32nd Annual Cincinnati

Employee Benefits Conference

Friday, June 7, 2019

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Cincinnati Employee Benefits Conference
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AGENDA

8:55 a.m.	**Welcome & Opening Remarks**	
9 a.m.	**ERISA Update** Brian K. Furgala, Esq., CPC, QPA *Wolters Kluwer-ftwilliam.com & TAGdata, Orlando, FL*	**TAB A**

(materials prepared by Sal Tripodi of TriPension; includes 15-minute break)

12:15 p.m.	**Group Luncheon** (included in registration)	
1:15 p.m.	**IRS Presentation** William Anderson, Esq., *Supervisory Tax Law Specialist, IRS, Cincinnati, OH* Milo Atlas and Angelo Noe, *EP Pre-Approved Plan Coordinators, IRS, Cincinnati, OH*	**TAB B**
2:15 p.m.	**Service Provider Contracting** Laura M. Nolen, Esq., *Ingersoll Rand Inc., Davidson, NC* Laura A. Ryan, Esq., *Thompson Hine LLP, Cincinnati, OH*	**TAB C**
3:15 p.m.	**Refreshment & Networking Break**	
3:30 p.m.	**Hot Topics in Fiduciary Litigation and Managing Fiduciary Responsibility** Brian J. Lamb, Esq., *Thompson Hine LLP, Cleveland, OH*	**TAB D**
4:30 p.m.	**Adjourn**	

TAB
A

Brian Furgala, Esq.

Brian Furgala, Esq, CPC, QPA recently joined *Wolters Kluwer's ftwilliam.com* team in offering employee benefit professionals modern and cloud-based plan document, government forms and compliance testing and reporting software. As Director of ERISA Services, he monitors all legal, regulatory and procedural changes that affect plan documents as well as working with the Technical Answer Group (TAG) to provide insight into customers' complex questions around retirement and welfare plan questions. Brian leverages his ten-year experience as an ERISA attorney along with his pre-law career in retirement plan administration in utilizing a practical and efficient approach to the design, installation and operation of qualified and non-qualified retirement and welfare plans. He also hosts a series of webinars through ftwilliam.com's CE webinar program and continues his speaking calendar at industry associations and conferences throughout the year.

Cincinnati Bar Association Employee Benefits Conference

June 7, 2019

ERISA Update

Brian Furgala, Esq., CPC, QPA
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DOL Update

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MEPs

- Proposed regs released 10/23/18
- Determining who is an "employer" in sponsoring a MEP
- Began with association health plan (AHP) proposed regs released 6/21/18
  - employers acting together to provide health benefits may meet the ERISA definition of "employer" if criteria satisfied
- State of NY v DOL (DC Cir 3/29/19)
  - striking provisions of AHP (owner as employee)

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MEPs

- IRS
  - 413(c): MEP is treated as a single plan for tax purposes
  - Treated as a single employer for eligibility, vesting, 415 limit, severance from employment
  - "one bad apple" issue
- DOL
  - MEP needs commonality of interests
  - If not, collection of separate plans

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MEPs

- ERISA defines "employer" as any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity
- Right now DOL examines whether a group or association has a sufficiently close economic or representational nexus to the employers to sponsor a plan

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MEPs

- DOL Adv. Op Ltr. 2012-04A
  - No nexus or common interest among the adopting employers results in a collection of separate plans, not a single plan
- Interpretative Bulletin 2015-02
  - Voluntary state retirement programs
  - Bona fide group satisfied by state's special representational interest in the health and welfare of its citizens

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MEPs

- Proposed regs only cover MEP plans through:
  - Group or association of employers; or
  - Professional employer organization (PEO)
- Only applies to DC MEPs
- Sets criteria for a "bona fide" group or association of employers or PEO in order to establish or maintain a MEP

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MEPs

- For a group or association of employers, criteria focuses on three main areas:
  - Whether the group or association is a bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits;
  - Whether the employers share some commonality and genuine organizational relationship unrelated to the provision of benefits; and
  - Whether the employers that participate in a plan, either directly or indirectly, exercise control over the plan, both in form and substance.

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"Bona Fide" Group Criteria

1. At least one substantial business purpose unrelated to MEP coverage or other employee benefits
   - promoting common business interests in a given trade or business community
   - not required to be a for-profit activity
   - safe harbor=viable entity in the absence of sponsoring a MEP

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"Bona Fide" Group Criteria

2. Each group member is a person acting directly as an employer of at least one employee who is a MEP participant

- Owner employee satisfies if:
  - ownership right of any nature in a trade/business;
  - earning wages or self-employment income for providing personal services to trade/business; and
  - works on average at least 20 hours per week or at least 80 hours per month providing personal services or earns wages or self-employment income at least equaling cost of coverage in any group health plan sponsored by the group

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“Bona Fide” Group Criteria

3. Group has formal organizational structure with a governing body and has by-laws or other similar indications of formality
4. Group functions and activities are controlled by its members and members that participate in the MEP control the plan in both form and in substance

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“Bona Fide” Group Criteria

5. Group members have a commonality of interest
   - same trade, industry, line of business or profession; or
   - principal place of business in the same region not exceeding single state or a metropolitan area
6. MEP participation only available to group members’ employees and former employees

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"Bona Fide" Group Criteria

7. Group not a bank or trust company, insurance issuer, broker-dealer, or other similar financial services firm (including pension record keepers and third-party administrators), or owned or controlled by such an entity or any subsidiary or affiliate of such an entity

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"Bona Fide" PEO Criteria

- For a PEO, criteria focuses on four main areas:
  - Perform substantial employment functions on behalf of the client employers;
  - Have substantial control over the functions and activities of the MEP, and assume certain statutory roles under ERISA;
  - Ensure that each client-employer participating in the MEP has at least one employee who is a participant covered under the MEP; and
  - Ensure that participation in the MEP is limited to current and former employees of the PEO and of client-employers, as well as their beneficiaries.

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Substantial Employment Functions

- Facts and circumstances test for performance of substantial employment functions
- Safe harbor if:
  - Organization is a "certified professional employer organization" (CPEO) as defined in Code section 7705(a) and regulations thereunder and two or more of the criteria set forth; or
  - Organization meets any five or more of the following criteria.

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Substantial Employment Functions

Organization responsible for:

- Wages regardless of receipt or adequacy of payment from clients
- Reporting, withholding, and paying applicable federal employment taxes
- Recruiting, hiring, and firing workers of its clients
- Establishing employment policies, establishing conditions of employment, and supervising employees
- Determining employee compensation, including method and amount
- Providing workers' compensation coverage
- Integral human-resource functions, such as job-description development, background screening, drug testing, employee-handbook preparation, performance review, paid time-off tracking, employee grievances, or exit interviews
- Regulatory compliance in the areas of workplace discrimination, family-and-medical leave, citizenship or immigration status, workplace safety and health
- Obligations to MEP participants after the client-employer no longer contracts with the organization

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Outstanding MEP Issues

- Comments on "Corporate" MEPs
- Comments on open MEPs
- Bills advocating for "pooled employer plans" which are essentially open MEPs
  - Include service provider maintaining MEPs as "pooled service providers"
  - Determining fiduciary status

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Auto-Portability PTE

- Mandatory cash-outs
- Terminating DC plans
- Retirement Clearinghouse, LLC developed RCH Auto-Portability Program
- Automatically move small accounts into default IRA upon termination from old ER

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Auto-Portability PTE

- Monitors "cooperating" RK systems
- If person becomes participant in new ER plan, then move assets from default IRA to new ER plan
  - New ER plan must agree to accept assets
  - Person may decline transfer
- Charges asset-based fees

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Auto-Portability PTE

- Fiduciary decision in selecting IRA provider for mandatory cash-outs between $1K and $5k or DC terms
- Cost benefit analysis should be performed evaluating service provided for costs charged
- DOL clarified that fiduciaries of neither old ER plan nor new ER plan have duty re: asset transfer from default IRA to new ER plan

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Auto-Portability PTE

- RCH acting as fiduciary for re: asset transfer from default IRA to new ER plan
- Self dealing violation without PTE
- PTE granted with conditions:
  - Independent fiduciary to approve fees
  - Detailed participant disclosures at each stage
  - Monthly search-and-match searches
  - Annual independent audit

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Fiduciary Rule

- Applicable June 9, 2017
- Transitional period to ~~1/01/18~~ 07/01/19
- Impartial Conduct Standards
  - Act in investors' best interest
  - Charge reasonable compensation
  - Avoid misleading statements
- No required disclosure during transition
  - Fiduciary status
  - Potential conflicts of interest
  - Restrictions on recommendations

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Death of Fiduciary Rule

- U.S. Chamber of Commerce v DOL
  - Fifth Circuit
  - March 15, 2018
  - Vacating fiduciary rule
  - Split panel
  - No appeal to 5th Circuit
  - No appeal to US Supreme Court
  - FAB 2018-02 (5/7/18)
    - No enforcement of PT claims against advisors complying with impartial conduct standards

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1975 Fiduciary Rule

- Recommendations as to the advisability of investments
- On a regular basis
- Pursuant to a mutual agreement between parties
- That such services will serve as a primary basis for investment decisions with respect to plan assets
- Based on its particular needs
- For a fee or direct or indirect comp

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SEC Proposed Rules

- Proposed April 18, 2018
- 90 day comment period
- Covers recommendations to ALL retail investors
  - Cover corporate accounts?
- Broker-dealers (BDs) have new "best interest" standard
- Registered Investment Advisors (RIAs) to have fiduciary standard (e.g. loyalty, care)

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SEC Proposed Rule

Regulation Best Interest standard for BDs:

- disclosure obligation
  - key facts about relationship
- care obligation
  - exercise reasonable diligence, care, skill, and prudence
  - reasonable basis to believe product and series in investor's best interest
- conflict-of-interest obligation
  - reasonably designed policies and procedures to identify and disclose conflicts of interest

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SEC Proposed Rule

- New SEC Form CRS
  - Customer/Client Relationship Summary
- Required for both BDs and RIAs
- Provide retail investors description of relationship
  - No longer than 4 pages
  - Can be provided digitally
- BDs cannot use "advisor" label

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DOL Enforcement Letters

- Late contributions
- Regional office sending letters around June, 2018
- Threatens "alternative enforcement measures" if submission through Voluntary Fiduciary Compliance Program (VFCP) not filed in 60 days
- Identified through Form 5500 disclosures

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VFCP - Late Contributions

- Ineligible if under DOL investigation
- No filing fee
- Avoid 20% civil penalty
- Corrections must be made prior to filing
- Allocation of earnings for delinquency
- No action letter upon filing

Waiving Statute of Limitations

- DOL investigation ongoing
- Agent asks sponsor to toll ERISA statute of limitations in order to investigation to continue
- Sponsors choice?
  - Face wrath of DOL by saying no
  - Agree to tolling which allows investigation to continue

Waiving Statute of Limitations

- DOL v Preston (11th Cir. 10/12/17)
  - 6/25/18 USSC petition declined
- Tolling or waiver is valid
- ERISA provision is non-jurisdictional
  - Speaks to timeliness, not court's power
- Subject to express waiver
- Sponsor must make decision on tolling or facing potential litigation

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State Payroll Deduction Plans

- OR, IL, MD, CA, CT, MA, NY, NJ, WA and VT
- Howard Jarvis Taxpayers Assoc vs. Cal. Secure Choice Retirement Savings Program (E.D. Cal. 3/28/19)
- CalSavers not excluded under 1975 DOL regs for employer payroll deduction IRAs
- ERISA exempt because only applies to employers without existing plans, no ERISA plans are governed or interfered with because of CalSavers

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State Payroll Deduction Plans

- Final regs in August 2016 providing guidance on being exempt from ERISA
- Regulation blocked by President Trump on April and May, 2017
  - EE participation voluntary (elect out)
  - Employers not permitted to make matching or other contributions
  - ER role limited to collecting/remitting payroll funds
  - ER only provides state limited information

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DOL Penalty Increase 2019

$1,100 | $2,140/day to $2,194/day
- Failure to file Form 5500

$1,000 | $1,693/day to $1,736/day
- Failure to furnish automatic contribution notice

$100 | $136/day to $139/day
- Failure to furnish blackout notice

$1,000 | $1,693/day to $1,736/day
- Failure to furnish 436 benefit restrictions notice

$11 | $29/participant to $30/participant
- Failure to furnish statements or maintain records

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Legislative Update?

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SECURE Bill

- Setting Every Community Up For Retirement Enhancement Act of 2019
- Removing barriers to open MEPs
- Dual eligibility requirement (500 hours in 3 consecutive years)
- Plans adopted by filing due date treated as in effect as of year end
- Fiduciary safe harbor for selecting a lifetime income provider
- Raising RMD age to 72

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SECURE Bill

- Eliminate the notice requirement for non-elective 401(k) safe harbor plans
- Flexibility for small businesses to switch to plans with non-elective 401(k) safe harbor plans
- QACA escalation cap increased from 10% to 15%
- Tax credit up to $500/year to defray costs for new 401(k)s that include auto enroll

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SECURE Bill

- Expand access to, and portability of, lifetime income products
- Penalty-free withdrawals for qualified birth or adoption distributions.
- Combined 5500 filing for DC plans, with same trustee, named fiduciary, administrator, plan year, and investments
- Providing lifetime monthly income estimates on benefit statements

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IRS Update

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Annuity to Lump Sum

- Notice 2019-18 (3/16/19)
- Lump sum offer to participants in pay status receiving annuities
- Retiree lump sum window amendments
- De-risking strategy for plan liabilities, PBGC premiums and admin costs
- IRS initially claimed to violate RMD rules
  - Released intent to propose regs (Notice 2015-49)

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Annuity to Lump Sum

- Retiree lump-sum window allegedly ineligible for RMD reg exception under which an annuity payment period may be changed in association with an annuity payment increase
- IRS argued RMD reg exemption only for annuity increases, not accelerated payments

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Annuity to Lump Sum

- Retracted intent to propose regs, but IRS "will continue to study the issue"
- No PLRs addressing retiree lump sum windows
- DL will no longer include caveat if present
- Amend for pre-approved DB plans?

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Hardship Prop Regs

- Released November 14, 2018
- Six month suspension
  - Voluntary to remove in 2019
  - Mandatory to remove in 2020
- So no more suspensions?
  - Careful with qualified reservist distributions or after tax withdrawals
- Taking a loan before hardship
  - No longer required, but discretionary
  - Still requires taking any other available distributions

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Hardship Prop Regs

- QNECs, QMACs, SH contributions and deferral earnings now available
  - Sponsor has discretion to include any or all
- 403(b) hardships
  - Deferral earnings still excluded
  - Access to QNECs, QMACs and SH contributions not applicable to custodial accounts
- Added SH immediate and heavy need for expenses attributable to federally declared disaster
- Amendment timing?

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Hardship Prop Regs

- Facts and circumstances test no longer required to determine amount necessary to satisfy need
  - Distribution cannot exceed amount of need
  - Must take all other available distributions, except loans
  - Written declaration by participant re: insufficient cash or other liquid assets to satisfy the financial need; unless plan sponsor has actual knowledge otherwise

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Tax Reform for Hardships

- Tax Cuts and Jobs Act (12/22/17)
- Generally effective January 1, 2018
- Hardship based on casualty loss under section 165
- Previously, deduction for losses arising from fire, storm, shipwreck or other casualty
  - Regardless of exceeding 10% of AGI
- Now, deduction must be attributable to a federally declared disaster area
- Fixed with hardship proposed regs

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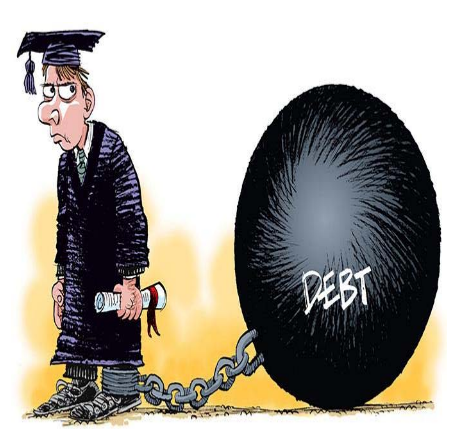
Student Loan Repayments

- Average student in the class of 2016 has $37,172 in student loan debt
- Average payment for borrowers aged 20 to 30: $351/month (2018)



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Student Loan Repayments

- PLR 201833012 (5/22/18)
- Deferrals > 2% of comp = 5% of comp match
- Student loan repayments > 2% of comp = 5% of comp nonelective contribution
- If participating in SLR program, can still defer, but no longer eligible for match
- However, if participating, but miss SLR, may defer > 2% of comp and receive "true-up" match of 5% comp

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Student Loan Repayments

- Approved by IRS
- No violation of contingent benefit prohibition
- Qualified CODA only if no other benefit is conditioned (directly or indirectly) upon the employee electing to make or not make elective contributions under the arrangement
- PLR expressly states no opinion as to whether the Plan satisfies the requirements of section 401(a)

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Student Loan Repayments

- Modifications to plan document?
- Impact on coverage and non-discrimination tests?
- Material effect on participation for costs involved?
- Marketing or disclosure of program?

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EPCRS Update

- Rev Proc 2019-19 (released 4/19/19)
- Expanding self correction program (SCP)
  - Operational failures corrected by amendment
  - Document failures
  - Loan failures
- Effective 4/19/19

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SCP - Correcting by Amendment

- May correct operational failures through retroactive plan amendment if:
  - Results in increase in benefits, rights or features
  - Increase in BRF available to all eligible employees
  - Providing increase in BRF permitted under the Code and EPCRS' correction principles

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SCP - Document Failures

- Failure to adopt good faith amendments
- Failure to adopt Interim amendments
- Nonamender Failure

- DOES NOT INCLUDE:
  - Failure to timely adopt initial plan document
  - failure to timely adopt discretionary amendment

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SCP - Loan Failures

- Deemed loans may now be reported on 1099-R in year of correction instead of failure
- Failure to repay loan pursuant to terms:
  - Single-sum corrective payment
  - Reamortization over current or max loan term
  - Some combination of above
- Permitting loans under plan not allowing loans
- Exceeding loans permitted by plan
- DOL relief? Still requires VCP submission
- NOT eligible for SCP:
  - Violating loan max amount
  - Violating max loan term or frequency

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SCP - Correction Period

- Two year period for significant errors
- Special timing for M&A transactions
  - Last day of first PY after transaction
- Substantial correction within two year period
  - Completed within 120 days of deadline
  - Reasonably prompt in identifying error, formulating and initiating correction
  - Correction made for 65% of affected participants

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SCP - Correction Period

- No time limit for insignificant errors
  - Percentage of plan assets or contributions
  - Number of years affected
  - Number of participants affected
  - Reason for the error
  - Multiple errors?

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Another EPCRS Update

- Rev Proc 2018-52 (9/28/18)
- Electronic VCP submission
- No more paper filing as of 4/1/19
- Payment through pay.gov (no Form 8951)
- Pay.gov tracking no. replaces IRS control no. (no acknowledgment letter)
- Gov't 457(b) plan submissions also electronically

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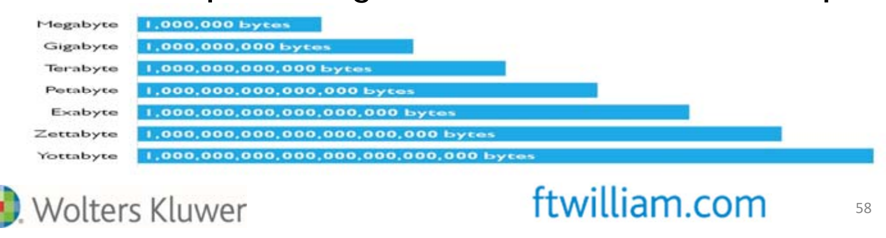
Another EPCRS Update

- Revised Form 8950 through pay.gov
- Other forms and docs in single PDF file
- 15 megabyte size limit – fax addt pages
- Separate penalty of perjury statement by plan sponsor
- 2848 rep can sign 8950, but not 8821 rep



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403(b) Once In Always In

- Notice 2018-95 (12/4/18)
- Universal availability for deferrals
- Annual notice requirement
- Exclusion for employees who normally work less than 20 hours per week
  - employer reasonably expects the employee to work fewer than 1,000 hours of service (first year exclusion); and
  - the employee worked fewer than 1,000 hours of service in the preceding 12-month period (preceding year exclusion)

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403(b) Once In Always In

- Pre-approved doc language utilizes "once in, always in" approach
- Relief period: 2009 - 12/31/19
  - Still compliant even if not using "once in, always in" approach
  - Not applicable if preceding year exclusion violated
- Fresh Start: beginning in 2019 plan year, must apply the "once in, always in" approach with 2018 as preceding year
- Plan amendment?

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Closed DB Relief

- Due to closed or frozen status, DB plan may not satisfy coverage or non-discrim testing
- To pass, may aggregate with DC plan
- May be subject to minimum allocation gateway
- Notice 2014-5 stated that if:
  - DB plan satisfied testing alone in 2013
  - DB/DC plan primarily DB in nature in 2013; or
  - DB/DC plan consisted of broadly available separate plans
- Then testing on benefits basis without gateway

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Closed DB Relief

- Notice 2018-69 (9/10/18) extends relief under Notice 2014-5 for plan years beg. prior to 2020
- Previously extended for 2017 plan years (Notice 2017-45), 2016 plan years (Notice 2016-57) and 2015 plan years (Notice 2015-28)
- Relief does not cover BRF testing or participation test under 401(a)(26)
- IRS still has proposed regs (Jan. 2016) allowing relief for closed DB plans

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Pre-Approved Plan Documents

- Rev Proc 2017-41 (6/30/17)
- Third restatement cycle (12/31/18)
- Pre-approved plan: no longer M&P or VS
- Still standardized and non-standardized
- Option between AA & BPD or just single document
- Allow 401(k) & MPPP or 401(k) & ESOP on same document

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Pre-Approved Plan Documents

- Cash balance plan with interest credits based on actual rate of return on assets
- Non-electing church plans
- Trust agreement no longer reviewed
  - Trust provisions must be separate from plan doc
- Clarifies that opinion letter has no bearing on Title I issues
- Seeking comments on retention of legacy benefits in pre-approved plans

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DL Submissions

- Eliminated RAP cycles effective 1/1/17
- Just new plans, terminations and…
- "Other" circumstances, but not in 2017 or 2018
- 2019? Notice 2018-4 (4/5/18) requests comments on circumstances IRS should consic accepting applications during 2(calendar year

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DL Submissions

- Rev Proc 2019-20 (5/1/19)
- "Other" circumstances include:
  - Statutory hybrid plans
  - Plan mergers
- Special sanctions – based on VCP filing fees – if plan document failures found in DL review
- No anti-cutback relief

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DL - Statutory hybrid plans

- Cash balance or pension equity plans
- Must be filed between 9/1/19-8/31/20
- Based on 2017 RAL (Notice 2017-72)
- Must be IDP docs (not pre-approved CB doc)

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DL - Plan mergers

- Submissions may be begin 9/1/19
- Plan merger must occur by last day of the first PY beginning after the PY including corporate transaction
- Submission must occur by last day of the first PY beginning after the PY including plan merger
- Based on RAL issued during the second full calendar year preceding the submission
- Must be IDP docs

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DL Filing Fees

- Rev Proc 2019-4
- $2,500 – Form 5300
- $800 – Form 5307 = minor modifier
- $3,000 – Form 5310 = termination
  - Effective July 1, 2019
  - Rev Proc 2018-8 increased from $2,300 to $3,000
  - Rev Proc 2018-19 reduced back to $2,300 retroactive to 1/2/18

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Required Amendments List (RAL)

- Notice 2018-91 (November 21, 2018)
- Changes in qualification requirements requiring an amendment = NONE
- Changes in qualification requirements that may require an amendment = NONE

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2017 RAL

- Notice 2017-72 (December 5, 2017)
- Changes in qualification requirements requiring an amendment =
- CB final regs – use of mkt rate of return
- DB benefit restrictions for cooperative or charity plans (but not CSEC plans)
- Changes in qualification requirements that may require an amendment =
- DB partial lump sum distributions

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2016 RAL

- Notice 2016-80 (December 27, 2016)
- Changes in qualification requirements requiring an amendment = NONE
- Changes in qualification requirements that may require an amendment =
  - Restrictions on union DB plan distributions in bankruptcy

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Operational Failures

- Operational Compliance List
- Identifying changes in qualification requirements
- Effective during the applicable calendar year
- Assistance, but not required, for plan sponsors
- 2016 & 2017 lists on IRS website 2/27/17

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2018 Operational Failures

- Final QNEC/QMAC regs (forf allocation)
- Disaster relief for California wildfires
- Another extension of temp nondiscrimination relief for closed DB plans
- Extended rollover periods for loans & levies

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2019 Operational Failures

- Hardship distribution proposed regs
- Another extension of temp nondiscrimination relief for closed DB plans
- Disaster relief for Hurricanes Florence and Michael

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Eligible Rollover Distrib Notice

- Notice 2018-74 (released 9/19/18)
- Non-Roth and Roth model notices
- Additional language to add to previous model notices

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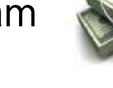
GAO Recommendation to IRS

- Clarify tax treatment of unclaimed 401(k) plan savings transferred to states
- Released 2/19/19
- Claimed $35m transferred in 2016
- Existing IRS regs only on transfer of unclaimed IRA assets to states
- Mandatory cash-out and terminated DC assets to rollover IRA
- PBGC missing participant program



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ERPAs

- Final regs increase user fees released 5/13/19
- Effective 6/13/19
- Renewal fee increased from $30 to $67
- Also removed language about enrollment fee
- Enrolled agent enrollment and renewal fee also raised from $30 to $67

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PBGC Update

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Underfunded Status Filing

- Posted on website 2/27/19
- 4010 Reporting
- Not sure if sponsor is an exempt entity?
- Schedule a pre-filing consultation with PBGC
- Provides an overview of the process, shares helpful tips on how to use the e-filing software and how to avoid common errors

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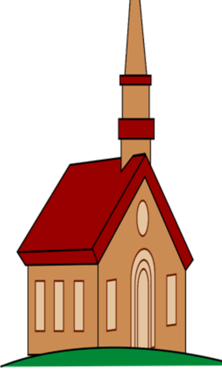
Coverage Determinations

- Requested OMB approval 12/4/18
- 5 page form for owner, professional service and church plans
- Church plans
  - Copy of IRS det. of church plan
  - Election to be covered under ERISA, if applicable
- Not on the form: gov't plans



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Disaster Relief

- Federal Register – July 2, 2018
- PBGC to grant disaster relief when, where and for the same period as IRS
- Sponsors no longer have to wait for PBGC to separately issue disaster relief
- Few isolated items on exception list
- How to notify PBGC of eligibility for disaster relief

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Premium Reduction?

- Underfunded plan with high premiums
- Spinoff almost all participants to identical plan late in plan year
- Then terminate remaining plan which contains only small number of retirees
- Premium reduction through special rules
  - Variable rate premiums not imposed in plan's final year
  - Spinoff plan's premiums pro-rated for first year
- PBGC potentially looking at substance over form to disregard the two step transaction (July, 2018)

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Case Law Update

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DB Plans in Cross Hairs?

- "Reasonable" actuarial assumptions
- Four class action lawsuits allege underpayment of benefits (MetLife, Pepsi, AA, US Bancorp)
- When do assumptions need to be reasonable?
  - Time of accrual
  - Adjust at payment (increased longevity)?
- Battle of the experts

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ERISA Jury Trial?

- Cunningham v. Cornell Univ. (S.D.N.Y., 9/6/18)
- No statutory right to ERISA jury trial
- Jury trial = legal claims, not equitable claims
- Personal liability of fiduciary = legal claim
- Amare v Cigna - ERISA equitable/legal claims
- Conflicts with other 2nd Cir cases (see also Tracey v. MIT (D. Mass. 2/28/19)

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ERISA Statute of Limitations

Breach of fiduciary duties:
- 6 years after breach or failure to cure omission; or
- 3 years if actual knowledge of breach

Tibble v. Edison
- Duty to monitor investments
- Continues running of 6 yr statute of limitation

Not applicable to benefit claims – use comparable state statute of limitations (e.g. breach of contract)

HELLO I AM...
SUING YOU

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ERISA Statute of Limitations

- Bernaola v Checksmart Financial (S.D. Ohio 7/12/18)
- Alleged fiduciary breach was including lifestyle funds charging higher fees than index funds
- Plan argued that participant had actual knowledge of fees in 2012; suit filed in 2016
- Fee info derived from enrollment kit and benefit statements referencing website with detailed fee info

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ERISA Statute of Limitations

- Sulyma v. Intel Corp (9th Cir 11/28/18)
- Alleged fiduciary breach was including alternative investments charging higher fees
- Participant admitted to accessing some information on the website
- Court decided that actual knowledge, not constructive knowledge, is required
- Takeaway = require acknowledgment of receipt and understanding

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Fiduciary Standard

- Meiners v Wells Fargo – 8th Cir – 8/3/18
- Standard for duty to monitor investments
- Wells Fargo plan used Wells Fargo TDFs
- Participants argued that Vanguard TDFs were cheaper
- Dismissed due to insufficient comparison
  - Different investment strategies based on fund prospectuses
  - No support that Wells Fargo TDFs more expensive than market as a whole
- "Meaningful benchmark" standard

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Fee Comparison

- Brotherston v Putnam (1st Cir 10/15/18)
- Use of expert's report on fee reasonableness
- Cannot benchmark actively managed funds against passive or index funds
- Partial summary judgment granted
- Reversed by First Circuit
- In *dicta* – "…any fiduciary of a plan…can easily insulate itself by selecting…market index funds."

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Church Plan Litigation

- What about healthcare systems as governmental plans?
- Shore v Charlotte-Mecklenburg Hosp Auth (M.D.N.C., filed 11/19/18)
- Federal government or government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing

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“Stock Drop” Standard

- Amgen Inc. v. Harris (USSC) - 2016
- Complaint must contain alternative action that no prudent fiduciary could have concluded would cause more harm than good
- Granting motions to dismiss
- Jander v. Retirement Plans Committee of IBM (2nd Cir. 12/10/18)
  - Plaintiffs sufficiently alleged alternative for ESOP

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Insider Information Claims

Alternatives must not result in “stock drop:”

- Close fund to future contributions
- Match in cash, not stock
- Disclose company issues or condition
- Resign as fiduciaries; seek outside expertise
- Optimistic statements = immaterial puffery

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Mandatory Arbitration

- Use of arbitration to avoid class action lawsuits
- AT&T Mobility v. Concepcion (2011)
- CompuCredit Corp. v. Greenwood (2012)
- American Express Co. v. Italian Colors Rest. (2013)
- EPIC Sys Corp v Lewis (2018): employment agreements requiring arbitration (and class action preclusion) are enforceable

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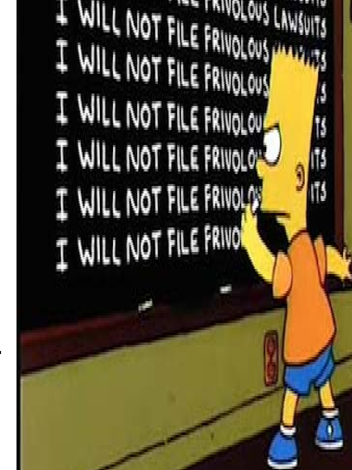
ERISA Arbitration Cases

- Munro v USC (C.D. Calif.)
- Plan fees class action lawsuit
- Denial of motion to compel arbitration on 3/23/17
- Upheld by 9th Circuit in July, 2018
- USSC denied petition 2/19/19
- Employees signed arbitration agreement for all employment-related claims
- However, fiduciary breach claims on behalf of whole plan



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ERISA Arbitration Cases

- Severson v Charles Schwab (N.D. Calif.)
- Use of in-house investment option
- Compel arbitration denied 1/18/18
- Employee signed severance agreement with arbitration provisions
- Excepted claims for ERISA benefits
- AND plan document contains arbitration provisions
- But executed after part took full distrib
- Cannot arbitrate rights belonging to plan

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Knowledgeable Plaintiff

- Karlson v. ConAgra (N.D. Ill. 12/19/18)
- Class action lawsuit alleging fiduciary breach
- Definition of comp not followed re: post-severance payments in 2016
- Incorrect deferrals and match
- Senior Director of Global Benefits and on plan's administrative committee

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When Disaster Strikes

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IRS

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IRC 7508A

- Secretary may disregard periods up to 1 year for determining tax liability in federally declared disaster areas
- Special rule for pensions: determining date upon which actions is required or permitted to be completed; no plan will be treated as failing to be operated in accordance with plan terms

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Rev Proc 2007-56

- Time-sensitive acts postponed due to impact of declared disaster zone
- Retirement plan acts include:
  - Deduction timing
  - Testing distributions
  - Loan payments
  - RMDs
  - 5500 Filing
  - SCP correction period

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Rev Proc 2007-56

IRS issues news release or other guidance

- Authorizing postponement
  - May limit to only certain acts
- Duration of postponement
- Define covered disaster area
- Define "affected taxpayers"

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Affected Taxpayers

- www.fema.gov/disasters
- If disaster area covers:
  - Individual's principal residence
  - Principal place of business
  - Records necessary to meet a deadline

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Iowa Severe Storm and Flooding

- Deadlines beginning 3/12/19 to 7/31/19
- Any IRS deadlines extended to July 31, 2019
  - Individual returns
  - Business returns
    - Quarterly payroll tax returns
  - Form 5500 filing extension
- W-2 reporting still required
- Employment tax deposits still required

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Nebraska Severe Winter Storm

- Deadlines beginning 3/9/19 to 7/31/19
- Any IRS deadlines extended to July 31, 2019
  - Individual returns
  - Business returns
    - Quarterly payroll tax returns
  - Form 5500 filing extension
- W-2 reporting still required
- Employment tax deposits still required

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Alabama Severe Storms

- Deadlines beginning 3/3/19 to 7/31/19
- Any IRS deadlines extended to July 31, 2019
  - Individual returns
  - Business returns
    - Quarterly payroll tax returns
  - Form 5500 filing extension
- W-2 reporting still required
- Employment tax deposits still required

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Alaska Earthquake

- Deadlines beginning 11/30/18 to 4/30/19
- Any IRS deadlines extended to April 30, 2019
  - Individual returns
  - Business returns
    - Quarterly payroll tax returns
  - Form 5500 filing extension
- W-2 reporting still required
- Employment tax deposits still required

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2018 California Wildfires

- Deadlines beginning 11/8/18 to 4/30/19
- Any IRS deadlines extended to April 30, 2019
  - Individual returns
  - Business returns
    - Quarterly payroll tax returns
  - Form 5500 filing extension
- W-2 reporting still required
- Employment tax deposits still required

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Hurricane Florence

- Deadlines beginning 9/7/18 to 1/31/19
- Any IRS deadlines extended to January 31, 2019
  - Individual returns
  - Business returns
    - Quarterly payroll tax returns
  - Form 5500 filing extension
- Preamble to proposed regs allowed hardships and loans
- W-2 reporting still required
- Employment tax deposits still required

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Hurricane Michael

- Deadlines beginning 10/9/18 to 2/28/19
- Any IRS deadlines extended to February 28, 2019
  - Individual returns
  - Business returns
    - Quarterly payroll tax returns
  - Form 5500 filing extension
- Preamble to proposed regs allowed hardships and loans
- W-2 reporting still required
- Employment tax deposits still required

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Hardship Availability

- Disaster considered eligible hardship event
  - Participants or relatives
  - Residing or working in disaster area
- Unforeseeable emergency for gov't 457(b) plans
- Service provider may rely on representations for need & amount

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Hardship Availability

- Distributions before plan amendment
- Not required to suspend contributions
- Spousal consent/death certificate

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Hardship Availability

- Still considered taxable income
- Still potentially subject to 10% early withdrawal
- Still not permitted from DB or MPPP

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Loan Availability

- Loan before plan amendment
- Delay in obtaining documentation
- Spousal consent/death certificate
- Ability to suspend loan payments

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DB Funding

- Minimum required contributions
- Quarterly installments
- AFTAP certification
- Funding waiver requests
- Confirm if relief provided!
  - Principal place of business having more than 50% of participants covered by plan

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Late Deferrals

- No enforcement of late deferrals if solely attributable to natural disaster
- Compliance as soon as practical under circumstances

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Blackout Notices

- Provided 30 days in advance of suspension, limitation or restriction lasting more than 3 consecutive business days
- Exception if inability beyond reasonable control of administrator
- Natural disaster beyond administrator's control

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PBGC

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PBGC Relief

- Paying premiums
- Plan terminations:
  - Filing notices
  - Distributing assets
  - Post-distribution certificate
- Reportable event notices

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Congress

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Qualified Hurricane Distributions

- Or Qualified Disaster Recovery Assistance Distribution
- Or Qualified 2016 Disaster Distribution
- Or Qualified Wildfire Distributions
- Participants with principal residence in declared disaster area
- Sustained economic loss due to disaster

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Eligible Distributions

- Katrina, Rita & Wilma (2005)
- Kansas Tornadoes (2007)
- Midwest Storms (2008)
- Major disaster areas (2016)
  - Principal residence in area in 2016
- Harvey, Irma & Maria (2017)
  - Principal residence in area
- California wildfires (2017)
  - Principal residence in area 10/8/17-12/31/17

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Qualified Hurricane Distributions

- Up to $100,000
- Avoid mandatory withholding
- Avoid early distribution penalty
- May be taxed equally over 3 years
- May return to plan as rollover without taxation within 3 year window
- Permissible, but not required - amend plan doc prior to end of 2019 yr end

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Qualified Hurricane Distributions

- HIM Hurricanes
  - Disaster Tax Relief & Airport & Airway Extension Act (9/29/17)
  - Distributions between 8/23/17 to 12/31/18
- 2016 Disaster Areas
  - Tax Cuts and Jobs Act (12/22/17)
  - Distributions between 2016 to 12/31/17
- California wildfires
  - Bipartisan Budget Act of 2018 (2/9/18)
  - Distributions between 10/8/17 to 1/1/19

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Qualified Hurricane Distributions

- Ability to repay hardship distribution if for principal residence which is cancelled due to disaster
  - HIM hurricanes - distributions between 2/28/17 to 9/21/17 must be repaid by 2/28/18
  - California wildfires - distributions between 3/31/17 to 1/15/18 must be repaid by 6/30/18
- NOT Available for 2016 Disaster Areas

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Qualified Hurricane Distributions

- Tax Reporting?
  - Distributions reported on 1099-R
- Income Inclusion?
  - 2016 Distributions: Form 8915A (to be attached to 1040)
  - 2017 Distributions: Form 8915B

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Hardship Relief

- Ability to repay hardship distribution if for principal residence which is cancelled due to disaster
  - HIM hurricanes - distributions between 2/28/17 to 9/21/17 must be repaid by 2/28/18
  - California wildfires - distributions between 3/31/17 to 1/15/18 must be repaid by 6/30/18
- NOT Available for 2016 Disaster Areas

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Loan Relief

- Increase max loan to $100,000
- No 50% of vested account req.
- Loan pmts may be delayed up to 1 yr
- Max amort up to 6 yrs
- Participants with principal residence in declared disaster area
- Permissible, but not required – amend prior to end of 2019 yr end

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Loan Relief

- Permissible, but not required – amend prior to end of 2019 yr end
- Participants with principal residence in declared disaster area
  - HIM Hurricanes – loans between 9/29/17 and 1/1/19
  - California wildfires – loans between 2/9/18 and 1/1/19
- NOT available for 2016 Disaster Areas

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Questions?

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ERISA SEMINAR

What's New In Pensions

June 7, 2019

Presented to:

Cincinnati Bar Association Employee Benefits Conference

Presented by:

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Table of Federal Circuit Court Jurisdictions

In many of the court citations provided in this book, reference is made to a Federal judicial circuit, which is the federal appellate court. The U.S. States and territories are divided among thirteen federal circuits. The following table identifies the jurisdiction of each circuit.

Circuit	Jurisdiction
First (abbreviated 1st Cir.)	Maine, Massachusetts, New Hampshire, Puerto Rico, Rhode Island
Second (abbreviated 2nd or 2d Cir.)	Connecticut, New York, Vermont
Third (abbreviated 3rd or 3d Cir.)	Delaware, New Jersey, Pennsylvania, Virgin Islands
Fourth (abbreviated 4th Cir.)	Maryland, North Carolina, South Carolina, Virginia, West Virginia
Fifth (abbreviated 5th Cir.)	Mississippi, Louisiana, Texas
Sixth (abbreviated 6th Cir.)	Kentucky, Michigan, Ohio, Tennessee
Seventh (abbreviated 7th Cir.)	Illinois, Indiana, Wisconsin
Eighth (abbreviated 8th Cir.)	Arkansas, Iowa, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
Ninth (abbreviated 9th Cir.)	Alaska, Arizona, California, Hawaii, Idaho, Montana, Oregon, Nevada, Washington
Tenth (abbreviated 10th Cir.)	Colorado, Kansas, New Mexico, Oklahoma, Utah, Wyoming
Eleventh (abbreviated 11th Cir.)	Alabama, Florida, Georgia
District of Columbia (abbreviated D.C. Cir.)	Washington, D.C.
Federal (abbreviated Fed. Cir.)	Washington, D.C.

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CURRENT DEVELOPMENTS

Applicable Dollar Limits/PBGC premiums

Adjusted dollar limits for 2019 [Citation: *Notice 2018-83*, Notice 2018-83, 2018-47 I.R.B. (November 19, 2018) (advance release on November 1, 2018)]
Text available at https://www.irs.gov/pub/irs-drop/n-18-83.pdf

The dollar limits for 2019 have been announced by the IRS and are reflected in the table below, along with the 2018 limits. The taxable wage base increase is announced separately by the Social Security Administration.

Description of Limitation	2018	2019
Annual benefit limit under IRC §415(b) (DB plans) (applies to limitation years *ending* in the indicated calendar year)	$220,000	$225,000
Annual additions limit under IRC §415(c) (DC plans) (applies to limitation years *ending* in the indicated calendar year)	$55,000	$56,000
Compensation dollar limit under IRC §401(a)(17) (applies to plan years *beginning* in the indicated calendar year) and under IRC §404(l) (taxable years beginning in the indicated calendar year)	$275,000	$280,000
Elective deferral limit under IRC §402(g)/IRC §401(a)(30) (applied on a calendar year basis, regardless of plan year period; applies to 401(k) and 403(b) plans)	$18,500	$19,000
Catch-up contribution limit under IRC §414(v) (applied on a calendar year basis, regardless of plan year period) (lower limit for SIMPLE plans - see below)	$6,000	$6,000
HCE compensation threshold under IRC §414(q) (applies to *lookback years* that *begin* in the applicable calendar year)	$120,000	$125,000
Compensation threshold for key employee officer test under IRC §416(i) (applies to plan years *beginning* in the applicable calendar year)	$175,000	$180,000
Multiplier for adjusting DB compensation limit for participant who has separated from service (multiply against the prior year's adjusted compensation limit)	1.0196	1.0264
Social Security Taxable Wage Base for calendar year indicated	$128,400	$132,900
Compensation limit under IRC §401(a)(17) for eligible participants in certain governmental plans that, under the plan as in effect on July 1, 1993, allowed COLAs to the compensation limitation under the plan under IRC §401(a)(17) to be taken	$405,000	$415,000

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Description of Limitation	2018	2019
into account (applies to plan years *beginning* in the applicable calendar year)		
SIMPLE contribution limit (IRC §408(p)(2)(E))	$12,500	$13,000
SIMPLE catch-up limit (IRC §414(v)(2)(B)(ii))	$3,000	$3,000
SEP - minimum compensation (IRC §408(k)(2)(C))	$600	$600
Qualified longevity annuity contract premiums dollar limit	$130,000	$130,000
ESOP distribution restrictions (IRC §409(o)(1)(C)) - minimum balance (dollar increments)	$1,105,000 ($220,000)	$1,130,000 ($225,000)
Qualified gratuitous transfer of qualified ER securities to an ESOP (IRC §664(g)(7)	$50,000	$50,000
Annual contribution limit for eligible deferred compensation plans under IRC §457 (IRC §457(e)(15))	$18,500	$19,000
IRA contribution limit (IRC §219(b)(5)(A))	$5,500	$6,000
IRA catch-up limit (IRC §219(b)(5)(B)) (not subject to COLAs)	$1,000	$1,000
IRA deduction AGI phase-out for active participants - married filing jointly or qualifying widow(er)	$101,000 - $121,000	$103,000 - $123,000
IRA deduction AGI phase-out for active participants - singles and heads of household	$63,000 - $73,000	$64,000 - $74,000
IRA deduction AGI phase-out for non-active participants who are married to an active participant	$189,000 - $199,000	$193,000 - $203,000
IRA deduction AGI phase-out for married filing separately	$0 - $10,000	$0 - $10,000
Roth contribution AGI phase-out for married filing jointly	$189,000 - $199,000	$193,000 - $203,000
Roth contrib. AGI phase out for single and head of household	$120,000 - $135,000	$122,000 - $137,000
Roth contribution AGI phase out for married filing	$0 - $10,000	$0 - $10,000
AGI limits for 50%, 20% and 10% saver's credit - married filing jointly	$38,000, $41,000, $63,000	$38,500, $41,500, $64,000
AGI limit for 50%, 20% and 10% saver's credit - heads of household	$28,500, $30,750, $47,250	$28,875, $31,125, $47,000
AGI limit for 50%, 20% and 10% saver's credit - singles and married filing separately	$19,000, $20,500, $31,500	$19,250, $20,750, $32,000

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PBGC Premium Rates (source: http://www.pbgc.gov/prac/prem/premium-rates.html)

Description of Premium	2018	2017
Flat-rate premium: single-employer plans	$74 per participant	$80 per participant
Flat-rate premium: multiemployer plan	$28 per participant	$29 per participant
Variable rate premium	$38 per $1,000 of underfunding	$43 per $1,000 of underfunding
Cap on variable rate premium	$523 per participant	$541 per participant

Changes made by the BBA 2015. Section 501 of the Bipartisan Budget Act of 2015 further increases the PBGC premiums for defined benefit plans other than multiemployer plans, starting with the 2017 plan year.

✪ *Flat rate premium.* Under the BBA 2015, the flat-rate premium increases from $64 to $69 for the 2017 plan year, $74 for the 2018 plan year, and $80 for the 2019 plan year. See ERISA §4006(a)(3)(A)(i)(VI), (VII) and (VIII), as amended. Thereafter, COLAs will resume, using 2017 as the base year. See ERISA §4006(a)(3)(G), as amended.

✪ *Variable rate premium.* Under the BBA 2015, the variable rate premium increases by a minimum of $3 for the 2017 plan year, bringing the minimum amount to $33 per $1,000 of underfunding. For each of the 2018 and 2019 plan years, the premium will increase by a minimum of $4, bringing the minimum amount to $37 per $1,000 of underfunding for the 2018 plan year and $41 per $1,000 underfunding for the 2019 plan year. See ERISA §4006(a)(8)(C)(iv), (v) and (vi), as amended. Due to the COLA increases with respect to the prior year's premium rate, the actual rates for 2018 and 2019 ended up being $38 and $43, respectively, per $1,000 of underfunding. See ERISA §4006(a)(8)(A)(v), (vi), and (vii), as amended. After the 2019 plan year, further increases will depend on the COLA formula, using 2017 as the base year. See ERISA §4006(a)(8)(vii), as amended.

Acceleration of 2025 premium due date. Section 502 of the BBA 2015 also accelerates by one month the premium due date for the premiums paid for the 2025 plan year. This will make the due date fall in September 2025, rather than in October 2025, so that the revenue generated could fall within the budgetary window.

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IRS issues 2019 covered compensation table [Citation: *Rev. Rul. 2019-08*, 2019-14 I.R.B. (April 1, 2019); advance publication on March 15, 2019)]
Text available at https://www.irs.gov/pub/irs-drop/rr-19-06.pdf

The tables below reflect the 2019 covered compensation table, based on the taxable wage base of $132,900 that is in effect for 2019.

2019 Covered Compensation Table

Calendar year of birth	Calendar year of Soc. Sec. ret. age	2019 covered compensation		Calendar year of birth	Calendar year of Soc. Sec. ret. age	2019 covered compensation
1907	1972	$4,488		1947	2013	$67,308
1908	1973	$4,704		1948	2014	$69,996
1909	1974	$5,004		1949	2015	$72,636
1910	1975	$5,316		1950	2016	$75,180
1911	1976	$5,664		1951	2017	$78,880
1912	1977	$6,060		1952	2018	$80,532
1913	1978	$6,480		1953	2019	$83,224
1914	1979	$7,044		1954	2020	$85,920
1915	1980	$7,692		1955	2022	$91,056
1916	1981	$8,460		1956	2023	$93,564
1917	1982	$9,300		1957	2024	$96,000
1918	1983	$10,236		1958	2025	$98,328
1919	1984	$11,232		1959	2026	$100,596
1920	1985	$12,276		1960	2027	$102,804
1921	1986	$13,368		1961	2028	$104,964
1922	1987	$14,520		1962	2029	$107,028
1923	1988	$15,708		1963	2030	$109,080
1924	1989	$16,968		1964	2031	$111,084
1925	1990	$18,312		1965	2032	$113,004
1926	1991	$19,728		1966	2033	$114,852
1927	1992	$21,192		1967	2034	$116,580
1928	1993	$22,716		1968	2035	$118,200
1929	1994	$24,312		1969	2036	$119,700
1930	1995	$25,920		1970	2037	$121,068
1931	1996	$27,576		1971	2038	$122,376
1932	1997	$29,304		1972	2039	$123,660
1933	1998	$31,128		1973	2040	$124,884
\1934	1999	$33,060		1974	2041	$126,000
1935	2000	$35,100		1975	2042	$127,008
1936	2001	$37,212		1976	2043	$127,884
1937	2002	$39,444		1977	2044	$128,640
1938	2004	$43,992		1978	2045	$129,384
1939	2005	$46,344		1979	2046	$130,128
1940	2006	$48,816		1980	2047	$130,776
1941	2007	$51,348		1981	2048	$131,328
1942	2008	$53,952		1982	2049	$131,784

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Calendar year of birth	Calendar year of Soc. Sec. ret. age	2019 covered compensation		Calendar year of birth	Calendar year of Soc. Sec. ret. age	2019 covered compensation
1943	2009	$56,628		1983	2050	$132,192
1944	2010	$59,268		1984	2051	$132,600
1945	2011	$61,884		1985	2052	$132,768
1946	2012	$64,560		1986 and later	2053 and later	$132,900

2019 Rounded Covered Compensation Table

Calendar year of birth	Covered compensation
1937	$39,000
1938 - 1939	$45,000
1940	$48,000
1941	$51,000
1942	$54,000
1943	$57,000
1944	$60,000
1945	$63,000
1946 - 1947	$66,000
1948	$69,000
1949	$72,000
1950	$75,000
1951	$78,000
1952	$81,000
1953	$84,000
1954	$87,000
1955	$90,000
1956	$93,000
1957	$96,000
1958	$99,000
1959 - 1960	$102,000
1961	$105,000
1962 - 1963	$108,000
1964	$111,000
1965 - 1966	$114,000
1967 - 1968	$117,000
1969 - 1970	$120,000
1971 - 1972	$123,000
1973 - 1975	$126,000
1976 - 1979	$129,000
1980 - 1983	$132,000
1984 and later	$132,900

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Tax Cut and Jobs Act of 2017

Pension-related provisions in the Tax Cut and Jobs Act [Citation: *P.L. 115-97* (December 22, 2017)]
Text available at http://bit.ly/2Cj4s5E

¶1. Extended rollover period for participant loan offsets. IRC §402(c)(3)(C), as added by TCJA §13613, provides additional time to rollover a qualified loan offset, which is defined in IRC §402(3)(C)(ii) as a loan offset treated as distributed solely by reason of the termination of the plan or the failure to meet the repayment terms by reason of the participant's severance from employment. Under this provision, the rollover may occur up to the due date (including extensions) for filing the distributee's federal income tax return for the taxable year in which the loan offset is treated as distributed from the plan. The rollover is completed by deposited with recipient plan or IRA an amount not exceeding the loan offset amount, which is the amount by which the participant's accrued benefit is reduced to repay the loan. See IRC §402(c)(3)(C)(iii). This provision applies only to loans from a qualified employer plan, defined in IRC §402(c)(3)(C)(v) to mean a qualified plan under IRC §401(a), a section 403(b) plan, or a governmental plan (as described in IRC §72(p)(4), which would include a governmental 457(b) plan).

Effective date. This provision is effective for qualified loan offsets that are treated as distributions in taxable years beginning after December 31, 2017.

Comment. This rollover relief will provide additional time for an individual who incurs the offset to accumulate the funds needed to avoid taxation on the loan offset. The extended rollover period also will provide time for the individual to receive the required Form 1099-R from the plan which, in some cases, may be the first the individual learns of the taxable amount triggered by the loan offset. For example, if a plan terminates in 2018, resulting in a loan offset for a participant, the participant would have until April 15, 2019 (or October 15, 2019, if his or her return is on extension) to complete the rollover.

¶2. Recharacterization of Roth IRA conversion back to traditional IRA not available after 2017. IRC §408A(d)(6) treats the transfer of contributions from one IRA to another, including a Roth IRA, as if the contribution was originally made to the transferee IRA (rather than to the transferor IRA), so long as the transfer is made by the due date (*including extensions*) for filing the individual's Federal income tax return. The transfer must include earnings (i.e., net gain or net loss) attributable to the contribution being transferred. The IRS refers to this type of transfer as a recharacterization. See Treas. Reg. §1.408A-5. When an individual converts non-Roth funds into a Roth IRA, the individual must include in gross income the amount of the conversion that would have been includible in income had the individual received a distribution of the non-Roth funds instead of electing a conversion. It is possible that, after a conversion, the value of the Roth IRA incurs significant investment losses. This has prompted some individuals to recharacterize the transaction under IRC §408A(d)(6), thereby reversing the transaction and eliminating the tax liability on the higher value of the converted funds at the time of the conversion. Section 13611 of the TCJA eliminates this option by adding IRC §408A(d)(6)(B)(iii), which provides that the recharacterization option does not apply to a conversion. The change is effective for recharacterizations made after December 31, 2017. See TCJA §13611(b). With the elimination of the recharacterization option, a conversion to a Roth IRA, whether it be funds from a traditional IRA or non-Roth funds from a workplace retirement plan, will result in irrevocable tax consequences based on the value of the funds at the time of the conversion.

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Internal Roth Conversions. A recharacterization of a Roth IRA conversion, as described in the preceding paragraph, was never available with respect to an Internal Roth Conversion, where non-Roth funds in a 401(k) plan, are converted into Roth funds and rolled over to a designated Roth account within the same plan. See Q&A-6 of Notice 2010-84. Only conversions involving Roth IRAs were eligible for the recharacterization prior to 2018.

Recharacterization of Roth IRA or traditional contribution still okay. The TCJA did not completely eliminate recharacterizations, it only took away this option with respect to the conversion of non-Roth funds into a Roth IRA. So, a taxpayer may still make a traditional IRA contribution and, no later than the due date of his or her tax return (including extensions) for the year in which that contribution was made, recharacterize the contribution (along with earnings on such contribution) into a Roth IRA contribution. The reverse transaction also is permissible.

Recharacterization of 2017 Roth IRA conversions. The IRS has confirmed in FAQs posted on its website (http://bit.ly/2EWa4D2) that a Roth IRA conversion made in 2017 may be recharacterized in 2018, if the recharacterization is made within the appropriate deadline. For example, if an individual converted a traditional IRA into a Roth IRA on August 1, 2017, and the individual's tax return for 2017 is due April 17, 2018 (the 15th is a Sunday and the 16th is Patriots Day), the recharacterization could be elected up to April 17, 2018. If the 2017 return is on extension, then the deadline would be October 15, 2018.

¶3. Liberalized distribution, rollover and loan rules, and premature distribution penalty relief for certain taxpayers affected by 2016 disasters. Section 11028 of the TCJA exempts "qualified 2016 disaster distributions" from the premature distribution penalty tax, and provides for income tax relief with respect to such withdrawals. The relief parallels the relief in IRC §1400Q that was enacted in 2005 in response to Hurricanes Katrina, Rita and Wilma, except the TCJA does not provide participant loan relief nor relief for an interrupted construction or purchase of a principal residence. Under the legislation, a ''qualified 2016 disaster distribution'' (any distribution from a retirement plan or IRA made on or after January 1, 2016, and before January 1, 2018, to an individual who is eligible for this relief) is: (1) exempt from the premature distribution penalty under IRC §72(t) (up to $100,000), (2) can be repaid during a 3-year rollover period to either the same or to another retirement plan or IRA, (3) may either be taxed in the year of the distribution, or included ratably in income over a 3-year period that begins with the year of the distribution, and (4) is deemed to meet the distribution restrictions that might otherwise preclude the distribution (IRC §§401(k)(2)(B)(I), 403(b)(7)(A)(ii), 403(b)(11), and 457(d)(1)(A)). Any amendment to a plan with respect to these provisions of the TCJA or any regulations issued by the Treasury or DOL must be adopted on or before the last day of the first plan year beginning on or after January 1, 2018 (i.e., the 2018 plan year), or such later date that the Treasury may prescribe.

* * * See the "Disaster Relief" section later in these materials for more details * * *

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¶4. Changes that may affect section 415 compensation determinations. The following sections of the TCJA make changes to the determination of an individual's income determined under the tax code that may affect section 415 compensation. Also see the discussion in ¶? regarding qualified equity grants under IRC §83(I).

(1) Qualified transportation fringe benefits - bicycle commuting expenses. IRC §132(f)(8), as added by TCJA §11047, suspends the income exclusion for qualified bicycle commuting reimbursements, as described in IRC §132(f)(1)(D), for taxable years beginning after December 31, 2017, and before January 1, 2026. Thus, if such a reimbursement is provided during this period, the amount would be includible in income and automatically included in a participant's section 415 compensation. Of course, an employer may choose not to reimburse an employee for out-of-pocket expenses relating to bicycle commuting expenses, in which case there would be no effect on section 415 compensation.

(1)(a) Loss of employer deduction for qualified transportation fringe benefits. IRC §274(a)(4), as added by TCJA §13304, eliminates the employer's deduction for the cost of qualified transportation fringe benefits, for taxable years beginning after December 31, 2017. Note that this is a permanent loss of deduction, as opposed to the suspension of the income exclusion discussed in (1) above for bicycle commuting reimbursements. Although the loss of the employer's deduction does not directly affect an employee's compensation (i.e., reimbursements for qualified transportation fringe benefits remain excludable from an employee's gross income, except for bicycle commuting expenses), but the loss of the deduction might prompt some employers to discontinue or reduce these benefits.

Salary reduction gross-up. **Although the employer loses the deduction for qualified transportation fringe benefits, it may still offer a salary reduction program for qualified transportation fringe benefits (other than bicycle commuting expenses for 2018-2025 taxable years), as described in IRC §132(f)(4). These amounts would still be excluded from an employee's gross income, but, pursuant to the "gross-up" rule in IRC §415(c)(3)(D), the amounts would be added back into section 415 compensation.**

(2) Qualified moving expense reimbursement. IRC §132(g)(2), as added by TCJA §11048, suspends the income exclusion for qualified moving expense reimbursements, as described in IRC §132(a)(6), for taxable years beginning after December 31, 2017, and before January 1, 2026, *unless* the individual is a member of the U.S. Armed Forces on active duty who moves pursuant to a military order and incident to a permanent change of station. Thus, if such a reimbursement is provided during this period, the amount would be includible in income and automatically included in a participant's section 415 compensation. Of course, an employer may choose not to reimburse an employee for out-of-pocket expenses relating to qualified moving expense reimbursements, in which case there would be no effect on section 415 compensation.

Individual's deduction suspended, too. **For the 2018 through 2025 taxable years, an individual also cannot deduct moving expenses, unless the individual is a member of the U.S. Armed Forces on active duty who moves pursuant to a military order and incident to a permanent change of station See IRC §217(k), as added by TCJA §11049. Accordingly, if the employer reimburses the moving expenses, not only will they be includible in income, as discussed in the prior paragraph, but the individual will not be able to offset the income with a deduction under IRC §217.**

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(3) Treatment of alimony. TCJA §11051 repeals IRC §§62(a)(10) and 215, which entitles the individual who pays alimony to deduct those payments, and IRC §§61(a)(8) and 71, which requires the individual who receives the alimony payments to include those amounts in income. Thus, individuals who pay alimony out of current income sources will, after 2018, recognize those amounts in income without an offsetting deduction, and the recipient of the alimony will receive the payments on a tax-free basis. These changes are effective for taxable years beginning on or after January 1, 2019. However, a divorce or separation instrument issued before January 1, 2019, may be modified to expressly provide that these new tax rules apply.

(3)(a) Effect on retirement savings programs. Since these payments are not made by an employer, there would not be any effect on section 415 compensation or compensation definitions used for other workplace retirement plans. However, alimony received by a spouse or former spouse, pursuant to divorce or separation instrument, was part of compensation under IRC §219(f)(1), pertaining to compensation for IRA purposes, so could support an IRA contribution by the spouse or former spouse in pre-2019 taxable years. For post-2018 taxable years, since the alimony payments won't be includible in the compensation of the spouse or former spouse who receives the alimony, an IRA contribution will not be supported by alimony payments in such years.

(3)(b) No effect on tax treatment of QDRO payments. The change in the law does not change the taxation of dispositions under a QDRO because taxation is governed by IRC §402(e)(1), which has not been amended by the TCJA. So, a spouse or former spouse who is the alternate payee under a QDRO will still be treated as the payee of those benefits for tax purposes (i.e., subject to income taxation unless the benefits are rolled over in a tax-deferred transaction). Similarly, if the alternate payee is not the spouse or former spouse (e.g., a child of the participant), the benefits remain taxable to the participant.

(3)(c) Division of IRAs not modified. IRC §408(d)(6) provides for the division of an IRA, pursuant to a divorce or separation instrument, without tax consequences to the IRA owner or to the spouse or former spouse. The only difference under the TCJA is that IRC §408(d)(6), for post-2018 taxable years, refers to IRC §121(d)(3)(C)(I) for the definition of "divorce or separation instrument" (formerly in IRC §71(b)(2), before the repeal of IRC §71).

¶5. UBTI calculated separately for each trade or business in post-2017 years. For taxable years beginning after December 31, 2017, if an organization (including a qualified plan exempt from tax pursuant to IRC §501) has more than one unrelated trade or business: (1) unrelated business taxable income (UBTI), is computed separately with respect to each such trade or business and without regard to the deduction taken under IRC §512(b)(12), (2) the UBTI of such organization is the sum of the UBTI so computed with respect to each such trade or business, less the specific deduction (usually $1,000) under IRC §512(b)(12), and (3) in computing the sum of the UBTI for all the trades or business, UBTI with respect to any separate trade or business cannot be less than zero (i.e., no negative UBTI can be used to reduce the sum of the UBTIs for all of the businesses). See IRC §512(a)(6), as added by TCJA §13702.

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Hardship Distributions

Congress eliminates 6-month suspension rule and requirement to access available plan loans, and permits all contributions sources and earnings on elective deferrals to be available for hardship withdrawal in post-2018 plan years [Citation: *Sections 41113 and 41114 of the Bipartisan Budget Act of 2018 ("BBA2018")*, P.L. 115-123 (February 9, 2018)]
Text available at http://bit.ly/2EnEhef

IRC §401(k)(14)(B), as added by Section 41114 of the BBA2018: (1) eliminates the requirement that a participant access all available loans under all plans of the employer before taking a hardship withdrawal on elective deferrals, and (2) permits earnings on elective deferrals, as well as QNECs, QMACs and 401(k) safe harbor contributions (and earnings on such contributions), to be available for hardship withdrawal. The elimination of the loan requirement does not apply to the regulatory requirement under Treas. Reg.§1.401(k)-1(d)(3)(iv)(E)(1) to access distributions available under the employer's plans as a condition for using the "safe harbor" conditions for determining whether a participant has a financial need. The elimination of the restrictions on sources for hardship withdrawals permits a 401(k) plan to offer hardship distributions from all contribution sources, alleviating burdensome recordkeeping requirements, especially regarding the restriction on hardship withdrawals on earnings on elective deferrals. These changes are effective for plan years beginning on or after January 1, 2019.

Section 41113 of the BBA2018 also requires the Treasury to amend Treas. Reg. §1.401(k)-1(d)(3)(iv)(E)(2) to eliminate the requirement that a participant's right to contribute to all plans of the employer be suspended for 6 months following a hardship distribution of elective deferrals. (The requirement applies only to plans that use the "safe harbor" standards for determining whether the participant has a financial need.) The amended regulations must be effective for plan years beginning on or after January 1, 2019. Although the change would not preclude plans from using a suspension rule, it is expected that the Treasury will not permit a safe harbor 401(k) plan under IRC §401(k)(12) or (13) to use a suspension rule after these regulations become effective. This would be consistent with the IRS' prohibition on safe harbor 401(k) plans using a suspension period longer than 6 months when the regulation reduced the mandatory suspension period from 12 months to 6 months. Since a safe harbor plan doesn't perform nondiscrimination testing on elective deferrals, the Treasury presumably would want NHCs who take hardship withdrawals not to be disadvantaged regarding the ability to defer (and, thus, earn safe harbor matching contributions).

Proposed regulations address new hardship distribution rules enacted by recent legislation, add safe harbor hardship event for natural disasters [Citation: *Prop. Treas. Reg. §§1.401(k)-1(d), 1.401(k)-3(c), 1.401(k)-6, 1.401(m)-3(c)(6)(v)*, 83 F.R. 56763 (November 14, 2018)]
Text available at http://bit.ly/2A8uec3
EOB2018 sections affected: Chapter 6, Section IV, Part D.4.

These proposed regulations address the following issues relating to hardship distributions under 401(k) plans from the account balance that is attributable to elective deferrals and other contributions that are subject to the 401(k) distribution restrictions (qualified nonelective contributions (QNECs) and qualified matching contributions (QMACs)).

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- The expansion of hardship distribution availability to earnings on 401(k) deferrals, QNECs, and QMACs, as required by IRC §401(k)(14), and whether this statutory change applies to safe harbor contributions under a QACA and to elective deferrals under a 403(b) plan.
- The elimination of the 6-month contribution suspension period following a hardship distribution under the regulatory safe harbor, as required by the Bipartisan Budget Act of 2018 (BBA 2018).
- The elimination of the requirement under the regulatory safe harbor that a participant take available plan loans before taking a hardship distribution, as required under IRC §401(k)(14) (enacted by BBA 2018).
- A proposal to impose a uniform standard for determining whether a hardship distribution is necessary to satisfy the participant's financial need, to replace the current system of either using a facts and circumstances test (which can rely on certain representations of a participant) or a safe harbor test.
- Clarification of how the safe harbor hardship event relating to casualty losses is applied in light of the change under IRC §165 to the casualty loss deduction made by the Tax Cut and Jobs Act of 2017.
- Incorporation into the regulations that a participant's primary beneficiary to receive hardship withdrawals under the same rules that apply to a participant's spouse, as required by the PPA 2006.
- Incorporation into the regulations of the permissible distribution event for qualified reservist distributions, pursuant to IRC §401(k)(2)(B)(i)(V) (enacted by the PPA 2006).
- Incorporation into the regulations of the 6-month contribution suspension after certain distributions to individuals performing service in the uniformed services, pursuant to IRC §414(u)(12)(B)(ii) (enacted by the HEART Act).

* **Effective date.** Except where otherwise noted, these changes would be effective for plan years beginning on or after January 1, 2019. See Prop. Treas. Reg. §1.401(k)-1(d)(3)(v)(A). As noted below, changes relating to the elimination of a contribution suspension due to a hardship withdrawals, and the requirement to obtain a participant's representation on other available resources, are not required until plan years beginning on or after January 1, 2020. In addition, casualty losses can be determined for hardship distributions without regard to IRC §165(h)(5), as enacted by the TCJA (see discussion below), for plan years beginning on or after January 1, 2018.

* **Plan amendments.** The timing for amendments to incorporate the proposed regulations will be governed by Rev. Proc. 2016-37. For an individually designed plan, the deadline for amending the plan to reflect a change in qualification requirements is the end of the second calendar year that begins after the issuance of the Required Amendments List that includes the regulations (longer period for governmental plans). It is unclear when plan amendments to reflect these regulations are required for Pre-Approved Plans. Although language in the proposed regulations might be interpreted to suggest that amendments are not required until after final regulations are issued, some practitioners are recommending that Pre-Approved Plans adopt interim amendments, in accordance with the rules under Rev. Proc. 2016-37, based on the proposed effective date of these rules (generally the 2019 plan year, although in some cases the 2020 plan year), rather than wait until final regulations are issued. One thing that is clear from the proposal is that the IRS intends these amendment deadlines to apply as if all provisions under the proposed regulations requiring plan amendment be treated as either disqualifying provisions or integrally related to a disqualifying provision, so that amendments to respond to all provisions under these proposed regulations have uniform deadlines. This is true even with respect regulatory provisions that have a discretionary element (e.g., an amendment reflecting the change in the casualty loss event and the addition of the disaster-related event

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under the safe harbor hardship definition, as discussed in 4.b.1) below). See the preamble to the proposed regulations, 83 F.R. 56766 (November 14, 2018). For a Pre-Approved Plan, the timing rules under Rev. Proc. 2016-37 for interim amendments will apply. See the preamble to the proposed regulations, 83 F.R. 56766.

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* **Restricted hardship sources.** Before the amendments made by the BBA 2018, earnings on elective contributions could not be available for hardship withdrawal. In addition, QNECs and QMACs (including earnings on those contributions) could not be available for hardship withdrawals. See IRC §401(k)(2) (before amendment by the BBA 2018) and Treas. Reg. §1.401(k)-1(d)(3)(ii)(A). An exception was made for earnings on elective deferrals and QNECs and QMACs accumulated through the end of the 1988 plan year. See Treas. Reg. §1.401(k)-1(d)(3)(ii)(B). IRC §401(k)(14), as enacted by BBA 2018, allows hardship distributions to be available from these sources. This change eliminates the complex plan accounting requirements relating to the determination of the portion of the participant's account is attributable to earnings on elective deferrals and, if applicable, the portion of such earnings and QNECs and QMACs accumulated by the end of the 1988 plan year. Accordingly, the proposal would eliminate Treas. Reg. §1.401(k)-1(d)(3)(ii). This would result in the redesignation of the hardship distribution events (see discussion below) as Treas. Reg. §1.401(k)-1(d)(3)(ii) (currently in (iii)), and the redesignation of the necessity determination (see discussion below) as Treas. Reg. §1.401(k)-1(d)(3)(iii) (currently in (iv)).

> ✪ *Safe harbor 401(k) contributions.* Under a safe harbor 401(k) plan described in IRC §401(k)(12) an employer must make either a safe harbor nonelective contribution or a safe harbor matching contribution. These contributions must be fully vested and subject to the IRC §401(k) distribution restrictions. Accordingly, the regulations refer to safe harbor contributions under IRC §401(k)(12) as QNECs (if nonelective) or QMACs (if matching). However, under IRC §401(k)(13), which applies to qualified automatic contribution arrangements (QACAs), the safe harbor contribution is not required to be fully vested. Instead, the plan may require up to two years of service before a participant vests in the QACA safe harbor contribution. Because of this difference, it wasn't clear whether the lifting on the hardship withdrawal prohibition for QNECs and QMACs would apply to QACA safe harbor contributions. The proposal clarifies that hardship withdrawals are permissible for QACA safe harbor contributions, too. This is true because Treas. Reg. §1.401(k)-3(k)(3)(i) states that QACA safe harbor contributions must satisfy the distribution restrictions applicable to QNECs and QMACs and the proposed regulations removes the prohibition on hardship withdrawals from QNECs and QMACs.

> ✪ *Plan may still restrict hardship distributions from these sources.* The statutory change does not require a plan to open up hardship distributions to these contribution sources. This ultimately is a plan design issue.

* **Hardship distribution events.** Treas. Reg. §1.401(k)-1(d)(3)(iii)(B) prescribes "safe harbor" hardship distribution events, which are incorporated by many plans to limit the types of expenses for which a participant may request a hardship withdrawal from elective deferrals and other restricted contributions. The proposed regulations make the following changes to these hardship events. Note that, due to the elimination of the hardship distribution prohibition on earnings on elective deferrals and QNECs and QMACs (see above), these hardship distribution events would be moved to Treas. Reg. §1.401(k)-1(d)(3)(ii)(B).

> ✪ *Disaster relief.* Prop. Treas. Reg. §1.401(k)-1(d)(3)(ii)(B)(*7*) would allow hardship distributions for expenses and losses (including loss of income) incurred by the participant on account of a disaster declared by FEMA. In order for this event to apply, the participant's principal residence or principal place of employment at the time of the disaster would have to be located in an area designated by FEMA for individual assistance with respect to the disaster. The intent of this change is to eliminate any delay or uncertainty concerning access to plan funds following a disaster. Currently, a plan administrator must wait for a formal IRS announcement in order to make hardship withdrawals for

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these disasters where the type of relief needed by the participant doesn't fall within the other acceptable distribution events.

✪ *Primary beneficiary.* The proposal would permit a participant to take hardship withdrawals to cover medical, educational, and funeral expenses of the participant's "primary beneficiary under the plan." See Prop. Treas. Reg. §1.401(k)-1(d)(3)(ii)(B)(*1*), *(3)* and (*5*). The current regulations allow for distributions relating to the same expenses incurred by the participant's spouse, so the proposal expands the rule to cover such expenses incurred by either the participant's spouse or primary beneficiary under the plan. For this purpose, the primary beneficiary under the plan is defined as individual who is named as a beneficiary under the plan and has an unconditional right, upon the death of the participant, to all or a portion of the participant's account balance. See Prop. Treas. Reg. §1.401(k)-1(d)(3)(ii)(C). The reference to the beneficiary being named under the plan does not mean that the plan document has to specify that beneficiary. It is sufficient (which is more often the case) that the beneficiary is named in a valid beneficiary designation by the participant, since plan documents will typically refer to the beneficiary designation as the determiner of the beneficiary, where a default beneficiary is specified in the plan only in the event that there is no valid beneficiary designation at the time of the participant's death. Also, since the beneficiary's right to the account must be unconditional, a contingent beneficiary, who would receive benefits only after the death of another beneficiary, would not be a primary beneficiary under the plan for purposes of these hardship distribution events.

✪ *Casualty loss deduction.* Under the current regulations, a hardship withdrawal is permitted for the repair of damage to the employee's principal residence that would qualify for the casualty deduction under IRC §165 (determined without regard to whether the loss exceeds 10% of adjusted gross income). The TCJA 2017 amended IRC §165 to permit casualty loss deductions during 2018-2025 only to the extent the loss is attributable to a federally declared disaster (see IRC §165(h)(5)). If applicable to the 401(k) distribution restrictions, the circumstances under which this hardship distribution event would apply are significantly restricted. The proposed regulations clarify that this limitation under amended IRC §165 does not apply to the 401(k) distribution restrictions. Accordingly, Treas. Reg. §1.401(k)-1(d)(3)(ii)(B)(*6*) would be amended to read as follows: "Expenses for the repair of damage to the employee's principal residence that would qualify for the casualty deduction under section 165 (determined without regard to section 165(h)(5)) and whether the loss exceeds 10% of adjusted gross income)." In addition, even though the proposed regulations are generally effective for plan years beginning on or after January 1, 2019, the regulations would allow this modified definition to apply for the 2018 plan year to coincide with when the TCJA change to IRC §165 was effective.

*** Is the hardship distribution *necessary* to satisfy the need?** Under the current regulations, Treas. Reg. §1.401(k)-1(d)(3)(iv) requires that a hardship distribution from these restricted accounts be necessary to satisfy the participant's financial need. A plan can satisfy this requirement either by making a facts-and-circumstances determination (see §1.401(k)-1(d)(3)(iv)(B)), which may be satisfied on the basis of an employee representation (see §1.401(k)-1(d)(3)(iv)(C)), or by using a safe harbor test for necessity (see §1.401(k)-1(d)(3)(iv)(E)). Under the safe harbor test, the plan must: (1) require the participant to first take all available distributions (other than hardship distributions) and all available nontaxable loans from the plan or any other plan of the employer), and (2) suspend the participant from making an elective deferrals or employee contributions under the plan or any other plan of the employer for at least 6 months following the hardship distribution. The proposal makes the following changes to this part of the regulations. Note that because of the elimination of current Treas. Reg. §1.401(k)-1(d)(3)(ii) (see above),

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the rules relating to the necessity determination would be redesignated as Treas. Treas. Reg. §1.401(k)-1(d)(3)(iii).

✪ *Suspension of contributions.* As required by the BBA 2018, the regulations would eliminate the requirement to impose the 6-month contribution suspension. But the regulation goes further by precluding a 401(k) plan from imposing any type of contribution suspension following a hardship withdrawal. See Prop. Treas. Reg. §§1.401(k)-1(d)(3)(iii)(C), 1.401(k)-3(c)(6)(v)(C) and 1.401(m)-3(d)(6)(v)(C). This prohibition on suspension would apply regardless of whether the plan is a safe harbor 401(k) plan or is subject to ADP/ACP testing. The Treasury believes that a general prohibition on suspensions addresses the concern that suspensions impede a participant's ability to replace the withdrawn funds through continued contributions.

- Delayed effective date. Because of the timing of the proposal, the mandatory elimination of suspension periods will not apply until plan years beginning on or after January 1 2020. See Prop. Treas. Reg. §1.401(k)-1(d)(3)(iii)(B).
- Transition rule. A plan may (but is not required to) eliminate the contribution suspension for the 2019 plan year as well (i.e., the first plan year beginning on or after January 1, 2019). In addition, this elimination of the contribution suspension may apply not only to hardship withdrawals taken in the 2019 plan year but also to suspensions that began before the start of that year. See Prop. Treas. Reg. §1.401(k)-1(d)(3)(v)(B). For example, a calendar year 401(k) plan could provide that a participant who is under a 6-month contribution suspension because of a hardship withdrawal taken in the second half of 2018, would no longer be subject to that suspension as of January 1, 2019, even though the 6-month period has not been completed.
- Eligible employees for ADP/ACP testing. Because of the elimination of contribution suspensions, Prop. Treas. Reg. §1.401(k)-6 modifies the eligible employee definition to eliminate the rule that, during a contribution suspension period due to a hardship distribution, an employee is treated as eligible for a 401(k) or 401(m) arrangement. However, the proposal would completely eliminate the sentence in the regulation that refers to suspensions. That sentence also refers to contribution suspensions due to a loan or due to a participant's election not to participate. It is not clear whether this is intended to change the effect of such suspensions. For example, if a participant is otherwise eligible for a 401(k) arrangement, but elects not to participate in the plan, the participant should still be taken into account in the ADP test at a 0% deferral rate unless the election is a one-time irrevocable election described in paragraph (3) of the eligible employee definition in §1.401(k)-6. This rule would not change merely because the sentence regarding the effect of suspensions would be eliminated from the regulations. Less clear is with respect to loans. The part of the proposal that prohibits contribution suspensions refers only to suspensions due to a hardship distribution. Presumably, a plan could choose to suspend contributions as a condition for taking a loan. However, the eliminate of the sentence in the eligible employee definition regarding the effect of a suspension could be an indirect way of the Treasury saying it would not consider a contribution suspension due to a participant loan to be a reasonable restriction on the right to defer under the 401(k) arrangement. Hopefully the final version of these regulations addresses this issue. Or, it may just be an oversight, since the proposal doesn't specifically prohibit contribution suspensions due to loans.

✪ *Requirement to take available loans.* The proposal would eliminate the requirement that a participant must first take all available loans from the plan or other plans of the employer, as required

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by IRC §401(k)(14)(B). However, pursuant to Prop. Treas. Reg. §1.401(k)-1(d)(3)(iii)(C), a plan could apply any additional conditions on taking hardship withdrawals (except for a contribution suspension in post-2019 plan years), including a requirement to first take available plan loans.

✪ *Uniform standard for determining financial necessity/participant representation requirement.* The proposal would modify the standards for determining whether the hardship distribution is necessary to meet the financial need to impose a uniform standard rather than a choice between facts and circumstances and a safe harbor standard. Under the uniform standard: (1) the participant would first have to take all available distributions (other than hardship distributions) from the plan and any other plan of the employer, including ESOP dividend distributions pursuant to IRC §404(k), and (2) the plan would have to obtain (in writing, by an electronic medium, or in such other form as may be prescribed by the IRS) a representation from the participant that he/she has insufficient cash or other liquid assets to satisfy the need. See Prop. Treas. Reg. §1.401(k)-1(d)(3)(iii)(B).

- Actual knowledge exception. If a plan administrator has actual knowledge that contradicts the participant's representation, the plan could not rely on such representation and, thus, would not be able to make the hardship distribution. However, the regulations do not impose a duty on the plan administrator to investigate whether the participant's representation is true.
- Delayed effective date on representations. The requirement to obtain the participant representation regarding other resources would not be effective until the 2020 plan year. Prior to the 2020 plan year, a plan could, but would not have to, impose a representation requirement.

✪ *Limitation on hardship dollar amount.* The proposal would not change the requirement that the amount of the hardship distribution cannot exceed the amount required to satisfy the financial need (including any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to result from the distribution). See Prop. Treas. Reg. §1.401(k)-1(d)(3)(iii)(A). [This requirement is currently in Treas. Reg. §1.401(k)-1(d)(3)(iv)(A).]

* **Effect on 403(b) plans.** As a general rule, the changes described above also apply to hardship withdrawals under a 403(b) plans. This is because Treas. Reg. §1.403(b)–6(d)(2) provides that a hardship distribution of section 403(b) elective deferrals is subject to the rules and restrictions set forth in Treas. §1.401(k)-1(d)(3).

✪ *Earnings on 403(b) elective deferrals.* The ability to take hardship withdrawals from earnings on elective deferrals does not extend to earnings on 403(b) deferrals. This is because IRC §403(b)(11) was not amended by the BBA 2018, and that section specifically prohibits hardship withdrawals from such earnings. Thus, the proposal would not amend Treas. Reg. §1.403(b)-6(d)(2), which reflects this limitation.

✪ *QNECs and QMACs.* QMACs and QNECs under a custodial account 403(b) plan continue not to be available for hardship distributions because IRC §403(b)(7) does not allow for hardship distributions from any employer contributions made to a 403(b) custodial account, and the BBA 2018 did not amend that tax code provision. See IRC §403(b)(7)(A)(ii). This restriction is reflected in Treas. Reg. §1.403(b)-6(c). However, QNECs and QMACs under a 403(b) annuity contract is not subject to the restrictions placed on custodial accounts and are available for hardship distributions in post-2018 plan years.

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* **Qualified reservist distributions.** To reflect statutory changes made by the PPA 2006, the proposal would modify the permissible distributions under Treas. Reg. §1.401(k)-1(d)(1) to allow for qualified reservist distributions, as described in IRC §72(t)(2)(G)(iii). See Prop. Treas. Reg. §1.401(k)-1(d)(1)(iv).

* **HEART-mandated suspensions.** IRC §414(u)(12)(B)(i) treats an individual as having been severed from employment for purposes of IRC §§401(k)(2)(B)(i)(I), 403(b)(7)(A)(ii), 403(b)(11)(A), or 457(d)(1)(A)(ii) during a period that the individual is performing service in the uniformed services described in IRC §3401(h)(2)(A). However, if an individual elects a distribution by reason of this rule, the individual is not permitted to make an elective deferral or employee contribution for the 6-month period following the distribution. See IRC §414(u)(12)(B)(ii). The proposal would amend the regulations to make clear that a suspension due to IRC §414(u)(12)(B)(ii) would not cause a 401(k) plan to fail to satisfy the safe harbor requirements under IRC §401(k)(12) or (13) or IRC §401(m)(11) or (12). See Prop. Treas. Reg. §§1.401(k)-3(c)(6)(v)(B) and 1.401(m)-3(d)(6)(v)(B).

Executive Order to Expand Access To Workplace Retirement Plans

Executive Order directs DOL and Treasury to expand access to MEPs, directs Treasury to review life expectancy factors for RMD purposes, and directs DOL to make disclosures more understandable and useful [*Executive Order 13847* (Strengthening Retirement Security In America) (August 31, 2018)]
Text available at http://bit.ly/2x1Wrkq

On August 31, 2018, the President issued an Executive Order to adopt a policy to expand access to workplace retirement plans for American Workers. The order cites regulatory burdens and complexity as costly and discouraging employers from adopting plans.

✪ *MEPs.* One of the initiatives in the order regards the expanding of access to multiple employer plans (MEPs) and other retirement plan options. The order focuses on the definition of employer and the "one bad apple" rule.

DOL directive: examination of definition of employer. The order directs the DOL to: (1) clarify and expand the circumstances under which 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. The DOL is ordered, within 180 days of the order (i.e., February 27, 2019), to consider whether to issue a notice of proposed rulemaking, other guidance, or both, that would 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). It is anticipated that actions taken in this regard by the DOL may include relaxation of the "commonality" standard for MEPs, probably along the lines adopted in DOL Reg. §2510.3-5 with respect to association health plans.

Treasury directive: "one bad apple" rule. Within 180 days of the date of this order (i.e., by February 27, 2019), the Treasury is directed to consider proposing amendments to regulations or other guidance, consistent with applicable law and the policy set forth in section 1 of this order, regarding the circumstances under which a MEP may satisfy the tax qualification requirements set forth in the tax code, including the consequences if one or more employers that sponsored or

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adopted the plan fails to take one or more actions necessary to meet those requirements (known as the "one bad apple" rule). In advance of issuing any such proposed guidance, the Treasury is directed to consult with the DOL, and the is directed to take steps to facilitate the implementation of any such guidance.

✪ *RMDs.* Another initiative in the order regards the life expectancy factors to use for required minimum distribution (RMD) purposes. Specifically, within 180 days of the date of this order (i.e., February 27, 2019), is directed to examine the life expectancy and distribution period tables in the RMD regulations 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. Mortality data accumulated since the last update of the RMD life expectancy factors in 2002 would suggest longer life expectancies, which would extend payout periods under the RMD rules, thereby preserving more retirement savings for longer investment horizons.

✪ *Disclosures.* Another initiative in the order regards making retirement plan disclosures more understandable and useful. To that end, within one year of the date of this order (i.e., by August 31, 2019), the DOL is directed, in consultation with the Treasury, to complete a review of actions that could be taken through regulation or guidance, or both, to make retirement plan disclosures required under ERISA and tax code 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._ This review shall include 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. This directive provides hope that options to consolidate and simplify disclosures may be offered in the future, and that there will be greater access to electronically-delivered information.

Disaster Relief

Updated procedure for acts that may be extended on account of a federally-declared disaster [Citation: *Rev. Proc. 2018-58*, 2018-50 I.R.B. (December 10, 2018) (advance release on November 20, 2018)]
Text available at http://bit.ly/2Qlka9W

This procedure updates and replaces Rev. Proc. 2007-56 to provide an updated list of time-sensitive acts, the
performance of which may be postponed under IRC §§7508 and 7508A. IRC §7508 applies to individuals serving in the Armed Forces of the United States or serving in support of such Armed Forces in a combat zone or serving with respect to a contingency operation (as defined in 10 U.S.C. §101(a)(13)). IRC §7508A applies to taxpayers in general, and permits a postponement of the time to perform specified acts for taxpayers affected by a federally declared disaster or a terroristic or military action. Section 8 of the procedure lists acts relating to employee benefits.

The new procedure adds the following acts that were not in the previous procedure.

- Deadlines for adopting plan amendments to reflect qualification changes, pursuant to Rev. Proc. 2016-37.

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- The reference to the deadline for self-correcting operational failures under the EPCRS procedures is updated to reflect the latest EPCRS procedure, Rev. Proc. 2016-51.
- The deadline for making an election to take a permissible withdrawal from an eligible automatic contribution arrangement (EACA) of automatic contributions made by the employee, pursuant to IRC §414(w)(2) and Treas. Reg. §1.414(w)-1(c).
- The deadline for rolling over a qualified loan offset distribution, pursuant to IRC §402(c)(3)(C).
- The deadline for rolling over amounts returned by the IRS because of an improper levy against retirement benefits, pursuant to IRC §6343(f).
- With respect to a qualified longevity annuity contract (QLAC), the deadline for commencing distributions, the deadline for designating a nonspouse beneficiary, and the deadline for distributing excess premiums.
- The deadline under IRC §4973 for withdrawing excess IRA contributions to avoid the imposition of a 6% excise tax.
- An election under IRC §83(i) to defer the recognition of income when a qualified stock option is exercised or restricted stock unit is settled.

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Congress provides liberalized distribution, rollover and loan rules, and premature distribution penalty relief for certain taxpayers affected by California Wildfires [Citation: *Section 20101 and 20102 of the Bipartisan Budget Act of 2018 ("BBA2018")*, P.L. 115-123 (February 9, 2018)]
Text available at http://bit.ly/2EnEhef

Section 20102 of the BBA 2018 exempts "qualified wildfire distributions" (as defined in the statute) from the premature distribution penalty tax, and provides for income tax relief with respect to such withdrawals. The legislation also liberalizes the participant loan rules for affected participants. The relief parallels the relief that was enacted in 2017 as part of the Disaster Tax Relief and Airport and Airway Extension Act of 2017 in response to Hurricanes Harvey, Irma, and Maria.

* **Definitions.** Unless otherwise noted in the summary below, the following definitions apply.

> ➢ *Definition of eligible retirement plan.* An "eligible retirement plan" for this purpose is one that is defined as such in IRC §402(c)(8)(B) (i.e., an IRA, a qualified plan under IRC §401(a) or IRC §403(a), a section 403(b) plan, or a governmental 457(b) plan). See BBA2018 §20102(a)(4)(B).

> ➢ *Definition of qualified individual.* A "qualified individual" is defined as an individual who has sustained an economic loss by reason of the California Wildfires and whose principal place of abode during any portion of the period from October 8, 2017, to December 31, 2017, is located in the California Wildfire disaster area. See BBA2018 §20102(c)(3). Note that this section uses the term "qualified individual" for purposes of the loan relief but, in defining an individual who is eligible for the IRC §72(t) penalty relief, BBA2018 §20102(a)(4) describes the individual in the same manner as the qualified individual definition. Thus, for purposes of this summary, we just refer to qualified individual.

> ➢ *Definition of disaster zone and disaster area.* A covered disaster zone is the portion of a covered disaster area determined by the President to warrant individual or individual and public assistance from the Federal Government under the Robert T. Stafford Disaster Relief and Emergency Assistance Act by reason of the California wildfires. See BBA2018 §501(a)(1), (b)(1) and (c)(1). A covered disaster area for purposes of this relief is an area with respect to which a major disaster has been declared by the President before January 19, 2018, under section 401 of such Act, by reason of the California Wildfires. See BBA2018 §20101.

* **Premature distribution penalty relief.** A "qualified wildfire distribution" is exempt from the premature distribution penalty under IRC §72(t). A qualified wildfire distribution is a distribution from an eligible retirement plan (see above) to a qualified individual (see above) that is made on or after October 8, 2017, and before January 1, 2019. See BBA2018 §20102(a)(4)(A).

> ➢ *$100,000 aggregate limit.* The maximum aggregate amount of distributions an individual may receive in any taxable year which may be treated as a qualified wildfire distribution is the excess (if any) of $100,000 over the aggregate amounts treated as qualified wildfire distributions received by such individual for all prior taxable years. See BBA2018 §20102(a)(2)(A). For example, if the individual receives $70,000 in qualified wildfire distributions in 2017, then no more than $30,000 may be withdrawn under this provision during 2018. Although a participant is subject to this aggregate limit, an employer-sponsored plan will not be treated as failing its qualification requirements under the tax code if it makes a distribution to a person which otherwise would be a qualified wildfire

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distribution, provided that the aggregate amount of such distributions from all plans maintained by the employer (or by any member of its related group under IRC §414(b), (c), (m) or (o)) to such individual does not exceed $100,000. See BBA2018 §20102(a)(2)(B) and (C). In other words, this rule operates similar to the annual dollar limit under IRC §402(g). At the employer level, only the plans of the employer and its related group must makes sure the individual defers no more than the annual dollar amount under such plans, pursuant to IRC §401(a)(30), but the individual must monitor what he or she defers into all plans, pursuant to IRC §402(g). Similarly, the participant must monitor aggregate qualified wildfire distributions in all plans and IRAs in which the participant has benefits, but the employer must monitor the aggregate distributions only from its plans and the plans of its related employers.

*** Extended rollover period of qualified wildfire distributions.** Normally a withdrawal from a plan, if distributed in the form of an eligible rollover distribution, may be rolled over within 60 days to another eligible plan. The BBA2018 grants a 3-year rollover period with respect to repayments of qualified wildfire distributions. The repayments may be made at any time during the 3-year period beginning on the day after the date on which the qualified wildfire distribution was received. The aggregate amount of repayments with respect to a qualified wildfire distribution may not exceed the amount of such distribution. The repayments must be made to an eligible retirement plan that is eligible to receive a rollover (i.e., qualified plan, 403(b) plan, governmental 457(b), or IRA), and the recipient plan treats the repayments as if they were made within the normal 60-day rollover period. See BBA2018 §20102(a)(3). The eligible retirement plan which receives the recontribution of a qualified wildfire distribution amount may be the same plan or IRA that originally made the distribution, or may be a different plan or IRA. To the extent the distribution is not restored within the applicable 3-year period, then the tax consequences on the distribution, as described below, would become irreversible. For example, an eligible participant who received a qualified wildfire distribution in the amount of $20,000 on September 10, 2017, would have until September 10, 2020, to complete the rollover. If $20,000 is rolled over by September 10, 2020, there would be no tax liability on the $20,000. If only $12,000 is rolled over by September 10, 2020, then the tax liability on the remaining $8,000 would remain.

➢ *IRS will have to prescribe procedures.* The BBA2018 does not prescribe procedures on how to claim the rollover status, particularly in the case of taxes being paid in earlier years. For example, an eligible participant might receive a qualified wildfire distribution in September 2017, for which taxes are due, but might complete a rollover of the distribution in 2019, resulting in a reversal of the tax consequences. The IRS guidance is likely to follow the procedures of Notice 2005-92, which provided guidance on similar rules for KETRA.

➢ *Separate 3-year period for each eligible distribution.* If an individual receives multiple qualified wildfire distributions, a separate 3-year period would apply to each distribution. For example, suppose a participant in a qualified plan receives $15,000 on September 20, 2017, and $10,000 on March 3, 2018. The rollover period for the $15,000 distribution ends on September 20, 2020, and the rollover period for the $10,000 distribution ends on March 3, 2021.

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*** Income inclusion relief for qualified wildfire distributions.** A qualified individual has two options for including a qualified wildfire distribution in income. One method is to elect 3-year ratable income inclusion, where the taxable portion of the distribution is included in income in 3 equal portions over a 3-year period that begins in the year of the distribution. See BBA2018 §20102(a)(5). For this purpose, the income averaging rules that pertained to Roth IRA conversions made in 1998, as described in IRC §408A(d)(3)(E), are made applicable. See BBA2018 §20102(a)(5)(B). For example, if the qualified wildfire distribution is $30,000, and it is paid in 2017, the individual would include $10,000 in 2017, $10,000 in 2018, and $10,000 in 2019 under this 3-year inclusion rule. Alternatively, the individual may elect out of the 3-year ratable income inclusion option and include the entire amount of the taxable portion of the distribution in income for the taxable year of the distribution (the "1-year inclusion option"). If more than one qualified wildfire distribution is received in the same year, either they all must be included ratably over a 3-year period, or must be included entirely in the year of the distribution.

*** Exemption from withholding rules for qualified wildfire distributions.** The rules under IRC §§401(a)(31), 402(f) and 3405 are not applicable to qualified wildfire distributions. See BBA2018 §20102(a)(6)(A). Therefore, even though the taxpayer is permitted to rollover these distributions, the plan need not apply the direct rollover rules under IRC §401(a)(31) (i.e., the plan may make the requested distribution without offering the direct rollover option), the tax notice rules under IRC §402(f) (i.e., the plan need not provide the tax notice normally required for eligible rollover distributions), and the withholding rules under IRC §3405 (i.e., the mandatory 20% withholding on eligible rollover distributions does not apply).

*** Qualified wildfire distributions deemed to meet proper distribution event.** A qualified wildfire distribution is deemed to meet the distribution restrictions that might otherwise preclude the distribution: IRC §§401(k)(2)(B)(i), 403(b)(7)(A)(ii), 403(b)(11), and 457(d)(1)(A). For example, an eligible participant in a 401(k) plan could receive a qualified wildfire distribution, even though the participant is still employed by the employer maintaining the 401(k) plan and is under age 59½, and the distribution would not otherwise satisfy the plan's definition of a hardship distribution.

Loan relief. The BBA2018 increases the loan limit under IRC §72(p)(2)(A) for qualified individuals, as defined above, to the lesser of: (1) $100,000 (rather than $50,000), or (2) 100% (rather than 50%) of the participant's vested account. See BBA2018 §20102(c)(1). The increased limit applies to loan taken during the period beginning on September 29, 2017 (the enactment date of the DTRA, which provided relief for the 2017 hurricanes) and ending on December 31, 2018. This increase in loan limits applies to qualified plans under IRC §§401(a) or 403(a), and to section 403(b) plans.

- *Delay of loan repayments.* In the case of a qualified individual with an outstanding loan on or after the "qualified beginning date," if the due date of a loan repayment, pursuant to IRC §72(p)(2)(B) or (C), loan occurs during the period beginning on the qualified beginning date and ending on December 31, 2018, the due date is delayed for 1 year. See BBA2018 §20102(c)(2)(A). Any subsequent repayments with respect to any such loan are to be appropriately adjusted to reflect the delay in the due date, and any interest accruing during such delay. See BBA2018 §20102(c)(2)(B). In addition, the 5-year period and the term of the loan under IRC §72(p)(2)(B) and (C) are determined by disregarding the delay period. See BBA2018 §20102(c)(2)(C). The qualified beginning date is August 23, 2017, in the case of Hurricane Harvey, September 4, 2017, in the case of Hurricane Irma, and September 16, 2017, in the case of Hurricane Maria. See BBA2018 §20102(c)(4).

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➢ *ERISA issue.* The Act does not modify Title I of ERISA. Although DOL regulations pertaining to prohibited transaction relief for participant loans would require loans above 50% of the vested account to be secured with other collateral, it is expected that the DOL will grant relief if a qualified loan was secured solely with the vested account.

Certain distributions for purchase or construction of principal residence. A "qualified distribution" (as defined in BBA2018 §20102(b)(2) - see below) may be repaid to an eligible retirement plan during the period beginning on October 8, 2017, and ending on June 30, 2018. An "eligible retirement plan" for this purpose is one that is defined as such in IRC §402(c)(8)(B) (i.e., an IRA, a qualified plan under IRC §401(a) or IRC §403(a), a section 403(b) plan, or a governmental 457(b) plan). The recipient plan treats the repayments as a rollover, as if they were contribution within the normal 60-day rollover period.

➢ *Definition of qualified distribution.* A qualified distribution for this purpose is: (1) a distribution described in IRC §401(k)(2)(B)(i)(IV) (hardship withdrawals under 401(k) plans), §403(b)(7)(A)(ii) (permissible withdrawals from a custodial account 403(b) plan), §403(b)(11)(B) (hardship withdrawal from 403(b) annuity contract), or §72(t)(2)(F) (first time homebuyer withdrawal from IRA), (2) which was received after March 31, 2017, and before January 15, 2018, and (3) which was to be used to purchase or construct a principal residence in the California Wildfire disaster area, but which was not so purchased or constructed on account of the disaster. See BBA2018 §20102(b)(2).

Plan amendments not due until 2019 plan year. Any amendment to a plan with respect to provisions of the BBA2018 or any regulations issued by the Treasury or DOL with respect to such provisions, must be adopted on or before the last day of the first plan year beginning on or after January 1, 2019 (i.e., the 2019 plan year), or such later date that the Treasury may prescribe. See BBA2018 §20102(d)(2)(A). A governmental plan is granted an additional 2 years with respect to this amendment deadline. This amendment relief is granted only if the plan is operated in accordance with the terms of the amendment for the period beginning with the date it was effective under the plan and ending with the deadline for adopting the amendment (or the date it was actually adopted, if earlier), and the amendment applies retroactively for such period. See BBA2018 §20102(d)(2)(B). During such operational compliance period, before the amendment is actually adopted, the plan is not treated as failing to be operated in accordance with its terms. See BBA2018 §20102(d)(1).

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Congress provides liberalized distribution, rollover and loan rules, and premature distribution penalty relief for certain taxpayers affected by 2016 disasters [Citation: *Section 11028 of the Tax Cut and Jobs Act of 2017 ("TCJA")*, P.L. 115-97 (December 22, 2017)]
Text available at http://bit.ly/2Cj4s5E

The TCJA exempts "qualified 2016 disaster distributions" from the premature distribution penalty tax, and provides for income tax relief with respect to such withdrawals. The relief parallels the relief in IRC §1400Q that was enacted in 2005 in response to Hurricanes Katrina, Rita and Wilma, except the TCJA does not provide participant loan relief nor relief for an interrupted construction or purchase of a principal residence.

* **Definitions.** Unless otherwise noted in the summary below, the following definitions apply.

- *Definition of eligible retirement plan.* An "eligible retirement plan" for this purpose is one that is defined as such in IRC §402(c)(8)(B) (i.e., an IRA, a qualified plan under IRC §401(a) or IRC §403(a), a section 403(b) plan, or a governmental 457(b) plan). See TCJA §11028(b)(1)(D)(ii).

- *Individuals eligible for this relief.* An individual is eligible to use the relief in section 11028 of the TCJA if the individual's principal place of abode at any time during calendar year 2016 was located in a 2016 disaster area described below and such individual sustained an economic loss by reason of the events giving rise to the applicable Presidential declaration. See TCJA §11028(b)(1)(D)(i).

- *Definition of 2016 disaster area.* A 2016 disaster area is any area with respect to which a major disaster has been declared by the President under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act during calendar year 2016. See TCJA §11028(a). For a list of 2016 disasters posted at the FEMA website, see http://bit.ly/2DuErnK.

- *Definition of qualified 2016 disaster distribution.* A ''qualified 2016 disaster distribution'' is any distribution from an eligible retirement plan made on or after January 1, 2016, and before January 1, 2018, to an individual who is eligible for this relief. See TCJA §11028(b)(1)(D)(i).

* **Premature distribution penalty relief.** A qualified 2016 disaster distribution is exempt from the premature distribution penalty under IRC §72(t). See TCJA §11028(b)(1)(A).

- *$100,000 aggregate limit.* The maximum aggregate amount of distributions received by an individual in any taxable year which may be treated as qualified 2016 disaster distributions may not exceed the excess (if any) of $100,000 over the aggregate amounts treated as qualified 2016 disaster distributions received by such individual for all prior taxable years. See TCJA §11028(b)(1)(B)(i). For example, if the individual receives $70,000 in qualified 2016 disaster distributions in 2016, then no more than $30,000 may be withdrawn under this provision during 2017. Although a participant is subject to this aggregate limit, an employer-sponsored plan will not be treated as failing its qualification requirements under the tax code if it makes a distribution to a person which otherwise would be a qualified 2016 disaster distribution, provided that the aggregate amount of such distributions from all plans maintained by the employer (or by any member of its related group under IRC §414(b), (c), (m) or (o)) to such individual does not exceed $100,000. See TCJA §11028(b)(1)(B)(ii) and (iii). In other words, this rule operates similar to the annual dollar limit under IRC §402(g). At the employer level, only the plans of the employer and its related group must makes

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sure the individual defers no more than the annual dollar amount under such plans, pursuant to IRC §401(a)(30), but the individual must monitor what he or she defers into all plans, pursuant to IRC §402(g). Similarly, the participant must monitor aggregate qualified 2016 disaster distributions in all plans and IRAs in which the participant has benefits, but the employer must monitor the aggregate distributions only from its plans and the plans of its related employers.

*** Extended rollover period for qualified 2016 disaster distributions.** Normally a withdrawal from a plan, if distributed in the form of an eligible rollover distribution, may be rolled over within 60 days to another eligible plan. The TCJA grants a 3-year rollover period with respect to repayments of qualified 2016 disaster distributions. The repayments may be made at any time during the 3-year period beginning on the day after the date on which the qualified 2016 disaster distribution was received. The aggregate amount of repayments with respect to a qualified 2016 disaster distribution may not exceed the amount of such distribution. The repayments must be made to an eligible retirement plan that is eligible to receive a rollover (i.e., qualified plan, 403(b) plan, governmental 457(b), or IRA), and the recipient plan treats the repayments as if they were made within the normal 60-day rollover period. See TCJA §11028(b)(1)(C). The eligible retirement plan which receives the recontribution of a qualified 2016 disaster distribution amount may be the same plan or IRA that originally made the distribution, or may be a different plan or IRA. To the extent the distribution is not restored within the applicable 3-year period, then the tax consequences on the distribution, as described below, would become irreversible. For example, an eligible participant who withdrew $20,000 from a qualified plan on September 10, 2016, that was a qualified 2016 disaster distribution would have until September 10, 2019, to complete the rollover. If $20,000 is rolled over by September 10, 2019, there would be no tax liability on the $20,000. If only $12,000 is rolled over by September 10, 2019, then the tax liability on the remaining $8,000 would become irreversible.

- *IRS will have to prescribe procedures.* The TCJA does not prescribe procedures on how to claim the rollover status, particularly in the case of taxes being paid in earlier years. For example, an eligible participant might receive a qualified 2016 disaster distribution in September 2017, for which taxes are due, but might complete a rollover of the distribution in 2019, resulting in a reversal of the tax consequences. Also, since qualified 2016 disaster distributions could have occurred in 2016, and a premature distribution penalty under IRC §72(t) might have been reported on the 2016 tax return, the IRS procedures will have to provide guidance on how to claim a refund for the penalty paid. Any IRS guidance is likely to follow the procedures of Notice 2005-92, which provided guidance on similar rules for KETRA.

- *Separate 3-year period for each eligible distribution.* If an individual receives multiple qualified 2016 disaster distributions, a separate 3-year period applies to each distribution. For example, suppose a participant in a qualified plan receives $15,000 on September 20, 2016, and $10,000 on March 3, 2017. The rollover period for the $15,000 distribution ends on September 20, 2019, and the rollover period for the $10,000 distribution ends on March 3, 2020.

*** Income inclusion relief for qualified 2016 disaster distributions.** A qualified individual has two options for including a qualified 2016 disaster distribution in income. One method is to elect 3-year ratable income inclusion, where the taxable portion of the distribution is included in income in 3 equal portions over a 3-year period that begins in the year of the distribution. See TCJA §11028(b)(1)(E)(i). For this purpose, the income averaging rules that pertained to Roth IRA conversions made in 1998, as described in IRC §408A(d)(3)(E), are made applicable. See TCJA §11028(b)(1)(E)(ii). For example, if the qualified 2016 disaster distribution is $30,000, and it is paid in 2017, the individual would include $10,000 in 2017,

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$10,000 in 2018, and $10,000 in 2019 under this 3-year inclusion rule. Alternatively, the individual may elect out of the 3-year ratable income inclusion option and include the entire amount of the taxable portion of the distribution in income for the taxable year of the distribution (the "1-year inclusion option"). If more than one qualified 2016 disaster distribution is received in the same year, either they all must be included ratably over a 3-year period, or must be included entirely in the year of the distribution.

*** Exemption from withholding rules for qualified 2016 disaster distributions.** The rules under IRC §§401(a)(31), 402(f) and 3405 are not applicable to qualified 2016 disaster distributions. See TCJA §11028(b)(1)(F)(i). Therefore, even though the taxpayer is permitted to rollover these distributions, the plan need not apply the direct rollover rules under IRC §401(a)(31) (i.e., the plan may make the requested distribution without offering the direct rollover option), the tax notice rules under IRC §402(f) (i.e., the plan need not provide the tax notice normally required for eligible rollover distributions), and the withholding rules under IRC §3405 (i.e., the mandatory 20% withholding on eligible rollover distributions does not apply).

*** Qualified 2016 disaster distributions deemed to meet proper distribution event.** A qualified 2016 disaster distribution is deemed to meet the distribution restrictions that might otherwise preclude the distribution: IRC §§401(k)(2)(B)(i), 403(b)(7)(A)(ii), 403(b)(11), and 457(d)(1)(A). See TCJA §11028(b)(1)(F)(ii). For example, an eligible participant in a 401(k) plan could receive a qualified 2016 disaster distribution, even though the participant is still employed by the employer maintaining the 401(k) plan and is under age 59½, and the distribution would not otherwise satisfy the plan's definition of a hardship distribution.

Plan amendments not due until 2018 plan year. Any amendment to a plan with respect to these provisions of the TCJA or any regulations issued by the Treasury or DOL must be adopted on or before the last day of the first plan year beginning on or after January 1, 2018 (i.e., the 2018 plan year), or such later date that the Treasury may prescribe. See TCJA §11028(b)(2)(B)(i). A governmental plan is granted an additional 2 years with respect to this amendment deadline. This amendment relief is granted only if the plan is operated in accordance with the terms of the amendment for the period beginning with the date it was effective under the plan and ending with the deadline for adopting the amendment (or the date it was actually adopted, if earlier), and the amendment applies retroactively for such period. See TCJA §11028(b)(2)(B)(ii). During such operational compliance period, before the amendment is actually adopted, the plan is not treated as failing to be operated in accordance with its terms. See TCJA §11028(b)(2)(A).

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IRS extends relief in Announcement 2017-15 to employees affected by Hurricanes Florence and Michael [*Preamble to Proposed Regulations on Hardship Distributions*, 83 F.R. at 56766 (November 14, 2018)]
Text available at http://bit.ly/2A8uec3
EOB2018 sections affected: Chapter 6, Section IV, Part C.4.

The relief provided to employees affected by Hurricane Maria, as set forth in Announcement 2017-15, applies to employees adversely affected by Hurricanes Florence and Michael, except that the ''Incident Dates'' are as specified by FEMA for these 2018 hurricanes. Relief is provided for hardship distributions and loans made in reliance of this relief through March 15, 2019. Rather than issuing a formal announcement (or amending Announcement 2017-15), the IRS announced this relief in the preamble to proposed regulations that are amending the 401(k) regulations to incorporate changes made by the Bipartisan Budget Act of 2018 (e.g., elimination of the 6-month contribution suspension following a hardship withdrawal) and other recent legislation. See the summary of those proposed regulations at ¶2.167.

* **Relief does not change normal hardship distribution rules.** Note that Announcement 2017-15 does not allow a plan to make a hardship withdrawal unless it is a plan that otherwise could permit hardship distributions (e.g., 401(k) plan), and only sources that otherwise could be available for hardship withdrawal. Since IRC §401(k)(14) allows hardship distributions for QMACs and QNECs in post-2018 plan years, hardship withdrawals made in reliance of this announcement between January 1 and March 15, 2019, could include QMACs and QNECs so long as the distribution date falls within a plan year that begins on or after January 1, 2019. The primary purpose of this relief is to allow plans to process hardship distributions and loans without meeting all of the normal administrative steps (e.g., obtaining spousal consent), but the plan has to follow up and satisfy these administrative requirements when it is able to. In addition, the plan's hardship distribution definition need not specifically allow for distributions due to the hurricanes.

* **Plan amendments.** An amendment is required on if the plan does not provide for a hardship distribution, but makes a hardship distribution pursuant to this relief, or the plan does not provide loans, but makes a loan pursuant to this relief. Announcement 2017-15 only seems to require a plan amendment to provide enabling language to *make* loans or hardship distributions. If the plan contains a hardship distribution or loan provision, as the case may be, no amendment is required merely because the plan is relaxing its procedural requirements, or merely because the plan's enumerated hardship distribution events wouldn't otherwise permit such a hardship distribution.

> ✪ *Timing of amendment.* The IRS will treat any amendment that is related to the extension of Announcement 2017-15 to Hurricanes Michael and Florence as integrally related to a disqualifying provision, even though it wouldn't be correcting a disqualifying provision. See the preamble to the proposed regulations, 83 F.R. 56766. Thus, amendments will be required in accordance with the timing rules in Rev. Proc. 2016-37, after the issuance of the final regulations.

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Vesting: Forfeitures

Forfeitures may be used to reduced employer's contribution liability for QNECs, QMACs and 401(k)(12) safe harbor contributions [Citation: *Treas. Reg. §§1.401(k)-1(g)(5), 1.401(k)-6, 1.401(m)-1(d)(4), and 1.401(m)-5*, 83 F.R. 34469 (July 20, 2018)]
Text available at http://bit.ly/2msZdt4

The regulations issued in 2004 under IRC §§401(k) and 401(m) defined qualified matching contributions (QMACs) and qualified nonelective contributions (QNECs) as matching or nonelective contributions made by the employer that satisfy the nonforfeitability requirements of Treas. Reg. §1.401(k)-1(c) and the distribution limitations of Treas. Reg. §1.401(k)-1(d) when they are contributed to the plan. In enforcing these regulations, the IRS had interpreted the "at the time contributed" language to prohibit the use of forfeitures to fund these contributions, because the forfeitures represent amounts that, at the time they were contributed by the plan, were not subject to these nonforfeitability and distribution limitations. For example, a forfeiture, by definition, is an amount that previously had been allocated to another participants and was subsequently forfeited by that participant, so that such a forfeiture, if allocated as a QNEC, would not have met the nonforfeiture requirement when the underlying contribution had originally been made.

* **Determination now made at time of allocation.** The amended regulations provide that the nonforfeitability requirement and the distribution limitations applicable to QNECs and QMACs must be met at the time these contributions are allocated. This change formally allows forfeitures to be used to fund QNECs and QMACs.

> ✪ *Applies to safe harbor contributions, too.* IRC §401(k)(12) prescribes safe harbor matching and nonelective contributions that may be made to a participant's account in order to waive the ADP test for the plan year. In addition, pursuant to IRC §401(m)(11), if the 401(k)(12) safe harbor contributions are made, and the plan's matching contribution formula(s) satisfy the safe harbor requirements in IRC §401(m)(11)(B), the ACP test is also waived. Treas. Reg. §1.401(k)-3 refers to the 401(k)(12) safe harbor matching contributions as QMACs and refers to the 401(k)(12) safe harbor nonelective contributions as QNECs. Thus, these changes to the regulations also result in forfeitures being available to fund the 401(k)(12) safe harbor contributions as well. [QACAs under IRC §401(k)(13) don't require the safe harbor contribution to meet the nonforfeitability requirements applicable to QNECs and QMACs, so safe harbor contributions under QACAs have not been subject to a prohibition on the use of forfeitures to satisfy those contribution obligations prior to the issuance of these amended regulations.]

* **Applicability date.** The modified definitions of QMACs and QNECs apply to plan years that *begin* on or after July 20, 2018 (the date the amended regulations were published in the Federal Register). However, taxpayers may apply these regulations for earlier periods. The reference to "earlier periods" encompasses periods prior to the January 18, 2017, publication date of the originally proposed regulations (which taxpayers were permitted to rely on pending the publication of final regulations).

> ✪ *Plan documents.* Because of its earlier interpretation that forfeitures could not be used to fund QMACs, QNECs, and 401(k)(12) safe harbor contributions, the IRS required many plans to be amended to reflect such interpretation. If the document specifically precludes the use of forfeitures to fund these contributions, it will need to be amended to reflect the modified definition of QNECs and QMACs. Pre-Approved Plans (i.e., master/prototype (M&P) plans and volume submitter (VS) plans)

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will need to adopt an interim amendment, pursuant to Rev. Proc. 2016-37 (generally in time to cover the due date of adopting employers' tax returns for the earliest plan year in which the change in the regulations is applicable - plan years beginning August 1, 2018, as a general rule, except for plans that start a plan year between the 20th to 31st of July 2018). Individually-designed plans have until the end of the second calendar year following the calendar year in which the amendment requirement is included in a Required Amendments List published by the IRS, as prescribed by Rev. Proc. 2016-37.

Additional guidance anticipated for Pre-Approved Plans. **Some commenters on the proposed version of the regulation had asked the IRS to address amendment issues for Pre-Approved Plans. The IRS, in the preamble to the final regulations, notes that such guidance is beyond the scope of the regulatory project, but that it has referred the issue to the IRS Tax Exempt and Government Entities (TE/GE), Employee Plans Division.**

✪ *Operational compliance prior to document being amended to lift prohibition on use of forfeitures to fund QNECs and QMACs.* If the current plan document precludes the use of forfeitures to fund these contributions, may the plan apply the revised regulatory definitions in operation before the plan is amended? Although the IRS does not discuss this issue in the preamble to the regulations, the IRS states in the preamble that the timing of a plan amendment must comply with the anti-cutback rule under IRC §411(d)(6).

- Forfeitures used to *reduce* employer contributions. If forfeitures used operationally to fund the QMACs, QNECs or 401(k)(12) safe harbor contributions represent forfeitures that would otherwise be applied to *reduce* employer contributions, rather than be allocated to increase allocations to other participants, operational compliance with the regulation would not violate the anti-cutback rule because the total amount to be allocated to any participant is not affected. Accordingly, an amendment to lift the prohibition on using forfeitures to fund QNECs and QMACs wouldn't necessarily have to be adopted before the employer complied with the amended regulation in order to avoid an IRC §411(d)(6) violation. Technically, however, the plan would not be operating in accordance with its terms, so apart from the IRC §411(d)(6) issue, it would be advisable to amend the prohibition out of the plan sooner than later.

- Forfeitures that *increase* allocations. If, under the terms of the plan, forfeitures increase allocations to participants, then the document must be amended in time so that the lifting of the prohibition under the plan on using forfeitures to fund QNECs and QMACs will not violate IRC §411(d)(6), because the amendment will could some participants to receive a reduced allocation for the plan year due to the forfeitures that are applied instead to fund the QNECs, QMACs or safe harbor contributions under the plan. The amendment must occur before any affected participant has met all of the allocation conditions required for the allocation of a forfeiture to increase the participant's allocations for the plan year. For example, if a participant must be employed on the last day of the plan year to receive an allocation of forfeitures, then the amendment can be adopted at any time prior to the end of the plan year without violating IRC §411(d)(6). On the other hand, if forfeitures are allocated to all participants who complete at least 1,000 hours for the plan year, but employment on the last day of the plan year is not a condition for such allocation, then the amendment would need to be adopted before any participant has completed 1,000 hours for the plan year. The anti-cutback issue applies both to: (1) forfeitures that are applied directly to increased participant allocations who meet the allocation conditions, and (2) forfeitures that are allocated as of the end of the plan year after forfeitures are first used to pay expenses. In the preamble to the regulation, the IRS discusses this type of forfeiture allocation described in (2), and notes

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that the amendment wouldn't violate IRC §411(d)(6) if it is adopted before the end of the plan year, because prior to the end of the plan year the forfeitures are used to pay for administrative expenses of the plan.

- May such a plan continue to prohibit forfeitures from being used to fund QNECs or QMACs? Although the definitions of QNECs and QMACs now permit the use of forfeitures to fund these contributions, a plan document is not required to use forfeitures in this manner. However, to the extent the plan contains language defining a QNEC or QMAC as having to meet the nonforfeitability requirement and the distribution limitations at the time of contribution, it should still be amended to reflect the new definition by the amendment deadlines described above, as applicable. In such case, there wouldn't be any IRC §411(d)(6) issues with respect to the timing of the amendment, because the amendment to conform the plan's definition of QNECs and QMACs to the new regulatory definition would not affect the manner in which forfeitures are allocated under the plan.

✪ *Use of forfeitures to fund QNECs and QMACs under plans that do not expressly preclude such use.* Some plan documents do not expressly prohibit the use of forfeitures to fund QNECs and QMACs. These plans could start using forfeitures in this manner (or might have continued to do so even before the proposed regulations were issued) without the need for a plan amendment. Since the regulations allow for application of the regulation for periods preceding the applicability date, the plan, without amendment, could use forfeitures to fund QNECs and QMACs for plan years preceding the first plan year that the regulation becomes applicable. In addition, the retroactive application option would not cause earlier plan years in which forfeitures were so allocated to be considered in violation of the regulations. However, if an employer maintaining a plan document that does not expressly prohibit forfeitures from being allocated as QNECs or QMACs would prefer not to use forfeitures in this manner (and might have operationally done this because of the IRS' prior view on the subject), the plan should be amended to formally apply such prohibition. Such an amendment would have to be adopted no later than the date within the first plan year beginning on or after July 20, 2018 (i.e., the plan year in which the regulatory applicability date occurs), so as not to violate the anti-cutback rule under IRC §411(d)(6) with respect to forfeitures that will be allocated in accordance with such amendment.

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Employee Plans Compliance Resolution System (EPCRS)

Latest update of the EPCRS Procedure revises the VCP submission procedures to require electronic submissions starting no later than April 1, 2019 [Citation: *Rev. Proc. 2018-52*,2018-42 I.R.B. (October 15, 2018; advance release on September 28, 2018)]
Text available at http://bit.ly/2xS5a9h

This revenue procedure supersedes Rev. Proc. 2016-51. The procedure is effective January 1, 2019. Any VCP submissions made before that date continue to be governed by Rev. Proc. 2016-51. Much of the EPCRS Procedure remains unmodified by Rev. Proc. 2018-52. The discussion below addresses only those portions of the EPCRS Procedure that have changed.

* **Electronic VCP submissions.** The primary purpose of this update is to require VCP submissions to be made electronically under the revised procedures in Sections 10 and 11 of Rev. Proc. 2018-52. Under these procedures, submitters will use www.pay.gov site to complete application forms, submit attachments, and pay VCP user fees.

✪ *Deadline to start using electronic VCP procedures.* Beginning April 1, 2019, Plan Sponsors are required to use the www.pay.gov website when filing a VCP submission and paying applicable user fees. However, the electronic procedures are available starting January 1, 2019. Paper VCP submissions will be accepted by the IRS between January 1 and March 31, 2019, but not after that.

✪ *Description of changes to the VCP submission procedures.* Revisions made to Sections 10 and 11 of the EPCRS Procedure make the following changes to the submission procedures.

- A pay.gov account must be created at the www.pay.gov website ("the website") before an electronic VCP submission can be made. See Section 11.03(3).
- After the account is established, the applicant must complete the application form (IRS Form 8950) using the website. See Section 11.03(3).
- All documents relating to the VCP submission, including the description of failures using the Form 14568 Series and any other applicable items (as set forth in Section 11.04 of the EPCRS Procedure) must be converted into a *single* PDF document and then loaded onto the website.
- The assembly instructions under Section 14.11 are revised to refer to the order in which documents should be presented in the PDF attachment in order to facilitate the IRS' processing of the submission.
- Section 11.03(2) provides that if the single PDF document exceeds the 15MB size limitation for uploading PDF files to the website, the applicant must remove documents (or parts of documents) so that the single PDF file meets the 15MB limitation. Consistent with the ordering of documents set forth in Section 14.11 to expedite processing, the applicant should first drop from the PDF attachment the documents listed last in Section 14.11, and then remove documents in reverse order until the size limitation can be satisfied. The documents that can't be included in the PDF file because of the size limitation must be faxed (1-855-203-6996) to the IRS, pursuant to Section 11.03(7). The fax must include the IRS control number applicable to the VCP submission so it can be associated with the proper file.
- User fees must be paid at the website, and payment confirmation is generated when the payment is made. Section 11.03(6) provides that if a payment confirmation is not generated, the VCP application is not considered to have been submitted, and the applicant should contact IRS customer account services (1-877-829-5500).

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- IRS will no longer mail acknowledgment letters regarding the VCP submission. Receipt of a submission will be acknowledged through the generation of a unique Pay.gov Tracking ID on the payment confirmation. See Section 11.09. Since acknowledgment letters no longer are sent, the IRS has dropped references to Letter 5265, which was a model acknowledgment letter that could be included as part of the VCP submission prior to this latest update.
- An authorized representative may be designated by the Plan Sponsor to file a VCP submission at the website on the Plan Sponsor's behalf. See Section 11.08(2) of the EPCRS Procedure for specific instructions on how to designate an authorized representative using Form 2848, which include a requirement that the form specifically indicate the scope of the authorization.
- Revisions or amendments to a filed VCP submission should not be filed as a new submission. Instead, the applicant should call the VCP Status Inquiry Line (626-927-2011) to obtain assistance on how to submit the revised documents. See Section 11.03(8).
- Corresponding changes are made to Section 10.09 (Anonymous Submissions) and Section 10.10 (Group Submissions) to reflect the electronic procedures.
- The Procedural Checklist in earlier EPCRS Procedures has been deleted since the submission is made electronically under the revised procedure.

*** Other modifications.** Rev. Proc. 2018-52 also makes the following changes to Rev. Proc. 2016-51.

- Clarifying changes are made to Section 4.03 of the EPCRS Procedure regarding the Favorable Letter requirement for using SCP to correct significant Operational Failures. The Favorable Letter requirement applies to Qualified Plans (see Section 5.01(4)) and to 403(b) Plans (see Sections 5.02(5) and 6.10(2)). In essence, a Pre-Approved Plan has a Favorable Letter if it has a letter for the most recently-expired 6-year cycle (or, in the case of a 403(b) plan, a timely written plan or a VCP or Audit CAP correction of a failure to adopt a written plan on a timely basis).
- Section 4.09, which pertains to provisional applications procedures for government 457(b) plans, is amended to require those submissions also to be made via the www.pay.gov website, as applicable to Qualified Plans and 403(b) Plans.
- References to Pre-Approved Plans have been modified in the Favorable Letter description to conform to the terminology adopted in Rev. Proc. 2017-41 (applicable to the third 6-year submission cycle), which included the discontinuance of the master/prototype and volume submitter terminology.
- Section 4.12, which applies to abusive tax avoidance transactions, is amended to refer to "appropriate IRS personnel" rather than to an "IRS Employee Plans Tax Shelter Coordinator."
- Section 6.02(5)(d)(iii) is eliminated. That section contained a transition rule for completing corrections affecting missing participants in light of the IRS' discontinuance of the use of its Letter Forwarding Program to find missing participants. The deadline under that transition rule has expired.
- Sections 6.05(2)(a) and 6.05(2)(b), which address corrective amendments needed as part of a VCP submission or Audit Cap proceeding and when such amendments will not cause the loss of reliance on the applicable opinion letter or advisory letter, are amended to apply the same rules to 403(b) Pre-Approved Plans.
- Section 6.09(6) discusses circumstances under which the IRS will not pursue the IRC §72(t) tax with respect to an impermissible distribution. Rev. Proc. 2018-52 clarifies that the amount the IRS may require a Plan Sponsor to pay when such penalties are not pursued (which will not exceed the additional tax that would have applied under IRC §72(t)) is a sanction, not an additional VCP fee.

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Accordingly, this sanction, if applied, is paid later, when the IRS requests it, rather than as part of the VCP fees paid at the time of submission.

- Pursuant to Section 6.10(3), a 403(b) plan may correct a failure to timely adopt a written plan document through VCP or Audit CAP. Having a timely written document is a condition for relying on the extended remedial amendment period rules. This section is amended to reference the intial remedial amendment period set forth in Rev. Proc. 2017-18 (which ends on March 31, 2020). This updated reference is also added to Section 10.07(2)(d), which explains that the issuance of a compliance statement with respect to such correction means the plan has the extended remedial amendment period available.
- Section 10.06(2) is amended to clarify that the IRS reserves the right not to issue a compliance statement (i.e., where the submission is seriously deficient or if the application of VCP would be inappropriate or impracticable), and to set forth the circumstances under which the user fee may or may not be refunded.
- Added language in Section 10.06(3) stating that, where a VCP submission is complete and sets forth an acceptable correction method, the IRS may issue a compliance statement without ever contacting the Plan Sponsor or its representative.
- Procedures for submitting a penalty of perjury statement when a VCP submission is *materially* modified are clarified in revised Section 10.06(8)(c).
- Clarifying changes in Section 10.10, relating to Group Submissions, incorporate the changes to the Pre-Approved Plan programs that were made by Rev. Proc. 2017-41 (i.e., adding a reference to a Provider of a Pre-Approved Plan, as that term is used in Rev. Proc. 2017-41).
- A special rule for calculating VCP fees attributable to a particular member of a multiple employer plan or multiemployer plan has been eliminated by deleting Section 10.11(2). All submissions for a multiple employer plan or multiemployer plan have to be filed by the plan administrator (or its authorized representative) using the electronic submission procedures discussed above, and the request must be with respect to the plan *as a whole*, rather than a portion of the plan affecting any particular employer.
- Section 10.01 and Section 12 now refer solely to Appendix A of Rev. Proc. 2018-4 (and its annual successors) for applicable user fees for VCP submissions. The same change is made to the description of the Audit CAP sanctions, as stated in Section 14.04, where a multiple of the VCP user fees described in Appendix A of Rev. Proc. 2018-4 applies to determine the sanction under certain circumstances. The EPCRS Procedure does not set forth any specific fees.
- Section 13.02 is revised to provide that sanctions under Audit CAP may be paid using any of the payment methods available on the www.pay.gov website, rather than setting forth specific payment methods. It is not mandatory to use the website to pay Audit Cap sanctions.
- Section 13.06, regarding procedural rules for Audit CAP, is updated to reflect that these rules are now provided in Internal Revenue Manual (IRM) 4.71.3.3.1., EPCRS Closing Agreements, and IRM 7.11.8, EP Determinations Closing Agreement Program, rather than the IRM section than was stated in Rev. Proc. 2016-51.

* **Future changes regarding Overpayments.** In Rev. Proc. 2015-27, the IRS had asked for comments on potential changes to EPCRS relating to the recoupment of Overpayments. The IRS is still considering those comments, but expects to modify the EPCRS Procedure in the future in response to those comments.

* **Expansion of the SCP program.** The IRS has received comments relating to expanding the SCP program. It is in the process of reviewing those comments and a future update may address those considerations.

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Rollover Notice under IRC §402(f) ("402(f) Notice")

IRS updates 402(f) notice to reflect the TCJA changes to the rollover deadline for qualified plan loan offsets, self-certification of eligibility for waivers of the 60-day rollover deadline, and other guidance and clarifying changes [Citation: *Notice 2018-74*, 2018-40 (October 1, 2018)]
Text available at http://bit.ly/2NpoTGX

Notice 2018-74 updates the safe harbor explanations published in Notice 2014-74. Use of these sample notices is not required. Plan administrators may use any other notice format as long as the requirements of IRC §402(f) are satisfied. However, those who use the sample notices are deemed to comply with IRC §402(f). The safe harbor explanations will not satisfy IRC §402(f) to the extent the explanation are no longer accurate due to a change in the relevant law occurring after September 18, 2018 (the date that the IRS first made the text of Notice 2018-74 public).

Changes reflected in updated notice. The updated notice reflects the following statutory and guidance changes.

- IRC §402(c)(3)(C)(ii), which allows a qualified loan offset to be rolled over up to the due date (including extensions) for filing the recipient's federal income tax return for the year in which the offset occurred. A qualified loan offset is one that is incurred solely by reason of: (1) the termination of the plan, or (2) the participant's severance from employment. The loan, at the time of the offset, must be otherwise in compliance with the requirements of IRC §72(p).
- IRC §72(t)(2)(A)(viii), as amended by MAP-21, to exempt certain federal retirees from the 10% premature distribution penalty on distributions made pursuant phased retirement distributions made under a phased retirement annuity, as defined in §8336a(a)(5) or §8412a(a)(5) of title 5 of the United States Code (U.S.C.), or a composite retirement annuity under 5 U.S.C. §§8336a(a)(1) or 8412a(a)(1).
- Amendments to the definition of a qualified public safety employee under IRC §72(t)(10)(B), as made by section 306 of the Protecting Americans from Tax Hikes Act of 2015, P.L. 114-113, and by section 2 of the Defending Public Safety Employees' Retirement Act, P.L. 114-26.
- Rev. Proc. 2016-47, which provides for a self-certification procedure that may be used by a taxpayer claiming, in specified circumstances, to be eligible for a waiver of the normal 60-day rollover deadline.

Other clarifying changes. Included in the revised sample notice are the following clarifying changes: (1) the application of the IRC §72(t) premature distribution penalty only to amounts includible in gross income, (2) the IRC §72(t) exception for payments from governmental plans made to qualified public safety employees after separation from service is not available for distributions from IRAs, and (3) recognizing the possibility that taxpayers affected by federally declared disasters and other events may have an extended deadline for making rollovers.

> ***New rollover option for return of levied amounts is not required in the 402(f) notice.*** **In footnote 1 of Notice 2018-74, the IRS references the amendments made to IRC §6343 by the Bipartisan Budget Act of 2018 to allow taxpayers to roll over amounts returned by the IRS as a result of an improper levy against the individual's retirement plan benefits. The footnote states that the 402(f) notice is not required to include this information. When the IRS returns improperly levied funds, the IRS, pursuant to IRC §6343, will notify the individual that the returned amount may be eligible for rollover.**

Sample language. The IRS provides sample language in two appendices to Notice 2018-74. Appendix A provides two complete model notices, one for distributions that are not from designated Roth accounts and

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one for distributions that <u>are</u> from such accounts. If the distribution contains both types of distributions, the plan administrator would provide both notices. The notices in Appendix A restate the safe harbor notices in their entirety. Appendix B of Notice 2018-74 provides <u>instructions on how to *amend the safe harbor explanations* contained in Notice 2014-74</u>, which was the previous model 402(f) notice published by the IRS. A plan administrator could either use Appendix B to amend the existing notice it is using or just use the notices in Appendix A instead.

✪ *Omission of nonrelevant language; addition of other information.* A plan administrator or payor may customize a safe harbor explanation by omitting any information that does not apply to the plan. For example, if the plan does not hold after-tax employee contributions, it would be appropriate to eliminate the section "If your payment includes after-tax contributions" in the explanation for payments not from a designated Roth account. Similarly, if the plan does not provide for distributions of employer stock or other employer securities, it would be appropriate to eliminate the section "If your payment includes employer stock that you do not roll over." Other information that may not be relevant to a particular plan includes, for example, the sections "If your payment is from a governmental section 457(b) plan" and "If you are an eligible retired public safety officer and your payment is used to pay for health coverage or qualified long-term care insurance." In addition, the plan administrator or payor may provide <u>additional information</u> with a safe harbor explanation if the information is not inconsistent with IRC §402(f).

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Section 401(k) Plans: Contingent Benefit Rule

Student loan program that provides an employer nonelective contribution to employee who enroll does not violate contingent benefit rule under IRC §401(k)(4)(A) [Citation: *PLR 201833012* (August 17, 2018)]
Text available at http://bit.ly/2MAywBo

A 401(k) plan provides for a regular matching contribution which equals 5% of eligible compensation for a payroll period, but only if an eligible employee makes an elective deferral equal to at least 2% of eligible compensation for such payroll period. The regular matching contribution is made on a payroll period basis, and does not require the employee to be employed by the employer at the end of the plan year. The plan is being amended to offer a student loan repayment (SLR) program to eligible employees. Under the program, if an employee, for a payroll period, makes a student loan repayment equal to at least 2% of the employee's eligible compensation for that payroll period, the employer agrees to make a nonelective contribution (identified as an SLR nonelective contribution) on behalf of the employee equal to 5% of the employee's eligible compensation for that payroll period. The SLR nonelective contribution is made as soon as practicable after the close of the plan year. However, the SLR nonelective contribution is made for the employee only if he/she is employed by the employer on the last day of the plan year (except in the case of employment termination due to death or disability).

- ✪ *Right to defer continues.* An employee who has elected to enroll in the SLR program does not give up the right to make elective deferrals to the plan for any payroll period, and may make such deferrals in addition to or in lieu of student loan repayments.
- ✪ *Right to make matchable elective deferrals if minimum SLR not made.* If an employee who has elected to enroll in the SLR program does not make a student loan repayment for a payroll period that is at least 2% of eligible compensation, but makes elective deferrals for such payroll period equal to at least 2% of eligible compensation, the employee is eligible for a "true-up" matching contribution equal to 5% of eligible compensation for that payroll period. Thus, on a payroll period by payroll period basis, an employee who has elected to participate in the SLR program can choose whether to receive the 5% contribution as an SLR nonelective contribution (by making a student loan repayment of at least 2% of eligible compensation for the payroll period) or as a true-up match (by making an elective deferral, in lieu of a student loan repayment, of at least 2% of eligible compensation for the payroll period). Like the SLR nonelective contribution, the true-up match is contributed for the employee after the close of the plan year, and only if the employee is employed by the employer on the last day of the plan year (except in the case of employment termination due to death or disability).
- ✪ *SLR contribution replaces eligibility for regular matching contributions.* If an employee elects to enroll in the SLR program, the employee is ineligible for the regular matching contribution for the plan.
- ✪ *Opt out at any time.* An employee who enrolls in the SLR program may opt out of the program at any time and resume eligibility for the regular matching contributions. For any payroll period that the employee has opted out of the SLR program, the employee regains eligibility for the regular matching contribution.
- ✪ *Regular match vs. "true-up" match.* Although the amount of the regular match or the "true-up" match for any payroll period is the same, the conditions for receiving the match are different. When an employee elects to participate in the SLR program, a true-up match is made only if the employee makes a minimum 2% elective deferral instead of a minimum 2% SLR, and only if the employee meets the last-day employment requirement. When an employee doesn't elect the SLR program, or after electing such program, opts out of the program, so that the regular match formula applies instead, there

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is no last-day employment requirement to receive the regular match, only the requirement to defer at least 2% of eligible compensation for the payroll period.

The IRS ruled that the SLR Program does not violate the contingent benefit requirement under IRC §401(k)(4)(A). The contingent benefit requirement only prohibits making an employer benefit other than a match contingent on making (or not making) elective deferrals. When an employee elects to participate in the SLR program, the employee is not giving up the right to make deferrals. The employee can still make deferrals for any payroll period in which the employee is enrolled in the SLR program. Thus, the SLR nonelective contribution is not contingent on whether the employee makes elective deferrals or what level of elective deferrals he/she makes. The requirement to make a specific level of student loan repayments for the payroll period in order to get the SLR nonelective contribution is not related to the right to make elective deferrals and, so, is not in contradiction with the contingent benefit rule.

✪ ***Comment: employer not lender/mechanism for determining eligibility for SLR nonelective contribution.*** **The IRS conditioned its ruling on the employer not having extended, nor intending to extend, student loans to the employees that are eligible for the SLR program. In other words, the employer is not the lender on the student loans. There is no discussion in the ruling regarding how the employer determines whether the minimum 2% SLR is made during a payroll period. Presumably an employer could offer a salary reduction program for making SLRs, deducting the student loan repayments from the employee's paycheck and transmitting those payments to the lender. Of course, a payroll deduction for SLRs would be made on an after-tax basis, since it wouldn't be an elective deferral under the 401(k) arrangement. But this is not a required mechanism for the applicability of this ruling. If the employer doesn't provide for a payroll withholding mechanism to make the SLRs, it would likely require some other form of substantiation (e.g., copy of SLR checks submitted by the employee, or a periodic statement from the lender showing loan repayments made during the year with amounts and dates of payment). However, the manner in which the employer determines an employee's eligibility for the SLR nonelective contribution is not addressed in the ruling nor is it a condition for the applicability of the ruling.**

Comment. This private letter had generated a great deal of publicity and interest. The program outlined here is designed to address the savings concerns for many younger workers who have significant student loan payment obligations that often mean little no retirement plan savings through the 401(k) arrangement. It is hoped that the IRS will issue a revenue ruling that will offer guidelines that can be relied on generally by plan sponsors. (A private letter ruling can be relied on only by the taxpayer to whom it is issued.) Any revenue ruling should address other matching contribution arrangements. The arrangement in this ruling is an unusual one where the match is a flat percentage (5% of compensation) for any employee who defers at least 2% of compensation. A more common match is a percentage of deferrals (e.g., 50% of elective deferrals up to 6% of compensation). When structuring these programs, the plan designer must consider that any amounts that "match" student loan payments cannot be treated as matching contributions under the plan (e.g., for ACP testing). To not run afoul of the contingent benefit rule with these more commonly used matching formulas, the student loan program will probably have to apply the student loan program to the maximum percentage of compensation that is eligible for a match. For example, in a 50% match formula that applies to the first 6% of pay deferred, the student loan program enrollee would receive a nonelective contribution (or "true up" match, if applicable) that equals 50% of a student loan payment that does not exceed 6% of compensation. The program, at least as structured in the PLR, also would unlikely be compatible with a safe harbor 401(k) arrangement. This is because an employee enrolled in the student loan program would not be eligible for the safe harbor contribution while enrolled in the student loan program, even if the employee deferred under the 401(k) arrangement in addition to make the student loan payments.

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Special Testing Rules Under IRC §§401(a)(4), 401(a)(26), 410(b): Offsets

IRS explains its interpretation of how offset arrangements affect benefiting determinations for 401(a)(4) and 401(a)(26) testing [Citation: *Application of Sections 401(a)(4) and 401(a)(26) to a Cash Balance Plan That Offsets Benefits With Benefits Under a Defined Contribution Plan*, CCA 201810008 (February 7, 2018; released March 9, 2018)]
Text available at http://bit.ly/2p5boxj

In this memorandum, the IRS Chief Counsel's Office explains its interpretation of how combined testing under Treas. Reg. §1.401(a)(4)-9(b)(2)(v) and the minimum participation test under IRC §401(a)(26) is affected by floor-offset arrangement with a defined contribution that is not attributable to pre-participation service and is not applied uniformly to participants in the defined contribution plan.

Description of floor-offset design. The plans in question are a cash balance plan and a profit sharing plan. The employer contributions under the profit sharing plan are allocated on a pro rata basis, providing a uniform allocation rate to all eligible participants. The cash balance plan provides a different pay credit for the two eligible groups of participants. The first group consists of owner-employees, who are all HCEs. The second group consists of the lowest-paid group of employees, all of whom are NHCs, who are not owner-employees and who perform at least one hour of service during the plan year. The NHC group is limited to the number of employees necessary to satisfy the 40% minimum participation test under IRC §401(a)(26) (or 50 employees, if less). The HCE group's annual pay credit equals the maximum pay credit that will not cause the resulting annual benefit to exceed the IRC §415(b) limit and also will enable the plan to comply with IRC §401(a)(4) (using a testing method specified under the plan). The NHC group's annual pay credit is 1% of compensation.

> ✪ Offset of NHC benefits attributable to profit sharing plan. The cash balance plan also provides that, only with respect to the NHC group, the annual annuity payable at age 65 with respect to the cash balance account is offset by a single life annuity payable at age 65 that is the actuarial equivalent of the of the participant's employer-derived vested account balance in the profit sharing plan. The effect of this offset is to completely eliminate the benefit under the cash balance plan for the NHC group employees because the actuarially-equivalent benefit attributable to the profit sharing account in the case of all of the NHC group employees exceeds the benefit payable with respect to their respective cash balance accounts.

Combined testing. The cash balance plan and the profit sharing plan are tested as a single plan (i.e., as a DB/DC combo), pursuant to Treas. Reg. §1.401(a)(4)-9. The IRS Chief Counsel's Office concludes that the DB/DC combo may not apply the "primarily defined benefit in character" nor the "broadly available separate plans" exceptions to the combined minimum gateway test under Treas. Reg. §1.401(a)(4)-9(b)(2)(v)(D). This is because the effect of the offset must be taken into consideration to determine if these exceptions apply. Treas. Reg. §1.401(a)(4)-3(f)(9) provides that, when testing under IRC §401(a)(4), any portion of a benefit that is reduced by an offset arrangement may be included only if the offset pertains to pre-participation service, as described in Treas. Reg. §1.401(a)(4)-11(d)(3)(i)(D). An offset that applies to concurrently earned benefits, such as the profit sharing allocations under the profit sharing plan in this plan design, are not eligible for this testing rule. Thus, the net benefits must be used to determine if the DB/DC plan is primarily defined benefit in character, as described in Treas. Reg. §1.401(a)(4)-9(b)(2)(v)(B), or if the DB plan and the DC plan separately meet IRC §410(b) under the "broadly available separately plans" exception under Treas. Reg. §1.401(a)(4)-9(b)(2)(v)(C). Since the net

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benefit in the cash balance plan for all of the NHCs is zero as a result of the offset, the DB/DC plan is not primarily defined benefit in character, and the DB plan component cannot satisfy IRC §410(b) for the "broadly available separately plans" exception. Accordingly, the NHCs must receive the minimum gateway allocation (generally 7½%) under the profit sharing plan in order for the DB/DC combo to be able to satisfy IRC §401(a)(4) through benefits testing.

Minimum participation test under IRC §401(a)(26). The IRS Chief Counsel also concludes that the net benefits, after the offset is applied, must be taken into account to determine if the cash balance plan satisfies IRC §401(a)(26). This is because the rule under Treas. Reg. §1.401(a)(26)-5(a)(2), which allows for the consideration of the "gross" benefit (i.e., the benefit before the offset is applied) to determine if the plan provides for meaningful benefits to a group of employees that satisfies the 40%/50-employee test under IRC §401(a)(26), is not applicable to this offset arrangement. Treas. Reg. §1.401(a)(26)-5(a)(2) applies only to concurrent offsets that are applied on a reasonable and uniform basis to the employees who benefit under the defined benefit plan. The offset arrangement in this case only applies to the NHC group, which renders it nonuniform. Thus, the NHC group members are treated as having a zero percent accrual under the cash balance plan, leaving only the HCE group to determine if the IRC §401(a)(26) test is satisfied. The number of HCE group employees does not satisfy this test, so the cash balance fails to satisfy IRC §401(a)(26). This is true even though the allocation rates in the profit sharing plan are uniform, because the offset is not applied uniformly. Through two other examples (see below), the IRS makes clear that its position is that the uniformity requirement for the concurrent offset exception must apply both to how the offset is applied and how allocations are determined under the defined contribution plan.

✪ Nonuniform DC plan allocations. The IRS describes an alternative approach where an offset applies under a defined benefit plan to all participants on a uniform basis, but the participants receive different allocation rates under the defined contribution plan. For example, suppose a defined contribution plan provides for a 6% allocation for one group of participants and a 3% allocation for a second group of participants. The benefit under the defined benefit plan is offset by 100% of the defined contribution plan benefits. This is not uniform for purposes of the concurrent offset exception under Treas. Reg. §1.401(a)(26)-5(a)(2) because the participants must benefit under the defined contribution plan on a reasonable and uniform basis, which is not satisfied with different allocation rates. Thus, a DB/DC combo that has nonuniform allocations in the defined contribution plan (i.e., any allocation method that is not deemed to be uniform under Treas. Reg. §1.401(a)(4)-2(b), including tiered allocations under a typical "new comparability" plan) must apply the IRC §401(a)(26) test to the defined benefit plan after taking into account any reduction of benefits as a result of a floor-offset arrangement between the two plans.

✪ Nonuniform offset percentages also would be a problem. Similarly, the IRS says, a floor-offset arrangement that provides for different offset percentages with respect to the DC-derived benefit is ineligible for the concurrent offset exception. For example, if 100% of the benefit attributable to the defined contribution plan is offset to determine the DB benefit for one group of participants, but a 50% offset of the benefit attributable to the defined contribution plan applies to determine the DB benefit for a second group of participants, the offset is nonuniform for purposes of Treas. Reg. §1.401(a)(26)-5(a)(2). Thus, net benefits would have to be taken into account in such a plan design to determine if IRC §401(a)(26) is satisfied under the defined benefit plan. The IRS sees this type of formula as indistinguishable from one that just applies an offset to one group (like the NHC group in the plan at issue) because it is akin to having a formula that technically applies the offset to both

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groups but states that the offset percentage is 100% of the DC benefit for one group and 0% of the DC benefit for the other group.

Minimum Distribution Requirements: Annuity Distributions

"De-risking" programs that allow retirees in pay status to convert annuity stream to lump sum payment will no longer be permitted under many circumstances [Citation: *Notice 2019-18* I.R.B. 2019-13 (March 25, 2019; advance release on March 6, 2019)
Text available at https://www.irs.gov/pub/irs-drop/n-19-18.pdf

Notice 2015-49 announced the IRS' intention to amend the IRC §401(a)(9) to prohibit so-called "de-risking" programs adopted by many defined benefit plan sponsors. A de-risking program provides a window period during which participants who are in pay status may commute the remaining value of their annuity benefit into a lump sum. These programs are referred to as "de-risking" programs because they shift longevity risk and investment risk to the retiree. However, upon further reflection, the IRS has decided not to pursue this amendment to the 401(a)(9) regulations, and announced this Notice 2019-13.

Notice 2019-13 warns that the Treasury Department and the IRS will continue to study the issue of retiree lump-sum windows. But, until further guidance is issued, the IRS will not assert that a plan amendment providing for a retiree lump-sum window program causes the plan to violate IRC §401(a)(9). If such an amendment is adopted, the IRS will continue to evaluate whether the plan, as amended, satisfies the requirements of IRC §§401(a)(4), 411, 415, 417, 436, and other sections of the tax code. During this period, the IRS will not issue private letter rulings with regard to retiree lump-sum windows.

With respect to determination letters issued on plans that are eligible to receive them, the IRS is discontinuing the caveat it had been including in defined benefit plan determining letters that the letter was not expressing an opinion regarding the tax consequences of a retiree lum-sum window.

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The Fiduciary Rule

Fifth Circuit vacates entire fiduciary regulation and related PT exemptions, while Tenth Circuit rules that limiting PTE 84-24 to fixed rate annuities was not an improper exercise of regulatory action [Citation: *Chamber of Commerce v. DOL*, 885 F.3d 360 (5th Cir. March 15, 2018); *Market Synergy Group, Inc. v. DOL*, No. 885 F.3d 676 (10th Cir. March 13, 2018)]
Text available at http://bit.ly/2pjT04o (*Chamber of Commerce* case); http://bit.ly/2uFlL0B (*Market Synergy* case)

The first two Federal appellate court cases involving the legitimacy of the DOL's Fiduciary Rule regarding investment advice fiduciaries have been decided. The Fifth Circuit's case (the "*Chamber of Commerce* case") completely vacates the Rule, whereas the Tenth Circuit's case (the "*Market Synergy* case") is a more narrow decision focusing solely on the treatment of fixed indexed annuities under the DOL's amendments to PTE 84-24.

Vacating of the Rule by Fifth Circuit. In the far more significant of the two cases, the Fifth Circuit concluded that the Fiduciary Rule exceeds the DOL's authority and is arbitrary and capricious. Determining that the comprehensiveness of the regulatory package is not amenable to severance, the Fifth Circuit vacated the Fiduciary Rule in its entirety.

✪ *Scope of the ruling.* The Fifth Circuit's decision to vacate the Fiduciary Rule appears to encompass not only the regulation under DOL Reg. §2510.3-21, but also the prohibited transaction exemptions that were issued as part of the regulatory package as well as amendments made to certain existing prohibited transaction exemptions. The court specifically addresses the Best Interest Contract Exemption (BIC Exemption) and the amendments to PTE 84-24 (relating to exemptions for certain transactions involving annuity contracts) in its decision. The regulatory package also issued a Principal Transactions Exemption (PTE 2016-02), and amended PTEs 86-128, 83-1, 80-83, 75-1. Since 2016-02 relates directly to the Fiduciary Rule, and the amendments to the other PTEs incorporate the Best Interest standard from the BIC Exemption, the Fifth Circuit's decision to vacate affects these exemptions as well even though they were not discussed in the court's opinion.

✪ *Basis of the court's decision.* The Fifth Circuit cited a number of reasons why it decided to vacate the Fiduciary Rule, including: (1) the old definition of an investment advice fiduciary was in effect for decades before this change ("it took DOL forty years to 'discover' its novel interpretation" under the Fiduciary Rule) and that old definition more properly reflected the distinction between an investment adviser as a fiduciary regulated by the Investment Advisers Act and a broker-dealer, whose advice is incidental to the business function, (2) the overbroad definition of an investment advice fiduciary resulting from the elimination of the "regular basis" and "primary basis" standards of the old regulation, necessitating a host of exceptions (including the BIC Exemption) to cover relationships that shouldn't have been swept up in the Fiduciary Rule to begin with, (3) the deviation from the common law definition of fiduciary status was contrary to Congressional intent, and failed to recognize long-held distinctions between sales and investment advice, (4) the extension of fiduciary standards to IRAs could not be saved from a finding of regulatory overreach merely because changes in the marketplace (e.g., transfer of a significant percentage of retirement assets to IRAs) created a need for more retirement investor protection, (5) the extension of the fiduciary standards to one-time IRA rollover or annuity transactions where "it is inconceivable that financial salespeople to insurance agents will have an intimate relationship of trust and confidence with prospective purchasers," which

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is a cornerstone of the fiduciary relationship, (6) the imposition of ERISA's loyalty and prudence requirements on persons not otherwise required by statute to assume such responsibility, (7) the use of the BIC Exemption to expose brokers and salespeople to contractual liability claims that go beyond the statutory mechanism of using excise taxes to enforce the prohibited transaction rules with respect to such persons, (8) conflicts between the Fiduciary Rule and the Dodd-Frank legislation (i.e., empowering the SEC to promulgate enhanced, uniform standards of conduct for broker-dealers and investment advisers who render personalized investment advice about securities to a retail customer, and the transfer of regulation of fixed indexed annuities to the States).

***Dissent.* There is a strong dissent filed with this opinion, arguing that the DOL's extension of its regulatory reach to cover more investment advice fiduciaries, and to impose additional conditions on conflicted transactions, was not contrary to Congress' directive and is well within its regulatory authority.**

✪ *What's next?* It is not anticipated that the DOL will seek further court action to revive the Fiduciary Rule. Instead, it will determine where it will reissue guidance and where it will abandon aspects of the Fiduciary Rule altogether. In the interim, a temporary enforcement policy is in place (see FAB 2018-02), that will allow fiduciaries to continue to rely on the BIC Exemptions and other exemptions released as part of the Fiduciary Rule. It should be noted that the SEC has proposed a regulatory package that would incorporate a best interest standard for broker-dealers and clarify investment professional client relationships. Some possible regulatory actions by the DOL would include: (1) reproposing the definition of an investment advice fiduciary under DOL Reg. §2510.3-21, that would back off of the very broad definition that the Fifth Circuit found to be objectionable, but "tweak" the definition that had been in effect for decades before the issuance of the Fiduciary Rule, (2) modifying the Best Interest Contract so that it is confined to investment advice fiduciaries under the original version of DOL Reg. §2510.3-21 or a reproposed version, (3) confirming retention of a best interest standard for fiduciaries under PTEs 75-1, 84-24, 86-128, 77-4, 80-83, and 83-81, but only for investment advice fiduciaries under the original or a reproposed version of the fiduciary regulation, and (4) retention of modifications to the scope of annuities covered by PTE 84-24. Regulation of the retail market (i.e., IRAs and non-ERISA plans) will likely be handled mostly by the SEC, except where the person providing investment advice is a fiduciary under the original or a reproposed version of DOL Reg. §2510.3-21.

Upholding of PTE 84-24 changes by Tenth Circuit. The *Market Synergy* decision by the Tenth Circuit is not a broad consideration of the Fiduciary Rule in its entirety. Rather, the case is limited to the permissibility of the DOL's exclusion of fixed indexed annuities from PTE 84-24 after July 1, 2019. The case was brought by a licensed insurance agency that partners with independent marketing organizations (IMOs) to distribute annuity products. The legal claim is that the decision to amend PTE 84-24 to cover only transactions involving fixed rate annuity contracts, and not fixed indexed annuity contracts, was a violation of the Administrative Procedure Act (APA). Under amended PTE 84-24, after July 1, 2019, a fiduciary investment adviser who engages in a transaction involving a fixed indexed annuity contract, must rely on the BIC Exemption if the transaction would otherwise result in a prohibited transaction. The Tenth Circuit determined that the DOL properly followed the APA procedures, and did not act in an arbitrary and capricious manner in excluding fixed indexed annuity contracts from PTE 84-24.

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DOL extends temporary enforcement policy on Fiduciary Rule pending further guidance; acknowleges impact of Fifth Circuit opinion vacating the Fiduciary Rule [Citation: *Field Assistance Bulletin (FAB) 2018-02* (May 7, 2018)]
Text available at http://bit.ly/2JZ0t0H

With the Fifth Circuit's decision to vacate the Fiduciary Rule[1] in its entirety, the DOL is issuing FAB 2018-02 to provide temporary guidance to stakeholders pending the issuance of further guidance. The Fiduciary Rule took effect on June 9, 2017, but most of the conditions in the Best Interest Contract Exemption, as well as conditions in the Principal Transactions Exemption and amendments to PTE 84-24, were postponed until July 1, 2019. However, the Impartial Conduct Standards incorporated into the Fiduciary Rule remained in effect after June 9, 2017. In March, the Fifth Circuit vacated the Fiduciary Rule in its entirety. See *Chamber of Commerce v. DOL*, 885 F.3d 360 (5th Cir. March 15, 2018).[2]

Under FAB 2018-02, the DOL will not pursue prohibited transactions claims against investment advice fiduciaries who are working diligently and in good faith to comply with the Impartial Conduct Standards for transactions that would have been exempted in the BIC Exemption and Principal Transactions Exemption, nor will the DOL treat such fiduciaries as violating the applicable prohibited transaction rules. This relief applies from June 9, 2017, through the time that regulations or exemptions or other administrative guidance has been issued to address the status of the Fiduciary Rule. This is essentially the same enforcement policy under FAB 2017-02, except that the policy will not expire on July 1, 2019, which was the date that the Fiduciary Rule originally was scheduled to become effective in its entirety. The DOL is extending this temporary enforcement policy in recognition that stakeholders (financial institutions, advisers, and retirement investors) have questions regarding the investment advice fiduciary definition and related exemptive relief following the Fifth Circuit's decision. Also, there is uncertainty as to the breadth of the prohibited transaction exemptions that remain available for investment advice fiduciaries. This uncertainty could disrupt existing investment advice arrangements to the detriment of retirement plans, retirement investors, and financial institutions. FAB 2018-02 also is intended to accommodate financial institutions who have devoted significant resources to comply with the BIC Exemption and the Principal Transactions Exemption, and may prefer to continue to rely upon the new compliance structures.

✪ *Other exemptions also available.* Pursuant to FAB 2018-02, an investment advice fiduciary may choose to rely upon other available exemptions that remain applicable after the Fifth Circuit's decision (exemptive relief that pre-existed the Fiduciary Rule). However, the DOL will not treat an adviser's failure to rely upon such other exemptions as resulting in a prohibited transaction if the terms of the temporary enforcement policy are met instead.

✪ *More guidance to come.* The DOL is evaluating the need for other temporary or permanent prohibited transaction relief for investment advice fiduciaries, including possible prospective and retroactive relief.

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[1] The term "Fiduciary Rule" refers collectively to DOL Reg. §2510.3-21 and the related prohibited transaction exemptions issued by the DOL in 2017.

[2] There were unsuccessful attempts by some States and the AARP to seek reconsideration of the Fifth Circuit's ruling, but the court denied them.

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SEC proposes rules to enhance protections for retail investors and to clarify investment professional relationships [Citation: *Prop. SEC Reg. §§240.15l-1, 240.17a-3 ("Rule 17a-3"), 240.17a-4(e)(5) ("Rule 17a-4")*, 83 F.R. 21574 (May 9, 2018), *Prop. SEC Reg. §§§240.17a-14(f), §275.211h–1, and 275.204-5(e)*, 83 F.R. 21416 (May 9, 2018), *Release No. IA–4889*, 83 F.R. 21203 (May 9, 2018)]
Text available at http://bit.ly/2I3pTOa (Best Interest Standard), http://bit.ly/2K5v4tA (Release No. 1A-4889), and http://bit.ly/2jKXhuM (CRS proposal)

Shortly after the Fifth Circuit vacated the Fiduciary Rule, the SEC proposed several pieces of guidance that are intended to fill the void created by that court decision. These proposals also signal an intent by the current Administration to back off of regulatory initiatives by the DOL to address standards of conduct with respect to retail customers (except as required by ERISA, if applicable), and focus on necessary regulatory protections through the SEC. This is exactly the type of approach favored by the Fifth Circuit, which cited the impact of the Fiduciary Rule on retail investment relationships not governed by ERISA as a key factor in its decision to vacate the Rule. The proposed regulatory package from the SEC would: (1) require broker-dealers to act in the best interest of a retail customer when making a recommendation of any securities transaction or investment strategy involving securities to a retail customer (Regulation Best Interest standard, (2) clarify the SEC's views on the fiduciary duty that investment advisers owe their clients, (3) prescribe a disclosure statement intended to clarify the nature of investors' relationships with investment professionals, and (4) restrict certain broker-dealers and their investment professionals from using the terms "adviser" or "advisor" as part of their name or title. As described by the SEC in a press release, http://bit.ly/2HCi80N, these proposals are intended to "enhance investor protection by applying consistent principles to investment advisers and broker-dealers: provide clear disclosures, exercise due care, and address conflicts of interest. The specific obligations of investment advisers and broker-dealers would be, however, tailored to the differences in the types of advice relationships that they offer."

Best interest standard for broker-dealers ("Regulation Best Interest"). Pursuant to its authority under the Securities Exchange Act of 1934, the SEC is proposing an express Best Interest obligation on broker-dealers. See Prop. SEC Reg. §240.15*l*-1 (May 9, 2018). The Best Interest standard would require that, when making a recommendation of any securities transaction or investment strategy involving securities to a retail customer, a broker-dealer act in the best interest of the retail customer at the time the recommendation is made without placing the financial or other interest of the broker-dealer or natural person who is an associated person making the recommendation ahead of the interest of the customer. The SEC refers to this as the Regulation Best Interest. This standard would be satisfied by meeting the requirements described in (1) below.

***Similarities to Fiduciary Rule.* At least as to intent, there are similarities in the Regulation Best Interest standard and the standards of conduct in the Fiduciary Rule. In fact, the SEC notes in its preamble to the proposal that it draws from the underlying principles of the best interest standard under the Fiduciary Rule and the conflict of interest concerns expressed in the Best Interest Contract Exemption. However, the Regulation Best Interest would not prescribe the same level of specificity with respect to policies and procedures, would not impose the extensive disclosure requirements that had been in the Fiduciary Rule, and would not prescribe enforcement standards through contractual arrangements. The preamble to the Regulation Best Interest provides guidelines for complying with the standard.**

(1) Meeting the Regulation Best Interest standard. The SEC proposal requires the broker-dealer to meet the following requirements in order to satisfy the Regulation Best Interest standard with respect to investment recommendations to retail customers.

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(a) Disclosure Obligation. The broker-dealer (or a natural person associated with the broker-dealer), prior to or at the time of the recommendation, reasonably discloses to the retail customer, in writing, the material facts relating to the scope and terms of the relationship with the retail customer (e.g., broker-dealer relationship, fees and charges, and type and scope of services), and all material conflicts of interest that are associated with the recommendation (i.e., what a reasonable person would expect might incline a broker-dealer, consciously or unconsciously, to make a recommendation that is not disinterested).

(b) Care Obligation. The broker-dealer (or a natural person associated with the broker-dealer, in making the recommendation, would have to exercise reasonable diligence, care, skill, and prudence to (1) understand the potential risks and rewards associated with the recommendation, and have a reasonable basis to believe that the recommendation could be in the best interest of at least some retail customers, (2) have a reasonable basis to believe that the recommendation is in the best interest of a *particular* retail customer based on that retail customer's investment profile and the potential risks and rewards associated with the recommendation, and (3) have a reasonable basis to believe that a series of recommended transactions, *even if in the retail customer's best interest when viewed in isolation*, is not excessive and is in the retail customer's best interest when taken together in light of the retail customer's investment profile.

> ***SEC commentary.*** **Although the broker-dealer would not be required to analyze all possible investment products or strategies to find the single "best" investment or strategy for the retail customer, the duty of care would require that consideration of reasonably available alternatives offered by the broker-dealer be part of having a reasonable basis for making the recommendation. Cost (including fees, compensation, other financial incentives) should be an important factor. But other factors also are important (e.g., the product's or strategy's investment objectives, characteristics of the investment, liquidity, risks and potential benefits, volatility, and likely performance in a variety of market and economic conditions). In some cases, these additional factors might outweigh the cost factor. Thus, simply recommending the least expensive investment without any further analysis of these other factors and the retail customer's investment profile would not meet the Care Obligation.**

(c) Conflict of Interest Obligation. The broker-dealer would have to establish, maintain, and enforce written policies and procedures reasonably designed to identify and *at a minimum* disclose, or eliminate, all material conflicts of interest that are associated with such recommendations (e.g., requirements to recommend proprietary products). In addition, there would need to be written policies and procedures intended to identify and disclose and mitigate, or eliminate, material conflicts of interest arising from financial incentives associated with such recommendations (e.g., transaction-based compensation, differential or variable compensation, incentives, quotas, bonuses, sales contests). Note that the SEC separately focuses on financial incentives, apart from other conflicts "associated" with the recommendation, suggesting a higher obligation with respect to financial-based conflicts that would include mitigation or elimination of such conflicts, as opposed to a disclosure at a minimum being satisfactory for other material conflicts.

> ***Not intended to limit investments.*** **The SEC specifically notes that the Regulation Best Interest is not intended to eliminate or prohibit transactions involving conflicts of interest, but such transactions must be evaluated by the broker-dealer (and associated natural persons) to ensure the Regulation Best Interest standard is met. Examples given by the SEC that are not *per se* in violation of the standard (and by the same token not *per se* consistent with the standard) include recommendations that involve commissions, differential compensation, third-party compensation (e.g., revenue-sharing, 12b-1 fees), proprietary products, securities underwritten by the**

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broker-dealer (or its affiliate), principal transactions, complex products, allocation of trades, research or investment opportunities among different types of customers, or consideration of cost to the broker-dealer effecting the transaction. The standard also does not *per se* prohibit accepting a customer's order that is contrary to the broker-dealer's recommendations.

(2) Definition of a recommendation. In constructing this proposal, the SEC is not intending to create a new definition of a recommendation. Rather, whether a recommendation is being made should be interpreted consistent with existing broker-dealer regulation under the federal securities laws and the rules of self-regulating organizations (SROs), such as FINRA, which would provide clarity to broker-dealers and is consistent with established infrastructures that already rely on this term. The SEC is concerned that even providing a principles-based definition, which draws upon the principles underlying existing SEC precedent and guidance, may create unnecessary confusion as to whether the language intentionally or unintentionally diverges from existing precedent. The Fiduciary Rule, on the other hand, had ventured into definitional territory and had created significant confusion.

(3) Definition of a retail customer. The proposal defines a retail customer as a person (or legal representative) who: (1) receives a recommendation of any securities transaction or investment strategy involving securities from a broker, dealer, or a natural person who is an associated person of a broker or dealer, and (2) uses the recommendation primarily for personal, family, or household purposes.

(4) Customer's investment profile. The proposal defines a retail customer's investment profile to include (but not limited to) the retail customer's age, other investments, financial situation and needs, tax status, *investment objectives*, investment experience, investment time horizon, liquidity needs, risk tolerance, and any other information the retail customer may disclose to the broker, dealer, or a natural person who is an associated person of a broker or dealer in connection with a recommendation.

(5) Recordkeeping requirement. SEC Reg. §240.17a-3 ("Rule 17a-3") would be amended to add a requirement that a record of all information collected from and provided to the retail customer pursuant to §240.15l–1, as well as the identity of each natural person who is an associated person, if any, responsible for the account, be maintained by the broker-dealers, subject to an exception if the customer refuses, neglects, or is unable to provide or update such information. The recordkeeping obligation would continue until at least six years after the *earlier* of: (1) the date the account was closed, or (2) the date on which the information was collected, provided, replaced, or updated. See Prop. SEC Reg. §240.17a-4(e)(5) ("Rule 17a-4").

(6) Does *not* replace any applicable ERISA standards. Note that, depending on the relationship, it is possible that the broker-dealer, or an associated natural person, will be an ERISA fiduciary, with respect to advice provided to an ERISA plan. The Regulation Best Interest standard is not intended to replace or dilute the ERISA obligations in such situations. An investment professional who serves in a fiduciary role would still be subject to ERISA's fiduciary standards and may need to look to prohibited transaction exemptions (e.g., the Best Interest Contract Exemption) if he/she makes recommendations in which there are conflicts of interest. The Regulation Best Interest standard described in (1) above is intended, in the retirement savings sphere, to address relationships between investment professionals and customers that are IRA owners or non-ERISA plan participants, or beneficiaries of such persons.

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Standard of conduct for investment advisers. In a separate proposal, the SEC offers an interpretation of the standard of conduct applicable to investment advisers under the Investment Advisers Act of 1940 ("1940 Act"). See Release No. IA–4889, 83 F.R. 21203 (May 9, 2018). The SEC issued this proposal in recognition of the fact that an investment adviser is a fiduciary (as defined under the 1940 Act), and as such is held to the highest standard of conduct and must act in the best interest of its client. Its fiduciary obligation includes an affirmative duty of utmost good faith and full and fair disclosure of all material facts. The proposed interpretation contained in this release is intended to reaffirm, and in some cases clarify, certain aspects of the fiduciary duty that an investment adviser owes to its clients under section 206 of the 1940 Act. The adviser's fiduciary standard is based on equitable common law principles and is fundamental to its relationships with clients.

(1) Duty of Care. An adviser's Duty of Care includes: (i) the duty to act and to provide advice that is in the best interest of the client (as discussed above), (ii) the duty to seek best execution of a client's transactions where the adviser has the responsibility to select broker-dealers to execute client trades, and (iii) the duty to provide advice and monitoring over the course of a relationship.

- ✪ *Client's investment profile.* Personalized investment advice should not be provided before the adviser make a reasonable inquiry into the client's investment profile and, except in the case of a one-time financial plan or other investment advice that is not provided on an ongoing basis, the adviser must update the client's profile in order to reflect changed circumstances.
- ✪ *Best execution.* When seeking best execution, an adviser should consider ''the full range and quality of a broker's services in placing brokerage including, among other things, the value of research provided as well as execution capability, commission rate, financial responsibility, and responsiveness'' to the adviser (i.e., the determinative factor is not the lowest possible commission cost but whether the transaction represents the best qualitative execution). An investment adviser also should ''periodically and systematically'' evaluate the execution it is receiving for clients.
- ✪ *Monitoring advice.* The duty to provide advice and monitoring is particularly important for an adviser that has an ongoing relationship with a client (e.g., adviser is compensated with a periodic asset-based fee or adviser has discretionary authority over the client assets). Conversely, the steps needed to fulfill this duty will be more limited when the adviser and client have agreed to a relationship of limited duration via contract (e.g., adviser is compensated with a fixed, one-time fee commensurate with the discrete, limited-duration nature of the advice provided). An adviser's duty to monitor extends to all personalized advice it provides the client, including an evaluation of whether a client's account or program type (e.g., wrap account) continues to be in the client's best interest.

(2) Duty of Loyalty. The Duty of Loyalty requires an investment adviser to put its client's interests first, which includes not favoring its own interests over those of a client or unfairly favoring one client over another. In seeking to meet its duty of loyalty, an adviser must: (i) make full and fair disclosure to its clients of all material facts relating to the advisory relationship, (ii) seek to avoid conflicts of interest with its clients, and, (iii) at a minimum, make full and fair disclosure of all material conflicts of interest that could affect the advisory relationship. The disclosure should be sufficiently specific so that a client is able to decide whether to provide informed consent to the conflict of interest. Some disclosure obligations are met through the required disclosures prescribed by SEC Form ADV.

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Client Relationship Summary (CRS). As part of its effort to reduce confusion among retail investors about the types of services offered by broker-dealers, investment advisers, and dual-registered firms (i.e., registered as both broker-dealers and investment advisers), the SEC is proposing to require these investment advice providers to furnish a Client Relationship Summary (Form CRS) to retail investors. These requirements would be incorporated as new rules under the Investment Advisers Act of 1940, with respect to investment advisers, and under the Securities Exchange Act of 1934, with respect to broker-dealers. The SEC is proposing to make the CRS requirement effective 6 months after the publication of a final rule. See Prop. SEC Reg. §§§240.17a-14(f) (broker-dealers) and 275.204-5(e) (investment advisers).

> ✪ Sample documents. The proposal contains five appendices with the following sample documents: Appendix A (Proposed modifications to Form ADV instructions to incorporate CRS and other changes), Appendix B (Proposed modification to add "Part 3: Instructions to Form CRS" to Form ADV), Appendix C (Hypothetical CRS for a Dually Registered Investment Adviser and Broker-Dealer (prepared by SEC staff)), Appendix D (Hypothetical CRS for a Broker-Dealer (prepared by SEC staff)), and Appendix E (Hypothetical CRS for an Investment Adviser (prepared by SEC staff)).

Restrictions on the use of the terms Adviser and Advisor. SEC Reg. §240.15*l*-2 (Rule 15*l*-2) would be added to prohibit a broker-dealer to use the term adviser or adviser as part of a name or title in communications with retail investors unless the broker-dealer is an investment adviser registered under Section 203 of the Investment Advisers Act of 1940 or with a State. Similar, a natural person associated with a broker-dealer would be subject to the same restriction unless the natural person is a supervised person of an investment adviser registered under Section 203 of the Investment Advisers Act of 1940 or with a State, and such person provides investment advice on behalf of such investment adviser. Examples of restricted usage would include financial advisor (or adviser), wealth advisor (or adviser), trusted advisor (or adviser), and XYZ advisory firm.

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Determination Letter Procedures

Annual update of determination letter procedure for 2019 [Citation: *Rev. Proc. 2019-4*, 2019-1 I.R.B. (January 2, 2019]
Text available at http://bit.ly/2SIxJyk (Internal Revenue Bulletin issue that contains Rev. Proc. 2019-4)

The IRS' "umbrella" procedure governing EP private letter rulings, determination letters, and user fees for Employee Plans Rulings and Agreements is updated on an annual basis in January. The procedure is the fourth revenue procedure for the year, so it numbered xxxx-4, where "xxxx" stands for the calendar year the procedure is issued. The determination letter procedures are primarily in Parts I and II of the Revenue Procedure. The 2019 procedure is effective for determination letter applications submitted on or after January 2, 2019. The addresses for filing determination letter applications are in section 31 of the procedure. A sample Interested Party Notice is provided in Appendix B of the procedure. For Determination requests under IRC §§401(h) and 420, see the checklist in Appendix C.

* **Primary changes made to the general determination letter procedure.** Notable changes from the 2018 procedure are listed below.

(1) Safe harbor plans. Section 9.03 is modified to clarifies that, for a plan to be reviewed for, and a determination letter relied upon with respect to, whether the terms of the plan satisfies one of the design-based safe harbors in Treas. Reg. §§1.401(a)(4)-2(b) and 1.401(a)(4)-3(b), the plan document must provide a definition of compensation that satisfies Treas. Reg. §1.414(s)-1(c) (i.e., a "safe harbor" definition of compensation that cannot fail to satisfy IRC §414(s)).

(2) Reference list recommendation deleted. Former Section 10.04 recommended that the determination letter submission include a reference list to indicate the location in the plan document of the items set forth in the Required Amendment Lists and, if applicable, any Cumulative Lists that are relevant to the plan being submitted. The new procedure deletes this section, resulting in the renumbering of former Section 10.05 and the following sections under Section 10 to Section 10.04, etc.

(3) Incomplete submissions. The procedures relating to procedurally or technically deficient submissions have been modified. The new procedures are reflected in the discussion in paragraph 16. below.

(4) Plan termination submissions (Form 5300). The user fee for plan termination submissions is increased to $3,000 (up from $2,300) for submissions postmarked on or after July 1, 2019.

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Determination Letters: User Fees

Annual update of user fee procedure for 2019 [Citation: *Rev. Proc. 2019-4*, 2018-1 I.R.B. (January 2, 2019)]
Text available at http://bit.ly/2SIxJyk (Internal Revenue Bulletin issue that contains Rev. Proc. 2019-4)

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* **Fee changes.** The only change made to the user fee structure for 2019 is an increase in the user fee for Form 5310 submissions (relating to plan termination) from $2,300 to $3,000. This change, however, has a delayed effective date, applying to submissions postmarked on or after July 1, 2019. Fees relating to other determination letters, to the approval of Pre-Approved Plans, and to private letter ruling requests handled by Employee Plans, did not change. Note that private letter ruling request handled by EB Chief Counsel, as discussed in ¶6.603 above, are subject to an increase user fee of $30,000 (up from $23,800), effective January 2, 2019.

* **Methods of payment.** Only determination letter applications filed on the Form 5300 series may be paid by credit card or by direct debit from a checking or savings account through www.pay.gov. Payment confirmations are provided through the www.pay.gov portal and must be submitted along with the paper Form 8717. Payment by check is also permitted. Private letter ruling requests, opinion letter and advisory letter applications, and EPCRS filings for a VCP Compliance Statement must be paid by check. See section 30.07

* **Addresses.** The addresses for filing determination letter applications, private letter ruling requests and VCP submissions are in section 31 of the procedure.

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Required Amendment List

2018 Required Amendment List issued by the IRS [Citation: *Notice 2018-91*, I.R.B. (December 26, 2018) (advance release on December 5, 2018)]
Text available at http://bit.ly/2OWOcvO

Required Amendment Lists are published by the IRS, pursuant to Rev Proc. 2016-37, for the purpose of setting amendment deadlines for individually-designed plans to respond to changes in plan qualification requirements. The Required Amendment Lists also are used to review determination letter applications filed by these plans.

Items includes on a calendar year's Required Amendments List. As a general rule, the Required Amendment List issued for a calendar year will include plan qualification changes that first become effective during the calendar year or for plan years beginning in such calendar year. Changes in qualification requirements that were first effective in a prior year that were not included on a prior Required Amendment List might appear on a subsequent year's list, such as changes in qualification requirements that were issued or enacted after the prior year's Required Amendment List was prepared. The list will not include: (1) statutory changes in qualification requirements for which the Treasury Department or the IRS expects to issue guidance (which would be included on a Required Amendments List issued in a future year), (2) changes in qualification requirements that permit (but do not require) optional plan provisions (in contrast to changes in the qualification requirements that cause existing plan provisions, which may include optional plan provisions previously adopted, to become disqualifying provisions), and (3) changes in the tax laws affecting qualified plans that do not change the qualification requirements under IRC §401(a) (such as changes to the tax treatment of plan distributions, or changes to the funding requirements for qualified plans). Optional provisions described in (2) fall within the realm of discretionary amendments, for which the amendment deadline is the last day of the plan year in which such amendments first become effective, rather than the remedial amendment period that is governed by items on the Required Amendments List. See Sections 5.05(2), 5.06(2), and 8.02 of Rev. Proc. 2016-37.

*Certain changes **deemed** to be included on Required Amendments List.* Annual, monthly, or other periodic changes to (1) the various dollar limits that are adjusted for cost of living increases as provided in IRC §415(d), (2) the spot segment rates used to determine the applicable interest rate under IRC §417(e)(3), and (3) the applicable mortality table under IRC §417(e)(3), are treated as included on the Required Amendments List for the year in which such changes are effective even though they are not directly referenced on such list. The IRS anticipates that few plans have language that will need to be amended on account of these changes because of incorporation by reference.

Plan sponsor must decide whether an amendment is needed. The fact that a change in a qualification requirement is included on the Required Amendments List does not mean that a plan must be amended as a result of that change. Each plan sponsor must determine whether a particular change in a qualification requirement requires an amendment to its plan. Most individually-designed plans will have legal counsel or other professional responsible for making these determinations.

2018 Required Amendments List

There are no items on the 2018 Required Amendment List.

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Maintaining Plan Qualification: Operational Compliance

IRS updates Operational Compliance Checklist to include rules taking affect in 2018 and 2019
[Citation: *Operational Compliance Checklist*, as updated on March 26, 2019]
Text available at https://www.irs.gov/retirement-plans/operational-compliance-list

The Operational Compliance List ("OC" List) is provided per Rev. Proc. 2016-37, Section 10, to help plan sponsors and practitioners achieve operational compliance by identifying changes in qualification requirements effective during a calendar year. See Rev. Proc. 2016-37 regarding the timing of plan amendments to reflect changes in the qualification rules, which differ depending on whether the plan is a pre-approved plan or an individually-designed plan.

Scope of the list. The OC List: (1) identifies matters that may involve either mandatory or discretionary plan amendments depending on the particular plan, (2) may reference other significant guidance that affects daily plan operations, (3) is available on the above-reference IRS webpage only. It is not published in the Internal Revenue Bulletin.

Routine changes not included. The OC list doesn't include annual, monthly, or other periodic changes that routinely occur (e.g., cost-of-living increases, spot segment rates, and applicable mortality tables). The IRS updates the OC List periodically, but not in uniform intervals, to reflect new legislation and IRS guidance. The OC List is not intended by the IRS to be a comprehensive list of every item of IRS guidance or new legislation for a year that could affect a particular plan. For a complete list of IRS guidance, see Recent Published Guidance at https://www.irs.gov/retirement-plans/recent-ep-published-guidance.

Compliance information. In order to be qualified, a plan must comply operationally with each relevant qualification requirement, even if the requirement is not included on the OC List. A plan must be operated in compliance with a change in qualification requirements from the effective date of the change.

Operation Compliance List Item	Type of Plans Affected
Effective in 2018	
Final QNEC and QMAC Regulations (T.D. 9835). These regulations provide that employer contributions to a 401(k) plan can be qualified nonelective contributions or qualified matching contributions if they satisfy the applicable nonforfeitability requirements and distribution limitations at the time they are allocated to participants' accounts. Accordingly, these regulations permit forfeitures to be used to fund qualified nonelective contributions and qualified matching contributions. The regulations apply to plan years beginning on or after July 20, 2018, but taxpayers may apply these regulations to earlier periods.	401(k) plans
Relief for California Wildfires (Bipartisan Budget Act of 2018, Section 20102). A plan may offer participants affected by the California wildfires: (1) new "qualified wildfire distributions," subject to special tax treatment and recontribution options; and (2) plan loans of up to $100,000, subject to special repayment rules. To take advantage of the options provided under this legislation, the loans or distributions must be made within a specified time frame ending December 31, 2018. If the plan makes such loans or distributions, any necessary retroactive amendments must be adopted on or before the last day of the first plan year beginning on or after January	All plans

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1, 2019 (or for IRC Section 414(d) governmental plans, the last day of the first plan year beginning on or after January 1, 2021). See IRS Publication 976 (Disaster Relief) for more information (available at https://www.irs.gov/pub/irs-pdf/p976.pdf).	
Extension of temporary nondiscrimination relief for closed defined benefit pension plans (Notice 2017-45). This notice extends, to plan years beginning before 2019, the relief provided to closed defined benefit plans under Notice 2014-5, as extended under Notice 2015-28 and Notice 2016-57. Also see Notice 2018-69, included in the list of items in this table that are effective in 2019, which further extends this temporary relief.	Defined benefit plans
Extended rollover periods for certain amounts. Recent legislation extended the deadline for individuals to roll over certain distributions from qualified retirement plans. A plan that accepts rollovers may choose to permit rollover contributions made within the new extended deadlines. The new rules extend the rollover deadline for: · Qualified plan loan offset amounts (Tax Cuts and Jobs Act of 2017, Section 13613). Qualified plan loan offset amounts (as defined in IRC §402(c)(3)(C)(ii)) may be rolled over by the due date (including extensions) for filing the tax return for the taxable year in which such amount is treated as distributed from a qualified employer plan. [Qualified plan loan offsets include only certain offsets made upon separation of service or termination of the plan.] The extended due date applies to qualified plan loan offset amounts which are treated as distributed in taxable years beginning after December 31, 2017. See IRC §402(c)(3)(C). · Refunds of improper tax levies (Bipartisan Budget Act of 2018, Section 41104). A plan may choose to permit participants whose account or benefit under the plan had been subject to an improper federal tax levy to roll over to the plan any refund of such levy (including interest) that the participant subsequently receives from the IRS, no later than the due date (not including extensions) for filing the participant's tax return for the taxable year in which the refund is received. These rules apply to levy refunds received in taxable years beginning after December 31, 2017. See IRC §6343(f).	All plans
Modification of deduction for personal casualty losses (Tax Cuts and Jobs Act, Section 11044). Under IRC §165(h)(5), for taxable years 2018 through 2025, the deduction for a personal casualty loss generally is available only to the extent the loss is attributable to a federally declared disaster (as defined in IRC §165(h)(5)). However, see proposed Treasury Regs. §1.401(k)-1(d)(3)(ii)(B)(6) (related to deemed immediate and heavy financial need - see list of 2019 items later in this table), which provide, in part, that expenses for the repair of damage to an employee's principal residence that would qualify for the IRC §165 casualty deduction is determined without regard to IRC §165(h). Thus, for example, a plan that made hardship distributions relating to casualty losses deductible under IRC §165 without regard to the changes made to IRC §165 by this legislation may be amended to apply the revised safe harbor expense relating to casualty losses to distributions made in 2018 so that plan provisions will conform to the plan's operation. Taxpayers may rely on the proposed regulations until the date of publication of final regulations in the Federal Register.	401k plans
Effective in 2019	

Changes Relating to Hardship Distributions. · Bipartisan Budget Act of 2018, Sections 41113 and 41114. These sections of	401(k) plans and other plans eligible to make

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this act: (1) provide that a distribution will not fail to be treated as made on account of hardship merely because the employee does not take any available loan from the plan, and (2) expand the types of contributions and earnings a plan may make available for hardship distributions. In addition, this legislation directs the IRS and Treasury to eliminate the safe harbor requirement to suspend participant contributions for six months in order for the distribution to be deemed necessary to satisfy an immediate and heavy financial need. These changes are effective for plan years beginning after December 31, 2018. · Proposed Regulations Regarding Hardship Withdrawals (83 F.R. 56763). The proposed regulations would revise the 401(k) regulations to reflect legislation regarding hardship distributions. The proposed regulations would prohibit a plan from suspending a participant's contributions as a condition of obtaining a hardship distribution. In addition, the proposed regulations would revise the safe harbor list of expenses deemed to constitute an immediate and heavy financial need, including modifications regarding casualty losses and disaster-related expenses. The proposed regulations are generally proposed to be effective for distributions made in plan years beginning after December 31, 2018, but would permit plans to: (1) choose to cease suspension of contributions on the first day of the first plan year that begins after December 31, 2018, even for distributions made before that date, and (2) choose to apply the changes to the list of safe harbor expenses to any hardship distribution made after December 31, 2017. In addition, under the proposed regulations the requirement to obtain a representation that a distribution is necessary to satisfy a financial need would only apply for a distribution that is made after 2019, and the prohibition on a plan providing for a suspension of elective contributions or employee contributions as a condition of obtaining a hardship distribution would only apply for a distribution made after 2019. **Note - amendment deadlines:** The proposed regulations provide that any plan amendments relating to the final regulations will be treated as integrally related to a disqualifying provision, and will thus have the *same amendment deadline as a disqualifying provision*, as set forth in Rev. Proc. 2016-37. For example, for an individually designed plan that is not a governmental plan, any plan amendments relating to the final regulations must be made by the end of the second calendar year that begins after the issuance of an annual Required Amendments List that includes the final regulations. **Note - reliance:** Taxpayers may rely on the proposed regulations until the date of publication of final regulations in the Federal Register. · Relief for Victims of Hurricanes Florence and Michael (83 F.R. 56766). The IRS and Treasury extended the retirement plan relief provided under Announcement 2017–15 to similarly situated victims of Hurricanes Florence and Michael, except that the ‘‘Incident Dates" (as defined in that announcement) are as specified by FEMA for these 2018 hurricanes, relief is provided through March 15, 2019, and any necessary amendments must be made no later than the deadline for amending a disqualifying provision, as set forth in Rev. Proc. 2016–37.	hardship distributions
Extension of temporary nondiscrimination relief for closed defined benefit pension plans (Notice 2018-69). This notice extends, to plan years beginning before 2020, the relief provided to closed defined benefit plans under Notice 2014-5, as extended under Notice 2015-28, Notice 2016-57 and Notice 2017-45.	Defined benefit plans

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Approval Procedures For Pre-Approved Plans

Procedures for second RAP cycle modified to permit cash balance plans that use actual return on total plan assets as the interest crediting rate; conforming language adopted for second cycle and third cycle procedures [Citation: *Rev. Proc. 2018-21*, 2018-14 I.R.B. (April 2, 2018) (advance release on March 16, 2018)]
Text available at http://bit.ly/2tY67NG

Rev. Proc. 2017-41, which applies to the third remedial amendment cycle for Pre-Approved Plans, allows nonstandardized defined benefit plans to provide for an interest crediting rate that is based on the actual return on plan assets. The IRS has now determined that Rev. Proc. 2015-36 should be amended so that, for the second cycle, nonstandardized M&P and volume submitter plans should be allowed to do the same. This was released early so that the opinion letters and advisory letters being issued to these plans for the second cycle would cover plan provisions that incorporated this interest rate option. The IRS also has determined that the interest rate under this option should equal the actual rate of return on aggregate plan assets (rather than a rate that is based on such actual return. To effect this change the following amendments have been made to Rev. Procs. 2015-36 and 2017-41.

- Section 6.03(7)(c) of both procedures, as well as section 16.03(7)(c) of Rev. Proc. 2015-36 (pertaining to volume submitter plans), are amended to provide that a interest rate that is equal to the actual rate of return on the aggregate plan assets is permissible.
- The same sections continue to prohibit the following types of equity-based interest rates: (1) rates that are based on (rather than equal to) the actual return on aggregate plan assets described in Treas. Reg. §1.411(b)(5)-1(d)(5)(ii)(A); (2) rates that are based on the rate of return on regulated investment companies (RIC) described in Treas. Reg. §1.411(b)(5)-1(d)(5)(iv); and (3) rates that are based on or equal to the actual rate of return on a subset of plan assets (as described in Treas. Reg. §1.411(b)(5)-1(d)(5)(ii)(B)).
- These same sections also clarify that, if the interest rate is equal to the actual rate of return on aggregate plan assets, that such actual return is permissible even if the plan assets include RICs.
- Rev. Proc. 2015-36 is also amended to replace the term “hypothetical interest” with the term “interest credit” so that the terminology in Rev. Procs. 2015-36 and 2017-41 coincide. The definition of hypothetical account balance is also revised to define it as generally consisting of Principal Credits and Interest Credits.

Verification of compliance with second cycle requirements for existing Pre-Approved Plan providers to submit opinion letter applications for the third cycle [Citation: *Applications for Pre-Approved Contribution Plan Opinion Letters* (May 23, 2018). at IRS website]
Text available at http://bit.ly/2saOLZS

For the IRS to consider a provider’s opinion application for the third 6-year remedial amendment cycle, the pre-approved DC plan provider must verify compliance with the second cycle’s requirements by using one of the following three verification methods. [Note that all applications for Pre-Approved Plans are for opinion letters, starting with the third cycle. Advisory letters are no longer being issued with respect to Pre-Approved Plans, regardless of how they are designed (i.e., Adoption Agreement Plans or Single Document Plans).

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(1) New plan. The provider states that an opinion or advisory letter wasn't requested for the DC Pre-Approved Plan for a prior cycle or at any prior time. In other words, the Pre-Approved Plan is a new plan. This might be because the provider has not previously sponsored a Pre-Approved Plan, or because the provider is adding the particular DC Pre-Approved Plan as an offering to adopting employers.

(2) Evidence of second-cycle letter. The provider attaches to the application the DC Pre-Approved Plan's most recent opinion letter or advisory letter for the second 6-year remedial amendment cycle.

(3) Satisfactory explanation. The opinion letter application includes a satisfactory explanation of why an opinion or advisory letter wasn't requested during the second 6-year remedial amendment cycle and how the second cycle's qualification requirements were timely satisfied by employers who adopted the Pre-Approved Plan.

For example, if a Pre-Approved Plan provider received an opinion letter for the DC Pre-Approved Plan for the first 6-year remedial amendment cycle, but didn't secure a letter for the second cycle, the IRS won't issue an opinion letter for the third cycle unless the provider can satisfy verification method (3).

If the provider cannot satisfy any of these verification methods, then it must correct the qualification failure under VCP before applying for a third cycle opinion letter.

Submission cycle for third cycle extended for DC Pre-Approved Plans [Citation: *Rev. Proc. 2018-42*, 2018-36 (September 4, 2018; advance release on August 15, 2018)]
Text available at http://bit.ly/2NuRjuZ

Rev. Proc. 2017-41, which governs the approval of Pre-Approved Plans for the third remedial amendment cycle, originally required DC Pre-Approved Plans to be submitted by October 1, 2018, to be considered "on-cycle" during the third cycle review process. Rev. Proc. 2018-42 extends that deadline to December 31, 2018.

Two-year window to restate defined benefit M&P plans and volume submitter plans for second remedial amendment cycle ends April 30, 2020; determination letter program opens May 1, 2018 [Citation: *Announcement 2018-5*, 2018-13 I.R.B. (March 26, 2018)]
Text available at http://bit.ly/2p4u14n

The two-year window for restating defined benefit pre-approved plans (master/prototype (M&P) plans and volume submitter (VS) plans) for the second remedial amendment cycle opens May 1, 2018. To retain qualification, adopters of pre-approved plans (as well as adopters of individually-designed plans that have timely execute Form 8905) must restate on a pre-approved plan document that satisfies the requirements of the 2012 Cumulative List. The 2012 Cumulative List was the list used by the IRS in reviewing pre-approved plan documents for opinion letters and advisory letters.

✪ ***Note:*** **Starting with the third cycle, the approval of pre-approved plans is governed by Rev. Proc. 2017-41, which eliminates the M&P and volume submitter terminology. Under that procedure, all approval letters will be in the form of opinion letters, regardless of whether the Pre-Approved Plan document uses an adoption agreement format. In addition, Form 8905 no longer is relevant starting with the third cycle because individually-designed plans are not subject to cyclical remedial amendment period**

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after 2016. However, for the second cycle, if an individually-designed plan did not timely amend under the applicable 5-year remedial amendment cycle because it executed Form 8905 must restate onto the Pre-Approved Plan by April 30, 2020, in order to be treated as timely restating within its applicable remedial amendment period.

Determination letter applications. May 1, 2018, also is the first day that the IRS will accept determination letter applications for adopters of defined benefit Pre-Approved Plans. Note, however, that a Pre-Approved Plan may be submitted by an adopting employer for a determination letter only if the plan adopted by the employer is a modified Pre-Approved Plan. An adopting employer of a modified volume submitter plan may apply for a determination letter for the plan on Form 5307 if the modifications are not so extensive as to cause the plan to be treated as an individually-designed plan. If the changes are too extensive, then Form 5300 must be used to apply for a determination letter. A modified master/prototype plan always must use Form 5300 to apply for a determination letter.

Third cycle submissions will be delayed. Under the applicable 6-year cycles, the second remedial amendment cycle for defined benefit Pre-Approved Plans was scheduled to end on January 31, 2019, pursuant to Rev. Proc. 2016-37. Since the two-year window for the second cycle will run through April 30, 2020, Announcement 2018-5 extends the end of the cycle to April 30, 2020. Thus, if the adopting employer is eligible for the 6-year cycle system, its adoption of an M&P or volume submitter defined benefit that was reviewed under the 2012 Cumulative List will be considered adopted within the second cycle if the adoption occurs no later than April 30, 2020. The scheduled beginning of the third cycle under Rev. Proc. 2016-37 is February 1, 2019. Since the second cycle is being extended to April 30, 2020, at a later time the IRS will announced a delayed starting date for the third cycle.

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Taxation of Distributions: Transfers Resulting In Taxation

Transfer to State's unclaimed property fund results in reporting taxation of affected participant or beneficiary [Citation: *Rev. Rul. 2018-17*, IRB 2018-25 (June 18, 2018) (advance release on May 29, 2018)]
Text available at http://bit.ly/2IUVS3H

Revenue Ruling 2018-17 describes the withholding and reporting obligations with respect to IRA interests transferred to a State unclaimed property fund. Under the facts, an IRA trustee, pursuant to State law, transfers an individual's IRA interest to the State's unclaimed property fund. The IRA interest is valued at $1,000 at the time of the transfer. At the time of the transfer, the individual did not have a withholding election on file with the IRA trustee. The transfer triggers taxation because it is a distribution from the IRA. Since no withholding election was made, the transferred amount is subject to the 10% withholding rule for nonperiodic distributions, as described in IRC §3405(e)(3). Accordingly, the IRA trustee must withhold $100 from the $1,000 payment and transmit that to the IRS. In addition, the $1,000 distribution must be reported, pursuant to IRC §408(i), on Form 1099-R for the calendar year in which the transfer is made to the unclaimed property fund. The 1099-R will show $1,000 total taxable amount, and $100 of withholding.

Apparently recognizing that persons might have interpreted the withholding and reporting rules in a manner inconsistent with this ruling, transition relief is provided by the ruling. Under that relief, a person (e.g., an IRA trustee) is not treated as failing to comply with the withholding and reporting requirements described in Rev. Rul. 2018-17 for payments made before the earlier of: (1) January 1, 2019, or (2) the date it becomes *reasonably* practicable for the person to comply with these requirements. Note that the transition relief does not affect the taxability of the distribution. Thus, if an IRA benefit is paid to an unclaimed property fund in September 2018, and it is not reasonably practicable for the IRA to comply with these withholding and reporting requirements, the IRA owner is still subject to taxation on the transfer, even though the IRA trustee does not issue Form 1099-R with respect to the transfer and/or does not deduct and remit withholding from the transferred amount.

Comment. Although the facts involve an IRA, there is no reason to believe these reporting requirements would not apply in the context of a qualified plan or 403(b) plan. However, if the plan is subject to ERISA, funds generally would not be transferred to a State unclaimed property fund unless the plan fiduciary has determined the participant or beneficiary is missing, the benefit is otherwise payable (e.g., plan termination), and a rollover to an IRA is not otherwise applicable (e.g., funds exceed $1,000).

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Tax Shelters: Listed Transactions Involving Retirement Vehicles

Regulations under IRC §6707A amend the calculation of the penalty for failure to disclose a reportable transaction to reflect changes made by the Small Business Job Act of 2010 [Citation: *Treas. Reg. §301.6707A-1*, 84 F.R. 11217 (March 26, 2019)]
Text at https://www.govinfo.gov/content/pkg/FR-2019-03-26/pdf/2019-05546.pdf

These regulations reflect the amendments made to the penalty structure under IRC §6707A by the Small Business Jobs Act of 2010. IRC §6707A imposes a penalty for failure to disclose a reportable transaction on a timely basis. [Note that this penalty is not on the transaction itself, but on the failure to provide timely notice to the IRS.] The notice requirements are prescribed by IRC §6011 and Treas. Reg. §1.6011-4.

Revised penalty calculation. Instead of a flat dollar amount, the general penalty for penalties assessed after December 31, 2006, is a 75% of the decrease in the tax shown on the return as a result of a reportable transaction. A minimum and a maximum penalty also apply (see below). The change was made to avoid cases where the applicable penalty was disproportionate to the tax benefit derived from the transaction.

✪ *Minimum penalty.* The minimum penalty is **$10,000** (**$5,000** in the case of a natural person).

✪ *Maximum penalty.* The maximum penalty is **$50,000** (**$10,000** in the case of a natural person). However, if the reportable transaction is a listed transaction, the maximum penalty is **$200,000** (**$100,000** in the case of a natural person). [The maximum penalty is the same as the flat penalty was prior to the statutory amendment.]

Definition of a reportable transaction. IRC §6707A(c)(1) defines a reportable transaction as any transaction with respect to which information is required to be included with a return or statement because, as determined under regulations under IRC §6011, such transaction is a type which the Treasury has identified as having a potential for tax avoidance or evasion.

Definition of a listed transaction. IRC §6707A(c)(2) defines a listed transaction as a reportable transaction which is the same as, or substantially similar to, a transaction specifically identified by the Treasury as a tax avoidance transaction for purposes of IRC §6011. The IRS' chronological list of listed transactions is posted at https://www.irs.gov/businesses/corporations/listed-transactions.

✪ *Examples of listed transactions in the retirement plan world.* The IRS has identified listed transactions revolving retirement plans in the following guidance (listed in chronological order from earliest to most recent).

- Deductions by an employer for 401(k) contributions and matching contributions that are in violation of the principles set forth in Rev. Ruls. 90-105 and 2002-46 (e.g., claiming deductions for elective deferrals or matching contributions that relate to compensation earned in taxable year's after the taxable year for which the employer's deduction is taken).
- Abusive ESOPs identified in Rev. Rul. 2003-6.
- Transactions segregating the business profits of an ESOP-owned S corporation in a qualified subchapter S subsidiary, as described in Rev. Rul. 2004-4.
- Deductions for death benefits in excess of the participant's death benefit under the terms of the plan, as identified in Rev. Rul. 2004-20.
- Transactions identified in Notice 2004-8 which are designed to avoid the contribution limitations for Roth IRAs (such transactions attempt to take advantage of the Roth rules exempting earnings from income tax).

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Clarification of how the "decrease in tax" should be determined. The "decrease in tax shown" that is used to compute the 75% penalty is generally the difference between the amount of tax reported on the return as filed and the amount of tax that would be reported on a hypothetical return where the taxpayer did not participate in the reportable transaction. See Treas. Reg. §301.6707A-1(d)(1)(i). However, the amount of tax shown on the return is deemed to include any other tax that results from participation in the reportable transaction but was not reported on the taxpayer's return. See Treas. Reg. §301.6707A-1(d)(1)(ii). This additional requirement addresses situations like an excise tax under IRC §4973 that would have applied to an excess contribution that resulted from a listed transaction involving a Roth IRA.

Closed years. Since the penalty can apply in a situation where a transaction is subsequently identified by the IRS as a listed transaction, the final regulations clarify how the penalty should be calculated where the limitations period on one or more affected returns has closed, and a taxpayer has failed to file a complete and proper disclosure statement in the time prescribed under Treas. Reg. §1.6011-4(a). Where the limitations period has closed on a return, any decreases in tax shown on such return is disregarded to compute the penalty. The IRS added this clarification so that there is certainty about which returns need to be reviewed and which decreases in taxes are taken into account in calculating the amount of the penalty.

Tax Procedures: Regulatory Administration

Treasury obsoletes outdated regulations [Citation: Treas. Reg. §§1.72-15, 1.72-17A, 1.72-18, 1.401-3, 1.401-4, 1.401-5, 1.401-6, 1.401-8, 1.401-10, 1.401-11 through 1.401-13, 1.401(e)-1 through 1.401(e)-6, 1.401(f)-1, 1.402(a)-1, 1.402(e)-1, 1.403(a)-1, 1.404(a)-1, 1.404(a)-2, 1.404(a)-2A, 1.404(a)-3, 1.404(a)-4 through 1.404(a)-7, 1.404(a)-8, 1.404(a)-9, 1.404(a)-10, 1.404(a)(8)-1T, 1.404(e)-1, 1.404(e)-1, 1.404(e)-1A, 1.405-1 through 1.405-3, 1.410(a)-1, 1.410(b)-0, 1.410(b)-1, 1.411(a)-1, 1.411(a)-5, 1.411(a)-9, 1.411(d)-2, 1.411(d)-5, 1.412(b)-5, 1.412(c)(1)-3T, 1.412(l)(7)-1, 1.414(r)-8, and 1.416-1, 84 F.R. 9231 (March 14, 2019)]
Text available at https://www.govinfo.gov/content/pkg/FR-2019-03-14/pdf/2019-03474.pdf

The Treasury has removed or amended regulations that are no longer necessary because they do not have any current or future applicability. The above-listed regulations are those that relate to the retirement plan rules.

Regulations removed. The following regulations have been removed.

- Regulations relating to plans covering self-employed individuals and owner-employees (known as the "Keogh" rules) [Treas. Reg. §§1.401-11 through 1.401-13, 1.401(e)-1 through 1.401(e)-6]
- Pre-ERISA breaks in service [Treas. Reg. §1.411(a)-9]
- Class year vesting rules [Treas. Reg. §1.411(d)-5]
- Pre-EGTRRA/PPA2006 deduction rules [Treas. Reg. §§1.404(a)-2A, 1.404(a)-4 through 1.404(a)-7, 1.404(a)-9, 1.404(a)(8)-1T, 1.404(e)-1]
- Outdated minimum funding rules [Treas. Reg. §§1.412(b)-5, 1.412(c)(1)-3T, 1.412(l)(7)-1]
- Pre-1994 coverage testing rules and pre-ERISA nondiscrimination testing [Treas. Reg. §§ 1.401-4 and 1.401-5, 1.410(b)-1]
- Pre-ERISA custodial accounts [Treas. Reg. §1.401-8]
- Retirement bonds [Treas. Reg. §§1.405-1 through 1.405-3]

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Missing Participants: Terminated Plans

PBGC adds optional participation in missing participant transfer program for most DC plans and non-covered DB plans; modifies missing participant procedures for terminated Title IV-covered plans; and extends missing participant procedures to terminated multiemployer DB plans [Citation: *PBGC Reg. §§4050.101-4050.407*, 82 F.R. 60800 (December 22, 2017)]
Text available at http://bit.ly/2BpdVY9

These regulations completely replace the previously-issued regulations under ERISA §4050 (PBGC Reg. §§4050.1-4050.12). Under the revised regulations, Part 4050 of the Code of Federal Regulations is divided into four subparts: (1) Subpart A (§§4050.101-4050.107) which applies to terminated defined benefit plans that are covered by Title IV of ERISA (other than multiemployer plans) (see ¶1 below), (2) Subpart B (§§4050.201-4050.207), which applies to eligible terminated defined contribution plans (see ¶2 below), (3) Subpart C (§§4050.301-4050.307), which applies to terminated defined benefit plans that are not covered by Title IV of ERISA because of the exception for small professional service employers (see ¶3 below), and (4) Subpart D (§§4050.401-4050.407), which applies to terminated multiemployer defined benefit plans that are covered by Title IV of ERISA (see ¶4 below) and closes out under the procedures for sufficient multiemployer plans. In the case of plans described in (2) and (3), participation in the PBGC missing participants program is elective. The PBGC was authorized to issue these regulations under the PPA 2006, which amended ERISA §4050 to expand its scope, including the authority to offer a missing participants program to terminated non-covered plans, and the required expansion of the program to cover multiemployer plans. PBGC is also authorized to provide for reporting by plans of the disposition of missing participants' benefits, which is incorporated into these regulations as well.

***Historical information about ERISA §4050.* ERISA §4050 was enacted as part of the Retirement Protection Act of 1994 (RPA '94). Regulations were issued in 1995, which applied to terminated defined benefit plans (other than multiemployer plans) that were covered by Title IV of ERISA and terminated in a plan year beginning on or after January 1, 1996.**

***No PBGC program for missing distributees under active plans.* Some commenters on the proposed version of these regulations asked the PBGC to consider expanding the program to cover terminated participants and beneficiaries under active defined contribution plans. Although the PBGC acknowledges the importance of the issues raised in these cases, it did not expand the program at this time to cover any active plans.**

✪ *Uniform layout of subparts.* To facilitate understanding and compliance with these new regulations, each subpart is structured in the same manner. Each subpart consists of seven sections. The first section (§§4050.101, 4050.201, 4050.301, 4050.401) explains the purpose and scope of that subpart (e.g., plans that are subject to that subpart). The second section (§§4050.102, 4050.202, 4050.302, 4050.402) contains definitions, which are uniform across subparts except where differentiation is needed. The third section (§§4050.103, 4050.203, 4050.303, 4050.403) explains the options and duties of the plan (e.g., options for distributing benefits, search requirement, PBGC filing). The fourth section (§§4050.104, 4050.204, 4050.304, 4050.404) provides guidelines on performing a diligent search. The fifth section (§§4050.105, 4050.205, 4050.305, 4050.405) prescribes filing requirements (or filing options, in some cases) with the PBGC. The sixth section (§§4050.106, 4050.206, 4050.306, 4050.406) prescribes rules for how the PBGC will pay missing distributee benefits that have been transferred to the PBGC. The distribution of benefits is subject to separate rules for defined contribution plans and defined benefit plans, with uniform rules for all defined benefit plans covered by the program (Subparts A, C and D). The seventh section (§§4050.107, 4050.207, 4050.307, 4050.407) grants the PBGC discretion with respect to certain issues (see next paragraph).

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✪ *Flexibility granted to the PBGC.* In recognition that circumstances will arise that cannot be anticipated by the regulations, the seventh section of each subpart contains the following identical language: "PBGC may in appropriate circumstances extend deadlines, excuse noncompliance, and grant waivers with regard to any provision of this subpart to promote the purposes of the missing participants program and title IV of ERISA. Like circumstances will be treated in like manner under this section." See PBGC Reg. §§4050.107, 4050.207, 4050.307, 4050.407. This replaces the rule previously in PBGC Reg. §4050.12(g).

* **Applicability date.** The regulations are effective on January 22, 2018, and apply to plans with termination dates occurring after December 31, 2017. However, for terminated plans described in Subpart D (see ¶4 below), the regulations apply to plans that complete the close-out process after December 31, 2017.

✪ *Prior terminations.* For terminations not subject to the procedures under these new regulations, the previously-issued regulations (PBGC Reg. §§4050.1-4050.12) continue to apply. These older terminations will represent a decreasing subset of Title IV defined benefit plans as time moves forward.

* **Overview.** Under the program: (1) fees are charged for transferring the benefits of missing participants and beneficiaries, as a one-time transfer fee, but there are no maintenance fees (see ¶6 below), (2) more specific guidance is provided for diligent searches (see ¶1(4) below), (3) the rules for paying benefits of missing participants and beneficiaries is changed to provide more flexibility (see ¶1(6) below), and (4) the PBGC forms relating to missing participants and beneficiaries are modified (see ¶5 below).

✪ "Missing distributee" terminology. To avoid confusion, the regulations adopt the term "missing distributee" to refer to any missing participant or missing beneficiary whose benefit is transferred or reported under the PBGC's missing participants program. A *distributee*, which is defined in PBGC Reg. §§4050.102, 4050.202, 4050.302, and 4050.402, is a participant or beneficiary entitled to a distribution pursuant to the close-out of the plan. Note, however, that although the regulations adopt the "missing distributee" terminology, the program itself is referred to as the missing participants program, and the title for Part 4050 of the Code of Federal Regulations is still "Missing Participants."

¶1. Changes to the missing participants program for terminated defined benefit plans covered by Title IV (Subpart A Plans). PBGC Reg. §§4050.101-4050.107 govern the procedures for Subpart A Plans, as defined in (1) below. These are the plans that have traditionally been subject to the missing participants program pursuant to ERISA §4050. Subpart A Plans continue to be required to follow the missing participant procedures.

(1) Definition of Subpart A Plans. Subpart A Plans are terminated defined benefit plans (other than multiemployer plans) that are covered by Title IV of ERISA, meaning that the plan is not exempt from coverage under ERISA §4021(b). See PBGC Reg. §4050.101(a)(1). These plans are also referred to "single-employer" defined benefit plans, although the term "single-employer" also includes plans maintained by more than one employer (usually referred to as a "multiple employer plan") that don't meet the definition of a "multiemployer plan."

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(1)(a) Only plans that are closing out. A Subpart A Plan must comply with the missing participants program only if it is closing out, meaning that the plan is in the process of the final distribution or transfer of assets pursuant to a standard termination under ERISA §4041(b) or in a distress termination described in ERISA §4041(c)(3)(B)(i) or (ii) (known as a "sufficient distress termination"). See PBGC Reg. §4050.101(a)(2). Other distress terminations, as described in ERISA §4041(c)(3)(B)(iii) ("insufficient distress terminations") are not subject to these procedures because such plans are not closing out. See PBGC Reg. §4050.101(b). Instead, the PBGC trustees these plans and closes out the payment of benefits, which would include the benefits of missing participants and beneficiaries.

(1)(b) Individual account plans. Subpart A does not apply to individual account plans under ERISA §3(34) (i.e., defined contribution plans). See PBGC Reg. §4050.101(c). This includes the "401(k) component" of a DB-K plan described in IRC §414(x) and ERISA §210(e), because the 401(k) and DB components of such plans are treated as separate plans under the termination procedures under the tax code and ERISA. Also, employee contributions that are held as individual accounts in a defined benefit plan (e.g., voluntary employee after-tax contributions) are treated as individual account plans, pursuant to ERISA §3(35)(B), and so, are not covered by Subpart A. However, these individual accounts could be transferred to the PBGC under the Subpart B procedures described in ¶2 below.

(1)(b)(i) Rollover accounts in a DB plan. How a rollover account in a DB plan is treated under the missing participant program depends on how the plan pays out benefits with respect to the rollover. If the rollover is treated as a separate account, from which a benefit is based on the value of the plan assets reserved for such account, the rollover account is an individual account portion of the plan, as described in IRC §414(k). In such case, payment of the rollover account to a missing distributee is subject to the DC plan rules and, if the plan administrator elects, could be transferred to the PBGC under Subpart B of these regulations, as described in ¶2 below. On the other hand, if the rollover is made to increase the participant's benefit under the DB plan and no separate DC account is maintained in the DB plan (e.g., a rollover from the employer's DC plan to the employer's DB plan to "purchase" additional pension benefits, as described in Rev. Rul. 2012-4), the rollover is part of the benefit payable under the rules for DB plans, as prescribed by the Subpart A procedures, including how the plan calculates the benefit and how the PBGC pays the benefit when the participant is located. This distinction is discussed in the preamble at 82 F.R. 60803.

(2) Definitions. The following definitions are used in the Subpart A procedures. These terms are also defined in the other subparts (see ¶2, ¶3 and ¶4 below) in the same manner except where the differences among the plans covered by the various subparts require modified definitions. All of these definitions are found, in alphabetical order, in PBGC Reg. §4050.102. The discussions of definitions in ¶2, ¶3 and ¶4 below focus on the changes to these definitions that are made for purposes of the plans covered by Subparts B, C and D.

(2)(a) Accumulated Single Sum. This is the missing distributee's Benefit Transfer Amount (see (2)(b) below), accumulated at the Missing Participants Interest Rate (see (2)(f) below) from the Benefit Determination Date (see (2)(c) below) to the date when PBGC makes or commences payment to or with respect to the distributee.

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(2)(b) Benefit Transfer Amount. This amount is determined as of the Benefit Determination Date (see (2)(c) below) using one of the methods described in (2)(b)(i) through (2)(b)(iii) below, whichever applies. See PBGC Reg. §4050.103(d).

(2)(b)(i) *De minimis* amounts. If the single sum actuarial equivalent of the distributee's benefits (including any payments missed in the past) determined using Plan Lump Sum Assumptions is *de minimis*, then the missing distributee's Benefit Transfer Amount is equal to that single sum. *De minimis* means that the value does not exceed the amount specified under ERISA §203(e)(1) and ERISA §411(a)(11)(A), *without regard to plan provisions*. This definition applies for all purposes of the missing participant program. Since the definition of *de minimis* is determined without regard to plan provisions, and ERISA §203(e)(4) and IRC §411(a)(11)(D) allow for the portion of the benefit attributable to a rollover to be disregarded in determining whether a participant's accrued benefit is within the $5,000 limit only if the plan so provides, the rollover-derived benefit must be taken into consideration to determine if the missing distributee's single-sum benefit is *de minimis* (assuming the rollover is part of the DB benefit, as discussed in (1)(b)(i) above). For example, if the benefit without regard to the rollover is under $5,000, but with the rollover-derived benefit taken into account is over $5,000, the distributee's benefit is not *de minimis*.

(2)(b)(ii) Non-*de-minimis*; single-sum payment *cannot* be elected. If (2)(b)(i) does not apply, and a single-sum payment cannot be elected, then the missing distributee's Benefit Transfer Amount is the present value of the distributee's accrued benefit using PBGC Missing Participant Assumptions (see (2)(h) below), plus the amounts (if applicable) described in (2)(b)(ii)(A) or (2)(b)(ii)(B) below (which account for payments that were due but not paid or which would have been payable had benefits commenced timely).

(2)(b)(ii)(A) Additional amount for missing distributees *not* in pay status. For a missing distributee not in pay status an additional amount is paid only if the Normal Retirement Date (or Accrual Cessation Date, if later) precedes the Benefit Determination Date. The Normal Retirement Date is determined in accordance with the terms of the plan, and the Accrual Cessation Date is the date the participant stopped accruing benefits under the terms of the plan. The additional amount is the aggregate value of payments of the straight life annuity that would have been payable beginning on the Normal Retirement Date (or Accrual Cessation Date, if later), accumulated at the Missing Participants Interest Rate from the date each payment would have been made to the Benefit Determination Date, assuming that the distributee survived to the Benefit Determination Date.

(2)(b)(ii)(B) Additional amount for missing distributees *in* pay status. For a missing distributee in pay status, the additional amount is the aggregate value of payments of the pay status annuity due but not made, accumulated at the Missing Participants Interest Rate from each payment due date to the Benefit Determination Date, assuming that the distributee survived to the Benefit Determination Date.

(2)(b)(iii) Non-*de-minimis;* single payment *can* be elected. If (2)(b)(i) does not apply, and a single sum payment can be elected, then the missing distributee's Benefit Transfer Amount is the greater of: (1) the single sum actuarial equivalent of the distributee's benefits (including

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any payments missed in the past) determined <u>using Plan Lump Sum Assumptions</u>, or (2) the amount determined under (2)(b)(ii) above.

(2)(b)(iv) <u>Grace period for transferring benefit amount</u>. The Benefit Transfer Amount described above will not change after the Benefit Determination Date, <u>even if it is paid to the PBGC on a later date</u>. However, when the amount is actually transferred to the PBGC, an interest charge is applied if the transfer occurs <u>more than 90 days from the Benefit Determination Date</u>. See (5)(a) below.

(2)(b)(v) <u>Auto-rollovers *before* the termination date</u>. *De minimis* amounts that are automatically rolled over to an IRA, pursuant to IRC §401(a)(31), are <u>not</u> taken into account because those benefits have been distributed before the termination of the plan. The participant for whose benefit the rollover was made is <u>not</u> a distributee under the missing participant program because the participant at the time of the close-out of the plan has already received the benefit in the form of the rollover. The PBGC notes in the preamble (82 F.R. 60805), however, that distributions made just before the formal commencement of termination proceedings in a form that <u>would be improper for a transfer upon plan termination</u> deserve particular scrutiny. If such a distribution were found to be in violation of Title IV, the appropriate remedy might be to reverse it.

***Auto-rollovers should not be made after termination date.* The PBGC's statements suggest that, once the termination date is established with respect to a Title IV plan, a missing distributee's benefit should <u>not</u> be auto-rolled to an IRA. Instead, it should be transferred to the PBGC in accordance with these procedures.**

(2)(c) <u>Benefit Determination Date</u>. This is the <u>single</u> date <u>selected by the plan administrator</u> for determining the Benefit Transfer Amounts under PBGC Reg. §4050.103(d) (as described in (2)(b) above). The date must fall within the period that begins on <u>the first day a distribution is made</u> pursuant to close-out of the plan to a distributee who is <u>not</u> a missing distributee, and ends on the <u>last day such a distribution is made</u>. The "close-out" of the plan is the process of the final distribution or transfer of assets pursuant to the termination of the plan. This definition provides the plan more flexibility for determining benefits of missing distributees, which, under the proposed version based the valuation on the date of the transfer of the benefit to the PBGC, determined separately for each missing distributee.

***Compare to prior regulations.* This definition replaces the <u>Deemed distribution date</u> definition in PBGC Reg. §4050.2 (in effect for pre-2018 close-outs), which describes this date with reference to the timeline for distribution of benefits under a standard termination under ERISA §4041. By adopting the Benefit Distribution Date definition, a uniform definition applies to all plans that are subject to the missing participants program (i.e., plans described in ¶2, ¶3 and ¶4 below, as well).**

(2)(d) <u>Missing</u>. A distributee is missing if any <u>one</u> of the following three conditions exists upon close-out of the plan: (1) the <u>plan administrator does not know *with reasonable certainty* the location of the distributee</u>, (2) <u>under the terms of the plan</u>, the benefit is to be paid in a lump sum <u>without the distributee's consent</u> (e.g., a benefit payable under the plan's mandatory cash-out rules) and the distributee <u>has not responded to a notice</u> about the distribution of the lump sum, or (3) the benefit is payable in lump sum pursuant to <u>the terms of the plan *or* an election by the distributee *and* the distributee does not accept the payment</u>. Condition (3) is intended to cover situations where there is an outstanding uncashed check, even though the distributee's

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whereabouts are known and even if the distributee affirmatively elected to receive the lump sum payment. In order to treat an uncashed check as not accepted by the distributee, the check must remain uncashed after the "cash-by" date (either on the check itself or in a notice accompanying the check) and that date is at least 45 days after the issuance of the check, or, if there is no "cash-by" date, after the check's "stale date" (as set by the applicable financial institution). Note that, if the benefit is payable in an annuity form, and the whereabouts of the participant are known with reasonable certainty (i.e., the participant is just unresponsive and the benefit is not payable as a lump sum), then none of these three conditions applies, and the plan administrator will have to annuitize the benefit. Through annuitization, the participant's rights and options under the plan are preserved, whereas some of them might be lost if the benefits were to be transferred to the PBGC under the missing participants program.

***Comment on mandatory cash-outs.* Note that the regulations are more liberal than the prior regulations by allowing unresponsive participants receiving mandatory lump-sum cashouts as Missing. Under the prior regulations, such an individual's whereabouts had to be unknown in order to treat him or her as Missing.**

(2)(d)(i)Uncashed checks. With respect to a distributee who is treated as Missing because of an uncashed check, as described in (2)(d) above, the benefit transfer amount is determined in the same way as for any other missing distributee. That means that the transfer amount may not reflect income tax withholding that already might have been withheld. Thus, the amount transferred to the PBGC might be greater than the amount of the uncashed check. The PBGC will then withhold taxes when it pays the benefit. The plan administrator will have to file a request for a refund of the amounts withheld, in accordance with IRS procedures (and State procedures, if applicable). However, the PBGC notes that it has flexibility in this regard if it is not practical to transfer the pre-withholding amount to the PBGC (e.g., in the case of an abandoned plan being administered by a qualified termination administrator (QTA)). See the preamble to the regulations at 82 F.R. 60805 for the discussion of this issue.

(2)(d)(ii) Conditional forfeitures. In the preamble (at page 60805), the PBGC also discusses the status of benefits that might have been forfeited pursuant to Treas. Reg. §1.411(a)-4(b)(6), when benefits became payable to a missing distributee while the plan was an ongoing plan. One of the conditions of such a forfeiture is that the plan provides for reinstatement of the benefit if a claim is made by the participant or beneficiary for the forfeited benefit. The PBGC is of the opinion that this claim for benefits is not lost when a plan terminates. Accordingly, the plan has an obligation to locate the participants whose benefits were subject to this conditional forfeiture. If such an individual is Missing, then the benefits are subject to the missing participant program. For a DB plan described in Subpart A, the plan must either purchase an irrevocable commitment from an insurer that will pay the benefit if the individual is located, or transfer the benefit to the PBGC under the Subpart A procedures. The PBGC assumes a plan will have the necessary records to deal with these individuals because it has an obligation to restore the benefit if a claim is made. If there are defects in the records, the PBGC generally will deal with such defects on a case-by-case basis. However, in the case of an abandoned plan, the PBGC recognizes that the benefit might not be able to be reinstated, and will use its discretion to accommodate such situations.

(2)(e) Missing Participants Forms and Instructions. This is a reference to the forms prescribed by the PBGC for use in connection with the missing participants program. See ¶5 below.

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(2)(f) Missing Participants Interest Rate. This rate, for each month, is the applicable federal mid-term rate (mid-term AFR), as determined pursuant to IRC §1274(d)(1)(C)(ii) for that month, compounded monthly.

> ***Effect on current rule.*** **The Missing Participant Interest Rate replaces the Designated benefit interest rate defined in PBGC Reg. §4050.2 (as in effect for pre-2018 close-outs).**

(2)(g) Pay-status or Pay Status. A distributee is considered to be in pay status if benefits have actually started before the Benefit Determination Date. Similarly, a benefit is considered to be in pay status if the benefit has actually started before the Benefit Determination Date.

(2)(h) PBGC Missing Participant Assumptions. These are the actuarial assumptions prescribed in PBGC Reg. §§4044.51 through 4044.57 (used to determine allocation of assets in an insufficient plan), but with the following modifications: (1) the Benefit Distribution Date is substituted for the plan termination date to determine present value, (2) the mortality assumption is a fixed blend of 50% of the healthy male mortality rates in PBGC Reg. §4044.53(c)(1) and 50% of the healthy female mortality rates in PBGC Reg. §4044.53(c)(2), (3) no adjustment is made for loading expenses under PBGC Reg. §4044.52(d), (4) the interest assumption is the assumption applicable to valuations occurring in January of the calendar year in which the Benefit Determination Date occurs, (5) the assumed payment form of a benefit not in pay status is a straight life annuity, (6) pre-retirement death benefits are disregarded, and (7) notwithstanding the expected normal retirement age (XRA) assumptions in PBGC Reg. §§4044.55-4044.57, benefits are assumed to commence on the following date (whichever applies): (a) on the XRA, determined using the high retirement rate category under Table II-C of Appendix D to part 4044 of the DOL Regulations, in the case of a participant who is not in pay status and whose Normal Retirement Date is on or after the Benefit Determination Date, (b) on the participant's Normal Retirement Date (or Accrual Cessation Date, if later) in the case of a participant who is not in pay status and whose Normal Retirement Date is before the Benefit Determination Date, (c) on the date on which benefits actually commenced, in the case of a participant who is in pay status, or (d) in the case of a beneficiary, the later of the Benefit Determination Date or the earliest date when the beneficiary could begin to receive benefits.

> ***Effect of new rule.*** **The PBGC Missing Participant Assumptions is a modified version of the Missing Participant Annuity Assumptions described in PBGC Reg. §4050.2. Of note is that the prior regulations added a $300 adjustment for expenses, which is eliminated by the revised regulations, because a separate fee is paid to the PBGC for transferring a missing distributee's benefit. The Missing Participant Lump Sum Assumptions in PBGC Reg. §4050.2 also are eliminated.**

(2)(i) Plan Lump Sum Assumptions. If the plan specifies actuarial assumptions and methods to be used to calculate a lump sum, then those assumptions and methods are the Plan Lump Sum Assumptions. If the plan does not so specify, the Plan Lump Sum Assumptions are the actuarial assumptions specified under ERISA §205(g)(3)/IRC §417(e)(3) (also known as the applicable interest rate and mortality table), determined as of the Benefit Determination Date. In this latter case, the Missing Participants Interest Rate (see (2)(f) above) is used to calculate the present value as of the Benefit Determination Date of any payments missed in the past.

(2)(j) Qualified Survivor. A Qualified Survivor under a Subpart A plan is: (1) a person who survives the participant or beneficiary, and is entitled under the provisions of a QDRO to receive the benefit, (2) a person that is identified by the plan in a submission to the PBGC as being entitled

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under applicable plan provisions (including elections, designations, and waivers consistent with such provisions) to receive a benefit, or (3) if no such person is so entitled, the participant's or beneficiary's living heir, identified in the following priority - spouse, child, parent, or sibling. The concept of a Qualified Survivor is new for the missing participant program. Under the prior regulations, death benefits were made either to a beneficiary of the participant (as designated under the plan's procedures) or the participant's estate, pursuant to PBGC Reg. §4050.10. Note that the participant's estate is not a Qualified Survivor under the revised regulations.

(3) Duties of the plan administrator. The plan administrator of a Subpart A Plan must: (1) provide for each missing distributee's benefit (see (3)(a) below), (2) conduct a diligent search with respect to each distributee whose location the plan administrator does not know with *reasonable certainty* upon close-out of the plan (see (4) below), and (3) file information with the PBGC (see (5) below). See PBGC Reg. §4050.103.

(3)(a) Providing for the distributee's benefit. To satisfy the requirements of Subpart A, the plan administrator must, with respect to each distributee who is Missing (as determined under (2)(d) above), either: (1) purchase an irrevocable commitment from an insurer, or (2) transfer to the PBGC an amount equal to the distributee's Benefit Transfer Amount (as described in (2)(b) above). See PBGC Reg. §4050.103(a).

(4) Diligent searches. The requirements for a diligent search differ depending on whether the plan is a DB plan or a DC plan (see ¶2(4) below). For a Subpart A Plan, a diligent search generally means that the plan administrator has employed the commercial locator service method described in (4)(a) below. However, for a distributee whose normal retirement benefit is *not more than $50 per month*, the plan administrator may use either the commercial locator service method or the records search method described in (4)(b) below. See PBGC Reg. §4050.104(a). If distributee is not found under the method used, no further search action is needed to satisfy the diligent search requirement. These same methods apply to Subpart C and Subpart D Plans.

Coordination with DOL standards. **The search requirements are expanded from those that were in PBGC Reg. §4050.4, and reflect some of the guidance provided by the DOL to terminated DC plans in Field Assistance Bulletin (FAB) 2014-01 (e.g., (4)(b)(iv) below and the more expanded identification of employer records in (4)(b)(ii) below). However, if the distributee's monthly normal retirement benefit is more than $50, these search requirements are not applicable because the plan administrator would be using the commercial locator service method to find that distributee.**

Expected information for search purposes**. The DOL expects that plan administrators to the extent possible will search using as much information about a distributee as possible, such as name, social security number, date of birth, and last known address. See the preamble to the regulations (82 F.R. 60807).**

Distributees whose location is known. **The PBGC recognizes that where the distributee's location is known with reasonable certainty, but is nonetheless treated as Missing under the definition in (2)(d) above, there is nothing gained by conducting a diligent search. Thus, the diligent search requirements do not apply to such distributees.**

(4)(a) Commercial locator service method. Under this search method, the plan administrator must search for information to locate the distributee using a commercial locator service. For this purpose, a commercial locator service is a business that holds itself out as a finder of lost persons

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for compensation using information from a database maintained by a consumer reporting agency (as defined in 15 U.S.C. 1681a(f)[3]). See PBGC Reg. §4050.104(b).

(4)(b) Records search method. Under this search method, the plan administrator searches for information to locate the distributee by complying with (4)(b)(i) through (4)(b)(v) below, to the extent reasonably feasible and affordable. See PBGC Reg. §4050.104(c)(1). For this purpose: (1) searching is not feasible if, as a practical matter, it is thwarted by legal or practical lack of access to records, and (2) searching is not affordable if the cost of searching (including the value of labor) is more than a reasonable fraction of the benefit of the distributee being searched for. See PBGC Reg. §4050.104(c)(2). In no event does searching have to be pursued beyond the point that the cost equals the value of the benefit.

(4)(b)(i) Plan records. The plan administrator must search the records of the plan for information to locate the distributee.

(4)(b)(ii) Most recent employer's records. The plan administrator must search the records of the most recent employer that maintained the plan and employed the distributee.

(4)(b)(iii) Other plan records. The plan administrator must search the records of each retirement or welfare plan of the contributing sponsor in which the distributee was a participant for information to locate the distributee.

(4)(b)(iv) Request for information from beneficiaries. The plan administrator must request information to locate the distributee from each beneficiary of the distributee identified from the records referred to in (4)(b)(i) through (4)(b)(iii) above.

(4)(b)(v) Internet search. The plan administrator must use an internet search method for which no fee is charged (e.g., a search engine, a network database, a public record database, such as those for licenses, mortgages, and real estate taxes, or a social media website).

(4)(c) Timeframe for search. The new regulations increase the time period for a diligent search to 9 months (6 months was the period in the prior regulations). See PBGC Reg. §4050.104(d). The 9-month period is measured for the period ending on the date a filing is made (see (5) below) that identifies the distributee as missing.

(5) Filing requirements with the PBGC. The plan administrator must file Form M-100 with the PBGC to report the missing distributees for whom an irrevocable commitment with an insurer has been purchased (Schedule A of the form) and the missing distributees whose benefits being transferred to the PBGC (Schedule B of the form). See PBGC Reg. §4050.105(a). For irrevocable commitments, the plan administrator supplies information about the insurer so that, if the distributee were to come forward to the PBGC, the PBGC could furnish that information. For benefit transfers, the plan

[3] The cited statute defines a consumer reporting agency as a "person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties, and which uses any means or facility of interstate commerce for the purpose of preparing or furnishing consumer reports." Equifax would be an example of a consumer reporting agency.

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administrator identifies the Benefit Transfer Amount for the missing distributee, along with other information required by the form.

(5)(a) Payment to the PBGC. Transmitted with the filing is: (1) the Benefit Transfer Amount for any missing distributee whose benefit has not been made in the irrevocable commitment with an insurer, (2) if the Benefit Transfer Amount is paid more than 90 days after the Benefit Determination Date, interest on such amount for period beginning on the 90th day after the benefit determination date and ending on the date the amount is paid to the PBGC, and (3) the applicable fee (as described in ¶6 below). See PBGC Reg. §4050.105(a).

(5)(b) When to file. The plan administrator must file the form and payments in accordance with the missing participants forms and instructions. See PBGC Reg. §4050.105(b). The initial forms are retaining the filing deadline in the prior regulations, i.e., when the post-distribution date certification is due. However, a different rule applies to plans that are not subject to Title IV, as discussed in ¶2(5) and ¶3(5) below. Payment of a Benefit Transfer Amount is considered timely for purposes of the plan termination rules under ERISA §4041 if they are made timely under these filing rules. A corresponding amendment is made to PBGC Reg. §4041.28 to provide that the distribution deadline for a standard termination is satisfied with respect to a missing distributee if the Benefit Transfer Amount is timely transferred to the PBGC under the Subpart A procedures. See revised PBGC Reg. §4041.28(a)(3).

(5)(b)(i) Place, method and date of filing. The rules under 29 C.F.R. Part 4000 apply to determine where to file (see PBGC Reg. §4000.4), permissible filing methods (subpart A of Part 4000), the date a filing is deemed to be made (see subpart C of Part 4000), and the measurement of filing time periods (see subpart D of Part 4000). See PBGC Reg. §4050.105(c).

(5)(c) PBGC may request supplemental information. Within 30 days after a written request by PBGC (or such other time as may be specified in the request), the plan administrator must file the requested information with the PBGC. See PBGC Reg. §4050.105(d). Although the PBGC generally will rely on the information reported by the plan administrator, it retains the authority to audit or make inquiries of the plan, including about the amount to which a missing distributee may be entitled. See PBGC Reg. §4050.105(e).

(6) Payout rules to missing distributees who later make a valid claim for benefits. Where a missing distributee's benefit has been satisfied through the purchase of an irrevocable commitment from an insurer, the PBGC's involvement with the payment of the benefit is limited to furnishing the information provided by the plan administrator to the distributee or another claimant that may be entitled to payment pursuant to the irrevocable commitment. See PBGC Reg. §4050.106(a)(1). Such information would be obtained from the forms filed with the PBGC, as described in (5) above. For missing distributees whose benefits have been transferred to the PBGC, the PBGC will handle the payout of such benefits, in accordance with the rules discussed below (except as provided in a QDRO), to the distributee or other claimant who makes a valid claim for benefits. See PBGC Reg. §4050.106(a)(2). If the missing distributee is a participant in the plan, the benefits are distributed in accordance with the rules in (6)(a) below. If the participant has died, payments are made in accordance with the rules in (6)(b) below. See ¶7 below regarding a database that is intended to facilitate the matching up of missing distributees with their benefits.

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***Spreadsheet.* PBGC has created an on-line spreadsheet that will calculate the present value of a missing participant's benefit expected to be paid on or after the benefit determination date. After the entry of data, such as eligibility for early and unreduced retirement and benefit amounts, the spreadsheet would do the calculations—including XRA calculations—necessary to determine the present value of benefits. The PBGC developed the spreadsheet to make the new PBGC missing participant assumptions easier to use.**

(6)(a) Distributions to missing participants. *De minimis* benefits (as defined in (2)(b)(i) above) are paid in a lump sum equal to the Accumulated Single Sum (as defined in (2)(a) above). See PBGC Reg. §4050.106(c). Other benefits are paid in accordance with the rules in (6)(a)(i) below. In the case of a contributory plan, the amount paid to the distributee (regardless of whether or not it is *de minimis*) may not be less than the minimum described in (6)(a)(ii) below.

***Comparison to prior regulations.* PBGC Reg. §4050.8 also provided for a lump sum for *de minimis* benefits, but the manner in which the lump sum is calculated is different under the revised regulations.**

(6)(a)(i) Participants with *non-de-minimis* benefits. For participants with benefits that are not *de minimis*, the distribution generally will consist of an annuity (see (6)(a)(i)(A) below), and, in the case of a participant who has passed the Normal Retirement Date (or, if later, the participant's Accrual Cessation Date) at the time the PBGC starts paying the benefit, a single-sum payment for the missed distributions (see (6)(a)(i)(B) below). However, if the Subpart A Plan would have allowed the participant to elect a lump sum, the participant may elect to have the benefit paid as a lump sum, as described in (6)(a)(i)(C) below). See PBGC Reg. §4050.106(d) and (e).

(6)(a)(i)(A) Annuity payout. The annuity paid to the participant will either be a default annuity or, if the participant so elects (with spousal consent, if the participant is married), an optional annuity form that is available under PBGC Reg. §4022.8[4] (not based on what the plan provided), payable no earlier that age 55 (even if the plan might have allowed for an earlier commencement date or might have deferred payments to a later age). See PBGC Reg. §4050.106(d) (unmarried participants) and §4050.106(e) (married participants). Thus, if the missing participant makes a claim before age 55, the PBGC will wait until age 55 before it will make payments. The default annuity paid by the PBGC is a straight life annuity, in the case of an unmarried participant, and a joint and 50% survivor annuity, in the case of a married participant (as determined in (6)(a)(i)(A)(I) below). See PBGC §4050.106(d)(1)(i) and (e)(1)(i), respectively. If the default annuity is a straight life annuity, the monthly annuity generally is the amount that would have been paid by the Subpart A Plan if payments started at the same time they are started by the PBGC. However, if the later of the participant's Normal Retirement Date or Accrual Cessation Date has passed at the time the PBGC starts benefits, then the annuity is deemed to have commenced at the later of those two dates, which will result in an additional payment, as described in (6)(a)(i)(B) below, for the missed payments. If the monthly annuity to be paid is the default joint and 50% survivor annuity for a married participant, or is any optional

[4] The optional annuity forms include a life annuity with a 5-year, 10-year, or 15-year certain, a joint and 50% survivor annuity, a joint and 50% "pop survivor "pop up" annuity (i.e., annuity pops up if the survivor annuitant predeceases the participant), a joint and 75% survivor annuity, or a joint and 100% survivor annuity.

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form of annuity with respect to a married or unmarried participant (other than a straight life annuity), the annuity amount is determined to be the actuarial equivalent of the straight life annuity that would be payable in the case of an unmarried participant, but using the actuarial assumptions in PBGC Reg. §4022.8(c)(7). The PBGC will rely on information reported on the Form M-100 to determine the amount of the straight life annuity that would be payable by the plan, including any early retirement subsidies. For participants who don't start payment at an exact age, the payment is determined through linear interpolation of the payments at the exact ages preceding and following the payment commencement age. See PBGC Reg. §4050.106(d)(1)(i). For example, if a monthly benefit starts at age 55-3/4, the monthly payment would be the sum of 75% of the age 56 amount and 25% of the age 55 amount.

Simpler and more flexible calculation. **The annuity payment rules reflect a combination of plan-specific information (e.g., the amount of the straight life annuity payable) and PBGC-generated rules (e.g., actuarial assumptions, permissible commencement ages, optional forms of annuity) with a view toward making the process simpler and offering more flexibility. The information needed from the plan is reported as part of the transfer procedure with the PBGC (see Form M-100). Plan features that the PBGC has chosen not to preserve in the payment of benefits to missing participants include annuity conversion factors, eligibility for *pre-retirement* death benefits, and earliest retirement age under the plan. The calculation of the annuity is not linked to the Benefit Transfer Amount (as described in (2)(b) above) that was paid to the PBGC by the plan administrator. For payment of benefits under the prior regulations, with respect to plan terminations before January 1, 2018, see PBGC Reg. §§4050.7-4050.9.**

No special rules for participants that were in pay status. **The revised regulations do not provide any special rules with respect to a missing participant who might have been in pay status before they went missing. The PBGC considers these circumstances sufficiently uncommon not to address them specifically. This is true also of the corresponding rules under Subparts B, C and D, as described in ¶2(6), ¶3 and ¶4, respectively.**

(6)(a)(i)(A)(I) Determination of marital status. Whether a person is married, and if so the identity of the spouse, would be determined as of the earlier of: (1) the date the person receives or begins to receive a benefit, or (2) the date the person dies. See PBGC Reg. §4050.106(l).

(6)(a)(i)(B) Make-up amount. If the PBGC begins to pay the annuity after the participant's Normal Retirement Date (or Accrual Cessation Date, if later), a make-up amount is paid in a single-sum. The make-up amount equals the aggregate value of payments of the annuity described in (6)(a)(i)(A) above that would have been payable to the participant (in the elected form) beginning on the Normal Retirement Date (or Accrual Cessation Date, if later), accumulated at the Missing Participants Interest Rate (see (2)(f) above) from the date each payment would have been made to the date when PBGC begins to pay the annuity. See PBGC Reg. §4050.106(d)(2) (unmarried participants) and (e)(2) (married participants). This calculation is made by the PBGC for purposes of determining its liability to the participant. This is not necessarily the same amount that is transferred to the PBGC by the plan administrator, as described in the Benefit Transfer Amount definition in (2)(b).

(6)(a)(i)(C) Lump sum option. If the PBGC will pay the benefit in a lump sum, the amount of the payment is equal to the Accumulated Single Sum (as described in (2)(a)

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above). See PBGC Reg. §4050.106(d)(3) (unmarried participants) and (e)(3) (married participants). However, a lump sum is not available unless the Subpart A plan would have permitted it, and, in the case of a married participant, spousal consent is obtained. If a lump sum is paid, it is in lieu of the annuity payment and make-up amount (if any) that would have otherwise been payable under (6)(a)(i)(A) and (6)(a)(i)(B) above. Unlike the annuity payout described in (6)(a)(i)(A) above, which may not commence before age 55, the lump sum may be paid at any age.

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(6)(a)(ii) Minimum payment under a contributory plan. If the Subpart A Plan has reported to the PBGC that a portion of a missing participant's Benefit Transfer Amount represents accumulated contributions as described in ERISA §204(c)(2)(C)/IRC §411(c)(2)(C), the PBGC will pay to the missing participant at least the amount of accumulated contributions as reported by the Subpart A Plan, accumulated at the Missing Participants Interest Rate from the Benefit Transfer Date to the date when PBGC makes payment. See PBGC Reg. §4050.106(k).

(6)(b) Death benefits. If a missing participant dies without receiving any benefits from the PBGC (i.e., the participant was not in pay status), the PBGC will pay a death benefit under the missing participant program. See PBGC Reg. §4050.106(f). [If the missing participant started payments before death, any death benefit payable will be based on the form of payment that had started to the missing participant.] If the benefit is *de minimis* (as defined in (2)(b)(i) above), the death benefit is a lump sum equal to the Accumulated Single Sum (as defined in (2)(a) above). See PBGC Reg. §4050.106(g). For non-*de-minimis* benefits, the method of payment will depend on whether the participant is married, as described in (6)(b)(i) (unmarried) and (6)(b)(ii) (married) below. Whether a person is married, and if so the identity of the spouse, is determined under the same rule described in (6)(a)(i)(A)(I) above. If the Subpart A Plan is a contributory plan, a minimum amount is paid. See (6)(b)(iii) below.

Missing beneficiary. **The rules below do not address the payout of benefits with respect to missing beneficiaries (e.g., a missing alternate payee under a QDRO, or a situation where the plan knows a participant is dead and has a beneficiary, but the beneficiary is missing.) The DOL considers these circumstances sufficiently uncommon not to address them specifically. This is true also of the corresponding rules under Subparts B, C and D.**

(6)(b)(i) Unmarried participants. For a non-*de-minimis* benefit, if the participant died before the Normal Retirement Date (or the Accrual Cessation Date, if later), no death benefit is paid by the PBGC. See PBGC Reg. §4050.106(h)(1). If death occurred on or after such date, then a death benefit is paid to the participant's Qualified Survivor(s) (see (2)(j) above), pursuant to PBGC Reg. §4050.106(h)(2). The death benefit equals the aggregate value of payments of the straight life annuity (as described in (6)(a)(i)(A) above) that would have been payable to the participant from the later of Normal Retirement Age or the Accrual Cessation Date to the participant's date of death. That amount is accumulated at the Missing Participants Interest Rate from the date each payment would have been made to the date when PBGC pays the Qualified Survivors. If there is more than Qualified Survivor (e.g., there is no living spouse, but more than one living child), the payment is divided equally.

(6)(b)(ii) Married participants. For a non-*de-minimis* benefit, if the spouse survives the participant and claims a benefit under the missing participants program, the spouse will receive the annuity described in (6)(b)(ii)(A) below and, if any, the make-up amounts described in (6)(b)(ii)(B) below, unless the small benefit lump sum described in (6)(b)(ii)(C) below is paid. See PBGC Reg. §4050.106(i). Also see (6)(b)(ii)(D) below if the spouse survives the participant, but dies before receiving a benefit under the missing participants program.

(6)(b)(ii)(A) Annuity. The annuity amount payable to the surviving spouse is the survivor portion of a joint and 50% survivor annuity that is actuarially equivalent (under

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the actuarial assumptions in PBGC Reg. §4022.8(c)(7)[5]) to the straight life annuity that the Subpart A Plan would have paid the participant, starting on the assumed starting date. The "assumed starting date" is: (1) the date the participant would have reached age 55 if the participant died before that date, (2) the date of death, if the participant died between age 55 and the Normal Retirement Date (or Accrual Cessation Date, if later), or (3) the Normal Retirement Date (or Accrual Cessation Date, if later), if the participant died after that date. See PBGC Reg. §4050.106(i)(1).

(6)(b)(ii)(B) Make-up amounts. The make-up amounts are the amounts described in (6)(b)(ii)(B)(I) and (6)(b)(ii)(B)(II) below, as applicable. See PBGC Reg. §4050.106(i)(2). If the participant dies before the Normal Retirement Date (or Accrual Cessation Date, if later), the amount in (6)(b)(ii)(B)(II) below will be zero, but there may be a make-up amount under (6)(b)(ii)(B)(I) below. If the participant dies before age 55, the amounts in both (6)(b)(ii)(B)(I) and (6)(b)(ii)(B)(II) below will be zero and no make-up amount will be paid.

(6)(b)(ii)(B)(I) Missed survivor annuity payments. This portion of the make-up amount is the aggregate value of the survivor annuity payments that would have been paid to the spouse under the survivor portion of the joint and 50% survivor annuity, beginning on the later of the participant's date of death or the date when the participant would have reached age 55, accumulated at the Missing Participants Interest Rate from the date each payment would have been made to the date when PBGC pays the spouse. See PBGC Reg. §4050.106(i)(2)(i).

(6)(b)(ii)(B)(II) Missed post-NRD payments. This portion of the make-up amount relates to the annuity payments that would have been made to the participant under the joint portion of the joint and 50% survivor annuity, from the Normal Retirement Date (or Accrual Cessation Date, if later) to the participant's date of death, accumulated at the Missing Participants Interest Rate from the date each payment would have been made to the date when PBGC pays the spouse. See PBGC Reg. §4050.106(i)(2)(ii).

(6)(b)(ii)(C) Lump sum payment of small benefits. If the sum of the actuarial present value of the annuity described in (6)(b)(ii)(A) above plus the make-up amounts described in (6)(b)(ii)(B) above is *de minimis* (as defined in (2)(b)(i) above), then the PBGC will pay the spouse a lump sum in an amount equal to that sum. For this purpose, the actuarial present value of the annuity is determined under the actuarial assumptions described in (6)(b)(ii)(A) above as of the date when the PBGC pays the spouse. See PBGC Reg. §4050.106(i)(3). No lump sum is available to a spouse who is entitled to a greater benefit (i.e., the annuity described in (6)(b)(ii)(A) plus any make-up amount described in (6)(b)(ii)(B) is paid instead), even if the plan might have permitted a lump sum.

[5] These assumptions currently are: (1) 6% interest rate, and (2) unisex mortality rates that are a fixed blend of 50% of the male mortality rates and 50% of the female mortality rates from the 1983 Group Annuity Mortality Table as prescribed in Rev. Rul. 95-6.

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(6)(b)(ii)(D)Suppose the spouse does not survive to time benefits commence? If, with respect to a non-*de-minimis* benefit, the spouse survives the participant, but dies before receiving a benefit under the missing participants program, the PBGC pays: (1) a make-up amount to the Qualified Survivor(s) of the spouse (see (6)(b)(ii)(D)(I) below), and (2) a make-up amount to the Qualified Survivor(s) of the participant (see (6)(b)(ii)(D)(II) below). See PBGC Reg. §4050.106(j). If the spouse dies before the participant would have reached age 55, there is no amount paid under (6)(b)(ii)(D)(I) below to the spouse's Qualified Survivor(s). If the participant died before the Normal Retirement Date, there is no amount paid under (6)(b)(ii)(D)(II) below to the participant's Qualified Survivor(s).

(6)(b)(ii)(D)(I) Amount paid to Qualified Survivor(s) of the spouse. This amount is a lump sum equal to the aggregate value of payments of the survivor portion of the joint and 50% survivor annuity described in (6)(b)(i)(A) above that would have been payable to the spouse from the participant's date of death (or the date when the participant would have reached age 55, if later) to the spouse's date of death, accumulated at the Missing Participants Interest Rate from the date each payment would have been made to the date when PBGC pays the spouse's Qualified Survivor(s). See PBGC Reg. §4050.106(j)(1). This amount parallels the make-up amount described in (6)(b)(ii)(B)(I) above that would have been paid to the spouse had the spouse survived to the benefit commencement date.

(6)(b)(ii)(D)(II) Amount paid to Qualified Survivor(s) of the participant. This amount is a lump sum equal to the aggregate value of payments of the joint portion of the joint and 50% survivor annuity described in (6)(b)(i)(A) above that would have been payable to the participant from the Normal Retirement Date (or the Accrual Cessation Date, if later) to the participant's date of death, accumulated at the Missing Participants Interest Rate from the date each payment would have been made to the date when PBGC pays the spouse's Qualified Survivor(s). See PBGC Reg. §4050.106(j)(2). This amount parallels the make-up amount described in (6)(b)(ii)(B)(II) above that would have been paid to the spouse had the spouse survived to the benefit commencement date.

(6)(b)(iii) Minimum payment under a contributory plan. If the Subpart A Plan has reported to the PBGC that a portion of a missing participant's Benefit Transfer Amount represents accumulated contributions, as described in ERISA §204(c)(2)(C)/IRC §411(c)(2)(C), PBGC will pay to the missing participant's spouse (or, if (6)(b)(ii)(D) applies, the participant's Qualified Survivor(s)) at least the amount of accumulated contributions as reported by the Subpart A Plan, accumulated at the Missing Participants Interest Rate from the Benefit Determination Date to the date when PBGC makes payment. See PBGC Reg. §4050.106(k).

(6)(c) Table summarizing the payout rules under a Subpart A plan. The table below summarizes the payout rules under (6)(a) and (6)(b) above.

Circumstances	Payout rule under proposal
Payments to living participants under missing participants program	
Living participant with *de minimis* benefit	PBGC pays participant a lump sum
Living participant with a benefit that is	PBGC pays participant an annuity in form elected by participant

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not *de minimis*; no living spouse	(default is straight life annuity) or, if plan so provided and participant so elects, a lump sum.
Living participant with benefit that is not *de minimis* benefit; living spouse	PBGC pays participant a joint and 50% survivor annuity (or at participant's election with spousal consent, another form of annuity) or, if plan so provided and participant so elects with spousal consent, a lump sum.
Payments with respect to deceased participants under missing participants program	
Deceased participant with *de minimis* benefit (married or unmarried)	PBGC pays Qualified Survivor(s) a lump sum equal to the participant's Accumulated Single Sum
Deceased participant; non-*de-minimis* benefit; no surviving spouse	If participant dies before the Normal Retirement Date (or Accrual Cessation Date, if later), PBGC pays no benefit; if participant died after such date, PBGC pays Qualified Survivor(s) accumulated amount of the missed payments from such date, with interest.
Deceased participant; non-*de minimis* benefit; living spouse	PBGC pays spouse survivor portion of joint and 50% survivor annuity (including missed payments); except that if actuarial value of the annuity and the make-up amount is small (i.e., less than $5,000), PBGC pays spouse a lump sum.
Deceased participant; non-*de-minimis* benefit; deceased surviving spouse	PBGC pays: (1) Qualified Survivor(s) of participant an amount equal to J&S payments that would have been made after Normal Retirement Date (or Accrual Cessation Date, if later) to participant's death, and (2) Qualified Survivor(s) of the spouse the missed payments under the 50% survivor annuity that would have been made from the date of the participant's death (or when the participant would have reached age 55, if later) to the spouse's date of death.

¶2. Optional missing participants program for terminated defined contribution plans (Subpart B Plans).

PBGC Reg. §§4050.201-4050.207 governs the procedures for Subpart B Plans, as defined in (1) below. Subpart B plans are not subject to Title IV of ERISA and, thus, are not required to follow these procedures. However, the plan administrator may elect to participate in the program in accordance with the rules discussed below.

(1) Definition of Subpart B Plans. A Subpart B Plan is: (1) an individual account plan (including multiemployer defined contribution plans), as described in ERISA §3(34), or the portion of a defined benefit plan that is treated as a defined contribution, pursuant to ERISA §3(35) (e.g., after-tax voluntary employee contribution account), (2) that is either covered by Title I of ERISA or is a qualified plan under IRC §401(a), including a section 403(b) plan that provides benefits through a custodial account, as described in IRC §403(b)(7), (3) that, if it is a Transferring Plan (see (2) below), pays all Benefit Transfer Amounts to PBGC, and (4) terminates and closes out. See PBGC Reg. §4050.201(a) and (b). A Subpart B Plan may be an abandoned plan, as defined in DOL Reg. §2578.1. Thus, a qualified plan termination administrator (QTA) of an abandoned plan is able to dispose of benefits through this program.

***Governmental plans and nonelecting church plans not eligible.* PBGC Reg. §4050.201(a)(2) provides that the plan cannot be described in any paragraph of ERISA §4021(b) other than paragraph (1), (5), (12) or (13). This means that a defined contribution plan that is governmental plan (ERISA §4021(b)(2)) or a church plan that has not elected to be subject to Title I of ERISA (ERISA**

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§4021(b)(3)) may not qualify as a Subpart B Plan and, thus, may not elect to use the PBGC's missing participants program.

(2) Definitions. The following definitions are used in the Subpart B procedures. There are significant differences in the definitions used in Subpart B as compared to the Subpart A because of the inherent differences between defined contribution plans and defined benefit plans. All of these definitions are found, in alphabetical order, in PBGC Reg. §4050.202.

(2)(a) Accumulated Single Sum. This is the missing distributee's Benefit Transfer Amount (see (2)(c) below), accumulated at the Missing Participants Interest Rate (see (2)(f) below) from the date the plan pays the PBGC the Benefit Transfer Amount to the date when PBGC makes or commences payment to or with respect to the distributee.

(2)(b) Benefit Conversion Assumptions. To convert the account into an annuity, the PBGC will use the applicable mortality table and applicable interest rate under ERISA §205(g)(3)/IRC 417(e)(3) for January of the calendar year in which the PBGC begins paying the annuity.

(2)(c) Benefit Transfer Amount. This is the amount in a Transferring Plan that is available for distribution to the distributee in connection with the close-out of the Subpart B Plan. For a missing distributee who was a participant, the Benefit Transfer Amount would generally be the participant's account balance, but might not be if (for example) a qualified domestic relations order (QDRO) required distribution of a portion of the account to another person. This is a much simpler definition than the one for Subpart A Plans because, under a defined contribution plan, the benefit payable is the account balance of the participant (less any amount that is awarded to an alternate payee under a QDRO). The PBGC defers to the plan and applicable law as to what administrative expenses might be charged against the account to arrive at the Benefit Transfer Amount. Such administrative expenses might include, for example, the cost of conducting a diligent search or the cost of paying the PBGC fees for participating in the missing participants program (see ¶ 6 below). The PBGC will not inquire into whether an account balance has been reduced for administrative expenses before it was transferred to the PBGC.

(2)(d) *De minimis*. See the definition in ¶1(2)(b)(i) above.

(2)(e) Missing. See the definition in ¶1(2)(d) above. In a departure from the proposed version of these regulations, the PBGC decided to adopt a uniform definition of Missing for DB and DC plans.

(2)(f) Missing Participants Interest Rate. See the definition ¶1(2)(f) above.

(2)(g) Qualified Survivor. See the definition in ¶1(2)(j) above.

(3) Options and duties of the plan administrator. If the plan administrator elects to close out a Subpart B Plan, it will elect whether to be a transferring plan (i.e., will transfer benefits of missing distributee to the PBGC), or a notifying plan (i.e., will notify the PBGC of benefits of missing distributees transferred to a financial institution). An electing plan administrator must: (1) notify the PBGC of whether it elects to be a transferring plan or a notifying plan (see (3)(a) below), (2) conduct a

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diligent search (see (3)(b) below), and (3) file information with the PBGC (see (5) below). See PBGC Reg. §4050.203.

(3)(a) Election/transfer of benefits. The plan administrator will make its election of transferring plan or notifying plan status on the applicable PBGC forms (see Form M-200), and the instructions to such forms. See PBGC Reg. §4050.203(a). If the administrator elects transferring plan status, then the Benefit Transfer Amount for all distributees who are Missing must be transferred to the PBGC (i.e., the plan administrator can't cherry-pick which ones are transferred). Information about the transferred benefits will be reported on the Form M-200. If the administrator elects notifying status, the plan administrator will notify the PBGC of the disposition of the benefits of each missing distributee identified in the Form M-200. Note that a notifying plan is not required to provide information on all missing distributees (i.e., the anti-cherry-picking rule applicable to transferring plans doesn't apply). For any distributee reported by a notifying plan, the plan must provide identifying information about distributee and the financial institution to which the account was transferred (e.g., IRA provider). Although participation in Subpart B will be voluntary, the plan administrator of a Subpart B Plan must agree to be bound by the provisions of Subpart B that apply to transferring plans or to notifying plans, as the case may be.

(3)(b) Diligent search. The plan administrator must have conducted a diligent search, in accordance with the rules discussed in (4) below: (1) with respect to each distributee who is Missing upon close-out of the plan, if the plan is a transferring plan, or (2) with respect to each distributee to whom an election to be a notifying plan applies. See PBGC Reg. §§4050.203(b) and 4050.204(a). A search is required only with respect to such distributees whose location is not known to the plan administrator with reasonable certainty. However, if the whereabouts of the distributee are known, no diligent search is required.

(4) Diligent searches. The diligent search requirements for Subpart B plans are governed by DOL guidance under ERISA §404. See PBGC Reg. §4050.204(a). The latest guidance on searching for missing distributees under terminated defined contribution plans is provided in Field Assistance Bulletin 2014-01. The diligent search requirements for Subparts A, C and D plans, which are defined benefit plans, are not explicitly subject to the DOL's guidance, so the diligent search requirements for those plans are written in the regulations (although the PBGC constructed the requirements under the records search method by taking into consideration the FAB 2014-01 guidance). The diligent search must be conducted within 9 months before a filing is made to the PBGC, as described in (5) below, identifying the distributee as a missing distributee.

***Deceased participant who has no known beneficiary.* In the preamble to the regulations (82 F.R. 60806), the PBGC notes that if a deceased participant in a DC plan has no known beneficiary, the unknown beneficiary is treated as a distributee under the missing participant program. PBGC will take into account the fact that there is no known person to search for in evaluating the plan's fulfillment of the diligent search requirement for any such distributee.**

(5) Filing requirements with the PBGC. The plan administrator must file Form M-200 with the PBGC to report the missing distributees for whom benefits have been transferred to a financial institution, in the case of a notifying plan, and the missing distributees whose benefits have been transferred to the PBGC, in the case of a transferring plan. See PBGC Reg. §4050.205(a). The plan must file the information and make payments to the PBGC (including the timing of the filing) in accordance with the instructions on the form. The requirements in PBGC Reg. §4050.205(b)-(d) parallel the rules in ¶1(5) above regarding PBGC filings, including the application of the PBGC

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regulations regarding the place, method and date of filing, and the PBGC's right to request additional information. PBGC will rely on the determination made and the information reported by the plan administrator to the PBGC. See PBGC Reg. §4050.205(e).

(6) Payout rules. If a notifying plan files information with the PBGC about a disposition of benefits to a financial institution, the PBGC's involvement is limited to furnishing the information provided by the plan administrator to the distributee or another claimant that may be entitled to payment of the benefit. See PBGC Reg. §4050.206(a)(1). Such information would be obtained from the forms filed with the PBGC, as described in (5) above. For a transferring plan, the PBGC will handle the payout of the missing distributees whose benefits have been transferred to the PBGC, in accordance with the rules discussed below (except as provided in a QDRO), upon the filing of a valid claim by a missing distributee. See PBGC Reg. §4050.206(a)(2). If the missing distributee is a participant in the plan, benefits are distributed in accordance with the rules in (6)(a) below. If the participant has died, payments are made in accordance with the rules in (6)(b) below.

***Deceased participant who has no known beneficiary.* In the preamble to the regulations (82 F.R. 60806), the PBGC notes that if a deceased participant has no known beneficiary, the unknown beneficiary is treated as a distributee under the missing participant program. Accordingly, the account in the DC plan will be transferred to the PBGC if the plan is a transferring plan.**

(6)(a) Distributions to missing participants. *De minimis* benefits (as defined in (2)(b) above) are paid in a lump sum equal to the Accumulated Single Sum (as defined in (2)(a) above). See PBGC Reg. §4050.206(c). For participants with benefits that exceed the *de minimis* threshold, the distribution generally would consist of an annuity (see (6)(a)(i) below). However, the participant may elect to have the benefit paid as a lump sum, as described in (6)(a)(ii) below. See PBGC Reg. §4050.206(d) and (e).

(6)(a)(i) Annuity payout of non-*de-minimis* benefits. For an unmarried participant, the annuity is paid in any form available under PBGC Reg. §4022.8 (not based on what the plan provided), as elected by the participant, commencing no earlier that age 55 (even if the plan might have allowed for an earlier commencement date or might have deferred payments to a later age). See PBGC Reg. §4050.206(d). For a married participants, the default annuity is a joint and 50% survivor annuity, but any optional form of annuity available under PBGC Reg. §4022.8 may be elected by the participant (if the spouse consents), commencing no earlier than age 55. See PBGC §4050.206(e)(1). The amount of the annuity is the actuarial equivalent of the participant's Accumulated Single Sum (see (2)(a) above), using the Benefit Conversion Assumptions (see (2)(b) above).

***Application of QJSA under the plan's terms is irrelevant.* The payout rules are applied as if the plan was subject to the QJSA rules with respect to the transferred benefit, even if the Subpart B Plan was exempt from the QJSA requirements. This is why spousal consent is required for an optional form of annuity or for the lump sum payment described in (6)(a)(ii) below.**

(6)(a)(i)(A) Determination of marital status. Whether a person is married, and if so the identity of the spouse, would be determined as of the earlier of: (1) the date the person receives or begins to receive a benefit, or (2) the date the person dies. See PBGC Reg. §4050.206(j).

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(6)(a)(ii) Lump sum option. If a lump sum is elected (with spousal consent, in the case of a married participant), the payout equals the Accumulated Single Sum, as defined in (2)(a) above. See PBGC Reg. §4050.106(d)(2) (unmarried participants) and (e)(2) (married participants).

Broader lump sum option than for Subpart A Plans. **Recognizing typical differences between DB and DC plans, the regulations allow a lump sum to be paid regardless of the size of the benefit and regardless of the actual terms of the plan. For DB plans (see ¶1(6) above), lump sums are paid only for *de minimis* benefits or if the plan allowed for lump sum.**

(6)(b) Death benefits. If the Benefit Transfer Amount with respect to the deceased participant is *de minimis* (as defined in (2)(d) above), the benefit is paid in a lump sum equal to the participant's Accumulated Single Sum. See PBGC Reg. §4050.206(g). This applies regardless of whether the Qualified Survivor is a spouse or a non-spouse beneficiary. For benefits that are not *de minimis*, the death benefit payment rules are described in (6)(b)(i) (unmarried participants) and (6)(b)(ii) (married participants) below. Whether a person is married, and if so the identity of the spouse, is determined under the same rule described in (6)(a)(i)(A) above.

Death benefit rules apply only if missing participant was not in pay status at death. **The rules below apply when the missing participant dies before benefits are paid. If the missing participant comes forward and is paid benefits under (6)(a) above, then there either will be no death benefit (i.e., lump sum was paid or a straight life annuity commenced) or the death benefit will be based on the annuity form that had commenced to the participant (i.e., survivor annuity or remaining term certain, as the case may be).**

(6)(b)(i) Non-*de-minimis* benefit: non-spouse Qualified Survivor. If the participant's Qualified Survivor is not the participant's surviving spouse, and claims a benefit under the missing participant program, the PBGC will pay the claimant the participant's Accumulated Single Sum, just as it would with a *de minimis* benefit. See PBGC Reg. §4050.106(h). This is true regardless of whether the participant was married (assuming, in the case of a married participant, that a non-spouse beneficiary is a proper claimant).

(6)(b)(ii) Non-*de-minimis benefit*: surviving spouse is Qualified Survivor. If the surviving spouse of a married participant claims a benefit under the missing participants program, the PBGC will pay the spouse an annuity (see (6)(b)(ii)(A) below) or a lump sum (see (6)(b)(ii)(B) below), as elected by the spouse. See PBGC Reg. §4050.206(i).

(6)(b)(ii)(A) Annuity. The annuity amount is a straight life annuity for the life of the spouse, commencing no earlier than when the participant would have reached age 55, in an amount that is actuarially equivalent to the participant's Accumulated Single Sum, using the Benefit Conversion Assumptions. See PBGC Reg. §4050.206(i)(1).

(6)(b)(ii)(B) Lump sum option. If the spouse elects a lump sum, the payout equals the participant's Accumulated Single Sum. See PBGC Reg. §4050.206(i)(2).

(6)(c) Table summarizing the payout rules. The table below summarizes the payout rules under (6)(a) and (6)(b) above. Note that the table is different from the one in ¶1(6)(c) above that applies to defined benefit plans.

Circumstances	Payout rule under proposal

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Payments to living participants under missing participants program	
Living participant with *de minimis* benefit	PBGC pays participant a lump sum
Living participant with a benefit that is not *de minimis*; no living spouse	PBGC pays participant an annuity in form elected by participant or, if the participant so elects, a lump sum.
Living participant with benefit that is not *de minimis* benefit; living spouse	PBGC pays participant a joint and 50% survivor annuity (or at participant's election with spousal consent, another form of annuity) or, if the participant so elects with spousal consent, a lump sum.
Payments with respect to deceased participants under missing participants program	
Deceased participant with *de minimis* benefit	PBGC pays Qualified Survivor(s) a lump sum.
Deceased participant with benefit that is not *de minimis* and Qualified Survivor is not the participant's surviving spouse	PBGC pays Qualified Survivor(s) a lump sum.
Deceased participant with benefit that is	PBGC pays spouse a straight life annuity or, if the spouse elects, a

¶3. Optional missing participants program for terminated defined benefit plans that are *not* covered by Title IV (Subpart C Plans).

PBGC Reg. §§4050.301-4050.307 govern the procedures for Subpart C Plans, as defined in (1) below. Since these plans are not covered by Title IV, the elective approach for participating in the missing participants program applies, along the lines of the rules applicable to Subpart B Plans. However, since Subpart C Plans are defined benefit plans, the calculating of benefit transfers and the payout rules applicable to those transferred benefits parallel the rules for Subpart A Plans.

(1) Definition of Subpart C Plans/governmental and "non-electing" church plans not eligible. Subpart C Plans are terminated defined benefit plans (other than multiemployer plans) that are not covered by Title IV of ERISA solely because they fall under the exception in ERISA §4021(b)(13) (plans maintained by professional service employers that have never had more than 25 active participants). See PBGC Reg. §4050.301(a). Note that there are other defined benefit plans that are exempt from Title IV, pursuant to ERISA §4021(b), that are not eligible for the missing participants program. For example, a governmental plan or a "non-electing" church plan (i.e., a church plan that has not elected to be covered by ERISA), as described in ERISA §4021(b)(2) and (3), respectively, are not Subpart C Plans and, therefore, are not eligible for the missing participants program.

(1)(a) Only plans that are closing out. A Subpart C Plan is eligible for the missing participants program only if it is closing out, meaning that the plan is in the process of the final distribution of assets. See PBGC Reg. §4050.301(a)(2).

(1)(b) Individual account plans. Subpart C does not apply to individual account plans under ERISA §3(34) (i.e., defined contribution plans). See PBGC Reg. §4050.301(b). For more discussion on what is treated as an individual account plan under a DB plan, see ¶1(b) above. Individual accounts in a Subpart C Plan could be transferred to the PBGC under the Subpart B procedures described in ¶2 above.

(2) Definitions. The following definitions are used in the Subpart C procedures. Since Subpart C plans are defined benefit plans, just like Subpart A Plans, the definitions of Accrual Cessation Date,

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Accumulated Single Sum, Benefit Determination Date, Benefit Transfer Amount, Missing, Missing Participants Interest Rate, Pay Status, PBGC Missing Participant Assumptions, Plan Lump Sum Assumptions, and Qualified Survivor are identical to the corresponding definitions under Subpart A, as described in ¶1(2) above, except substitute "Subpart C Plan" where "Subpart A Plan" appears in the definition. All of these definitions for Subpart C Plans are found, in alphabetical order, in PBGC Reg. §4050.302.

(3) Duties of the plan administrator. The duties of the plan administrator of a Subpart C Plan are similar to those discussed for Subpart B Plans, as described in ¶2(3) above because plans under both subparts are electing to participate in the missing participants program. Accordingly, if the plan administrator elects to close out a Subpart C Plan under the missing participants program, the plan administrator will elect whether to be a transferring plan (i.e., will transfer benefits of missing distributee to the PBGC), or a notifying plan (i.e., will notify the PBGC of benefits of missing distributees transferred to a financial institution). An electing plan administrator must: (1) notify the PBGC of whether it elects to be a transferring plan or a notifying plan (see (3)(a) below), (2) conduct a diligent search (see (3)(b) below), and (3) file information with the PBGC (see (5) below). See PBGC Reg. §4050.303. However, the calculation of benefit transfers, the diligent search requirements, and the payout rules parallel the rules for Subpart A Plans because plans under both Subpart A and Subpart C are defined benefit plans.

(3)(a) Election/transfer of benefits. The plan administrator will make its election of transferring plan or notifying plan status on the applicable PBGC forms (see Form M-300), and the instructions to such forms. See PBGC Reg. §4050.103(a). If the administrator elects transferring plan status, then the Benefit Transfer Amount for all distributees who are Missing must be transferred to the PBGC (i.e., no cherry-picking). If the administrator elects notifying status, it will report only the missing distributees the plan administrator has elected to report under the missing participants program. Thus, as under the rules for Subpart B plans, the administrator of a notifying plan is not required to report information about all missing distributees. For any missing distributee reported the PBGC, the plan will provide the information required by the form instructions. Although participation in Subpart C will be voluntary, the plan administrator of a Subpart C Plan must agree to be bound by the provisions of Subpart C that apply to transferring plans or to notifying plans, as the case may be.

(3)(b) Diligent search. The plan administrator must have conducted a diligent search, in accordance with the rules discussed in (4) below: (1) with respect to each distributee who is Missing upon close-out of the plan, if the plan is a transferring plan, or (2) with respect to each distributee identified in the filing, if the plan is a notifying plan. See PBGC Reg. §4050.303(c). However, if the location of the distributee is known with reasonable certainty, no diligent search is required. See PBGC Reg. §4050.303(b).

(3)(c) Compliance; audits. Even though Subpart C is elective, if the plan elects to participate, compliance with Subpart C is required. Accordingly, the PBGC may audit relevant plan and plan sponsor records if there is reasonable cause to suspect substantial non-compliance and may refer its findings to the appropriate regulator. See PBGC Reg. §4050.303(a).

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(4) Diligent searches. The diligent search requirements for Subpart C Plans mirror those for Subpart A Plans because the PBGC is prescribing uniform rules for defined benefit plans. See PBGC Reg. §4050.304. For details, refer to the search methods described in ¶1(4) above for Subpart A Plans.

(4)(a) Timeframe for search. The diligent search for a missing distributee under a Subpart C Plan must be conducted within 9 months before a filing is made to the PBGC (as described in (5) below) identifying the distributee as a missing distributee. See PBGC Reg. §4050.304(d). This rule parallels the one for Subpart B Plans (see ¶2(4) above), because participation in both Subpart B and Subpart C is voluntary.

(5) Filing requirements with the PBGC. The plan administrator must file Form M-300 with the PBGC to report the information specified in the form and, in the case of a transferring plan, pay the Benefit Transfer Amount for each missing distributee. The interest charge for Benefit Transfer Amounts paid more than 90 days after the Benefit Determination Date, as described in ¶1(5)(a) above, applies to Subpart C plans as well. The requirements in PBGC Reg. §4050.305(b)-(d) parallel the rules in ¶1(5) above regarding PBGC filings, including the application of the PBGC regulations regarding the place, method and date of filing, and the PBGC's right to request additional information. PBGC will rely on the determination made and the information reported by the plan administrator to the PBGC. See PBGC Reg. §4050.305(e).

(6) Payout rules. If a notifying plan files information with the PBGC about a disposition of benefits to a financial institution, the PBGC's involvement is limited to furnishing the information provided by the plan administrator to the distributee or another claimant that may be entitled to payment of the benefit. See PBGC Reg. §4050.306(a)(1). Such information is obtained from the forms filed with the PBGC, as described in (5) above. For a transferring plan, the PBGC will handle the payout of the missing distributees whose benefits have been transferred to the PBGC, in accordance with the rules in PBGC Reg. §4050.306. See PBGC Reg. §4050.306(a)(2). The payout rules for Subpart C Plans are identical to those for Subpart A Plans, recognizing that both types of plans are defined benefit plans. Accordingly, refer to the discussion in ¶1(6)(a) above for the payout rules for distributions to missing participants, and ¶1(6)(b) above for the payout rules for distributions with respect to deceased missing participants. Also, the table summarizing the distribution provisions in ¶1(6)(c) above applies to Subpart C Plans as well. All references in ¶1(6) above to PBGC Reg. §4050.106(c)-(l) should be treated as references to PBGC Reg. §4050.306(c)-(l) for Subpart C Plans.

¶4. Missing participants program for terminated multiemployer plans that are covered by Title IV (Subpart D Plans).

PBGC Reg. §§4050.401-4050.407 govern the procedures for Subpart D Plans, which are multiemployer defined benefit plans that are covered by Title IV of ERISA, meaning that the plan is not exempt from coverage under ERISA §4021(b) (e.g., the multiemployer plan is not a governmental plan or a church plan that has elected to be covered by ERISA), but only if the plan is closing out under the rules in PBGC Reg. §§4041A.41 through 4041.A-44 for sufficient terminated multiemployer plans (referred to as subpart D of 29 C.F.R. Part 4041A). See PBGC Reg. §4050.401(a). A sufficient terminated multiemployer plan for this purpose means that the plan's assets, excluding any claim of the plan for unpaid withdrawal liability, are sufficient to satisfy all obligations for nonforfeitable benefits provided under the plan. See PBGC Reg. §4041A.41. Unlike for Subpart B Plans and Subpart C Plans, where the plan administrator voluntarily decides to participate in the missing participants program, a Subpart D Plan must close out by either

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transferring to the PBGC the benefits of missing distributees, or purchase irrevocable commitments from an insurer to pay those benefits. The definitions, filing procedures, diligent search requirements, and payout rules are essentially the same as for Subpart A Plans. Accordingly, refer to the discussion in ¶1(2) through ¶1(6) above for specifics on these issues. All references in ¶1(2) through ¶(6) to PBGC Reg. §§4050.102 through 4050.106 should be treated as references to PBGC Reg. §§4050.402 through 4050.406 for Subpart D Plans. The discussion in (1) below identify differences between Subpart A and Subpart D.

(1) Filing requirements with the PBGC. The plan administrator must file Form M-400 with the PBGC to report the missing distributees for whom an irrevocable commitment with an insurer has been purchased and the missing distributees whose benefits have been transferred to the PBGC. See PBGC Reg. §4050.405(a). Otherwise the filing rules are the same as those described in ¶1(5) above. Payments that represent benefits transferred to the PBGC under Subpart D would be considered timely for purposes of ERISA §§4041A-4044A if they are made timely under these filing rules. See PBGC Reg. §4050.405(b).

¶5. Forms and instructions. After it receives OMB approval, the PBGC will publish at its website the forms and instructions used under these regulations. The relevant PBGC website page is https://www.pbgc.gov/prac/forms. One of the menu options is for Missing Participant Filings for plans that terminate on or after 1/1/2018 (all plans covered by Missing Participants Program). When the forms become available, there will be a click-through to the appropriate form. The forms that pertain to these new regulations are: (1) PBGC Form MP-100 (Subpart A Plans - see ¶1(5) above), which includes Schedule A for individual information about annuity purchases (irrevocable commitments), and Schedule B for individual information about transfers to the PBGC, (2) PBGC Form MP-200 (Subpart B Plans - see ¶2(5) above), which includes Schedule A for individual information about transfers to financial institutions (e.g., IRA rollovers), and Schedule B for individual information about transfers to the PBGC, (3) PBGC Form MP-300 (Subpart C Plans - see ¶3(5) above), which includes Schedule A for individual information about transfers to financial institutions (e.g., IRA rollovers), and Schedule B for individual information about transfers to the PBGC, and (4) PBGC Form MP-400 (Subpart D Plans - see ¶4(1) above), which includes Schedule A for individual information about annuity purchases (irrevocable commitments), and Schedule B for individual information about transfers to the PBGC.

¶6. Fees. The PBGC is charging a one-time fee of $35 per missing distributee for whom a Benefit Transfer Amount is paid by the plan to the PBGC, which is waived for Benefit Transfer Amounts that are $250 or less. There are no continuing "maintenance" fees while the benefits are held by the PBGC, and no distributee fees when the benefits are paid by the PBGC. These fees are set forth in the instructions to the forms described in ¶5 above. In the case of missing distributees for which only information is reported to the PBGC (e.g., benefits payable through an irrevocable commitment, or benefits transferred to a financial institution) but no benefits are transferred to the PBGC, there is no fee.

(1) Future increases in fees. The PBGC's methodology for setting future fees under the missing participants program will incorporate the following elements and principles: (a) fees will be set in a manner consistent with the requirements of 31 U.S.C. 9701 and relevant guidance of the Office of Management and Budget and the Government Accountability Office, (b) fees will be set with a view to collecting, on average and over time, no more than the PBGC's out-of-pocket costs for the services of private-sector contractors to perform non-governmental functions in support of the missing participants program (the value of in-house performance of governmental functions by government

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employees will not be factored in), and (c) to estimate contractor costs, the PBGC will use cost-smoothing methods and will break such costs down into systems costs (i.e., establishing, maintaining, modifying, updating, and replacing hardware, software and other infrastructure used to support the missing participants program), amortized over 5 year, and processing costs (i.e., labor, office supplies, utilities, and other such items charged the PBGC by the contractor), which are treated as incurred and satisfied currently. See the preamble at 82 F.R. 60804.

¶7. Missing distributee database. The PBGC notes in the preamble to the proposal (see 81 F.R. 64702) that a new unified pension search database would be established that would be integral to the success of the missing participants program. This database would be designed and operated for the PBGC according to best practices by a private-sector entity with expertise in such enterprises and will be implemented in a way that protects individuals' privacy. It would include information about missing participants and their benefits and a directory through which members of the public could easily query the database (using a choice of fields) to determine whether it contained information about benefits being held for them. The PBGC anticipates that its new pension search database would provide a comprehensive, nationwide, authoritative, reliable, easy- to-use source of information about missing participants and the benefits being held for them.

¶8. Residual assets. The proposal would not deal with the treatment of residual assets, which may come into play with terminated defined benefit plans described in Subparts A and C. The PBGC is soliciting comments on the appropriate way to deal with excess assets.

¶9. Administrative review. PBGC Reg. §4003.1 addresses the issuance of all initial determinations by the PBGC on cases pending before it that involve matters set forth in §4003.1(b) and the procedures for requesting and obtaining administrative review by the PBGC. PBGC Reg. §4003.1(b)(11), prior to the issuance of the revised regulations, referred to two determinations relating to the missing participant program: (1) that the amount of a participant's or beneficiary's benefit under ERISA §4050(a)(3) has been correctly computed based on the designated benefit paid to the PBGC under ERISA §4050(b)(2), and (2) that the designated benefit is correct, but only to the extent that the benefit to be paid does not exceed the participant's or beneficiary's guaranteed benefit. Revised PBGC Reg. §4003.1(b)(11) now reads that administrative review procedures apply only to determinations of the amount of benefit payable by PBGC under ERISA §4050 and the regulations thereunder. This section no longer refers to the calculation of benefits transferred to the PBGC because those amounts are based on information reported by the plan. Thus, there is no PBGC action for a person to be aggrieved by or for the PBGC to revoke or change. Recourse must be against the plan or, if the plan no longer exists, the plan sponsor. If a claimant's benefit is guaranteed by the PBGC, and the claimant is unable to collect from the plan or sponsor, the claimant may have a right to payment of the guaranteed benefit by the PBGC, and a dispute about the PBGC's determination of the amount of that benefit is subject to the requirement to pursue administrative review under PBGC Reg. §4003.1(b)(8).

¶10. Participation in program does not result in Title IV coverage. PBGC Reg. §4001.1 has been amended to add §4001.1(b) to clarify that a plan is not subject to Title IV of ERISA merely because it elects to participate in the missing participants program. This is aimed at Subpart B and Subpart C Plans.

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Minimum Distribution Requirements

IRS examiners told not to challenge plans that have not made timely RMDs to missing participants if reasonable search steps have been taken [Citation: *TEGE-04-1017-003* (October 19, 2017) (qualified plans); *TEGE-04-0218-0011* (February 23, 2018) (403(b) plans]
Text available at http://bit.ly/2zcc7ji

This memorandum directs EP examiners not to challenge a qualified plan or a 403(b) plan as failing to satisfy the required minimum distribution (RMD) standards under IRC §401(a)(9) if the failure relates to the plan's inability to locate a participant or beneficiary, if there is evidence that the plan has taken reasonable steps to find the individual. Specifically, EP examiners shall not challenge the plan for violation of the RMD standards for the failure to commence or make a distribution to a participant or beneficiary to whom a payment is due, if the plan has taken all of the following steps described in (1), (2) and (3) below.

(1) Alternative contact information. A search of plan and related plan, sponsor, and publicly-available records or directories for alternative contact information.

(2) Minimum search efforts. The use of at least one of the following search methods: (a) a commercial locator service, (b) a credit reporting agency, or (c) a proprietary internet search tool for locating individuals.

(3) Certified mail. An attempt to contact via the United States Postal Service (USPS) certified mail to the last known mailing address *and* through appropriate means for any address or contact information (including email addresses and telephone numbers).

If a plan has not completed the steps above, the EP examiners may challenge the plan for violation of the RMD standards for the failure to commence or make a distribution to a participant or beneficiary to whom a payment is due.

The qualified plan memo took effect on October 19, 2017, which the IRS expects to incorporate into the Internal Revenue Manual (IRM 4.71.1) by October 19, 2019. The 403(b) plan memo took effect on February 23, 2018, which the IRS expects to incorporate into the Internal Revenue Manual (IRM 4.72.13) by February 23, 2020.

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Section 403(b) Arrangements: Universal Availability Rule

Relief given to 403(b) plans regarding the "once" lookback rule for applying the part-time employee exclusion under the universal availability test [Citation: *Notice 2018-95*, 2018-52 I.R.B. (December 24, 2018) (advance release on December 4, 2018)]
Text available at http://bit.ly/2G0uoZv

This notice provides important transition relief with respect to the exclusion of part-time employees, pursuant to Treas. Reg. §1.403(b)-5(b)(4)(iii)(B), to determine if the 403(b) plan satisfies the universal availability requirement under IRC §403(b)(12)(A). The universal availability rule generally requires all employees to be eligible to make elective deferrals under the 403(b) plan if any employee is so eligible. However, there are exceptions under which certain employees do not have to have the elective deferral arrangement available to them. One of these exceptions applies to part-time employees who *normally* work less than 20 hours per week.

* Regulatory exclusion for part-time employees. Treas. Reg. §1.403(b)-5(b)(4)(ii)(B) defines an employee who normally works fewer than 20 hours per year. This definition can be explained as containing three separate conditions. For purposes of the rules below, an "exclusion year" means a measurement period for determining whether the part-time exclusion rule applies following the employer's first year of employment.

✪ *First-year exclusion condition.* In the first year of employment (measured from the employee's employment commencement date), the exclusion applies if the employer reasonably expects the employee to work fewer than 1,000 hours during that year. This rule doesn't look at actual hours worked because the determination has to be made on the date of employment in order to know whether to provide the employee a deferral opportunity in accordance with the universal availability rule.

✪ *Preceding-year exclusion condition.* For each exclusion year ending after the first year of employment, the exclusion applies only if the employee actually worked fewer than 1,000 hours in the preceding 12-month period following each of those exclusion years. The first exclusion year that this rule applies is either: (1) the plan year that ends after the first year of employment, or (2) the end of the anniversary period following the initial year of employment (i.e., 12-month periods following the first year of employment start on anniversaries of the employment commencement date. When the plan year option is used, unless an employee's employment commencement date coincides with the first day of the plan year, there will be some overlap between the first and second measurement periods. The 403(b) plan document must specify which of these measuring periods apply to determine exclusion years.

- Example - measuring exclusion years. A 403(b) plan uses a calendar-year plan year. Julius commences employment on March 20, 2019. Julius' first measurement period is measured from March 20, 2019, through March 19, 2020. If years following the initial year of employment are measured with reference to the plan year, Julius' second exclusion year is January 1 through December 31, 2020. Thus, the first and second exclusion years overlap from January 1 through March 19, 2020. If years following the initial year of employment are measured with reference to anniversary dates of the employment commencement date, then Julius' second exclusion year runs from March 20, 2020, to March 19, 2021.

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✪ *"Once-In-Always-In" (OIAI) exclusion condition.* Under this condition, once an employee first becomes eligible to make elective deferrals (i.e., either the employee fails the first-year exclusion condition, or, in a subsequent exclusion year, fails to meet the preceding-year exclusion condition), the employee may not again be excluded from making elective deferrals in any later year by reason of the part-time exclusion. The IRS reads this condition into the part-time exclusion because of the language in the regulations that an employee is treated as normally working fewer than 20 hours per week "if and only if" both the first-year exclusion condition and the preceding-year exclusion condition is met with respect to each exclusion year.

* Consistency rule for using part-time exclusion. In order to use the part-time exclusion, the 403(b) plan must exclude all employees who meet the conditions of that exclusion. See Treas. Reg. §1.403(b)-5(b)(4)(i). For example, if the employer allowed a certain class of employee to make elective deferrals, and any of such employees would have been excluded had the part-time exclusion applied to them, then the plan may not use the part-time exclusion rule to exclude any employees who are outside of that class of employees.

* Pre-approved 403(b) plans reviewed under language reflecting the OIAI rule. As part of its pre-approval program for 403(b) plans, the IRS issued a Listing of Required Modifications (LRMs) for 403(b) documents. LRM 17 contains the part-time exclusion rule, using the regulatory language. In 2015, it revised LRM 17 to emphasize the consequences of the OIAI rule by adding the following explicit language: "Once an Employee becomes eligible to have Elective Deferrals made on his or her behalf under the Plan under this [part-time exclusion] standard, the Employee cannot be excluded from eligibility to have Elective Deferrals made on his or her behalf in any later year under this standard." All pre-approved 403(b) plans were reviewed using the LRMs. Thus, pre-approved 403(b) plans reflect language or similar language that incorporates the OIAI rule, either with or without the explicit language emphasizing the OIAI rule.

* Transition relief regarding OIAI exclusion condition. The IRS has been made aware of many employers who have not applied the OIAI exclusion condition in the operation of the 403(b) plan. In addition, the IRS did not modify the language in LRM 17 until 2015, which was 6 years after 403(b) plans had to start complying with the regulations. Accordingly, some employees have been excluded from deferring under the part-time exclusion rule even though in a prior exclusion year they were allowed to defer because the preceding-year condition was not met. To eliminate any need to correct the operation of these plans for prior years, Notice 2018-95 grants the following transition relief.

✪ *Plan operations during a Relief Period.* During a Relief Period granted with respect to the part-time exclusion, a 403(b) plan will not be treated as failing the conditions of the part-time exclusion merely because the plan did not apply the OIAI condition.

· Relief Period. The Relief Period begins with the first taxable year beginning after December 31, 2008, which coincides with the effective date of the 403(b) regulations. The Relief Period ends on the last day of the last exclusion year that ends *before* December 31, 2019. For plans that use the plan year to measure exclusion years after the employee's initial year of employment, this ending day will coincide with the last day of the plan year that ends before December 31, 2019. For calendar-year plans, that means December 31, 2018. For noncalendar-year plans, that means the plan year that starts in 2018 and ends sometime in 2019 (e.g., June 30, 2019, for a plan year that began July 1, 2018). For plans that use anniversary years to calculate the exclusion year, the ending date will be different for each

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employee based on the employee's employment commencement date. For employees who commenced employment on January 1, the Relief Period ends on December 31, 2018. For employees who commenced employment on a day other than January 1, the Relief Period ends on the last anniversary period that ends before December 31, 2019 (e.g., November 29, 2019, for an employee whose employment commencement date was on a November 30th).

- Other exclusion conditions still apply. This relief does not apply to the first-year exclusion condition or to the preceding-year exclusion condition. It just relieves the plan from having to apply the OIAI exclusion condition during the Relief Period.

✪ *Fresh-start opportunity.* For exclusion years that begin on or after January 1, 2019 (i.e., the first year after the Relief Period ends and subsequent years), plans must generally apply the OIAI exclusion condition. However, to eliminate unnecessarily complicated administrative procedures involving lookback rules with respect to years before the plan began applying the OIAI condition, Notice 2018-95 give plans a fresh-start opportunity with respect to the part-time exclusion. Under the fresh-start relief, the plan would apply the part-time exclusion in exclusion years beginning after the Relief Period ends as if the OIAI condition first became effective on January 1, 2018. This would mean that, for any exclusion beginning after the Relief Period ends, the plan would apply the OIAI exclusion condition by: (1) disregarding an employee's failure to meet the first-year exclusion condition for an initial year of employment that began before January 1, 2018 (i.e., the employee started work before 2018), and (2) disregarding any exclusion year for which the preceding-year exclusion condition was not met if such exclusion year began before January 1, 2018.

Comment: Note that this fresh-start opportunity is available only if, during the Relief Period, the plan either must have been operated using the OIAI exclusion condition or pursuant to the relief granted under Notice 2018-95.

* Example of transition relief. A 403(b) plan has a calendar-year plan year. The plan applies the part-time exclusion and uses the plan year as the exclusion year to determine if the part-time exclusion applies after an employee's initial year of employment. An employee commenced employment on January 1, 2012. Thus, the initial employment year coincided with the 2012 plan year, resulting in no overlap between initial year and the first subsequent exclusion year. The following chart shows the actual hours worked by the employee (second column) for each plan year that is included in the Relief Period, whether the plan applied the part-time exclusion to the employee for that plan year, based on the assumption that the plan's operation did not apply the OIAI exclusion condition (third column), and how the regulations would have applied the exclusion to this employee by taking into account the OIAI exclusion condition (fourth column). This example is similar to the one appearing in Notice 2018-95, but has been modified to emphasize the effect of the OIAI exclusion condition.

Plan Year	**Hours Actually Worked**	**Plan's Application of Part-Time Exclusion**	**Regulatory Application Using OIAI Condition**
2012 (initial employment year)	690	EE excluded b/c ER reasonably anticipated EE would work < 1,000 hours	EE excluded for same reason as shown in third column
2013	1,020	EE excluded from deferring b/c EE actually worked < 1,000 hours in 2012 (i.e., preceding-year exclusion condition was met)	EE excluded from deferring for same reason as shown in third column

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Plan Year	Hours Actually Worked	Plan's Application of Part-Time Exclusion	Regulatory Application Using OIAI Condition
2014	625	EE eligible to defer for the 2014 plan year b/c EE actually worked at least 1,000 hours in 2013 (i.e., preceding-year exclusion condition was not met)	EE eligible to defer for the 2014 plan year b/c of same reason shown in third column.
2015	500	EE again excluded from deferring b/c EE actually worked < 1,000 hours in 2014 (i.e., preceding-year exclusion condition was met)	EE continues to be eligible to defer for b/c of the OIAI rule (i.e., the preceding-year condition was not met for all prior years)
2016	610	EE again excluded from deferring b/c EE actually worked < 1,000 hours in 2015 (i.e., preceding-year exclusion condition was met)	EE continues to be eligible to defer for same reasons given for 2015
2017	725	EE again excluded from deferring b/c EE actually worked < 1,000 hours in 2016 (i.e., preceding-year exclusion condition was met)	EE continues to be eligible to defer for same reasons given for 2015-2016
2018	800	EE again excluded from deferring b/c EE actually worked < 1,000 hours in 2017 (i.e., preceding-year exclusion condition was met)	EE continues to be eligible to defer for same reasons given for 2015-2017

As the above table shows, the plan's actual operation (third column) allowed this employee to defer during the 2014 year, but excluded the employee from deferring for the 2015-2018 plan years based on applying the preceding-year exclusion condition without applying the OIAI exclusion condition. The fourth column shows that, had the plan applied the OIAI during these years, the employee would have been eligible every year from 2014 through 2018. In other words, the plan's operation was consistent with the regulations for 2012-2014, but then diverged from the regulations starting in 2015 because it was not applying the OIAI exclusion condition.

✪ *End of Relief Period.* The Relief Period under Notice 2018-95 for the plan in this example ends on December 31, 2018. The next plan year ends December 31, 2019, and the Relief Period must end with the last plan year that ends *before* December 31, 2019. So the 2018 plan year, shown in the last row of the above table, is the last plan year for which the part-time exclusion rule can be applied using the relief in Notice 2018-95.

✪ *Application of the fresh-start opportunity.* The fresh-start opportunity is available for this plan starting with the 2019 plan year (i.e., the first exclusion year that begins after the end of the Relief Period). Without a fresh-start election, because of the OIAI rule, the plan would have to make this employee eligible to defer for the 2019 plan year (i.e., the preceding-year exclusion condition was not

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met for the 2014 plan year), and that right to defer would continue for all subsequent years. If, instead, the fresh-start election is made, the plan would disregard the fact that this employee actually worked at least 1,000 hours in the 2013 plan year). In such case, the employee would be excluded from deferring as of January 1, 2019, and would continue to be excluded until the first subsequent plan year when the preceding-year exclusion condition is not satisfied. For example, if this employee works fewer than 1,000 hours in 2019-2021 but works at least 1,000 hours of service in 2022, the employee would be excluded from deferring under the fresh-start opportunity for 2019-2022 and then, effective January 1, 2023 would become eligible to defer because the preceding-year exclusion condition is not met for the 2023 plan year (i.e., at least 1,000 hours were worked in 2022). Thereafter, because of the OIAI exclusion condition, the employee could no longer be excluded from deferring by reason of the part-time exclusion rule. *Note that, if the employee had at least 1,000 hours in 2017, the fresh-start opportunity could not apply to this employee because for 2018 the preceding-year exclusion condition is not met, and the fresh-start opportunity only allows the preceding-year exclusion condition to be disregarded for an exclusion year that begins before January 1, 2018.*

* How should part-time exclusion apply to overlapping periods? Suppose the employee in the above example had started work on March 1, 2012, instead of January 1, 2012. In that case the employee's initial year would have run from March 1, 2012, through February 28, 2013, rather than calendar-year 2012, so it would have overlapped with the 2013 plan year for two months. That period would have been substituted for the 2012 calendar year in the first row of the table.

✪ *Application issue for overlapping periods.* An issue arises under the part-time exclusion rule with respect to whether the employee would be eligible to defer during the two-month overlap period under these alternative facts. Since the 2013 plan year is the first plan year that ends after the end of the initial employment year, but that year starts on January 1, 2013, which is before the initial employment year ends, the employee's actual hours for the initial employment year may not be known as of that date (or may still not have accumulated to at least 1,000 hours by such date). Notice 2018-95 states that a plan will not be treated as failing to satisfy the part-time exclusion rule as long as it has applied the rule to the overlapping period in a consistent manner to all employees. For example, some employers might interpret the rule as requiring the start of elective deferrals for this employee on March 1, 2013, since the initial period doesn't end until February 28, 2013, while other employers might interpret the rule as requiring the start of elective deferrals for this employee on January 1 2013, if, as of such date, the employee already has completed at least 1,000 hours of service for the initial employment year or would be reasonably expected to do so by the end of such year.

* Are plan amendments needed? Amendment rules differ for pre-approved 403(b) plans and individually-designed plans.

✪ *Pre-approved 403(b) plans.* If the employer adopts the pre-approved plan document by March 31, 2020 (i.e., the end of the initial remedial amendment period applicable to 403(b) plans), the document will be retroactive to the 2009 plan year in order to comply with the remedial amendment period rules. This will result in the retroactively-effective document failing to reflect the adopting employer's reliance on the transition rule during the Relief Period, if applicable. This means that, without relief, the employer would have an operational failure for any years during the Relief Period that it failed to apply the OIAI rule. These documents also don't reflect the fresh-start opportunity. However, the IRS provides the following broad relief with respect to amendments.

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- An adopting employer will not be treated as failing to satisfy the conditions of the part-time exclusion, and the plan will not be treated as having a failure to follow plan terms, merely because the form of the pre-approved 403(b) plan for the Relief Period does not match the plan's operation with regard to the OIAI exclusion condition during the Relief Period. Thus, no plan amendment is required, neither by the firm that sponsors the pre-approved plan nor by the adopting employer.
- No amendments are required to reflect the election of the fresh-start opportunity by the adopting employer. Thus, the firm that sponsors the pre-approved plan need not amend the prototype or volume submitter language, no adopting employer that avails itself of the fresh-start rule need amend the document, and an adopting employer may choose to use the fresh-start rule regardless of whether other adopting employers have chosen to use it.
- Bottom line? No amendments are needed for pre-approved 403(b) plans to reflect operation during the Relief Period, nor for the fresh-start opportunity.

✪ *Individually-designed plans.* Unlike a pre-approved 403(b) plan, an individually-designed 403(b) plan may have to be amended to reflect the plan's operation from the 2009 plan year through the end of the Relief Period, if the plan operated during any part of that period without applying the OIAI exclusion condition and the plan's language explicitly included the OIAI condition.

- If an amendment is required, it needs to be adopted by March 31, 2020.
- A timely amendment will be treated by the IRS as a correction of a form defect during the remedial amendment period.
- If the plan contains language that tracks the regulatory language of the part-time exclusion without explicitly highlighting the OIAI exclusion condition (such as the language that was in the 2013 version of the LRMs), the IRS will treat that language as reflecting that the OIAI exclusion condition was not applied, in which case further amendment to reflect the plan's operation disregarding that condition *will not be necessary*. This is true even though, for periods after the Relief Period ends, these same plan provisions that reflect the regulatory language, even if not explicitly highlighting the OIAI exclusion condition, are treated as complying with the OIAI exclusion condition (i.e., no further amendment would be required to address the plan language issue discussed below for document requirements after the Relief Period ends).
- Taking into consideration the above, the only reason an individually-designed plan will need to be amended retroactively by March 31, 2020, to address the OIAI exclusion condition is if: (1) the plan was operated by not applying the OIAI exclusion condition, and (2) the plan contained language that explicitly highlighted the OIAI exclusion condition. In other words, there has to be a direct conflict between the clear language of the plan and the plan's operation during this Relief Period.
- Like pre-approved 403(b) plans, individually-designed 403(b) plan do not have to adopt amendments to reflect the use of the fresh-start opportunity.

✪ *Document requirements after the Relief Period ends.* By March 31, 2020, any pre-approved or individually-designed 403(b) plan that does not contain the OIAI exclusion condition must be amended to do so, and to make that provision effective after the Relief Period ends. If the pre-approved plan or individually-designed plan includes the language in the LRMs, which contained the OIAI rule, no amendment would be required. This is true even if the 403(b) plan reflects the LRM provision prior to the addition of the language emphasizing the OIAI rule (i.e.,

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the plan used the 2013 version that reflected the regulatory language implicitly applying the OIAI exclusion condition, rather than the 2015 of the LRM language that included explicit language highlighting the OIAI exclusion condition). Other 403(b) plans will have to be examined to see if the OIAI exclusion condition is missing and, if so, will need to be amended no later than March 31, 2020, to correct that document failure. Presumably, all pre-approved 403(b) plans will meet this requirement unless there was an oversight in the IRS' review of the document language. So this amendment requirement will primarily be an issue only for certain individually-designed plans.

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ERISA Enforcement: Civil and Criminal Penalties

Civil penalty adjustments for 2019 [Citation: *DOL Federal Civil Penalties Inflation Adjustment Act Annual Adjustments for 2018, DOL Reg. §2575.3*, 84 F.R. 213 (January 23, 2019)]
Text available at http://bit.ly/2DuyB4e

On November 2, 2015, Congress enacted the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, Public Law 114–74 ("Inflation Adjustment Act"), to improve the effectiveness of civil monetary penalties and to maintain their deterrent effect. The Inflation Adjustment Act required agencies to: (1) adjust the level of civil monetary penalties with an initial ''catch-up'' adjustment through an interim final rule (adopted in 2017), and (2) make subsequent annual adjustments for inflation. The DOL is required to publish an annual inflation adjustment by January 15 of each year. On July 1, 2016, the DOL published an interim final rule that established the initial catch-up adjustment for civil penalties that the DOL administers, including the Employee Benefit Security Administration (EBSA).

* **2019 Adjustment.** The adjustment multiplier for 2019 is 1.02522, rounded to the nearest dollar.

Date of Violations	Date Penalty Assessed	Penalty Level
On or before November 2, 2015	On or before August 1, 2016	Pre-August 1, 2016, levels
On or before November 2, 2015	After August 1, 2016	Pre-August 1, 2016, levels
After November 2, 2015	After August 1, 2016, but on or before January 13, 2017	August 1, 2016, levels
After November 2, 2015	After January 13, 2017, and before January 3, 2018	2017 levels
After November 2, 2015	After January 2, 2018	2018 levels
After November 2, 2015	After date January 23, 2019	2019 levels

* **Specific penalty amounts.** The following table shows the 2019 and 2018 penalty amounts. Note that the tables include the civil penalties under ERISA §§502(c)(1) and 502(c)(3), but these penalties were not subject to the annual adjustments required by the Inflation Adjustment Act. See DOL Reg. §2575.2. The civil penalty under ERISA §502(c)(1) is set forth in DOL Reg. §2575.502c-1, and the civil penalty under ERISA §502(c)(3) is set forth in DOL Reg. §2575.502c-3. These penalties, which started at $100 per violation, were adjusted to $110 for violations occurring after July 29, 1997, and have not been adjusted since.

Penalty	2018 penalty level	2019 penalty level
ERISA §209(c) (employee benefit statements)	$29 per employee	$30 per employee
ERISA §502(c)(1) (periodic benefit statements under ERISA §105; defined benefit funding notices; failure to provide requested information)	$110 per day	$110 per day
ERISA §502(c)(2) (late Form 5500)	$2,140 per day	$2,194 per day
ERISA §502(c)(3) (missed funding payments; notice of transfers to health benefits accounts)	$110 per day	$110 per day
ERISA §502(c)(4) (notice of benefit restrictions under IRC §436, multiemployer plan disclosures required under ERISA §101(k) and (l), and notice of automatic contribution arrangement under ERISA §514(e)(3))	$1,693 per day	$1,736 per day
ERISA §502(c)(5) (reporting requirements for	$1,558 per day	$1,558 per day

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MEWAs)		
ERISA §502(c)(6) (furnishing documents requested by the DOL)	$152 per day (cap of $1,496)	$156 per day (Cap of $1,566)
ERISA §502(c)(7) (blackout notices under ERISA §101(i); notice under ERISA §101(m) of right to divest employer securities	$136 per day	$139 per day
ERISA §502(m) (penalty on plan fiduciary for permitting plan to make a "prohibited payment" under ERISA §206(e) when the plan has a liquidity shortfall	$16,499	$16,915

Note: The table above does not include penalties applicable under ERISA §502(c)(8)-(12), but the latest penalties applicable to these ERISA sections are available in DOL Reg. §2575.3. Also, the penalty amount for ERISA §502(m) cannot exceed the value of the prohibited payment, if that's less than the shown dollar amount.

Definition of a Fiduciary

DOL opines on fiduciary responsibilities associated with an auto-portability program designed to match former employees' default IRAs with plans of a subsequent employer [Citation: *DOL Advisory Opinion 2018-01A* (November 5, 2018)]
Text available at http://bit.ly/2B4K5uf

The DOL was asked for its opinion on fiduciary status for certain parties participating in an auto-portability program. The program, administered by Retirement Clearinghouse LLC (RCH) is designed to help employees who may have multiple job changes over their career to consolidate small accounts held in a prior employer's individual account plan or in a rollover IRA into a new employer's 401(k) or other defined contribution individual account plan.

* Description of the auto-portability arrangement. Here's how it works.

- A plan adopts the RCH Program through a written agreement with RCH or the plan's recordkeeper.
- A third-party recordkeeper enters into an agreement to participate in RCH's electronic records matching technology to locate and match participants in connection with plans that have adopted the RCH Program.
- A participating plan sponsor chooses whether to designate RCH or the recordkeeper to be the default IRA provider. RCH's default IRAs are custodied by an unaffiliated bank, and unrelated financial institutions provide all investment products and investment management services.
- Plan sponsors agree to adopt any plan amendments needed to implement the RCH program and to make disclosures to plan participants and beneficiaries about the program (which include fee disclosures and a description of how the program works).
- If a separated participant's account is subject to mandatory distribution under IRC §401(a)(31)(B), a mandatory distribution letter is sent to the participant, either by RCH or the recordkeeper, depending on the arrangements made in the governing agreements. The letter includes a description of distribution options, a disclosure of all fees and features of the RCH Program, the 402(f) notice requirements, and an advisory that the participant's account will be rolled over into a default IRA unless the participant makes an affirmative direction to the contrary. The letter also states that the participant may opt out of the automated transfer service to a new employer's plan,

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and includes information of how to opt out. The investment of the mandatory distribution in the default IRA satisfies the fiduciary safe harbor under DOL Reg. §2550.404a-2.

- If the plan is terminating, and a participant's account is subject to mandatory distribution pursuant to the termination, a letter similar to the one provided for separated participants is furnished. The investment of the terminated plan participant's account in the default IRA satisfies the fiduciary safe harbor under DOL Reg. §2550.404a-3.
- After transfer into a default IRA, RCH or the recordkeeper sends a "welcome letter" describing the program, including the auto-transfer process if the participant is matched to a new employer's plan. This information is also provided annually as part of the IRA statement.
- When RCH matches a participant in a new employer's plan to the participant's former plan or default IRA account, RCH sends a "consent letter" to the IRA owner/participant to transfer the funds to the new employer's plan (referred to as a "roll-in").
- The participant can approve the roll-in by giving an affirmative consent when enrolling in the new employer's plan (via website, automated voice response system, or call center). If there is no response within 30 days of the consent letter, either affirmatively consenting to or declining the roll-in to the new employer's plan, the default roll-in transaction is activated. The new employer's plan must agree to accept the roll-in funds for the transfer to be completed.
- Where the default IRA is with a recordkeeper, the roll-in to the new employer's plan is implemented by transferring the default IRA first into an RCH default IRA and then from that IRA to the new employer's plan. Under such a transaction, the RCH default IRA is acting solely as a conduit.

* Fees collected by RCH. Under the RCH Program, RCH receives: (1) a one-time communication fee covering the cost of notices and communications associated with the Program; (2) a monthly administrative fee covering the provision of administrative services to the IRA; (3) a distribution fee if the IRA is terminated and the IRA owner decides to cash out or transfer the IRA account balance to another qualified retirement plan; (4) a sub-transfer agency fee paid by the IRA investment provider selected by the responsible plan fiduciary as part of the plan's adoption of the RCH Program; and (5) a roll-in fee paid if the IRA is terminated and the IRA account balance is rolled in to a new employer plan with the assistance of RCH. Any changes in the types or amounts of these fees would have to be approved prospectively by a fiduciary of a participating plan. However, where the RCH default IRA is used solely as a conduit to transfer the funds to a new employer's plan, RCH *only* collects a one-time communication fee and a one-time transfer fee (for locate, match and roll-in services).

* Fiduciary analysis. The DOL addresses the fiduciary status of the plan sponsors with respect to their participation in the RCH Program, and the fiduciary status of RCH for transfers to the new employer's plan.

(1) Participating plan fiduciary - selection of the RCH Program. The fiduciary responsibilities of the plan sponsor or other responsible fiduciary lie solely with its decision to participate in the program and its duty to monitor the arrangement. Thus, the plan fiduciary must evaluate the package of services and separate service providers that are part of the RCH Program and conclude that the services, including the portability services, are appropriate and helpful to carrying out the purposes of the plan, and that the compensation paid or received by the service providers is no more than reasonable taking into account the services provided and available alternatives. The plan fiduciary also must monitor the arrangement and periodically ensure the plan's continued participation in the RCH Program is consistent with ERISA's standards.

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(2) Former and new employer - default transfer of IRA funds to new employer plan. Once a participant's plan funds are transferred to a default IRA, the plan sponsor of the former employer's plan has no discretion or authority ov er decisions of the IRA owner or any future transfer of the default IRA assets. In addition, the new employer's only involvement in the roll-in is to acknowledge that the transfer is consistent with the plan's terms and it will accept the roll-in. If there is no affirmative consent from the participant, RCH assumes the responsibility to direct the roll-in. Based on these aspects of the program, the DOL opined that the plan sponsors of both the former and new plans would not be acting as a fiduciary with respect to the roll-in decision. For the former employer, once the assets are transferred from its plan to a default IRA, the plan has fully distributed the individual's benefits so the individual is no longer a participant within the meaning of ERISA (DOL Reg. §2510.3-3(d)(2)(ii)(B)), and the distributed assets are no longer plan assets. For the new employer, although the fiduciaries of that plan are responsible for determining whether the roll-in is consistent with the plan's terms and accepting the roll-in (including allocating the assets to investment alternatives in the new plan), those actions do not cause the fiduciaries of the new employer's plan to exercise fiduciary authority in connection with RCH's decision to roll the IRA assets into the new employer's plan. Of course, once the funds are in the new employer's plan, the fiduciaries of that plan assume investment responsibility for those funds unless an exception applies (e.g., relief for participant-directed investments or for qualified default investment alternatives (QDIAs)).

(3) Fiduciary status of RCH. The DOL concluded that, with respect to the transfer from the default IRA to the plan of the new employer, RCH is acting as a fiduciary when there is no *affirmative consent* of the IRA owner/participant. A failure to respond, which results in a default transfer, is not considered to be affirmative consent for this purpose. The fiduciary safe harbors in DOL Reg. §§2550.404a-2 and 2550.404a-3, which apply to auto-rollovers from the former employer's plan to a default IRA, with respect to a mandatory distribution under IRC §401(a)(31)(B) or a defined contribution plan termination, respectively, do not apply to transfers from the default IRA to the new employer's plan. Even where the default IRA is with the recordkeeper, RCH acts as a fiduciary in directing the transfer of the default IRA to the new employer's plan in the absence of an affirmative election because the transfer is implementing through the use of a conduit default IRA maintained by RCH.

Comment. This type of program could significantly improve portability and prevent "leakage" of plan benefits prior to the retirement of the plan participant. However, the fiduciary concerns might dissuade some potential service providers from offer this type of auto-portability program. Had the DOL created a fiduciary safe harbor for roll-ins into the new employer's plan that occur by reason of a default transfer (i.e., no affirmative election by the participant), the arrangement would become much more attractive. Companies like RCH that offer programs like this will likely factor in their fiduciary responsibilities regarding the roll-in transactions when pricing out these services.

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Fiduciary Duties and Liability: Prudence and Diversification

DOL clarifies aspects of Interpretive Bulletins 2016-01 and 2015-01 [Citation: *Field Assistance Bulletin 2018-01* (April 23, 2018)]
Text available at http://bit.ly/2K9yc8G

Economically-targeted investments. Interpretative Bulletin (IB) 2015-01 states the DOL's latest views on economically-target investments, which are defined as investments that consider environmental, social and governance (ESG) factors. One of the statements in the preamble to IB 2015-01 that may have been misleading says that "if a fiduciary prudently determines that an investment is appropriate based solely on economic considerations, including those that may derive from environmental, social and governance factors, the fiduciary may make the investment without regard to any collateral benefits the investment may also promote." Field Assistance Bulletin (FAB 2018-01) clarifies that the DOL was merely recognizing that there could be instances when otherwise collateral ESG issues present material business risk or opportunities to companies that qualified investment professionals would treat as economic considerations under generally accepted investment theories. In such situations, these ordinarily collateral issues are themselves appropriate economic considerations and must be considered by a prudent fiduciary along with other relevant economic factors to evaluate the risk and return profiles of alternative investments. Accordingly, such factors are more than mere tie-breakers. ERISA fiduciaries must put first the economic interests of the plan in providing retirement benefits, focusing on financial factors that have a *material effect* on the return and risk of an investment based on appropriate investment horizons consistent with the plan's articulated funding and investment objectives.

✪ *Effect on investment policy statements.* IB 2015-01 permits investment policy statements (ISP) to include policies concerning the use of ESG factors to evaluate investments, or on integrating ESG-related tools, metrics, or analyses to evaluate an investment's risk or return. FAB 2018-01 warns, however, that this discussion of ISPs does not reflect a view that ISPs must contain guidelines on ESG investments or integrating ESG-related tools to comply with ERISA. Moreover, IB 2015-01 does not imply that if an ISP contains such guidelines then fiduciaries managing plan assets, including appointed section 3(38) investment managers, must always adhere to them (i.e., if it is imprudent in a particular case to comply with such provisions in the ISP).

✪ *ESG-themed fund in plan with broad investment options.* FAB 2018-01 confirms that, for a plan with a broad range of investment options, it would be permissible to include an ESG-themed fund in response to participant requests for an investment alternative that reflects their personal values. However, such inclusion in the investment menu does not foreclose the fiduciary from including non-ESG-themed funds on the platform. Rather, in such a case, a prudently-selected, well managed, and properly diversified ESG-themed investment alternative could be added to the available investment options on a 401(k) plan platform without requiring the plan to remove or forgo adding other non-ESG-themed options.

✪ *Different considerations for QDIAs.* With respect to a qualified default investment alternative (QDIA), FAB 2018-01 notes that selection of an investment fund is not analogous to merely offering participants an additional investment alternative as part of a prudently constructed lineup of investment alternatives from which participants may choose. Nothing in the QDIA regulation suggests that fiduciaries should choose QDIAs based on collateral public policy goals. For a QDIA, the decision to favor the fiduciary's own policy preferences in selecting an ESG-themed investment option for a

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> 401(k)-type plan without regard to possibly different or competing views of plan participants and beneficiaries would raise questions about the fiduciary's compliance with ERISA's duty of loyalty. Even if consideration of such factors could be shown to be appropriate in the selection of a QDIA for a particular plan population, the fiduciaries would have to ensure compliance with the guidance in IB 2015-01 (e.g., the selection of a ESG-themed target date fund as a QDIA would not be prudent if the fund would provide a lower expected rate of return than available non-ESG alternative target date funds with commensurate degrees of risk, or if the fund would be riskier than non-ESG alternative available target date funds with commensurate rates of return).

Shareholder activism. The language in IB 2016-01 regarding shareholder activism (i.e., engaging in shareholder activities that are intended to monitor or influence the management of corporations in which the plan owns stock) should be read in the context of the DOL's observation that proxy voting and other shareholder engagement typically does not involve a significant expenditure of funds by individual plan investors because the activities are generally undertaken by institutional investment managers that are appointed as the responsible plan fiduciary pursuant to ERISA §§402(c)(3), 403(a)(2), and 3(38). It was not intended to signal that it is appropriate for an individual plan investor to routinely incur 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. Similarly, IB 2016-01 was not meant to imply that plan fiduciaries, including appointed investment managers, should routinely incur significant plan expenses to, for example, fund advocacy, press, or mailing campaigns on shareholder resolutions, call special shareholder meetings, or initiate or actively sponsor proxy fights on environmental or social issues relating to such companies. The DOL would reject a construction of ERISA that would render ERISA's tight limits on the use of plan assets illusory and that would permit plan fiduciaries to expend trust assets to promote myriad public policy preferences. Rather, plan fiduciaries may not increase expenses, sacrifice investment returns, or reduce the security of plan benefits in order to promote collateral goals.

> ✪ *Documented analysis may be needed for ESG-themed shareholder action.* FAB 2018-01 goes on to warn that, if a plan fiduciary is considering a routine or substantial expenditure of plan assets to actively engage with management on environmental or social factors, either directly or through the plan's investment manager, that may well constitute the type of "special circumstances" that the preamble to IB 2016-01 described as warranting a documented analysis of the cost of the shareholder activity compared to the expected economic benefit (gain) over an appropriate investment horizon.

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Claims Procedures

DOL updates claims procedures for disability benefits to coordinate with ACA procedures [Citation: *DOL Reg. §2560.503-1(b)(7), (g)(1)(v), (g)(1)(vii) and (viii), (h)(4), (i)(3)(i), (j)(4), (j)(5),(j)(6), (j)(7), (l), (m)(4), (o) and (p)*, 81 F.R. 92316-92343 (December 19, 2016); *DOL Reg. §2560.503-1(p)(3) and (4)*, 82 F.R. 56560 (November 29, 2017) (delay to April 1, 2019)]
Text available at http://bit.ly/2hAGxXj (regulations); http://bit.ly/2Bmjnum (delay to April 1, 2019)

Delay on Applicability Date: On February 24, 2017, Presidential Executive Order 13777, titled Enforcing the Regulatory Reform Agenda, was issued. It required the designation of a Regulatory Reform Officer and the establishment of a Regulatory Reform Task Force within each federal agency covered by the Order. The Task Forces were directed to evaluate existing regulations and make recommendations regarding those that can be repealed, replaced, or modified to make them less burdensome. In response to this Executive Order, the DOL is delaying the Applicability Date of these regulations to apply to disability claims filed after April 1, 2018, with the transition period to be extended through April 1, 2018. The DOL adopted this delay after requesting additional public input the regulatory impact analysis in the 2016 regulations.

Discussion of regulations. These regulations revise and strengthen the current claims procedures primarily by adopting certain of the new procedural protections and safeguards made applicable to group health plans by the Affordable Care Act (ACA), P.L. 111-148 (March 20, 2010). The pre-amended claims procedure regulations were published 16 years ago. Because of the volume and constancy of litigation in this area, and in light of advancements in claims processing technology, the DOL decided to revisit, reexamine, and revise the current regulations in order to ensure that disability benefit claimants receive a fair review of denied claims. The revisions align the disability claims procedures with the requirements regarding internal claims and appeals for group health plans under the regulations implementing the ACA. To this end, the regulations apply the procedural protections for health care claimants in the ACA to disability benefit claimants, including provisions that seek to ensure that: (1) claims and appeals are adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the decision, (2) benefit denial notices contain a full discussion of why the plan denied the claim and the standards behind the decision, (3) claimants have access to their entire claim file and are allowed to present evidence and testimony during the review process, (4) claimants are notified of and have an opportunity to respond to any new evidence reasonably in advance of an appeal decision, (5) final denials at the appeals stage are not based on new or additional rationales unless claimants first are given notice and a fair opportunity to respond, (6) if plans do not adhere to all claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the plan, unless the violation was the result of a minor error and other specified conditions are met, (7) certain rescissions of coverage are treated as adverse benefit determinations, thereby triggering the plan's appeals procedures, and (8) notices are written in a culturally and linguistically appropriate manner. See the preamble to the proposed version, published on November 18, 2015, and to the final version published on December 19, 2016.

* **Effective date/applicability date.** The changes made by these regulations generally apply to disability claims filed on or after April 1, 2018. See DOL Reg. §2560.503-1(p)(3). However, for claims filed under a plan from January 18, 2017 (which is the effective date of the final rule and 30 days after it was published in the Federal Register) through March 31, 2018, modified new rules applied. See DOL Reg. §2560.503-1(p)(4). These special rules are discussed in the appropriate sections of the discussion below.

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* **Impartiality.** In the case of a plan providing disability benefits, the plan must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (e.g., a claims adjudicator or medical or vocational expert) may not be based upon the likelihood that the individual will support the denial of benefits. See DOL Reg. §2560.503-1(b)(7). For example, a plan is not permitted to provide bonuses based on the number of denials made by a claims adjudicator. Similarly, a plan is not permitted to contract with a medical or vocational expert based on the expert's reputation for outcomes in contested cases, rather than based on the expert's professional qualifications.

* **Adverse determinations - initial notice.** Currently, §2560.503-1(g)(1)(v) prescribes a uniform notice requirement for initial adverse determinations under group health benefits or with respect to disability benefits. Effective January 18, 2017, the amended regulations apply the requirements in subparagraph (v) only to group health plans and add new subparagraph (vii) to apply separate requirements for disability benefit claims. Under the revised standards, the notice of an adverse determination on disability benefits must include the following information. See DOL Reg. §2560.503-1(g)(1)(vii). Items (1) and (2) below are intended to give claimants a better understanding of why a claim is denied. Item (4) below previously was available only in notices of an adverse benefit determination denied on appeal. Item (5) below applies to determinations made for claims filed from January 18, 2017, through March 31, 2018, in lieu of the rules described in (1) through (4) below. Also see the "Definition of adverse determination" below, which is revised by the new regulations.

(1) Required discussion. The adverse determination must include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant, (ii) views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) a disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration. See DOL Reg. §2560.503-1(g)(1)(vii)(A).

(2) Medical necessity or experimental treatment. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the adverse determination must include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. See DOL Reg. §2560.503-1(g)(1)(vii)(B).

(3) Internal procedures. The adverse benefit determination must explain the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination. If such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist, then in lieu of the explanation described in the preceding sentence, the determination must include a statement to that effect. See DOL Reg. §2560.503-1(g)(1)(vii)(C).

(4) Access to information. The adverse benefit determination must include a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant (see (4)(a) below) to the claimant's claim for benefits. See DOL Reg. §2560.503-1(g)(1)(vii)(D).

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(4)(a) Relevant information. DOL Reg. §2560.503-1(m)(8) (which is not amended by this final rule) defines "relevant information" to be any document, record, or other information that: (1) was relied on in making the benefit determination, (2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination, (3) demonstrates compliance with DOL Reg. §2560.503-1(b)(5) in making the benefit determination (i.e., the plan's claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants), or (4) in the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(5) Transition rule. For adverse benefit determinations made on disability claims filed from January 18, 2017, through March 31, 2018, the following information must be provided, in a manner calculated to be understood by the claimant, *in lieu of* the information described in (1), (2), (3) and (4) above, and the non-English language notice requirements described below. See DOL Reg. §2560.503-1(p)(4).

(5)(a) Internal procedures. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either: (1) the specific rule, guideline, protocol, or other similar criterion, or (2) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request. See DOL Reg. §2560.503-1(p)(4)(i)(A). This rule is similar to the one in (3) above except that, in lieu of the explanation of the specific rule, guidelines, etc., the plan may provide notice of the right to receive a copy of such information upon request.

(5)(b) Medical necessity or experimental treatment. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. See DOL Reg. §2560.503-1(p)(4)(i)(B). This is similar to the rule in (2) above except that, in lieu of the explanation of the scientific or clinical judgment, the plan may provide notice of the right to receive the explanation upon request.

* **Adverse benefit determinations on appeal.** A notice of adverse benefit determination on appeal must include the notice requirements described in (1), (2) and (3) above for the initial notice of an adverse benefit determination. See DOL Reg. §2560.503-1(j)(6). Prior to the adoption of these separate standards for appeals of adverse disability benefit determinations, the notice requirements under DOL Reg. §2560.503-1(j)(5) applied to both group health plans and disability benefits. As revised effective January 18, 2017, the notice requirements under §2560.503-1(j)(5) are confined to group health plans. For disability benefit claims filed from January 18, 2017, through March 31, 2018, the transition rules described in (5) above for the initial notice of an adverse benefit determination apply instead.

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* **Notice requirements in certain non-English languages.** The notices described above, both for initial adverse benefit determinations and for adverse benefit determinations on appeal, must be presented in a "culturally and linguistically appropriate" manner. See DOL Reg. §2560.503-1(g)(1)(viii) and (j)(7). This means that certain non-English languages have to be accommodated, as prescribed by DOL Reg. §2560.503-1(o) (see (1) and (2) below). These requirements do not apply for disability benefit claims filed before April 1, 2018. See DOL Reg. §2560.503-1(p)(3).

(1) Application. Whether a non-English language must be accommodated (referred to as an "applicable" non-English language) depends on the county to which the notice is sent (i.e., the claimant's address). Presumably, the claimant's physical address would be the relevant factor here, regardless of whether written notice is mailed or provided electronically (e.g., email). The threshold test is that 10% or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the DOL. See DOL Reg. §2560.503-1(o)(2). This determination is made in accordance with the American Community Survey (ACS) data published by the United States Census Bureau. See the preamble at 81 F.R. 92329 (December 19, 2016). In the preamble to the proposed version of these regulations, the DOL noted that, as of the November 18, 2015, 255 U.S. counties (78 of which are in Puerto Rico) meet the 10% threshold. The overwhelming majority of these are Spanish; however, Chinese, Tagalog, and Navajo are present in a few counties, affecting five states (Alaska, Arizona, California, New Mexico, and Utah). A full list of the affected U.S. counties is available on the Department's website, and is updated annually. See http://bit.ly/2i3y4MY (go to the link for "Culturally and Linguistically Appropriate Services (CLAS) County Data" on that page).

(2) Culturally and linguistically appropriate standards. A notice is treated as meeting these standards if: (i) the plan provides oral language services (e.g., telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non- English language, (ii) plan provides, upon request, a notice in any applicable non- English language, and (iii) the plan includes in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan. See DOL Reg. §2560.503-1(o)(1).

* **Definition of adverse determination.** The definition of adverse determination formerly in DOL Reg. §2560.503-1(m)(4) is redesignated as §2560.503-1(m)(4)(i), and the definition is expanded for disability benefit claims by including any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). See DOL Reg. §2560.503-1(m)(4)(ii). A "rescission" for this purpose means a cancellation or discontinuance of coverage that has retroactive effect, *except* to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Thus, for example, a rescission of disability benefit coverage is an adverse benefit determination even if the affected participant or beneficiary was not receiving disability benefits at the time of the rescission, thereby triggering the applicable procedural rights under ERISA §503. This expanded definition applies to disability benefit claims filed on or after April 1, 2018.

* **Opportunity for full and fair review of disability claims.** The revised regulations expand the review requirements with respect to adverse determinations on disability benefits. Under the revised rules, the plan is not treated as providing a reasonable opportunity for full and fair review of a claim and adverse determination unless, in addition to meeting the requirements of §2560.503-1(h)(2)(ii) through (iv) and

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(h)(3)(i) through (v) (which, prior to the amendment of the regulations, were the only standards applicable to adverse disability determinations), the plan's claims procedures meet the requirements in (1) and (2) below. See DOL Reg. §2560.503-1(h)(4).

(1) New or additional evidence. The procedures must provide that, before the plan can issue an adverse benefit determination on review on a disability benefit claim, the plan administrator must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination (or at the direction of the plan, insurer or such other person) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. See DOL Reg. §2560.503-1(h)(4)(i).

(2) Rationale. The procedures must provide that, before the plan can issue an adverse benefit determination on review on a disability benefit claim *based on a new or additional rationale*, the plan administrator must provide the claimant, free of charge, with the rationale for the adverse determination. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. See DOL Reg. §2560-503-1(h)(4)(ii).

(3) Example - generation of new medical report. In the preamble, the DOL offers an example of how these enhanced review procedures on appeal would work. See 81 F.R. 92325. Assume the plan denies a claim at the initial stage based on a medical report generated by the plan administrator. Also assume the claimant appeals the adverse benefit determination and, during the 45-day period the plan has to make its decision on appeal, the plan administrator causes a new medical report to be generated by a medical specialist who was not involved with developing the first medical report. The regulations require the plan to automatically furnish to the claimant any new evidence in the second report. The plan must furnish the new evidence to the claimant before the expiration of the 45- day review period. The evidence must be furnished as soon as possible and sufficiently in advance of the applicable deadline (including an extension if available) in order to give the claimant a reasonable opportunity to respond to the new evidence. The plan is required to consider any response from the claimant. If the claimant's response happened to cause the plan to generate a third medical report containing new evidence, the plan would have to automatically furnish to the claimant any new evidence in the third report. The new evidence would have to be furnished as soon as possible and sufficiently in advance of the applicable deadline to allow the claimant a reasonable opportunity to respond to the new evidence in the third report.

(4) Reasonable opportunity for full and fair review during transition period. For disability benefit claims filed from January 18, 2017, through March 31, 2018, the claims procedures will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of DOL Reg. §2560.503-1(h)(2)(ii) through (iv) and (h)(3)(i) through (v) (not modified by the amended regulations), which is the standard under the regulations before they were amended on December 19, 2016. Accordingly, the additional standards for full and fair review, as discussed in (1) and (2) above, are not applicable for disability benefit claims filed before April 1, 2018. See DOL Reg. §2560.503-1(p)(4)(ii).

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* **Deemed exhaustion of administrative remedies.** DOL Reg. §2560.503-1(*l*), provides that, where a plan fails to establish or follow claims procedures, the claimant is deemed to have exhausted administrative remedies available under the plan, and is entitled to pursue any available remedies under ERISA §502(a) on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. This rule has been redesignated as DOL Reg. §2560.503-1(*l*)(1). DOL Reg. §2560.503-1(*l*)(2) has been added to prescribe more specific rules for disability benefit claims with respect to the deemed exhaustion of administrative remedies. The revised rules for disability benefit claims distinguish between failure to *strictly adhere* to the claims procedures (see (1) below) and *de minimis* failures (see (2) below). The revised rules for disability benefit claims apply to claims filed on or after April 1, 2018. See DOL Reg. §2560.503-1(p)(3).

(1) Failure to strictly adhere. The general deemed exhaustion rule for disability benefit claims applies where the plan does not strictly adhere to all the requirements of DOL Reg. §2560.503-1. Under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary, thereby allowing for a *de novo* standard of review by the court, rather than the more deferential "arbitrary and capricious" standard of review. See DOL Reg. §2560.503-1(*l*)(2)(i).

(2) Exception for *de minimis* failures. *De minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant do not trigger the deemed exhaustion rule for disability benefit claims. However, the plan has to demonstrate that the violation was for good cause or due to matters beyond the control of the plan, and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. See DOL Reg. §2560.503-1(*l*)(2)(ii).

- Limitation on exception. The exception for *de minimis* failures is not available if the violation is part of a pattern or practice of violations by the plan.
- Written explanation. The claimant may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted.
- Effect of court rejection of immediate review. If a court rejects the claimant's request for immediate review on the basis that the plan met the standards for the *de minimis* exception, the claim is considered as re-filed on appeal upon the plan's receipt of the decision of the court. Within a reasonable time after the receipt of the court's decision, the plan must provide the claimant with notice of the resubmission of appeal to the plan. At this point, the claimant would have the right to pursue the claim in accordance with the plan's provisions governing appeals, including the right to present evidence and testimony.

* **Notification of contractual limitations periods.** DOL Reg. §2560.503-1(j)(4)(i) requires the notification of a benefit determination to include a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in DOL Reg. §2560.503-1(c)(3)(iv), and a statement of the claimant's right to bring an action under section 502(a). For disability benefit claims filed on or after April 1, 2018, the statement of the claimant's right to bring an action under ERISA §502(a) also must describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim. See DOL Reg. §§2560.503-1(j)(4)(ii) (requirement) and 2560.503-1(p)(3) (effective date). Right now there is a disagreement in the Federal appellate courts on whether such notification is required. See *Moyer v. Metropolitan Life Ins. Co.*, 762 F.3d 503, 505 (6th Cir. 2014) (''The claimant's right to bring a civil action is expressly included as a part of those procedures for

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which applicable time limits must be provided'' in the notice of adverse benefit determination on review) and *Wilson v. Standard Ins. Co.*, 613 F. App'x 841, 844 n.3 (11th Cir. 2015) (per curiam) (''We are not persuaded by the Sixth Circuit's conclusion that a claims administrator's interpretation of the ambiguous §2560.503–1(g)(1)(iv) not to require notice in the claim denial letter of the contractual time limit for judicial review necessarily amounts to a failure to comply with [ERISA §503] that renders the contractual limitations provision unenforceable.''). Nonetheless, the DOL has decided to incorporate this requirement into the notification rules for disability benefit determinations.

Multiple Employer Plans

DOL proposes to relax "commonality" standard to determine if certain multiple employer *defined contribution* plans constitute a single-plan in order to expand coverage of employees in workplace retirement plans [Citation: *Prop. DOL Reg. §2510.3-55*, 83 F.R. 53534 (October 25, 2018)]
Text available at http://bit.ly/2SdGBfb

Proposals before Congress would create truly open MEPs without any commonality requirement. It is anticipated that, if Congress enacts this legislation, the DOL will not issue these regulations in final form.

In response to Executive Order 13847, "Strengthening Retirement Security in America," the DOL has issued proposed regulations to loosen the "commonality rule" for defined contribution multiple employer plans (MEPs) maintained by an employer group or association or by a professional employer organization (PEO). The purpose of the proposal is to expand coverage in workplace retirement plans. The regulations allow more employers to form defined contribution MEPs, thereby enabling small businesses to offer such plans (including 401(k) plans) a single ERISA-covered plan. To accomplish its goal, the DOL focuses on the definition of an employer under ERISA §3(5) and prescribes a more relaxed standard for commonality with respect to these plans to allow a larger number of employers to join in a single plan. The guidance is patterned after the final regulations that were issued for association health plans (AHPs), but reflecting the differences between welfare plans and retirement plans. The regulations would supersede the subregulatory interpretive rulings under ERISA §3(5) (e.g., the "open" MEP ruling in Advisory Opinion 2012-04A), and would establish more flexible standards and criteria for sponsorship of these MEPs than currently articulated in that prior guidance. The DOL also is seeking comments on whether other types of entities should be treated as an "employer" under ERISA §3(5).

✪ *Advantages of MEPs cited.* In the preamble to the proposal, discusses the benefits of making MEPs more available to small businesses. A MEP can present an attractive alternative to taking on the responsibilities of sponsoring or administering its own plan. The DOL acknowledges that the MEP structure can reduce the employer's cost of sponsoring a benefit plan and effectively transfer substantial legal risk to professional fiduciaries responsible for the management of the plan. However, the DOL also recognizes that adopting employers would retain some fiduciary responsibility for choosing and monitoring the arrangement and forwarding required contributions to the MEP. Nonetheless, the employer could keep more of its day-to-day focus on managing its business, rather than on its plan.

✪ *Why reform is needed.* The DOL discusses the limited tax-favored options available to workers to save for retirement beyond workplace plans. IRAs are not comparable to workplace retirement savings because workplace plans provide: (1) higher contribution limits; (2) generally lower investment

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management fees as the size of plan assets increases; (3) a well-established uniform regulatory structure with important consumer protections, including fiduciary obligations, recordkeeping and disclosure requirements, legal accountability provisions, and spousal protections; (4) automatic enrollment; and (5) stronger protections from creditors. At the same time, workplace retirement plans provide employers with choice among plan features and the flexibility to tailor retirement plans that meet their business and employment needs. The DOL acknowledges that although many MEPs already exist, there are reasons why they are not more widely available, such as the DOL's restrictive interpretive rulings (e.g., Advisory Opinion 2012-04 on "open" MEPs).

✪ *Not applicable to defined benefit plans.* The proposal does not apply to defined benefit plans because, in the DOL's view, such plans raise different policy considerations.

✪ *Joint employer status not created merely by reason of a MEP.* Nothing in the proposed rule is intended to suggest that participating in a MEP sponsored either by a bona fide group or association of employers or by a PEO gives rise to joint employer status under any federal or State law, rule, or regulation. The proposal also should not be read to indicate that a business that contracts with individuals as independent contractors becomes the employer of the independent contractor merely by participating in a MEP with those independent contractors, who would participate as working owners, if applicable, or promoting participation in a MEP to those independent contractors, as working owners. The Department asks for comment as to whether concerns about joint employment issues should be addressed further as part of any final rule.

Effective date/applicability date. The proposed regulations do not include a proposed effective date or applicability date. Presumably, it would apply to plan years beginning on or after a date specified in the final regulations.

Background on the commonality rule. ERISA §3(5) refers to a group or association of employers as being able to act as an employer for ERISA plan purposes. DOL's previously-issued guidance states that a group or association of employers can constitute an employer under ERISA §3(5) with respect to the maintenance of a single plan if the group or association, acting in the interest of its employer members, establishes a benefit program for the employees of member employers and exercises control over the amendment process, plan termination, and similar functions on behalf of these members. Examples of "bona fide" employer groups or associations are discussed in Advisory Opinions 2008-07A, 2003-17A and 2001-04A. Where the group or association does not itself constitute an "employer" under this concept, then each employer adopting a plan sponsored by such group or association is treated as establishing a separate plan. See, for example, Advisory Opinion 2012-4 (involving a so-called "open MEP"). The touchstone of the DOL's definition of a group or association acting as an employer is the "commonality test," where the group or association has a sufficiently close economic or representational nexus to the employers and employees that participate in the plan.

Requirements for bona fide groups or associations or PEOs. Under these proposed regulations, a bona group or association of employers and a bona fide professional employer organization (PEO) would be deemed to be able to act in the interest of an employer, within the meaning of ERISA §3(5), and thus, sponsoring a defined contribution MEP.

(1) Bona fide group or association of employers. Under the proposed regulation, a bona fide group or association of employers that is capable of establishing a defined contribution MEP would include a

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group or association that meets the following requirements: (1) although the group or association's primary purpose may be to offer and provide MEP coverage to its employer members and their employees, the group or association would have to have at least one substantial business purposes *unrelated* to offering and providing MEP coverage or other employee benefits (see safe harbor below), (2) each employer member of the group or association participating in the plan would have to be a person acting directly as an employer of at least one employee who is a participant covered under the plan, (3) the group or association would have to have a formal organizational structure with a governing body and by-laws or other similar indications of formality, (4) the functions and activities of the group or association would have to be controlled by its employer members, and the group's or association's employer members that participate in the plan would have to control the plan (*in form and in substance*), (5) the employer members would have to have a commonality of interest (see (1)(b) below), (6) the group or association would have to not make plan participation through the association available other than to employees and former employees of employer members and beneficiaries, and (7) the group or association could not be a bank or trust company, insurance issuer, broker-dealer, or other similar financial services firm (including pension recordkeepers and third party administrators) or owned or controlled by such an entity or any subsidiary or affiliate of such an entity, other than to the extent such an entity, subsidiary or affiliate partiicpates in the group or association *in its capacity as an employer member*. See DOL Reg. §2510.3-5(b)(1).

➢ *Safe harbor rule for substantial business purpose.* Element (1) of the definition of a bona fide group or association is that there be at least one additional substantial business purposes besides offering health plan or other employee benefits. DOL Reg. §2510.3-5(b)(1)(i) includes a safe harbor rule which deems such a substantial business purpose to exist if the group or association would be a viable entity in the absence of sponsoring an employee benefit plan. A business purpose includes promoting common business interests of its members or the common economic interests in a given trade or employer community, and is not required to be a for-profit activity.

✪ Examples providing in the AHP regulatory preamble. In the preamble to its regulations dealing with association health plans (AHPs), the DOL offered examples of other substantial business purposes, including: (1) offering classes or education materials on business issues of interest to the association members, (2) establishing business standards or practices for members, (3) engaging in public relations activities such as advertising, education, and publishing on business issues of interest to members, or (4) advancing the well-being of the industry in which the members operate through activities other than the offering of a group health plan. In each of these cases, the other business purpose or activity must be substantial enough so that the association could be a viable entity apart from the offering of the plan. If the association operated with active membership before sponsoring the plan, that would be compelling evidence that a substantial business purpose exists. The preamble to the AHP regulations also noted that an association that otherwise meets the substantial business purpose requirement may establish a subsidiary that is formed solely to administer the plan.

✪ Defined contribution MEP proposal intended to be applied in the same manner. In the preamble to these proposed regulations on group or association defined contribution MEPs, the DOL states that parallel provisions between the AHP regulation and the proposed defined contribution MEP regulation are intended to have the same meaning and effect. Accordingly, it would be reasonable to apply the criteria in the prior paragraph in determining whether the group or association maintaining a defined contribution MEP would be a viable entity in the absence of sponsoring an employee benefit plan.

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➢ *Control*. As noted above, control over the group or association and control over the group health plan, as required by the definition of a bona fide group or association, are determined by considering all relevant facts and circumstances. In the preamble to the final AHP rule, the DOL offered a non-exclusive list of relevant factors: whether employer members regularly nominate and elect directors, officers, trustees, or other similar representatives that constitute the governing body of the group or association or of the plan, (2) whether employer members have authority to remove such director, officer, trustee, or 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 (e.g., material amendments to the plan, including changes in coverage, benefits, and premiums). The DOL stated that it ordinarily will consider the presence of these three factors as sufficient to meet the control test. Again, the DOL's expressed intent in the preamble to the proposed defined contribution MEP regulations to interpret parallel terminology with the AHP rule in the same manner, these standards also would apply in determining if the control test is met for the group or association sponsoring the defined contribution MEP.

➢ *Preclusion of commercial service providers as groups or associations.* As noted above, a bona group or association under this regulation cannot be a bank or trust company, insurance issuer, broker-dealer, or other similar financial services firm (including pension recordkeepers and third party administrators). This prohibition was designed by the DOL to draw a line between the sorts of employer-sponsored arrangements that are regulated by ERISA and commercial service providers that lack the requisite connection to the employment relationship. For example, the DOL would not recognize a bank's trust department as a group or association of the employers that might maintain plans with that bank, nor a TPA firm with respect to its employer-clients that maintain plans administered by the TPA. To include commercial service providers as groups or associations would, in the DOL's view, read the definition's employment-based limitation out of the statute. The DOL recognizes that, "in a broad colloquial sense," one could say that these commercial service providers act indirectly in the interest of their customers, but that does not convert every service provider into an ERISA-covered employer of their customer's employees within the meaning of ERISA §3(5).

(2) Commonality of interest. The commonality of interest requirement is addressed in Prop. DOL Reg. §2510.3-55(b)(2) and can be met in one of two ways. One way is for the employers to be in the same trade, industry, line of business or profession. See Prop. DOL Reg. §2510.3-55(b)(2)(i)(A). For example, a defined contribution MEP could be made available to a group or association open to employers who are law firms. The other way is for the employers to have a principal place of business in a region that does not exceed the boundaries of the same State (e.g., employers in the State of California) *or* of the same metropolitan area (e.g., an area that matches a Metropolitan Statistical Area, as defined by OMB), even if the metropolitan area includes more than one State (e.g., the Washington, DC area). See Prop. DOL Reg. §2510.3-5(b)(2)(i)(B). If the same State or metropolitan area option is used, then the group or association may have members of different types of business that need not be in the same trade, industry or line of business. The State or metropolitan area option need not include all employers within the designated area. For example, a group or association could include only certain provisions, certain types of owners (e.g., women or minority owners) or persons who share religious convictions who are within that designated area. Commonality determinations are based on relevant facts and circumstances.

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Participation by group or association in the plan. **Prop. DOL Reg. §2510.3-55(b)(2)(ii) provides that, if the group or association itself is an employer member of the group or association, it is deemed to meet the condition that the member employees be in the same trade, industry, line of business, or profession.**

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PEOs. The proposed regulations create a separate category for bona fide PEOs. Thus, the bona fide group or association definition above would not apply to a PEO that sponsors a defined contribution MEP under this proposal. The definition of a PEO for purposes of this regulation is a human-resource company that contractually assumes certain employer responsibilities of its client employers.

(1) Definition of a bona fide PEO. A bona fide PEO is an organization that meets the following requirements: (a) The organization performs substantial employment functions (see (2) below) on behalf of its client employers, and maintains adequate records relating to such functions; (b) the organization has substantial control over the functions and activities of the MEP, as the plan sponsor (as defined in ERISA §3(16)(B)), the plan administrator (as defined in ERISA §3(16)(A)), and a named fiduciary (as defined in ERISA §402); (c) the organization ensures that each client employer that adopts the MEP acts directly as an employer of at least one employee who is a participant covered under the defined contribution MEP; and (d) the organization ensures that participation in the MEP is available only to employees and former employees of the organization and client employers, and their beneficiaries. See Prop. DOL Reg. §2510.3-55(c)(1).

(2) Safe harbor criteria for substantial employment functions. As a safe harbor, an organization would be considered to perform substantial employment functions on behalf of its client employers if it is a certified PEO (see (2)(a) below), or meets at least five of nine criteria described in (2)(b) below. However, the DOL recognizes in the introductory paragraph of Prop. DOL Reg. 2510.3-55(c)(2) that a single criterion could alone establish substantial employment functions, depending on the facts and circumstances of a particular situation and the particular criterion. However, the safe harbor below services as a means of eliminating a more subjective facts and circumstances test.

(2)(a) Certified PEO. A certified PEO (CPEO) is defined in IRC §7705(a) and regulations thereunder. A CPEO would be permitted to sponsor a defined contribution MEP if it has entered into a service contract within the meaning of IRC §7705(e)(2) of the Internal Revenue Code with respect to its client-employers that adopt the defined contribution MEP with respect to the client-employer employees participating in the MEP, pursuant to which it satisfies the criteria in (i), (ii) and (iii) of (2)(b) below, and the organization meets any two or more of the criteria set forth (iv) through (ix) of (2)(b) below. See Prop. DOL Reg. §2510.3-55(c)(2)(i).

(2)(b) Criteria-based determination. The organization would be treated as performing substantial employment functions if it meets any five or more of the following nine criteria described in (2)(b)(i) through (2)(b)(ix) below with respect to client-employer employees participating in the plan. See Prop. DOL Reg. §2510.3-55(c)(2)(ii). Note that this determination is made with respect to the client-employers who will be adopting the MEP. The PEO's relationship with other client-employers would not have to meet these criteria.

(2)(b)(i) Wages. The organization is responsible for payment of wages to employees of its client-employers that adopt the plan without regard to the receipt or adequacy of payment from those client-employers.

(2)(b)(ii) Employment taxes. The organization is responsible for reporting, withholding, and paying any applicable federal employment taxes for its client employers that adopt the plan, without regard to the receipt or adequacy of payment from those client- employers.

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(2)(b)(iii) Hiring/firing. The organization is responsible for recruiting, hiring, and firing workers of its client-employers that adopt the plan in addition to the client-employer's responsibility for recruiting, hiring, and firing workers.

(2)(b)(iv) Employment policies The organization is responsible for establishing employment policies, establishing conditions of employment, and supervising employees of its client- employers that adopt the plan in addition to the client-employer's responsibility to perform these same functions.

(2)(b)(v) Compensation. The organization is responsible for determining employee compensation, including method and amount, of employees of its client-employers that adopt the plan in addition to the client-employers' responsibility to determine employee compensation.

(2)(b)(vi) Workers' compensation. The organization is responsible for providing workers' compensation coverage in satisfaction of applicable State law to employees of its client- employers that adopt the plan, without regard to the receipt or adequacy of payment from those client-employers.

(2)(b)(vii) Human resources. The organization is responsible for integral human-resource functions of its client-employers that adopt the plan, such as job-description development, background screening, drug testing, employee-handbook preparation, performance review, paid time-off tracking, employee grievances, or exit interviews, in addition to the client employer's responsibility to perform these same functions.

(2)(b)(viii) Regulatory compliance. The organization is responsible for regulatory compliance of its client-employers participating in the plan in the areas of workplace discrimination, family-and-medical leave, citizenship or immigration status, workplace safety and health, or Program Electronic Review Management labor certification, in addition to the client-employer's responsibility for regulatory compliance.

(2)(b)(ix) Continuing plan obligations. The organization continues to have employee-benefit-plan obligations to MEP participants after the client employer no longer contracts with the organization.

Treatment of working owners. The regulation also would treat a working owner of a trade or business as both an employer that would be eligible to be a member of a group or association, and an employee of such employer. See Prop. DOL Reg. §2510.3-55(d)(1). This rule would not apply to the definition of MEPs sponsored by PEOs. For a working owner to participate in a MEP sponsored by a PEO, the working owner's trade or business would have to have at least one common law employee to participate in that MEP. A working owner without employees would unlikely have a relationship with a PEO anyway.

(1) Definition of working owner. A working owner for this purpose means an individual who a responsible plan fiduciary determines is an individual who: (1) has an ownership right of any nature in a trade or business (whether incorporated or unincorporated, such as an S corporation, an LLC, or a sole proprietorship), including partners or other self-employed individuals, (2) is earning wages or self-employment income from the trade or business for providing personal services to the trade or business, and (3) either works on average at least 20 hours per week (or at least 80 hours per month)

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providing personal services to the working owner's trade or business, or, in the case of a MEP sponsored by a bona group or association, has wages or self-employment income from the trade or business that at least equals the working owner's cost of coverage for participation by the working owner (and any covered beneficiaries) in any group health plan sponsored by the group or association in which the individual is participating or is eligible to participate. See Prop. DOL Reg. §2510.3-5(d)(2). DOL Reg. §2510.3-3(c) (which defines an employee for ERISA purposes) would be amended to reflect that, for purposes of DOL Reg. §2510.3-55, a working owner as defined in §2510.3-55(d), would be treated as an employee for purposes of the MEP.

(2) Establishing and monitoring eligibility of working owner. The determination under this paragraph of whether a working owner may participate in the group health plan must be made when the working owner first becomes eligible for coverage under the plan. In addition, continued eligibility must be periodically confirmed pursuant to reasonable monitoring procedures. See Prop. DOL Reg. §2510.3-55(d)(3). A reasonable procedure could involve reliance on written documentation or a sworn statement by the working owner, without independent verification, of hours worked or of earned income levels, provided there isn't something in the document or statement, or other knowledge possessed by the fiduciary, that would cause a reasonable fiduciary to question the accuracy or completeness of the documentation.

ERISA obligations. The MEP sponsor (i.e., the group or association that satisfies the regulatory requirements, or a PEO) would generally be the one primarily responsible, as the plan administrator and named fiduciary, for compliance with the requirements of Title I of ERISA, including reporting and disclosure, and fiduciary obligations. A MEP under this proposal would be subject to all of the ERISA Provisions applicable to defined contribution retirement plans, including the fiduciary responsibility and prohibited transaction provisions of Title I of ERISA. As a plan maintained by more than one employer, the MEP also would have to satisfy the service crediting rules under ERISA §210(a), regarding the determination of eligibility, vesting and accrual service for employees covered by the plan and one might work for more than one of the participating employers.

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DOL relaxes "commonality" standard to determine if certain multiple employer *welfare* plans (Association Health Plans) constitute a single-plan in order to expand the market for group health coverage [Citation: *DOL Reg. §2510.3-5*, 83 F.R. 28912 (June 21, 2018)]
Text available at http://bit.ly/2IaWrkH

In response to Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States," the DOL has issued final regulations to loosen the "commonality rule" for association health plans (AHPs), to expand access to health coverage. The regulations allow more employers to form AHPs, thereby enabling small businesses to purchase large group health insurance or to self-insure health coverage for their employees through a single ERISA-covered plan that will qualify as a multiple employer welfare plan. These plans are distinct from non-plan multiple employer welfare arrangements (MEWAs). Health insurance coverage sold to MEWAs continues as under present arrangements.

To accomplish its goal, the DOL focuses on the definition of an employer under ERISA §3(5) and prescribes a more relaxed standard for commonality with respect to AHPs to allow a larger number of employers to join in a single plan.

Effective date/applicability date. The regulations are effective August 20, 2018, but the DOL has designed a staged applicability date system, depending on the type of plan involved. Thus, the regulations become applicable on: (1) September 1, 2018, for fully-insured employee welfare benefit plans that meet the conditions of these regulations, (2) January 1, 2019, for any employee welfare benefit plan that is not fully insured, was in existence on June 21, 2018, *and* met the DOL's sub-regulatory guidance on bona fide groups and associations that applied before June 21, 2018, and that chooses to become an AHP sponsored by a bona fide group or association of employers that meets the conditions of these regulations, and (3) April 1, 2019, for any other employee employer benefit plan that satisfies these regulations.

Background on the commonality rule. ERISA §3(5) refers to a group or association of employers as being able to act as an employer for ERISA plan purposes. DOL's previously-issued guidance states that a group or association of employers can constitute an employer under ERISA §3(5) with respect to the maintenance of a single plan if the group or association, acting in the interest of its employer members, establishes a benefit program for the employees of member employers and exercises control over the amendment process, plan termination, and similar functions on behalf of these members. Examples of "bona fide" employer groups or associations are discussed in Advisory Opinions 2008-07A, 2003-17A and 2001-04A. Where the group or association does not itself constitute an "employer" under this concept, then each employer adopting a plan sponsored by such group or association is treated as establishing a separate plan. See, for example, Advisory Opinion 2012-4 (involving a so-called "open multiple employer plan (MEP)"). The touchstone of the DOL's definition of a group or association acting as an employer is the "commonality test," where the group or association has a sufficiently close economic or representational nexus to the employers and employees that participate in the plan.

New regulatory requirements. Under these new regulations, to be treated as an employer with respect to a group health plan, an association must: (1) satisfy the definition of a bona fide group or association of employers under DOL Reg. §2510.3-5(b), (2) meet the commonality of interest rule under DOL Reg. §2510.3-5(c), and (3) comply with the nondiscrimination requirements of DOL Reg. §2510.3-5(d). The commonality rule under this regulation is more relaxed than under the historical guidance on the subject. The DOL expects these rules will prompt some working owners who were previously uninsured and some small businesses that did not previously offer insurance to their employees to enroll in an AHP. The new

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rule also may prompt some small businesses to switch from existing individual or small group policies to AHPs.

***Intended to be additional alternative.* In the preamble, the DOL notes that some AHPs that have relied on prior DOL guidance (e.g., Advisory Opinions 94-07A, 2003-13A, and 2007-06A) may not be able to meet all of the conditions of these new regulations. The DOL clarifies that the regulation is intended to be an additional mechanism for groups or associations to meet the definition on an "employer"" and sponsor a single ERISA-covered group health plan. AHPs may continue to rely on the previous guidance instead. See DOL Reg. §2510.3-5(a) and 83 F.R. at 28916.**

✪ *Bona fide group or association.* Under the regulation, a bona fide group or association that is capable of establishing a group health plan that is an employee welfare benefit plan includes a group or association that meets the following requirements: (1) although the group or association's primary purpose may be to offer and provide group health plan coverage to its employer members and their employees, the group or association must have at least one substantial business purposes *unrelated* to offering and providing health coverage or other employee benefits (see safe harbor below), (2) each employer member of the group or association participating in the group health plan must be a person acting directly as an employer of at least one employee who is a participant covered under the plan, (3) the group or association must have a formal organizational structure with a governing body and by-laws or other similar indications of formality, (4) the functions and activities of the group or association must be controlled by its employer members, and the group's or association's employer members that participate in the group health plan must control the plan (*in form and in substance*), determining the requisite control on the basis of all relevant facts and circumstances (see below), (5) the group or association does not make health coverage through the group's or association's plan available other than to employees and former employees of employer members and beneficiaries (e.g., spouses, dependents) of those employees and former employees, except as required by COBRA, and (6) the group or association is not a health insurance issuer (as described in ERISA §733(b)(2) - i.e., an insurance company, insurance service, or insurance organization (including a health maintenance organization) that is required to be licensed to engage in the business of insurance and that is subject to state law that regulates insurance) or owned or controlled by such a health insurance issuer. See DOL Reg. §2510.3-5(b)(1), (2), (3), (4), (6) and (8). In addition, the definition of a bona fide group or association is not met unless the commonality of interest and nondiscrimination requirements described below are also satisfied. See DOL Reg. §2510.3-5(b)(5) and (7).

➢ *Safe harbor rule for substantial business purpose.* Element (1) of the definition of a bona fide group or association is that there be at least one additional substantial business purposes besides offering health plan or other employee benefits. DOL Reg. §2510.3-5(b)(1) includes a safe harbor rule which deems such a substantial business purpose to exist if the group or association would be a viable entity in the absence of sponsoring an employee benefit plan. A business purpose includes promoting common business interests of its members or the common economic interests in a given trade or employer community, and is not required to be a for-profit activity. The DOL offers examples of other substantial business purposes in the preamble to the final rule, including: (1) offering classes or education materials on business issues of interest to the association members, (2) establishing business standards or practices for members, (3) engaging in public relations activities such as advertising, education, and publishing on business issues of interest to members, or (4) advancing the well-being of the industry in which the members operate through activities other than the offering of a group health plan. In each of these cases, the other business purpose or activity must be substantial enough so that the association could be a viable entity apart from the offering of the AHP. If the association operated with active membership before sponsoring the

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AHP, that would be compelling evidence that a substantial business purpose exists. The preamble also notes that an association that otherwise meets the substantial business purpose requirement may establish a subsidiary that is formed solely to administer the AHP.

➢ *Control.* As noted above, control over the group or association and control over the group health plan, as required by the definition of a bona fide group or association, are determined by considering all relevant facts and circumstances. In the preamble to the final rule, the DOL offers a non-exclusive list of relevant factors: (1) whether employer members regularly nominate and elect directors, officers, trustees, or other similar representatives that constitute the governing body of the group or association or of the plan, (2) whether employer members have authority to remove such director, officer, trustee, or 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 (e.g., material amendments to the plan, including changes in coverage, benefits, and premiums). The DOL states that it ordinarily will consider the presence of these three factors as sufficient to meet the control test.

➢ *Preclusion of insurance issuers.* As noted above, a bona group or association under this regulation cannot be a health insurance issuer. This prohibition was designed by the DOL to draw a line between the sorts of employer-sponsored arrangements that are regulated by ERISA and commercial insurance arrangements that lack the requisite connection to the employment relationship. In the DOL's view, being an insurance company or concern necessarily would require the group or association to serve and advance the exclusive business interests of the company or concern, including its shareholders or other owners, which might stand as an obstacle to acting in the interests of the employer members of the group or association. The prohibition also serves to prevent the various conflicts of interest that could arise (e.g., a health insurance issuer acts as both an AHP plan sponsor and also offers an insurance policy or administrative services in connection with the plan in exchange for compensation). However, this prohibition does not prevent a health insurance issuer from participating as an employer member of a bona fide association of insurers that sponsors an AHP. Nor does it prevent a group or association of health insurance issuers acting as employers from sponsoring an AHP for the benefit of their employees. In such cases, the health insurance issuers would be controlling the AHP in their capacity as employers of covered employees, and not in their capacity as health insurance companies, insurance services, or insurance organizations.

Insurer may provide administrative services to the AHP. **The fact that the group or association not be a health insurance issuer does not preclude a health insurance issuer or other business entity that is part of the U.S. healthcare delivery system from providing administrative services to an AHP. For example, a health insurance issuer could provide: (1) third party claims administration and payment services to an AHP, or (2) services to an AHP such as medical provider network design, pharmacy network design, formulary design, recordkeeping services, reporting and disclosure services, wellness program administration, 24-hour nurse helpline services, or audits services.**

✪ *Commonality of interest.* The commonality of interest requirement can be met in one of two ways. One way is for the employers to be in the same trade, industry, line of business or profession. See DOL Reg. §2510.3-5(c)(1)(i). For example, an AHP could be made available to a group or association open to employers who are law firms. The other way is for the employers to have a principal place of business in a region that does not exceed the boundaries of the same State (e.g., employers in the State

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of California) *or* of the same metropolitan area (e.g., an area that matches a Metropolitan Statistical Area, as defined by OMB), even if the metropolitan area includes more than one State (e.g., the Washington, DC area). See DOL Reg. §2510.3-5(c)(1)(ii). If the same State or metropolitan area option is used, then the group or association may have members of different types of business that need not be in the same trade, industry or line of business. The State or metropolitan area option need not include all employers within the designated area. For example, a group or association could include only certain provisions, certain types of owners (e.g., women or minority owners) or persons who share religious convictions who are within that designated area. See 83 F.R. at page 28926. Commonality determinations are based on relevant facts and circumstances.

Participation by group or association in the health plan. **DOL Reg. §2510.3-5(c)(2) provides that, if the group or association itself is an employer member of the group or association, it is deemed to meet the condition in §2510.305(c)(1)(i) that the member employees be in the same trade, industry, line of business, or profession. This rule was added by the DOL for clarification.**

✪ *Nondiscrimination.* There are three nondiscrimination requirements imposed under DOL Reg. §2510.3-5(d).

(1) Health factors. Employer membership in the group or association may not be subject to a condition that is based on any health factor, as defined in DOL Reg. §2590.702(a) (e.g., benefit claims history or type of disease) of an employee or former employee (or any family members or other beneficiaries of such individuals). See DOL Reg. §2510.3-5(d)(1), and Examples 1 and 2 in DOL Reg. §2510.3-5(d)(5).

(2) Eligibility. The group health plan must comply with the rules of DOL Reg. §2590.702(b) with respect to nondiscrimination rules for eligibility for benefits (subject to the rule in (4) below). See DOL Reg. §2510.3-5(d)(2). For example, different coverage waiting periods for full-time and part-time employees would be a permitted distinction. See Example 3 of DOL Reg. §2510.3-5(d)(2).

(3) Premiums. The group health plan must comply with the rules of DOL Reg. §2590.702(c) with respect to nondiscrimination in premiums or contributions required by any participant or beneficiary for coverage under the plan (subject to the rule in (4) below). Some examples are cited in (4) below.

(4) Employer members cannot be treated as distinct groups. In applying the nondiscrimination rules in (2) and (3) above, the group or association may not treat the employees of different employer members as distinct groups of similarly-situated employees based on a health factor of one or more individuals. See DOL Reg. §2510.3-(d)(4). In other words, eligibility or premium differences related to health factors cannot apply just to the employees of a particular member employer by treating such employees as "similarly-situated" merely because they work for that particular employer.

Examples of impermissible and permissible premium category distinctions. The examples in DOL Reg. §2510.3-5(d)(5) provide illustrations of classifications for differential premiums that would and would not be acceptable, taking into consider the requirement described in (4) above.

- *Chronic illness classification.* Example 4 involves employees of one specified member employer being charged higher premiums because that member employer has employees who have chronic illnesses. This violates the requirement described in (4) above.
- *Location of business.* A group or association of employers in a particular State could charge different premiums depending on whether an employer member's *principal business* was inside or outside the capital city of that State without violating the requirement in (4) above. This is because location within the capital city is not a health factor. See Example 5. On the

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other hand, in Example 6, a limitation based on location is found to violate the requirement in (4) above because it is aimed at a particular employer member who has an employee with cancer (i.e., that employer is the only member that fits the particular location description that is subject to the higher premiums).

- *Industry, industry subsector or job classification.* Example 7 permits different premiums to be based on an industry subsector in which the employer member primarily operates within the industry in which employer members belong (e.g., agricultural subsectors, such as crop farming, livestock, fishing, forestry among members of an agriculture industry association). Similarly, Example 8 illustrates the acceptability of different premiums for employers within a retail industry association plan that is based on occupations within the industry (e.g., cashier, stocker, sales associate). Where the group or association is not within a single industry, but rather covers employees in various industries within a State, different premiums may be applied based on the particular industry of the employer member (e.g., construction, education, health, financial services, manufacturing, transportation) or the work schedule of the employees (e.g., part-time and full-time charged different rates), or a combination of both (e.g., part-time construction workers charged different premiums than full-time construction workers). See Example 9.
- *Rewards for wellness programs.* Example 10 illustrates the acceptability of providing rewards, such as a premiums discount or rebate, a waiver of all or part of copays, or any financial or other incentives, in return for adherence to a wellness program that satisfies the conditions in DOL Reg. §2590.702(f).

Treatment of working owners. The regulation also treats a working owner of a trade or business as both an employer that would be eligible to be a member of a group or association, and an employee of such employer. See DOL Reg. §2510.3-5(e)(1). A working owner for this purpose means an individual who: (1) has an ownership right of any nature in a trade or business (whether incorporated or unincorporated, such as an S corporation, an LLC, or a sole proprietorship), including partners and other self-employed individuals, (2) is earning wages or self-employment income for providing personal services to the trade or business, and (3) either works on average at least 20 hours per week (or at least 80 hours per month) providing personal services to the trade or business, or has wages or self-employment income from the trade or business that at least equals the working owner's cost of coverage for participation of the owner (and any covered beneficiaries) in the group health plan sponsored by the group or association in which the individual is participating. See DOL Reg. §2510.3-5(e)(2). By adding this provision, it wouldn't matter whether the individual would otherwise be treated as an employee for ERISA purposes under DOL Reg. §2510.3-3 in order to be covered by the AHP, and DOL Reg. §2510.3-3(c) (which defines an employee for ERISA purposes) is amended to reflect that.

✪ *Establishing and monitoring eligibility of working owner.* The determination under this paragraph of whether a working owner may participate in the group health plan must be made when the working owner first becomes eligible for coverage under the plan. In addition, continued eligibility must be periodically confirmed pursuant to reasonable monitoring procedures. See DOL Reg. §2510.3-5(e)(3). The periodic confirmation of eligibility replaced the self-representation rule that was originally proposed, in order to put some more "teeth" into the definition of a working owner for purposes of this rule. However, a reasonable procedure could involve reliance on written documentation or a sworn statement by the working owner, without independent verification, of hours worked or of earned income levels, provided there isn't something in the document or statement, or other knowledge possessed by the fiduciary, that would cause a reasonable fiduciary to question the accuracy or completeness of the documentation.

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Severability. DOL Reg. §2510.3-5(g) prescribes a severability rule under which, if any provision of DOL Reg. §2510.3-5 is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, the provision will be construed so as to continue to give the maximum effect to the provision permitted by law. However, if such holding is one of utter invalidity or unenforceability, the provision is treated to be severable from DOL Reg. §2510.3-5 and will not affect the remainder of these regulations. For example, if a court rules that the ''working owners'' provision in §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 §2510.3-5(c) by being located in the same geographic locale.

Expanded definition of employer *limited to group health plans*. The regulatory language is limited to a group health plan that is an employee welfare benefit plan (i.e., AHPs) and is not intended to address the application of ERISA §3(5) in any other context. The DOL acknowledges, however, that the statute does not refer to the elements of the historical commonality test, so that a determination may be more broadly guided by ERISA's purposes, including, as in the case of these regulations, the need to expand access to healthcare and to respond to statutory changes and changing market dynamics. It is unlikely that the DOL on its own motion would issue a similar regulation to allow open MEPs, as described in Advisory Opinion 2012-4, to be treated as a single plan. But the DOL may be open to relaxing in the future the commonality standards for some employee pension benefit plans that might not squarely fall within the historical commonality rule analysis.

ERISA obligations. As group health plans, AHPs are subject to the disclosure requirements of Title I of ERISA. This includes the requirement to provide an SPD and Summary of Material Modifications (SMMs). The AHP's SPD must disclose, in a manner calculated to be understood by the average plan participant, the participants' rights and obligations under the plan. The SPD must include, among other requirements, a description of the cost- sharing provisions, limits on benefits, and the extent to which preventive services, prescription drugs, and medical tests, devices and procedures must be covered under the plan. Other applicable requirements, such as the fiduciary requirements under Part 4 of Subtitle B of Title I, also apply.

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ADDITIONAL DEFINED BENEFIT PLAN ISSUES

PBGC Disaster Relief

PBGC simplifies procedures for determining whether PBGC relief applies to a disaster; coordination with IRS announcements [Citation: *Announcement of PBGC Disaster Relief*, 83 F.R. 30991 (July 2, 2018)]
Text available at http://bit.ly/2zr44En

The PBGC is changing its approach for granting relief under Title IV for victims of disasters. In the past, affected persons had to wait for a formal announcement by the PBGC's disaster relief page is at http://bit.ly/2fzXA9V. Going forward, the PBGC's grant of disaster relief will be triggered by IRS news releases of disaster relief, with certain exceptions identified in this announcement. The details of this new disaster relief approach are detailed below.

General relief. Unless a filing or action is on the Exceptions List (see below), persons subject to a filing or action requirement under Title IV of ERISA can be assured that the PBGC grants disaster relief when, where, and for the *same* relief period that IRS grants relief for taxpayers affected by a disaster. Filers will not have to wait for PBGC to issue a separate announcement. IRS relief is posted at the IRS website. See http://bit.ly/2dJlhuZ. In many cases, the IRS refers taxpayers to FEMA for more specifics about covered counties within a disaster era. See the FEMA website at https://www.fema.gov/disasters.

✪ *Covered disasters.* Disasters covered by this relief approach are those for which the IRS announces that tax relief is being granted for affected taxpayers that includes filing extensions for the Form 5500 series returns. The relief will apply to the disaster cited in the IRS news relief, and to the covered disaster area identified in that release. The PBGC relief period will coincide with the starting and ending dates of the relief period covered by the IRS news release. If the IRS updates its release to broaden the disaster area, the PBGC relief will apply to that broadened area.

✪ *Conditions for relief.* To qualify for the relief, all of the following conditions must be met.

- Who qualifies. The relief is sought by: (1) the person responsible for a filing, payment, or other action under PBGC regulations (e.g., a plan administrator or contributing sponsor) is located in the disaster area, or (2) a person responsible for providing information or other assistance needed for the filing, payment, or other action (e.g., a service provider (such as the plan's enrolled actuary) or bank) is located in the disaster area. [Note that the standard of eligibility is based on the location of the responsible person in the disaster area, rather than the vague standard formerly used by the PBGC that referred to persons "directly affected" by the disaster.]
- Applicable due date. The due date of the filing, payment, or other action falls within the relief period.
- PBGC notification. The filer must notify the PBGC of the filer's eligibility for disaster relief on or before the last day of the relief period. See the discussion of the notification procedures below.
- Not excepted from relief. The filing or action is not described in the Exceptions List (see below).

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✪ *Scope of relief.* If the above conditions are met, the due date of any eligible filing, payment, or other action is extended to the end of the relief period. Any eligible filing will not be subject to a late filing penalty under ERISA §4071 or ERISA §4302 (pertaining to multiemployer plans). In addition, the extension of a premium payment under this relief means that neither late payment penalties under ERISA §4007 nor interest charges will apply. [Before this announcement, the PBGC would treat the extended due date as applying only for late payment penalties and not for interest. This new approach will also waive interest from the original due date to the relief-extended due date.]

- Effect on other filings or actions. If the due date for another filing or other action is based on the due date of a filing or action that qualifies for this relief, then the due date for that other filing or action is also extended. For example, if a plan is filing certain actuarial information by an alternative due date that is 15 days after a plan's Form 5500 due date (see ERISA §4010.10(b)), and the deadline to file a Form 5500 is extended because of a disaster, then the 15-day period in PBGC's regulation is automatically measured from the last day of the Form 5500 disaster relief period.
- ERISA §4010 filings. Previously, the PBGC generally did not grant relief for ERISA §4010 filings. Under this new approach, ERISA §4010 filings are covered by the relief because they are not listed on the Exceptions List.

PBGC notification. The notification procedure differs for premium filings and other filings or actions.

✪ *Premium filings.* The PBGC should be notified by providing certain information, as set forth in the Filing Instructions for the applicable plan year, as part of the Comprehensive Premium Filing. The PBGC also is encouraging filers to notify it by email *to premiums@pbgc.gov* as soon as reasonably possible after the filer determines it is eligible for disaster relief. The email should contain the following identifying information: (1) the number of the applicable IRS News Release, (2) plan information (i.e., plan name, EIN, plan number), and (3) the name and address of the person affected by the disaster. Item (3) may be omitted if the plan administrator's address reported in the most recently submitted premium filing is in the applicable disaster area. In situations where a filer is unable to submit the Comprehensive Premium Filing by the end of the relief period (or anticipates having difficulty in doing so), the filer should notify the PBGC by sending an email with this information. [Note that these procedures provide an option where the Comprehensive Premium Filing cannot be filed by the extended due date. Previously, relief was contingent upon the filing being made by the applicable extended due date.]

✪ *All other filings or actions.* If a filing other than a premium filing is involved, the instructions for that filing generally will provide disaster relief instructions that need to be filed. If there are no such instructions, or if the relief is to apply to an action other than a filing, the PBGC should be notified of the person's eligibility for relief by sending an email by the end of the relief period. The notification should be made using the email address included in the instructions for the particular filing (if applicable), or on a PBGC web page listing applicable contact information, such as PBGC's Contact Information for Practitioners page. The notification email should contain the identifying information described above for premium filings.

Example. Plan A is a calendar year plan. Absent disaster relief, Plan A would be required to submit the 2018 Comprehensive Premium Filing (CPF) and pay its 2018 premium by October 15, 2018. IRS issues a news release providing disaster relief for taxpayers in a specified disaster area for the period September 4, 2018 through January 31, 2019. Plan A's plan administrator is located in the disaster area covered by the

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IRS disaster relief news release. Plan A notifies PBGC that it is eligible for disaster relief on or before January 31, 2019 (either by submitting a CPF in which such eligibility is reported or by sending an email to PBGC). If Plan A pays its 2018 premium on or before January 31, 2019 (the end of the relief period), no late payment charges (interest or penalties) will be assessed by the PBGC. If Plan A pays its 2018 after January 31, 2019, late payment charges will begin accruing on February 1, 2019 (not retroactive to the original due date).

Exceptions List. The following filings or actions are not automatically extended under the disaster relief policy described above. The PBGC has identified these to be of particular importance or of sufficient time sensitivity to create a high risk of substantial harm to participants or to the PBGC's insurance program. For relief on these filings, the person must follow the case-by-case relief procedures described below.

- Advance notices of reportable events under ERISA §4043 (Form 10-Advance filing requirement),
- Notices of large missed contributions under ERISA §303(k) (Form 200 filing requirement),
- Any of the following post-event notices under ERISA §4043 (Form 10 filing requirement): (1) failure to make required contributions under $1 million, (2) inability to pay benefits when due, (3) liquidation, (4) loan default, or (5) insolvency or similar settlement, and
- Actions related to distress terminations for which the PBGC has already issued a distribution notice.

Previously, the PBGC granted relief on all post-event notices under ERISA §4043. Under this new approach, general relief applies only to the post-event notices not listed in the above Exceptions List.

Case-by-case relief. The affected person should follow the instructions for requesting a waiver or extension, as set forth in the instructions for the particular filing. For example, for a reportable events filing on the Exceptions List, follow the provision for waivers and extensions in PBGC's reportable events regulation (PBGC Reg §4043.4). That provision explains that a request for a waiver or extension must be filed with PBGC in writing (which may be in electronic form) and must state the facts and circumstances on which the request is based. If there is no such guidance, the person should contact the PBGC as soon as reasonably possible using the phone number or email address in the instructions for the particular filing, or on a PBGC web page listing applicable contact information, such as PBGC's Contact Information for Practitioners page.

> ✪ *Other method.* If the above procedures are not applicable, the person should contact the PBGC's Practitioner Problem Resolution Officer by: (1) email at *practitioner.pro@pbgc.gov,* (2) telephone at 800–736–2444, or (3) U.S. mail, addressed to Practitioner Problem Resolution Officer, Pension Benefit Guaranty Corporation, 1200 K Street NW, Suite 610, Washington, DC 20005-4026.

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Minimum Funding Requirements: Mortality Assumptions

Static mortality tables for IRC §430(h)(3) funding calculations for 2019 valuation dates; applicable mortality tables for IRC §417(e) determinations for annuity starting dates that occur in stability periods beginning in 2019; mortality improvement rates for 2019 valuation dates [Citation: *Notice 2018-02*, 2018-2 I.R.B. (January 8, 2018) (advance release on December 14, 2017)]
Text available http://bit.ly/2AAzIeQ

Notice 2018-02 publishes the static mortality table for valuation dates occurring in 2019. See the factors in the Appendix of the Notice. The tables were developed from the base mortality rates, projection factors, and weighting factors set forth in Treas. Reg. §1.430(h)(3)-1, as published on October 5, 2017, with respect to post-2018 plan years. The Notice also provides the applicable mortality tables that are to be used for IRC §417(e)(3) calculations for distributions with annuity starting dates occurring during stability periods beginning in 2019 (see the unisex factors in the Appendix of Notice 2018-02).

The 2017 regulations use the Mortality Improvement Scale MP–2016 Report (issued by the Retirement Plans Experience Committee (RPEC) of the Society of Actuaries) for plan years beginning in 2018, with updated mortality improvement rates for subsequent plan years that take into account new data for mortality improvement trends of the general population to be provided in guidance published by the IRS in the Internal Revenue Bulletin. See Treas. Reg. §1.430(h)(3)-1(a)(2)(i)(C). The first update on the mortality improvement rates used in the 2018 regulations is published in Notice 2018-02. The updated rates, which apply to valuation dates ocurring in 2019, are the mortality improvement rates in the Mortality Improvement Scale MP-2017 Report (issued by the Retirement Plans Experience Committee (RPEC) of the Society of Actuaries, which are available at http://bit.ly/2kJdgJF. If the plan uses the static mortality tables in Notice 2018-02, these updated improvement rates are built into that table. If the plan uses generational tables, then those tables must be updated for the new mortality improvement rates with respect to 2019 valuation dates.

Static mortality tables for IRC §430(h)(3) funding calculations for 2020 valuation dates; applicable mortality tables for IRC §417(e) determinations for annuity starting dates that occur in stability periods beginning in 2020; mortality improvement rates for 2020 valuation dates [Citation: *Notice 2019-26,* 2019-25 I.R.B. (April 8, 2019) (advance release on March 22, 2019)]
Text available https://www.irs.gov/pub/irs-drop/n-19-26

Notice 2019-26 publishes the static mortality table for valuation dates occurring in 2020. See the factors in the Appendix of the Notice. The tables were developed from the base mortality rates, projection factors, and weighting factors set forth in Treas. Reg. §1.430(h)(3)-1, as published on October 5, 2017, with respect to post-2017 plan years. The Notice also provides the applicable mortality tables that are to be used for IRC §417(e)(3) calculations for distributions with annuity starting dates occurring during stability periods beginning in 2020 (see the unisex factors in the Appendix of Notice 2019-26).

The 2017 regulations use the Mortality Improvement Scale MP–2016 Report (issued by the Retirement Plans Experience Committee (RPEC) of the Society of Actuaries) for plan years beginning in 2018, with updated mortality improvement rates for subsequent plan years that take into account new data for mortality improvement trends of the general population to be provided in guidance published by the IRS in the Internal Revenue Bulletin. See Treas. Reg. §1.430(h)(3)-1(a)(2)(i)(C). Notice 2019-26 updates the

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mortality improvement rates which apply to valuation dates ocurring in 2020. The mortality improvement rates used are those found in the Mortality Improvement Scale MP-2018 Report (issued by the Retirement Plans Experience Committee (RPEC) of the Society of Actuaries, which are available at http://bit.ly/2TBTT4S. If the plan uses the static mortality tables in Notice 2018-02, these updated improvement rates are built into that table. If the plan uses generational tables, then those tables must be updated for the new mortality improvement rates with respect to 2019 valuation dates.

Nondiscrimination Testing Under IRC §401(a)(4): DB/DC Combo Plans

Extension of temporary relief for certain DB/DC combo plans involving a "closed" DB plan to pre-2020 plan years [Citation: *Notice 2018-69*, 2018-37 I.R.B. (September 6, 2018)
Text available at http://bit.ly/2wcTqx9

Notice 2014-5, http://www.irs.gov/pub/irs-drop/n-14-05.pdf, the IRS provided temporary testing relief for closed DB plans that are part of a DB/DC combo for testing purposes, if certain requirements are met. The relief applies only with respect to amendments that were adopted no later than December 31, 2013. For details on this relief, please refer to Section IX, Part B.5.f., of Chapter 9 of The ERISA Outline Book. Pending the finalization of regulations that will provide permanent relief for certain closed DB plans, the IRS has been extending the applicability of the Notice 2014-5 relief. The latest such extension was announced in Notice 2018-69, http://bit.ly/2wcTqx9, which extended the relief to run through the end of the 2019 plan year. So, at this point, the relief will no longer apply starting with the 2020 plan year when, presumably, regulations will be in effect that such plans will have to comply with. For plans that don't qualify for the relief under Notice 2014-15 are able to rely on a special relief provision in the proposed regulations. See Prop. Treas. Reg. §1.401(a)(4)-9(b)(2)(v)(F). The relief in the proposed regulations is available for post-2013 plan years, pending the issuance of final regulations.

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Title IV: Plan Termination Procedures

Regulations incorporate PPA 2006 changes to the phase-in rules for guaranteed benefits for majority owners [Citation: *PBGC Reg. §§4001.2, 4022.24-4022.26, 4022.62-4022.63, 4043.2, 4044.10, 4044.14*, 83 F.R. 49799 (October 3, 2018)]
Text available at http://bit.ly

The PPA 2006 amended ERISA §4022(b)(5)(B) to replace the 30-year phase-in for "substantial owners" with a 10-year phase-in for majority owners, effective for plan terminations with respect to which a notice for intent to terminate is provided, or with respect to which involuntary termination proceedings are commenced, after December 31, 2005. Under this amended rule, the guaranteed benefit for a majority owner is reduced if the plan has been in existence for fewer than 10 years. To make the adjustment, the normal guaranteed benefit is multiplied by a fraction (not exceeding 1), the numerator of which is the number of years from the later of the adoption date or effective date of the plan, and the denominator of which is 10. This is a much simpler rule than what previously applied for substantial owners. Substantial owners who are not majority owners are now subject only to the standard 5-year phase-in rule under ERISA §4022(b)(1) that applies to all participants. The PBGC has issued regulations that incorporate this rule into its regulations. Prior to the adoption of these amended regulations, the PBGC's regulations referred to the substantial owner phase-in rule.

Definition of majority owner. A majority owner is an individual who, at any time during the 60-month period ending on the date the determination is made: (1) owns the entire interest in an unincorporated business, (2) is a partner of a partnership who has 50% or more interest in capital or profits, or (3) is a shareholder of a corporation who owns 50% or more of the value of either the voting stock or the entire stock of the corporation. See ERISA §4022(b)(5)(A), as amended by section 407 of the PPA 2006. PBGC 4001.2 adds this definition of majority owner to the general definitions section for the Title IV regulations.

✪ Attribution of ownership to determine majority owners. The flush paragraph following ERISA §4022(b)(5)(A)(iii) states that the attribution rules in IRC §1563(e) (including the rules under IRC §414(c)) apply to determine who is a majority owner, but only for purposes of applying ERISA §4022(b)(5)(A)(iii) (which applies only to a corporation). Was this an intentional limitation of the attribution rules only to incorporated companies? Apparently the PBGC does not believe so. In PBGC Reg. §4001.2, a definition of majority owner is added to the regulations that refers to the attribution rules under IRC §414(b) (which refers to IRC §1563(e)) and IRC §414(c) as applying to ownership in both unincorporated and incorporated businesses. The section 1563 attribution rules are discussed in Part B. of the attribution definition in Chapter 1A.

✪ Attribution from qualified plan *applies*. The flush paragraph of ERISA §4022(b)(5)(A) provides that the attribution rules of IRC §1563(e) are applied without regard to the rule under IRC §1563(e)(3)(C). [Note that PBGC Reg. §4001.2, as discussed in the prior paragraph, refers to IRC §414(b), which incorporates IRC §1563(e) and provides for the rule under IRC §1563(e)(3)(C) to be disregarded.] IRC §1563(e)(3)(C) provides that stock held by a qualified trust under IRC §401(a), such as an ESOP, is not attributed to the beneficiaries of that trust. Since this rule is disregarded to determine majority owners, the determination of whether an individual is a majority owner includes stock held indirectly by that individual in his or her capacity as the beneficiary of a qualified plan that holds stock in the corporation. For example, suppose an ESOP owns 100% of the stock of a corporation that maintains a PBGC-covered defined benefit plan. Further assume that one of the

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participants has more than 50% of the corporation's stock allocable to her account under the ESOP. That participant is deemed to own more than 50% of the corporation and, so, is a majority owner for purposes of ERISA §4022(b)(5)(A).

Interaction between general phase-in rule and the majority owner phase-in rule. The general phase-in rule applies for the 5-year period the plan is first in effect, and then separately with respect to each amendment that increases benefits, and doesn't distinguish among participants. However, for a majority owner, a separate phase-in of the guaranteed benefit applies during the first 10 plan years of the plan's existence. Once the plan is in effect for at least 10 years, then a majority owner remains subject only to the phase-ins with respect to benefit increases, just like any other participant, which is calculated over a 5-year period applied separately to each benefit increase.

✪ Formula for the majority owner phase-in. A majority owner's benefit guaranteed by the PBGC for the first 10 years of a plan's existence is determined using the following formula: Otherwise Guaranteed Benefit x Phase-In Fraction. The Otherwise Guaranteed Benefit is the benefit that the PBGC would otherwise guarantee under ERISA §4022 (taking into account the normal phase-in rules under ERISA §4022(b)(1) and (7) and other limitations described in Treas. Reg. §4022.21) if the participant were not a majority owner. The Phase-In Fraction is the number of full years (see next paragraph) of the plan's existence divided by 10. In other words 10% of the otherwise guaranteed benefit is phased-in for each year of the plan's existence. This formula is described in ERISA §4022(b)(5)(B) and is incorporated into the regulations by PBGC Reg. §4022.26(b).

✪ Measurement period for majority owner phase-in period. The first year taken into account under the 10-year period is the 12-month period starting on the later of: (1) the date the plan is adopted, or (2) the effective date of the plan. Each additional 12-month period thereafter is an additional year until the 10-year period is reached. No credit is given for periods of less than 12 months. When the plan terminates, the plan's period of existence is calculated through the plan's termination date (subject to the exception described below for PPA 2006 bankruptcy filings), with a partial year ending on such termination date being disregarded to determine if the 10-year phase-in period has been completed.

Example. A plan is adopted on November 1, 2018, effective January 1, 2019, the first year is the 12-month period ending December 31, 2019 (measured from January 1, 2019, because the effective date is later than the plan adoption date), and the tenth year would end December 31, 2029. If the plan were to terminate on October 31, 2028, there would only be 9 years credit (the partial year from January 1 through October 31, 2028, would not count), and 90% of the majority owner's Otherwise Guaranteed Benefit would be phased-in. On the other hand, if the plan were adopted on November 1, 2018, but made effective retroactive to January 1, 2018, the 10-year period would be measured from November 1, 2018 (the adoption date, because it is later than the effective date), and a full 10 years would be satisfied as of October 31, 2028, allowing 100% of the majority owner's guaranteed benefit to be paid if the plan's termination date were October 31, 2028.

✪ Bankruptcy filings. If the plan termination is a PPA 2006 bankruptcy termination, then the phase-in period is measured from the later of adoption date or effective date of the plan to the bankruptcy filing date. See PBGC Reg. §4022.26(c). [The term "PPA 2006 bankruptcy termination" is a reference to a plan that must use the bankruptcy filing date, in lieu of the plan termination date, for certain Title IV determinations, as a result of statutory changes made by the PPA 2006.]

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Modifications to reflect applicability of benefit increase phase-ins to all participants. Amended PBGC Reg. §§4022.24(a) and (b) and 4022.25 no longer include references to substantial owners. The result is to apply the 5-year phase-in for benefit increases to all participants, regardless of whether the participant is a majority owner. However, during the initial 10-year period of the plan's existence, benefit increases adopted during that initial period would not fully phase-in for the majority owner before the 10-year phase-in period is completed.

Payment limitations for distressed plans. A plan that is undergoing a distress termination under ERISA §4041 is subject to the benefit payment limitations under PBGC Reg. §4022.61. In order to minimize potential overpayments and exhaustion of plan assets before the PBGC becomes the trustee and assumes payment of benefits, PBGC Reg. §4022.61, which implements ERISA §4041(c)(3)(D), requires the plan administrator to limit benefits payable in a participant in pay status to the greater of: (1) the participant's estimated guaranteed benefit (as determined under PBGC Reg. §4022.62), or (2) the participant's estimated asset-funded benefit (as determined under PBGC Reg. §4022.63). The estimated guaranteed benefit anticipates how much of the benefit the PBGC will have to pay, while the estimated asset-funded benefit anticipates how much of the total benefit the plan's assets could cover, in accordance with the priority allocation classes under ERISA §4044.

✪ Estimated guaranteed benefit. To reflect the PPA changes, amended PBGC Reg. §4022.62 does not include references to substantial owners. PBGC Reg. §4022.62(d), which previously applied to substantial owners, applies only to majority owners, and only if the 10-year phase-in period is not completed by the proposed termination date (or bankruptcy filing date, if applicable).

✪ Estimated asset-funded benefits. PBGC Reg. §4022.63, before its amendment, referred to "estimated Title IV benefits" but the amended regulations change the terminology to estimated asset-funded benefits to better reflect the purpose of the calculation and the fact that the estimate applies only to the first four priority categories under ERISA §4044. Revised PBGC Reg. §4022.63 eliminates references to substantial owners and includes rules applicable to majority owners under the PPA changes. However, the PBGC has decided not to change the Priority Category 4 (PC4) funding ratio calculation under Reg. §4022.63(d) that would be used to calculate estimated asset-funded benefits for a majority owner, even though under the PPA 2006, the third subcategory under PC4 is payable to a majority owner only if assets are sufficient to pay all other PC4 benefits. Since there is a limited number of instances where a plan will have any majority owners, the PBGC decided not to add the complexity associated with modifying the estimated asset-funded benefits to take into account that third subcategory.

PC4 modifications. PPA 2006 modified ERISA §4044(a)(4) (PC4) to give priority to benefits assigned to PC4 that are not impacted by the 10-year phase-in rule for majority owners. Thus, majority owners are allocated PC4 benefits that are reduced by the 10-year phase-in rule would receive an allocation of assets to cover those benefits only to the extent the assets satisfy all other PC4 benefits. PBGC Reg. §4044.10, as amended, reflects this rule. As discussed above, although there is a distinction made under PC4 for benefits that are subject to the majority owner phase-in rule, that distinction is not taken into account by a plan administrator in calculating the estimated asset-funded benefit for a majority owner who is in pay status.

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ERISA LITIGATION UPDATE

Definition of Employee

Sixth Circuit favors more nuanced standard of review of *Darden* factors used to establish employee or independent contractor status; gives substantial weight to independent contractor agreement entered into by parties [Citation: *Jammal v. American Family Insurance Company*, No. 17-4125, ___ F.3d ___ (6th Cir. January 29, 2019)]
Text available at http://bit.ly/2DW0Qb8

This case involves the determination of whether insurance agents should be considered employees or independent contractors of American Family Insurance. In *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 321 (1992), the Supreme Court established factors used to determine whether a worker is an employee or an independent contractor for ERISA purposes (*Darden* factors). The ultimate determination is one of control, i.e., whether the hiring party's right to control the manner and means by which the work is accomplished is more consistent with employee status or independent contractor status. The *Darden* factors relating to the determination of control are as follows.[6]

Factor	Description
53.	Skill required (higher levels of skill and a greater degree of separateness from the service recipient's business favors independent contractor status).
54.	Source of the instrumentalities and tools (independent contractor would more likely provide his/her own tools)
55.	Location of the work (onsite vs. offsite)
56.	Duration of the relationship between the parties (independent contractor more likely subject to contractual term of service)
57.	Service recipient's right to assign additional projects to the worker (greater assignment control favors employee status)
58.	Worker's discretion over when and how long to work (independent contractor more likely to set its own hours).
59.	Method of payment (independent contractor would have more control or be in a position to negotiate how payment will be made)
60.	Worker's role in hiring and paying assistants (independent contractor would have more control over hiring and paying assistants)
61.	Whether the work is part of the regular business of the service recipient (an employer is more likely to hire employees to perform the company's regular business activities)
62.	Whether the service recipient is in business (a person retained to provide services to a non-business recipient is more likely to be an independent contractor)
63.	Provision of employee benefits (employers provide such benefits whereas

[6] In listing the factors, we use the term "service recipient" and "worker," which the Supreme Court refers to in the *Darden* opinion as "hiring party" and "hired party," respectively.

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	independent contractor provide their own benefits)
64.	Tax treatment of the worker (employees receive W-2s and report income as wages, whereas independent contractor filed Schedule C or separate tax form for business and receive Form 1099 from service recipient)

Typically a scenario will involve some factors that weigh in favor of employee status and other factors that weigh in favor of independent contractor status. The determination ultimately involves which factors have more weight.

Agreement of the parties. Although not discussed by the Supreme Court in the *Darden* case, the agreement of the parties (i.e., the worker and the service recipient) is a relevant consideration to the Sixth Circuit. See *Weary v. Cochran*, 377 F.3d 522 (6th Cir. 2004). In this case, the insurance agents and the insurance company signed agreements that identified the agents as independent contractors.

Standard of appellate review. As part of its discussion of the district court's application of the *Darden* factors, the Sixth Circuit adopts a standard of review that differs from those of the other Circuit Courts considering this issue. Although each of the *Darden* factors requires a factual determination, the Sixth Circuit held that these determinations involve the application of a legal standard to a particular factual finding. For example, factor 1 above requires a factual determination of whether the skill required of the worker is an independent discipline (or profession) that is separate from the service recipient's business and could be (or was) learned elsewhere. However, there is an inherent legal issue as to whether to consider the amount of the skill required or whether to consider the separateness of the activity from the service recipient's business. The Sixth Circuit believes that each factor involves a legal standard to determine how to apply each of the factors. In this regard, the Sixth Circuit applies a different standard of review than the Second, Eighth and Tenth Circuits (*Brock v. Superior Care, Inc*., 840 F.2d 1054, (2nd Cir. 1988); *Berger Transfer & Storage v. Cent. States, Se. and Sw. Areas Pension Fund,* 85 F.3d 1374 (8th Cir. 1996); *Dole v. Snell*, 875 F.2d 802 (10th Cir. 1989)), which treat these matters as strictly factual in nature. The reason why this is important is because treatment of the determination as solely factual results in appellate review only for clear error (i.e., deference to the district court's determinations), whereas the Sixth Circuit's approach involves a *de novo* standard of review. This led to the Sixth Circuit's reversal of the district court's determination on the grounds that the lower court misapplied the legal standard. It should be noted that there is a strong dissent to this opinion because of the standard of review adopted by the majority.

ERISA cases. In an ERISA context, the Sixth Circuit believes that control and supervision are not as important in an ERISA case because such a case focuses on the financial benefits that a company should have provided. Thus, the financial structure of the company-worker relationship should guide the inquiry, and factors that most pertain to financial structure favor independent contractor status and should carry more weight. Such factors include 2, 3, 7, 11 and 12 above, which were inherent in the district court's findings that the insurance agents invested heavily in their offices and instrumentalities (factor 2), paid rent and worked out of their own offices (factor 3), earned commissions on sales (factor 7), were not eligible for employment benefits (factor 11), and paid taxes as independent contractors (factor 12).

Conclusion. The Sixth Circuit concluded that, on balance, the factors weighed in favor of independent contractor status, not employee status (as determined by the lower court). In reaching this conclusion, the Sixth Circuit gave greater weight to the agreement of the parties, which explicitly recognized the workers as independent contracts, and placed more weight on factors 1 and 8 above, which favor independent

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contractor status, than were placed by the district court. The court also noted the long history of declared insurance agents being treated as independent contractors. These addition considerations, coupled with the financial structure factors applicable to ERISA cases, led the Sixth Circuit to conclude that the workers were independent contractors for ERISA purposes and not entitled to ERISA benefits provided by the employer/service recipient.

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Fiduciary Requirements: Definition of a Fiduciary

Financial institution's engagement in foreign exchange transactions on behalf of client plans did not cause the institution to be an ERISA fiduciary with respect to such plans [Citation: *Allen v. Credit Suisse Securities LLC*, Nos 16-3327-cv (L) and 16-3571-cv (CON), ___ F.3d ___ (2nd Cir. July 10, 2018)] Text available at http://bit.ly/2miMA3I

In the FX market, a dealer bank provides a bid price (the price at which the customer can sell the currency) and an ask price (the price at which the customer can purchase the currency). The bid/ask spread forms the basis for the dealer bank's compensation. FX transactions can be spot transactions (i.e., settled exchange rate on a specified value date) or benchmark transactions (i.e., use of a daily fixing rate published for a pair of currencies that is calculated by various third parties at a daily specified time). When arranging benchmark transactions, the dealer guarantees execution at the fixing rate, or at a rate determined by reference to the fixing rate, and derives its compensation based on an agreed-upon markup. ERISA plans trade currencies to settle their purchases and sales of foreign securities, or to repatriate dividends, interest, and redemptions that are paid in foreign currencies.

The defendant banks in this case conducted foreign currency exchange (FX) market transactions on behalf of the plaintiff plans. The plaintiffs alleged that the defendant banks engaged in activities with respect to these transactions that effectively resulted in their control over plan assets involved in such transactions, resulting in a functional fiduciary status. The alleged conduct included capitalizing on the dealer banks' knowledge of customers' order flows, colluding with one another to benefit collectively form customer order information, and manipulation of benchmark fixing rates. The Second Circuit upheld dismissal of the claims because the defendants were not acting as fiduciaries with respect to the transactions at issue. This conclusion was based on the following factors: (1) the banks did not initiate the transactions (i.e., the plan's independent investment managers initiated the transactions at their discretion), (2) the transactions were executed in accordance with the instructions received from the independent investment managers, (3) alleged market manipulations to secure higher compensation for the FX transactions depended on many different persons and manipulations to preclude an inference that the defendants had an unfettered ability to dictate their compensation for each transaction that could establish control over plan assets, and (4) wrongdoing (e.g., fraudulent conduct) in performing non-fiduciary functions does not transform the wrongdoer into a fiduciary, even if the fraud resulted in some dissipation of plan assets (see *Geller v. Cty. Line Auto Sales, Inc.*, 86 F.3d 18 (2nd Cir. 1996)).

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Financial service provider was not a fiduciary merely because it had the authority to change the credited rate on stable value product since, after any such change, the plan fiduciary could eliminate the investment and participants could direct out of that investment [Citation: *Teets v. Great-Wrst Life & Annuity Insurance Company*, No. 18-1019, ___ F.3d ___ (10th Cir. March 27, 2019)]
Text available at https://www.ca10.uscourts.gov/opinions/18/18-1019.pdf

The definition of a fiduciary under ERISA §3(21)(A)(i) is at issue here, specifically regarding the part of the definition that refers to a person who "exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets."

Investment provided by Great-West. Great-West provided a stable value fund as an investment menu option under the plan involved in this litigation. The stable value fund promised an interest rate return equal to the Credited Rate established by the contract. The Credited Rate was set by Great-West on a quarterly basis, with any change in the rate effective as of the start of the quarter immediately following the announcement of the new rate. An announcement changing the rate had to be at least two business days before that next quarter. The Credited Rate may never be less than zero so that principal is preserved for those who investment in the fund. Participant funds invested in the stable value fund are deposited into Great-West's general account. Any investment return earned by Great-West in excess of the Credited Rate represents profits made by Great-West. If the general account earns less than the Credited Rate, the participants' investments in the fund still earn the Credited Rate, so that Great-West bears the risk of loss.

Fiduciary status of Great-West. Whether Great-West was a fiduciary was important to the fiduciary claims brought in this case because the plaintiffs claimed that Great-West breached its fiduciary duties by: (1) setting the Credited Rate for its own benefit rather than for the plans' benefit or for the participants' benefit, (2) setting the Credited Rate artificially low and retaining the difference as profit, and (3) charging excessive fees. None of these claims can succeed unless Great-West was acting as a fiduciary when it changed the Credited Rate.

➔ Status of the case law on this issue. Where fiduciary status hinges on an investment service provider's ability to affect the rate of return on an investment, the case law has developed a two-step analysis. First, the service provider must be taking action that went beyond the terms of the contract. By following the terms of an arm's-length negotiation set forth in the governing contract, the service provider does not act as a fiduciary. See *Schulist v. Blue Cross of Iowa*, 717 F.2d 1127 (7th Cir. 1983) (holding service provider was not a fiduciary where its compensation was established through successive negotiations). Second, if the service provider takes unilateral action respecting the management of a plan or its assets, the service provider is a fiduciary unless the plan or the participants have the unimpeded ability to reject the service provider's action or to terminate the relationship with the service provider. See *Midwest Cmty. Health Serv., Inc. v. Am. United Life Ins. Co.*, 255 F.3d 374 (7th Cir. 2001) (holding service provider was fiduciary when it could make changes to plan contract without plan approval and would assess a fee for plans withdrawing funds). Other examples cited by the court: *Chicago Bd. Options Exch., Inc. v. Conn. Gen. Life Ins. Co.*, 713 F.2d 254 (7th Cir. 1983) (service provider limited withdrawals from the fund to 10% per year, requiring a 10-year period for funds to be fully withdrawn following a unilateral change by the service provider), *Hecker v. Deere & Co.*, 556 F.3d 575 (7th Cir. 2009) (changes made by investment service provider to investment options it advised the plan to include did not constitute discretion because the plan, not the service provider, had final say on which investment options are included in the plan), and *Santomenno ex rel. John*

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Hancock Tr. v. John Hancock Life Ins. Co., 768 F.3d 284 (3rd Cir. 2014) (trustees had final authority over which funds to include in a plan).

➔ Mere authority to set Credited Rate did not result in fiduciary status for Great-West. In this litigation, there was no arm's-length agreement regarding the Credited Rate because the contract did not set the rate nor did it prescribe a formula for adjusting the rate. So, fiduciary status had to rest on the second component described in the prior paragraph. The Tenth Circuit determined that Great-West's authority to change the Credited Rate did not alone make it a fiduciary of the plan because the plan fiduciary and the invested plan participants had a meaningful opportunity to reject the change in the Credited Rate by moving investments out of the stable-value fund (participants) or eliminating the investment menu option (plan fiduciary). So, Great-West could not effectively control the plan's rate of return.

- *Waiting period did not change result because Great-West did not exercise it.* The plaintiffs argued that Great-West did not have requisite control because it had the ability to bind the plan to the change in the Credited Rate for up to a 12-month period. Under the governing contract, Great-West was permitted to impose up to a one-year waiting period for withdrawal of the funds. The Tenth Circuit rejected this argument because Great-West never *exercised* it. Whether such a waiting period would actually be imposed is "too speculative" to affect a determination at this juncture that Great-West had the requisite control over plan assets. The cases cited above with respect to the right to set penalties or withdrawal restrictions either had been enforced or, under the facts found by the court, were certain to be enforced. There was no such certainty here, given Great-West's track record with respect to the stable value fund (even with investors other than the plan involved in this litigation).

- *Prohibition on other similar investment menu options did not change the result.* The governing contract prohibited the plan from offering participants another stable-value fund or similar investment option. The plaintiffs argued that this effectively inhibited the participants from moving their investments when Great-West changed the Crediting Rate. Again, the argument was "too speculative" to impose a fiduciary duty on Great-West merely because of the possibility that a participant may perceive the investment limitation as having to accept the change in the Crediting Rate. In the court's view, there are too many considerations inherent in a participant's individual decision regarding how to allocate investment options among his or her funds. There was no evidence offered by the plaintiffs that the competing fund prohibition affected any of the 270,000 participants' decisions to stay with or leave the stable value fund.

- *Discretion to change rate did not give Great-West control over its compensation.* Another argument raised by the plaintiffs was that Great-West's ability to change the rate gave it control over its compensation because the Credited Rate affected Great-West's profit margin with respect to the investment of the stable value funds in its general account. However, since the court also found that the plan or the participants could effectively reject the change by withdrawing from the fund, Great-West did not have the requisite control over its compensation.

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ERISA Enforcement: Equitable Relief Under ERISA §502(a)(3)

Ninth Circuit rejects claims for restitution and disgorgement because they were not equitable in nature; service provider not acting as fiduciary when selling its product even if fees excessive; ERISA doesn't preempt state law regarding fraudulent sales practices [Citation: *The Depot, Inc. v. Caring For Montanans, Inc.*, No. 17-35597, ___ F.3d ___ (9th Cir. February 6, 2019)]
Text available at http://bit.ly/2TusKEX

This lawsuit was brought by several small businesses to challenge the premiums charged by a health insurer that was on a preferred provider list for members of the Montana Chamber of Commerce. The ERISA claims alleged that the premiums were excessive, constituting a fiduciary breach under ERISA §409. The plaintiffs also sought equitable relief under ERISA §502(a)(3) in the form of restitution or disgorgement to the plan relating to prohibited transactions stemming from unreasonable charges for kickbacks and unrequested benefits. The Ninth Circuit affirmed the dismissal of both ERISA claims. The court also considered whether the ERISA preempted the state law claims relating to alleged misrepresentations regarding the premiums charged. The Ninth Circuit determined that the state law claims were not preempted.

* *Breach of fiduciary duty.* The breach claim failed in this case because the insurer was not acting as a fiduciary when it charged the alleged excessive premiums. The court rejected the idea that, by secretly charging excessive premiums, the insurer had exercised discretionary authority or discretionary control respecting plan management, within the meaning of ERISA §3(21)(A)(i) (part of the statutory definition of a fiduciary). The setting of the premium rates was part of the negotiation of the contracts sold to the plaintiff. Because negotiations occurred before the insurer had any relationship to the plan, the insurer could not have any discretion over the plan's management at such time. This is consistent with the Ninth Circuit's decision in *Santomenno v. Transamerica Life Ins. Co.*, 883 F.3d 833 (9th Cir. 2018), where the court held that a service provider was not acting as a fiduciary when negotiating its fees with the plan and thus could not be sued for fiduciary breach with respect to allegations that the fees were excessive. In the court's view, the same principle applies to rate-setting by insurance companies with respect to policies sold to an ERISA plan. This holds true even if, as alleged, the rates being negotiated are misrepresented by the insurer. [Such alleged conduct is more appropriate for the state law claim discussed later in this summary.]

> ➢ Mere existence of discretionary right to modify plan terms not sufficient to confer fiduciary status. The court also addressed the insurer's rights under the contract to make administrative changes to the plan, or to change dues, terms or benefits, by giving written notice to the plan beneficiaries. The mere existence of such discretion does not confer fiduciary status if it is not exercised. And even if such discretion was later exercised by the insurer, it was not being exercised at the time the action subject to the lawsuit was taken (i.e., the negotiation of allegedly excessive premiums), so could not support a fiduciary breach claim with respect to the negotiated premiums. This issue also had been addressed in the *Santomenno* case with respect to a service providers right to delete or substitute funds available in a plan's investment menu.

> ➢ Premiums are not plan assets. The court also held that the insurer was not acting as a fiduciary merely because it accepted premiums for the health coverage provided under the ERISA plan. The plaintiffs had argued that the acceptance of the premiums constituted the exercise of authority or control over the management or disposition of plan assets, as contemplated by ERISA §3(21)(A)(i). The Ninth Circuit ruled that premiums paid to an insurance company in return for coverage under a

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fully insured insurance policy are not plan assets. Neither the plaintiffs nor their employees had a property interest in the premium payments once they were paid to the insurer. Thus, the premiums themselves were not plan assets under "ordinary notions of property rights." Premiums paid for insurance coverage are distinguishable from contributions made to a self-funded plan to provide health benefits, which are plan assets.

* *Prohibited transaction claims and equitable relief.* Although the insurer was not acting as a fiduciary, there could still be relief obtained through the prohibited transaction rules since those rules reach non-fiduciary service providers, such as the insurer. However, the relief sought by the plaintiffs was found by the Ninth Circuit to be unavailable under ERISA §502(a)(3) because it was not equitable in nature. The claims classified the relief sought as either equitable restitution or disgorgement of profits earned through the alleged prohibited transactions. The claim failed on both points. The Ninth Circuit categorized the relief sought as essentially a money judgement, which is legal in nature, not equitable. The plaintiffs want the insurer to pay a sum of money to make up for the alleged kickbacks and unrequested benefits reflected in the premiums.

➢ Restitution. In determining that the relief sought did not fall within the definition of equitable restitution, the court turned to the Supreme Court's decision in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002). Restitution in equity generally must be in the form of a constructive trust or equitable lien against money or property identified as belonging "in good conscience to the plaintiff." Restitution at law seeks to impose personal liability on the defendant to recover money to pay for some benefit the defendant received from the plaintiff. Thus, equitable restitution is available where there is a specifically identified fund in the defendants' possession from which restitution is sought, not where recovery is from the defendant's assets generally. The latter is the nature of the relief sought by the plaintiffs in this case and, thus, is not recoverable in an ERISA §502(a)(3) claim. The identifiable fund concept is discussed by the Supreme Court in *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006) and *Montanile v. Bd. of Trs. of Nat'l Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651 (2016) (where the identifiable funds had been dissipated by the defendant, leaving the plaintiff to have to seek recovery out of the defendant's general assets and, thus, losing the equitable nature of the claim). Since there were no allegations of any traceable funds with respect to the excessive premiums, the restitution claim failed to meet the equitable nature requirement under ERISA §502(a)(3).

➢ Disgorgement. Disgorgement focuses on the profits earned by the defendant in the alleged prohibited transaction, rather than on the loss incurred by the plaintiff. However, the same principles regarding identifiable funds and general assets, as described above for restitution, apply to determine whether a disgorgement claim is equitable or legal in nature. Thus, the plaintiffs failed here too because the disgorgement claim sought legal damages and, thus, was not recoverable under ERISA §502(a)(3).

* *Preemption of state law claims.* The claims brought by the plaintiffs also included state law claims relating to the misrepresentations made about the premiums being charged. The Ninth Circuit analyzed two preemption concepts: (1) "express" preemption under ERISA §514, and (2) "conflict" preemption based on ERISA §502(a). The state law claims were not preempted under either theory.

➢ Express preemption. The statutory preemption provision under ERISA §514 results in express preemption when the state law relates to an ERISA plan. The Ninth Circuit relies primarily on the

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Supreme Court's decision in *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016), which established workable standards for determining the scope of ERISA §514 preemption, to determine that the state law claims were not preempted by ERISA §514. Under the *Gobeille* standards, a state law "relates to" an ERISA plan if either the state law references an ERISA plan or has an impermissible connection with an ERISA plan. The state law involved in this case meet neither of these standards. The state law is aimed at preventing sellers of goods and services from misrepresenting the contents of their wares, which is a traditional area of state regulation. There is no reference to ERISA plans specifically. The fact that an ERISA plan might be the victim of misrepresentations relating to the sale of goods and services to the plan does not cause the law to refer to ERISA plans. In addition, the state law is aimed at conduct that does not bear on an ERISA-regulated relationship (e.g., reporting, disclosure, fiduciary responsibility), which would cause it to have an "impermissible connection" with ERISA plans. The alleged misrepresentations under the applicable state law relates to the conduct of the defendants with respect to any commercial entity, whether an ERISA plan or not.

➢ Conflict preemption. The concept of conflict preemption looks at ERISA's enforcement scheme under ERISA §502(a), and whether the state law action duplicates, supplements, or supplants the ERISA civil enforcement remedies. The state law claims in this case do not relate to duties that are derived from ERISA. ERISA does not purport to govern negotiations between insurance companies and employers. The legal duties at issue under the state law claims are independent of the duties imposed by ERISA and would exist regardless of whether an ERISA plan existed. Conflict preemption was addressed by the Supreme Court in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

* *Review of main principles gleaned from this decision.* In summary, this opinion by the Ninth Circuit addresses the following important concepts.

- When negotiating insurance rates, an insurer is not acting as a fiduciary of the plan to which the insurer is trying to sell its product, similar to the nonfiduciary status of a service provider negotiating fees to be paid by a plan for retaining the service provider.
- Insurance premiums under a fully insured policy are not ERISA plan assets.
- Restitution or disgorgement sought under the equitable relief provisions of ERISA §502(a)(3) must relate to a separately identified fund that can be traceable, not from the general assets of the defendant.
- State law relating to regulation of conduct in the sale of a product or services does not impermissibly relate to an ERISA plan that would result in preemption under ERISA §514, nor does it conflict with ERISA's remedies under ERISA §502.

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Employer Securities: Fiduciary Issues Under Title I of ERISA

On remand, Fifth Circuit dismisses fiduciary claims regarding retention of publicly-traded stock, illustrating difficulties for plaintiffs in stock drop cases in a post-*Dudenhoeffer* environment
[Citation: *Kopp v. Klein*, 894 F.3d 214 (5th Cir. June 27, 2018)]
Text available at http://bit.ly/2LnGAS1

This case landed in the middle of a sweeping change in the case law regarding stock drop case as a result of the Supreme Court's decision in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S.Ct. 2459 (2014) (*Dudenhoeffer*). The *Dudenhoeffer* case led to the Fifth Circuit's vacating its prior opinion in *Kopp v. Klein*, 762 F.3d 450 (5th Cir. 2014) (per curiam). This latest opinion is the appeal from the district court's decision on remand to dismiss the claims against the plan fiduciaries. Based on the pleading constraints in the *Dudenhoeffer* opinion, the Fifth Circuit affirms the district court's dismissal with this opinion.

This case illustrates the difficultly that plaintiffs have in a post-*Dudenhoeffer* world in bringing successful "stock drop" cases involving publicly-traded employer securities. Many plaintiffs, like the one in this case, haven't been able to get passed a motion to dismiss. The plaintiffs argued that the fiduciaries breached the duty of prudence by allowing plan participants to continue to invest in the employer stock, despite public information about the company's financial instability, and the fiduciaries' allegedly fraudulent conduct. The plaintiffs also contended that the fiduciaries did not fulfill their procedural duty regarding the monitoring of the plan's investment in employer stock, as evidence by their failure to even consider taking action in response to the long-term deterioration of the company's financial condition.

The Fifth Circuit started with the proposition from *Dudenhoeffer* that the price of publicly-traded stock is reflective of public information regarding the state of the company (i.e., the "efficient market hypothesis"). Thus, a fiduciary is usually not going to be imprudent to assume that a major stock market provided the best estimate of the value of the stocks traded on that market. To refute this in a manner consistent with *Dudenhoeffer* and its progeny of cases decided since, the plaintiffs must demonstrate special circumstances that would make the market price unreliable in order to challenge the fiduciaries' reliance on the market pricing of the stock. The Fifth Circuit rejected "riskiness" of the stock as a special circumstance, but rather just another way to view value that is already reflected in the stock's price. In addition, the court rejected the alleged fraud by the fiduciaries as a special circumstance because the alleged fraud is based on non-public information. For a special circumstance to exist, the plaintiff would have to make a showing that the non-public information would affect the reliability of the market price as an unbiased assessment of the stock's value in light of all public information. Without special circumstances, the plaintiffs only other recourse under *Dudenhoeffer* is to show that no reasonable fiduciary could view as prudent a decision not act on non-public information. Since that argument was not pursued on appeal, its application to this case was not considered by the Fifth Circuit.

As an alternative to relief under *Dudenhoeffer*, the plaintiffs looked to the procedural principles established in *Tibble v. Edison International*, 135 S.Ct. 1823 (2015) regarding the monitoring of investments. The plaintiffs argued that, by failing to meet and discuss a possible course of action regarding the plan's investment in the employer stock, the fiduciaries breached their procedural duty of prudence. The Fifth Circuit held that, even if the fiduciaries were procedurally imprudent, the allegations do not support a finding that the losses incurred by the plan stemmed from such procedural failure. To proceed, the plaintiff must allege facts to support the conclusion that the fiduciaries would have acted differently had they

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engaged in proper monitoring, and that an alternative course of action could have *prevented the plan's losses*.

Second Circuit breathes some life into pleading standards for stock drop cases based on nonpublic information [Citation: *Jander v. Retirement Plans Committee of IBM*, ___ F.3d ___, No. 17-3518 (2nd Cir. December 10, 2018)]
Text available at http://bit.ly/2Rlrnrd

In this case, Second Circuit revisits the pleading standards for stock drop cases based on nonpublic information. The fiduciaries of the plan, who were IBM insiders, were aware of nonpublic information that a particular division was overvalued. The Second Circuit held that the plaintiffs met the *Dudenhoeffer* pleading standard and allowed the case to proceed to trial. The lower court had dismissed the claim because the alternative actions proposed by the plaintiffs in its duty-of-prudence claim might cause more harm than good, in violation of the *Dudenhoeffer* pleading standard. The three alternative actions the plaintiffs proposed would have met the duty of prudence were: public disclosure of the overvaluation; halting further plan investments in IBM stock; or purchasing hedging products to mitigate potential declines in the value of the IBM stock.

✪ Analysis of the pleading. On appeal, the plaintiffs focused on the first alternative as sufficient to meet the *Dudenhoeffer* pleading standard - i.e., early corrective disclosure of the overvaluation. They argued that: (1) the fiduciaries knew the stock was artificially inflated, (2) that they had the power to disclose the truth to the public and correct the artificial valuation within the normal reporting regime under SEC rules (i.e., the class period of the alleged imprudent conduct encompassed a period during which regular quarterly filings with the SEC were made that could have reflected the correction of the valuation), and (3) the failure to make prompt disclosure hurt management's credibility and the long-term prospects of IBM as an investment. In support of the third point, the plaintiffs cited economic analyses showing that reputational harm is a common result of fraud and grows the longer the fraud is concealed (i.e., greater stock drops).

✪ Courts must treat well-pleaded allegations as true in determining whether to dismiss. The Second Circuit focused on the procedural rules a district court must follow whether considering whether to dismiss a claim. Under those rules, the court must accept well-pleaded allegations as true. Thus, the economic studies of general market experience cannot be dismissed as merely theoretical. In fact, the fiduciaries knew the disclosure of the true valuation was inevitable because IBM was likely to sell the division that had been overvalued, so that the public would ultimately learn of the overvaluation. This put into issue the economic analyses regarding the impact of longer periods of concealment. During the course of trial, determinations will need to be made about whether there was concealment, whether the concealment was known by the fiduciaries, and whether under the circumstances it would have nonetheless made immediate disclosure particularly dangerous so that the general economic analyses would not apply. But those later determinations should not bear on whether the claim should be dismissed before getting to trial.

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Sale of company stock to ESOP was a prohibited transaction because ESOP overpaid for stock; ERISA §408(e)(1) exemption not applicable because overpayment by ESOP fails "adequate consideration" requirement [Citation: *Brundle v. Wilmington Trust, N.A.*, No. 17-1873, ___ F.3d ___ (4th Cir. March 27, 2019)]
Text available at http://www.ca4.uscourts.gov/Opinions/171873.P.pdf

This case involves the purchase of a company by an ESOP and the allegations of breach of fiduciary duty surrounding the sale, primarily focusing on whether the sale of stock to the ESOP was for "adequate consideration" (as required by the prohibited transaction exemption under ERISA §408(e)). Because the ESOP overpaid for the employer stock, as established by the trial court, the Fourth Circuit affirmed the judgment against the ESOP trustee.

Details of the transaction. The sale of employer stock to the ESOP was made in a transaction that the court categorized as a unique ESOP structure. Although the ESOP purchased 100% of the company, the sellers retained de facto control of the company. This was accomplished by exchanging 10% of the stock for "equity-like" warrants that entitled the sellers to buy back equity at a designated price and guaranteed the sellers a majority of the board of directors. The share price was for $4,235 per share, which was at the top of the ESOP trustee's authorized negotiation range. Shortly before the sale, the firm hired by the trustee to be its financial advisor on the ESOP's purchase of the company revised its valuation range downward, but no adjustment was made of the purchase price.

Adequate consideration defense. When an ESOP fiduciary is sued for a breach surrounding the purchase of employer securities by the ESOP, ERISA §408(e)(1) provides an affirmative defense. Under this statutory exemption from the prohibited transaction rules banning the sale of property between a plan and a party-in-interest (the company in this case), a plan may purchase "qualifying employer securities" if the acquisition is for adequate consideration. [There also must not be any commission paid on the sale and the plan must be an individual account plan, but these additional requirements are not relevant to this litigation.]

✪ *Burden of proof is on the fiduciary.* Because ERISA §408(e) counters the fiduciary breach allegation, it is an affirmative defense to avoid ERISA liability for an otherwise prohibited transaction. As a result, the fiduciary bears the burden of proving by the preponderance of evidence that the sale was for adequate consideration. The leading case on this issue is *Elmore v. Cone Mills Corp.*, 23 F.3d 855 (4th Cir. 1994) (en banc). The ESOP trustee failed to meet its burden of proof.

Other court cases examining fiduciary conduct surrounding stock sales to ESOPs. See *Henry v. Champlain Enters., Inc.*, 445 F.3d 610 (2nd Cir. 2006), *Perez v. Bruister*, 823 F.3d 250 (5th Cir. 2016), *Chao v. Hall Holding Co.*, 285 F.3d 415 (6th Cir. 2002), *Howard v. Shay*, 100 F.3d 1484 (9th Cir. 1996).

Process/conduct is key. There is no strictly objective test for determining whether the "adequate consideration" requirement is satisfied. In the absence of guidance, the courts have focused on the conduct of the fiduciary and whether than conduct satisfies the ERISA prudence standard. [Although the DOL proposed regulations on the definition of adequate consideration in 1988, it never finalized them. Accordingly, they are not binding.] The evidence supporting a fiduciary's breach of its ERISA duties are generally fact-specific. However, we can glean from the court's opinion some review angles used by the court to establish the fiduciary breach that can be of help in other cases.

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✪ *Relevant factors.* The district court found four designated fiduciary failures.

- The ESOP trustee failed to investigate the financial advisor's omission in its valuation report of a much lower valuation of the company stock that the trustee would have had access to. [An investment bank that periodically provided share valuations to the company for use with stock options prepared the report showing the much lower valuation.]
- The ESOP trustee failed to adequately probe the *reliability* of financial projections prepared by company management and used by the financial advisor in its valuation report. [Several red flags casting a shadow on the reliability of the projections are discussed by the court in its opinion.]
- The ESOP trustee failed to investigate the appropriateness of applying a 10% control premium. Even though the transaction was structured so that effective control of the company was retained by the sellers, the financial advisor's valuation report still applied a 10% control premium on the share price to be paid by the ESOP. [Although control premiums normally range from 35% to 40%, the reduction of the premium to 10% was not consistent with the facts of the transaction regarding control of the company.]
- The ESOP trustee failed to probe why the financial advisor consistently rounded the company's stock valuation upwards. [The court also rejected consideration of the higher sale price for the company stock that the ESOP trustee was subsequently able to obtain from a third-party buyer because the buyer's objectives for the purchase led to different considerations for the stock price it was willing to pay. In addition, the third-party buyer ended up with absolute control of the company, which the ESOP lacked.]

Damages. Where the fiduciary breach is rooted in the overpayment by an ESOP for employer securities, the damages typically reflect the amount of the overpayment (plus an interest adjustment). The overpayment is determined by subtracting from the inflated stock price the fair market value of the stock. This is what was awarded in this case.

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Plan Administration: Interpretation of Plan Document

Equitable reformation resolved ambiguous plan provision regarding calculation of benefits for rehired employees [*Frommert v. Conkwright*, Nos. 17 114 cv(L), 17 738 cv(CON), ___ F.3d ___ (2nd Cir. January 14, 2019)]
Text available at http://bit.ly/2BmqJ3d

A complicated litigation history precedes this opinion, but the main lesson to take from the case is the importance of clarity in plan documentation. The issue at hand was the proper calculation of benefits accrued by rehired employees who had received distribution of accrued benefits when they previously had terminated from employment. Over the course of the litigation, various interpretations of the plan administrator were rejected, including one that established a "phantom account" with respect to the amount distribution, and used the current value of that phantom account to offset against additional benefits earned by the rehired employees. The ultimate remedy fashioned by the district court, which was affirmed in this opinion by the Second Circuit, was to apply equitably reform the document to treat the rehired employees as newly-hired. By doing so, any benefits attributable to the prior distributions were ignored. However, prior service earned before rehire was also ignored in order to above the potential of a double-crediting of benefits with respect to the same years of service. Although it was argued by the plaintiffs that the new-hire approach could result in lesser benefits than if the plaintiffs had been given credit for prior years of service with an offset based on an actuarially-determined equivalent of the prior distributions (rather than the phantom account approach originally used by the administrator), the Second Circuit opted to affirm the district court's resolution as reasonable.

- *Lesson to be learned.* Had the drafter of the document been clear regarding how a rehired employee's benefits would be calculated, and how prior distributions should be taken into account in post-rehired benefit determinations, years of litigation could have been avoided. The drafter of a defined benefit plan document should be consulting with the employer and the plan actuary to ensure that the plan document reflects the intention of the parties.

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ERISA Enforcement: Arbitration

Arbitration clause in employment clause did not apply to action under ERISA §502(a)(2) because the suit was brought *on behalf of the plan* [Citation: *Munro v. University of Southern California*, ___ F.3d ___ (9th Cir. July 24, 2018)]
Text available at http://bit.ly/2Jb9h4q

The plaintiffs brought this class action lawsuit pursuant to ERISA §502(a)(2) for breach of fiduciary duty under ERISA §409. The relief is sought on behalf of the plan, as is required for 502(a)(2) suits. The plaintiffs have employment contracts that require them to sign arbitration agreements. The arbitration agreement requires them to arbitrate all claims that either the employee or the employer have against the other. The agreement expressly covers claims for violations of federal law. The Ninth Circuit concluded that the arbitration agreements did not preclude the 502(a)(2) suit because the arbitration claims only cover individuals who signed these arbitration agreements. Pursuant to governing case law, 502(a)(2) cases must be brought for relief on behalf of the plan even though, as under *LaRue v. DeWolff, Roberg & Associates, Inc.*, 552 U.S. 248 (2008), the recovery by the plan might affect only certain individual accounts in a defined contribution plan. The employees in this case are seeking financial and equitable remedies to benefit the plan and all affected participants and beneficiaries, including a determination as to the method of calculating losses, removal of breaching fiduciaries, a full accounting of Plan losses, reformation of the Plans, and an order regarding appropriate future investments. The relief sought demonstrates that the employees are bringing their claims to benefit the plan across the board, which are beyond the scope of the arbitration agreements.

Fiduciary Duties and Liabilities: Exclusive Purpose Rule/Payment of Fees

First Circuit addresses burden of proof issues surrounding fiduciary breach allegations regarding use of proprietary funds and unreasonableness of fees, and the application of PTE 77-3 to in-house mutual fund investments [Citation: *Brotherston v. Putnam Investments, LLC*, No. 17-1711, ___ F.3d ___ (1st Cir. October 15, 2018)]
Text available at http://bit.ly/2qv2c6r

Participants in Putnam's 401(k) plan claimed breach of fiduciary duties with respect to the plan's investments in Putnam's funds, including allegations that the fees associated with the funds were not reasonable and excessive. The plan's investment menu included only Putnam funds, but also made available a self-directed brokerage account option, through which a participant could invest outside of Putnam funds. The First Circuit found errors in the district court's determination of whether PTE 77-3 was applicable in protecting the plan fiduciaries, and in the court's decision to issue an interim ruling finding a fiduciary breach. The case is remanded to the district court to complete the trial and making determinations regarding whether a breach occurred, the amount of the plan's loss and whether the fiduciary breach caused such loss. More details on these issues are provided below.

* Application of PTE 77-3. PTE 77-3, which applies to plan investments in in-house mutual funds, includes a requirement that dealings between the plan and the investment adviser or principal underwriter for the mutual fund company, or any affiliated person of such adviser or underwriter, are on a basis no less favorable to the plan than such dealings are with other shareholders of the mutual fund company. The First Circuit determined that the district court failed to make a finding on this issue. A determination of whether

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this element has been satisfied must take into account that a third-party plan investing in Putnam funds pay fees to a company that provides services (e.g., recordkeeping) to the plan, which the mutual fund pays through revenue sharing or reimbursement to the service provider, which the service provider may or may not credit to the plan. In other arrangements, the revenue sharing payment might be paid directly to the plan. For the Putnam plan, the arrangement differs because Putnam directly pays the recordkeeper for the plan, and no recordkeeping fees are charged to the plan. Accordingly, no revenue sharing is paid from the mutual funds to the plan or to the recordkeeper. The plaintiffs' argument is that these differences in the arrangements work to the Putnam plan's disadvantage. However, in the First Circuit's opinion, the differences are unfavorable only if the value of the revenue sharing that the third-party plans receive exceeds the value of the service fees borne by those plans. Otherwise, the third-party plans are being compensated for costs that the Putnam plan never bears in the first place, and the arrangements are equivalent on a net-fee basis.

✪ *Directions to the lower court regarding this issue.* On remand, the district court is instructed to determine whether the arrangements with third-party plans are more favorable than the arrangement with the Putnam plan. In doing so, the lower court should consider the administrative fees paid by Putnam, as well as any fees paid by the plan itself. However, the court is not to consider the value of discretionary employer contributions that Putnam makes to the plan in determining the comparative net value of the investment arrangements for the Putnam plan and the third-party plans. The PTE 77-3 analysis must be from a fiduciary perspective, and is irrelevant to discretionary contribution determinations made by Putnam as part of its employees' compensation, where Putnam is wearing its employer hat rather than its fiduciary-hat.

* Burden of proof regarding fiduciary breach allegations. The First Circuit also addressed certain elements of the fiduciary claims regarding the selection of the Putnam funds, and specifically considered the burden of proof on these elements.

✪ *Determination of loss.* A breaching fiduciary is liable for any losses to the plan resulting from the breach. To establish loss for breaches surrounding investment selection, it is not sufficient to look only to whether the investments selected lost value. Rather, if an ERISA fiduciary imprudently performs its discretionary investment decisions, including the design of a portfolio of funds to offer as investment options, the fiduciary should be chargeable with the amount required to restore the value of the trust and the trust distributions to *what they would have been* if the portion of the trust affected by the breach had been properly administered.

✪ *Shifting burdens of proof.* The plaintiff has the burden to establish that a fiduciary breach has occurred and that the plan has incurred a loss. However, once loss is established, the defendant has the burden to show that the fiduciary breach was not the cause of that loss (i.e., the investment decisions made by the fiduciary were objectively prudent). Causation must be established before damages can be awarded. In concluding that the burden falls on the defendant to show lack of causation, the First Circuit joined the Fourth, Fifth and Eighth Circuits. See *Tatum v. RJR Pension Inv. Comm.*, 761 F.3d 346 (4th Cir. 2014), *McDonald v. Provident Indem. Life Ins. Co.*, 60 F.3d 234 (5th Cir. 1995), and *Martin v. Feilen*, 965 F.2d 660 (8th Cir. 1992). The First Circuit believes that this burden-shift is more consistent with trust law principles, which are embodied within ERISA. Other Circuits (Sixth, Ninth, Tenth and Eleventh) have adopted what is known as the ordinary default rule (burden rests on plaintiff to prove all essential aspects of its claim), meaning that the burden of proving loss causation also falls on the plaintiff asserting a fiduciary breach claim. See *Pioneer Centres Holding Co. ESOP v. Alerus Fin., N.A.*, 858 F.3d 1324 (10th Cir. 2017), *Saumer v. Cliffs Natural Resources Inc.*, 853 F.3d 855 (6th Cir. 2017), *Wright v. Oregon Metallurgical Corp.*, 360 F.3d 1090 (9th Cir. 2004), and *Willett v. Blue Cross & Blue Shield of Alabama*, 953 F.2d 1335 (11th Cir. 1992).

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Fiduciary Duties Regarding Disclosure

Ministerial employees' misinformation about distribution options may amount to a fiduciary breach by the fiduciary for whom the employees work as agents, but accurate information in SPD will foreclose recovery [Citation: *DeRogatis v. Board of Trustees of the Central Pension Fund*, ___ F.3d ___, No. 16-3549-cv (2nd Cir. September 14, 2018)]
Text available at http://bit.ly/2xKeEmH

This case addresses two important issues: (1) whether a fiduciary breach can be established through actions taken by ministerial employees serving as agents of the plan fiduciary, and (2) whether accurate information in the SPD can override any potential liability for the misstatements made by such ministerial employees. The Second Circuit answers "yes" to both issues.

Basis of claims. In this case, the participant, who ultimately died of lung cancer, and his wife sought information about retirement options. Under the terms of the plan, if a participant died while actively working a preretirement death benefit was paid that equaled the 50% survivor annuity that would have been payable had a joint and 50% survivor annuity under the plan had commenced to the participant. The plan contained retirement payment options that allowed a participant to elect a 100% survivor annuity, but that required retirement under the plan's early, "special," or normal retirement provisions and the affirmative election of the 100% survivor annuity. Based on information received from ministerial employees (i.e., employees of the company responsible for communicating with participants about benefit options), the wife was under the impression that she was entitled to the 100% survivor annuity without formally electing a retirement distribution option. One of the ministerial employees had told her that if the participant were to retire before age 62 (which was not until the next year and ended up being after the participant died), they would lose their health benefits under the company's welfare benefit plan. The wife interpreted this to mean she could still be entitled to the 100% survivor annuity if they waited to elect retirement in order to maintain health insurance. Claims were brought under both ERISA §502(a)(1)(B) (claim for benefits) and ERISA §502(a)(3) (equitable relief for fiduciary violation). The claim for benefits failed because, under the unambiguous terms of the plan, only a 50% survivor annuity was payable. However, the court had to analyze whether ERISA §502(a)(3) relief could be available, because the terms of the plans do not have to control under such relief. Specifically, the claim sought equitable relief to make the wife whole, either by providing her with the 100% survivor annuity or by imposing a surcharge on the plan that would compensate her for the loss of the larger annuity amount.

Liability through ministerial employees. The lower court had declined to consider the fiduciary breach claim with respect to the conversations held with the ministerial employees on the basis that the plan did not perform a fiduciary function through communications made by the ministerial employees. The Second Circuit disagreed. As administrators of the plan, trustees act as fiduciaries when they communicate with plan members and plan beneficiaries about their benefits. The fiduciary quality of their function continues when they communicate on those key topics through the statements of agents who do not, themselves, meet the definition of a fiduciary in their own right. Thus, the court rejected the contention that fiduciaries cannot be liable for a breach based on statements made by non-fiduciary ministerial employees.

SPD saved the day for the fiduciaries. The Second Circuit determined that, even if a fiduciary breach claim could be sustained based on the statements made by the ministerial employees, the SPD provided to the participant (and which was also attached in correspondence from the plan to the participant and his wife) was clear on the death benefit that would be payable under the circumstances. The court referred to its

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opinion in *Becker v. Eastman Kodak Co.*, 120 F.3d 5 (2d Cir. 1997), in which it held that a fiduciary may be liable for fiduciary breach if a plan member is misled due to a combination of an unclear SPD and misrepresentations by the fiduciary's agents. The fact that the SPD clearly communicated the eligibility requirements for pension and survivor benefits, liability under the *Becker* decision was precluded. Although the circumstances of the participant and surviving spouse were sympathetic, the Second Circuit emphasized the importance of clarity in the SPD in coming to this conclusion.

ERISA Preemption

Killer statute determined not to be preempted by ERISA; applicable to person found not guilty by reason of insanity [Citation: *Laborers' Pension Fund v. Miscevic*, 880 F.3d 927 (7th Cir. January 29, 2018)]
Text available at http://bit.ly/2BHAB51

The Seventh Circuit is the first federal appellate court to take up the issue of whether ERISA preempts "killer" statutes (also known as "slayer" statutes), and has concluded that it does not because slayer laws are an aspect of family law, which is a traditional area of state regulation. The court cited numerous district courts that have ruled the same way.

Scope of killer statute is important. Some states require conviction for the killing before the killer statute will result in forfeiture of benefits. In the *Miscevic* case, the killer was found not guilty by reason of insanity. The applicable law (Illinois) did not require conviction but required that the person intentionally and unjustifiably caused the death. The Seventh Circuit analyzed cases in Illinois state courts and determined that a not guilty verdict by reason of insanity was still consistent with an intentional and unjustifiable killing, and ruled that the killer forfeited the ERISA benefit. A failure to convict because of insanity means that the killer did not understand the criminality of his or her actions, but the killing can still be intentional in a civil case. The fact that the Illinois statute is not confined to criminal convictions opens the door to the civil case analysis of intention. In addition, an insanity defense is an excuse defense, as opposed to a justification defense (e.g., self-defense). An excuse defense does not make a killing justifiable, whereas a justification defense does.

Statute of limitations for ERISA actions

Application of state law limitations period depended on the basis of the claim [Citation: *Clemons v. Norton Healthcare Inc. Retirement Plan*, 890 F.3d 254 (6th Cir. 2018)]
Text available at http://bit.ly/2G4nbSH

The Sixth Circuit applied different statutory periods for different aspects of a plaintiff's claim based on the applicable state law (Kentucky law in this case). The claims in the case could be divided into two parts: alleged violations of ERISA's statutory provisions, and interpretation of the plan terms. With respect to alleged ERISA violations (i.e., the improper application of ERISA's actuarial equivalence requirements), the court ruled that the proper limitations period was the one for claims relating to statutory violations, which was five (5) years. However, a longer limitations period of fifteen (15) years applies to claims on written contracts. To the extent the claims were based on interpretation of the plan's terms (i.e., claims

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relating to alleged underpayment of benefits under the terms of the plan), the 15-year limitations period for contract claims applied instead of the 5-year period for statutory violations.

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Anti-Cutback Rules

Amending that assumed future compensation increases with respect to protected traditional-formula benefit did not violate anti-cutback rule [Citation: *Teufel v. Northern Trust Company*, 887 F.3d 799 (7th Cir. April 11, 2018)]
Text available at http://bit.ly/2HiIy7G

The defined benefit plan in this case was amended to change the traditional benefit formula to a pension equity plan (PEP) formula. The traditional formula based benefits on a percentage of high-5 average compensation times years of credited service. The PEP formula multiplied years worked by a percentage of the highest average compensation. The amendment adopting the PEP formula provided for a transitional benefit for employees hired prior to a specified date (10 years prior to the amendment's effective date), which was designed to minimize the impact on pension expectations for workers who had relied on the transitional formula. Under the transitional benefit, rather than calculating the protected traditional benefit without recognizing any further increases in compensation, the protected traditional benefit would be increased for years after the amendment by assuming salary increases of 1.5% per year to compute the high-5 average compensation. The plaintiff challenged the amendment as violating the anti-cutback rule under ERISA §204(g).

The Seventh Circuit held that the amendment did not violate the anti-cutback rule because it did not affect the benefit that had accrued as of the effective date of the amendment. Under a traditional formula, the protected benefit at any time is the accrued benefit calculated under the current formula, taking into account compensation earned through such date. Once the amendment changed the formula, any future increases in compensation were not required by law to determine the protected traditional benefit. The transitional benefit adopted as part of the plan amendment went beyond what the anti-cutback rule required by recognizing future increases in compensation, but under an assumed increase formula, rather than looking at actual increases in compensation. The court noted that if, instead of amending the plan, the employer changed it's compensation practices and limited all salary increases to 1.5%, which it had the power to do, the impact on future benefit increases would have been the same as under the transitional benefit amendment. Similarly, if the plan had terminated, the traditional benefit would have been calculated without regard to future compensation increases. The bottom line is that the effect actual increases in future compensation might have on one's benefit is not part of the accrued benefit, but merely an expectation for future benefit accruals, and not protected by the anti-cutback rule.

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Distribution Procedures

Wire transfer of funds out of plan to participant reasonably interpreted by administrator as paid as of such date, even though funds did not hit transferee account until after participant's death [Citation: *Wengert v. Rajendran*, 866 F.3d 725 (8th Cir. April 3, 2018)]
Text available at http://bit.ly/2GW60nQ

A participant requested lump sum payment of his benefit that was wire-transferred by the plan on a Friday. The transferred funds, however, did not hit the transferee account (a trust designated by the participant) until Monday. In the interim, the participant had died. His surviving spouse brought this suit claiming that the benefit (over $2 million) should be paid to her as the deceased participant's beneficiary because the transferee account did not receive the payment under after the participant's death. The plan administrator interpreted the plan document as recognizing a distribution as occurring once funds are transferred out of the plan, at which point all obligations to the participant or a beneficiary are satisfied. Thus, it denied the surviving spouse's claim for benefits. The Eighth Circuit held for the plan. The court's reviewed the administrator's interpretation of the plan under an abuse-of-discretion standard because the administrator had discretionary authority to determine eligibility for benefits (known as the *Firestone* rule). Since the administrator's interpretation of the plan was reasonable, it could not be overruled under an abuse-of-discretion standard, regardless of whether an alternative interpretation (e.g., looking to the date payment is received by the transferee) might have also been reasonable. The court also rejected an argument that the plan administrator was obligated to follow state law (Nebraska law in this case) which provides that a funds transfer is completed by acceptance by the beneficiary's bank of a payment order for the benefit of the beneficiary. Since the payments are made under an ERISA plan, the administrator was not bound by state law to interpret the plan document.

> ✪ *Comment.* Although not mentioned in the court's opinion, it should be inferred that the payment did not violate any surviving spouse requirements under the ERISA plan. The plan at issue was a defined contribution plan which apparently did not provide for a qualified joint and survivor annuity and presumably met the requirements under IRC §401(a)(11)(B) to be exempt from the QJSA rules. This is why the determination of when the distribution occurred was so important in this case. Had the court ruled that the distribution should not be treated as made until after the participant's death, that probably would have triggered spousal benefits (i.e., under IRC §401(a)(11)(B), the surviving spouse is beneficiary of 100% of the vested benefit unless the spouse has consented to an alternative beneficiary).

Death Benefits

Participant's death three days before annuity starting date resulted in no death benefit for nonspouse beneficiary because plan only provides spousal preretirement death benefits [Citation: *Estate of Jones v. Children's Hospital and Health Systems Incorporated Pension Plan*, 892 F.3d 919 (7th Cir. June 13, 2018)]
Text available at http://bit.ly/2L7SrDY

The defined benefit plan in question allowed for benefit payment methods that included post-retirement death benefits (e.g., life annuity with term certain), but for participants who died prior to their annuity starting date, death benefits were limited to spousal benefits. The deceased participant in this case had

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elected an early retirement pension in the form of a 10-year annuity. Her daughter was the designated beneficiary under the annuity. The participant retired on August 26, 2015, with the early retirement pension scheduled to begin on September 1, 2015 (i.e., the first day of the month following her retirement election, in accordance with the terms of the plan). However, she died of cancer three days later, on August 29, 2015. Since her death occurred prior to her first pension payment, the plan administrator treated her death as covered by the preretirement death benefit provisions of the plan. This resulted in no death benefit being payable because the participant did not have a surviving spouse, and only spouses qualified for preretirement death benefits under the plan. The Seventh Circuit upheld the plan administrator's determination that the plan terms did not support any death benefit to the daughter. The administrator's determination was reviewed under an arbitrary or capricious standard, pursuant to the *Firestone* principles. The court determined that the administrator's interpretation was reasonable, even though, at the time of the participant's death, the 10-year annuity had been elected and the beneficiary designation had been made.

Claims Procedures

Clarification of participant's right to appoint representative for disability claims; plan must not impede ability to appoint representatives [Citation: *Information Letter to Jonathan Sistare of The Law Offices of Jonathan Sistare, PLLC* (February 27, 2019)]
Text available at http://bit.ly/2IWLU22.7.

The law firm requesting this letter from the DOL acts as a patient advocate and healthcare claim recovery expert for plan participants and beneficiaries, both at the initial application stage and when claimants appeal adverse benefit determinations. The firm sought clarification of the participants' rights under the DOL's revised disability claim regulations to have such representation. The DOL refers to the FAQs at its website, which clearly state that when a claimant clearly designates an authorized representative to act and receive notices on his or her behalf with respect to a claim, the plan should, in the absence of a contrary direction from the claimant, direct all information and notifications to which the claimant is otherwise entitled to the representative authorized to act on the claimant's behalf with respect to that aspect of the claim (e.g., initial determination, request for documents, appeal, etc.). In this regard, it is important that *both* claimants and plans understand and make clear the extent to which an authorized representative will be acting on behalf of the claimant. See Benefit Claims Procedure Regulation FAQs, FAQ B-3, at http://bit.ly/2UmvcdM.

Right to representation. Although a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, the procedure cannot prevent claimants from choosing for themselves who will act as their representative or preclude them from designating an authorized
representative for the initial claim, an appeal of an adverse benefit determination, or both.

Disclosure requirements. The procedures for appointing a representative must be stated in the plan's claims procedures. In addition, this information must appear in the SPD or in a separate document that accompanies the SPD.

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Bankruptcy

IRA and 401(k) funds obtained in a property settlement were not exempt from bankruptcy estate as retirement funds [Citation: *Lerbakken v. Sieloff and Associates, P.A. (In re Lerbakken)*, ___ F.3d ___, No. 18-6018 (8th Cir. October 16, 2018)]
Text available at http://bit.ly/2ySORJt
EOB2018 sections affected: Chapter 3B, Section XI, Part B.2.b.1)

Relying on *Clark v Rameker*, 134 S.Ct. 2242 (2014), the Eighth Circuit held that a debtor's interest in his ex-wife's 401(k) account and IRA, awarded pursuant to the dissolution of their marriage, was not exempt retirement funds with respect to his Chapter 7 bankruptcy estate. The Bankruptcy Code exempts "[r]etirement funds to the extent that those funds are in a fund or account that is exempt from taxation under" IRC §§401, 403, 408, 408A, 414, 457, or 501(a). The court did not see a distinction between the inherited IRA funds at issue in *Clark v. Rameker*, which were inherited by reason of the death of the IRA owner, and funds that are awarded by reason of a divorce. The Supreme Court's case limited the bankruptcy exemption to individuals who create and contribute funds into a retirement account. Retirement funds obtained or received by any other means do not meet this definition. The court was not persuaded by the fact that the funds were accumulated during the marriage and were intended to be used for the joint retirement of the debtor and his wife.

It is noted in the opinion that a QDRO was not obtained with respect to the 401(k) plan. It is not clear whether the court might have ruled differently if those funds were formally assigned through a QDRO, since in that case, the debtor could have rolled the funds to his own retirement plan. However, the court's statement that "[a]ny interest [the debtor] holds in the Accounts resulted from nothing more than a property settlement" suggests that a formal QDRO would not have made a difference, since a QDRO is merely a formal recognition of a property settlement that is needed to satisfy the anti-assignment rule under IRC §401(a)(13) and ERISA §206(d). Even if the Eighth Circuit might rule differently if a QDRO had been issued on the 401(k) funds, there shouldn't be any effect on the court's view regarding IRA funds that are awarded in a divorce.

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Church Plans

Tenth Circuit tackles issue of what is a "principal purpose organization" for purposes of the church plan exemption from ERISA [Citation: *Medina v. Catholic Health Initiatives*, 877 F.3d 1213 (10th Cir. December 19, 2017)]
Text available at http://bit.ly/2CN45Uk

In the *Medina* case, the Tenth Circuit took up the definition of a principal purpose organization head on. The plan in this case was maintained by a Defined Benefit Plan Subcommittee ("Subcommittee"), which is a subcommittee of the board of Catholic Health Initiatives (CHI). The court used a three-step analysis to determine whether an entity is properly seeking to use the church-plan exemption for plans maintained by a principal purpose organization: (1) the entity whose employees are covered by the plan has to be a tax-exempt nonprofit organization associated with a church, (2) the retirement plan has to be maintained by a principal purpose organization, and (3) the principal purpose organization also has to be associated with a church. The following determinations were made with respect to this three-step analysis.

(1) "Association" of covered employees' employer with a church. Canon law under Catholic doctrine was relevant in determining whether the CHI was "associated" with a church because the CHI is the civil-law counterpart (the tax-exempt organization) of the cannon-law canon-law person known as the Catholic Healthcare Foundation (CHF), which the Catholic Church regards as an official part of the church. CHI's Article of Incorporation provide that it is organized and operated exclusively for the benefit of performing the functions of, and carrying out the purposes of the CHF. The court distinguished a Fourth Circuit case (*Lown c. Continental Casualty Company*, 238 F.3d 543 (4th Cir. 2001), which set three very specific factors as relevant to determine association with a church, which looked to governance of the organization by the church and other operational factors. The Tenth Circuit believes that, not only did the *Lown* case deal with an organization that had disaffiliated itself from the Baptist Convention, but the specific factors in *Lown*, although sufficient to establish association with a church, should not be viewed as the exclusive means of meeting the much broader statutory description of association or affiliation.

(2) Principal purpose organization. The Tenth Circuit held that the Subcommittee could satisfy the statutory requirements of a principal purpose organization. The court found that the Subcommittee was formed for the purpose of maintaining the plan, and that, as a formal subcommittee of the CHI board, had sufficient structure to be treated as an "organization" for purposes of the church exemption, even though it is not a formal, separately-incorporated entity and not independent of CHI. [This analysis was critical to upholding the church exemption because CHI's has the principal purpose of providing healthcare, not administering the plan.]

(3) Association of principal purpose organization with the church. Since the finding in (1) concluded that CHI was associated with the Catholic Church, the Tenth Circuit held that association of the Subcommittee, as the principal purpose organization, necessarily followed. In addition, the plan documents made clear that the Subcommittee is associated with the church.

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Title IV: PBGC Enforcement

Court held trust that is in a controlled group with employer was liable to PBGC for funding liabilities because its leasing of land to the employer was a trade or business, and federal common law of successor liability also can be applied [Citation: *PBGC v. Findlay Industries, Inc.*, ___ F.3d ___, No. 17-3520 (6th Cir. September 4, 2018)]
Text available at http://bit.ly/2wNpCX8

The Sixth Circuit makes two important holdings in this opinion.

(1) A trust under common control with the employer, which was funded with plan assets that it leased back to the plan, is a trade or business to determine liability to the PBGC.

(2) The common law doctrine of successor liability is properly applied to determine liability to the PBGC where it is necessary to implement the fundamental ERISA policy of protecting employees, in part by guaranteeing that employers who have promised a pension uphold their part of the deal.

Facts. There were two transactions that led to the above two holdings.

✪ *Lease between trust and employer.* In 1986, the the employer maintaining the PBGC-covered plan transferred two pieces of property owned by the plan to the company's founder and owner. The owner then transferred that property to an irrevocable trust for the benefit of his sisters, during their lifetimes, with the remainder going to the owner's two sons. During a period of more than 15 years, the trust leased that transferred property to the corporation before the corporation failed.

✪ *Asset sale.* When the corporation that maintained the PBGC-covered plan failed (the "defunct company"), it sold off assets (equipment, inventory and receivables) from two plants to an LLC for $2.2 million in cash and $1.2 in assumed trade debt, for a total purchase price of $3.4 million. These assets were in turn transferred from the LLC partly to the son of the owner of the defunct company and partly to a company owned entirely by the son. Shortly after that, the son transferred the assets to two other newly-formed companies owned by the son. Up until two months before the sale of the assets to the LLC, the owner's son served as CEO and a director of the corporation maintaining the PBGC-covered plan. The two companies that ultimately ended up with these assets were in effect duplicates of the defunct corporation, each establishing a plant on the defunct company's lots and hiring many of the former employees of the defunct company. At the time of the sale of the assets, the defunct corporation had an outstanding pension liability of over $18 million, even though it received only $3.4 million for the sale.

Liability of the controlled trust. Pursuant to ERISA §4062, a controlled member of the employer sponsoring a PBGC-covered plan can be liable to the PBGC for unfunded liabilities under a terminated plan. The defendants argued that the trust that was under common control with the defunct corporation should not be subject to liability because it was not engaged in a trade or business. The Sixth Circuit formally adopted what it calls the "categorical" test with respect to this issue. Under this holding, any trust that leases property to a commonly controlled business is categorically engaged in a trade or business for ERISA purposes. The purpose of this categorical test is to prevent companies from using the leasing of assets between controlled group members as a way to offer the leasing entity protection from ERISA liability with very little risk. When the owner of the corporation gave the property to the trust, he guaranteed that the corporation would have the benefit of use of the land in the same manner as it would have if it had never given away the property. By adopting this categorical test, the Sixth Circuit formerly joins other Circuit Courts that have considered this issue. See *Cent. States Se. & Sw. Areas Pension Fund v. Messina Prods.*, LLC, 706 F.3d 874, 882 (7th Cir. 2013), *Vaughn v. Sexton*, 975 F.2d 498, 503 (8th Cir.

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1992), and *Bd. of Trustees of W. Conf. of Teamsters Pension Trust Fund v. Lafrenz*, 837 F.2d 892, 894-895 (9th Cir. 1988).

Successor liability. The PBGC sought liability under the common law doctrine of successor liability because ERISA §4069(b) did not reach the business that had purchased the assets of the defunct corporation. In order to create federal common law, the Sixth Circuit requires at least one of three elements to be present: (1) ERISA must be silent or ambiguous on the issue before the court, (2) there must be an awkward gap in the statutory scheme, or (3) federal common law must be essential to the promotion of fundamental ERISA policies. The Sixth Circuit was most persuaded by element (3) in this case.

✪ *Policies of ERISA.* ERISA's fundamental protections of employment benefits function in two ways -- guaranteeing that employees receive the benefits they were promised and making sure that employers keep up their end of the deal. To that end, the official policy of ERISA is to protect "the interests of participants in employee-benefit plans and their beneficiaries" while "establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans." See ERISA §4001(b). In addition, ERISA §4002(a), which creates the PBGC, states that the purpose of Title IV is to "encourage the continuation and maintenance of voluntary private pension plans for the benefit of their participants" and "provide for the timely and uninterrupted payment of pension benefits to participants and beneficiaries." Finally, the PBGC must maintain the lowest possible premiums, which best accomplished if the PBGC minimizes its liability to pay out benefits by holding employers liable for their promises. Successor liability promotes these fundamental ERISA policies by guaranteeing that substance matters over form.

✪ *Analysis of facts.* It appears from the alleged facts that the owner's son had extensive information about the company's debts and pension funding. The assets that his company purchased for $3.4 million netted his two companies nearly $12 million in four-and-a-half years. And the companies operated from two former sites of the defunct company, with former employees, making the same products, and selling to the defunct company's principal customer. The Sixth Circuit believes that if there is no successor liability here, this case will provide "an incentive to find new, clever financial transactions to evade the technical requirements of ERISA and, thus, escape any liability, a result that flies in the face of" ERISA §2(b).

✪ *Successor liability under federal common law.* Because there is a body of federal common law applying successor liability in employment and labor cases, the Sixth Circuit determined it was appropriate to apply that law here, too. Successor liability is an equitable doctrine that requires the court to balance (1) the interests of the defendant, (2) the interests of the plaintiff, and (3) the goals of federal policy, in light of the particular facts of a case and the particular legal obligation at issue. See *Cobb v. Contract Trans., Inc.*, 452 F.3d 543, 554 (6th Cir. 2006) (applying successor liability to the Family and Medical Leave Act). Furthermore, adopting the federal common law of successor liability would best serve ERISA's purposes.

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Milo Atlas currently serves as a Pre-approved Plans Coordinator in Cincinnati, Ohio. His experience includes the performance of examinations, determinations, quality assurance, and serving as a coach and instructor. He has over 25 years of government service, primarily in employee plans.

Milo is a Certified Public Accountant.

ANGELO NOE
PRE-APPROVED PLANS PROGRAM COORDINATOR
TAX EXEMPT/GOVERNMENT ENTITIES
INTERNAL REVENUE SERVICE, CINCINNATI, OHIO

Angelo has been with the Service for over 30 years. During his career, Angelo has performed Form 5500 examinations, reviewed determination letter applications, worked in the technical screening function, assisted in the closing agreement function, served as an on-the-job instructor for new employees, assisted in the writing of technical material for training purposes, served as a classroom instructor, reviewed specimen plans in the Volume Submitter Program, and previously served as coordinator of the Volume Submitter Program. Angelo currently serves as one of the two Pre-approved Plans Program Coordinators.

Tax Exempt & Government Entities | EP Rulings & Agreements

2019 Cincinnati Employee Benefits Conference

Updates on the Pre-approved Plans Programs

Milo Atlas, Pre-approved Plans Coordinator

Angelo Noe, Pre-approved Plans Coordinator

June 7, 2019

1

Current Status of IRC 401(a), 3rd Cycle Defined Contribution Program

- Mass Submitter Lead Plans – 40
- Non Mass Submitter Lead Plans – 115
- Word For Words -1600
- Minor Modifiers - 30

2

2

Review Process For 3rd Cycle Defined Contribution Plans

- Team of reviewers
- Two levels of review
- Request for changes
- Your response to 1st level reviewer
- Final 2nd level review
- Pre-approved Coordinators

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Other Applications Being Accepted For Completed Programs

- Additional Word For Words For The Following:
- a) DC PPA
- b) DB PPA
- c) 403(b)

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Issues Encountered To Date – Slayer Statute

- Slayer Statute – “Killer Statute”
- Governed by state law
- Prohibits inheritance by a person as a result of killing another person they would otherwise be entitled under normal conditions
- Permitted in pre-approved program if it is restricted to viability under state law

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Issues Encountered To Date – Bipartisan Budget Act of 2018

- Changes in hardship distribution rules, e.g. Elimination of the requirement that a participant’s contributions to the 401(k) plan and all other employer plans be suspended for at least 6 months following the receipt of a hardship distribution
- Remember our 3rd cycle review is limited to cumulative list per Notice 2017-37

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Trusts/Custodial Account Documents and 3rd Cycle Plans

- Rev Proc 2017-41
- Section 3.11 – IRS no longer rules on exempt status
- Section 4.10 – Must be in document separate from the plan
- Section 9.03 – Do not submit trusts or other funding mediums
- No language in trust can conflict with plan

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Trust/Custodial Account Documents and 3rd Cycle

- Items seen to date which are not allowed:
- a) separate trust or full trust article in plan
- b) Duty to collect language per DOL FAB 2008-1
- c) Statement of various trustee responsibilities, such as assets being held in trustee's name, need to forward notices, proxies, etc. to participant/beneficiary

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Trust/Custodial Account Documents and 3rd Cycle

- The following are permitted:
- Mention that a trust exists as a separate document for use with this plan
- If the plan permits participant directed investments existence of the trustee responsibility may be noted

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Discretionary Match & True-Ups

- Past problems with completely discretionary matching formulas in 401(k) plans
- 401 regs do not allow allocation formula to be discretionary
- Matching computation period, such as payroll period or plan year, must also be identified

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Discretionary Match & True-Ups (continued)

- Eliminate ambiguity over need for true-up
- Document must contain note regarding possible need for true-up at year end where ER contributes more often than computation period
- Example of definite allocation for discretionary match: "discretionary match shall be allocated to each participant as a uniform rate up to a uniform deferral percentage"

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Forfeiture Disposal Provision

- Issue developed during 2nd (PPA) cycle
- Plan must be clear as to how a forfeiture will be utilized and how quickly
- Can be utilized as an additional allocation, ER contribution offset, payment of plan expenses, or combo of the three with an "ordering" rule

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Forfeiture Disposal Provision (continued)

- Disposal must occur as soon as administratively feasible but no later than the end of the following plan year
- See DC LRM 39, Treas. Reg. 1.401-7, and Code section 401(a)(8)

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401(k) Safe Harbor Issues

- Use of “Wait and See” method of Treas. Reg. 1.401(k)-3(f) available for safe harbor non-elective contribution
- Permitted in a pre-approved 401(k) plan
- Must be drafted appropriately to address the timing and notice requirements as well as the need for an employer implementing amendment to be adopted

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401(k) Safe Harbor Issues (continued)

- Permissible reduction/suspension of safe harbor contributions during the plan year under Treas. Reg. 1.401(k)-3(g)
- Permitted in a pre-approved 401(k) plan
- Available for safe harbor match and safe harbor non-elective contribution
- Again, must be drafted appropriately to address the timing and notice requirements as well as the need for an employer implementing amendment to be adopted

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Student Loan Repayment Program

- An arrangement under a plan whereby a participant's receipt of an employer contribution is contingent on that participant making a payment(s) on their student loan debt
- In May of 2018, the IRS issued a PLR to a taxpayer who proposed to add such an arrangement to their existing 401(k) plan

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Student Loan Repayment Program (continued)

- The PLR only addressed whether the addition of the arrangement would have a negative impact on the CODA's satisfaction of the "contingent benefit" prohibition of Code section 401(k)(4)(A) and Treas. Reg. 1.401(k)-1(e)(6)
- Such an arrangement or program is NOT permitted in a pre-approved plan

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Combo Plan Option

- Rev. Proc. 2017-41 allows for the combination of a profit sharing plan with/without a CODA and a money purchase plan into one single document plan or one adoption agreement
- Combo allowance is for the convenience of the provider or mass submitter
- Per Program policy, if an employer wants to sponsor both plan types, two single document plans or two adoption agreements must be signed

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Combo Plan Option (continued)

- So-called “collapsible” adoption agreement plans are permissible in the Program
- “Collapsible” means ONLY the choices/selections made by an employer appear in its signed adoption agreement; those not selected disappear
- To accommodate combo plans, the Program will allow a variation to “collapsible”

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Combo Plan Option (continued)

- The variation allows the provider or mass submitter to “collapse out” (or drop out) from an adoption agreement the provisions of the plan type for which an employer is not adopting with that adoption agreement
- This variation must be clearly presented to the IRS during the pre-approval process

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Tax Exempt & Government Entities | EP Rulings & Agreements

Changes to EP Programs

William H. Anderson, Esq., Supervisory Tax Law Specialist

Revenue Procedure 2019-19

- Replaces Rev. Proc. 2018-52
- Effective April 19, 2019
- Expands what failures are eligible for self-correction under EPCRS

Expansion of Self Correction Program (SCP)

•Expands SCP to allow Plan Sponsors to self-correct certain:

- Participant loan failures
- Operational Failures via retroactive amendment
- Plan Document Failures

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What is the Self-Correction Program?

- Under SCP
  - Plan Sponsors are permitted to correct failures on their own
  - no fee or sanction
  - IRS approval not needed
- Timing of correction for operational failures:
  - **Insignificant**: Can correct at any time, even if discovered on an IRS examination
  - **Significant**: time limited (generally within 2 years after year of failure)
    - Plan Document failures are considered significant

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Loan related Failures that can now be addressed under SCP

- Defaulted loans
- Failure to timely report deemed distribution
- Failure to obtain spousal consent
- Failure to follow plan terms that limit the number of loans allowed

•See, section 6.07 of Rev. Proc. 2019-19

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Defaulted Loans

- Plan loan must have been an enforceable agreement as described in Treas. Reg. 1.72(p)-1 (Q&A-3)
- Loan terms satisfied IRC § 72(p)(2)(A),(B) & (C) in form at loan inception
- Default occurred because the loan payments were not made in accordance with the terms of the loan and amortization schedule
- Plan document and/or loan policy typically specifies when default occurs

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Defaulted Loans, continued

•New to SCP:

- Plan sponsors have two ways to deal with defaulted plan loans
- Option 1: Report the deemed distribution in the year of correction
- Option 2: Avoid the deemed distribution entirely

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Defaulted Loans, continued

•Report the deemed distribution in the year of correction:

- Amount reported on Form 1099-R includes:
  - Unpaid loan principal balance
  - Accrued, but unpaid interest. See Treas. Reg. 1.72(p)-1 (Q&A-10) for more info
- Plan sponsor responsible for paying income tax withholding under certain conditions discussed in Treas. Reg. 1.72(p)-1 (Q&A-15)

•See, Rev. Proc. 2019-19, section 6.07(1)

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Defaulted Loans, continued

•For loan failures involving missed payments, plan sponsors can now report the deemed distribution in the year of correction under SCP or correct the loan under SCP by:

1)allowing the participant to repay all the missed loan payments, with interest, in a lump sum and continuing the payments under the old loan schedule,

2)allow the plan to reamortize the outstanding loan balance, including accrued interest, over the remaining life of the loan (or the period remaining had the loan been reamortized over the maximum period allowed from the date of the original loan) and have the participant begin making payments under the new loan schedule, or

•3) A combination of 1 or 2.

•Note: Can't avoid a deemed distribution if the maximum period for repayment under 72(p)(2)(B) has expired by the time correction occurs.

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What is a deemed distribution?

- Taxable distribution
  - If the loan fails to meet the plan loan rules regarding amount, duration, level amortization or enforceable agreement, the loan is treated as a taxable distribution from the plan.
  - The amount is included in the participant's gross income and may be subject to 72(t) tax (10% on early distribution).

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Deemed Distributions

•*Result:* plan loan failures that result in a "deemed" distribution must be reported on Form 1099-R in the year of the failure, unless the employer corrects the failure through VCP or Audit CAP.

•

•*Rev. Proc. 2018-52*—allows the plan sponsor, under *VCP or Audit CAP, to* report the deemed distribution on Form 1099-R in the year of the correction (instead of the year of the failure) if specifically requested in submission (See section 11.04(10)).

•*Rev. Proc. 2019-19*—allows the plan sponsor, under *SCP, VCP or Audit CAP,* to report the deemed distribution on Form 1099-R in the year of the correction (instead of the year of the failure). Requirement to request reporting relief has been eliminated.

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Loan Failures not eligible to be corrected under SCP

- Certain loan failures can be corrected only under VCP or Audit CAP.
- Those failures that may be corrected only under VCP or Audit CAP are loan failures where the loan fails to meet:
  - Amount Limitation—loan in excess of 72(p)(2)(A) amount
  - Repayment Period—loan does not meet the repayment term in 72(p)(2)(B)
  - Level Amortization—loan does not meet level amortization requirement in 72(p)(2)(C)

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Spousal consent for participant loans

•For failures to obtain spousal consent, allow the plan sponsor to self-correct by securing spouse's consent:

- Plan Sponsor must notify the affected participant and spouse (to whom the participant was married at the time of the plan loan), so that the spouse can provide spousal consent to the plan loan.

•Note: If plan cannot obtain consent, the failure to obtain the consent can only be corrected under VCP and Audit CAP.

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Number of loans

•For failures where the plan made multiple loans where only a single loan was permitted by the plan terms, the plan sponsor can self-correct by:

- amending the plan retroactively to allow for more than one loan.

- This correction option is only available if the conditions for making a retroactive amendment are satisfied.
- This correction option was previously available only under VCP and Audit CAP.

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Plan Document Failures

- Applies to qualified and 403(b) plans
- Plan Document Failures are deemed significant for SCP purposes
  - Impacts timing of correction
  - Rule that applies to substantial completion of correction does not apply
- Failure to timely adopt initial plan is a Plan Document Failure but is **not** eligible for correction under SCP.

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Correction by Retroactive Amendment

•An Operational Failure may be corrected by plan amendment under SCP if three conditions are satisfied:

1.the plan amendment would result in an increase of a participant's benefit, right, or feature

2.the increase in a benefit, right, or feature is available to all eligible employees, AND

3.providing an increase in benefit, right or feature is allowable under the Code and satisfies the correction principles of Rev. Proc. 2019-19, section 6.02.

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Correction of Failures to Obtain Spousal Consent

•Failure to obtain spousal consent to a distribution may be corrected under SCP (VCP and Audit CAP are also available) if the participant and the spouse are notified, so that:

- The spouse can provide consent to the distribution made **OR**
- The participant can repay the distribution and receive a qualified joint and survivor annuity.

•If consent cannot be obtained there are alternative safe harbor correction approaches:

- Spouse entitled to a benefit equal to the portion of the QJSA that would have been payable to the spouse on the death of the participant OR
- Spouse can be provided with a choice between the option above or a single-sum payment equal to the actuarial present value of the survivor annuity benefit.

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Revenue Procedure 2019-20: New DL Program

- First time expansion of DL program in 2-3 years
- Amended individually designed plans that can now come in
  - Cash balance plans – 1 time submission period (09-01-19 -> 08-31-2020)
  - Merged plans – perpetual, beginning 09-01-19
- Free pass
  - Won't challenge 'bad' cash balance final reg language
  - Won't challenge 'bad' merger language
  - EPCRS relief

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Revenue Procedure 2019-20: New DL Program

- Refresher
- Sept 1, 1977-February 12, 2005 "*ANY PLAN, ANY TIME*"
  - **ERISA** > Eff. 09-01-1974; Restatement period 01-01-77 to 12-31-80
  - **TDR** > Eff. 1982; Restatement period 01-01-84 to 12-31-86
  - **TRA 86**>Eff. 1-1-87; Restatement period 01-01-89 to 12-31-94
  - **GUST** >Eff. 12-2-94; Restatement period 01-01-97 to 09-30-04

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Revenue Procedure 2019-20: New DL Program

- Refresher
- 02-13-2005 to 12-31-2016 "*ANY PLAN, NOT ANY TIME*"
- 02-13-2005 > 1st cycle inbound Preapp DC leads
- IDPs on Cycle System:
  - **A**02-01-06 to 01-31-07 (EIN)(Parent-Sub electors)……repeat
  - **B**02-01-07 to 01-31-08 (EIN)(Multiple Employers)……repeat
  - **C**02-01-08 to 01-31-09 (EIN)(Governmentals)……repeat
  - **D**02-01-09 to 01-31-10 (EIN) (Multiemployers)…..repeat
  - **E** 02-01-10 to 01-31-11 (EIN)
- Preapproved plans on separate alternating 6-year cycles

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Revenue Procedure 2019-20: New DL Program

- Refresher

- 01-01-2017 to 08-31-2019 "*NOT ANY PLAN, ANY TIME*"
- Determination letter program closed to all but
  1. Initial / New Plans (ie no prior letter)
  2. Terminating Plans (ie F5310)
  3. "Limited Circumstance Amended plans, as shall from time-to-time be accepted"
- Since 1/1/17, EP Determs has worked #1 and #2 submissions, but not accepted any #3's
- FY '18 – solicited public comments re possible program expansion

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Revenue Procedure 2019-20: New DL Program

- Effective 09-01-2019 (ie this forthcoming September), accepting
  - "Statutory Hybrid Plans" – ie cash balance plans
    - Includes PEPs / VAPs / Other hybrids that don't fit on CB Preapp
  - One time, one year submission window – Sept 1, 2019-Aug 31, 2020
  - Merged Plans as a result of a corporate merger (perpetual change) ("#4")

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Revenue Procedure 2019-20: New DL Program

- CASH BALANCE PLANS
- One year submission period - 09-01-19 to 08-31-2020
- 2017 RAL – which includes hybrid plan regs
  - 2010 proposed, 2014 half finalization, 2015 other half finalization
  - 2016 DL program closes
  - 2017 put on OCL and RAL

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Revenue Procedure 2019-20: New DL Program

- MERGED PLANS
- 2 or more plans maintained by previously unrelated employers
  - i.e., not collapsing two plans of same employer
  - i.e., not merger of controlled group members
- Open ended submission period, beginning 09-01-2019, no closure
- Timing rule:
  - Plan merger must have occurred no later than the last day of the first plan year that begins after the plan year that includes the date of Corporate Merger
  - DL submission must be made within period beginning on plan merger date and ending the last day of the first plan year that begins after the date of plan merger

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Revenue Procedure 2019-20: New DL Program

- EPCRS Relief – Hybrid Plans
- No sanctions for deficient prior hybrid plan language (i.e. bad interims)
  - When plan leaves DL process, however, language must be 'good'
- Any other bad, non-hybrid language (i.e. not related to deficient interest crediting, bad accrual rule, etc.), subject to
  - VCP user fee, if made in 'good faith'
  - Audit CAP sanction if not (ie 150%-250% of applicable VCP nonamender sanction fee)

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Revenue Procedure 2019-20: New DL Program

- EPCRS Relief – Merged Plans
- No sanctions for deficient merger language (i.e. bad interims)
- Any other bad, non-merger language, subject to
  - VCP user fee, if made in 'good faith'
  - Audit CAP sanction if not (ie 150%-250% of applicable VCP nonamender sanction fee)

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Questions??

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Contact Information

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Department of the Treasury
Internal Revenue Service
www.irs.gov/ep

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TAB
C

Laura A. Ryan

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Employee Benefits & Executive Compensation
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Education

- University of Cincinnati College of Law, J.D., 1992
- Northern Kentucky University, B.S., 1989, *cum laude*

Overview

Laura is the leader of the firm's Employee Benefits & Executive Compensation practice group. She focuses her practice on the design, maintenance and termination of tax-qualified retirement plans and trusts; analysis of employee benefit issues in the context of corporate mergers and acquisitions; welfare plan and flexible benefit plan administration and documentation; various aspects of executive compensation including establishment and maintenance of non-qualified deferred compensation plans; IRS and Department of Labor plan audits; governmental reporting obligations; compliance with ERISA fiduciary and prohibited transaction rules; and corrective actions under regulatory relief programs.

From 2001-2005 Laura served as senior attorney for Convergys Corporation. The combination of her years of experience in private practice and as in-house counsel to a large public corporation with a global footprint provides her with unique and valuable perspective and experience.

Publications

- "Open Enrollment Checklist," Thompson Hine *The Law@Work Newsletter*, Fall 2017
- "'Clarification' About Out-of-Pocket Maximums Under Group Health Plans May Require Plan Design Changes and Increase Costs in 2016," Thompson Hine *The Law@Work*, Summer 2015
- "Health Care Reform Update – Changes Coming for Over-the-Counter Drugs," *CBA Report*, November 2010
- "Health Care Reform Update – External Reviews of Benefit Claims Under Health Care Reform," *CBA Report*, October 2010
- "Health Care Reform Update – Employers Must Take Second Look at Grandfathered Status," *CBA Report*, September 2010
- "Health Care Reform Update – More Questions Answered," *CBA Report*, August 2010
- "Health Care Reform Update – Complying With Federal, State Dependent Coverage Requirements", *CBA Report*, July, 2010
- "Understanding Required Changes for Health Plans," *CBA Report*, June, 2010
- "The Clock's Ticking on Compliance With New Compensation Rules," *Scrap*

magazine, July/August 2007
- "New Tax Rules are Creating Work for Firms," *Cincinnati Business Courier*, June 2007
- "Changes in Benefits Part of Trade Treaty," *Cincinnati Business Courier*, 1995
- Contributing author, *Doing Business in and with the United States*

Presentations

- “Surge in ERISA Litigation Leading to Multimillion-Dollar Settlements,” Thompson Hine Premier Client Summit, May 2016
- “What to Do When…the DOL Investigates Your Benefit Plan,” Thompson Hine Human Resources Briefing, May 2015
- “401(k) Plan Fees and Funds,” Thompson Hine Premier Client Summit, May 2015
- “Retirement Plan Update,” Thompson Hine Benefits Briefing, September 2014
- “New Benefit Plan Disclosure Requirements,” Louisville Area Chapter CEBS Meeting, July 2012
- "Plan Fiduciary Best Practices – What are they? Why are they so important?", Florida West Coast Employee Benefits Council, January 2011
- "New Laws, Trends and Best Practices Affecting Group Health Plans," Thompson Hine Spotlight on Women Program, December 2009
- "Employee Benefit Trends and Issues in Tough Economic Times," Association of Corporate Counsel Southwest Ohio Chapter, February 2009
- "The Clock is Still Ticking: Despite Extension Full Steam Ahead With 409A," Greater Cincinnati Compensation and Benefits Association, September 2007
- Panelist, "Executive Compensation- No Longer Business As Usual," Business Courier Business Law Roundtable Series, Cincinnati Ohio, February, 2005
- "An Introduction to Qualified Retirement Plans and Overview of ERISA," Cincinnati/Dayton Chapter of International CEBS Society, 1996
- "Overview of Qualified and Non-Qualified Retirement Plans," Cincinnati Chapter of OSCPA, 1995

Distinctions

- Recognized for excellence in Employment Benefits (ERISA) Law by *The Best Lawyers in America*, 2015, 2017, 2018 and 2019; recognized in *Best Lawyers 2019* Lawyer of the Year
- Listed in *Legal 500* in Employee Benefits and Executive Compensation, 2012 to 2014, 2017 and 2018

Professional & Civic

Professional Associations

- Cincinnati Bar Association

- Ohio State Bar Association
- American Bar Association

Professional Activities

- Planning Committee for annual Cincinnati Employee Benefits Conference, 1998 to 2001
- Cincinnati Bar Association, former chairperson of the Employee Benefits Committee, 2000 to 2001
- Cincinnati Academy of Leadership for Lawyers, Class V, 2001

Admissions

- Ohio

Laura M. Nolen, Esq., Ingersoll Rand Inc., Davidson, NC

Laura currently serves as Associate General Counsel, Employee Benefits and Executive Compensation for Ingersoll Rand. Laura arrived in that role after having spent several years in private practice and more than 10 years in the tax and legal organizations of a U.S. oil exploration and production company. Laura's experience includes advising on insured and self-funded health and welfare plans; defined benefit and defined contribution retirement plans; executive employment agreements; equity incentive plans and non-qualified deferred compensation arrangements. She has provided guidance in connection with the requirements of ERISA, COBRA and the Affordable Care Act, and has managed IRS, Department of Labor and Pension Benefit Guaranty Corporation audits and inquiries. Laura also has experience working on the benefits and employment-related aspects of acquisitions and dispositions.

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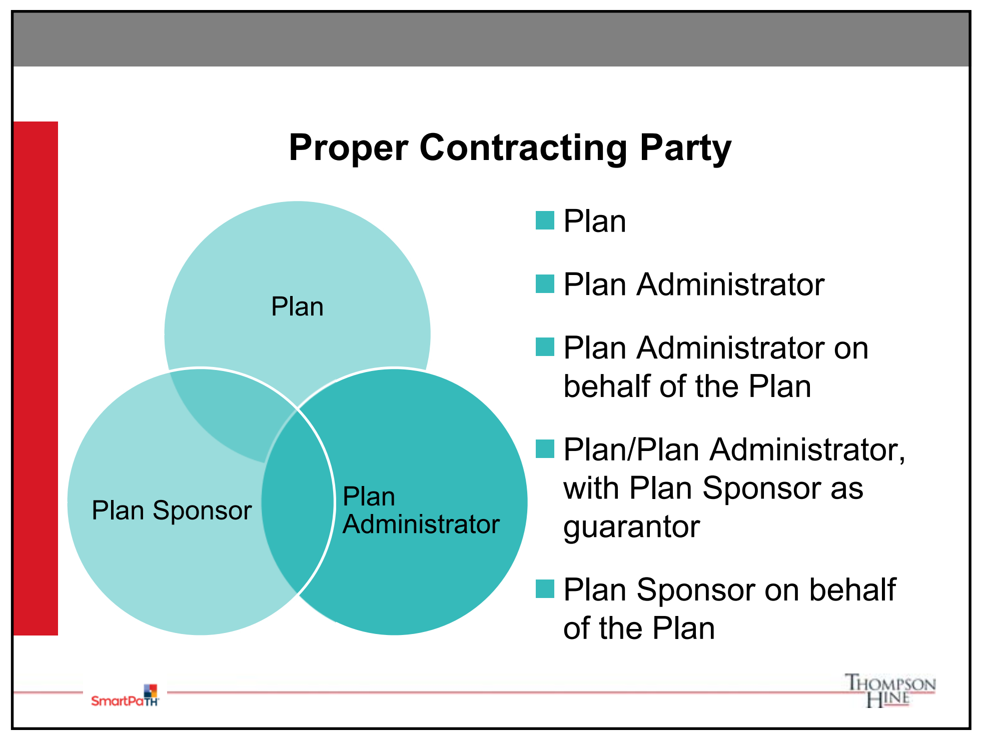

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Claims Administration

- Fiduciary delegation
- Consideration and review of service provider processes (e.g., cross-plan offsetting, precertification and MHPAEA)
- Run-in and run-out (when transitioning service providers)

SmartPath THOMPSON HINE

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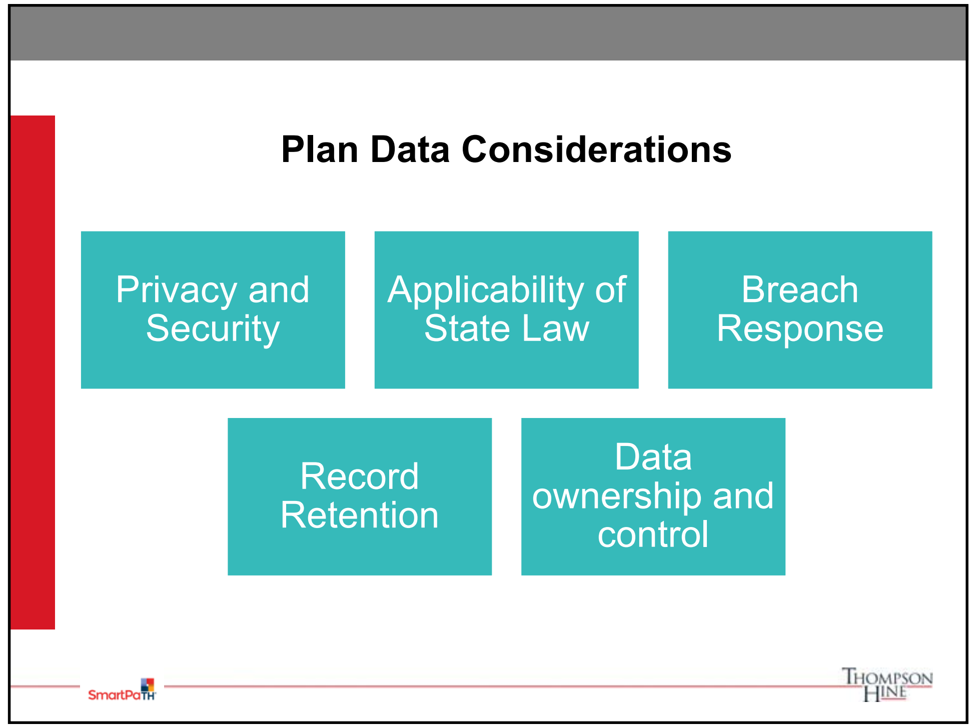

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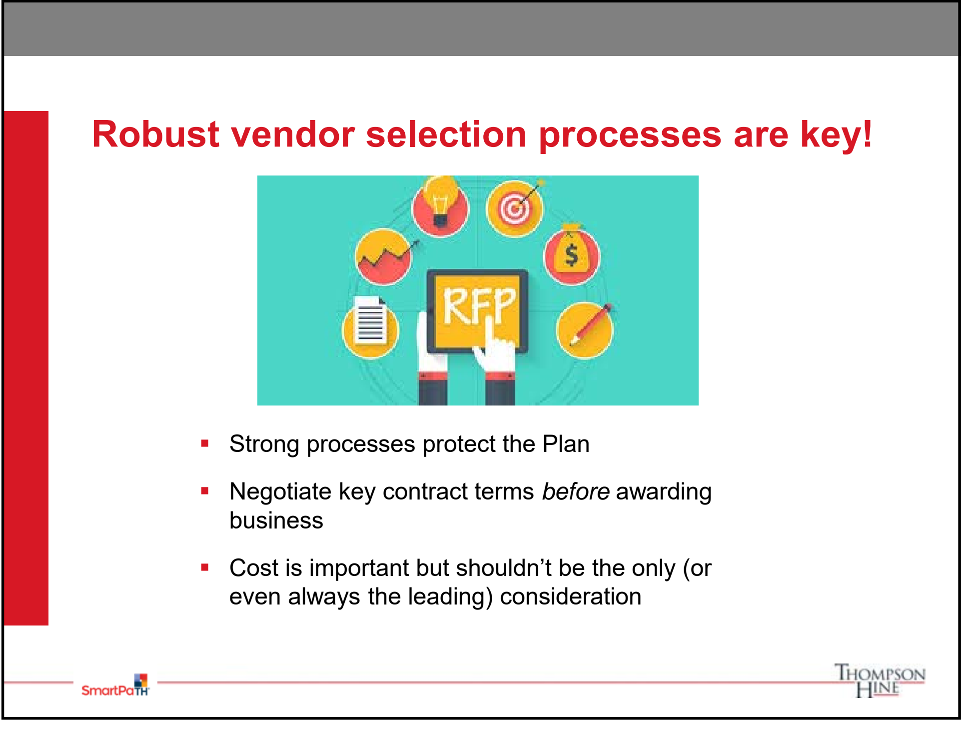

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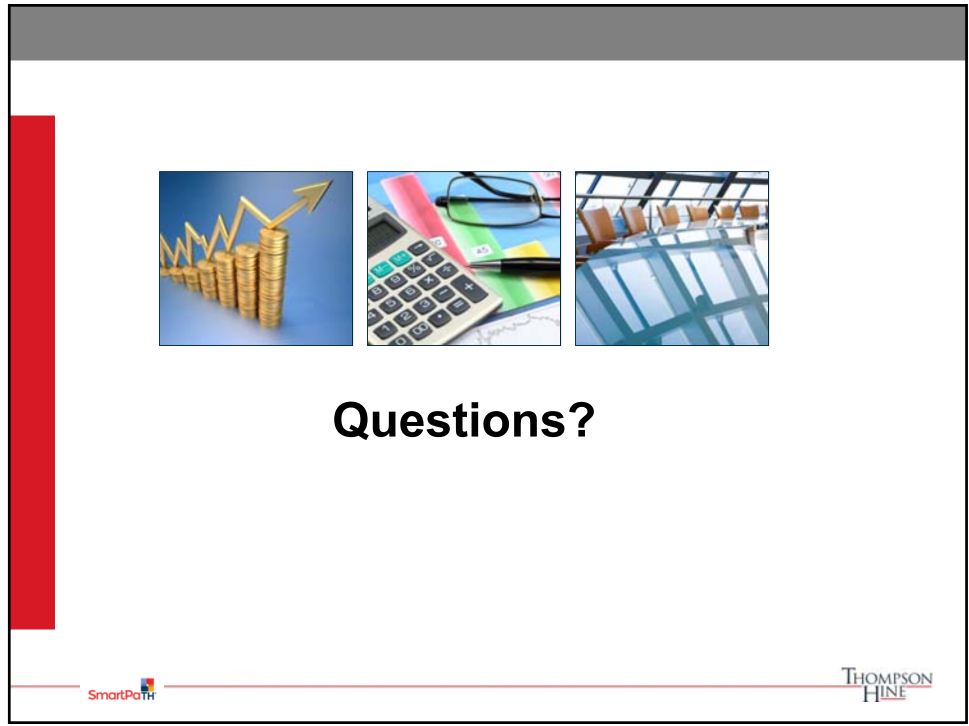

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MEMORANDUM

RE: Discussion Points Regarding Service Agreement Provisions

1. Party Names. Verify accuracy of the names of the parties to the Agreement, including references to any plan names.

2. Sub-Contractors. Consider whether company wants authority to consent to or have notice of the use of any sub-contractors. Agreement should explicitly provide that provider is liable for the acts of its sub-contractors. Agreement should explicitly require provider to have an agreement with the sub-contractor containing applicable provisions similar to those contained in the agreement with the company. Consider the extent to which company might want to limit off-shoring of services or at least for core services.

3. Fees and Invoices. Consider whether time permitted for payment is reasonable. Review for reasonableness any provisions related to interest. Consider level of detail provider should be required to provide in detailed invoices. Ensure there is a process described for disputing invoices.

4. Audit Rights. Ensure the Agreement contains a provision permitting the company to audit those parts of provider's business or operations used in the performance of services. Reasonable rules regarding audits (e.g., advance notice, performed during normal business hours) are acceptable. Unreasonable limitations, including limitations on the frequency with which audits may be performed, should be questioned. If any frequency limitations are agreed to, consider carve-outs where there is reason to suspect fraud or negligence.

5. Records/Record Retention. If applicable, ensure that the provider's obligations to maintain records in a safe and secure manner are clear. Ensure that the provider is obligated to retain the records for the required retention period.

6. Term. Review the provisions regarding the term of the Agreement and consider whether it is reasonable and consistent with what the company has negotiated. Determine whether there is a separate term governing the period during which fees will not be changed. Avoid provisions providing for automatic renewal of the Agreement.

7. Termination. Review circumstances under which the Agreement can be terminated, with a goal to providing as much flexibility to the company as possible. Is there a term for convenience? If not, is one appropriate? Is the amount of notice the provider must provide in the event it wants to terminate the Agreement sufficient to allow the company to find a new service provider? Ensure company has the ability to terminate in the event of a breach. If there are penalties for early termination, review for reasonableness; do they decrease with time? Avoid a provision that allows a provider to stop performing services in the event an invoice is

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not paid.

8. Representations by Provider. Agreement should contain representations that the services will be performed in a timely, diligent, competent, professional manner. Provider should warrant that the services will be performed in accordance with the Agreement and in compliance with all applicable laws. Consider requiring provider to represent that it will abide by the highest standards of business ethics and honest business practices. Consider whether a representation regarding non-infringement is appropriate where software or other IP is being provided in addition to services. Consider whether a representation that the provider will comply with all of the company's conducts and safety standards when working at the company's premises is warranted.

9. Indemnification. If the Agreement contains a provision requiring the company to indemnify the provider for liability arising out of or related to the Agreement, ensure that the Agreement does not provide for indemnification where the liability was caused by the service provider's negligence or breach of the Agreement. Also suggest that the service provider indemnify the company for damages arising out of the provider's negligence or breach of the Agreement. Beware of language that relieves the company from its obligation to indemnify the provider only where the liability arose **solely** due to provider's negligence or breach of the Agreement. Ensure that the Agreement requires provider to promptly notify company of any claim, or potential claim, allows the company to participate in the defense of any claim and prohibits the provider from compromising the company's right to defend the claim.

10. Insurance Requirements. Ensure that the Agreement explicitly requires the provider to maintain insurance coverage. Determine whether the level of coverage is appropriate based on the potential liability. Consider to what extent some or all of the following types of insurance should be required: worker's compensation, commercial general liability insurance, employee dishonesty and computer fraud coverage, errors and omissions liability insurance, and property insurance.

11. Limitation of Liability. Review any limitation of liability provisions closely. Consider whether any dollar cap on liability is reasonable. Beware of language that ties the dollar cap to the amount of fees paid **for the services to which the error that gave rise to the liability related**. Consider whether a limitation to direct damages versus consequential, indirect and punitive damages is reasonable. If it is, such limitation should be mutual (i.e., apply to both parties' liability under the Agreement). Attempt to negotiate exceptions to the limitation of liability for items such as indemnification and liability for breach of confidentiality.

12. Confidentiality Obligations. Review the definition of confidential information to ensure it includes such items as employee information and data. Ensure that the confidentiality obligations are mutual. In addition to requiring the provider to protect confidential information with the same degree of care it uses to protect its own information, there should also be an obligation to protect the information in a manner no less than that which is commercially reasonable. Consider borrowing language from Business Associate Agreement regarding duty to implement appropriate and reasonable safeguards to protect the accessibility, integrity and availability of information. Consider provision restricting use and disclosure of the information only as necessary to provide the services and to require that access to confidential information by employees, agents or independent contractors be based on a need to know basis. Consider whether an exception to confidentiality should be carved out for a public company company who may have disclosure obligations under SEC rules.

13. Exclusivity Clauses. Determine whether the Agreement requires that the company use the provider exclusively for services described in the Agreement. If so, confirm that company is aware of this provision and is in agreement with it.

14. Assignment. Determine whether the provisions regarding assignment of the Agreement are appropriate. Typically, we would want to ensure that our companys have notice and an opportunity to consent regarding any assignment of the Agreement (with a possible exception for assignment to a related subsidiary).

15. Dispute Resolution. Determine whether there are any special dispute resolution provisions and whether those provisions are reasonable and acceptable to the company. This may include internal escalation requirements and binding arbitration.

16. Disaster Recovery/Business Continuity/Force Majeure. Provider should be required to maintain and test from time to time a plan designed to ensure continuity of operations in the event of a "disaster". Typically, providers will explicitly exclude liability for any loss or damage resulting from delay or failure to perform due to an event or force beyond its reasonable control. However, this exclusion should not relieve provider from its obligation to have in place and implement when necessary a business continuity plan. Also consider the extent to which termination of the Agreement should be permissible in the event services remain "down" for more than a designated number of days.

17. Governing Law. Consider the state law that will apply in interpreting the Agreement. Be cautious of any provision specifying venue.

18. Non-Solicitation. Any agreement to not solicit each other's employees should be mutual. It should also be narrowly drafted to apply only to those employees involved in the performance of the services and to exclude situations where an employee becomes employed due to responding to a general public advertisement for an open position.

19. Use of Company Name by Provider. Review such provisions carefully. Allow the company to withhold its consent to the use of its name or trademark in its sole discretion. Ensure the provisions are satisfactory with the company.

20. Data/Work Product. Make sure that the provisions regarding which party owns the work product, reports, etc. are appropriate for the arrangement. Typically reports and data created and maintained on behalf of a benefit plan belong to the plan and the provisions of the agreement should reflect this. Be cautious of provisions that give a sponsor a short period of time to review data/reports, etc. after which such reports are deemed accurate and the service provider will have no liability for inaccuracy/mistakes.

21. Service Provider and Company Obligations. Review list of services to be performed by service provider and determine whether it is as comprehensive as it should be. Review obligations of company under the agreement – are they reasonable; are they what you would expect. Be weary of a provision that absolves service provider from satisfying its obligations in the event company fails to meet its obligations.

22. Performance Standards/Penalties. Is this an agreement covering services for which performance standards should be addressed? If yes, and no performance standards have been proposed, suggest that the service provider make some recommendations. If performance standards have been proposed have the company confirm that they are what they have negotiated for, make sure they are understandable, that how the penalties are calculated is clear, and that how and when the company is entitled to payment/credit for any penalties is specified (especially those penalties that may be accessed after termination of the contract (when credits against future invoices are not feasible)).

ERISA Fiduciary Contract Review Considerations

Parties

The Plan is separate from the company. The Plan Administrator is charged with operating (or overseeing operation of) the Plan. Section 402(a)(1) of ERISA provides, "Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one of more named fiduciaries who jointly or severally have authority to control and manage the operation and administration of the plan."

Practical action: Consider what party should be named in a contract for administration of a benefit plan:

- First choice: the Plan as party or the Plan Administrator on behalf of the Plan. Note that vendors tend to push back on this because the Plan Administrator is generally a committee with no assets and the Plan's assets may not be available for payments to vendor or for meeting indemnity obligations. (If you have an individual Plan Administrator, he or she may also not be keen to be the party to the contract.)
- Second choice: the Plan or the Plan Administrator for most provisions with the Company or Plan Sponsor as guarantor of payments and provider of indemnity.
- Third choice: the Company on behalf of the Plan.
  - In this case, may be desirable to add provision in "Whereas" clauses that the plan administrator has reviewed and approved to show that fiduciaries are engaged.
  - See "Limitation of Liability" for more info about why the Plan is the preferred party.
- Not a preferred option to name the company only. This causes the company to become an ERISA fiduciary and undermines the entire fiduciary committee structure if a committee has been set up to avoid this.

Who is the plan administrator and who is the named fiduciary?

- Under Section 3(16)(A) of ERISA, the administrator is "(i) the person specifically so designated by the terms of the instrument under which the plan is operated; or (ii) if an administrator is not so designated, the plan sponsor, or (iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe."
- Typical provision : Company has designated a Plan Administrator for non-insured ERISA plans, which is the Benefits Administration Committee. For investment decisions regarding pension assets, the Named Fiduciary is the Benefits Investment Committee. Sample plan provisions:
  - "The Plan shall be administered by the Benefits Administration Committee which shall be appointed by the CEO of Company. The Committee is the named fiduciary for administration of the Plan."
  - "The Benefits Investment Committee is a committee appointed by the Board or its delegate. The Benefits Investment Committee shall have and may exercise all powers given to the Board and to the Company in the Trust Agreement which relate to the investment policy, practice and management to be followed by the Trustee."

- “Committee shall mean the Company Benefits Administration Committee, established to administer the Plan pursuant to Section [X]. This term is interchangeable with ‘Plan Administrator.’”
  - “The Committee is the ‘Plan Administrator’ and a ‘named fiduciary’ of the Plan (as those terms are used in ERISA). The Committee shall consist of such members as may be determined and appointed from time to time by the Board or its delegate.”
- Plan may also contain provisions that describe the duties and responsibilities of the Plan Administrator, including “(x) to appoint persons to assist in the administration of the Plan and any other agents it deems advisable, including legal counsel.”
  - Alternative is to refer to duties and responsibilities as described in Committee Charter. This option may be preferable so that this can be updated without the need to update all plan documents.
  - BE AWARE: If you reference Committee Charter, do you need to provide updated charter to recordkeepers, TPAs or other vendors when you amend the charter? Check contract terms.

Practical action: Look out for contract language that states that the employer or plan sponsor is also the plan administrator. Contract provisions should match reality.

Who selects the service provider?

The definition of fiduciary under ERISA is a functional definition. Selection of a service provider such as a recordkeeper or TPA is a fiduciary decision. In addition, any decision that involves the discretionary use of plan assets (e.g., compensation paid to service providers) is a fiduciary decision, and anyone who approves the discretionary use of plan assets is a fiduciary.

The charter of the Benefits Administration Committee also provides that the Committee shall have such powers, duties and responsibilities as are set forth in the Plans, including the following specific discretionary powers and duties: “To appoint, employ and remove persons to assist it in the administration or management of each Plan, and appoint, employ and remove any other agents it deems advisable, including without limitation legal counsel, actuaries, auditors, record keepers, and third party administrators, to serve at its direction (this includes reviewing, negotiating, approving, and delegating to a Committee member the authority to execute service contracts with such parties);”

If someone other than the Benefits Administration Committee is selecting and engaging administrative service providers, consider whether plans are being operated in accordance with their terms, and whether the Benefits Administration Committee is fulfilling its responsibilities under its Charter. In addition, is having the Company as a party making officers of the Company and the Company itself into ERISA fiduciaries without providing fiduciary training? As noted above, this undermines the entire fiduciary committee structure! Concern is that plaintiffs’ counsel could have a field day in depositions!

What are “plan assets”?

Reg. Section 2510.3-102(a)(1) provides in part, “… the assets of a plan include amounts (other than union dues) that a participant or beneficiary pays to an employer, or amounts that a participant has withheld from his wages by an employer, for contribution or repayment of a participant loan to the plan, as of the earliest date on which such contributions or repayments can reasonably be segregated from

the employer's general assets." The DOL takes the position that participant contributions or deductions from pay are always plan assets.

Note that some vendors will try to include statements in the contract that no plan assets are used to pay the vendor, or that amounts in a payment account are not plan assets. The purpose of this language is to bolster the vendor's argument that it is not a fiduciary. Or alternatively, it may be a fiduciary, but the company or plan administrator failed to tell the vendor that it was dealing with plan assets.

<u>Practical actions</u>:

- Word search contracts for "plan asset" or "plan assets" and if a contract contains the term "plan assets," let's examine that section and ensure statements about plan assets are accurate.
- If a vendor is going to be paid with money that came from employees' paychecks, that probably means the Benefits Administration Committee should be the party to the contract.

<u>Standard of Care</u>

ERISA requires that fiduciaries act in accordance with duties of loyalty and prudence. Typical ask in a contract that is entered into with an ERISA fiduciary is that the service provider act in accordance with this duty of prudence.

<u>Practical action</u>: Include standard of care language in the contract. Service providers will often push back, but some language regarding standard of care is market. Examples of standard of care language:

- "TPA will perform the services provided for under this Agreement with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent service provider, acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." (This basically parrots the statutory duty of prudence, but service providers will typically seek a watered down version like the example below.)
- "TPA and Customer will discharge their obligations under this Agreement with the level of care which a similarly situated service provider or plan administrator, respectively, would exercise under similar circumstances, and in any event with reasonable care. If Customer delegates claim fiduciary duties to TPA pursuant to Schedule A, TPA shall observe the standard of care and diligence required of a fiduciary under section 404(a)(1)(B) of ERISA."

<u>Who owns data?</u>

- The Plan should always own participant data and claims data, and the contract should be clear.
- Some medical plan TPAs will claim that their negotiated network reimbursement rates are confidential, and it is fair to agree to protect negotiated network reimbursement rates and pricing data as confidential information, but it's important to think through how the Plan may want to use cost data.
    - Consider whether the Plan needs to share data with consultants and actuaries for plan design and pricing purposes, review utilization with wellness vendors to target wellness initiatives or use data for other purposes?
    - Does the contract protect the Plan's ability to do these things?
- Reports created on behalf of the Plan belong to the Plan and the provisions of the contract should reflect this. Be cautious of provisions that limit time to review data/reports, etc. after

which such reports are deemed accurate and the service provider will have no liability for inaccuracy/mistakes.

- Consider limitation on use of data to market other services to plan participants.
  - Note that Vanderbilt University fiduciary breach lawsuit claimed that TIAA-CREF and Fidelity marketed other services to plan participants and the plan should have been compensated for this.
  - In addition, settlement of the Vanderbilt litigation expressly prohibited marketing by Fidelity.
  - May need to look through terms and conditions for vendor web portal log-in that participants are agreeing to in order to ensure that vendor is not seeking participant consent to marketing efforts as a condition of using web portal for 401(k).

Records retention

- Section 209(a) of ERISA requires the employer to "maintain records with respect to each of his employees sufficient to determine the benefits due or which may become due to such employees."
- Responsibility is on the Plan to show that benefits have been paid, and the time period for retirement plan benefits is generally the life of the participant.
- All plans are not alike. No one asks about dental or vision benefits from a decade ago. Consider appropriate record retention period.
  - Consider record retentions period for participant data vs. vendor contracts.
  - Practical Action: Hard to fight the records retention gurus within the Company, so see if you can live with their schedules. Where you can't live with more general schedules, one good argument is that the Plan is a separate legal entity from the Company, and so the Plan gets its own retention schedules – easier to argue this for retirement plan benefits.
- Service providers typically keep data according to their records retention for the category because they can't follow different retention schedules for each client. Ask the service provider to provide a schedule of retention periods (at least for key categories of data) and contract to receive notice in the event a retention period is changed to shorten the period.
  - Ideal is ample advance notice, but this is generally unrealistic. Seek a provision that if a period is shortened, the Plan will have at least one year to request affected records before destruction. Idea is to avoid a situation where retention period goes from "indefinite" to "seven years" and all records that are 8+ years old are immediately destroyed.

Termination of contact

- What is the initial term and when can the plan terminate?
  - Plan should always be able to terminate for cause.
  - Plan should be able to terminate for convenience upon reasonable notice, but this provision is typically reciprocal, so don't automatically seek the shortest period. Consider how long it would take to transition if the vendor gave notice (90 to 180 days depending on vendor type).

- DOL has expressed concern with plan provisions that impose penalties for early termination, but there is an exception where the vendor is recouping its implementation costs. If there are penalties for early termination, consider inclusion of language documenting this as a negotiated pricing term that obtained more favorable plan pricing or, alternatively, documenting that amount is intended to recoup implementation costs in which case, the penalty should decline over time.

<u>Transfer of data on termination of contract</u>

- What data needs to transfer to a successor vendor on contract termination?
- Example: A 401(k) plan could get a qualified domestic relations order ("QDRO") stating that an ex-spouse is entitled to receive 50% of the participant's account balance on the date of divorce, adjusted for earnings through the date of distribution. The date of divorce could be years in the past by the time the QDRO is received by the Plan. Be sure the plan has a right to current and historical data for retirement plans.

<u>Limitation of Liability</u>

- If contract includes insurance requirements, try to make limitation of liability line up with policy limits, or be in excess of policy limits for risks that are insurable.
- DOL Advisory Opinion 2002-08A provides, in part:

  > "The Department does not believe that, in and of themselves, most limitation of liability and indemnification provisions in a service provider contract are either per se imprudent under ERISA section 404(a)(1)(B) or per se unreasonable under ERISA section 408(b)(2). The Department believes, however, that provisions that purport to apply to fraud or willful misconduct by the service provider are void as against public policy and that it would not be prudent or reasonable to agree to such provisions. Other limitations of liability and indemnification provisions, applying to negligence and unintentional malpractice, may be consistent with sections 404(a)(1) and 408(b)(2) of ERISA when considered in connection with the reasonableness of the arrangement as a whole and the potential risks to participants and beneficiaries. At a minimum, compliance with these standards would require that a fiduciary assess the plan's ability to obtain comparable services at comparable costs either from service providers without having to agree to such provisions, or from service providers who have provisions that provide greater protection to the plan."
- Note that this Advisory Opinion is addressed to a union pension fund. The ability to ask for a limitation of liability in the event of fraud or misconduct is one of the reasons that service providers want a contract with the company, rather than with the plan or the ERISA fiduciary.
- Limitation of liability based on annual payments (e.g., 2x annual fees) is the norm for certain consulting contracts (e.g., actuarial or design consulting), but it not the norm in a contract with a health plan TPA.

<u>Indemnity in the event of lawsuit</u>

- ERISA provides for Federal jurisdiction, while many plaintiffs' attorneys file in state court.

- Notice of removal must generally be filed within 30 days after the defendant receives a copy of the initial pleading (which may be earlier than date of service of process), so the timeframe is relatively short. The contract should provide for a specific and brief (e.g., 3-5 business days) period for the service provider to inform the plan administrator of receipt of any pleadings.
- In addition, consider including language that relieves the Plan from its duty to indemnify a service provider (and also requires the service provider to indemnify the Plan more fully) if prompt notice was not provided and failure to provide prompt notice has prejudiced defense of the claim. We do not want to be litigating in state court.
- Consider provisions allowing the plan administrator (or company if the company is providing indemnity) to control defense.
- Agree on which party can settle. (Note that certain TPAs never want to agree to Plan consent to settle multi-party litigation.)
- Review indemnity to ensure that plan/company will indemnify only where the vendor is "innocent" and will not indemnify if the vendor's standard practice (e.g., cross plan offsetting) resulted in a breach of fiduciary duty claim. In that situation, the vendor should be obligated to protect the plan – particularly because the plan administrator is not in a position to know all details about vendor administrative practices.

<u>Specific to medical plans</u>

- UCR Rates
  - Payments to non-network providers are typically made at a UCR rate. Practices for describing what this rate is vary dramatically – some plans use a percentage of the Medicare reimbursement rate, while others pay at a certain percentile based on location-specific databases or national databases.
  - How UCR is determined should be a contract term. Often this is very vague. Even if not spelled out in the contract, Plan fiduciaries and counsel should understand how UCR is being calculated.
  - It is not a best practice to say that the TPA will determine the UCR rate in accordance with "industry standards" or its "standard methodology" because there is such a huge variation in the rates that differing methodologies produce, and the reasonableness of UCR rates is a source of litigation.
  - TPAs will typically want the ability to change methodology, and this is fine, but ideally the change will be subject to advance notice.
  - A change that result in a substantial reduction in UCR rates should be grounds to terminate the contract for convenience, as the litigation risk may be materially different after such a change.
- Anti-assignment
  - Medical plans typically include stiff anti-assignment language. However, the TPA will make payment directly to providers on behalf of plan participants. Some providers will also appeal denial of claims without informing participants.
  - Best practice is to ensure that, to the extent the TPA is reviewing a claim or first level appeal, notification will be provided to both the provider and to the participant, and this requirement should be reflected in the contract.

  - Consider also requiring formal designation of providers as "authorized representatives" before accepting appeals from providers and contracting with TPAs to administer this process. Some TPAs will provide a form and administer this process. (See, for example: https://quartzbenefits.com/docs/default-source/members-general/appointmentofauthrep.pdf?sfvrsn=593d66da_2)
- Cross-plan offsets by TPA
  - Cross-plan offsets occur when a TPA identifies overpayment by one plan it administers (or overpayment in its insured book of business). The amount of this overpayment is then characterized by the TPA as payment on a different claim, often involving a participant in a different plan. The TPA adjusts accounting entries in its system to show both claims as paid. The provider, however, may view the initial payment as payment in full for the first claim and then view the second claim as unpaid. Lawsuits seek payment of claims and allege fiduciary breach and misappropriation of plan assets.
  - May be changing -- Most TPAs apply some form of cross-plan offsetting, although certain TPAs have been known to permit plans to opt out. A best practice is for the contract and the plan document to reflect cross-plan offsets where the TPA will apply them.
  - Some vendors (Quartz) do not apply cross-plan offsets and will offset only within the same plan. This seems to be a minority position, but could be changing?
- Run-out period
  - How will IBNR claims be administered? What are time frames – think through maximum time periods (e.g., IBNR claim decided + 180 day period for participant to appeal + time to work through appeals process).
- Interface with other service providers
  - Should the contract require service provider to cooperate/coordinate with any third parties who also provide services for the Plan (e.g., to track deductible spend).
  - Stop loss policies typically require notice to the carrier of claims that meet attachment thresholds or are likely to meet attachment thresholds, and these notice periods can be very short. TPAs for the medical plans will be the ones with data to identify these claims within applicable time frames. As a result, a best practice is to include contract provisions that contemplate notification and data sharing with stop loss insurers (or are at least flexible enough to allow for that).
  - Need to consider current provider arrangements and terms of current stop loss policy, but also have contract terms flexible enough to accommodate changes.
- Eligibility.
  - Generally, the contract should specify that the plan administrator is responsible for determining basic eligibility but should require the service provider to update its systems/eligibility records regularly and in a timely manner.
  - Review carefully provisions regarding determination of when dependents cease to qualify for coverage (e.g., turn age 26, no longer disabled) and if the service provider is making the determination, this should be described in the contract.
- Disclosures and Filings.
  - TPA should be required to at least provide draft Benefits Booklets describing covered services, exclusions, and the administrator's claims processes. (This is the case even for

self-funded plans because the TPA's system will administer for its insured book as a default, and you want to be aware of what the system default is in order to know how Plan provisions may differ. Differences are a source of incorrect administration.)
  - Require TPA to prepare or at least provide draft SBC.
  - Consider what reporting is required for the Plan and if so, what assistance will be needed from the service provider (i.e., provision of schedules/information needed for filing Form 5500, 1094/1095-C) and make sure the contract contemplates timely provision of relevant data. (Note that it is common to have a general provision that says reporting assistance is available per a Schedule or at an additional cost, but to the extent that you know data will be required, this should be an included cost rather than an add-on, and you can keep the add-on language for new/additional reporting.)
  - Will the service provider have any responsibilities with respect to required notices (e.g., initial COBRA or Medicare Part D notices)?
- Claims Processing.
  - Clearly state which party is responsible for processing claims and appeals.
  - Generally the TPA must process urgent care appeals because in-house plan administrators do not have resources to respond within short timeframes.
  - The contract should provide the plan administrator with the ability to review and make changes to form notification letters to ensure that all elements required by the ERISA claims procedures are included in the forms. (Note that some TPA form letters for denial of benefits are shockingly bad, and the Plan often doesn't know this until there is a lawsuit.)
  - To what extent does the TPA accept responsibility for coordination of benefits? Confirm whether the TPA will follow the COB provisions in the Plan or its own COB procedures. If the latter, the Plan may need to be amended.
  - The contract should specify whether, and to what extent, fiduciary authority is being delegated to the TPA. Consider initial determinations/processing and internal appeals and whether the TPA is being appointed as the claims fiduciary for the first level of appeals or all appeals or only urgent care appeals?
  - If the TPA has claims or appeals processing responsibilities, the contract must require the TPA to comply with the terms of the Plan and with applicable law, including but not limited to ERISA (and ACA, if applicable).
  - The contract should obligate the TPA to maintain contracts with independent review organizations and to coordinate the external review process. If the TPA does not contract with IROs and the Plan is contracting directly with an IRO to provide external review, the TPA should still be contractually obligated to coordinate with the IRO.
  - Address external review fees and try to negotiate a flat fee rate per external review.
- COBRA Administration – address COBRA administration or provide for coordination with COBRA administrator.
- Subrogation and Recovery.
  - The contract typically should address the extent to which the TPA will engage in subrogation and overpayment recovery efforts on the Plan's behalf.
  - Approval of a compromise on a subrogation claim is a fiduciary decision because plan assets are involved. Fiduciary can approve a matrix for small amounts, but compromises

that leave larger amounts unpaid may need to be approved. Be wary about permitting vendor to settle any claim for a specified percentage, as the dollar amount left on the table can be very high in some cases.
    - Service providers typically contract with a vendor to provide subrogation services, and they will seek a very short turn-around on proposed settlements where the plan must approve, and this can be tricky based on the need for fiduciary approval.
    - Consider the scope of authority the plan administrator wishes to delegate and any restrictions (e.g., TPA is prohibited from instituting formal legal proceedings against participants absent written consent). Also consider de minimis thresholds for write-off. (Note that some TPAs refuse to include de minimis thresholds in contract.)
    - Overpayment recovery – consider whether TPA should be compensated for overpayment recovery from in-network providers. Isn't the TPA supposed to be delivering a network that doesn't try to "up code" procedures and overbill the plan?
- Disaster Provisions.
    - Note that certain TPAs will suspend certain Plan requirements (e.g., preauthorization or time limits on prescription refills) for participants in disaster areas. Understand where this is the case and be sure Plan language is flexible enough to accommodate so there is not a failure to follow terms of the Plan.
- Provider Networks.
    - Understand if providers are being classified in different ways for different purposes – for example, in the disruption analysis, you're told you have providers to cover 99% of participants, but then the TPA tries to classify some of those same providers as out-of-network for in-network pricing/discount purposes.

General Contract Provisions

- Payment terms.
    - Many companies seek to push out payment timing to 75 days or 90 days. Need to consider whether this makes sense if the vendor is being paid with plan assets – is that worth trading something else for? Payment terms should be reciprocal and same timing should apply for refund of overpayments.
    - Interest on late payments should be reciprocal and should apply to both sides.
- Subcontractors.
    - Consider whether Plan should have authority to consent to or have notice of the use of any subcontractors. Consider whether Plan might want to limit off-shoring of services or sending data outside the U.S.
        - Be careful though – limit notices received to only those that are meaningful.
    - Contract should explicitly state that service provider is liable for the acts of its subcontractors.
- Services to be Performed.
    - Review list of services to be performed by service provider and determine whether it is as comprehensive as it should be.
    - Review obligations of Plan and be wary of a provision that absolves the service provider from satisfying its obligations in the event the Plan fails to meet its obligations.

- Rebates.
    - Both medical and pharmacy agreements should address rebates. Rebates are offered to medical plan TPAs on certain drugs administered in hospital settings. In addition, there may be rebates on durable medical equipment.
    - Rebates should be assigned to the Plan.

<u>Data Privacy and Security (other than HIPAA/BAA)</u>

- Typical standard is NIST 800-53, which seems more common than other standards. This is generally used as the floor, rather than the ceiling.
    - The data security program "must be on par with NIST 800-53 or a higher standard".
- Seek contractual protections from service provider to ensure the privacy of participant data, specifically with respect to personally identifiable data ("PII").
    - Consider asking for data protection standards similar to those set forth in a business associate agreement, but with respect to all personally identifiable information ("PII"), not just protected health information ("PHI").
    - Consider imposing strict liability/indemnity obligations on service provider for any security breach involving PII, and outline service provider's responsibilities with respect to responding to, mitigating loss/damage, and notifying appropriate parties in the event of a breach (e.g., service provider to notify client immediately, reimburse client for all costs of notifying participants, etc.).
    - Discuss uses for de-identified data (PII and PHI) and consider restricting use of de-identified data to certain purposes if you can. (Is data really de-identified???)
- Breach notification – some contracts will limit vendor's obligation to provide breach notification related to PII to situations where notification is legally required.
    - This is a scary provision because the plan may want to take the position that ERISA preempts state data privacy laws. Would that mean that the vendor NEVER has to notify?
    - What about situations where there are participants in multiple states?
    - Ask for vendor to provide notifications to participants where legally required AND:
        - For purposes of determining whether notice is legally required, include contractual provision that requires notification that assumes for purposes of the specific notification requirement that ERISA does not preempt state law.
        - Require notification of ALL affected participants where notification to any participant is required to address multiple states issue.
        - Make sure plan has a right to review and revise the notice! (In small breaches, vendors are very amenable to suggested revisions. Unclear if same flexibility is there for large data breaches?) And then review the notice!
            - You do not want send a notice that says it is required to be provided under Florida law and then try to argue that ERISA preempts Florida data privacy law later on.
            - Make sure the notice fits the breach – for example, if child's information was disclosed, the notice should be addressed to the parent, not the child.

Audit Rights

- If any frequency limitations are agreed to, consider carve-outs where there is reason to suspect fraud or negligence.
- If there is an audit finding, will the plan be informed of steps taken to resolve the issue?
    - IT audit provisions don't always provide for plan to be informed.
    - Plan will sometimes want the authority to approve the "fix," which many recordkeepers will not agree to.
    - Ask for vendor to bear costs of subsequent audits if there are findings that previously identified issues were not properly corrected. (Sometimes vendors will agree.)

Dispute Resolution

- Preference for discussion among business leaders first, then non-binding mediation. Arbitration is not preferred.
    - Arbitrators always want to split the baby.
    - Idea that arbitration is faster and cheaper may be a myth when it comes to ERISA claims, which many federal judges will resolve at the motion to dismiss or summary judgment stage. (Built in conflict of interest for arbitrators who want to hear the whole case and be paid for their time?)
- Ensure there is a process described for disputing invoices.
    - Process should not require plan to pay now and dispute later. Potential prohibited transaction if vendor will have use of plan assets for an indeterminate period? Suggest reasonable time frames (which can be extended) for achieving resolution.
- Beware of provisions that provide a short period of time to review or contest invoices because the Plan should be entitled to recover benefit or fees paid in error regardless of when the error is discovered.

TAB
D

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Overview

Brian represents companies and their directors and officers in complex business disputes, including ERISA litigation, securities and shareholder litigation, corporate governance and fiduciary disputes, and litigation arising out of mergers, acquisitions and tender offers, and complex contract disputes. Brian also has significant experience litigating tax controversies against the federal government.

Brian is the leader of the firm's Business Litigation practice group, which has 80 lawyers in seven offices. Brian has served in other leadership positions in the firm and in the community.

Experience

ERISA Litigation

- Represented Fortune 500 retailer in defending multi-million dollar ERISA claims brought by the Pension Benefit Guaranty Corporation arising from alleged purchase of an alleged "controlled group" member and pursuing indemnification and fraud claims against the Seller and its law firm for failing to disclose the PBGC's claim before the closing of the purchase transaction. *Pension Benefit Guaranty Corporation v. Uforma/Shelby Business Forms, Inc., et al.,* (S.D. Ohio).
- Represented plan administrator in defense of civil penalty proceedings under Section 502(c)(2) of ERISA in connection with alleged deficiencies in report of independent auditor. *In the Matter of U.S. Department of Labor v. Plan Administrator, Next 15 Communications Group Retirement Plan*, Case No. 2018-RIS-000032 (U.S. Dept. of Labor Office of Administrative Law Judges).
- Represented plan sponsor/plan administrator in defense of breach of fiduciary duty claims brought by the Department of Labor in connection the Plan's health screening wellness program. The DOL alleged the plan required participants to pay a premium or contribution which was greater than such premium or contribution for similarly situated participants on the basis of a health status-related factor in violation of ERISA § 702(b) and sought the return of excess premiums withheld. *R. Alexander Acosta v. Chemstation International, Inc.*, No. 3:18-cv-00338 (S.D. Ohio) (Consent Order and Judgment, Oct. 19, 2018)

- Represented an Irish public company and its U.S. affiliate, as buyer, in a post-closing dispute regarding contractual indemnification and withdrawal liability under ERISA. Obtained a confidential settlement in a mediation in New York.
- Successfully defended the corporate trustee of an Employee Stock Ownership Plan from breach of fiduciary duty claims under ERISA in connection with an ESOP's holdings of employer securities that suffered a precipitous drop in value. *Wright v. Oregon Metallurgical Corp.,* 350 F.3d 1090 (9th Cir. 2004) (affirming district court order granting Rule 12(b)(6) motion to dismiss all claims against trustee).
- Defended the corporate trustee of a publicly traded company's 401(k) plan and ESOP from ERISA breach of fiduciary duty claims in connection with the plans' holdings of employer securities, which suffered a $200 million drop in value, and obtained federal court approval of a class action settlement, despite objections from co-defendants. *Hunter v. Caliber Systems, Inc., et al.,* 96-CV-01186-JLG (S.D. Ohio).
- Represented bank-trustee of a pension plan regarding participant's claims arising out of the trustee's alleged failure to distribute assets upon termination of the plan.
- Representing plan sponsors and fiduciaries on:

o claims for plan benefits;
o out-of-network reimbursement disputes; and
o issues involving employer securities and proprietary funds

Corporate Control, Merger and Tender Offer Litigation, Director & Officer Liability Litigation

- Represented company in defense of shareholder lawsuit challenging proxy disclosures and seeking emergency injunctive relief under federal securities laws in connection with a $6.9 billion merger (over $11 billion including debt). Less than 48 hours before a scheduled stockholder vote, plaintiff sought an injunction to delay or potentially derail the merger. After a hearing, the shareholder's request for injunctive relief was denied and the shareholder vote proceeded on time. *Ratner v. Forest City Realty Trust, Inc.,* No. 1:18-cv-2605 (N.D. Ohio, Nov. 26, 2018). (Forest City/Brookfield)
- Represented company and its board in defense of shareholder lawsuits challenging the proxy disclosures under federal securities laws in connection with a $4.2 billion public company merger (AdvancePierre/Tyson Foods) (S.D. Ohio).
- Represented acquirer in defense of shareholder lawsuits in Maryland and Delaware challenging the proxy disclosures under federal securities laws in connection with a public company merger (Intrexon/GenVec).
- Represented board of publicly traded company in response to a shareholder demand letter alleging the board breached its fiduciary duties in awarding stock options in excess of authorized sub-limits in the plan documents. (Confidential).
- Represented the company and two board members in defense of a shareholder challenge to the fairness of a $300 million merger. (National Interstate/Great American Insurance)
- Represented a bank and its board of directors in defense of two shareholder derivative and class action complaints challenging the fairness of a $111 million bank merger. (Cheviot Financial Group/MainSource)
- Represented the members of the board of directors in defense of three shareholder derivative and class action complaints in Ohio and Texas challenging the fairness of a $2.5 billion merger transaction. (Robbins &

Myers/National Oilwell Varco)

- Represented an insurance company in defense of three expedited shareholder injunction actions in three different cities involving an unsolicited tender offer made by the company's majority shareholder and also involving the applicability of Ohio's Control Share Acquisition Act. (National Interstate/AFG)
- Represented the acquiring company in defense of federal and state shareholder derivative and class action complaints challenging the fairness of a $2.5 billion merger. (Brookfield/Associated Estates)
- Represented the members of the board of directors in defense of two shareholder derivative and class action complaints challenging the fairness of a $1.6 billion going private merger transaction. (Jo-Ann Stores/Leonard Green)
- Represented the members of the board of directors of an Ohio bank in defense of shareholder complaints challenging the fairness of a $10 billion merger. (Charter One Financial/RBS)
- Represented financial advisor in a dispute arising out of a going private transaction. (American Greetings)

Securities Litigation

- Obtained dismissal of securities claims against various market-makers under Section 12(a)(1) of the Securities Act of 1933 and various state law theories, resulting from an alleged pump-and-dump scheme in Biozoom Securities via motion to dismiss (three clients) and summary judgment (four clients). *In re Biozoom, Inc. Securities Litigation,* Case No. 1:14-CV-01087.
- Represented syndicate of underwriters in class action litigation brought by shareholders of a public company asserting strict liability under Sections 11 and 12(a)(2) of the Securities Act of 1933 for allegedly false and misleading statements in a registration statement and prospectus for depositary shares. *Rosenberg v. Cliffs Natural Resources Inc.,* No. CV-14-828-140 (Cuyahoga County, Ohio)
- Represented the Richard E. Jacobs Group in defense against a securities fraud action in connection with a billion-dollar transaction. After denying the plaintiff's motion for injunctive relief, the court granted our motion to dismiss and awarded our client attorney fees as sanctions - the first reported award under the mandatory Rule 11 review section of the Private Securities Litigation Reform Act of 1995. The Second Circuit affirmed the award against the plaintiff's attorneys.

Post-Closing Disputes

- Represented Fortune 500 retailer in multi-million dollar earnout and indemnification dispute involving former shareholders of a business acquired by client.
- Represented Irish pharma company in multi-million dollar earnout and indemnification dispute with former shareholders of a business acquired by client.
- Represented an energy business in an arbitration proceeding (and related state and federal court litigation) over an option to purchase a public utility in Akron, Ohio. Obtained from the arbitrator an award of specific performance ordering the transfer of ownership of the public utility to our client, as optionholder, and an award dismissing the opponent's RICO and defamation counterclaims. Obtained confirmation of the arbitration award from the common pleas court and the Ohio court of appeals under the Arbitration Act.

Thermal Ventures II, L.P. v. Thermal Ventures, Inc., 2005-Ohio-3389 (Cuyahoga Cty.).

- In a dispute between two corporations regarding post-closing adjustments under an asset purchase agreement, obtained a court order staying an arbitration proceeding initiated by the seller where the seller's claims were outside the scope of the parties' arbitration clause. *Isola Aktiengesellschaft, et al. v. Honeywell International, Inc.,* 730 N.Y.S.2d 709 (N.Y. App. Div. 2001).
- Represented a buyer in a post-closing, working capital adjustment dispute. Obtained arbitration award in full amount requested.
- Represented a Japanese company, as seller, in a post-closing dispute in Delaware regarding contractual indemnification of environmental liabilities under a stock purchase agreement.
- Represented an Irish public company and its U.S. affiliate, as buyer, in a post-closing dispute regarding contractual indemnification and withdrawal liability under ERISA. Obtained a confidential settlement in a mediation in New York.
- Represented an energy company, as seller, in a post-closing dispute regarding contractual indemnification involving representations and warranties governing trademark matters. Obtained confidential settlement.

Fiduciary Litigation

- Won a 4-3 decision from the Ohio Supreme Court exonerating a national bank of fiduciary and *respondeat superior* liability in connection with an employee's conduct. *Groob v. KeyBank*, 108 Ohio St. 3d 348 (2006) (Syllabus 1: "A bank dealing at arm's length with a prospective borrower does not have a fiduciary duty to that prospective borrower unless special circumstances exist." Syllabus 2: "For an employer to be liable for a tortious act of its employee, that employee must be acting within the scope of employment when the employee commits the tortious act.").
- Represented a major financial institution, which acted as trustee of a large charitable split-interest trust, in defense of fiduciary duty claims brought by beneficiaries alleging millions of dollars of damages from real estate investments. Obtained confidential settlement approved by the federal court and the state attorney general. *Roush, et al v. Society National Bank.*
- Represented a major financial institution and its board of directors in defense of putative class action fiduciary duty claims brought by a putative class asserting that the bank and its directors breached their duty of loyalty by converting the assets of two trusts into "common trust funds" in order to charge additional fees for "company owned or managed" funds. Obtained dismissal of the complaint. *Beller v. KeyBank.*
- Represented a leading presenter of museum-quality touring exhibitions in litigation with former CEO over his departure.
- Represented a corrugated packaging company in litigation with former CEO and majority shareholder over his departure.

SIPC Proceedings

- Represented a court-appointed trustee of a bankrupt broker-dealer in connection with a fraud and embezzlement investigation under the Securities Investor Protection Act and worked with the Securities Investor Protection Corporation (SIPC) to recover funds for the victims of the scheme. *In re the Liquidation of NEBS Financial Services, Inc.,* Case No. 04-1648 (Bkrtcy. N.D. Ohio).

Other Class Actions

- Represented a major consumer goods manufacturer and a major retailer in defense of a putative class action alleging unfair consumer sales practices based on nationwide advertising and marketing initiatives for a highly popular washing machine. Obtained dismissal of the complaint on the grounds of forum non conveniens. *Laura Green, et al. v. Sears Roebuck & Co., et al.,* 04-CV-537772 (Cuyahoga Cty.).
- Represented the bank trustee of a large, World War II-era charitable trust in litigation brought by competing beneficiaries, including a class of individual claimants. Obtained state attorney general and court approval for a class action settlement after a fairness hearing, along with an award of fees to the trustee. *Richard Hallman, et al. v. National City Bank, Trustee, et al.,* 99-CV-387410 (Cuyahoga Cty.).

Tax Controversies

- Represented a national bank's equipment leasing business in a week-long trial in federal court against the Department of Justice and Internal Revenue Service in a dispute over the proper federal income tax treatment of a sale-leaseback transaction involving a waste-to-energy facility in Germany. *KSP Investments, Inc. v. United States,* 07-CV-857 (N.D. Ohio).
- Represented one of the largest U.S. telephone companies in an IRS Appeals administrative proceeding involving the investment tax credit provisions of TRA 86 as applied to digital switching equipment. Obtained the only known settlement on the issue in the telecom industry.
- Wrote an *amicus curiae* brief on behalf of the United States Telephone Association in the Third Circuit Court of Appeals in connection with a tax controversy of industry-wide interest. *Bell Atlantic v. United States,* 224 F.3d 220 (3d Cir. 2000).

Arbitrations and Related Court Proceedings

- Successfully confirmed a $68 million arbitration award in favor of our client, a major pharmaceutical company, against another major pharmaceutical company, and successfully fended off opponent's efforts to vacate the arbitration award under the Federal Arbitration Act. *Solvay Pharmaceuticals, Inc. v. Duramed Pharmaceuticals, Inc.,* 442 F.3d 471 (6th Cir. 2006).

Significant Contract Disputes

- Represented a major financial institution, as insured, in suit against title insurance company, challenging denial of over 200 claims made under hybrid title insurance policy, sometimes called lien protection insurance, after real estate market collapse. Obtained confidential settlement after three days of mediation. *KeyBank National Association v. First American Title Ins. Co.*, Case No. 1:10 CV 2143 (N.D. Ohio).
- Successfully represented health insurer before the Ohio Supreme Court in litigation over subrogation rights under an insurance policy. *Blue Cross & Blue Shield of Ohio v. Hrenko,* 72 Ohio St. 3d 120 (1995) (Syllabus: "Pursuant to the terms of an insurance contract, a health insurer that has paid medical benefits to its insured and has been subrogated to the rights of the insured may recover from the insured after the insured receives full compensation by way of a settlement with the insured's uninsured motorist carrier.").
- Represented an owner of an NFL franchise in a contract dispute regarding an alleged finder's fee due in connection with the transfer of ownership interests. Obtained dismissal of the complaint on the grounds of forum non conveniens

and obtained dismissal of the appeal for lack of appealability.

- Represented a major financial institution in federal court litigation against a disaster recovery services provider over a multimillion dollar services contract. Obtained confidential settlement.
- Represented a tree service company in the defense of fraud claims filed by a public utility in connection with the linear footage of power lines cleared in Florida. Obtained a confidential settlement.

Accounting Malpractice Defense

- Represented a Big Four accounting firm in defense of an accounting malpractice lawsuit brought by its municipal client alleging multimillion dollar trading losses in risky interest-only and inverse interest-only securities. Obtained confidential settlement.

Non-US Clients

- Has represented public companies from Turkey, Japan and Ireland in business disputes.

Publications

- "INSIGHT: The Dog Ate My Form 5500 Audit Report Will My Penalty Be Reduced," *Bloomberg BNA*, May 2019
- "Second Circuit Permits Madoff Trustee to Pursue Transfers Made Between Foreign Entities," Thompson Hine *Business Restructuring, Creditors' Rights & Bankruptcy and Business Litigation Update*, March 2019
- "Mandatory Budgets? At a Law Firm? You Have Got to Be ... Thompson Hine," *The American Lawyer*, February 2019
- "So Your Company Has Asked You to Serve as a Fiduciary for an ERISA Plan …," Thompson Hine *Business Law Update*, Fall 2018
- "INSIGHT: Unpacking the Bundle--Prudent Practices for Assessing Bundled Services in This Era of 401(k) Plan Fee Litigation," *Bloomberg BNA*, September 2018
- "Fiduciary Liability of the Board of Directors under ERISA," Thompson Hine *Business Law Update*, Summer 2018
- "Adviser: Protect Corporate Boards From 401(k) Claims," *Crain's Cleveland Business*, June 2018
- "The Working Capital Adjustment Dispute That Never Was," *Law360*, August 2017
- "The Business Judgment Rule: Protecting Ohio-Specific Values," *Cleveland Metropolitan Bar Journal,* November 2016
- "*Tackett* Opens Door to Review & Modify Collectively Bargained Retiree Benefits," Thompson Hine *ERISA Litigation Update*, January 2015
- "Budgeting for Litigation: Obtaining Efficiencies and Meeting Client Goals," *Benchmark Litigation*, November 2014
- "Supreme Court Rejects Presumption of Prudence But Raises Bar for ESOP Fiduciary Breach Claims," Thompson Hine *ERISA Litigation Update,* June 2014
- "Supreme Court: Defendants May Rebut *Basic, Inc.* Presumption of Reliance Before Class Certification," Thompson Hine *Corporate Law Update,* June 23, 2014

Presentations

- "ERISA Litigation Update," NYCBA Title I Subcommittee Meeting, New York, February 2019
- "Applying ERISA Fiduciary Rules to Health Plans, Services and Products," Practising Law Institute, New York, January 2019
- "Fiduciary Liability of the Board of Directors Under ERISA," Washington, DC and Cleveland, Ohio, May 2018
- "Contract Drafting - A Litigator's Perspective," Little Rock, Arkansas, May 2018
- "Professionalism in the Practice of Law," Little Rock, Arkansas, May 2018
- "2014-15 Term in Review: Notable Decisions from the U.S. Supreme Court & Supreme Court of Ohio," John M. Manos Inn of Court, 2015
- "Director & Officer Liability Trends," Chemical Industry General Counsel Symposium, 2015
- "Budgeting for Litigation: A Disciplined Approach," Network of Trial Law Firms, 2014

Distinctions

- Recognized for "excellent client care and quality of service" as the exclusive winner in Ohio for litigation, Lexology Client Choice Award, 2019
- AV® Preeminent Rated by Martindale-Hubbell
- Named as one of *The Best Lawyers in America* in the area of Commercial Litigation, 2010 to 2019; recognized in *Best Lawyers* 2019 Lawyer of the Year
- Selected for inclusion in Super Lawyers by *Ohio Super Lawyers* magazine, 2012 to 2019
- Recognized as a BTI Client Service All-Star, 2011
- Listed as a Litigation Star by *Benchmark Litigation*, 2014 to 2019

Professional & Civic

Professional Associations

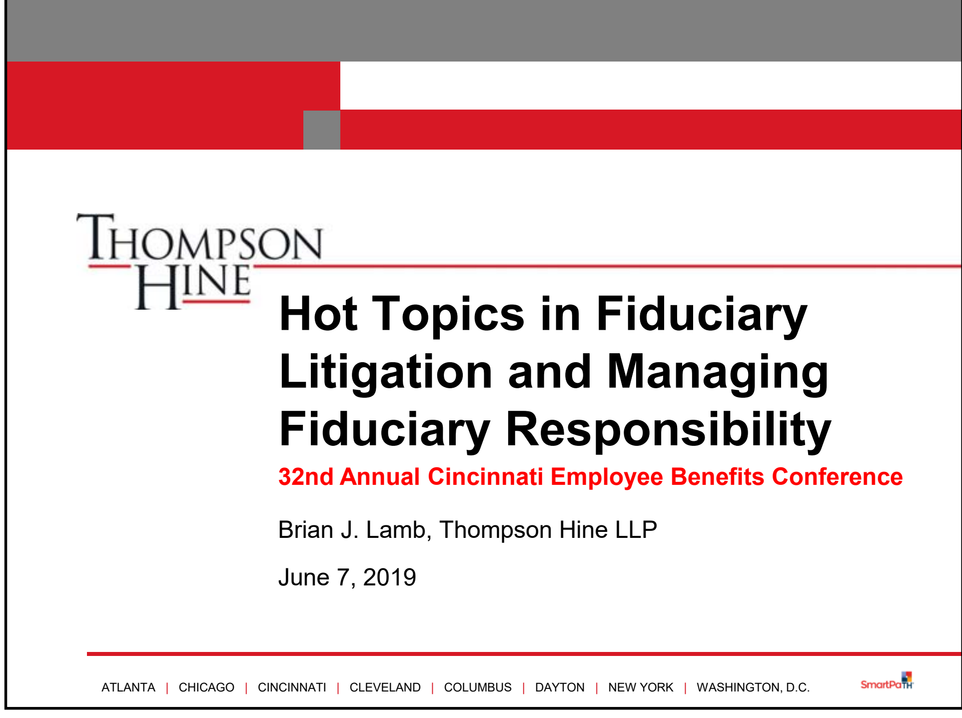
- Cleveland Metropolitan Bar Association
- American Bar Association

Community Activities

- Towards Employment (non-profit organization that supports low income individuals in their efforts to find and keep quality jobs); President, 2015-2017; Vice President, 2013-2015; Board of Trustees, 2009 to present
- Avon Lake Lacrosse Club (high school and youth lacrosse program), president, trustee and co-founder, 2009-2014
- Leadership Cleveland, graduate, Class of 2011
- Cleveland Bridge Builders (Leadership Organization), member, Charter Class of 2000-2001

Admissions

- Ohio
- U.S. Court of Appeals for the Third Circuit
- U.S. Court of Appeals for the Fifth Circuit
- U.S. Court of Appeals for the Sixth Circuit
- U.S. Court of Appeals for the Ninth Circuit
- U.S. District Court, Eastern District of Michigan
- U.S. District Court, Northern District of Ohio
- U.S. District Court, Southern District of Ohio
- U.S. Supreme Court



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Agenda

1. Employer Securities – IBM Stock Drop Case
2. ERISA Fee Litigation
3. Actuarial Assumptions Litigation
4. Bonus Category – Fiduciary Status (or Not) of Pharmacy Benefit Managers

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1. EMPLOYER SECURITIES – IBM STOCK DROP CASE

Life After *Dudenhoeffer*

- *Dudenhoeffer* (2014) and *Amgen* (2016) made it more difficult, as a practical matter, for plaintiffs to bring ERISA duty of prudence claims involving employer stock
- In the ensuing years, every stock drop complaint filed by ERISA plan participants around the country was dismissed for failure to allege facts satisfying *Dudenhoeffer* . . .
- However, defendants' winning streak was broken in December 2018

The IBM Stock Drop Case: A Surprise Ruling

- *Jander v. Retirement Plans Committee of IBM*, 910 F. 3d 620 (2d Cir., Dec. 10, 2018), *cert pending*
- The Second Circuit held that a complaint against the fiduciaries of an ESOP sponsored by IBM sufficiently pled a claim for violation of ERISA's duty of prudence in connection with alleged overinflated employer stock, and that it was improper for the lower court to have dismissed the complaint.
- This ruling caught many observers by surprise, given that all complaints of this type filed in the past 4-5 years have been dismissed.
- Aberration or start of a plaintiff-friendly trend in employer stock cases?

The IBM Stock Drop Case: Plaintiff's Path to Success?

- General allegations of stock volatility or downward declines in stock price (even those resulting in bankruptcy) have been found insufficient to support a duty of prudence claim since 2014.
- But the more specific factual allegations in *IBM* highlight a potential roadmap for plaintiffs.

The IBM Stock Drop Case: Plaintiff's Path to Success?

1. Allege that plan defendants knew that the company stock was overvalued due to a failure to disclose some adverse information.

In IBM's case, the defendants allegedly failed to disclose that the value of a business unit, and therefore the overall stock price, was artificially inflated through accounting violations.

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The IBM Stock Drop Case: Plaintiff's Path to Success?

2. Allege that the plan fiduciaries had the power to disclose the truth and correct the artificial inflation, but did not.

In IBM's case, the plan fiduciaries were also the CAO, CFO and GC.

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The IBM Stock Drop Case: Plaintiff's Path to Success?

3. Allege that the company stock traded on an efficient market such that correcting the accounting fraud would reduce the stock price only by the amount by which it was artificially inflated and that earlier disclosure of the accounting fraud (as opposed to later disclosure) would have reduced the risk of over-correction.

IBM stock is traded on a national exchange.

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The IBM Stock Drop Case: Plaintiff's Path to Success?

4. Allege that the plan fiduciaries knew that disclosure of the truth was "inevitable."

In IBM's case, the court found disclosure was inevitable because IBM was looking to sell this particular business unit and would be unable to hide the overvaluation from the public once a third party buyer vetted the business and a purchase price was disclosed – in the end, IBM actually paid $1.5 billion to a buyer to take the business unit off IBM's hands, and IBM's stock dropped by $12 per share.

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IBM Distinguished in *Exxon Mobil*

- In the first post-*IBM* case, the court made a strong effort to limit *IBM* to its facts. *Fentress v. Exxon Mobil Corp.*, No. 4:16-cv-3484 (S.D. Tex., Feb. 4, 2019) (granting motion to dismiss).
- The *Exxon* court addressed plaintiff's allegations that defendants violated their duty of prudence because they knew that Exxon's stock prices were artificially inflated and yet continued to invest in Exxon stock. Plaintiff alleged that defendants should have sought out those responsible for Exxon's disclosures under federal securities laws and tried to persuade them to refrain from making affirmative misrepresentations regarding the value of Exxon's oil reserves.

IBM Distinguished in *Exxon Mobil*

- The *Exxon* court held that the two arguments the *IBM* court appeared to find most persuasive – "that the fraud became more damaging over time and that the eventual disclosure was inevitable" – do not apply to Exxon.
- As to reputational damage, the *Exxon* court held that the Fifth Circuit recently rejected the identical argument in the *Whole Foods* stock drop case.
- As to inevitability, the *Exxon* court held that there was no major triggering event that made Exxon's eventual disclosure of its oil reserve troubles inevitable. Though Exxon was being investigated by authorities regarding statements about its oil reserves, investigations are often long and may not result in any charges against a company. Thus, while Exxon's eventual disclosure was probably foreseeable, the Court could not say it was inevitable.

The IBM Stock Drop Case: What Does it Portend?

- Plaintiffs recently sued **Boeing** in an ERISA stock drop case.
- Plaintiffs claim that Boeing knew about problems with its 737 MAX aircraft before two high-profile crashes brought worldwide attention to issues with this particular aircraft.
- The complaint cites the *IBM* case, and argues that, as in *IBM*, here "disclosure [of the allegedly non-disclosed negative information] was inevitable" because Boeing is in a highly-regulated industry. *Burke v. The Boeing Company*, No. 1:19-cv-02203, N.D. Ill (complaint filed on 3/31/19).

The IBM Stock Drop Case: What Does it Portend?

- The *IBM* litigation continues, so it is too early to assess whether this procedural setback for the IBM fiduciaries was an aberration or the start of a new, plaintiff-friendly trend in employer stock cases.
- Merely because a plaintiff was able to survive a motion to dismiss does not mean the plaintiff will actually prevail in the case at summary judgment or trial. But if a fiduciary's first line of defense (a motion to dismiss) fails, the case gets more expensive and risky.

2. ERISA FEE LITIGATION

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Current Trends – 401(k) Plan Fee Litigation

Recent Settlements

- Lockheed Martin - $62 million
- Boeing - $57 million
- ABB - $55 million
- Novant Health - $32 million
- International Paper - $30 million
- Ameriprise - $27.5 million
- BB&T Bank - $24.1 million
- American Airlines - $22 million
- Deutsche Bank - $21.9 million
- Fujitsu - $14 million
- Allianz - $12 million
- Citigroup - $6.9 million
- Univ. of Chicago - $6.5 million
- TIAA - $5 million
- Edward Jones - $3.175 million
- New York Life - $3 million
- Principal Life Ins - $3 million

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ERISA Fee Litigation: Proprietary Fund Cases

- American Century wins after 11 day bench trial
- Plaintiffs alleged that defendants should have offered non-proprietary funds, offered less expensive alternative funds, and controlled administrative costs
- Decision granting judgment in full to defendants. *Wildman v. Am. Century Servs., LLC*, 2019 U.S. Dist. LEXIS 10672 (W.D. Mo. Jan. 23, 2019)
- Essential Holdings
  - No duty to utilize index funds
  - No duty to utilize stable value fund instead of money market fund
  - Use of mutual funds in 401(k) plan is allowed, even when Plaintiffs allege cheaper products exist
  - Sector funds are allowed
  - No requirement to utilize only a limited number of funds (up to 46 funds and a self-directed brokerage were offered)
  - No duty to utilize competitors' funds

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ERISA Fee Litigation: Proprietary Fund Cases

- Putnam wins at trial, but victory gets reversed. *Brotherston v. Putnam Investments, LLC*, 907 F.3d 17 (1st Cir. 2018)
  - Allegations
    - Proprietary fund case. Defendants should have offered non-proprietary funds and offered less expensive alternative funds, refrained from prohibited transactions, and lacked a fiduciary process
  - Judgment on Partial Findings, Mar. 2017, Vacated & Remanded Oct. 2018
    - Affirmed decision that there was no breach of duty of loyalty for including proprietary funds as plan options, refusing to consider alternative investments, and retaining funds despite underperformance
    - Reversed based on the trial court's finding that the plaintiffs did not make a prima facie showing of loss causation
      - Index funds can serve as valid comparisons for actively-managed funds
      - Comparison to fund benchmark alone not enough to prove causation, but burden of proof shifts to the fiduciary to disprove causation
    - Petition for Cert filed Jan. 11, 2019 (No. 18-926)

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ERISA Fee Litigation: General Excessive Fee Cases

- Dismissal of claims against Chevron upheld on appeal.
  - $20B plan: 13 Vanguard mutual funds, 12 Vanguard CITs (TDFs), a Vanguard money market fund, 3 non-Vanguard funds, self-directed brokerage
  - Motions to dismiss granted, first without prejudice, then with prejudice:
    - Retail class shares not imprudent. Fiduciaries are required to consider features other than price
    - Lineup was diversified. Total menu ranged from 5-124 bps; brokerage window provided access to thousands of funds
    - No inference that revenue sharing is unreasonable; it is a common practice and benefits the plan
    - ERISA does not require competitive bidding or stable value fund
    - Underperformance allegations were based on hindsight. Can't infer inadequate investigation merely due to underperformance
    - Changes to plan demonstrate that Defendants were monitoring
    - Allegations that fiduciaries favored Vanguard was conjecture
  - *White v. Chevron,* 2016 WL 4502808 (N.D. Cal., Aug. 29, 2016), 2017 WL 2352137 (N.D. Cal., May 31, 2017), 2018 WL 5919670 (9th Cir. Nov. 13, 2018), aff'd on Nov. 13, 2018; motion for rehearing denied Jan. 3, 2019.

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ERISA Fee Litigation: University 403(b) Cases

- Overview
  - Cases have allegations that are similar to other fee cases:
    - E.g. failure to use plan bargaining power to reduce costs/fees, investment underperformance, and prohibited transactions
  - Other allegations are unique to 403(b) cases:
    - Use of multiple recordkeepers
    - Inclusion of annuities as plan options
- *Sacerdote v. New York Univ.*, 328 F. Supp. 3d 273 (S.D.N.Y. 2018), *appeal filed*, No. 18-2707 (2d Cir. Sept. 12, 2018)
  - Only university case to be tried to date. Verdict for NYU, largely based on finding that NYU employed prudent practices. Appeal pending in Second Circuit
- Some cases have survived motions to dismiss, but several others have been dismissed at the MTD stage:
  - *Wilcox v. Georgetown Univ.*, No. 18-422, 2019 WL 132281 (D.D.C. Jan. 8, 2019)
  - *Divane v. Northwest Univ.*, No. 16-8157, 2018 WL 2388118 (N.D. Ill. May 25, 2018), appeal filed, No. 18-2569 (7th Cir. Jul. 18, 2018)
  - *Sweda v. The Univ. of Pa.*, No. 16-4329, 2017 WL 4179752 (E.D. Pa. Sept. 21, 2017), *appeal filed,* No. 17-3244 (3d Cir. Oct. 13, 2017)

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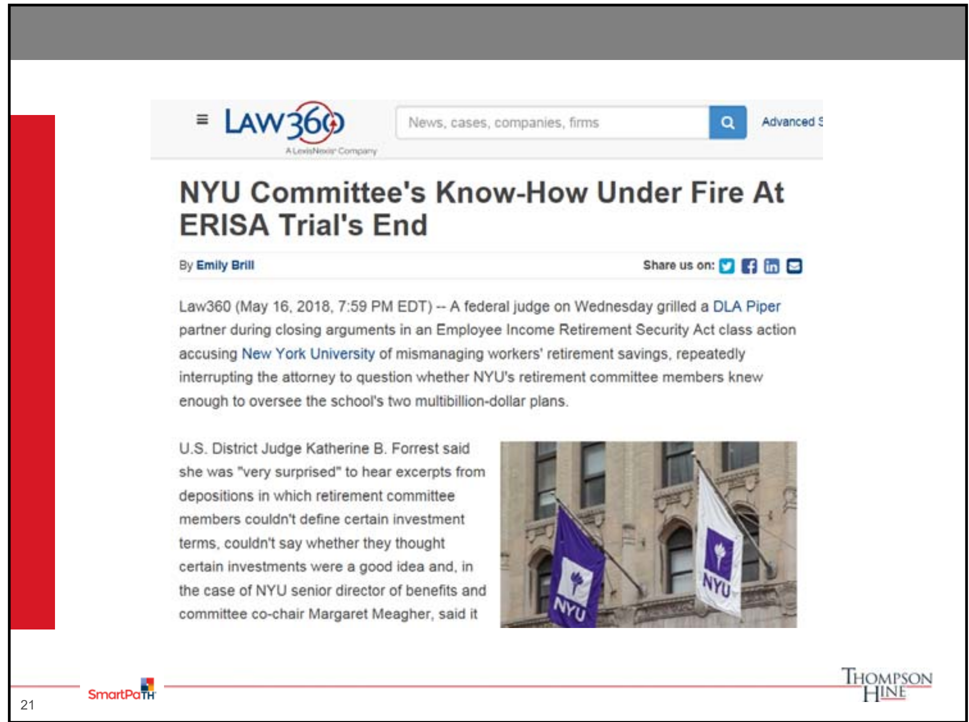

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Judge Forrest's Essential Holding

- "After careful review of the record, the Court finds by a preponderance of the evidence that while there were deficiencies in the Committee's processes – including that several members displayed a concerning lack of knowledge relevant to the Committee's mandate – plaintiffs have not proven that the Committee acted imprudently or that the Plans suffered losses as a result."

- *Sacerdote v. New York Univ.*, 16-cv-6284, S.D.N.Y. July 31, 2018 Opinion and Order

What the fiduciaries did wrong

- Certain Committee members testified "that they – in effect – assumed that on financial issues … they could defer virtually entirely to [the outside consulting firm] for expertise and information and rely on its recommendations. This is incorrect."
- "In this regard, good old-fashioned 'kicking of the tires' of the appointed fiduciary's work is required."

What the fiduciaries did wrong

- Fiduciaries may not "unthinkingly defer to [another's] expertise." Rather, they must "meaningfully probe [the expert's] advice and make informed but independent decisions."

What the fiduciaries did wrong (cont'd)

- "Meagher's testimony was concerning." She focused on "paper movement" and "she displayed a surprising lack of in-depth knowledge concerning the financial aspects of managing a multi-billion-dollar pension portfolio and a lack of true appreciation for the significance of her role as a fiduciary."
- "She appeared to believe it was sufficient for her to have relied rather blindly on [the consultant's] expertise. As a matter of law, blind reliance is inappropriate."
- "The Court found [Meagher's] testimony concerning—she did not demonstrate the depth of knowledge one would expect from a fiduciary."

What the fiduciaries did wrong (cont'd)

- "[Meagher's supervisor], also a Committee member, was similarly unfamiliar with the basic concepts relating to the Plans, such as who filled the role of administrator for the Faculty Plan." She explained that she "has a big job (referring to her HR role, not her Committee membership)…. [suggesting] that she does not view herself as having adequate time to serve effectively on the Committee."

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What the fiduciaries did wrong (cont'd)

- The supervisor testified: "I don't review the plan documents. That's what I have staff for."
- The Court commented: "This under-preparedness was not limited to just these two Committee members."

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What the fiduciaries did right

- They hired strong, credible subject matter experts as consultants to advise them on the administration of the Plans.
- The Court singled out for praise one Committee member, Tina Surh, who "questioned [the consultant's] recommendations all the time" and "appeared to be very knowledgeable in the area of investing generally."

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What the fiduciaries did right

- "Between [the consultant's] advice and the guidance of the more well-equipped Committee members (such as Suhr), the Court is persuaded that the Committee performed its role adequately."

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Plaintiffs Seek the Removal of The Two Committee Members the Court Criticized

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

DR. ALAN SACERDOTE, et al.,

Plaintiffs,

v.

NEW YORK UNIVERSITY,

Defendant.

No. 16 Civ. 6284 (KBF)

MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR AMENDED OR ADDITIONAL FINDINGS AND TO ALTER OR AMEND JUDGMENT TO INCLUDE EQUITABLE RELIEF REMOVING MARGARET MEAGHER AND NANCY SANCHEZ AS FIDUCIARIES

After a bench trial, the Court concluded that "Plaintiffs have not proven that [NYU's Retirement Plan] *Committee* acted imprudently or that the Plans suffered

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Defendants are Pushing Back

- After prevailing at trial, NYU filed a motion for sanctions against the plaintiffs and their law firm (Schlichter Bogard) for their tactical decision to file a duplicative lawsuit after certain events in the first lawsuit were not going favorably for plaintiffs. (Pending)
- Plaintiffs are trying to increase pressure by naming individual defendants (e.g., committee members and board members) as defendants. The judge in the **Cornell Univ.** fee case ordered plaintiffs' counsel to show cause why it was necessary to add these individual defendants to the case, other than the *in terrorem* effect of trying to scare the defendants into settling.

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Takeaways from the NYU Case

- In assessing the committee's overall performance, the Court evaluated each individual member's contributions and deficiencies.
- Each committee member should picture themselves explaining to a federal judge under cross-examination how they approached and discharged their duties.
- Fiduciaries should not be clock-watchers or paper-pushers; instead, they should ask questions, kick the tires, and stay informed.

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Sweda v. University of Pennsylvania: dismissal reversed on appeal

- District Court's granting of defendants' motion to dismiss was reversed by the Third Circuit in a 2-1 decision. 2019 U.S. App. LEXIS 13284
- The first university fee case to get to a U.S. Court of Appeals
- Focused more on the pleading standard in court, rather than the standard of conduct a prudent fiduciary must employ under ERISA.
- The real rub is that standards like "prudent" and "reasonable" are broad and inherently devoid of specific, bright-line rules. The opinion says such bright line rules would "hinder" courts' evaluation of fiduciaries, but of course, this makes it difficult for fiduciaries to know in advance what conduct will insulate them from liability.
- In the Third Circuit, one cannot win a motion to dismiss merely by arguing that the plan has a meaningful mix of investment options. Such a rule would encourage fiduciaries to stuff plans with hundreds of options, even if they are overpriced or underperforming.
- Bottom line: The defense-side effort to come up with a *Dudenhoeffer*-like standard that would make successful motions to dismiss the norm in fee cases (as they are in employer stock cases) continues to hit potholes.

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Use of Participant Data for Marketing

- *Divane v. Northwestern* (N.D. Ill. 2018)
  - District Court refused to allow plaintiffs to add a claim that defendants should be liable for allowing the plan's recordkeeper to market products to plan participants using participants' contact information, their choices of investments, the asset size of their account, their employment status, age, and proximity to retirement.

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Use of Participant Data for Marketing

- *Divane v. Northwestern (cont'd)*
  - Not imprudent to allow the recordkeepr to have access to such information
  - Disclosure of such information does not implicate ERISA fiduciary functions
  - Not a single court has held that releasing confidential information or allowing someone to use confidential information is a breach of fiduciary duty
  - "This Court will not be the first, particularly in light of Congress's hope that litigation would not discourage employers from offering plans."
  - Also not a prohibited transaction. Not convinced such information is a plan asset.
- Currently on appeal to the Seventh Circuit

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Use of Participant Data for Marketing

- *Casell v. Vanderbilt*
  - Plaintiffs alleged, among other things, that Vanderbilt failed to protect confidential participant information from being used by one of the plan's recordkeepers to market a variety of financial products to plan participants.

Use of Participant Data for Marketing

- Vanderbilt's proposed settlement (court approval pending)
  - $14.5 million settlement payment
  - Additional disclosures re: investment options and associated fees
  - Will conduct RFP for recordkeeping services, with fees to be expressed on a per-participant basis
  - The fiduciaries shall contractually prohibit the recordkeeper from using information about Plan participants acquired in the course of providing recordkeeping services to the Plan to market or sell products or services unrelated to the Plan to Plan participants unless initiated by a Plan participant.

3. ACTUARIAL ASSUMPTIONS LITIGATION

Actuarial Assumptions Litigation -Fundamental Allegations

- Plaintiffs allege the plan fiduciaries of a defined benefit plan fail to pay alternative forms of benefits in amounts that are actuarially equivalent to a single life annuity (the plan's default benefit)
- In particular, plaintiffs challenge the use of outdated mortality tables, unreasonable interest rates, and/or other unreasonable custom conversion factors used to calculate alternative benefits, such as joint and survivor annuities or life-certain annuities, saying they are not actuarially equivalent to single life annuities
- Plaintiffs contend the fiduciaries have caused retirees to lose part of their vested retirement benefits in violation of ERISA § 203(a) (nonforfeitability requirements)

Actuarial Assumptions Litigation

Sponsor	Mortality Table or Other Assumption Used	Interest Rate Used
MetLife	1971 Group Annuity Mortality Table for Males ("1971 GAM") and 1983 Group Annuity Table ("1983 GAM Table") for males set back one year	6%
American Airlines	1984 Unisex Pension Mortality Table ("UP 1984")	5%
PepsiCo	Custom "conversion factors" resulting in lower benefit	
US Bank	Custom "early commencement factors" applied to pay formula of early retirees resulting in lower benefit	
Rockwell Automation	1971 GAM Table (for Main Plan) UP 1984 Table (for the Cleveland Sub-Plan)	7% 6%
Anheuser-Busch	1984 Unisex Pension Mortality Table ("UP 1984"), adjusted for likely increases in life expectancy from 1957-1967.	6.5% 7.0%
Huntington Ingalls	1971 GAM Table, assuming 90% employees are male and 90% of contingent annuitants are female	6%

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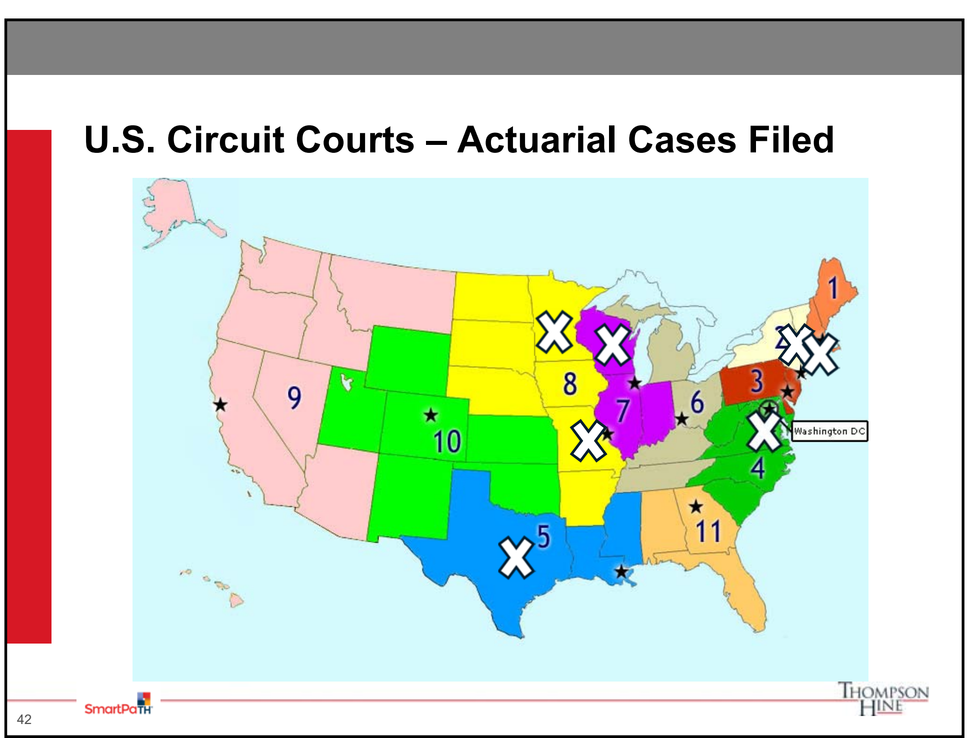
U.S. Circuit Courts – Actuarial Cases Filed



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ERISA Actuarial Assumptions Litigation -Claims for Relief

- Declaratory and Equitable Relief
  - ERISA § 502(a)(3)
- Reformation of the Plan and Recovery of Benefits under the Reformed Plan
  - ERISA § 502(a)(1) and (3)
- Breach of Fiduciary Duty
  - ERISA §§1104 and 502(a)(3)

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Defenses in Motions to Dismiss

- Matter of plan design
  - Benefits were calculated using assumptions mandated by the plan
  - Union may have a say in changing mortality tables in a collectively bargained plan
- Interplay of mortality assumptions and interest rates
  - A high interest rate can offset outdated mortality rates
- Statute of limitations (more than 6 years since plaintiff received paperwork)
- Failure to exhaust administrative remedies (claim depends on administrative interpretation)
- Standing issues (if no harm suffered by plaintiff)

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Defenses in Motions to Dismiss

- Regulations
  - The ERISA regulations cited do not require the use of any particular assumptions in this context, and in other contexts (ERISA's non-discrimination rules) the regs specifically authorize the use of the same mortality tables used here
  - Nothing in ERISA's statutory provisions requires that actuarial assumptions used in calculating ECF be "reasonable" or imposes liability when those factors are not reasonable. (addressing §§1053 and 1054)
  - Congress could have required that plans only use "reasonable" actuarial factors for calculating benefits at early commencement, but it did not. (contrasting plan-funding provisions of 29 U.S.C. §1085a, withdrawal liability provisions of 29 U.S.C. §1393(a)(1), and lump sum benefit provisions of 29 U.S.C. §1055(g)(3)(B)).
  - There is no private right of action under ERISA to enforce the Code regulation upon which plaintiffs rely (26 C.F.R. §1.401(a)-11). ERISA's relevant enforcement mechanism allows redress of any violation of "any provision of this subchapter" -- not the Code or regulations.
  - Other regulations expressly say the mortality table used is a "standard mortality table" that is "reasonable" for plan administrators to use. (citing 26 C.F.R. § 1.401(a)(4)-12 and (a)(4)-3f(7))
  - When Congress intends mortality tables to be updated, it specifies that timing expressly

Defenses in Motions to Dismiss

- Reasonableness
  - Complaint does not identify what conversion factor would be reasonable or why the ones used were unreasonable.
  - Plaintiffs allege a less than 3% difference between the benefits calculated using the actuarial factors in the plan and the actuarial factors they argue are acceptable (for lump sum calculations). Treasury regs make clear that a benefit difference of 5% or less is not only reasonable, but is deemed "approximately equal in value" as a matter of law. (citing 26 C.F.R. § 1.417(a)(3)-1(c)(2)(iii)(C)).
  - Life expectancy has been falling for years, contrary to plaintiff's underlying premise.

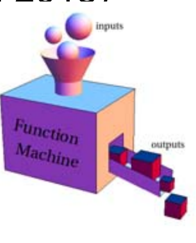
Big Picture Issues

- For plan sponsors and fiduciaries, what are the pros and cons of changing actuarial assumptions now, either for future benefits or previous pay status benefits?
- Should plan sponsors and fiduciaries be proactive now, or wait for court cases to play out and/or for Congress or regulators to act?

4. BONUS CATEGORY – THE FIDUCIARY STATUS (OR NOT) OF PBM'S?

The Fiduciary Analysis Applied to Service Providers

- ERISA's usual "functional test" applies to determine whether a service provider is a fiduciary.
  - *Santomenno v. Transamerica Life Ins. Co.*, 883 F.3d 833, 837 (9th Cir. 2018)



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Is a PBM a Fiduciary?

- Whether a pharmacy benefit manager (PBM) is an ERISA fiduciary turns, not on the title, but on the functions performed.
- Although PBMs are usually careful to include language in their contracts disclaiming fiduciary responsibility under ERISA, simply disclaiming fiduciary status is not determinative.
  - *See, e.g., Bickley v. Caremark*, 361 F. Supp. 2d 1317, 1324-25 and n. 7 (N.D. Ala. 2004) (describing clause in drug prescription plan agreement -- ". . . nothing in this Agreement shall be deemed to confer upon [the PBM] the status of fiduciary as defined by ERISA" -- and finding "this ERISA fiduciary exculpatory language has no effect whatsoever on whether or not [the PBM] is an ERISA fiduciary.").

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Is a PBM a Fiduciary?

- Regardless of how the contract characterizes the PBM's duties, the critical inquiry is whether the PBM actually possesses or exercises discretionary authority within the meaning of ERISA's definition of fiduciary.
  - *See, e.g., IT Corp. v. Gen. Am. Life Ins. Co.*, 107 F.3d 1415, 1418 (9th Cir. 1997).

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Alleged Fiduciary Functions of PBMs

- Negotiating agreements with healthcare benefit providers
- Negotiating pricing and rebates with pharmacies
- Collecting a spread or a "clawback" or otherwise setting their own compensation
- Prohibiting pharmacies from disclosing cost information to patients
- Classifying drugs as brand or generic
- Managing formulary programs
- Computing benefits
- Failing to abide by the terms of the plan

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Typical PBM Counterarguments

- Lack of discretionary authority or control
  - *In re UnitedHealth Group, Inc. PBM Litigation*, No. 16-CV-3352, (D. Minn., Dec. 19, 2017) ("there can be no breach of fiduciary duty where an ERISA plan is implemented according to its written, nondiscretionary terms")
- Contractually-permitted business decisions
  - *In re Express Scripts, Inc., PBM Litigation*, No. 4:05-MD-01672 SNL, 2008 U.S. Dist. LEXIS 26127 (E.D. Mo., July 30, 2008) ("ESI's standard pricing policy . . . is a business decision outside its relationships (fiduciary or otherwise,) with ERISA plans.")
- Ministerial functions
  - 29 C.F.R. § 2509.75-8, D-2 (giving examples of non-fiduciary ministerial functions, including calculation of benefits, processing of claims, and application of rules determining eligibility for participation or benefits)

Is a PBM a Fiduciary? Examples of No

- *In re Express Scripts/Anthem ERISA Litig.*, 285 F. Supp. 3d 655, 677-81 (S.D.N.Y. 2018), appeal pending *In re Express Scripts/Anthem*, No. 18-346 (2d Cir.).
  - PBM did not have discretion over pricing or compensation under PBM agreement and therefore plaintiffs did not allege sufficient facts to support a finding that PBM acted as a fiduciary in its relevant conduct
- *In re UnitedHealth Grp. PBM Litigation*, No. 16-CV-3352 (D. Minn., Dec. 19, 2017)
  - Negotiating prices with providers is not a fiduciary function, but rather the administration of a network administrator's business; performing "instantaneous calculations," based on plan terms, does not constitute a fiduciary action; and the "spreads" collected on participant copayments are not plan assets over which PBM exercised authority or control.

Is a PBM a Fiduciary? Examples of No

- *In re Express Scripts, Inc., PBM Litigation*, No. 4:05-MD-01672 SNL, 2008 U.S. Dist. LEXIS 26127 (E.D. Mo., July 30, 2008)
  - PBM was not a fiduciary in establishing "ceiling prices" for generics; in determining drug prices by selecting a pricing source; in negotiating rebates with drug manufacturers; in selecting or modifying formulary content or making drug-switching decisions; or in generating and retaining interest on rebates; but PBM was a fiduciary in controlling and disposing of certain "savings" owed to the plan.
- *Moeckel v. Caremark, Inc.*, 622 F. Supp. 2d 663, 682 (M.D. Tenn. 2007)
  - "The court finds that [the PBM] was not acting as an ERISA fiduciary when performing the five distinct acts of plan management alleged by the plaintiff."

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Is a PBM a Fiduciary? Examples of No

- *Chicago District Council of Carpenters Welfare Fund v. Caremark, Inc.,* 474 F. 3d 463, 472-77 (7th Cir. 2007)
  - PBM was not an ERISA fiduciary while negotiating with a health plan, even where a contract provision stated that the PBM "will use its best commercially reasonable efforts to negotiate these rates with the existing pharmacies in [the PBM's] network."
- *Mulder v. PCS Systems Inc.*, 432 F. Supp. 2d 450, 455 (D.N.J. 2006)
  - PBM was not an ERISA fiduciary for any alleged activity, including helping to determine which drugs a plan would cover and contracting to receive its compensation for services through drug manufacturer rebates.

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Is a PBM a Fiduciary? Examples of No

- *Pharm. Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294, 300-01 (1st Cir. 2005), *cert. denied*, 126 S. Ct. 2360 (2006).
  - In the context of a preemption dispute, Maine Attorney General argued, in the abstract, not in connection with a particular fiduciary duty claim, that PBMs are not ERISA fiduciaries because they do not exercise discretionary authority or control in the management and administration of ERISA plans; the Court and the PBM agreed.
- *Bickley v. Caremark Rx, Inc.*, 361 F. Supp. 2d 1317, 1332 (N.D. Ala. 2004)
  - PBM was not a fiduciary merely because it collected a spread between the prices it paid for prescription drugs and the prices it charged the ERISA plan, noting that "[m]aking an advantageous contractual agreement with an ERISA plan does not make one an ERISA fiduciary."

Is a PBM a Fiduciary? Examples of Yes

- *Glanton v. AdvancePCS, Inc.*, 465 F.3d 1123, 1124 (9th Cir. 2006)
  - Without much analysis, and while ruling on a separate standing issue, the Ninth Circuit stated that the defendant PBM "easily fits" ERISA's definition of a fiduciary because "[i]n choosing whether to fill a prescription or shift a participant to a different drug, it exercises discretion over the plans' assets."

Is a PBM a Fiduciary? Examples of Yes

- *Negron v. Cigna Health and Life Ins. Co. and OptumRx, Inc.*, No. 3:16-cv-01702 (D. Conn., March 12, 2018)
  - The court addressed four distinct allegations, finding each one pled facts sufficient to support the PBM's fiduciary status for MTD purposes:
    - By determining the amount pharmacies charged patients for prescription drugs and by requiring pharmacies to charge more than required under the plan
    - By exercising authority that was not contemplated by the plan
    - By exercising authority and control over plan assets, including participant cost-sharing payments and spread amounts recouped by the pharmacies, in a manner not authorized by the agreement
    - By inflating cost-sharing payments in contravention of the plan terms.

Is a PBM a Fiduciary? Examples of Yes

- *In re: EpiPen ERISA Litigation*, 2018 U.S. Dist. LEXIS 183650 (D. Minn., Oct. 26, 2018)
  - The court refused "to construe the complicated and multi-faceted agreements at issue here as a matter of law."
  - Plainly the court did not want to wade into a detailed analysis of multiple complex contracts on a motion to dismiss, and thus accepted at face value plaintiffs' allegations that the arms'-length bargaining between the PBMs and the manufacturer "was in fact a concerted effort to raise the price for EpiPens" to the detriment of plan participants.
  - Accordingly, the court denied the PBMs' motions to dismiss the breach of fiduciary duty claims against them.

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