. § 2510.3-1(j)(3), in that the policy was “referred to as the ‘Bryan Cave’ plan” and “the SPD describing the plan as one governed by ERISA was ‘provided and included’ at Bryan Cave’s request.” The court said that Bryan Cave’s payment of the premiums under the policies also supported its conclusion, although it did not need to rely on that fact.**

**Palsgaard v. Commissioner, 115 T.C.M. (CCH) 1450 (June 13, 2018), concluded that Social Security Disability Insurance (“SSDI”) benefits are not excluded from gross income under Code § 104(a)(1) (workmen’s compensation), (a)(2) (damages for personal physical injuries or sickness) or (a)(3) (accident or health insurance), but instead are included in income under Code § 86. Regarding Code § 104(a)(3), it explained that “the SSDI program is a Government-sponsored insurance plan that is a product of legislative enactment.”**
In Re: Jimmy John’s Overtime Litigation, 2018 WL 3231273 (N.D. Ill., June 14, 2018), concluded that Jimmy John’s did not jointly employ, along with its franchisees, assistant store managers who claimed they were misclassified as exempt from overtime. It applied the four-factor test from Moldenhauer v. Tazewell-Pekin Consolidated Communications Center, 536 F.3d 640, 644 (7th Cir. 2008), to determine that Jimmy John’s did not have sufficient control over the franchisees’ workers, and that “any control that Jimmy John’s does exert over the franchisees relates to brand standards, which Jimmy John’s is entitled to enforce.”

Cahill v. Commissioner, 115 T.C.M. (CCH) 1463 (June 18, 2018), denied summary judgment to the taxpayer in this split dollar life insurance estate tax controversy, with which we have been involved to a limited extent.

Lee-Thomas v. Laboratory Corp. of America, 316 F. Supp. 3d 471 (D.D.C., June 15, 2018), rejected, for failure to state a claim on which relief could be granted, an individual’s suit alleging that LabCorp violated HIPAA by allowing her personal health information to be visible to another patient, because “[g]iven the statutory language and the clear consensus among courts that have addressed the question, no private action exists under HIPAA.”

Hampton Software Development LLC v. Commissioner, 115 T.C.M. (CCH) 1490 (June 19, 2018), concluded that the property manager for a company that operated an apartment complex was an employee of the company. The court used the seven factors it applied in Weber v. Commissioner, 103 T.C. 378, 386 (1994), aff’d per curiam, 60 F.3d 1104 (4th Cir. 1995), and has applied in other cases such as Ewens & Miller, Inc. v. Commissioner, 117 T.C. 263, 270 (2001). It discounted the significance of the fact that the company “did not closely supervise Mr. Herndon or did not supervise him at all in his performance of routine general maintenance work or minor tasks . . . [because] he was thoroughly familiar with how to perform, and experienced in performing, routine general maintenance work or minor tasks, and therefore [the company] generally did not have to supervise closely or supervise at all those types of work or tasks.” It concluded that the company was not entitled to section 530 relief because it failed to report the property manager’s income on Form 1099-MISC (or any other form).

Hipsher v. Los Angeles County Employees Retirement Association, 24 Cal. App. 5th 740, 234 Cal. Rptr. 3d 564 (Cal. Ct. App., June 19, 2018), as modified (July 16, 2018), concluded that LACERA’s reduction of a participant’s retirement benefits for running an illegal gambling operation was permitted by a felony forfeiture statute enacted in 2013, and that the reduction did not violate either the contract clause or the “ex post facto” prohibition of the federal or California Constitutions, even though the individual was already working at the time of its enactment. The court reasoned that, even though the individual had a vested right to his retirement benefits, “even ‘a substantial [contractual] impairment may be constitutional if it is ‘reasonable and necessary to serve an important public purpose’,” and also that “[a] public employee’s vested retirement benefits can be defeated upon the occurrence of a ‘condition subsequent’.”

Wisconsin Central Ltd. v. United States, 138 S. Ct. 2067 June 21, 2018), reversed the Seventh Circuit’s decision at 856 F.3d 490 (7th Cir. 2017), which held that “compensation” subject to tax under RRTA includes gains from the exercise of nonqualified stock options because stock options are a form of cash. The majority opinion explained that “in light of all the textual and structural clues before us, we think it’s clear enough that the term ‘money’ excludes ‘stock,’
leaving no ambiguity for the agency to fill.” The dissenting opinion objected that “in respect to stock options, the Act’s language has a degree of ambiguity. But the statute’s purpose, along with its amendments, argues in favor of including stock options. The Government has so interpreted the statute for decades, and Congress has never suggested it held a contrary view, despite making other statutory changes.”

South Dakota v. Wayfair, Inc., 138 S. Ct. 2080 (June 21, 2018), overruled National Bellas Hess, Inc. v. Department of Revenue of Illinois, 386 U.S. 753 (1967), and Quill Corp. v. North Dakota, 504 U.S. 298 (1992), which held that a state cannot require an out-of-state seller with no physical presence in the state to collect and remit sales taxes on goods the seller ships to consumers in the state, as “unsound and incorrect.” Many states already limited Quill’s physical presence requirement to sales and use tax and applied an “economic nexus” approach for other types of taxes, including state income tax withholding requirements. Every state except Indiana, Kentucky, Maryland, Mississippi and Oklahoma treats the presence of one employee (even a telecommuter) as enough of a connection.

On June 21, 2018, the Fifth Circuit issued its final “mandate” in U.S. Chamber of Commerce v. DOL, 885 F.3d 360 (5th Cir. 2018). The mandate says “It is ordered and adjudged that the judgment of the District Court is reversed, and vacate [sic] the Fiduciary Rule in toto.” Presumably as a result Adv. Op. 2005-23A (Dec. 7, 2005), which concluded that a recommendation that a participant roll over his or her account balance to an IRA to take advantage of investment options not available under the plan is not investment advice, will be effective again.

Sammons v. Regence Bluecross Blueshield of Oregon, 739 F. App’x 385 (9th Cir., June 22, 2018), agreed with the district court’s use of a five-year period to determine the efficacy of artificial disc replacement surgery to treat a degenerative disc disease for purposes of a plan’s “investigational” exclusion, even though the plan itself contained no such time limit. A dissenting judge would have interpreted this ambiguity against Bluecross, which drafted the exclusion, based on Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534 (9th Cir. 1990).

Moore v. Apple Central, LLC, 893 F.3d 573 (8th Cir., June 25, 2018), concluded, erroneously in my view, that a claim by the beneficiary of a life insurance policy purchased under an employer-sponsored life insurance plan for the difference between the benefit elected by the employee and the benefit actually paid by the insurance company, which was lower because the employer failed to remit premiums withheld from the employee’s paycheck, had to be brought as a claim for benefits under ERISA § 502(a)(1)(B) (and that her state-law claim was completely preempted), but that if the employer had failed to submit any information (or premiums, presumably) to the insurance company, and therefore the beneficiary had been denied any benefit at all, she could have sought an equitable make-whole or “surcharge” remedy under ERISA § 502(a)(3) based on the employer’s breach of its fiduciary duty to obtain life coverage the employee applied and paid for.

On June 25, 2018, the Supreme Court (138 S. Ct. 2672), granted certiorari in Steager v. Dawson, 2017 WL 2172006 (W.Va., May 17, 2017), which concluded that exempting groups of state retirees from state income taxes, without affording federal retirees the same treatment, did not unlawfully discriminate against federal retirees. The Court granted certiorari on the issue of whether this violates the doctrine of intergovernmental tax immunity; it previously called for the
views of the Solicitor General on this issue. The Court heard oral arguments on December 3, 2018.

Val Lanes Recreation Center Corp. v. Commissioner, 115 T.C.M. (CCH) 1517 (June 26, 2018), concluded that the IRS abused its discretion in revoking a favorable determination letter previously issued to an ESOP, based primarily on its disagreement with factual conclusions by the IRS relating to (1) the value of a stock contribution and therefore whether the stock contribution exceeded the limits in Code § 415, (2) whether the appraiser that was used met the “independent appraiser” requirements in Code § 401(a)(28)(C), and (3) whether the company had timely adopted language implanting Code § 414(u). It cited Buzzetta Construction Corp. v. Commissioner, 92 T.C. 641, 648 (1989), which in turn cited Code § 7805(b), for the rule that the IRS’s determination that a plan is not qualified is reviewable only for abuse of discretion. However, it did not add, as Buzzetta did, that in Treas. Reg. § 601.201(1)(5) the Commissioner “limited his own discretion to revoke retroactively a favorable ruling.”

Trump v. Hawaii, 138 S. Ct. 2392 (June 26, 2018), contains a concurring opinion by Justice Thomas which argues at length against the legitimacy of nationwide injunctions. It cites Bray, Multiple Chancellors: Reforming the National Injunction, 131 Harv. L. Rev. 417 (2017), frequently.

Janus v. American Federation of State, County and Municipal Employees, 138 S. Ct. 54 (June 27, 2018), overruled Abood v. Detroit Board of Education, 431 U.S. 209 (1977), as “poorly reasoned” and concluded that an Illinois law designating the union selected by a majority vote of the members of a bargaining unit as the exclusive representative of all members of the unit violate the First Amendment. Quoting Knox v. Service Employees, 567 U.S. 298 (2012), the majority opinion by Justice Alito stated that a “significant impingement on First Amendment rights” occurs when public employees are required to provide financial support for a union that “takes many positions during collective bargaining that have powerful political and civic consequences,” and applied “exacting scrutiny” to determine that Illinois did not have a compelling state interest justifying that impingement. (Previously, in Connick v. Myers, 461 U.S. 138 (1983), the Court held that the “limited First Amendment interest involved” in workplace-related speech by public employees permitted any restriction on speech that the employer “reasonably believed” might have utility.) The minority opinion by Justice Kagan strongly disagreed with the majority’s criticisms and stated that “[t]oday, the Court succeeds in its 6-year campaign to reverse Abood,” starting with Knox. It warned that the decision “weaponiz[es] the First Amendment, in a way that unleashes judges, now and in the future, to intervene in economic and regulatory policy.” It noted that the court relied on Abood to conclude that mandatory fees imposed on state bar members are constitutional, raising the question of whether that is still allowed.

Condry v. UnitedHealth Group, Inc., 2018 WL 3203046 (N.D. Cal., June 27, 2018), concluded that UnitedHealth violated 29 C.F.R. § 2590.715-2713(a)(1)(iv) by failing to provide “meaningful access” to coverage for comprehensive lactation support and counseling to several women.

Findling v. United States, 2018 WL 3159600 (E.D. Mich., June 28, 2018), concluded, in an interpleader action filed by a court-appointed receiver in a divorce proceeding, that a tax lien on property of the husband under Code § 6321 (for failing to pay taxes in a year after their divorce)
did not extend to his benefits under a nonqualified deferred compensation plan because a previous order in the proceeding had given “all interest and title” in the plan to the wife.

*Natural Resources Defense Council v. National Highway Traffic Safety Administration, 894 F.3d 95 (2d Cir., June 29, 2018)*, concluded that “NHTSA exceeded its statutory authority in indefinitely delaying [a regulation implementing a statutorily required increase in civil penalties for violating the CAFE standards] and failed to follow the requirements of the APA when it did so.” It applied an arbitrary and capricious standard of review with no deference to the NTHSA because it found no ambiguity in the statute. It explained that “NHTSA’s argument . . . is essentially that there is a categorical authority for an agency to delay an effective date of an earlier rule pending reconsideration. We disagree. As the D.C. Circuit recently held, a decision to reconsider a rule does not simultaneously convey authority to indefinitely delay the existing rule pending that reconsideration.” It added that “NHTSA . . . argues that delay pending reconsideration is authorized because that is what many other agencies do. We take no position on whether the actions referred to by NHTSA involving different agencies operating under different statutory schemes and bound by different rules are lawful or not.”

*In re Allergan ERISA Litigation, No. 2:17-cv-01554-SDW-LDW (D.N.J., July 2, 2018)*, dismissed, for failure to state a claim, a class action brought by participants in a company-sponsored savings plan alleging that the fiduciaries of the plans violated their fiduciary duties by continuing to offer company stock as an investment option even though Allergan made statements that allegedly “misrepresented and failed to disclose adverse facts pertaining to Allergan’s business, operational and financial results,” and the fiduciaries “knew or should have known that Allergan’s statements artificially inflated its stock prices.” The court explained that the complaint failed to satisfy the pleading standards in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459 (2014). It also concluded that Allergan itself was not a plan fiduciary.

*In re Lusk, 589 B.R. 678 (Bankr. E.D. Cal., July 5, 2018)*, concluded that an employee acted in a fiduciary capacity when he knowingly withdrew, and spent, all of his retirement accounts without informing his ex-wife, even though she had an interest in them under a QDRO, and that he could not discharge his liability in bankruptcy because his failure to pay the amounts due under the QDRO constituted a “defalcation” within the meaning of Bankruptcy Code § 523(a)(4).

The exact contours of *Johnson v. Couturier*, 572 F.3d 1067 (9th Cir. 2009) (forbidding the enforcement of indemnification agreements that require a company that is wholly owned by an ESOP to pay the defense costs of the ESOP’s fiduciaries), including whether it applies whenever the company is 100%-owned and whether it ever applies outside that situation, continue to be litigated, at least in California. See, e.g., *Hurtado v. Rainbow Disposal Co., Inc.*, 2018 WL 3372752 (C.D. Cal., July 9, 2018); *Fernandez v. Franklin Res., Inc.*, 2018 WL 1697089 (N.D. Cal., April 6, 2018); *Harris v. GreatBanc Trust Co.*, 2013 WL 1136558 (C.D. Cal., March 15, 2013).

*Sivolella v. AXA Equitable Life Ins. Co.*, 742 F. App’x 604 (3d Cir., July 10, 2018), affirmed the district court’s decision rejecting a complaint that an AXA subsidiary “breached its fiduciary duty under § 36(b) of the Investment Company Act because the investment management and fund administration fees it collected [from mutual funds offered as investment options under
AXA variable annuity contracts] were excessive given the proportion of its responsibilities it delegated to its sub-administrator and its sub-advisers.” The district court applied the six factors identified in *Gartenberg v. Merrill Lynch Asset Management, Inc.*, 694 F.2d 923 (2d Cir. 1982), and endorsed in *Jones v. Harris Assoc’s, L.P.*, 559 U.S. 335 (2010), for determining whether a breach of fiduciary duty has occurred under ICA § 36(b).

*Campbell v. Commissioner*, T.C. Summ. Op. 2018-37 (July 12, 2018), concluded that a taxpayer who “routinely worked at various temporary worksites in the Chicago metropolitan area” was not entitled to deduct expenses for transportation between his residence and those worksites because “[a] taxpayer is entitled to deduct transportation expenses between the taxpayer’s residence and the taxpayer’s place of business only if the place of business constitutes a temporary distant worksite,” because they are not “outside the metropolitan area where . . . [petitioner] lives and normally works,” citing *Schurer v. Commissioner*, 3 T.C. 544 (1944), and Rev. Rul. 99-7, 1999-1 C.B. 361.

*HC4, Inc. Employee Stock Ownership Plan v. HC4, Inc.*, 2018 WL 3388870 (S.D. Tex., July 12, 2018), granted summary judgment to a company that sponsored an ESOP, which the ESOP alleged had violated its fiduciary duties to the ESOP by agreeing to a financially disastrous merger without performing adequate due diligence. The court explained that “[w]hen [HC4] decided to merge its company with [the other] companies, it was not acting in the capacity of a fiduciary of the ESOP. Rather, the decision to merge was an executive business decision. Furthermore, in making these business decisions, Defendant acted in good faith, with the care of an ordinarily prudent person under similar circumstances, and with the belief that the actions taken were in the best interests of the corporation.” The court noted that the ESOP in its complaint and brief “raise[d] many sound arguments regarding the prohibited transactions of ESOP fiduciaries in violation of ERISA § 406 [but the court] does not address these arguments because the Plaintiff did not plead a cause of action under that Section in its complaint.”

*The Boeing Co. v. Spirit Aerosystems, Inc.*, 190 A.3d 999 (Del., July 12, 2018), reargument denied (July 26, 2018), concluded that a purchase agreement in which Boeing sold a few of its manufacturing facilities to Spirit Aerosystems did not require Spirit to assume the special early pension and retiree medical benefits to which another court found they were entitled because it viewed their transfer to Spirit as a “layoff” within the meaning of their CBA, but only the standard pension and retiree medical benefits to which they were entitled by virtue of their seniority with Boeing.


*University Spine Center v. Empire Blue Cross and Blue Shield*, 2018 WL 3435074 (D.N.J., July 17, 2018), dismissed, for failure to state a claim as well as lack of subject-matter jurisdiction, a similar provider reimbursement claims even though it asked to amend its complaint to assert that it had standing to sue based a power of attorney, and *American Orthopedic & Sports Medicine v. Independence Blue Cross Blue Shield*, 890 F.3d 445 (3d Cir. 2018), which adopted the majority
rule in other circuits that valid anti-assignment clauses preclude claims based on assignments, also said that they were ineffective against valid powers of attorney. The court explained that it “need not reach the question of whether a valid power of attorney transferred from Patient to Plaintiff would allow Plaintiff to pursue claims on Patient’s behalf because Patient is time-barred from pursuing his ERISA claims under the plain language of the Plan,” which required a participant to commence a lawsuit within two years after receiving the service for which payment was sought.

Ryan v. Flowers Foods, Inc., 2018 WL 3427878 (N.D. Ga., July 16, 2018), granted summary judgment to the employer on a claim by three distributors that it misclassified them as independent contractors to deny them retirement plan benefits. The court explained that, even if they were employees, the plan excluded them from coverage as “individuals who are not treated as common law employees by the Employer or a Controlled Group member for purposes of its payroll records” and “individuals who are distributors or thrift store operators and who have executed a written agreement with a member of the Controlled Group for the distribution or sale of goods or products.”

Fletcher v. Honeywell International Inc., 892 F.3d 217 (6th Cir., June 8, 2018), cert. denied, 2018 WL 4954073 (U.S., Nov. 13, 2018), concluded that a CBA promised lifetime benefits for surviving spouses and dependents but not for retirees. It said that “[p]laintiffs can succeed on their claims [for lifetime benefits] only if they prove one of two things: (1) the CBAs unambiguously provide retirees with lifetime healthcare benefits, or (2) the CBAs are ambiguous, and the extrinsic evidence demonstrates that the parties intended to vest retiree healthcare benefits.” It interpreted CNH Industrial N.V. v. Reese, 138 S. Ct. 761 (2018), rev’g Reese v. CNH Industrial N.V., 854 F.3d 877 (6th Cir. 2017), to mean that “where a CBA has a general durational clause, that clause must be enforced absent a specific alternative end date provided for retiree healthcare benefits, or some other clear indication in the CBA that the general durational clause is not intended to apply to retiree healthcare.” It agreed with Bouboulis v. Transportation Workers Union of America, 442 F.3d 55 (2d Cir. 2006), that the grant of lifetime benefits for surviving spouses and dependents did not “constitute affirmative language that could reasonably be interpreted as creating a promise to vest the Retirees’ benefits.” It cited its own reasoning in Gallo v. Moen Inc., 813 F.3d 265 (6th Cir. 2016), that, in fact, “this tends to show that they knew how to provide for vested benefits and chose not to for retirees.” A concurring opinion said “I reluctantly concur because I am required to do so by binding case law. However, it is not obvious that the intent of the parties was as clearly expressed as our cases indicate.” UAW v. Honeywell International Inc., 2018 WL 3574718 (E.D. Mich., July 25, 2018), reached a similar conclusion with respect to language in an appendix to a CBA with the UAW.

In Bostock v. Clayton County Board of Commissioners, 894 F.3d 1335 (11th Cir., July 18, 2018), the Eleventh Circuit declined to rehear Bostock v. Clayton County Board of Commissioners, 723 Fed. Appx. 964 (Mem) (11th Cir., May 10, 2018), which had concluded that sexual orientation discrimination was not a form of sex discrimination under Title VII. A dissenting judge criticized the majority’s reliance on “a 39-year-old precedent, Blum v. Gulf Oil Corp., 597 F.2d 936, 938 (5th Cir. 1979),” describing it as “the precedential equivalent of an Edsel with a missing engine,” and noted that the en banc Seventh and Second Circuits had ruled to the contrary in Hively v. Ivy Tech Community College of Indiana, 853 F.3d 339 (7th Cir. 2017), and Zarda
v. Altitude Express, Inc., 883 F.3d 100 (2d Cir. 2018), respectively. A petition for certiorari was filed on May 25, 2018.

Johnson v. VCG-IS LLC, No. 30-2015-00802813 (Cal. Super. Ct., July 18, 2018), concluded that Dynamex Operations West Inc. v. Superior Court of Los Angeles County, 4 Cal. 5th 903, 416 P.3d 1 (April 30, 2018), applied retroactively because the Supreme Court “did not state that its decision applied only prospectively,” and also applied to the workers’ PAGA claims even though they were premised on labor code violations and did not directly seek to enforce any wage orders.

In re Wells Fargo ERISA 401(k) Litigation, Litig., 331 F. Supp. 3d 868 (D. Minn., July 19, 2018), dismissed a follow-on to the stock-drop lawsuit it dismissed in In re Wells Fargo ERISA 401(k) Litigation, 2017 WL 4220439 (D. Minn., Sept. 21, 2017). The earlier lawsuit was based on the defendants’ alleged breach of their duty of prudence – the duty at issued in Fifth Third Bancorp v. Dudenhoeffer, 134 S. Ct. 2459 (2014). The later lawsuit was based on the defendants’ alleged breach of their duty of loyalty. The court agreed with Wells Fargo that “the concerns that Dudenhoeffer expressed about prudence claims apply with equal force to loyalty claims, and therefore that judges must be as concerned about weeding out meritless loyalty claims as they are about weeding out meritless prudence claims.” However, it said that the “mechanism for weeding out meritless claims” announced in Dudenhoeffer, namely application of the “more-harm-than-good standard,” “wrenches [that] standard out of context.” Instead, it said that in a loyalty suit “the plaintiff must plead and prove that the defendant acted to further his own interests rather than the interests of the fund.” The court concluded that the plaintiffs had not done so, because their complaint merely alleged that “defendants failed to disclose inside corporate information,” but “defendants have no duty under ERISA to disclose that information; any such duty would arise under the securities laws, and, if defendants have acted wrongly, they can be held accountable under those laws.” The complaint also seemed to allege that “defendants breached their duty of loyalty not merely by failing to disclose inside corporate information, but also by making affirmative misrepresentations to the general public,” but it failed to allege that “defendants made such misrepresentations in their fiduciary capacity,” or that “plaintiffs chose to continue holding Wells Fargo stock in their 401(k) account because of any affirmative misrepresentation made by defendants.”

Sheedy v. Adventist Health System Sunbelt Healthcare Corp., 2018 WL 3538441 (M.D. Fla., July 23, 2018), refused to dismiss, for failure to state a claim, a lawsuit alleging that two DB plans associated with AHS were not exempt from ERISA as church plans. The court explained that it was a matter of fact whether the plans were “maintained by AHS, whose purpose is to operate health care facilities,” and thus that the plans were not church plans, or that they were “maintained by the designated administrative committees who are associated with the Seventh-Day Adventist Church,” and thus that they were church plans.

Munro v. University of Southern California, 896 F.3d 1088 (9th Cir., July 24, 2018), affirmed the district court’s conclusion in Munro v. University of Southern California, 2017 WL 1654075 (C.D. Cal., March 23, 2017), that participants in a class action lawsuit filed against fiduciaries of the university’s TDA plan alleging that they breached their fiduciary duties in the way they administered the plan could not be compelled to arbitrate their claims because the claims were
brought under ERISA § 502(a)(2) on behalf of the plan. The opinion did not address whether a plan document could be drafted so as to subject such claims to mandatory arbitration.

Altera v. Commissioner, 2018 WL 3542989 (9th Cir., July 24, 2018), reversed Altera v. Commissioner, 145 T.C. 91 (2015), which held that Treasury’s explanation of its decision in the preamble to the 2003 regulations requiring the inclusion of stock-based compensation in cost-sharing arrangements (T.D. 9088) was inadequate and therefore failed to meet the “reasoned decision-making” standard in Motor Vehicle Manufacturers Ass’n of the U.S. v. State Farm Mutual Auto Ins. Co., 463 U.S. 29 (1983). It treated the “reasoned decision-making” standard in State Farm as separate from the requirements for deference under Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984). It concluded that Treasury satisfied the the “reasoned decision-making” standard because “Treasury’s ‘path may reasonably be discerned’” (quoting State Farm). It concluded that Chevron deference was appropriate because there was enough support for Treasury’s conclusion in the wording of the 1986 amendment to Code § 482 and the legislative history. The dissenting judge said that “[t]he majority, in effect, ‘suppl[ies] a reasoned basis for the agency’s action that the agency itself has not given’” (again quoting State Farm). The majority opinion added in an interesting footnote that “[b]ecause the Commissioner does not contest the applicability of the APA or Chevron in this context, this case does not require us to decide the broader questions of the precise contours of the application of APA to the Commissioner’s administration of the tax system or the continued vitality of the theory of tax exceptionalism.” The July 24 decision was withdrawn on August 7, 2018, due to the death of one of the panel members, “to allow time for the reconstituted panel to confer on this appeal.”

Chamber of Commerce of the U.S. v. IRS, 2018 WL 3946143 (5th Cir., July 26, 2018), dismissed the IRS’s appeal at its request and therefore left the district court’s ruling at 2017 WL 4682049 (W.D. Tex., Sept. 29, 2017) intact. The district court concluded that a regulation under Code § 7874 “is a substantive or legislative regulation, not an interpretive regulation, and the Agencies are therefore not excused from the notice-and-comment procedure required by the APA,” and that “the Rule was unlawfully issued without adherence to the APA’s notice-and-comment requirements.” It also concluded that “the temporary nature of the Rule does not excuse the Agencies from the notice-and-comment procedure required by the APA.”

Good Fortune Shipping SA v. Commissioner 897 F.3d 256 (D.C. Cir., July 27, 2018), rev’g 148 T.C. No. 10 (2017), concluded that a regulation providing that bearer shares could not be used to satisfy an ownership requirement under Code § 883(c)(1) was invalid under step 2 of Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984), because it was “unreasonable.” The court explained that “[t]he IRS’s interpretation . . . appears to rewrite § 883(c)(1) to require not only valid ownership, but ownership that is not “difficult” to track.”

Martin S. Azarian, P.A. v. Commissioner, 897 F.3d 943 (8th Cir., July 27, 2018), affirmed a Tax Court determination that it did not have jurisdiction under Code § 7436(a)(1) to hear a dispute over whether the P.A. (an S corporation) owned additional employment tax based on the IRS’s determination that some of its distributions to Azarian should be recharacterized as wages rather than dividends. The P.A. argued that “the Commissioner’s determination that some of the payments were wages, not dividends, was a determination that – as to those payments – Azarian is an employee, not an owner.” However, “[t]he question is not only whether the recipient is an
employee, but also whether the payment is remuneration for services. Here, the only issue the Commissioner examined is the amount of remuneration for Azarian’s services.”

**Sacerdote v. New York University**, 328 F. Supp. 3d 273 (S.D.N.Y., July 31, 2018), concluded after a bench trial that NYU did not breach its duty of prudence in its administration of two section 403(b) plans though its Retirement Plan Committee (1) by failing to consolidate the two recordkeepers that each plan had into single recordkeeper sooner than it did, (2) by failing to conduct more frequent request-for-proposal processes related to recordkeeping vendors for the plans, (3) when it negotiated recordkeeping fee reductions for the plans, (4) by choosing to employ revenue-sharing model, rather than flat per-participant model, for collecting recordkeeping fees or (5) by continuing to offer real estate fund as investment option for the plans. It also concluded that (6) NYU closely monitored investment fund options for the plans, although it noted that only a few Committee members were active: “While the Court finds the level of involvement and seriousness with which several Committee members treated their fiduciary duty troubling, it does not find that this rose to a level of failure to fulfill fiduciary obligations. Between [the outside investment adviser]’s advice and the guidance of the more well-equipped Committee members . . ., the Court is persuaded that the Committee performed its role adequately.” Finally, it concluded that (7) the participants did not demonstrate that they sustained any damages for excessive recordkeeping fees.

**Charleston Area Medical Center, Inc. v. United States**, 138 Fed. Cl. 626 (July 31, 2018), concluded that the corporate interest rate should be used to calculate employment tax refunds to a non-profit entity because it was a corporation for federal tax purposes under Code § 7701(a)(3). The Second and Seventh Circuits reached the same conclusion in Maimonides Medical Center v. United States, 809 F.3d 85 (2d Cir. 2015), and Medical College of Wisconsin Affiliated Hospitals, Inc. v. United States, 854 F.3d 930 (7th Cir. 2017), respectively, as did a district court in Wichita Center for Graduate Medical Education v. United States, 2017 WL 6055708 (D. Kan., Dec. 7, 2017). As the opinion states, “This Court now joins that unanimous consensus.”

**In re Daley**, 2018 WL 3682487 (D. Mass., Aug. 2, 2018), concluded that the Code § 72(t) additional tax on early withdrawals is a penalty, not a tax, for purposes of Chapter 13 of the Bankruptcy Code, and therefore is classified as a general unsecured claim. The court explained that “[u]nder the so-called ‘Feiring-Anderson’ standard, taxes are defined as ‘pecuniary burdens laid upon individuals or their property, regardless of their consent, for the purpose of defraying the expenses of government or of undertakings authorized by it’.” It agreed with the debtors that “because the primary purpose of the 10% exaction is to deter taxpayers from taking early withdrawals from their retirement accounts, it is not a penalty for pecuniary loss and thus should be characterized as an unsecured general claim.” It disagreed with the IRS and agreed with In re Cassidy, 983 F.2d 161 (10th Cir. 1992), the only appeals court decision, that “the § 72(t) penalty is not for actual pecuniary loss [for the cost incurred in deferring tax revenue] because it is a flat rate penalty ‘bearing no relationship to the direct financial loss of the government’.” It noted that “[t]he exaction is also imposed on Roth IRAs, from which the government generally expects no tax revenue, and the rate does not change relative to the taxpayer’s age.”

**United States v. Chesapeake Firestop Products, Inc.**, 2018 WL 3729036 (D. Md., Aug. 6, 2018), granted a request by the government for an injunction against a business from which the IRS had difficulty collecting employment taxes. Authority for the injunction was based on Code
§ 7402(a), which gives district courts the ability to “issue in civil actions, writs and orders of injunction . . . and to render such judgments and decrees as may be necessary or appropriate for the enforcement of the internal revenue laws.” The court noted that courts are split as to the standard for granting an injunction pursuant to Code § 7402(a), but that most courts have concluded that the government need only show that an injunction is appropriate for the enforcement of the internal revenue laws, “without reference to the traditional equitable factors.” It noted that the Fourth Circuit had not determined which standard applies, but “[t]he question need not be addressed in the present case . . . because an injunction is appropriate under both the standard described in the statute and the traditional equitable principles.”

Guerra v. Teixeria, 2018 WL 3756716 (D. Md., Aug. 8, 2018), concluded that an employer’s willful filing of Forms 1099 instead of Forms W-2 for a worker does not violate Code § 7434(a), which provides that: “[i]f any person willfully files a fraudulent information return with respect to payments purported to be made to any other person, such other person may bring a civil action for damages against the person so filing such return.” The court agreed with Liverett v. Torres Advanced Enterprise Solutions, LLC, 192 F. Supp. 3d 648, 655 (E.D. Va. 2016), that “Congress’s goal in enacting § 7434 was to give redress to taxpayers aggrieved by the filing of information returns that fraudulently misrepresent the amount paid to the taxpayer” (emphasis added), and is not a proper vehicle by which to challenge the misclassification of an employee as an independent contractor.

Levy v. Young Adult Institute, Inc., 2018 WL 3773654 (2d Cir., Aug. 9, 2018), agreed with the district court that a Supplemental Pension Plan and Trust and Life Insurance Plan and Trust promised to the former CEO of YAI, a nonprofit, “were enforceable notwithstanding that they violate the public policy against excessive or unreasonable compensation for executives of nonprofit and tax exempt corporations.”

AICPA v. IRS, 2018 WL 3893768 (D.C. Cir., Aug. 14, 2018), concluded that Rev. Proc. 2014-42, which lays out the requirements for unenrolled tax return preparers under the IRS’s Annual Filing Season Program, was an “interpretive” rather than a “legislative” rule under the APA and therefore did not require notice and comment. It reasoned that the program was voluntary for unenrolled preparers, and merely interpreted the terms “necessary qualifications” and “competency” in 31 U.S.C. § 330(a). The dissent argued that it was a “legislative” rule because it effectively amended a prior legislative rule, and “there is no way an interpretation of ‘competency’ ‘can produce the sort of detailed . . . and rigid’ requirements the IRS has set forth in the Program.”


Enforcement Section of the Massachusetts Securities Division v. Scottrade, Inc., 327 F. Supp. 3d 345 (D. Mass., Aug. 16, 2018), granted the Enforcement Section’s motion to remand its enforcement action back to the Securities Division – in effect to reverse Scottrade’s earlier removal of the action to the district court. The Enforcement Section claimed that Scottrade violated internal policies that it had adopted to comply with the DOL’s fiduciary rule, mostly in connection with IRAs, and that this constituted “unethical or dishonest conduct or practices” in the securities business, and demonstrated that Scottrade “failed reasonably to supervise agents, investment adviser representatives or other employees,” both in violation of Massachusetts law. Scottrade alleged that the Enforcement Section was “merely attempting to enforce federal standards that were set forth in the now-vacated ‘Fiduciary Rule’,” and that the district court had jurisdiction to consider these claims under the “federal ingredient doctrine” and ERISA’s complete preemption doctrine. It might have made more sense for Scottrade to argue for this purpose that U.S. Chamber of Commerce v. DOL, 885 F.3d 360 (5th Cir. 2018), did not vacate the fiduciary rule in Massachusetts, because presumably there is more of a federal ingredient, and ERISA is more likely to require a state law claim to be converted into an ERISA claim, if the ERISA claim still exists, but Scottrade’s counsel did not seem to think that was possible, stating in oral argument that “if a federal appellate court vacates an order, it isn’t that it existed and no longer exists; it’s as if it never existed at all . . . . I don’t know that there’s a contrary view, frankly.” In any event, the district court disagreed, and said “[t]here is no explicit statement [in Chamber of Commerce] that the Court expected its judgment to apply nationwide and therefore defendant’s contention that the Fifth Circuit decision binds this Court is tenuous at best.” The court went on to conclude that it did not have jurisdiction under the “federal ingredient doctrine” because it “[i]t is true that Scottrade adopted its Impartial Conduct policy in response to the Fiduciary Rule but this Court need not interpret the Fiduciary Rule nor rule on its validity to determine whether Scottrade violated that policy.” It also concluded that it did not have jurisdiction under the complete preemption doctrine because the Enforcement Section did not have statutory standing to sue under ERISA. (Before reaching this conclusion the court erroneously asserted that ERISA applies to IRAs, citing case law dealing with employer-sponsored IRAs rather than regular IRAs. It also failed to consider that the Enforcement Section probably wouldn’t have had any cause of action under ERISA at all, even assuming it had statutory standing and the fiduciary rule was still valid, since all the fiduciary rule did did with respect to ERISA was force vendors to adopt policies like Scottrade’s in order to avoid prohibited transactions, not actually require them to do anything.) The debate about preemption is a reminder of the risk the DOL created when it issued the fiduciary rule of completely federalizing the field of IRA regulation and squeezing out state regulation.
IUE-CWA v. General Electric Co., 2018 WL 3949188(6th Cir., Aug. 16, 2018), concluded that language in a CBA and related documents prohibited GE from eliminating lifetime retiree health coverage for members of the bargaining unit only while the CBA was in effect, and did not prohibit GE from doing so for existing retirees at all. The court’s opinion observed that “[t]he most plausible explanation for the absence of explicit vesting language in these contracts is that they were negotiated when [Yard-Man] was still the law and so the parties did not think such language was necessary. Unfortunately for the retirees, that argument fails under our case law.” A concurring judge stated that “I concur in the majority opinion because our recent caselaw compels the conclusion that the vesting of lifetime healthcare benefits cannot be required under the collective bargaining agreements (CBAs) at issue. I write separately to express my concern about the jurisprudential path we have chosen to follow.” She noted that “[i]n 2011, GE managers and human resources representatives advised union-represented employees to retire before a new CBA took effect to ‘make sure that they would be able to continue to participate in the Retiree Benefit Plans’ under their existing terms. During the term of the 2011 CBA, hundreds of union-represented employees took a special form of early retirement that allowed for continued medical coverage, and ‘[e]ach of those individuals was promised continuing health benefits during her or his retirement in the form and with the benefits that were available under that collective bargaining agreement’.”

Dezelan v. Voya Retirement Ins. & Annuity Co., 2018 WL 3962924 (D. Conn., Aug. 17, 2018), dismissed, for failure to state a claim, an action brought by a participant in Cedars-Sinai Medical Center’s retirement plan alleging that Voya violated its fiduciary duties and engaged in prohibited transactions by setting the crediting rate for a stable value fund for its own benefit. The court explained that the contract did not allow Voya to increase its compensation and the complaint did not specifically allege that it did.

Lewis v. PBGC, 901 F.3d 406 (D.C. Cir., Aug. 21, 2018), interpreted the last sentence of ERISA § 4044(c) to require all post-termination gains and losses of a plan to be assigned to the PBGC, as the guarantor of benefits under the plan, regardless of whether it is acting as the statutory trustee, and therefore concluded that participants in a terminated plan had no claim for breach of fiduciary duty against the PBGC for keeping the gains earned by the plan. It explained that “[r]equiring the [PBGC] to disgorge a post-termination increase in the value of plan assets flatly contradicts § 1344(c). By statute, the pilots are entitled to their guaranteed benefits, while Congress directed that any post-termination increase or decrease in the value of plan assets should go to the Corporation. The pilots cannot circumvent that decision under the heading of equitable relief.”

In re Xiao, No. 13-51186 (JJT) (Bankr. D. Conn., Aug. 22, 2018), concluded that a pension plan that was amended (and apparently always intended) to cover only the debtor and his wife could not be excluded from his estate in a Chapter 7 bankruptcy under 11 U.S.C. § 522(d)(12). The court explained, colorfully, that “[t]he effect and calculus achieved by the decisions and modifications made to the Plan were, according to Mr. Xiao’s advisors, at his behest and at all times manifestly served to exclusively benefit Mr. Xiao and his then wife . . . . In the end, his tortured, incomplete, and contrived navigation of the [Code’s] compliance requirements for the Plan in order to support his claimed exemption under 11 U.S.C. § 522(d)(12) fails for the reasons articulated herein.” The court refused to apply 11 U.S.C. § 522(b)(4)(A) and presume the plan to be tax-qualified, even though it had received favorable determination letters, because “the
determination letters merely found the form of the plan acceptable,” and “[f]or this reason, a number of courts have not given presumptive effect to such letters under Section 522(b)(4)(A).” It explained that “[t]he evidence presented at trial, however, overwhelmingly supports that the Plan was not in substantial compliance with the [Code].”

Pacella v Town of Newburgh Volunteer Ambulance Corps, Inc., Nos. 2015-11948, 2015-11988, 2016-05403 & 2018-08922 (N.Y. App. Div., Aug. 22, 2018), concluded that ERISA did not apply to a length of service award program for volunteer firefighters “because the plaintiffs were not employees within the meaning of the statute” (citing Nationwide Mutual Ins. Co. v. Darden, 503 U.S. 318 (1992)).

Ramsay v. Commissioner, 732 Fed. Appx. 307 (5th Cir., July 23, 2018), upheld the Tax Court’s determination that the value of employer-provided group term life insurance was taxable compensation even though the employee neither requested nor wanted the coverage.

Brief for the Secretary of Labor as amicus curiae in Laurent v. PricewaterhouseCoopers LLP, No. 18-487-cv (2d Cir., filed Aug. 22, 2018), urges the Second Circuit to reverse the lower court’s decision in Laurent v. PricewaterhouseCoopers LLP, 2017 WL 3142067 (S.D.N.Y., July 24, 2017), that, even if the employer’s use of the 30-year Treasury rate to calculate future interest credits under a cash balance plan for purposes of determining their lump sum benefits was illegal, the participants had no remedy under ERISA § 502(a)(1)(B) because they were seeking a reformation rather than an interpretation of the plan.

Stokes v. North Coast Obstetrics & Gynecology, Inc., 2018 WL 4042350 (N.D. Ohio, Aug. 24, 2018), concluded that a provision in a physician’s employment contract stating that his compensation “shall include North Coast’s contribution to the 401(k) plan on his behalf” “impose[d] a contractual duty on Defendants to contribute to Plaintiff’s 401(k) [that is] not derived from the ERISA plan, but from the Employment Agreement,” and therefore the physician’s claim for damages for failure to comply with the provision was not completely preempted by ERISA.

Griffin v. Aetna Health Inc., 740 F. App’x 169 (11th Cir., Aug. 24, 2018), held that a health care provider was not entitled to statutory damages on the basis that a plan administrator refused to provide her with a copy of the plan’s SPD, because at the time she requested the SPD she had assignments from her patients that conferred only the right to receive benefits, not the right to sue under ERISA for statutory penalties.

Colvill v. Life Ins. Co. of North America, 2018 WL 4078398 (E.D. Wis., Aug. 27, 2018), concluded that an Appointment of Claim Fiduciary Form (“ACF”) which appointed the insurance company as the claims fiduciary for an employer’s LTD plan conferred enough discretion to satisfy Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), and required the court to apply an arbitrary and capricious standard of review to a denial of benefits, even though the ACF was “neither incorporated in the underlying policy nor explicitly referenced in the SPD.” The court explained that, under CIGNA Corp. v. Amara, 563 U.S. 421 (2011), “[a]n SPD requires express incorporation because its default function, as provided by statute, is as a non-plan, purely informational document. An ACF, on the other hand, may be one of the ‘series of documents none clearly labeled as “the plan”’ from which courts within the Seventh Circuit are accustomed to inferring the terms of an ERISA plan.”
Sanzone v. Mercy Health, 326 F. Supp. 3d 795 (E.D. Mo., Aug. 27, 2018), dismissed a lawsuit alleging that a Mercy Health pension plan was not exempt from ERISA as a church plan for lack of subject-matter jurisdiction (i.e., because it concluded that ERISA did not apply to the plan, and therefore there was no federal question). The court reasoned that (1) “the totality of the circumstances shows that the [Mercy Health] Benefits Committee is the entity that actually ‘maintains’ the Plan as that term is ordinarily used in the context most relevant here,” even though “plaintiffs are correct that Mercy Health is the sole entity that can modify or terminate the Plan,” (2) “[b]ecause the Benefits Committee is a body of persons formed for a common and particular purpose and has specific and exclusive responsibilities to further this purpose, it meets the dictionary definition of ‘organization’ as that term is ordinarily used,” and (3) Mercy Health is controlled by or associated with a church because it is “listed in the Official Catholic Directory,” and the Benefits Committee also is controlled by or associated with a church because “Mercy Health includes the Benefits Committee.” It also concluded that the plaintiffs lacked Article III standing to pursue their claim that the church plan exemption violates the Establishment Clause because they did not “demonstrate harm that is ‘actual or imminent, not conjectural or hypothetical.’” (It is not clear what standard the court applied in dismissing the ERISA claim. The Eighth Circuit previously concluded in Stalley v. Catholic Health Initiatives, 509 F.3d 517 (8th Cir. 2007), that the Twombly “facial plausibility” requirement for pleading a claim also applied to pleas for subject matter jurisdiction.)

Thompson v. United States, 2018 WL 4181958 (N.D. Cal., Aug. 30, 2018), concluded that the exception from the early withdrawal penalty in Code § 72(t) for distributions that are “made on account of a levy under section 6331 on the qualified retirement plan” does not apply in the absence of an actual levy. It explained that Congress “did not intend to include situations in which a withdrawal is made to avoid an impending levy that has not yet occurred.”

Quezada v. IRS, 2018 WL 4191856 (Bankr. W.D. Tex., Aug. 31, 2018), concluded that the IRS was not barred by the three-year statute of limitations in Code § 6501 from assessing backup withholding tax liabilities for 2005-2008 against a masonry contractor, because the period of limitations does not begin to run until a taxpayer files a return, and the contractor never filed Forms 945. The court rejected the contractor’s arguments that (1) it was sufficient that he filed Forms 1040 for 2005-2008, explaining that, like the taxpayer in Commissioner v. Lane-Wells Co., 321 U.S. 219 (1944), “Quezada also faced two liabilities – income taxes and backup withholding – and needed to file two returns, Forms 1040 and 945,” and (2) “all the information needed to assess the amount of backup withholding is in his Form 1040, and so the Form 1040 should count as a return under Beard v. Commissioner[, 82 T.C. 766 (1984), aff’d, 793 F.2d 139 (6th Cir. 1986)], explaining that “this very argument was made and rejected in Lane-Wells” because, when a taxpayer has two different liabilities, the IRS is entitled to require the information to be reported in a separate return.

Martone v. Robb, 902 F.3d 519 (5th Cir., Sept. 4, 2018), affirmed Martone v. Robb, 2017 WL 3326966 (W.D. Tex., Aug. 2, 2017), which dismissed, for failure to state a claim, a class action brought by participants in a 401(k) alleging that the fiduciaries of the plan violated their fiduciary duties by allowing workers to invest their savings in Whole Foods stock, based on Fifth Third Bancorp v. Dudenhoeffer, 134 S. Ct. 2459 (2014).

Pharmaceutical Care Management Association v. Tufte, No. 1:17-cv-141 (D.N.D., Sept. 5, 2018), concluded that ERISA does not preempt a North Dakota law that, among other things, “obligates PBMs and third-party payers having ownership interest in a pharmacy to disclose, to plan sponsors, on request, the difference between the amount paid to the pharmacy and the amount charged to the plan sponsor.” It refused to read Pharmaceutical Care Management Association v. Rutledge, 891 F.3d 1109 (8th Cir. 2018), and Pharmaceutical Care Management Association v. Gerhart, 852 F.3d 722 (8th Cir. 2017), as broadly as the PCMA wished, i.e., to preempt “a general state-law provision broad enough to encompass ERISA plans within its scope.” It noted that “North Dakota’s definition of ‘pharmacy benefits manager’ includes entities that contract with a broad range of parties. Although insurance plans may be one of these parties, the definition makes no distinction as to whether an insurance plan is subject to ERISA.” It added that “PCMA has explained, in detail, how the legislation will force PBMs to modify their business practices. [citation omitted] But it has not articulated a change in custom or practice that the legislation requires ERISA plans to make. A state law interferes with nationally uniform plan administration when it subjects plans to different requirements in different states. [citation omitted]” North Dakota’s law does not impose any requirements on ERISA plans. Consequently, the Court finds the legislation does not interfere with nationally uniform plan administration.”

Hager v. DBG Partners, Inc., 903 F.3d 460 (5th Cir., Sept. 6, 2018), reversed the district court’s holding that a former employee on COBRA had no remedy under ERISA for the employer’s failure to notify him when it terminated its health plan, thereby cutting short his COBRA coverage period. The court concluded that 29 C.F.R. § 2590.606-4(d) required the plan administrator (here the employer) to notify him when it terminated the plan, and ERISA § 502(a)(1)(A) allowed him to bring an action for the $100/day civil penalty described in ERISA § 502(c). It explained that “some district courts have ‘deemed [it] proper’ to award medical expenses as a penalty under [§ 502(c)]” and “[w]e can discern no barrier to the court awarding the amount of [the employee] medical expenses as a penalty.” It might have been influenced by the fact that the employee continued paying COBRA premiums after the termination date, and that the employer continued depositing them.

Rollins v. Dignity Health, 338 F. Supp. 3d 1025 (N.D. Cal., Sept. 6, 2018), refused to dismiss, for failure to state a claim, a lawsuit alleging that a Dignity Health pension plan was not exempt from ERISA as a church plan. The court concluded that the plaintiffs plausibly alleged that, for the exemption to apply, (1) the Dignity Health Retirement Plans Sub-Committee not only had to “administer” the plan, but also had to “maintain” it, and that, based on Advocate Health Care Network v. Stapleton, 137 S. Ct. 1652 (2017), to “maintain” a plan means to have the “primary ongoing responsibility (and potential liability) to plan participants,” which the Sub-Committee lacked because it did not have “the power to fund, continue, amend and/or terminate the Plan,” and (2) the Sub-Committee had to be “separately constituted from the plan sponsor,” which admittedly it was not. The court also concluded that it was a matter of fact whether Dignity Health or the Sub-Committee were “associated with” a church and therefore refused to dismiss the lawsuit on that basis. It said it would not address the plaintiffs’ claim that the church plan
exemption violates the Establishment Clause until it determined that the plan was in fact a church plan.

Clay v. Commissioner, 116 T.C.M. (CCH) 257 (Sept. 10, 2018), concluded that an employee’s LTD benefits were includible in her gross income in 2011 because her employer paid the premiums for the coverage, “none of which were included in her taxable income,” and the LTD benefits “were computed solely on a percentage of her salary and not on the nature of her injury.” It also concluded that the amount by which the LTD benefits had been overpaid, and which she therefore had an obligation to return, was includible in her gross income under the claim-of-right doctrine, and that it was not eligible for the same-year exception to the claim-of-right doctrine first enunciated in United States v. Merrill, 211 F.2d 297 (9th Cir. 1954), and adopted by the Tax Court in Bishop v. Commissioner, 25 T.C. 969 (1956), because “she did not make provision for repayment in 2011.”

California Trucking Ass’n v. Su, 903 F.3d 953 (9th Cir., Sept. 10, 2018), concluded that Dynamex Operations West Inc. v. Superior Court of Los Angeles County, 4 Cal. 5th 903, 416 P.3d 1 (April 30, 2018), required the “ABC” test to be used only for purposes of some aspects of state wage-and-hour law, and that therefore the California the Division of Labor Standards Enforcement could continue to use the more flexible “control test” in S. G. Borello & Sons Inc. v. Department of Industrial Relations, 48 Cal. 3d 341 (1989), in applying the minimum workplace standards it enforced. It also concluded that the Federal Aviation Administration Authorization Act of 1994, which preempts any state law “relating to a price, route or service of any motor carrier,” did not preclude the use of the Borello standard.

Gartlan v. Commissioner, T.C. Summ. Op. 2018-42 (Sept. 11, 2018), concluded that a taxpayer was not entitled to premium tax credits under S 36B because he had modified adjusted gross income below 100% of the federal poverty level. The court explained that “[w]hile we are not unsympathetic to petitioner’s situation, we are bound by the statute as written and the accompanying regulations when consistent therewith.”

Americans for Prosperity Foundation v. Becerra, 903 F.3d 1000 (9th Cir., Sept. 11, 2018), concluded that a requirement imposed on charities by the California Attorney General under a law allowing him to obtain “whatever information, copies of instruments, reports, and records are needed for the establishment and maintenance of [a registry of charitable corporations]” to submit copies of Schedule B to their Form 990s “survives exacting scrutiny as applied to the plaintiffs because it is substantially related to an important state interest in policing charitable fraud.” The court explained that, “[e]ven assuming arguendo that the plaintiffs’ contributors would face substantial harassment if Schedule B information became public, the strength of the state’s interest in collecting Schedule B information reflects the actual burden on First Amendment rights because the information is collected solely for nonpublic use, and the risk of inadvertent public disclosure is slight.” The court was not persuaded by the plaintiffs’ arguments that “disclosure to the California Attorney General would chill contributions” significantly, including “a letter from a contributor who chose to make a $25 contribution anonymously out of fear that ISIS would break into the [plaintiffs’] office, obtain a list of contributors and target them” and evidence that “some California officials harbor a negative attitude toward Charles and David Koch.” The Second Circuit reached the same conclusion in Citizens United v. Schneiderman, 882 F.3d 374 (2d Cir. 2018).
Omega Hospital, LLC v. United Healthcare Services, Inc., 2018 WL 4343411 (M.D. La., Sept. 11, 2018), involved a dispute over United’s recoupment of overpayments to a Louisiana hospital by reducing subsequent payments for services rendered by the hospital to patients who were not covered by the same group plan (cross-plan recoupment). The court concluded that (1) “United’s anti-assignment provisions are invalidated by La. R.S. § 40:2010,” (2) that law was not preempted by ERISA, notwithstanding United’s argument that Gobeille v. Liberty Mutual Ins. Co., 136 S. Ct. 936 (2016), “eviscerated the very reasoning upon which the Fifth Circuit relied on in [Louisiana Health Service & Indemnity Co. v. Rapides Healthcare System, 461 F.3d 529 (5th Cir. 2006),] in declining to hold La. R.S. [§] 40:2010 was preempted,” (3) the hospital “has sufficiently alleged that exhaustion should be excused due to United’s failure to provide meaningful access to administrative remedies,” but (4) the hospital’s claim “must fail because it has not plausibly plead [sic] that it is entitled to the benefits at issue [because it] has failed to allege that United directly recouped any overpayments from the ERISA Plans of SJ or LL as a result of the unilateral post-payment audits.” Instead, “in order for [the hospital] to challenge the legality of the cross-plan offsets, it must sue using the rights of patients who are participants in the Plans that executed the offsets.”

Gallagher v. Empire HealthChoice Assurance, Inc., 339 F. Supp. 3d 248 (S.D.N.Y., Sept. 11, 2018), refused to dismiss, for failure to state a claim, a lawsuit alleging that Empire violated the MHPAEA by consistently denying coverage for wilderness therapy for behavioral or substance abuse problems in administering Mount Sinai Health System’s health plan. It agreed with Vorpahl v. Harvard Pilgrim Health Ins. Co., 2018 WL 3518511 (D. Mass., July 20, 2018), that “[a]t least at the motion to dismiss stage, the relevant comparison is not whether benefits for wilderness therapy are available for medical/surgical patients, but rather whether the Plan has chosen to provide benefits for skilled nursing facilities and rehabilitation centers for medical/surgical patients, but chosen to deny benefits to those with mental health conditions who seek coverage for a residential treatment center offering wilderness therapy.” Courts have refused to dismiss similar lawsuits against Regence Blue Shield (A.Z. v. Regence Blueshield, 333 F. Supp. 3d 1069 (W.D. Wash., Aug. 9, 2018)), Harvard Pilgrim (Vorpahl, supra), and Microsoft (A.H. v. Microsoft Corp. Welfare Plan, 2018 WL 2684387 (W.D. Wash., June 5, 2018)). Last year, Cigna (Welp v. Cigna Health & Life Ins. Co., 2017 WL 3263138 (S.D. Fla. July 20, 2017)) became the first insurer to defeat one of these lawsuits, in a situation where (1) its exclusion of wilderness therapy programs was based on a broader set of requirements which the programs did not meet but which were applied to other programs, as well, and (2) the plaintiff did not “identify the treatments in the medical/surgical arena that are analogous to [wilderness therapy programs] and allege that there is a disparity in their limitation criteria.”

CustomAir Ambulance, LLC v. Lund Food Holdings, Inc., 2018 WL 4387575 (D. Minn., Sept. 14, 2018), concluded that a $234,373 claim for additional reimbursements by CustomAir Ambulance, an out-of-network air ambulance transport company, against a self-insured employer health plan could not proceed because CustomAir – as the assignee of the participant’s claim for benefits – had failed to exhaust the plan’s administrative claims procedure before filing suit. The plan administrator (which appeared to be a 10-or-more-employer VEBA active in the Midwest) argued that, while CustomAir had appealed its original decision to deny the entire $399,464 claim, that denial had been based on the conclusion that the service was not “medically necessary,” but “upon reconsideration of its initial denial, its subsequent decision required a separate first level review because its second, partial denial was based on different reasons than its initial
denial.” The court was understandably exasperated and wrote that “[t]he time has long since passed for the parties to resolve this issue among themselves.”

**Medical Mutual of Ohio v. Air Evac EMS, Inc.** 2018 WL 4411695 (N.D. Ohio, Sept. 17, 2018), concluded that state law claims for $5 million in additional reimbursements by Air Evac, an out-of-network air ambulance transport company, against MMO, an insurance company, were not completely preempted by ERISA where “Air Evac seeks damages as a result of the alleged breach of an implied contract between Air Evac and MMO[, and] [i]n bringing its claim, Air Evac makes no mention of ERISA plans, nor does it reference any MMO representations to MMO-insured patients regarding their ERISA plans in establishing its claim.”

**De Los Santos v. Commissioner.** 116 T.C.M. (CCH) 304 (Sept. 18, 2018), concluded that a life insurance policy purchased through the welfare benefit plan of the taxpayer’s S corporation was a split-dollar life insurance arrangement under Treas. Reg. § 1.61-22(b)(2).

**Boyden v. Conlin,** 2018 WL 4473347 (W.D. Wis., Sept. 18, 2018), concluded on a motion for summary judgment that an exclusion for “[p]rocedures, services, and supplies related to surgery and sex hormones associated with gender reassignment” adopted by the Wisconsin Government Insurance Board (GIB), which determines the terms of the insurance plans offered to state employees through the Employee Trust Fund (ETF), “constitutes sex discrimination in violation of Title VII and [ACA § 1557],” and also violates the Equal Protection Clause of the U.S. Constitution. It said it “continues to join other district courts in finding a private right of action under [ACA § 1557].” The GIB removed the exclusion in mid-2016, based largely on an ETF staff conclusion that HHS regulations under ACA § 1557 (81 Fed. Reg. 31375 (May 18, 2016)) prohibited the exclusion and that ETF was a “covered entity” because of its receipt of Medicare Part D subsidies, but reinstated the exclusion in late 2016 after receiving a memorandum from the Deputy Attorney General “at the behest of the Governor’s office” that the HHS rules were “unlawful.” At that time Wisconsin was part of a lawsuit challenging the HHS regulation, which ultimately resulted in the issuance of a nationwide injunction in **Franciscan Alliance, Inc. v. Burwell,** 227 F. Supp. 3d 660 (N.D. Tex., Dec. 31, 2016). But the court noted that the Seventh Circuit in **Hively v. Ivy Tech Community College,** 853 F.3d 339 (7th Cir., April 4, 2017) (en banc), and **Whitaker v. Kenosha Unified School District,** 858 F.3d 1034 (7th Cir., May 30, 2017), had concluded, to the contrary, that Title VII and Title IX (and consequently § 1557) prohibited discrimination based on sexual orientation. The court applied strict scrutiny to the exclusion under the Equal Protection Clause because it “treat[s] individuals differently based on sex,” and concluded that the exclusion violated the Clause because “the actual or genuine reason for the reinstatement had to do with the [Wisconsin] DOJ’s guidance – specifically, the belief that the Texas court’s entry of an injunction absolved defendants of any legal obligation to provide coverage” – rather than the cost, efficacy or safety of gender transition surgery.

**EEOC v. Baltimore County,** 904 F.3d 330 (4th Cir., Sept. 19, 2018), concluded that the appropriate remedy for having discriminated against older employees by requiring them to pay higher pension plan contributions than younger employees was to pay each worker affected by the bias the amount that he or she overpaid into the plan, because back pay is a mandatory remedy under the ADEA.
PBGC v. Findlay Industries, Inc., 902 F.3d 597 (6th Cir., Sept. 4, 2018), reversed PBGC v. Findlay Industries, Inc., 2016 WL 7474404 (N.D. Ohio, Dec. 29, 2016), which had rejected two arguments made by the PBGC in an attempt to collect liabilities relating to the termination of a single-employer plan. The first argument was that a trust for the benefit of the company founder’s sisters should be included in the company’s controlled group because, among other things, the trust was a “trade or business” for purposes of that section because it was leasing a parcel of property to the company, and the second was that certain purchasers of the assets of the company should be liable as “successors” of the company. The district court adopted the definition of a “trade or business” from Commissioner v. Groetzinger, 480 U.S. 23 (1987), which did not encompass the mere leasing of property, and it reasoned that the corporate reorganization rule in ERISA § 4069(b) “defines[s] the contours of successor liability” in the single-employer context. By contrast, the Sixth Circuit rejected the Groetzinger test as “narrow and specific to tax law,” and adopted the “categorical test” favored by the PBGC and applied by the Second, Seventh and Ninth Circuits in the multiemployer context under which “any entity that leases property to a commonly controlled company is categorically a trade or business.” It also reasoned that “[s]uccessor liability promotes fundamental ERISA policies by guaranteeing that substance matters over form,” and decided that the best way to accomplish that was to apply the “body of federal common law applying successor liability in employment and labor cases.” However, it cautioned that “[a]ll that we decide today is that when there is a sale that is not conducted at arm’s length, successor liability can apply.”

Hansen v. Group Health Cooperative, 902 F.3d 1051 (9th Cir., Sept. 4, 2018), concluded that a claim by a group of psychotherapists against an insurer was not completely preempted by ERISA, and remanded the claim to state court for further proceedings. The therapists claimed that the insurer injured their practices in violation of the Washington Consumer Protection Act by using the “Milliman Care Guidelines” as its primary criteria for authorizing mental health treatment. There seemed to be three components to this claim, namely that the use of the guidelines was inherently unfair and deceptive because they were biased against mental healthcare, that the insurer deceptively use the guidelines to avoid paying for mental healthcare coverage required by Washington’s Mental Health Parity Act, and that the insurer unfairly competed by employing its own therapists who strictly adhere to the guidelines and by discouraging patients from seeking treatment from therapists who do not work for the insurer. The court concluded that the district court had misapplied Aetna Health Inc. v. Davila, 542 U.S. 200 (2004). As to the first argument, it reasoned that “[t]here is no dispute that the [therapists’] claim for wrongfully licensing allegedly biased mental health coverage guidelines is based on an independent duty to refrain from engaging in unfair and deceptive business practices.” As to the second argument, it reasoned – surprisingly in my view – that Washington’s Mental Health Parity Act created a statutory duty that was independent of the existence of any ERISA-covered health plans because “[t]he relevant inquiry . . . focuses on the origin of the duty, not its relationship with health plans.” As to the third argument, it reasoned that “[a]ny duty for [the insurer] to refrain from unfairly harming its competitors arises under state law, not under the terms of an ERISA plan.”

Roy C. v. Aetna Life Ins. Co., No. 2:17-cv-01216-DB (D. Utah, Sept. 19, 2018), dismissed, for failure to state a claim, a lawsuit alleging that Aetna violated the MHPAEA by excluding wilderness therapy from coverage in administering the KPMG LLP Health and Welfare Plan, because “Plaintiffs have failed to sufficiently identify a comparison or analogue to wilderness treatment in the medical and surgical fields of treatment.” Without saying so, the court disagreed with
courts like Gallagher v. Empire HealthChoice Assurance, Inc., 339 F. Supp. 3d 248 (S.D.N.Y., Sept. 11, 2018), and Vorpahl v. Harvard Pilgrim Health Ins. Co., 2018 WL 3518511 (D. Mass., July 20, 2018), which reasoned that “the relevant comparison is not whether benefits for wilderness therapy are available for medical/surgical patients, but rather whether the Plan has chosen to provide benefits for skilled nursing facilities and rehabilitation centers for medical/surgical patients, but chosen to deny benefits to those with mental health conditions who seek coverage for a residential treatment center offering wilderness therapy.”

Tovar v. Essentia Health, 2018 WL 4516949 (D. Minn., Sept. 20, 2018), dismissed, for failure to state a claim, a claim by a covered employee, whose son had been diagnosed with gender dysphoria, that a categorical exclusion in a health plan for all health services related to gender transition violated ACA § 1557. The court explained that she “lacks Article III standing and this Court therefore lacks jurisdiction to consider her claim against HealthPartners.” However, it refused to dismiss the claim by the employee’s son. The court refused to dismiss the claim on the basis, asserted by the defendants, that “Section 1557 does not provide protection against gender identity discrimination,” explaining that “[b]ecause Title VII, and by extension Title IX, recognize that sex discrimination encompasses gender-identity discrimination, the Court concludes that Section 1557 also prohibits discrimination on the basis of gender identity.” It also refused to dismiss the claim against the TPA on the basis, asserted by the defendants, that “because Plaintiffs did not allege that HealthPartners had the authority to change the Plan, Plaintiffs have failed to state a plausible Section 1557 claim,” explaining that “[n]othing in Section 1557, explicitly or implicitly, suggests that TPAs are exempt from the statute’s nondiscrimination requirements.” It also concluded that the employee’s son had statutory standing to bring his claim, explaining that his “interest . . . falls within the zone of interests meant to be protected by Section 1557,” and that “the harm that [he] suffered, i.e., being denied access and receiving delayed access to medically necessary care, was proximately caused by HealthPartners’ designing and providing to Essentia the discriminatory provisions in the Plan.”

Wigdahl v. Fox Valley Family Physicians, S.C., 2018 WL 4520380 (N.D. Ill., Sept. 21, 2018), concluded that a surviving spouse’s lawsuit against UnitedHealthcare of Illinois for negligence in failing to instruct her husband to call 911 given his description of his medical symptoms when he contacted the insurer, and in failing to instruct him to go to the emergency room, was not completely preempted by ERISA and thus could be remanded to a state court, because she “focuses her claim on the quality of care UHC and its employees . . . provided, not any denial of specific benefits under [her husband]’s insurance plan.”

O’Connor v. Uber Technologies, Inc., 904 F.3d 1087 (9th Cir., Sept. 25, 2018), applied Epic Systems Corp. v. Lewis, 138 S. Ct. 1612 (2018), to reverse the district court’s orders denying Uber’s motions to compel arbitration by members of a previously certified class of its drivers who had accepted arbitration agreements (and alleged they had been misclassified as independent contractors), as well as its previous certification of the class itself.

Tellep v. Oxford Health Plans, 2018 WL 4590000 (D.N.J., Sept. 25, 2018), applied Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon, 541 U.S. 1 (2004), to conclude that a sole proprietor’s state-law claims against an insurer from which he had purchased a plan for himself and his employees was completely preempted by ERISA. The court explained that the claims related to the administration of the plan, and that “Plaintiff was a working owner with non-owner
employees, and therefore the health insurance plan he purchased falls entirely within ERISA’s compass.”

**Quatrone v. Gannett Co., Inc.**, No. 1:18-cv-00325 (E.D. Va., Sept. 26, 2018), dismissed, for failure to state a claim, of an action brought by a participant in a 401(k) plan alleging that Gannett violated its fiduciary duties by continuing to allow the plan to invest in the stock of Tegna Inc., a spun-off company, even though the complaint alleged that it was approximately 90% more volatile the market as a whole. The court reasoned that the participant had not alleged any of the special circumstances – such as fraud, improper accounting or illegal conduct – contemplated by the Supreme Court in **Fifth Third Bancorp v. Dudenhoeffer**, 134 S. Ct. 2459 (2014).

**Bajrami v. Reliance Standard Life Ins. Co.**, F. Supp. 3d 659 (E.D. Pa., Sept. 27, 2018), applied the doctrine of extraterritoriality to ERISA. Citing **EEOC v. Arabian American Oil Co.**, 499 U.S. 244 (1991), it described that doctrine as holding that “legislation of Congress, unless a contrary intent appears, is meant to apply only within the territorial jurisdiction of the United States.” It noted that two other decisions, **Maurus v. Snyder**, 2000 WL 1368024 (E.D. Pa., Sept. 14, 2000), and **Chong v. InFocus Corp.**, 2008 WL 5205968 (D. Ore., Oct. 24, 2008), had applied the doctrine to ERISA, as well. It therefore concluded that a claim for disability benefits by a Kosovo national employed by a foreign affiliate of a United States company in Afghanistan was governed by state law (as provided in the disability policy) rather than ERISA. It explained that “[e]ven though the plan is administered in the United States and the decision to deny the claim allegedly occurred domestically, as in Chong, whether the disability benefits plan was properly denied greatly depends on issues arising outside of the United States. Bajrami’s employment was wholly within Afghanistan, his offer of disability insurance coverage was made in Afghanistan to be performed outside the territorial limits of the United States, and his physical examinations and medical diagnoses were conducted abroad.”

**Smith v. OSF Healthcare System**, 2018 WL 4680671 (S.D. Ill., Sept. 28, 2018), followed the analysis in **Medina v. Catholic Health Initiatives**, 877 F.3d 1213 (10th Cir. 2017), and **Sanzone v. Mercy Health**, 326 F. Supp. 3d 795 (E.D. Mo., Aug. 27, 2018), in concluding that a Catholic health care system’s pension plan qualified as a “church plan” because it was “maintained” by a qualifying organization that was controlled by or associated with a church (the same analysis the IRS uses).

**In re Huenerberg**, 590 B.R. 862 (Bankr. E.D. Wis., Sept. 28, 2018), concluded that the excise tax imposed by Code § 5000A for violating the individual mandate is not a penalty (as argued by the debtors) but also not an excise tax (as argued by the IRS) for purposes of 11 U.S.C. § 507(a) and therefore is not entitled to priority status in bankruptcy.

**Davis v. Washington University in St. Louis**, 2018 WL 4684244 (E.D. Mo., Sept. 28, 2018), dismissed claims that Washington University and its Board of Trustees, which were the named fiduciaries for its section 403(b) plan, breached their fiduciary duties of prudence and loyalty and engaged in prohibited transactions by (1) causing the Plan to overpay for recordkeeping and administrative services, (2) causing the Plan to pay higher fees by offering “retail” investment class shares, (3) including duplicative and poorly performing funds “bundled” into the Plan by TIAA-CREF and Vanguard, (4) failing to take action to address persistent underperformance of
certain investment options, and (5) approving a loan program that was prohibited by ERISA. The court explained that “Plaintiffs start with the false premise that just because the Plan’s fees could have been lower that necessarily Defendants’ breached their fiduciary duties [and] fail to allege that the process of choosing the investment options was flawed, other than a mere inference of fiduciary wrongdoing.”

On October 1, 2018, the Supreme Court invited the solicitor general to file a brief on whether the Court should review Thole v. U.S. Bank National Ass’n, 873 F.3d 617 (8th Cir. 2017).

F. Lee Bailey v. United States, 592 B.R. 400 (B.A.P. 1st Cir., Oct. 3, 2018), concluded that a bankruptcy court’s order concluding that the debtor’s interests in future pension and Social Security payments were not property of the debtor’s estate was an interlocutory order and did not satisfy the established criteria for reviewing such an order. The court explained that “[t]o warrant interlocutory review, the order on appeal must . . . involve a legal issue on which there is a substantial ground for difference of opinion,” but that, “[h]ere, although the First Circuit has yet to address the question, there is no longer a ‘stark’ or ‘bad’ split among the courts that have addressed the issue since 2003. Since [IRS v. Snyder, 343 F.3d 1171 (9th Cir. 2003) (ruling that an anti-alienation clause in a debtor’s pension plan prevented the debtor’s interest in the plan from being included in the bankruptcy with respect to all creditors, including the IRS)], courts have consistently ruled that a debtor’s interest in an ERISA-qualified pension fund does not constitute property of the debtor’s bankruptcy estate, and cannot be the basis for establishing a secured claim by the IRS.”

McCann v. Unum Provident, 907 F.3d 130 (3d Cir., Oct. 5, 2018), concluded that a claim for LTD benefits under a supplemental policy purchased by a resident through Henry Ford Hospital, where he once worked, had to be brought under ERISA because the LTD policy did not fit within the safe harbor in 29 C.F.R. § 2510.3-1(j)(3), in that (1) “residents were not presented with a menu of options or free to select any insurer,” (2) the hospital’s insurance broker explained that “Provident ‘is the industry’s leader in individual disability coverage for physicians’ and was ‘chosen by the Henry Ford Medical Group to provide supplemental disability insurance to Ford physicians,’ [and thus a] reasonable employee could conclude the Hospital was endorsing the plan,” and (3) the hospital determined eligibility for the policy. The court reasoned that “the key inquiry for endorsement [under 29 C.F.R. § 2510.3-1(j)(3)] is whether an employer has strayed from the equilibrium of neutrality,” “endorsement exists where there is some showing of material employer involvement in the creation or administration of a plan, and “this involvement may manifest as an expression of encouragement.”

On October 8, 2018, the parties announced a settlement of claims brought against HCSC in Doe v. Health Care Services Corp., No. 1:16-cv-04571 (N.D. Ill.), alleging that it wrongly denied coverage for stays at residential mental health treatment facilities.

Vest v. Resolute FP US Inc., 905 F.3d 985 (6th Cir., Oct. 10, 2018), concluded that an employer did not breach its fiduciary duty under ERISA when it failed to notify an employee of his right to “port or convert” his optional group life policy into an individual life insurance policy once he ceased employment. It agreed with the district court that fiduciaries are liable for failures to disclose information not otherwise required to be disclosed by ERISA only when “(1) an early retiree asks a plan provider about the possibility of the plan changing and receives a misleading
or inaccurate answer or (2) a plan provider on its own initiative provides misleading or inaccurate information about the future of the plan or (3) ERISA or its implementing regulations required the employer to forecast the future and the employer failed to do so” (quoting Haviland v. Metropolitan Life Ins. Co., 730 F.3d 563, 572 (6th Cir. 2013), and Sprague v. General Motors Corp., 133 F.3d 388, 405, 406 (6th Cir. 1998) (en banc)).

Communications Workers of America v. Alcatel-Lucent United States, Inc., 2018 WL 4908281 (D.N.J., Oct. 10, 2018), dismissed a claim that Alcatel’s transfer of participants in an overfunded pension plan (LTPP), along with shares of the plan’s overfunding, to two different underfunded pension plans “constitutes a violation of the exclusive benefit rule in ERISA Section 403(c)(1) and the fiduciary duties in ERISA Section 404(a) because it does not satisfy any of the limited exceptions to ERISA Sections [sic] 403(c)(1) or 404(d) . . . and results in LTPP assets being used to benefit both [Alcatel] and persons who are not and never were participants in the LTPP.” The court concluded that (1) the plaintiffs lacked Article III standing because the plan merely stated (in section 4.11) that any surplus remaining when the LTPP was terminated “shall be applied solely for pension purposes in an equitable manner consistent with the purposes of the Plan,” and “ Plaintiffs are unable to point to any case in which a provision like Section 4.11 . . . granted plan participants a revisionary interest in surplus plan assets”; (2) even if they had standing Alcatel “amended the LTPP by transferring retirees and assets from the LTPP to two other plans through plan amendments. Accordingly, . . . neither Section 403(c)(1) nor Section 404(a) are implicated by Defendants’ actions because such actions were not fiduciary in nature”; and (3) “[e]ven if [Alcatel’s] actions were considered fiduciary in nature, . . . Plaintiffs fail to state a claim upon which relief may be granted” because the case law – including Hughes Aircraft Co v. Jacobson, 525 U.S. 432 (1999), and Trenton v. Scott Paper Co., 832 F.2d 806 (3d Cir. 1987) – allows employers to use surplus assets in this way.

Machacek v.Commissioner, 906 F.3d 429 (6th Cir., Oct. 12, 2018), reversed the Tax Court and concluded that when an S corporation pays a premium on a life insurance policy for the benefit of an employee-shareholder, and the payment is a “compensatory” split-dollar arrangement under Treas. Reg. § 1.61-22(b)(2)(ii), Treas. Reg. § 1.301-1(q)(1)(i) requires the economic benefits of the arrangement to be treated as distributions of property to the employee-shareholder even in the S corporation context, and the S corporation rules prevent that constructive distributions from being taxed. The court observed that “[t]he non-deductibility of the premium payment is not disputed, and the Machaceks concede that they must report the amount of the premium payment as pass-through income.” The IRS (and apparently the Tax Court) would have allowed the S corporation to take a deduction under Code § 83(h) in a future tax year “when it actually transfers ownership of the policy to [the employee-shareholder],” but meanwhile would have taxed the economic benefits as compensation. The difference seems to be that, under the Sixth Circuit’s interpretation, the inside build-up under the policy will not be subject to tax currently, and might escape tax entirely if the policy is held until the employee-shareholder dies.

Brotherston v. Putnam Investments, LLC, 907 F.3d 17 (1st Cir., Oct. 15, 2018), involved claims by a group of 401(k) plan participants that Putnam’s selection of in-house mutual funds as investment options under the plan and its receipt of management fees from the funds violated the plan fiduciaries’ duties under ERISA and constituted prohibited transactions. The court (1) affirmed the district court’s conclusion in Brotherston v. Putnam Investments, LLC. 2017 WL 1196648 (D. Mass., March 30, 2017), that the selection of the in-house mutual funds did not
violate ERISA § 406(a)(1)(C) because of the reasonable compensation exception in ERISA § 408(b)(2), (2) remanded for further consideration whether it violated ERISA § 406(b)(3) or was exempt based on PTCE 77-3, and (3) concluded that the defendants had conceded that Putnam “failed to discharge its fiduciary duty” in selecting the funds. In light of the last conclusion, the principal issue then became which party bore the burden of proving that the plan suffered a loss as a result of the breach. The court joined the Fourth, Fifth and Eighth Circuits in ruling that the burden of demonstrating a lack of causation falls to the defendant after a valid case for fiduciary breach has been made. On March 19, 2018, the Court invited the solicitor general to file a brief expressing the government’s views on the subject in connection with a petition for certiorari in Pioneer Centres Holding Co. Stock Ownership Plan v. Alerus Financial, N.A., 138 S. Ct. 1317 (March 19, 2018). But on September 20, 2018, the petition for certiorari was dismissed.

Sellers v. Minerals Technologies, Inc., No. 17-20555 (5th Cir., Oct. 18, 2018), concluded that an executive of an acquired company was entitled to incentive compensation even though his employment agreement required him to be employed on January 18, 2015, in order to receive the incentive compensation, and the new owners terminated his employment in December 2014, because (1) the court read the pay-in-lieu-of-notice provision in the agreement extend his employment until February 14, 2015, and (2) even if it did not “we find it appropriate under the circumstances of this case to deem the condition fulfilled or excuse its fulfillment [because,] under Texas jurisprudence, if one party prevents another from performing a condition precedent or renders its fulfillment impossible, then the condition may be considered fulfilled.”

Leading Age New York Inc. v. Shah, No. 93 (N.Y., Oct. 18, 2018), struck down, as arbitrary and capricious, regulations promulgated by the New York Department of Health limiting executive compensation paid by certain healthcare providers receiving state funds (primarily Medicaid) to $199,000 per year unless one of two exceptions applied. The court reasoned that “[b]y attempting to control how an entity uses its private funding, DOH has ventured beyond legislative directives relating to the efficient use of state funds and into the realm of broader public policy concerns. Put another way, the soft cap imposes a restriction on management of the health care industry that is not sufficiently tethered to the enabling legislation identified by DOH, which largely concerns the expenditure of state funding for public healthcare.”

Self Insured Services Co. v. Panel Systems, Inc., 2018 WL 5260025 (E.D. Va., Oct. 22, 2018), applied state (Virginia) law in determining whether the TPA for a self-insured plan had a contractual duty to indemnify an employer for costs, claims and expenses, including damages and attorney’s fees, arising out of a provider’s lawsuit demanding additional payments from the plan. The employer alleged that the TPA failed to disclose its financial interest in ensuring that the provider be paid, which caused it to make the payments. The case is interesting in that (1) there was no argument that the employer’s state law claims were completely preempted by ERISA, and (2) the court rejected the employer’s claim that the TPA had a fiduciary duty under ERISA to communicate complete and accurate information to the employer, which it failed to do, because the employer “has not alleged any loss to the Plan at issue here, nor will its desired relief inure to the benefit of the Plan.”

The Electrical Welfare Trust Fund v. United States, 907 F.3d 165 (4th Cir., Oct. 23, 2018), agreed with the district court that it did not have jurisdiction to consider a claim by a self-insured
group health plan for a refund of the transitional reinsurance fee under ACA § 1341 that the plan paid for 2014. (CMS-9954-F, 79 Fed. Reg. 13744 (March 11, 2014), exempted self-administered self-insured plans from transitional reinsurance fees for 2015-2016, but not 2014.) The court said that exclusive jurisdiction therefore rested with the Court of Federal Claims. Citing Flora v. United States, 357 U.S. 63 (1958), among others, the court explained that “internal revenue taxes are those collected by the IRS, under the authority of the Internal Revenue Code. That conclusion disposes of this case: because the payment here was made not to the Treasury, but to HHS under the Transitional Reinsurance Plan, it was not an internal revenue tax.” The court noted that the Supreme Court used the same analysis in National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012). It noted that “[w]hile the Fund seeks to characterize Sebelius as ‘a results-driven analysis by a Court intent on upholding the constitutionality of the ACA,’ . . . . it is neither the Fund’s prerogative nor ours to speak of the Court’s decisions in such derisive terms.” The Eighth Circuit reached the same conclusion in Batsche v. Price, 875 F.3d 1176 (8th Cir. 2017).

Griffin v. United Healthcare of Georgia, Inc., 2018 WL 5304739 (11th Cir., Oct. 25, 2018), affirmed the district court’s conclusion that an assignment of benefits by a plan participant authorizing a provider to request plan documents, which was executed by the plan participant several years after the plan initially denied the provider’s claims, could not be applied retroactively against the third party administrator.

Liljeberg v. Commissioner, 907 F.3d 623 (D.C. Cir., Nov. 2, 2018), concluded that three students at foreign universities who worked in the U.S. during the summer of 2012 on J visas under the State Department’s Summer Work Travel Program could not deduct the cost of traveling from their home countries and living in the U.S. as “away from home” business expenses under Code § 162(a)(2). Citing Commissioner v. Flowers, 326 U.S. 465 (1946), the court said that, even if they were correct that the expenses were incurred while they were “away from home,” the expenses did not satisfy the third condition of Code § 162(a)(2), which requires a taxpayer to show that he or she incurred the expenses “in the pursuit of a trade or business,” because their U.S. employers “did not require [them] to move to the [U.S.] temporarily; rather, [they] chose to come to the [U.S.] to participate in the Summer Work Travel Program. Their travel expenses flowed from that choice rather than the needs of their temporary employers.” The court also strongly implied that the presumption that expenses are incurred while “away from home” if they are incurred in connection with temporary employment applies only if a taxpayer is otherwise regularly employed at his or her tax home, noting that that was one of the facts of the examples in Rev. Rul. 93-86, 1993-2 C.B. 71. The court (and apparently the IRS) dismissed a statement in Pub. 515 that “nonresident alien [scholarship] student or grantee may deduct away-from-home expenses (meals, lodging, and transportation) . . . if he or she expects to be away from his or her tax home for 1 year or less,” explaining that “Agency guidance [cannot] contradict the plain terms of the third condition of the statute.”

Paza Staffing Services Inc. v. Commissioner, 2018 WL 5778258 (3d Cir., Nov. 2, 2018), affirmed Paza Staffing Services Inc. v. Commissioner, Order No. 6881-12R (T.C., Aug. 17, 2017), and upheld the IRS’s determination that an ESOP was disqualified for failing to meet the non-discriminatory coverage requirements of Code § 410(b)(1). It agreed that the rule in Code § 1563(e)(3)(C) that stock owned by a trust will not be attributed to its beneficiary under Code § 1563(e)(3)(A) if the trust is tax-qualified did not apply because Code § 414(b) says that rule
does not apply for purposes of the sections listed there, including Code § 410. A similar trust attribution rule, under Code § 267(c)(1), was at issue in Petersen v. Commissioner, 148 T.C. 463 (2017).

Valle v. Commissioner, T.C. Summ. Op. 2018-51 (Nov. 5, 2018), agreed with the IRS that the expense incurred by a Spanish attorney to obtain an LL.M. at NYU was a personal expenditure rather than an ordinary and necessary business expense because “although petitioner may have improved his skills as an international attorney by obtaining his LL.M., the degree qualified him for a new trade or business, the practice of law in New York.” It distinguished Allemeier v. Commissioner, 90 T.C.M. (CCH) 197 (2005), because, as the opinion in that case noted, “an M.B.A. differs from a professional degree such as an LL.M. received by a foreign lawyer not admitted to a State bar because the M.B.A. is not a course of study that leads to qualification for a professional certification or license.”

Mount Lemmon Fire District v. Guido, 139 S. Ct. 22 (Nov. 6, 2018), agreed with the EEOC that ADEA applies to political subdivisions no matter what size (i.e., even if they have fewer than 20 employees).

On November 7, 2018, the PBGC filed an amicus brief, and The Segal Group, Inc. filed a notice of appearance as amicus counsel, in The New York Times Company v. Newspaper and Mail Deliverers’-Publishers’ Pension Fund, No. 18-1140 (2d. Cir., appeal filed April 19, 2018). The Second Circuit is reviewing the district court’s decision at 303 F. Supp.3d 236 (S.D.N.Y. 2018) that a multiemployer plan could not use the “Segal Blend” to calculate the liability of employers that withdrew from the plan because it didn’t represent the “best estimate” of how the fund’s assets would perform over time. By contrast, Manhattan Ford Lincoln, Inc. v. UAW Local 259 Pension Fund, 331 F. Supp. 3d 365 (D.N.J., July 3, 2018) (appeal filed Aug. 2, 2018), ruled that a different multiemployer plan could rely on that method.

Bunn v. FDIC, 908 F.3d 290 (7th Cir., Nov. 8, 2018), concluded that the FDIC, which had been appointed as the receiver for Valley Bank Illinois, was authorized by 12 U.S.C. § 1828(k)(1), which allows it to “prohibit or limit, by regulation or order, any golden parachute payment or indemnification payment,” to refuse to pay a “change of control termination benefit” to an executive of the bank. The statute defines a golden parachute payment as one that is “contingent on the termination of such party’s affiliation with the institution or covered company” and is paid after the appointment of a receiver. The statute contain an exception for a “bona fide deferred compensation plan,” but the court agreed with the District Court that the exception did not apply because the regulations require, among other things, that the bank have accrued a liability for benefits under such a plan according to the rules of GAAP.

Gernandt v. SandRidge Energy, Inc., 2018 WL 5851519 (W.D. Okla., Nov. 8, 2018), dismissed, for failure to state a claim, an action brought by participants in SandRidge’s 401(k) Plan alleging that the fiduciaries of the plans violated their fiduciary duties by continuing to offer company stock as an investment option despite “SandRidge stock ceased trading on a major market while being held by the Plan, . . . its January 2016 delisting, 2015 warnings regarding the imminent delisting, and status as an unreliable penny stock.” The court explained that the complaint “remains devoid of any well-pleaded facts which show the events complained of constituted
“special circumstances” as to impose fiduciary liability under Fifth Third [Bancorp v. Dudenhoeffer, 134 S. Ct. 2459 (2014)].”

Northwest Administrators, Inc. v. Santa Clarita Convalescent Corp., 2018 WL 5886454 (W.D. Wash., Nov. 9, 2018), concluded that a company formed to acquire a skilled nursing facility from Santa Clarita Convalescent Corp. (SCCC), and the company’s owner, did not have actual or constructive notice of SCCC’s potential withdrawal liability from a multiemployer plan at the time of the asset purchase, and therefore under Resilient Floor Covering Pension Trust Fund v. Michael’s Floor Covering, Inc., 801 F.3d 1079 (9th Cir. 2015), were not jointly or severally liable for it. It explained that they did not have actual knowledge because they “had not previously purchased, owned, or operated an entity affiliated with a labor union or participating in a multi-employer pension plan,” the company “was unfamiliar with the concept of withdrawal liability,” and the seller “expressly warranted that it did not sponsor, maintain, or contribute to any pension or benefit plans.” It explained that they did not have constructive knowledge because “all [the company] knew was that SCCC was a party to a collective bargaining agreement,” and “given the information [it] had, further investigation was simply not indicated.” It distinguished Heavenly Hana LLC v. Hotel Union & Hotel Industry of Hawaii Pension Plan, 891 F.3d 839 (9th Cir. 2018), as involving a purchaser that “operated other hotels that participated in multi-employer pension plans, knew that the seller contributed to such a plan, and, in previous deals, had instructed its due diligence team to investigate potential withdrawal liability.”

White v. Chevron Corp., 2018 WL 5919670 (9th Cir., Nov. 13, 2018), affirmed the district court’s dismissal of a claim that the fiduciaries of Chevron’s retirement plan had breached their fiduciary duties of loyalty and prudence because “the allegations showed only that Chevron could have chosen different vehicles for investment that performed better during the relevant period, or sought lower fees for administration of the fund. None of the allegations made it more plausible than not that any breach of a fiduciary duty had occurred.”

Mostajo v. Nationwide Mut. Ins. Co., 2018 WL 5979603 (E.D. Cal., Nov. 13, 2018), concluded that Nationwide’s vacation plan was a “payroll practice” under ERISA based on 29 C.F.R. § 2510.3-1(b)(3) and Massachusetts v. Morash, 490 U.S. 107 (1989). It explained that Nationwide paid the vacation benefits from its “general assets” as required by those authorities even though it paid them through a trust because “[t]he Trust has no other source of funding beyond Nationwide, the Nationwide Benefits Administrative Committee determines the payments to be made to the Trust and by the Trust, and the Trust has no independent recourse against Nationwide for failure to pay. Thus, the vacation benefits payments here rely almost entirely on Nationwide’s, not the trust’s, financial health because Nationwide is essentially funding the account on a fortnightly basis in relation to its anticipated payments.”

Baouch v. Werner Enterprises, Inc., 908 F.3d 1107 (8th Cir., Nov. 14, 2018), concluded that travel expense reimbursements could be counted towards minimum wages even though they were provided under an accountable plan and therefore were excluded from gross income. The court explained that “[t]he IRS regulations governing accountable plans are not identical to the DOL regulations governing the calculation of employees’ regular rates for minimum wage purposes. There are legal differences and, in the case of a regular rate calculation, many additional factors at play. The two findings are not coextensive and thus a finding in one does not negate or direct a finding in the other.”
CSX Corp. v. United States, 909 F.3d 366 (11th Cir., Nov. 21, 2018), concluded that relocation benefits and moving expense reimbursements were not RRTA wages based on Code § 3231(e)(1)(iii), which excludes “an amount paid specifically – either as an advance, as reimbursement or allowance – for traveling or other bona fide and necessary expenses incurred or reasonably expected to be incurred in the business of the employer.” It also stated that Wisconsin Central Ltd. v. United States, 138 S. Ct. 2067 (2018), “suggested” that they were not included in RRTA wages as “money remuneration” in the first place, but declined to address that issue because “it is not clear that CSX preserved [it] on appeal.”

Sun Capital Partners III, LP v. New England Teamsters & Trucking Industry Pension Fund, 2018 WL 6169366 (D. Mass., Nov. 26, 2018), concluded that the fund could recover from Sun Capital an additional $3.5 million for mandatory interest, damages, fees, and other costs relating to a portfolio company’s withdrawal from the fund, which was the subject of previous litigation.

Griffin v. Teamcare, 2018 WL 6166252 (7th Cir., Nov. 26, 2018), concluded that a health care provider who had been assigned a patient’s rights to “pursue claims for benefits, statutory penalties, [and] breach of fiduciary duty” under a plan was entitled to statutory damages under ERISA § 502(c)(1) because the plan administrator delayed providing her the plan’s SPD for five months and refused to provide her with a third party’s fee schedule that was used to calculate the amounts paid by the plan. The court explained that “[a]n assignee designated to receive benefits is considered a beneficiary and can sue for unpaid benefits under [ERISA § 502(a)(1)(B)]—something the plan does not dispute. [citations omitted] Bringing that suit (or an administrative appeal) requires access to information about the plan and its payment calculations—here, how Central States determined the usual, reasonable, and customary rate. [citations omitted] It follows that Dr. Griffin also must be a beneficiary able to sue when she is denied requested information.”

Sulyma v. Intel Corp. Investment Policy Committee, 909 F.3d 1069 (9th Cir., Nov. 28, 2018), reversed and remanded Sulyma v. Intel Corp. Investment Policy Committee, 2017 WL 1217185 (N.D. Cal., March 31, 2017), which dismissed, as barred by the statute of limitations in ERISA § 413, a claim that the fiduciaries of a Code § 401(k) plan violated their fiduciary duties by offering as an investment option a fund that made significant investments in hedge funds and private equity. The court concluded that, to satisfy the knowledge requirement under ERISA § 413, “the defendant must show that the plaintiff was actually aware of the nature of the alleged breach more than three years before the plaintiff’s action is filed.”

Acosta v. Chimes D.C., Inc., 2018 WL 6251002 (D. Md., Nov. 29, 2018), ruled, on a motion for summary judgment, that nonfiduciary service-providers to a welfare benefit plan did not knowingly participate in prohibited transactions with the plan by receiving 7.5% of plan contributions for their services, because the DOL “failed to put forth evidence to demonstrate that the BCG Defendants had actual or constructive knowledge that the bargained-for fees that they were receiving from the Plan were excessive at that time such that Chimes DC was committing a prohibited transaction by paying the fees to BCG. Such a showing is essential to making their case.”

Carmichael v. Laborers’ & Retirement Board Employees’ Annuity & Benefit Fund of Chicago, Ill., 2018 IL 122793 (Nov. 29, 2018), concluded that the Illinois legislature violated the pension
protection clause of the Illinois Constitution when it prospectively eliminated the ability of participants in the fund to receive service credits for employment with private unions while on leaves of absence from their public positions with the city, and “clarified” retroactively that their higher private union salary could not be used in their public annuity calculation. It also concluded that an existing rule prohibiting participants from using these techniques if they participated in “any pension plan” of the private union applied only to participation in DB plans.

Archuleta v. Commissioner, T.C. Summ. Op. 2018-55 (Dec. 3, 2018), denied deductions to a taxpayer for unreimbursed employee business expenses for car and truck and cell phone expenses related to his employment. It explained that “an employee business expense is not deductible as ‘ordinary and necessary’ if the employee is entitled to reimbursement from his or her employer. [citations omitted] If an employee is entitled to reimbursement under the employer’s reimbursement policy and fails or forgets to seek it, the employee is not allowed a deduction for the expenses. See Orvis v. Commissioner, 788 F.2d 1406, 1408 (9th Cir. 1986), aff’g [48 T.C.M. (CCH) 1295 (1984)]; Lucas v. Commissioner, 79 T.C. 1, 7 (1982); Kennelly v. Commissioner, 56 T.C. 936, 943 (1971), aff’d without published opinion, 456 F.2d 1335 (2d Cir. 1972).”

Thompson v. Reliant Care Management Company, LLC, 2018 WL 6331806 (E.D. Mo., Dec. 4, 2018), concluded that a severance pay provision in an employment contract was not subject to ERISA where “the severance payments would be easily calculated by simple or mechanical determinations not an ongoing administrative scheme.”

The California Supreme Court heard arguments on December 5, 2018, on the appeal of Goonewardene v. ADP LLC, 5 Cal. App. 5th 154 (Nov. 4, 2016), which concluded that ADP could be held liable for the torts of negligent misrepresentation and professional negligence for issuing wage statements that omitted certain double time payments, and that ADP fell outside the limitation of liability applicable to professional providers of financial reports (i.e., auditors).

Cotten v. Blue Cross & Blue Shield of Massachusetts HMO Blue, Inc., 2018 WL 6416813 (D. Mass., Dec. 6, 2018), dismissed, for failure to state a claim, an ERISA § 502(a)(1)(B) claim that BCBSMA denied plan participants promised benefits by refusing to cover wilderness therapy for children with mental health and substance abuse disorders, because “[t]he exclusionary language cited by BCBS is unambiguous: it specifically disclaims coverage for ‘residential or other care that is custodial care,’ including ‘services that are performed in educational, vocational, or recreational settings; and outward bound-type, wilderness, camp, or ranch programs’.” It also refused to allow the plaintiffs to make an ERISA § 502(a)(3) (breach of fiduciary duty) claim in the alternative because, despite CIGNA Corp. v. Amara, 563 U.S. 421 (2011), the court was “reasonably confident” that the First Circuit would adhere to its position in LaRocca v. Borden, Inc., 276 F.3d 22 (1st Cir. 2002), that, if a plaintiff can pursue benefits under the plan under ERISA § 502(a)(1)(B), there is an adequate remedy under the plan which bars a further remedy under ERISA § 502(a)(3).

concluded that the complaint plausibly alleged that a prudent fiduciary in the position of the plan fiduciaries could not have concluded that the alternatives available to them would have done more harm than good. Specifically, it concluded that the complaint plausibly alleged that disclosures of alleged accounting improprieties, which concealed the fact that IBM’s Microelectronics unit was impaired, “could have been included within IBM’s quarterly SEC filings and disclosed to the ESOP’s beneficiaries at the same time in the Plan defendants’ fiduciary capacity” without requiring (in the words of the district court) an “unusual disclosure outside the securities laws’ normal reporting regime [that] could spook the market, causing a more significant drop in price than if the disclosure were made through the customary procedures,” and that such disclosures could have avoided the reputational harm that “is a common result of fraud and grows the longer the fraud is concealed, translating into larger stock drops.”

H.H. v. Aetna Life Ins. Co., 2018 WL 6614223 (S.D. Fla., Dec. 13, 2018), dismissed, for failure to state a claim, ERISA § 502(a)(1)(B) claims for reimbursement of the costs of wilderness therapy for two teenagers at two different facilities, and a claim that the failure to cover the costs at one of the facilities violated the MHPAEA. The court explained that (1) the relevant Aetna insurance plans both covered the costs of treatment at “residential treatment facilities,” and the complaints had not sufficiently alleged that the wilderness therapies at the two facilities satisfied the plans’ definitions or other coverage criteria; and (2) the failure to cover the costs at one of the facilities did not violate the MHPAEA because “[o]n the face of the insurance plan, there is simply no blanket exclusion of mental health or substance abuse treatment provided by residential treatment center programs,” the “Plaintiffs do not sufficiently allege that Aetna has a practice of categorically denying coverage for mental health or substance abuse services at residential treatment centers,” and the plaintiffs’ assertions that the requirements Aetna imposed on residential treatment centers were more onerous than those it imposed on medically necessary services at skilled nursing facilities were “conclusory and unsupported by anything else in the Complaint.”

Maccarone v. Lineage Law, LLC, 2018 WL 6579161 (M.D. La., Dec. 13, 2018), denied an employer’s motion for summary judgment to dismiss a claim by an employee for reimbursement of her medical expenses that would have been covered by the employer’s SHOP health plan but for the fact that the employer – in admitted violation of its fiduciary duties – failed to remit premiums for the plan. The court explained that “monetary relief, limited to making the employee whole, is within the scope of appropriate equitable remedies available under [ERISA § 502(a)(3)],” and that she could not have brought a claim for benefits under ERISA § 502(a)(1)(B) “because the plan no longer exists.”

California v. Azar, 911 F.3d 558 (9th Cir., Dec. 13, 2018), affirmed the district court’s decision in California v. HHS, 281 F. Supp. 3d 806 (N.D. Cal. 2017), that the administration’s issuance of the expanded religious and “moral” exemptions from the contraceptive mandate in the temporary regulations published in 2017 (82 Fed. Reg. 47792 (Oct. 13, 2017) and 82 Fed. Reg. 47838 (Oct. 13, 2017)) violated the APA because the agencies did not have statutory authority for bypassing notice and comment and bypassing notice and comment was not harmless to the plaintiff states, but reversed its issuance of a nationwide injunction and limited it to the plaintiff states. The court explained that “[t]he detrimental consequences of a nationwide injunction are not limited to their effects on judicial decisionmaking. There are also the equities of non-parties who are deprived the right to litigate in other forums. [citations omitted] Short of intervening in a case,
non-parties are essentially deprived of their ability to participate, and these collateral consequences are not minimal. Nationwide injunctions are also associated with forum shopping, which hinders the equitable administration of laws. See Samuel L. Bray, Multiple Chancellors: Reforming the National Injunction, 131 Harv. L. Rev. 417, 458-59 (2017) (citing five nationwide injunctions issued by Texas district courts in just over a year).”

Texas v. United States, 2018 WL 6589412 (N.D. Tex., Dec. 14, 2018), concluded, on a motion for summary judgment, that as a result of the TCJA’s reduction of the individual shared-responsibility penalty in Code § 5000A(c) to zero, “the Individual Mandate no longer ‘triggers a tax’ beginning in 2019. So long as the shared-responsibility payment is zero, the saving construction articulated in [National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012),] is inapplicable and the Individual Mandate cannot be upheld under Congress's Tax Power.” “Further, the Court declares the remaining provisions of the ACA . . . are INSEVERABLE and therefore INVALID” (emphasis in original). The court did not issue an injunction, so the ACA remains in effect pending the inevitable appeal. Later the same day CMS Administrator Seema Verma tweeted that “[t]he recent federal court decision is still moving through the courts, and the exchanges are still open for business and we will continue with open enrollment. There is no impact to current coverage or coverage in a 2019 plan.”

Summa Holdings, Inc. v. Commissioner, 848 F.3d 779 (6th Cir. 2017), Benenson v. Commissioner, 887 F.3d 511 (1st Cir. 2018), and Benenson v. Commissioner, 910 F.3d 690 (2d Cir., Dec. 14, 2018), collectively reversed Summa Holdings, Inc. v. Commissioner, 109 T.C.M. (CCH) 1612 (2015), as it pertained to three different groups of taxpayers living in three different circuits. All of the decisions related to transactions in which a family-owned C corporation, Summa, paid tax-deductible DISC commissions to a DISC, the DISC distributed them as taxable (per Code § 246(d)) dividends to its parent, another C corporation, and that C corporation distributed them as non-taxable dividends to Roth IRAs owned by the sons of the family. Applying the substance-over-form doctrine, the IRS recharacterized the DISC commissions as constructive dividends to the shareholders of Summa, and the dividends paid by the C corporation to the Roth IRAs as excess contributions rather than investment earnings of the IRAs, and issued notices of deficiency to Summa, its shareholders, and the sons, and the Tax Court upheld those deficiencies. The Sixth Circuit decision rejected this recharacterization as it pertained to Summa; the First Circuit decision rejected this recharacterization as it pertained to the sons; and the Second Circuit decision rejected this recharacterization as it pertained to certain shareholders of Summa. The First Circuit decision explained that “[s]ome may call the Benensons’ transaction clever. Others may call it unseemly. The sole question presented to us is whether the Commissioner has the power to call it a violation of the Tax Code. We hold that he does not. The substance over form doctrine is not a smell test. It is, in this circuit, a tool of statutory interpretation. When, as here, we find that the transaction does not violate the plain intent of the relevant statutes, we can push the doctrine no further.”

In re General Electric ERISA Litigation, 2018 WL 6592091 (D. Mass., Dec. 14, 2018), involved claims by a group of 401(k) plan participants that GE’s selection of in-house mutual funds as investment options under the plan and its receipt of management fees from the funds constituted prohibited transactions and violated the plan fiduciaries’ duties under ERISA. The court concluded that (1) the first claim was barred by the statute of limitation, but (2) the second claim could not be dismissed for failure to state a claim. The court distinguished In re Fidelity ERISA
Float Litigation, 829 F.3d 55 (1st Cir. 2016), and Brotherston v. Putman Investments, LLC, 2017 WL 1196648 (D. Mass., March 30, 2017), rev’d on other grounds, 907 F.3d 17 (1st Cir., Oct. 15, 2018), which dismissed similar claims on the grounds that the accounts from which the amounts were paid were not “plan assets,” noting that “Plaintiffs are not simply alleging that Defendants received financial benefit from the fees, but that as the funds failed to perform, and as other outside investor left the funds, the number of Plan participants in the funds continued to increase. [citation omitted] Because Plaintiffs’ claim is broader and also encompasses the shares of the funds that financially benefitted Defendants, Plaintiffs’ argument would not be precluded by these cases. Plaintiffs’ claim would properly fall under ERISA § 406(b)(1).”

United States v. Berry, 2018 WL 6602184 (S.D. Tex., Dec. 17, 2018), concluded that ERISA did not prevent the government from garnishing a man’s rollover IRAs, which were community property with his wife, to recover restitution stemming from his wife’s involvement in wire fraud, mail fraud, and making and subscribing a false tax return, because ERISA does not apply to IRAs and “[t]here is no federal case, involving an IRA rollover, that holds that some federal law, other than ERISA, preempts state community property law.” The court agreed with PLR 199937055 (Sept. 17, 1999) that Code § 408(g) did not preempt state community property law, and reached the same conclusion with respect to Code § 408(a)(4).

Trustees of the United Mine Workers of America 1992 Benefit Plan v. Westmoreland Coal Co., 2018 WL 6920227 (Bankr. S.D. Tex., Dec. 29, 2018), concluded that the obligations under the federal Coal Industry Retiree Health Benefit Act of 1992 of Westmoreland Coal Co. and its affiliates, which filed for bankruptcy under Chapter 11 of the Bankruptcy Code on October 9, 2018, were subject to Bankruptcy Code § 1114 because “[t]he definition of ‘retiree benefits’ [in that section] contains no limitation to suggest that Congress intended for contractual benefits to be treated any differently than statutorily created ones.” It also concluded that the obligations were not taxes subject to the Anti-Injunction Act. United Mine Works of America Combined Benefit Fund v. Toffel, 2018 WL 6803736 (11th Cir., Dec. 27, 2018), reached the same conclusions regarding the obligations of Walter Energy, Inc. and its affiliates.

IHC Health Service, Inc. v. Swire Pacific Holdings, Inc., 2019 WL 131855 (D. Utah, Jan. 8, 2019), concluded that, under Geddes v. United Staffing Alliance Employee Medical Plan, 469 F.3d 919 (10th Cir. 2006), “the plan administrator [Swire], who possesses ‘the final authority for the administration and interpretation of the Plan documents[,]’ is a proper defendant to an action under [ERISA § 502(a)(1)(B)].”

Wilcox v. Georgetown University, 2019 WL 132281 (Jan. 8, 2019), dismissed claims that Georgetown University and two individual defendants, which were the named fiduciaries for its section 403(b) plan, “imprudently selected and retained certain investment options that caused excessively high administrative fees and that it failed to manage the plans’ investments prudently.” The court dismissed the allegations with respect to certain investment options because the named plaintiffs failed to allege an injury-in-fact sufficient to satisfy the standing requirement under Article III. It dismissed the allegation that “[d]efendants breached their fiduciary duties by allowing three recordkeepers – TIAA, Vanguard and Fidelity – and thereby ‘creat[ed] needless additional expense and complexity’,” because “[a] fiduciary may carry out his duties in different ways but whether he violates his duty of prudence requires that ‘the advisor-manager must charge a fee that is so disproportionately large that it bears no reasonable relationship to the
services rendered and could not have been the product of arm’s-length bargaining.’ [citation omitted] Plaintiffs’ allegations fail to meet this standard.”

Weaver v. HealthComp, Inc., 2019 WL 151564 (Cal. Ct. App., Jan. 10, 2019), concluded that an employee’s state law causes of action against administrators of an employer health plan for giving the employer information about and the employee’s health status (and firing her) were preempted by ERISA. The court explained that “when, as in this case, a plaintiff asserts state law claims based on alleged misconduct that was within the scope of the conduct regulated by ERISA, including the privacy protections required to be included in ERISA group health plans, invoking state law remedies for that alleged misconduct constitutes an impermissible attempt to enforce ERISA privacy rights by means of an alternative enforcement mechanism; as to those claims, the state law provisions have an impermissible connection with ERISA plans and are therefore preempted.”

G. OTHER GUIDANCE

1. EEOC Guidance


2. HHS/CMS (and Related) Guidance

83 Fed. Reg. 3880 (Jan. 26, 2018) contains proposed regulations which would delegate to HHS’s Office for Civil Rights (OCR) the “authority to enforce the Federal health care conscience and associated anti-discrimination laws,” e.g., relating to the funding of abortions, the names and citations to which are listed in the proposed regulations.

83 Fed. Reg. 7437 (Feb. 21, 2018), contains proposed rules jointly issued by Treasury (REG-133491-17), DOL, and HHS (CMS-9924-P) that would (1) amend the definition of short-term, limited-duration insurance in Treas. Reg. § 54.9801-2 to require a maximum coverage period of less than 12 months (rather than three months as required by the existing regulations, which were amended in 2016 (81 Fed. Reg. 75316 (Oct. 31, 2016))) and (2) require a notice to appear in the contract stating that the coverage is not MEC and is not required to comply with the ACA. The change was expected after Executive Order 13813, Promoting Healthcare Choice and Competition Across the United States, 82 Fed. Reg. 48385 (Oct. 17, 2017), which instructed the DOL, Treasury and HHS to “consider proposing regulations or revising guidance, consistent with law, to expand the availability of [short-term, limited-duration insurance].”

83 Fed. Reg. 8487 (Feb. 27, 2018), contains a notice from HHS’s Health Resources and Service Administration announcing that it updated its Women’s Preventive Services Guidelines effective
as of December 29, 2017. The update added two additional services: screening for Diabetes Mellitus after pregnancy and screening for urinary incontinence.

83 Fed. Reg. 16930 (April 17, 2018) contains final HHS rules (CMS-9930-F) (notice of benefit and payment parameters for 2019) making miscellaneous changes relating to the risk adjustment, reinsurance, and risk corridors programs and changes to many other provisions for 2019. The final rules make few changes to the proposed rules issued in 2017 (82 Fed. Reg. 51052 (Nov. 2, 2017)). Among other things, those proposed rules allowed each state to choose a benchmark plan or benefits offered in another state, or “otherwise select a set of benefits,” to define EHBs, as long as it at least equaled the scope of benefits provided under a typical employer plan, allowed state-based exchanges that use the federal HealthCare.gov platform to set their own standards for network adequacy of providers and essential community providers, and removed the actuarial value requirements for stand-alone dental plans. The final rules were accompanied by a fact sheet, the final 2018 annual letter to issuers, and other documents.


HHS Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs, 83 Fed. Reg. 22692 (May 16, 2018), is a request for information on “how the Department can take action to improve competition and end the gaming of regulatory processes, support better negotiation of drug discounts through government insurance programs, create incentives for pharmaceutical companies to lower list prices, and reduce consumer out-of-pocket spending at the pharmacy and other care settings [and] comments about the general structure and function of the pharmaceutical market, to inform these actions.” The request contains a long list of steps HHS and the Trump Administration claim to have taken or to be considering taking to address these issues. It specifically asks for information on whether government programs are “cross-subsidized by higher list prices and excess costs paid by individuals and employers in the commercial market,” and whether PBMs should be “obligated to act solely in the interest of the entity for whom they are managing pharmaceutical benefits” (along with a number of other questions about PBMs.

An HHS press release on July 7, 2018, announced that HHS had directed CMA to halt payments to insurers for 2017 under the permanent risk adjustment program created by ACA § 1343, because New Mexico Health Connections v. HHS, 2018 WL 1136901 (D.N.M., Feb. 28, 2018), rejected a portion of the methodology used to determine the payments as arbitrary and capricious under the APA (because HHS assumed that the ACA requires risk adjustments to be budget neutral). It is not clear how long the suspension will last, why a complete suspension rather than an adjustment was necessary, or why any adjustment was necessary if HHS disagreed with the

An HHS press release on July 24, 2018, announced that CMA would resume payments to insurers for 2017 under the permanent risk adjustment program created by ACA § 1343, using the methodology previously adopted by HHS (see 77 Fed. Reg. 17220 (March 23, 2012), and 81 Fed. Reg. 12204 (March 8, 2016)). The press release explained that “[i]t was clear that the case would not be resolved through the normal process in time for the agency to make scheduled risk adjustment payments and collections in August,” and that “[t]his circumstance provided good cause for CMS to issue a final rule that dispenses with the typical notice and comment period [and] provides a fuller explanation supporting the 2017 risk adjustment methodology, consistent with the judge’s request.” The final rule is at CMS-9920-F, 83 Fed. Reg. 36456 (July 30, 2018). A similar proposed rule for 2018 is at CMS-9919-P, 83 Fed. Reg. 39644 (Aug. 10, 2018).

83 Fed. Reg. 38212 (Aug. 3, 2018), contains final rules jointly issued by Treasury (T.D. 9837), DOL, and HHS (CMS-9924-F) that finalize the proposed rules changing the definition of short-term, limited-duration insurance issued earlier this year (83 Fed. Reg. 7437 (Feb. 21, 2018)) with two minor modifications. First, they modify the notice that must appear in the contract stating that the coverage is not MEC, and, second, they add a severability clause because “the Departments recognize there is a possibility that some stakeholders may challenge the 36-month maximum duration standard in court.” The preamble notes that the 36-month maximum does not prohibit “a separate transaction or other instrument under which the individual can, in advance, lock in a premium rate in the future or the ability to purchase a new, separate short-term, limited-duration insurance policy at a specified premium rate at a future date without re-underwriting,” and that “[t]hrough these mechanisms, it may be possible for a consumer to maintain coverage under short-term, limited-duration insurance policies for extended periods of time to protect themselves [sic] against financial vulnerabilities, such as developing a costly medical condition.” It also notes that “[premium tax credits and cost-sharing reductions generally are not available to purchasers of short-term, limited-duration insurance. However, states may be able to provide subsidies to purchasers of short-term, limited-duration insurance with funds provided under waivers authorized by [ACA § 1332] should they choose to do so and should the waiver satisfy all applicable requirements.” The rules are effective for insurance policies sold on or after October 2, 2018.

A CCIIO memorandum dated September 12, 2018, entitled Guidance on Claiming a Hardship Exemption through the Internal Revenue Service (IRS) announces that “consumers may claim all hardship exemptions available under [45 C.F.R.] § 155.605(d)(1) either by obtaining an [exemption certificate number] through the [Federally-facilitated Exchange] using the existing application process, or on a federal income tax return without presenting the documentary evidence or written explanation generally required for hardship exemptions. Consumers should keep with their other tax records any documentation that demonstrates qualification for the hardship exemption.”

83 Fed. Reg. 51369 (Oct. 11, 2018) contains final rules that increase various civil monetary penalties (CMPs) under laws administered by HHS, including HIPAA.
83 Fed. Reg. 54420 (Oct. 29, 2018), contains proposed rules jointly issued by Treasury (REG-136724-17), DOL, and HHS (CMS-9918-P) that would allow employers to offer HRAs (and other specified “account-based group health plans” such as the reimbursement arrangements described in Rev. Rul. 61-146, 1961-2 C.B. 25) through which employees could purchase individual health insurance coverage, without many of the limitations imposed on “qualified small employer health reimbursement arrangements” or “QSEHRAs.” Specifically:

- They would allow an HRA to be integrated with individual health insurance coverage, and thus satisfy PHSA §§ 2711 and 2713, if—
  - The HRA required the employee and any dependent(s) to be enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits) for each month the individual(s) are covered by the HRA, and, similarly, the HRA provided that medical care expenses of an individual will not be reimbursed from the HRA if the individual ceased to be enrolled in individual health insurance coverage. The HRA would be required to have reasonable procedures in place to verify that the individuals were in fact enrolled.
  - The employer did not offer the same class of employees a traditional group health plan (i.e., one other than an account-based group health plan or a group health plan that consists solely of excepted benefits), and offered the HRA on the same terms to all employees within the class. The classes would be (1) full-time employees, (2) part-time employees, (3) seasonal employees, (4) collectively bargained employees, (5) employees in the plan’s waiting period, (6) employees under age 25 at the beginning of the plan year, (7) non-resident aliens with no U.S.-income, and (8) employees in the same rating area. The employer could define the first three classes using the definitions in either Code § 105(h) or Code § 4980H. A former employee would be considered to be in the same class he was immediately before separation from service. The traditional group health plan requirement would not be violated if the employer allowed an employee to pay the balance of the premium for the individual health insurance coverage through a cafeteria plan (and offered this feature on the same terms to other members of the same class). The same-terms requirement would not be violated if the maximum dollar amount available under the HRA increased with the age of the employee or the number of the employee’s dependents; Treasury and the IRS would create a safe harbor to prevent this from violating Code § 105(h). It also generally would not be violated if the HRA was offered to only some former employees (e.g., those with X years of service for the employer) as long as it was offered on the same terms to other former employees in that class.
  - The employee was allowed to opt out at least annually (in order to purchase coverage on an Exchange), and amounts in the HRA were forfeited on termination of employment or the employee waived future reimbursements from the HRA.
  - The employer provided a written notice describing the features of the HRA to each participant at least 90 days before the beginning of the plan year.

- They would create a new category of “excepted benefits” for certain small HRAs. To qualify (1) other group health plan coverage that is not limited to excepted benefits and that is not an HRA or other account-based group health plan would have to be offered to employees eligible for the HRA, and the HRA could not be an integral part of that plan (i.e., employees would have to be able to enroll in it separately), (2) the HRA would have
to provide benefits that were limited in amount (i.e., $1,800, indexed), (3) the HRA could not reimburse other health plan premiums for (generally other than COBRA coverage or coverage consisting of excepted benefits), and (4) the HRA would have to be made available under the same terms to all similarly situated individuals (as defined in the HIPAA nondiscrimination regulations).

- They would provide rules for determining whether an HRA integrated with individual health insurance coverage (I call it a “HIIHIC”) was affordable and provided minimum value (MV) and thus whether the employee could claim the premium tax credit under Code § 36B. (The coverage that would be used for MV purposes would be the lowest cost silver-level Exchange coverage for the rating area, which will always provide MV.)
- They would treat individual health insurance purchased through a HIIHIC as not being a group health plan under ERISA if (1) the purchase was completely voluntary, (2) the employer did not select or endorse any particular issuer or coverage, (3) reimbursement for premiums was limited to the individual health insurance coverage, (4) the employer received no consideration in connection with the employee’s selection or renewal of the coverage, and (5) each plan participant was notified annually that the coverage was not subject to ERISA.
- They would establish a special enrollment period for individual health insurance coverage for when an individual gained access to and enrolled in a HIIHIC or was provided a QSEHRA.
- According to the preamble, an ALE would be treated as satisfying its obligations under Code § 4980H(a) if it offered any kind of HRA (because any HRA is a group health plan) and as satisfying its obligations under Code § 4980H(b) if it satisfied an affordability and MV safe harbor that Treasury and the IRS intend to issue.

The regulations would apply to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020.

83 Fed. Reg. 57536 (Nov. 15, 2018) contains final rules jointly issued by Treasury (T.D. 9840), DOL, and HHS (CMS-9940-F2) modifying the exemption for certain “religious employers” from the ACA requirement to provide contraceptive coverage without cost-sharing and the “accommodation” under that requirement for non-profit religious organizations and closely held for-profit entities that have religious objections to providing the coverage. The rules finalize with some modifications “to clarify the intended scope of the language in the [rule]” the temporary and proposed regulations that were issued jointly by the Treasury (T.D. 9827 and REG-115615-17), Labor and HHS (CMS-9940-IFC) in October 2017. Related to this, 83 Fed. Reg. 25502 (June 1, 2018) contains proposed rules issued by HHS (HHS-OS-2018-0008) that would revise the regulations implementing Title X of the PHSA to allow a grantee to consider a woman to be from a “low-income family” with respect to contraceptive services “if she has health insurance coverage through an employer which does not provide the contraceptive services sought by the woman because it has a sincerely held religious or moral objection to providing such coverage.” Planned Parenthood clinics are major recipients of Title X funding, but other proposed changes appear designed to exclude them from the program, including prohibiting recipients from providing abortions or referrals for abortions. The proposed regulations are very similar to Reagan-era regulations that were challenged in court and ultimately repealed by the Clinton Administration before they went into effect.
83 Fed. Reg. 57592 (Nov. 15, 2018) contains final rules jointly issued by Treasury (T.D. 9841), DOL, and HHS (CMS-9925-F) extending the exemption and modification to certain non-governmental non-profit organizations and non-public for-profit entities that object to providing contraceptive coverage “based on [their] sincerely held moral convictions.” The rules finalize with some modifications “to clarify the intended scope of the language in the [rule]” the temporary and proposed regulations that were issued jointly by the Treasury (T.D. 9828 and REG-129631-17), Labor and HHS (CMS-9925-IFC) in October 2017. As noted earlier, Pennsylvania v. Trump, 281 F. Supp.3d 553 (E.D. Pa., Dec. 15, 2017), already issued a preliminary injunction prohibiting the government from enforcing the expanded religious and “moral” exemptions, and California v. HHS, 281 F. Supp.3d 806 (N.D. Cal., Dec. 21, 2017), did the same, specifying that its injunction was nationwide.

CMS Discussion Paper, Section 1332 State Relief and Empowerment Waiver Concepts (Nov. 29, 2018), outlines four new “waiver concepts” that are “intended to foster discussion with states by illustrating how states might take advantage of [CMS-9936-NC, 83 Fed. Reg. 53575 (Oct. 24, 2018)].” CMS-9936-NC gave states significantly more flexibility regarding their ability to obtain exemptions from various ACA requirements under ACA § 1332 (which CMS-9936-NC renamed “State Relief and Empowerment Waivers”). One of the waiver concepts is an account-based approach that would allow a state to provide a cash contribution to an account that people can use to pay both premiums and any out-of-pocket health expenses. Another would allow a state to develop a new premium subsidy structure and decide how those premium subsidies should be targeted. Commentary by the Brookings Institute observed that “[t]here are serious questions about whether the policy articulated in [CMS-9936-NC] is a permissible interpretation of the underlying statute, but, at the very least, it is likely invalid for the agency to attempt to make this policy without a full rulemaking process.”

CMS-9919-F, 83 Fed. Reg. 63419 (Dec. 10, 2018), finalizes without change CMS-9919-P, 83 Fed. Reg. 39644 (Aug. 10, 2018), which proposed to continue using the methodology previously adopted by HHS, which was based on statewide average premiums in the applicable state market risk pool, for the state payment transfer formula under the permanent risk adjustment program created by ACA § 1343. New Mexico Health Connections v. HHS, 312 F. Supp. 3d 1164 (D.N.M., Feb. 28, 2018), vacated HHS’s use of that methodology on the grounds that HHS had not adequately explained the decision to adopt it.”

3. NLRA Guidance

On February 26, 2018, the NLRB vacated its ruling in Hy-Brand Industrial Contractors Ltd. and Brandt Construction Co., NLRB Case Nos. 25-CA-163189, 25-CA-163208, 25-CA-163297, 25-CA-163317, 25-CA-163373, 25-CA-163376, 25-CA-163398, 25-CA-163414, 25-CA-164941, and 25-CA-164945 (Dec. 14, 2017), which overruled the NLRB’s expansion of the definition of joint employment in Browning-Ferris Indus. of California Inc. v. Sanitary Truck Drivers and Helpers Local 350, NLRB Case No. 32-RC-109684 (Aug. 27, 2015). The action was taken because of member William Emanuel’s participation in Hy-Brand, which had been criticized in an inspector general report. As a result of the action, on March 2, 2018, the NLRB asked the D.C. Circuit to revive its review of Browning-Ferris.
83 Fed. Reg. 46681 (Sept. 14, 2018), contains a proposed rule from the NLRB “establishing the standard for determining whether two employers, as defined in Section 2(2) of the Act, are a joint employer of a group of employees under the NLRA.” The preamble notes that “a petition for review of [the NLRB’s expansion of the definition of joint employment in Browning-Ferris Indus. of California Inc. v. Sanitary Truck Drivers and Helpers Local 350, 362 NLRB No. 186 (Aug. 27, 2015),] remains pending in the court of appeals,” but apparently the court wasn’t acting fast enough. (Hy-Brand Industrial Contractors Ltd. and Brandt Construction Co., 365 NLRB No. 156 (Dec. 14, 2017), overruled Browning-Ferris, but that decision was vacated after an inspector general report criticized new member William Emanuel’s participation, which led the NLRB to petition for the review.)

4. SSA Guidance

83 Fed. Reg. 52298 (Oct. 16, 2018) contains a notice from the Social Security Administration announcing that a social security tax treaty (a.k.a. totalization agreement) between the United States and Brazil, which was signed on June 30, 2015, entered into force on October 1, 2018.

A Social Security Administration fact sheet announces the cost-of-living adjustments for 2019 for the social security wage base and other social security provisions. Among other things, the wage base will increase to $132,900 in 2019.

83 Fed. Reg. 53936 (Oct. 25, 2018) contains a notice from the Social Security Administration announcing that a social security tax treaty (a.k.a. totalization agreement) between the United States and Uruguay, which was signed on January 10, 2017, entered into force on November 1, 2018.

83 Fed. Reg. 64631 (Dec. 17, 2018) contains a notice from the Social Security Administration announcing that a social security tax treaty (aka totalization agreement) between the United States and Slovenia, which was signed on January 17, 2017, will enter into force on February 1, 2019.

5. Other Federal Guidance

On January 25, 2018, DOJ released a memorandum from Associate Attorney General Rachel Brand prohibiting DOJ litigators from using noncompliance with subregulatory “guidance documents” as a basis for proving violations of applicable law in civil lawsuits imposing penalties for violations of Federal health, safety, civil rights or environmental laws. The memorandum notes that on November 16, 2017, Attorney General Jeff Sessions issued a memorandum prohibiting DOJ from “issuing guidance documents that effectively bind the public without undergoing the notice-and-comment rulemaking process.” On December 21, 2017, Attorney General Sessions also rescinded 25 guidance documents that were “outdated, used to circumvent the regulatory process, or that improperly [went] beyond what is provided for in statutes or regulation,” including several relating to the ADA.

The Office of Information and Regulatory Affairs’ 2017 Draft Report to Congress on the Benefits and Costs of Federal Regulations and Agency Compliance with the Unfunded Mandates Reform Act was released on February 23, 2018, after a long delay. It concluded that:
The estimated annual benefits of major Federal regulations reviewed by OMB from October 1, 2006, to September 30, 2016, for which agencies estimated and monetized both benefits and costs, are in the aggregate between $219 billion and $695 billion, while the estimated annual costs are in the aggregate between $59 billion and $88 billion, reported in 2001 dollars. In 2015 dollars, aggregate annual benefits are estimated to be between $287 and $911 billion and costs between $78 and $115 billion.

The Regulatory Right-to-Know Act requires OMB to submit an annual report to Congress that includes an estimate of the total annual benefits and costs of federal rules in the aggregate, by agency, and by major rule. It does not define “major rule,” but successive administrations have defined it to include “major rules” under the Regulatory Flexibility Act and “significant regulatory actions” under Executive Order 12866.

On July 3, 2018, Attorney General Jeff Sessions announced that he was rescinding 24 DOJ guidance documents as “unnecessary, outdated, inconsistent with existing law, or otherwise improper.” A few could impact the implementation of ACA § 1557, including the rescission of Federal Protections Against National Origin Discrimination (April 30, 2006) and FAQs About the Protection of Limited English Proficiency (LEP) Individuals under Title VI of the Civil Rights Act of 1964 and Title VI Regulations (March 1, 2011).

Executive Order 13847, Strengthening Retirement Security in America (Aug. 31, 2018), 83 Fed. Reg. 45321 (Sept. 6, 2018), states that “[e]xpanding access to multiple employer plans (MEPs) . . . is an efficient way to reduce administrative costs of retirement plan establishment and maintenance and would encourage more plan formation and broader availability of workplace retirement plans, especially among small employers.” Accordingly, it instructs the DOL to “examine policies that would: (1) clarify and expand the circumstances under which United States employers, especially small and mid-sized businesses, may sponsor or adopt a MEP as a workplace retirement option for their employees, subject to appropriate safeguards; and (2) increase retirement security for part-time workers, sole proprietors, working owners, and other entrepreneurial workers with non-traditional employer-employee relationships by expanding their access to workplace retirement plans, including MEPS.” More specifically, it instructs (1) the DOL within 180 days to consider whether to issue guidance to “clarify when a group or association of employers or other appropriate business or organization could be an ‘employer’ within the meaning of [ERISA §] 3(5),” (2) the Treasury Department within 180 days to consider issuing guidance “regarding the circumstances under which a MEP may satisfy the tax qualification requirements,” including the so-called “one bad apple” rule, (3) the DOL, in consultation with the Department of the Treasury, within one year to “complete a review of actions that could be taken . . . to make retirement plan disclosures required under ERISA and the Internal Revenue Code of 1986 more understandable and useful for participants and beneficiaries, while also reducing the costs and burdens they impose on employers and other plan fiduciaries responsible for their production and distribution,” including “an exploration of the potential for broader use of electronic delivery as a way to improve the effectiveness of disclosures and to reduce their associated costs and burdens,” and (4) the Treasury Department within 180 days to “examine the life expectancy and distribution period tables in the regulations on [RMDs] and determine whether they should be updated to reflect current mortality data and whether such updates should be made annually or on another periodic basis.” These initiatives resemble proposals in President Obama’s FY 2016 and 2017 budgets to (1) require Code § 401(k) plans to allow employees
to make salary reduction contributions if they have worked at least 500 hours per year for at least three years, (2) exempt individuals with benefits under $100,000 from the MRD requirements, and (in 2017 only) (3) permit “open” MEPs by eliminating the “common bond” requirement if the provider, the participating employers, and the plan meet certain requirements (including that employers have not maintained a qualified plan within the previous three years).

6. States

On January 23, 2018, Oregon voters voted to preserve the temporary taxes on health insurance plans and hospitals approved by the legislature in 2017, which were designed to help fund the state’s Medicaid program.

*Texas Attorney General Opinion No. KP-0179* (Feb. 13, 2018), concludes that “a court would likely determine that ERISA now preempts” a Bulletin interpreting §§ 1501.003 and 1501.004 of the Texas Insurance Code to mean that “the payment of individual health benefit plan premiums through an employer-funded [HRA] creates a small or large employer health benefit plan subject to regulation under chapter 1501 of the Insurance Code.”

On March 30, 2018, New York Governor Andrew Cuomo signed into law a New York State Budget bill that allows employers to opt into a new Employer Compensation Expense Program (“ECEP”) structure under which they would be subject to a 5% tax on all annual payroll expenses in excess of $40,000 per employee, phased in over three years beginning on January 1, 2019. A new tax credit corresponding to the ECEP would be available to the affected individual employees.

On May 15, 2018, Illinois launched the pilot phase of the Secure Choice Savings Program Act it enacted in 2015. The first phase of the full program will begin in November for employers with 500 or more employees. The Act requires employers with more than 25 employees in Illinois that do not maintain a qualified retirement plan to withhold 5% [3%?] of each employee’s pay and contribute it to a state-sponsored Roth IRA program unless the employee opts out or opts for a different contribution percentage. The director of the program said that it checks the Form 5500 filings to see which employers already have ERISA-covered plans so that it doesn’t mistakenly invite those employers to join the program.

On May 7, 2018, the San Francisco Office of Labor Standards Enforcement published new rules for interpreting the San Francisco Paid Sick Leave Ordinance (“PSLO”). Among other things, they allow employers to require confirmation (such as a doctor’s note) that an absence was for a statutory reason (e.g., illness, injury or domestic violence).

On May 28, 2018, Vermont Governor Phil Scott signed H. 696, which establishes a state individual mandate, into law as Act 182. On May 30, 2018, New Jersey Governor Phil Murphy signed A3380, the New Jersey Health Insurance Market Preservation Act, which establishes a state individual mandate, into law as P.L. 2018, c. 31. On June 27, 2018, the D.C. Council approved Bill 22-753, the Fiscal Year 2019 Budget Support Act of 2018, Title V of which establishes an individual mandate in the District. Massachusetts already has an individual mandate. California, Connecticut, Hawaii, Maryland, Rhode Island and Washington are considering establishing them.
Technical Memorandum TSB-M-18(1)ECEP (July 3, 2018) contains guidance on how electing employers can pay the new optional employer compensation expense tax if they have employees earning more than $40,000 in wages and compensation in the state. The tax was created by the Employer Compensation Expense Program (ECEP), which New York State established to circumvent the TCJA’s cap on the deductibility of state and local taxes (SALT). Separately, on July 17, 2018, in State of New York v. Mnuchin, Connecticut, Maryland, New Jersey and New York filed a complaint in the S.D.N.Y. arguing that the SALT deduction cap is unconstitutional and should be blocked from enforcement.

In a July 19, 2018, news release the New York Taxi Workers Alliance announced that the New York State Unemployment Insurance Appeal Board had affirmed an administrative law judge’s determination that three former Uber drivers, and those similarly situated, were employees for the purpose of receiving state unemployment benefits.

On August 10, 2018, the New Jersey Department of Labor announced that it had signed an agreement with the U.S. Department of Labor “to work together to end illegal employee misclassification.”

On September 22, 2018, California Governor Jerry Brown signed S.B. 910, which bans the sale of short-term health insurance policies, into law as Chapter 687, Statutes of 2018. Three other states (Massachusetts, New Jersey, and New York) already ban the sale of such policies.

CalSavers, California’s voluntary IRA savings program for private businesses, announced on November 27, 2018, that it would launch its pilot phase with 20 companies on January 1, 2019. Meanwhile, California is being sued by the Howard Jarvis Taxpayers Association, arguing that the CalSavers program is preempted by ERISA.