IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

DATA MARKETING PARTNERSHIP, LP and LP MANAGEMENT SERVICES, LLC,	)	
Plaintiffs,	)	
UNITED STATES DEPARTMENT OF LABOR, EUGENE SCALIA, *in his official capacity as Secretary of the United States Department of Labor*, and UNITED STATES OF AMERICA,	)	Civil Action File No. 4:19-cv-00800-O
Defendants.	)	

FIRST AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Pursuant to the Court's Order dated January 30, 2020 [ECF No. 8] and Fed. R. Civ. P. 15(a) and 20(a)(1), Plaintiff Data Marketing Partnership, LP ("DMP") and newly joined Plaintiff LP Management Services, LLC ("LPMS") (collectively, DMP and LPMS are referred to herein as "Plaintiffs") hereby file this First Amended Complaint, fully substituting and restating the original Complaint [ECF No. 1], against Defendants United States Department of Labor ("DOL"), Eugene Scalia, solely in his official capacity as Secretary of the United States Department of Labor ("Secretary Scalia"), and the United States of America ("USA"), (collectively, DOL, Secretary Scalia and USA are referred to herein as "Defendants"), showing this Court as follows:

INTRODUCTION

1. Plaintiffs are asking this honorable court to correct the fatally-flawed, arbitrary and capricious actions of the United States Department of Labor ("DOL"). DOL seeks to invalidate a legitimate and innovative business model offering the benefit of a group health plan. Its actions would have the practical effect of depriving over 50,000 Americans health coverage and access to affordable healthcare.

2. Plaintiffs seek a declaratory judgment to settle an immediate controversy caused by DOL's ill-informed response to an advisory opinion request filed by LPMS on November 8, 2018, revised as of January 15, 2019 and February 27, 2019 (the "AO Request"). A true and correct copy of the AO Request is attached hereto and incorporated herein as Exhibit A.

3. On January 24, 2020, four hundred forty-two (442) days after submission of the AO Request, one hundred twelve (112) days after filing the original Complaint, and a mere eleven (11) days before an answer was due to the original Complaint, DOL issued its response to the AO Request (the "AO Response"). A true and correct copy of the AO Response is attached hereto and incorporated herein as Exhibit B.

4. The AO Request was submitted because LPMS, at the time of original submission, was intending to act as the plan administrator and named fiduciary of self-insured health plans – in its role as the anticipated general partner of DMP and several similar limited partnerships – those partnerships would maintain for their common law employees and limited partners. LPMS, as the general partner of anticipated adopting employers, sought to confirm that DOL would not classify such partnership health plans as a multiple employer welfare arrangement ("MEWA") as that term is defined in 29 U.S.C. § 1002(40) of the Employee Retirement Income Security Act ("ERISA").

5. Subsequent to the submission of the AO Request and in reliance on various representations from DOL officials as detailed below, DMP established a self-insured health plan for its common law employees and partners (the "Plan").

6. LPMS is the general partner of DMP.

7. According to the AO Request, neither DMP nor LPMS believes the Plan is a MEWA because the applicable statutory terms set forth under ERISA and its accompanying regulations do not dictate such an interpretation.

8. However, because the limited partnership is a potentially novel sponsor of a health plan, LPMS sought an advisory opinion pursuant to ERISA Procedure 76-1 to achieve clarity on this issue and to assuage the concerns of DMP's current employees, partners and potential partners.

9. Apart from the federal judiciary, DOL is solely responsible for interpreting ERISA – within statutory limitations – and has acknowledged this responsibility both in guidance it has provided concerning whether a plan should be classified as a single-employer plan or a MEWA, and in its actions issuing approximately 140 advisory opinions and information letters on issues concerning MEWAs issued under DOL Procedure 76-1.

10. In addition to private parties such as LPMS, States have also routinely filed advisory opinion requests with DOL, similar to the AO Request, seeking guidance on many issues presented by ERISA, including issues concerning MEWAs. Indeed, States and others have no alternative but to engage in this process where, as here, the issue presented requires an interpretation of ERISA, as States are not authorized to assign their own meaning to terms set forth in a federal statute.

11. While not filing their own advisory opinion request, several States submitted to DOL a letter in support of the AO Request. On February 21, 2019, the Attorneys General of Louisiana, Arkansas, Georgia, Indiana, Nebraska, South Carolina and Texas jointly signed a letter in support of the AO Request (the "State AG Letter"). A true and correct copy of the State AG Letter is attached hereto as Exhibit C.

12. In the State AG Letter, the respective Attorneys General stated, "[w]e are interested in this request and encourage DOL to respond as soon as possible. The [AO Request] sought by [LPMS] provides an alternative for expanded access to ERISA plans. We support the intent behind the request and find its legal arguments well-reasoned and thorough, but ***interpretation and enforcement of ERISA falls under the exclusive authority of DOL***." See Exhibit C, p. 1 (emphasis added).

13. Although DOL finally filed the AO Response well over a year after the AO Request was made, the unreasonable delay from DOL and the subsequent confusion created by DOL through its flawed, arbitrary and capricious interpretation of the issues presented actively undermines DMP's ability to do business throughout the United States.

14. Given the position taken by DOL in the AO Response, DMP now faces catastrophic regulatory penalties and enforcement actions as a sponsor of a Plan covering limited partners and Texas employees. Should DOL be permitted to maintain the legally erroneous and factually inaccurate interpretation of the Plan as not covered by ERISA but "mere commercial insurance," then DMP will have no choice but to dissolve the Plan. In such event, the participants would lose their health coverage and access to affordable health care.

15. LPMS serves as the general partner for several other limited partnerships in the electronic data generation, aggregation and sales arena. As with DMP, LPMS has established similar, self-insured group health plans for those limited partnerships as a significant attractor for partners willing to generate a sufficient amount of electronic data for resale by the partnership. This commitment to sponsor such a plan is one almost every business considers to attract service providers, whether they be employees or self-employed individuals. Should DOL be permitted to maintain the legally erroneous and factually inaccurate interpretation of similar plans as not

covered by ERISA, then LPMS will have no choice but to dissolve all those plans. In such event, more than 50,000 Americans would lose their health coverage and access to affordable health care.

16. In addition to the impending regulatory burden, the hollow guidance DOL has set forth in the AO Response on a fundamental issue of statutory interpretation has resulted and will continue to result in many potential limited partners declining to join DMP for fear that their health coverage will be cancelled. A significant attractor for limited partners joining the partnership and generating electronic data for the partnership is the Plan offered by DMP.

17. Each limited partner that refuses to join for the reason set forth above limits the scope of the data pool that DMP can offer to potential customers, thus undermining DMP's overall business purpose and eliminating revenue and profits that would have been had but for DOL's erroneous AO Response.

18. In establishing similar limited partnerships in an effort to build a sufficient user base of data contributing limited partners, LPMS faces the same harm for each of those business entities. The AO Response has resulted, and will continue to result, in many potential limited partners declining to join these other limited partnerships managed by LPMS for fear that their health coverage will be cancelled.

19. Each limited partner that refuses to join other LPMS managed limited partnerships for the reason set forth above limits the scope of the data pool that these other LPMS managed limited partnerships can offer to potential customers, thus undermining the overall business purpose and directly eliminating revenue and profits that would have been achieved but for DOL's erroneous AO Response.

20. Plaintiffs accordingly ask the Court to declare that (i) the AO Response is null, void, and of no force or effect against Plaintiffs or any similarly situated organizations because

such a ruling would be an "action contrary to the provisions of" ERISA; (ii) the Plan is a single-employer group health plan subject to ERISA; and (iii) as a single-employer group health plan, the Plan is not a MEWA or "mere commercial insurance."

21. Plaintiffs also request the Court award other relief as set forth below.

JURISDICTION AND VENUE

22. The Court has subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331 and 2201(a) and 29 U.S.C. §§ 1132(a)(3) and 1132(k). Jurisdiction is also proper under the judicial review provisions of the Administrative Procedure Act, 5 U.S.C. §§ 702 and 704 and 29 U.S.C. §§ 1137(a).

23. Venue is proper in this district pursuant to the express provisions of ERISA, 29 U.S.C. §§ 1132(k). Venue is also proper in this district pursuant to 28 U.S.C. §§ 1391(b) and (e)(1). Defendants are United States agencies or officers sued in their official capacities; Defendants reside in this District; and a substantial part of the events giving rise to this action occurred in this District.

PARTIES

24. Plaintiffs are organizations aggrieved by the erroneous interpretation of federal law by the federal Defendants in their recently filed AO Response because it is arbitrary, capricious, or otherwise manifestly contrary to the language of the statute.

25. Defendant DOL is an agency of the United States government and has responsibility for implementing and enforcing portions of ERISA. It is an "agency" under 5 U.S.C. § 551(1).

26. Defendant Eugene Scalia ("Secretary") is the Secretary of Labor and is joined in this action solely in his official capacity.

27. Defendant the United States of America is joined in this action as permitted under 5 U.S.C. § 702.

FACTS

PLAINTIFFS' BUSINESS AND BUSINESS MODEL

28. LPMS, a limited liability company that is duly formed under the laws of the State of Georgia and registered to do business in the State of Texas, submitted the AO Request to DOL. LPMS is the general partner of DMP. LPMS also serves as the general partner for several other limited partnerships similar to DMP whose primary business purpose, together with providing other opportunities for limited partners to earn extra income, is the generation, aggregation, and sale of electronic data.

29. DMP, a limited partnership that is duly formed under the laws of the State of Texas and qualified to do business in the State of Texas, is directly impacted by the adverse ruling in DOL's AO Response. The stipulated facts presented in the AO Request are hereby incorporated by reference.

30. LPMS, as the general partner of DMP, is responsible for day-to-day business management decisions including, but not limited to, the execution of rental/office lease agreements, employment contracts, distribution of revenue producing agreements, and grantor decisions to form a group health plan.

31. The limited partners of DMP are individuals who have obtained a limited partnership interest through the execution of a joinder agreement with DMP, which is approved by the general partner adding the new limited partner and updates DMP's partnership information to include this information. The limited partners, in the aggregate, own eighty percent (80%) of

the partnership. LPMS owns the other twenty percent (20%) of the partnership. Thus, the partners are the sole owners of DMP.

32. Limited partners participate in global management issues through periodic votes of all partners of DMP. Together, the general partner and the limited partners wholly control and operate DMP.

33. DMP's primary business purpose and main source of revenue is the generation, organization, aggregation, and sale to third-parties of electronic data. This electronic data is generated by limited partners who transmit such electronic data to DMP via proprietary software and applications for mobile devices installed on the limited partners' computers, smart phones, tablets and other electronic devices. While this is the primary business purpose, DMP also provides the partners opportunities to provide personal services to various third-parties as an additional revenue opportunity.

34. In addition to certain other management rights, limited partners influence how the electronic data they generate will be sold or used by DMP.

35. If a limited partner desires to enroll in the Plan, the partner agrees to contribute at least five hundred (500) hours of work per year through the generation, transmitting, and sharing of their electronic data. This is a clear condition of eligibility for the Plan. The generation and aggregation of these bytes of electronic data transmitted by each partner represents the most significant commodity which DMP seeks to sell to third parties. Without the generation, tracking and transmission of significant quantities of data by limited partners, DMP would have no ability to attract buyers and become profitable. Thus all limited partners who transmit their generated electronic data to the partnership are active, material participants in creating DMP's primary

commercial offering by committing time and service to the revenue-generating activity of DMP which, among other things, makes them "working owners."

36. Limited partners resulting from such revenue-generating activities will be reported as guaranteed payments, subject to employment taxes applicable to self-employed individuals, based on the work product they individually produce and the revenue derived from this work product.

37. DMP also employs at least one common law employee to assist DMP with administrative and/or revenue generating services.

38. In order for DMP or any of the other limited partnerships managed by LPMS to be financially successful in the electronic data resale market, large quantities of electronic data must be generated, aggregated and organized for purchasers to be interested in paying for the electronic data. In other words, the electronic data aggregation market is a market of scale – the greater the scale of the electronic data generated and aggregated, the greater the economic value of the data.

DMP'S SELF-INSURED GROUP HEALTH PLAN DETAILS

39. To attract, retain, and motivate talent in support of DMP's primary business purpose, DMP established the Plan. The Plan automatically covers all common law employees of DMP. The Plan is available to provide coverage to limited partners if they qualify and choose to participate.

40. The Plan document states in its "Eligibility" section that only eligible plan participants of which DMP is an employer, as defined by 29 U.S.C. § 1002(7), including certain employees and partners of DMP, are eligible to participate in the Plan. No other persons (other than spouses and dependents of eligible plan participants) are eligible to participate in the Plan. One of the requirements to be an eligible participant for limited partners is the providing of at least

500 hours of service to the partnership. Since the partnership's primary business purpose is the generation, aggregation, organization and sale of electronic data, those hours of service to the partnership may be satisfied with the transmission of 500 hours of electronic data to the partnership for sale to third parties.

41. The Plan automatically covers all common law employees of DMP. The Plan is available to provide coverage to limited partners if they qualify and choose to participate. No other persons (other than spouses and dependents of eligible plan participants) are eligible to participate in the Plan.

42. DMP pays 100% of the premiums for coverage under the Plan for common law employees of DMP. Limited partners are 100% responsible for paying their own premiums for coverage under the Plan.

43. The Plan is intended to comply with ERISA, including, but not limited to, Parts 1, 4, 5, and 7 of Subtitle B of Subchapter I of ERISA.

44. Since the Plan is formed and sponsored only by DMP – and not in concert with any other employer – the Plan is a single employer, self-insured group health plan. This is so under ERISA because such status is defined as any plan that is not a MEWA.

45. DMP is the named Fiduciary and Plan Administrator of the Plan.

46. LPMS, serves as a fiduciary of the Plan as the General Partner and manager of the Plan Administrator. LPMS intends to appoint an independent fiduciary to assist with fiduciary obligations and administration matters associated with the Plan.

47. LPMS recognizes that while its policies and procedures ensure financial stability and prudent exercise of fiduciary responsibilities for the benefit plans of its partnerships, other sponsors imitating its model may encounter risks which could lead to plan failure(s), whether due

to ill-conceived structure, inadequate (re)insurance reserves, or some combination of these and other factors. LPMS has established strong safeguards as a commitment to employees and partners – which are described in detail in Paragraphs 47 through 51 – to address each vulnerability both as to sponsorship and participation. These safeguards are an integral component of fulfilling the purpose of ERISA to protect employees and their welfare benefits.

48. The Plan has a number of third-party vendors LPMS engages on behalf of DMP to administer. First, LPMS hired a consulting and benefits design firm for guidance and assistance with fulfilling plan requirements pursuant to ERISA and related statutes. Second, LPMS appointed a licensed and bonded Third Party Administrator ("TPA") to collect funds and allocate funds, adjudicate claims, manage claims appeals, execute the payment of claims for benefits under the Plan, and perform other traditional services performed by a TPA. Third, LPMS appointed a benefits administrator to assist its staff in managing eligibility data and plan participant customer service issues on an ongoing basis. Fourth, LPMS hired a directed trustee to custody and manage a Trust to hold any plan assets related to the Plan. Finally, LPMS obtained a reinsurance policy for the Plan.

49. These third-party vendors service the Plan as their delegated duties require. For example, the TPA collects monthly payments from the Plan's participants. The TPA allocates these funds appropriately, routing plan assets to the Trust (which is solely controlled by a Directed Trustee), paying vendors their fees, and ensuring premium payments are timely made to the reinsurance carrier underwriting the Plan's reinsurance policy. The TPA withholds a certain amount of premium due to the reinsurance carrier covering the Plan. With respect to paying claims for benefits, in cases where the TPA has received and approved a claim, the TPA will access the plan assets held in Trust to pay such claim. Should a claim require a payment in excess of the

funds available to the TPA on an immediate basis, the TPA coordinates with the reinsurance carrier covering the Plan for transmission of additional funds to the TPA's claims-paying account. Once received, the TPA will continue paying claims.

50. The reinsurance policy is of a comprehensive and specific nature. Coverage is obtained from first-dollar and to an unlimited degree per the terms of the reinsurance policy. This policy is supported by multiple layers of retrocessionary coverage without a risk corridor by retrocessionaires.

51. LPMS requires the following features of any policy it obtains to cover the Plan now or in the future. First, any group health plan sponsored by any limited partnership managed by LPMS and which offers ERISA plan participation to its eligible plan participants, including certain employees and partners, must first obtain Qualifying Reinsurance Coverage. "Qualifying Reinsurance Coverage" means excess/stop loss insurance, indemnity insurance for a self-insured plan or employee benefit trust, insurance for a self-insured plan or trust, or reinsurance coverage purchased from an excess/stop loss, indemnity, insurance, or reinsurance carrier that meets the key requirements described in Paragraph 51.

52. These requirements for Qualifying Reinsurance Coverage are:

a. an agreement to (re)insure, without limitation, all benefits covered by the Plan which it (re)insures;

b. provided Plan and Reinsurance coverage must be identical as to benefits and limitations;

c. it may only be issued by a carrier which establishes and maintains retrocessionary coverage from one or more (re)insurer(s) with at least $100,000,000 in aggregate equity for any

claims which the plan is unable to satisfy by reason of a solvency event affecting said carrier's ability to pay claims, to an unlimited degree;

d. it must note on any contract for coverage a definite starting or attachment point of such coverage which is conspicuous and clear to the plan member(s) prior to purchase of such coverage, and qualifying (re)insurance coverage issued on a non-stop loss (re)insurance basis must have a first-dollar starting point;

e. it must note on any contract for coverage an unlimited liability of the carrier issuing such coverage for benefits covered by such coverage which is conspicuous and clear to the plan member(s) prior to purchase of such coverage;

f. it must have been approved by one or more regulatory body or bodies duly authorized to license and regulate the business of insurance within the United States and/or a member of the National Association of Insurance Commissioners, for a minimum of twenty-four months, and been issued to at least one insured party for the direct and/or indirect coverage of health and/or medical benefits, and in force throughout said period;

g. it may only be issued by a carrier which establishes and maintains reserves with respect to covered benefits, in an amount recommended (or the mid-point of multiple recommendations) by an actuary certified by the American Academy of Actuaries, consisting of reserves sufficient for:

i. unearned contributions;

ii. benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

iii. any other obligations of the plan; and

iv. a margin of error and other fluctuations, taking into account the specific circumstances of the plan;

h. May only be issued by a carrier which establishes and maintains additional reserves of at least $500,000 above the reserves noted above;

i. Carriers issuing Qualifying Reinsurance Coverage may demonstrate compliance with the reserve requirements described above with alternative reserves in the form of a contract of indemnification, lien, bonding, (re)insurance, letter of credit, or security; and

j. Any business of insurance, including but not limited to the obtaining of Qualified Reinsurance Coverage, conducted in any State must comply with the insurance laws of said State, and obtain all required State approvals.

APPLICATION OF ERISA TO LIMITED PARTNERS' ELIGIBILITY TO BE PARTICIPANTS IN THE PLAN

53. Congress enacted ERISA in 1974 principally to protect employees, pensioners, and their employee pension and welfare benefits. ERISA imposed fiduciary obligations on plan administrators, and implemented disclosure requirements, and other safeguards.

54. Title I of ERISA, which governs employee benefit plans – including group health plans – "was adopted … [in part] to remedy the abuses that existed in the handling and management of welfare and pension plan assets … Workers in such traditional employer-employee relationships are more vulnerable than self-employed individuals to abuses because the workers usually lack the control and understanding required to manage pension funds created for their benefit" *Schwartz v. Gordon*, 761 F.2d 864, 868 (2d Cir. 1985). Therefore, ERISA is designed to protect "participants" who are "employees" that participate in employee benefit plans which are subject to its regulatory scope.

55. Subchapter I of ERISA is comprised of Subtitle A – General Provisions and Subtitle B – Regulatory Provisions. For purposes of Subchapter I, 29 U.S.C. § 1002 sets forth all defined terms. The statute provides that an "employee welfare benefit plan" means "any plan, fund, or program . . . established or maintained by an employer or employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants and beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits." 29 U.S.C. § 1002(1).[1] A "participant" refers to an "employee or former employee of an employer…" *Id.* § 1002(7). "Employee" means "any individual employed by an employer." *Id.* § 1002(6). ERISA defines "employer" in relevant part as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan…." *Id.* § 1002(5).

56. Under ERISA, the term "multiple employer welfare arrangement" (or MEWA) means "an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) [referring to employee welfare benefits] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries…"[2] *Id.* at § 1002(40). The term "single-employer plan" means "an employee benefit plan other than a multiemployer plan." *Id.* at § 1002(41).

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[1] A type of "employee welfare benefit plan" is a "group health plan" defined in Part 7, Subtitle B of ERISA and is discussed *infra*. Also, under ERISA, an "employee welfare benefit plan" can be formed to offer "benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services," 29 U.S.C. § 1002(1), or any benefit listed in 29 U.S.C. § 186(c). ERISA also establishes "employee pension benefit plans." *Id.* § 1002(2). All of these types of plans are interconnected with the definition of "employer" at § 1002(5).

[2] The remainder of the definition sets forth exceptions to MEWA status, none of which are applicable here.

57. While 29 U.S.C. § 1002(7), the definitional section of ERISA, is silent about the status of partners as participants in ERISA plans, other sections of ERISA, the initial regulations promulgated by DOL along with subsequent regulatory iterations, various Advisory Opinions, and informal guidance all compel the conclusion that limited partners in partnerships like DMP are "employees" within the meaning of 29 U.S.C. § 1002(7).

58. Importantly, the applicable regulations do not say that a partner cannot be an "employee" and state that a partner can be an ERISA governed participant. DOL has agreed with this position as recently as 2019 in an appellate brief citing *Yates* with approval for the proposition that working owners "can be both an employer and an employee for purposes of establishing and participating in an ERISA-covered benefit plan." Brief for Appellants at 3, State of New York, et al. v. U.S. Department of Labor, et al., No. 19-5125, (D.C. Cir. *appeal docketed* Aug. 8, 2019).

59. In 1999, DOL clarified in an exhaustive opinion the intended scope of 29 U.S.C. § 1002(3) of ERISA and its regulations set forth at 29 U.S.C. § 2510.3-3(b), making clear that self-employed individuals (including partnerships and partners which are specifically referenced therein) who are "working-owners" may have dual status as an "employer" and an "employee," and therefore, may be considered a "participant" in an ERISA-covered plan where such working owners participate along-side of their common law employees. DOL Op. No. 99-04A (Feb. 4, 1999).

60. More specifically, DOL opined that 29 U.S.C. §§ 1101(a)(2), 1103(b)(3)(A), 1108, 1301(b)(1), 1321(b)(9), and 1322(b)(5)(A) all support this conclusion. *Id.* Moreover, DOL noted that to treat such working owners differently than employees would cause "intolerable conflicts" between the different Parts of ERISA and lead to "absurd results." *Id.* (referring to the warning issued by the Supreme Court in *Nationwide Mutual Insurance Co. v Darden*, 503 U.S. 318, 323

(1992), which held that the common law definition of employee must be graphed into ERISA to at least partially define the statutory meaning of "employee.").

61. Considering the circumstances of the limited partners participating in the Plan, DMP is a valid limited partnership and the limited partners will actively provide valuable services to DMP in support of and essential to its profit goals.

62. DMP employs common law employees and those employees along with the limited partners are eligible to participate in the Plan. Limited partners actively provide electronic data to the partnership for re-sale. Limited partners will not be paid based on a pro rata share of ownership; rather, the partners who generate large quantities of valuable electronic data will be paid more than partners who generate lower quantities of valuable electronic data. Consequently, and consistent with DOL Op. No. 99-04A, the limited partners should be treated as "working owners" and, therefore, employees who along with their common law employees of DMP are participants in an ERISA covered plan.

63. With respect to DMP, limited partners actively provide services on behalf of the partnership in support of its profit goals and income derived therefrom will be reported as guaranteed payments as that term is used in IRC §§ 707(c) and 1402(a)(13), which addresses the taxation of limited partner income. Therefore, the income received by the limited partners will be subject to employment taxes under IRC §1402(b) (self-employment income is subject to Social Security taxes and in other important ways is treated as *de facto* wages).

64. This tax treatment, of course, is the hallmark of service performed by an employee on behalf of an employer as distinguished from partners earning distributive shares as

contemplated by IRC §1402(a)(13) who are merely passive equity owners. *Renkemeyer, Campbell & Weaver LLP v. Commissioner,* is instructive on this point. 136 T.C. 137 (2011).[3]

65. Lastly, at the time 29 U.S.C. §2590.732(d) was finalized, the Treasury Department also finalized mirror regulations at Treas. Reg. §54.9831-1(d). It appears that this mirroring was supplemental to the amendment by Congress of IRC §5000(b)(2), which clarified that self-employed persons could sponsor group health plans. While ERISA does not have a clear approach to classifying partners, the IRC does. In this regard, service by a partner on behalf of the partnership very clearly causes self-employment income tax treatment on guaranteed payments. The relationship between the partner and the partnership is *de facto* employment. This closely aligns with ERISA's goals of regulating employment relationships and serves as a good bridge to achieve the policy objectives which expressly calls for harmonizing the Department and Treasury provisions that relate to the same subject matter. *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 13 (2004) ("…Congress' objective was to harmonize ERISA with long standing tax provision.").

LPMS MEETINGS WITH DOL

66. In October, 2018 (the "October Meeting"), representatives of LPMS met with DOL in an effort to be transparent with the relevant regulatory agencies that would interact with the Plan, its participants, and its sponsors.

67. In attendance at the October Meeting and representing the interests of LPMS was Alex Renfro, among others.

[3] The Tax Court also provides a thorough history of emerging hybrid corporate business forms like limited partnerships which as a point of reference provides relevant detail supporting the need for consistent regulation by the Department of Treasury and DOL.

68. In attendance at the October Meeting and representing the interests of DOL were Preston Rutledge, Assistant Secretary of Labor for the Employee Benefits Security Administration (EBSA), among others. EBSA has direct oversight of EIRSA within DOL.

69. By all accounts, the October Meeting was very successful. LPMS representatives explained the plan structure to DOL representatives and provided high level detail of the goals of the Plan and the business structure.

70. At the October Meeting, DOL Assistant Secretary Rutledge told representatives from LPMS that an Advisory Opinion Request was the best route to ensure approval of the Plan by DOL. The AO Request submitted on November 8, 2018 was the response to this advice from DOL.

71. The parties parted ways with the tacit agreement to continue discussions so that DOL could be comfortable approving the Plan as a single-employer group health plan subject to ERISA.

72. In the weeks and months that followed, informal conversations were had between representatives of LPMS and representatives of DOL in anticipation that a more formal meeting would soon follow.

73. Assistant Secretary Rutledge, head of Employee Benefits Security Administration division of DOL, changed course and verbally expressed to Christopher Condeluci, a paid advisor to one of the Plan services providers, that he did not see why DOL needed to issue an Advisory Opinion, because ERISA already allows partners to be treated as employees for purposes of plan eligibility.

74. During this conversation, Mr. Rutledge told Mr. Condeluci that LPMS should "just do it," meaning implement the Plan.

75. As a result of informal verbal questions and observations from DOL, the AO Request was slightly revised and resubmitted to DOL in early 2019, culminating in the final version of the AO Request submitted on or about February 26, 2019.

76. Simultaneously, and in reliance on Mr. Rutledge's statements, LPMS began accepting limited partners into other limited partnerships it manages and formed the Plan. As of January 15, 2020, more than fifty thousand Americans have become limited partners of the partnerships managed by LPMS and they, along with their eligible dependents, are participants in the partnership health plans offered by those partnerships. Those joinders and plan enrollments were offered based in large measure on the representations made by Mr. Rutledge and other DOL officials.

77. At or around this time, seven sitting state Attorneys General sent a letter to then DOL Secretary Alexander Acosta, stressing the urgency of the public health problem that the LPMS working partner model addressed, and requesting expedited consideration of the AO Request (see State AG Letter attached as Exhibit C). DOL made no response at all to the State AG Letter before the AO Response and, while it saw fit to reference this litigation, DOL did not so much as mention the State AG Letter in the AO Response.

78. During a meeting on March 6, 2019, then DOL Chief of Staff Nicholas Geale told a group of representatives from LPMS and interested states, including Mr. Renfro, Mr. Condeluci, and Louisiana Attorney General Jeff Landry (the lead signatory to the State AG Letter), that although the LPMS structure was "ingenious" and that he "wished he'd thought of it," DOL could not respond to the AO Request due to perceived conflict with litigation around DOL's new Association Health Plan (AHP) rule.

79. At one point during the meeting, representatives from DOL became animated said that if the LPMS group disagreed about DOL's priorities, they should "take it up with the White House."

80. In a subsequent meeting that Mr. Condeluci had with Mr. Geale at DOL, Mr. Geale proposed that if LPMS would withdraw its AO request (and/or cease pressing for an answer to it), Mr. Geale would "look [LPMS representatives] in the eye" and promise that DOL would not investigate or otherwise interfere with any LPMS-managed partnership plans.

81. LPMS' representatives attempted to explain to Mr. Geale that even assuming DOL refrained from investigating or hampering LPMS-managed partnership plans such as DMP's Plan, the over fifty (50), separate insurance regulators could pose significant and indefinite regulatory burdens on LPMS-managed partnership plans through investigations and rulings of their own. It simply was not practical or advisable to rely on handshake promises with the threat of politically motivated investigations by individual States in the absence of an ERISA ruling.

EXAMPLES OF FATAL FLAWS IN AO RESPONSE

82. In its AO Response, DOL disagreed with Plaintiffs' legal conclusions in the AO Request and, contrary to its own published rules regarding the consideration of advisory opinion requests, ignored the factual and legal landscape set forth in the AO Request. Furthermore, the AO Response actually distorts and misrepresents several key factual predicates laid out in the AO Request.

83. The AO Response simply stated it is, "the Department's view that the proposed LP health benefit programs would not be single-employer group health plans ***or ERISA plans at all***." (emphasis added). AO Response, p. 6.

84. DOL never requested any follow up information from LPMS.

85. DOL never contacted any representative of LPMS to confirm its understanding of the facts presented in the AO Request.

86. DOL failed to follow its own procedures set forth in DOL Procedure 76-1.

87. Crucially, DOL applied little, if any, of the relevant law discussed above or in the AO Request to the facts presented, which resulted in its poorly conceived and legally defective AO Response.

88. DOL further stated that the AO Response "does not address the status of the limited partnership programs as … [MEWAs]" because of their conclusion that "the programs are not ERISA-covered plans…" AO Response, p. 6, FN 5.

89. Accordingly, a crucial corollary to the AO Request, whether the Plan is a MEWA, was not even addressed by DOL due to its improper understanding of the factual circumstances presented to it, and its counterfactual interpretation of ERISA. Incredulously, DOL asserts that LPMS did not ask for a determination as to whether the Plan is a MEWA (see AO Response, p.6, FN 6) despite the AO Request clearly seeking a determination that the Plan is a single-employer plan – defined in ERISA as "an employee benefit plan other than a [MEWA]." 29 U.S.C. § 1002(41).

90. Unconstrained by *Yates* and 99-04A, DOL takes the liberty to engage in a robust, common law employment analysis to determine whether the limited partners described in the AO Request are eligible to participate as ERISA "employees" and "participants" in a health plan sponsored by the partnership. For example, DOL calls out and expressly relies on the following employment related factors in the AO Response:

a. "According to the representations you have provided in support of your request, limited partners do not appear to report to any assigned "work" location or

otherwise notify the partnership that they are commencing their work; and they are not required to possess any particular work-related skills." See AO Response, p. 2.

b. "These provisions, like the title of the law itself — the *Employee* Retirement Income Security Act (emphasis added) — are replete with references to the employment relationship, and ERISA's coverage expressly turns on the provision of benefits in the employment context. As the above quoted language demonstrates, ERISA covers employee welfare benefit plans sponsored by an employer or employee organization for the benefit of plan participants who are themselves employees or former employees. The arrangements proposed by LP Management meet none of these criteria, inasmuch as the partnership is not the limited partners' employer, and the partners are neither employees nor employers with respect to the partnership." See AO Response, p. 3.

c. "The fact that one common law employee participates in a purported partnership program does not mean that everyone covered by the arrangement is participating in an ERISA plan. Rather, the regulation must be read in light of the Department's authority under ERISA to regulate the provision of employee benefits offered in the context of a genuine employment relationship." See AO Response, p. 4.

91. None of these employment related factors, however, can be relied on by DOL based on the Supreme Court's holding in *Yates* because this very test was specifically rejected. Instead, in relevant part, the Supreme Court directs us to Code Sections 26 U.S.C. §§ 401(c)(1)((A), 401(c)(1)(B) and 401(c)(2)(A)(i) and 99-04A as the "specific guidance" that makes owner employees ERISA employees. By rejecting the application of *Darden*, the Supreme Court intentionally treats owner employees differently recognizing that it is the Internal Revenue Code

that actually defines the terms "self-employed individuals" and "owner employees" whereas ERISA does not. DOL's reliance on common law employment factors to make its determination in the Opinion is contrary to law. In short, DOL engaged in the wrong analysis in reaching its conclusions.

92. Even if DOL had a basis to undertake an analysis based on common law employment, DOL's approach is fatally flawed in its own right. Specifically, DOL relied on speculative facts even though ERISA procedure 76-1 bars such reliance. Specifically, Sec. 10 of 76-1 states, "The opinion assumes that all material facts and representations set forth in the request are accurate, and applies only to the situation described therein."

93. In the AO Response, however, DOL does not accept as true even the most basic facts presented in the AO Request. For example, DOL makes the following factual statement: "In fact, the limited partnership agreement does not appear to require that a limited partner perform any service for or through the partnership apart from permitting tracking of the limited partner's use of the Internet on a personal device, as the limited partner sees fit." AO Response, p. 2. What LPMS actually proffered as the facts on this point is that the limited partners are required to provide 500 or more hours of service annually in the form of intentional activity on their computers and electronic devices, which is generated, aggregated, and organized into an electronic data set that, when combined with other limited partners' electronic data sets, creates a marketable commodity. In no way did LPMS characterize the limited partners' services as mindless, unintentional and inconsequential to the partnerships business. Rather, it is simply DOL's bald assertion that these are the "real" facts. Similarly, DOL wildly speculates that "as a matter of economic reality, it does not appear that the limited partners depend on the limited partnership as a source of business revenue. Indeed, it appears from your representations that the revenue that a limited partner could

reasonably expect from the limited partnership will typically be approximately zero." AO Response, pp. 2 and 3. In truth, there are absolutely no facts presented in LPMS' request that state the limited partners do not expect business revenue from their services or that the revenue received will be zero.

94. In the AO Response, in addition to inserting employment classification requirements that cannot apply, DOL also takes the liberty to re-write other standards set forth in its regulations in a manner wholly inconsistent with *Yates* and 99-04A. In this regard, DOL conjures up the following standards for limited partners that if met creates a scenario where "… it would be ***plausible*** to treat them as employed by the partnership in the relevant sense." AO Response, p. 5. (Emphasis added.) DOL states that limited partners can only be "bona fide" if "…the limited partners worked for or through the partnership, had ***a material ownership interest*** in the partnership, and earned income for work that ***generated material income for the partnership*** …" *Id.* (Emphasis added).

95. By comparison, according to *Yates* and 99-04A, for a partner, any partner, to be a working owner he/she has "an ***equity ownership right of any nature*** in a business enterprise and [who] is ***actively engaged in providing services*** to that business." 99-04A, FN3. (Emphasis added.) On its face, DOL's requirement of a "material ownership interest" is inconsistent with law. The "any nature" standard established by *Yates* and 99-04A in no way implies a materiality requirement nor can it. Partnership and partner status is determined by state not Federal law.[4]

96. Moreover, with respect to DOL's standard that "earned income" must derive from "work that generated material income for the partnership," there is again no legal basis. The actual test regarding self-employment status is set forth in Code Sections 26 U.S.C §§ 401(c)(1)(B) and

[4] See *Renkemeyer,* 136 T.C. 137, 148-149 (The Tax Court provides a history of the relevance of state law regulation of entities like partnerships).

401(c)(2)(A)(i), which define "'a self-employed individual' to cover an individual with 'earned income' from 'a trade or business in which personal services of the taxpayer ***are a material income-producing factor***.'" *Yates*, at 14. (Emphasis added.) Here, DOL seeks to require an economic threshold to be achieved even though the law requires none. In DOL's version, material income must be generated, but the law requires only that the income result from services that are a material factor or "input."[5] Therefore, in the AO Response, DOL plainly changes the standards articulated in *Yates* and 99-04A and thereby impermissibly abandons the Supreme Court's carefully considered analysis and its own prior guidance.

THE ADVISORY OPINION AO RESPONSE HARMS PLAINTIFFS

97. As detailed in the preceding paragraphs, the lengthy delay in DOL responding to the AO Request, and its subsequently invalid legal interpretation contained in its AO Response harms Plaintiffs.

98. The requested relief, if granted, will redress the injuries to the interests of Plaintiffs caused by DOL's extended delay and defective AO Response.

CAUSES OF ACTION

COUNT ONE
DECLARATORY JUDGMENT

99. Plaintiffs incorporate each of the foregoing paragraphs by reference as if they were fully set forth herein.

100. Pursuant to 29 U.S.C. §§ 1132(a)(3) and 1132(k), the "administrator, fiduciary, participant, or beneficiary of an employee benefit plan" may bring suit "to restrain the Secretary from taking any action contrary to the provisions of this Act…"

[5] Merriam-Webster defines a "factor" as "one that actively contributes to the production of a result." See "Factor." Merriam-Webster.com Dictionary, Merriam-Webster, http://www.merriam-webster.com/dictionary/factor?src+search-dict-box. Accessed Jan. 29, 2020.

101. Plaintiffs bring this suit in their capacity as fiduciaries of the Plan, and request that this Court declare the limited partners of DMP actively contributing work product in the form of marketable electronic data to the partnership are "employees" and "participants" in an ERISA covered employee welfare benefit plan.

102. Plaintiffs further request this Court declare the AO Response null, void, and of no force or effect against Plaintiffs or any similarly situated organizations because such an adivisory opinion would be an "action contrary to the provisions of" ERISA.

103. Further, Plaintiffs request this Court declare that the Plan is (i) subject to ERISA, (ii) a single-employer group health plan, and (iii) as a single-employer group health plan, does not constitute a MEWA or is "mere commercial insurance."

104. Further, Plaintiffs request this Court declare that partners who meet the Plan's eligibility requirements are (i) "working owners" and "bona fide partners" and (ii) are permitted to participate in the Plan.

105. Further, Plaintiffs request that this Court prohibit the Secretary from ruling otherwise because such a ruling would be an "action contrary to the provisions of" ERISA.

COUNT TWO
INJUNCTIVE RELIEF

106. Plaintiffs incorporate each of the foregoing paragraphs by reference as if they were fully set forth herein.

107. Pursuant to 29 U.S.C. §§ 1132(a)(3) and 1132(k), under Rule 65 of the Federal Rules of Civil Procedure, this Court may issue a preliminary and subsequent permanent injunction enjoining the Secretary from taking any action with respect to the AO Response while this case is pending, including posting the AO Response on its website (or removing it from said website if such posting has already occurred) or otherwise allowing the Secretary to take any action with

respect to the Plaintiffs on the basis of the belief that the Plan is not subject to ERISA until a final ruling from this Court.

108. Plaintiffs respectfully request the Court issue such injunction at the earliest possible time in order to prevent continuing and irreparable harm to Plaintiffs.

109. Plaintiffs further respectfully request the Court issue an injunction preventing the Secretary from taking action that is contrary to this Court's finding on the merits with respect to Count 1 of Plaintiffs' Complaint.

COUNT THREE
VIOLATIONS OF THE ADMINISTRATIVE PROCEDURE ACT ("APA")

110. The preceding allegations are all incorporated by reference herein as if fully set forth herein.

111. The APA provides a cause of action for persons suffering a legal wrong from – or adversely or aggrieved by – actions or inactions of an agency of the United States or officers thereof acting in an official capacity. 5 U.S.C. § 702.

112. The APA requires the federal courts to: (1) compel agency action unlawfully withheld or unreasonably delayed and (2) hold unlawful and set aside agency action, findings, and conclusions found to be contrary to any constitutional right, power, privilege, or immunity. 5 U.S.C. § 706.

113. The United States has waived its sovereign immunity pursuant to 5 U.S.C. § 702 in actions seeking relief other than money damages and stating a claim that an agency of the United States and/or officers thereof acted or failed to act in an official capacity.

114. DOL is an agency of the United States for purposes of the APA.

115. The AO Response is a final order. For this purpose, "order" means the "whole or a part of a final disposition, whether affirmative, negative, injunctive, or declaratory in form, of an

agency in a matter other than rule making…" See 5 U.S.C. § 551(6). Pursuant to ERISA Proc. 76-1, once DOL issues an order, it may not be withdrawn and it is binding on the parties to the order. Moreover, ERISA Proc. 76-1 does not provide for an administrative appeal.

116. The AO Response is arbitrary and capricious as, among other reasons, it:

a. Fails to follow DOL's own procedures set forth in ERISA Procedure 76-1 by omitting and, thus, not analyzing relevant applicable law;

b. Fails to cite to relevant law as required by the APA;

c. Is based on speculative and/or willfully misrepresented factual findings which violates ERISA Procedure 76-1 and the APA; and

d. Violates the APA by implying standards that are inconsistent with applicable law.

117. The AO Response is plainly contrary to the intent of Congress as expressed in ERISA and therefore, such action is not committed to agency discretion by law. 5 U.S.C. §701(a)(2).

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court:

a. Declare the limited partners of DMP are "employees" and "participants" in an ERISA covered employee welfare benefit plan;

b. Declare that the Plan and similar plans adopted by other partnerships managed by LPMS is subject to ERISA;

c. Declare that the Plan and similar plans adopted by other partnerships managed by LPMS are single-employer group health plans under ERISA;

d. Declare that the Plan and similar plans adopted by other partnerships managed by LPMS are not MEWAs as that term is defined under ERISA;

e. Declare that partners of DMP who meet the Plan's eligibility requirements and partners of other similarly situated partnerships managed by LPMS which have the same eligibility requirements for like plans are (i) "working owners" and "bona fide partners" and (ii) are permitted to participate in the Plan;

f. Declare that the AO Response is unlawful and, therefore, in the interest of judicial economy, DOL may not opine on or take any action whatsoever on the substance of the AO Response or enforcement of the AO Response but rather must await the final disposition of this action before taking any independent course of action;

g. Enjoin DOL and all its officers, employees, and agents, and anyone acting in concert with them, from implementing, applying, or taking any action that is contrary to the findings of this Court;

h. Declare the AO Response violated the Administrative Procedure Act;

i. Award Plaintiffs' costs, expenses, and reasonable attorneys' fees; and

j. Award such other relief as the Court deems just and proper.

Respectfully submitted,

TAYLOR ENGLISH DUMA LLP

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CERTIFICATE OF SERVICE

IT IS HEREBY CERTIFIED that service of the foregoing *First Amended Complaint for Declaratory and Injunctive Releif* was made, this 3rd day of February, 2020, by the Court's Case Management/Electronic Files system upon the attorneys for the parties.

Respectfully submitted this 3rd day of February, 2020.

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Counsel for Plaintiffs

November 8, 2018
Revised as of January 15, 2019
Revised as of February 28, 2019

Submitted Electronically via email

Joseph Canary
Director, Office of Regulations and Interpretations
U.S. Department of Labor
Employee Benefits Security Administration
Office of Regulations and Interpretations
200 Constitution Avenue, NW
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RE: Request for Advisory Opinion Concerning a Limited Partnership and Its Sponsorship of a Single-Employer Self-Insured Group Health Plan

Dear Director Canary:

The Law Office of Alexander Renfro ("Renfro") makes this request for consideration and possible issuance of an Advisory Opinion on behalf of our client, LP Management Services, LLC, a Georgia Limited Liability Company ("LPMS"). The primary business purpose of LPMS is to serve as General Partner of various Limited Partnerships and manage the day-to-day affairs of these Partnerships. At least one of these Limited Partnerships (the "LP") desires to sponsor an "employee welfare benefit plan" as defined under section 3(1) of the Employee Retirement Income Security Act ("ERISA"). The primary business purpose of LP is the aggregation and profitable sale of electronic user data from its partners. In addition to other inducements, including guaranteed payments, LP wishes to offer access to its group health plan as an inducement to attract, retain, and motivate partners. The plan will be organized as a single-employer self-insured group health plan that will provide major medical health benefits to LP's eligible employees, along with LP's limited partners. On behalf of LPMS, Renfro hereby seeks confirmation from the Department of Labor, Employee Benefits Security Administration (the "Department") that:

(1) The single-employer self-insured group health plan sponsored by LP is an "employee welfare benefit plan" within the meaning of ERISA section 3(1).

(2) The limited partners participating in LP's single-employer self-insured group health plan are "participants" within the meaning of ERISA section 3(7).

(3) The single-employer self-insured group health plan sponsored by LP is governed by Title I of ERISA.

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Renfro and LPMS recognize that any contemplated expansion of the traditional scope of ERISA, even if permissible under the existing statutes, may raise concerns at the Department as to the potential for plan failure(s), whether due to ill-conceived structure, inadequate (re)insurance reserves, fraud, or some combination of these and other factors. We share these concerns, and LPMS has established strong safeguards as a commitment to employees and partners – which are described in detail below – to address each partnership plan vulnerability both as to sponsorship and participation. LPMS anticipates that if the Department provides the confirmations requested above, it will do so in explicit consideration of all the specific facts and circumstances provided herein, and that neither LPMS nor any other ERISA plan sponsor will be able to rely upon a favorable Advisory Opinion letter unless all such safeguard standards are met or exceeded.

Further, while Renfro and LPMS have gone to considerable effort to foresee and guard against all possible causes of plan failure, we welcome input from the Department as to any additional areas of concern and solutions thereto. Such solutions could be incorporated into LP's manual of Standard Operating Procedures, as well into a further revision of this request (and any subsequent Advisory Opinion). Finally, we believe that while an Advisory Opinion is the appropriate first step toward defining allowable uses of partnerships as ERISA plan sponsors, it should perhaps be followed by informal Department guidance, and/or rulemaking in accordance with the Administrative Procedures Act, primarily in order to strengthen the enforceability of the safeguard requirements.

I. Background

A. Statement of Facts Concerning the Corporate Structure of LP

LP is a Limited Partnership duly registered and formed in the State of Georgia. LP's Partnership Agreement appoints LPMS as General Partner and delegates day-to-day business management decisions to LPMS, including but not limited to the execution of rental/office lease agreements, employment contracts, distribution of revenue producing agreements, and grantor decisions to form a group health plan. LP's Limited Partners ("LPartners") are individuals who have obtained a Limited Partnership Interest ("LPI") through the execution of a joinder agreement with LP. LPMS, as General Partner, correspondingly counter-executes such agreements, files a resolution on the addition of a new LPartner, and updates LP's partnership information to include the addition of a new LPartner. LPartners participate in global management issues through periodic votes of all Partners, as well as contribute time and service to revenue-generating activities of LP. Income distributions by LP to LPartners resulting from such revenue-generating activities will be reported as guaranteed payments and subject to employment taxes. Together, LPMS, as General Partner, and LPartners wholly control and operate LP.

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LP's primary business purpose and main source of revenue is the capture, segregation, aggregation, and sale to third-party marketing firms of electronic data generated by LPartners who share such data with LP. Participating LPartners install specific software which, among other things, tracks the capture of such data by other companies, such as Google or Facebook, and provides access of such data to LP. LP then decides how such data is used and sold to third-party marketing firms, generating revenue. LPartners control and manage the capture, segregation, aggregation, and sale of their own data, empowering LPartners in a manner not otherwise available to them when they utilize services over the Internet through their computers, phones, televisions, and other devices.

As discussed above, LPartners all gain status as a limited partner in LP by executing a joinder agreement, establishing each LPartner's rights. These rights are subsequently exercised on a regular basis through votes on how aggregated data will be sold or used by LP as well as votes on other partnership matters. Finally, through the sharing of data, LPartners are committing time and service to revenue-generating activity on behalf of LP. Income distributions by LP to LPartners resulting from such revenue-generating activities will be reported as guaranteed payments and subject to employment taxes.

LP also employs at least one common law employee to assist the partnership with administrative and/or revenue generating services.

B. Statement of Facts Concerning LP's Single-Employer Self-Insured Group Health Plan

In an effort to attract, retain, and motivate talent in service of LP's primary business purpose, LP will establish a single-employer self-insured group health plan (the "Plan"). The Plan will reflect the substantial commitment that LP is making to employees and LPartners. Since this Plan is formed and sponsored only by LP – and not in concert with any other employer – the Plan is a single-employer self-insured group health plan. LPMS, as the General Partner, serves as the Named Fiduciary and Plan Administrator of the Plan. LPMS intends to appoint an independent fiduciary to assist with fiduciary obligations and administration matters associated with the Plan.

The Plan has a number of third-party vendors which LPMS engages on behalf of LP to administer the Plan. First, LPMS hires a consulting and benefits design firm for guidance and assistance with fulfilling plan requirements pursuant to the ERISA and related statutes. Second, LPMS appoints a licensed and bonded Third Party Administrator ("TPA") to collect funds and allocate funds, adjudicate claims, manage claims appeals, execute the payment of claims for benefits under the Plan, and perform other traditional services performed by a TPA. Third, LPMS appoints a benefits administrator to assist its staff in managing eligibility data and plan participant customer service issues on an ongoing basis. Fourth, LPMS creates a Trust to hold any plan assets related to the Plan. Finally, LPMS obtains a reinsurance policy for the Plan. This reinsurance policy is of a comprehensive and specific nature, as described more fully below.

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The terms of the Plan are outlined in a Plan Document and are intended to comply with ERISA, including but not limited to, Parts 1, 4, 5, and 7. This Plan Document contains information on the benefits provided by the Plan to Plan participants, eligibility information, instructions on claims for benefits, claims appeals information, coordination of benefits provisions, disclaimers concerning certain federal statutes, and other information. With respect to eligibility, the Plan Document notes that both employees and partners are eligible to participate in the Plan. As discussed above, at least one common law employee participates in the Plan, as well as a number of LPartners, although not all LPartners participate in the Plan. LP will pay 100% of the premiums for coverage under the Plan for LP's employees. LPartners will be 100% responsible for paying their own premiums for coverage under the Plan. According to the enrollment procedures as outlined in the Plan Document, annual Open Enrollment periods, as well as Special Enrollment periods, as required by law, are utilized to permit eligible plan participants to join the Plan.

The aforementioned third-party vendors service the Plan as their delegated duties require. For example, the TPA collects monthly premium payments from the Plan's participants. The TPA allocates these funds appropriately, routing plan assets to the Trust (which is solely controlled by a Directed Trustee), paying vendors their fees, and ensuring premium payments are timely made to the reinsurance carrier underwriting the Plan's reinsurance policy. The TPA withholds a certain amount of premium due to the reinsurance carrier covering the Plan in order to expedite payment of claims for benefits. With respect to paying claims for benefits, in cases where the TPA has received and approved a claim, the TPA will access the plan assets held in Trust to pay said claim. Should a claim require a payment in excess of the funds available to the TPA on an immediate basis, the TPA coordinates with the reinsurance carrier covering the Plan for transmission of additional funds to the TPA's claims-paying account. Once received, the TPA will continue paying claims.

C. Additional Plan Features

LP is sensitive to prospective concerns with respect to the solvency of its Plan as well as the need for credibility of its Named Fiduciary. To that end, LP has made a substantial commitment to offer a reliable health plan including, but not limited to, offering health benefits backed by extremely well-funded layers of reinsurance policies, and LPMS – as General Partner and Named Fiduciary – has obtained a fiduciary liability policy in addition to the required fidelity insurance coverage under ERISA section 412. The intended hiring of an independent fiduciary provides yet another substantial level of protection of Plan participants.

With respect to the primary reinsurance policy covering the Plan, coverage is obtained from first-dollar and to an unlimited degree per the terms of the reinsurance policy. This policy is supported by multiple layers of retrocessionary coverage without a risk corridor by retrocessionaires with an excess of $7,000,000,000 in assets to cover risk with respect to the Plan. LPMS requires the following features of any policy it obtains to cover the Plan now or in the future:

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Any group health plan sponsored by LP, or by any other entity managed by LPMS and which offers ERISA plan participation to its eligible plan participants, including certain employees and partners, must first obtain Qualifying Reinsurance Coverage. "Qualifying Reinsurance Coverage" means excess/stop loss insurance, indemnity insurance for a self-insured plan or employee benefit trust, insurance for a self-insured plan or trust, or reinsurance coverage purchased from an excess/stop loss, indemnity, insurance, or reinsurance carrier that meets the following requirements:

- The carrier providing Qualifying Reinsurance Coverage must provide the following information to LPMS:
    - The name, address, and phone number of the carrier;
    - Statement(s) certifying compliance with all requirements described in below;
    - A statement of compliance with the reserve requirements described below;
    - A notification of any material changes to the Qualifying Reinsurance Coverage.

- The Qualifying Reinsurance Coverage:
    - Must (re)insure, without limitation, all benefits covered by the Group Health Plan which it (re)insures. Plan and Reinsurance coverage must be identical as to benefits and limitations.
    - May only be issued by a carrier which establishes and maintains retrocessionary coverage from one or more (re)insurer(s) with at least $100,000,000 in aggregate equity for any claims which the plan is unable to satisfy by reason of a solvency event affecting said carrier's ability to pay claims, to an unlimited degree;
    - Must note on any contract for coverage a definite starting or attachment point of such coverage which is conspicuous and clear to the plan member(s) prior to purchase of such coverage, and qualifying (re)insurance coverage issued on a non-stop loss (re)insurance basis must have a first-dollar starting point;
    - Must note on any contract for coverage an unlimited liability of the carrier issuing such coverage for benefits covered by such coverage which is conspicuous and clear to the plan member(s) prior to purchase of such coverage;
    - Must have been approved by one or more regulatory body or bodies duly authorized to license and regulate the business of insurance within the United States and/or a member of the National Association of Insurance

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Commissioners, for a minimum of twenty-four months, and been issued to at least one insured party for the direct and/or indirect coverage of health and/or medical benefits, and in force throughout said period;

- May only be issued by a carrier which establishes and maintains reserves with respect to covered benefits, in an amount recommended (or the mid-point of multiple recommendations) by an actuary certified by the American Academy of Actuaries, consisting of reserves sufficient for:

  - Unearned contributions;
  - Benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;
  - Any other obligations of the plan; and
  - A margin of error and other fluctuations, taking into account the specific circumstances of the plan.

- May only be issued by a carrier which establishes and maintains additional reserves of at least $500,000 above the reserves noted above.

- Carriers issuing Qualifying Reinsurance Coverage may demonstrate compliance with the reserve requirements described above with alternative reserves in the form of a contract of indemnification, lien, bonding, (re)insurance, letter of credit, or security.

- Any business of insurance, including but not limited to the obtaining of Qualified Reinsurance Coverage, conducted in any State must comply with the insurance laws of said State, and obtain all required State approvals.

II. Law and Analysis

A. Treatment of a Partner as an "Employee" Under ERISA

ERISA provides specific rules and regulations applicable to (1) an "employee welfare benefit plan," (2) "employees," and (3) "participants" that may participate in an "employee welfare benefit plan."

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An "employee welfare benefit plan" is defined as:[1]

> "any plan, fund, or program…established or maintained by an employer…for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits…"

An "employee" is defined as:[2]

> "an individual employed by an employer."

A "participant" is defined as:[3]

> "any employee or former employee of an employer…who is or may become eligible to receive a benefit…from an employee benefit plan which covers employees of such employer."

On its face and without further context provided elsewhere in ERISA, it appears that a partner in a partnership is not an "employee" within the meaning of ERISA section 3(6). Relying on the common law definition of an "employee," a partner also would not be considered an employee.[4] If a partner is not considered an "employee" for ERISA purposes, a partner cannot be considered a "participant" in an ERISA-covered "employee welfare benefit plan."

DOL Reg. section 2510.3-3(b) confirms that, for limited purposes, a partner is not considered an "employee" for purposes of determining the existence of an "employee benefit plan," which includes an "employee welfare benefit plan." DOL Reg. section 2510.3-3(b) further explains that a "plan without employees" is excluded from the requirements under Title I of ERISA (i.e., a plan covering partners is not considered an ERISA-covered plan).

Importantly, however, DOL Reg. section 2510.3-3(b) does *not* prohibit a partner from participating in a Title I ERISA-covered plan, *nor does* the regulation prohibit a partner from being considered an "employee" for ERISA purposes. There are multiple circumstances in which the Department – and the courts – have found that partners do have "employee" status.

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[1] Section 3(1) of the Employee Income Retirement Security Act ("ERISA").
[2] ERISA section 3(6).
[3] ERISA section 3(7).
[4] In accordance with the Supreme Court's ruling in *Nationwide Mutual Insurance Company v. Darden*, the Department has found that the common law standard for determining employee status is whether someone is hired by an employer, with the employer having the "right to control and direct" the individual's work. [*See* DOL Information Letter (May 8, 2006); DOL Advisory Opinion 95-29A (Dec. 7, 1995); DOL Advisory Opinion 95-22A (Aug. 25, 1995)].

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For example, the Department acknowledges that the U.S. Supreme Court in *Yates v. Hendon*[5] concluded that under ERISA, a "working owner" – which may include a partner – may have dual status (i.e., he or she can be an employee entitled to participate in a plan, and, at the same time, the employer (or owner or member of the employer) who established the plan).[6] The Department has also noted that section 401(c) of the Internal Revenue Code ("Code") treats partners (including owners of entities taxed as partnerships, such as limited liability companies) as employees of the partnership.[7]

In addition, according to ERISA section 732(d) – which is the only section of ERISA that contemplates partners participating in a group health plan – a "bona fide partner" is considered an "employee" for purposes of regulating a group health plan that covers partners. The regulations implementing ERISA section 732(d) provide that for purposes of treating a partner as an "employee" – and thus a "participant" in a group health plan subject to the requirements under Part 7 of ERISA – the "the term employee includes any bona fide partner."[8] The implementing regulations go on to state that "whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual *performs services on behalf of the partnership*."[9]

Although a bona fide partner is not further defined in ERISA or its implementing regulations, the term "bona fide partner" can be found elsewhere in Federal law, specifically in guidance from the Internal Revenue Service ("IRS").[10] According to the IRS, a bona fide partner is an individual with rights in a partnership, who exercises said rights, and who *commits time and energies in the conduct of the trade or business of the partnership*.[11] The consistency between the IRS's definition of a bona fide partner and the manner in which the Department described a bona fide partner in ERISA section 732(d) implementing regulations supports the interpretation that for purposes of ERISA, a partner should be defined as "an individual who commits time to and performs services on behalf of the partnership." Upon the satisfaction of this definition, the bona fide partner would be considered an "employee" for ERISA purposes.

LPMS believes that the LPartners satisfy the definition of a "bona fide partner." LPartners have actual rights in LP as dictated in both LP's Partnership Agreement and the joinder to said agreement signed by each LPartner. LPartners regularly exercise these rights in periodic votes on partnership business. Finally, LPartners contribute time and energies/services to LP by sharing data and assisting in LP's primary business purpose and revenue generation activity. The time and energies/services contributed by LPartners comprise the sole means of revenue generation of LP. In other words, without this activity, LP would not earn revenue or survive as an entity. By these acts,

[5] 541 U.S. 1 (2004).
[6] 83 Fed. Reg. 614, 621 (Jan. 5, 2018).
[7] *Id*.
[8] DOL Reg. section 2590.732(d)(2).
[9] *Id*.
[10] *See* Rev. Rul. 69-184.
[11] *Id*.

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LPartners meet both the IRS's and the Department's standards to qualify as bona fide partners, and thus, would be considered "employees" for ERISA purposes.

B. A Partner May Be a "Participant" In an ERISA-Covered Single-Employer Plan Alongside At Least One Common Law Employee

In line with the reasoning discussed above, the Department has concluded that a "working owner" – in particular, a partner – may have dual status as an "employer" and an "employee," and thus, permissibly be considered a "participant" in an ERISA-covered plan.[12] Specifically, the Department opined that ERISA section 402(a)(2), ERISA section 403(b)(3)(A), ERISA section 408, ERISA section 4001(b)(1), ERISA section 4021(b)(9), and ERISA section 4022(b)(5)(A) all serve as an indication that "working owners" – including partners – may be considered "participants" for purposes of ERISA coverage.[13] The Department has found that there is a clear Congressional design to include "working owners" – including partners – within the definition of "participant" for purposes of Title I of ERISA.[14]

The Department has also concluded that if a partner participates in an employee benefit plan along with at least one common law employee, DOL Reg. section 2510.3-3 does *not* exclude this plan from being covered by Title I of ERISA.[15] Specifically, the Department has found that a plan covering partners (who are considered "working owners") as well as their non-owner employees clearly falls within ERISA's scope.[16] The Department explained that "[t]he definition of 'plans without employees' in DOL Reg. section 2510.3-3(b) simply defines a limited circumstance in which the only parties participating in a benefit arrangement are an individual owner/partner…and declines to deem the individual[], in that limited circumstance, as [an] employee[]…for purpose of the regulation."[17] The Department explains further that DOL Reg. section 2510.3-3(b) "does not apply, however, outside that limited context and, accordingly, does not prevent sole proprietors or other working owners – [including partners] – from being participants in broader benefit plan arrangements…"[18]

The conclusion that partners can participate in an ERISA-covered plan where the plan also covers at least one common law employee is consistent with the finding of the courts. For example, the Supreme Court in *Yates v. Hendon*[19] found that a plan covering both a "working owner" – including a partner in a partnership – and at least one common law employee is governed by ERISA.[20]

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[12] DOL Adv. Op. 99-04A (Feb. 4, 1999).
[13] *Id*.; *see also*, 83 Fed. Reg. at 621 (Jan. 5, 2018) and 83 Fed. Reg. at 28930 (June 21, 2018).
[14] *Id*.
[15] 83 Fed. Reg. at 621 (Jan. 5, 2018).
[16] *Id*.
[17] *Id*.; *see also*, 83 Fed. Reg. 28912, 28930 (June 21, 2018).
[18] *Id*.
[19] 41 U.S. 1 (2004).
[20] *Id.* at 9.

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In other words, in cases where a benefit plan covers both partners and common law employees, the plan will be covered by Title I of ERISA.[21]

The Fifth Circuit Court of Appeals, in *House v. American United Life Insurance Company*,[22] also concluded that ERISA applies to a benefit arrangement that provided coverage to a firm's partners that also covered the firm's common law employees. In *House*, a partnership established a plan that provided disability benefits to both employees of the partnership, as well as the partners. The partnership – as the employer of the employees – paid 100% of the premiums for the disability coverage for its employees. The partners, on the other hand, were responsible for 100% of their own premium payments. The Circuit Court found that despite the differences in the manner in which premiums were paid, the partnership established a comprehensive employee welfare benefit plan covering both partners and employees, thus creating a single-employer ERISA-covered plan.[23]

LPMS believes *House* is particularly instructive because of its similarities to the facts described in Section I.B. above, where LPartners will be required to pay their own premiums for the self-insured group health plan coverage sponsored by LP, while LP will pay 100% of the premiums for eligible employees. Based on the conclusion in *House*, the Supreme Court in *Yates*, and the Department's interpretations as set forth in proposed and final regulations, it is clear that LPartners may permissibly be considered "participants" in an ERISA-covered plan where at least one common law employee participates in the plan.

Given the above guidance and precedent, it is also clear that the single-employer self-insured group health plan sponsored by LP – acting in the capacity of an employer – to provide major medical health benefits to LP's common law employees and limited partners is an "employee welfare benefit plan" within the meaning of ERISA section 3(1). As a result, because both LP's employees and LPartners may permissibly participate in this ERISA-covered "employee welfare benefit plan," the Plan would be governed by Title I of ERISA.

C. In Cases Where a Partner Receives Guaranteed Payments for Hours of Service Contributed to the Partnership, an Employment Relationship Exists Between the Partner and the Partnership

As discussed, the Department has concluded that (1) partners who qualify as "bona fide partners" are "employees" for ERISA purposes and (2) partners can participate in an ERISA-covered plan where the plan also covers at least one common law employee. An argument can be made, however, that a plan sponsored by a partnership that covers both partners and at least one common law

[21] *Id.*
[22] 499 F.3d 443 (5th Cir. 2007).
[23] *Id.* at 451-452.

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employee may not be considered an ERISA-covered plan if the partner-participants do not have some sort of employment relationship with the partnership sponsoring the plan.

In a traditional employment setting, an employer will have the right to direct and control employees, which results in a "common law" employer and employee relationship.[24] In this case, the employee is providing services directly to the employer. In the context of a partnership, however, this same "common law" principle may not apply. For example, in certain situations where a partnership exists, the partners of the partnership may merely hold an equity interest, whereby the partner may receive a distributive share without providing services directly for the partnership. However, there are other instances in which a partner of a partnership is indeed providing services directly for the partnership, which produces a "guaranteed payment" (i.e., earned income for services rendered).[25]

While partners earning distributive shares may have little connection to a partnership beyond equity ownership, partners earning guaranteed payments must be providing services directly to the partnership in the form of hours of service contributed by the partner to the partnership. Importantly, Congress intended partners who contributed hours of service to a partnership to pay employment taxes on the income derived from such services.[26] Distributive shares are distinguished from guaranteed payments based on whether they are paid with respect to hours of service contributed by the partner, which alters the tax treatment of such payments.[27]

Case law further supports the idea that partners contributing hours of service to a partnership have an employment connection to the partnership relative to a mere passive investor. For example, in *Renkemeyer, Campbell & Weaver LLP v. Commissioner*,[28] the Tax Court held that due to the contribution of hours of service by the partners, the income derived from such activity was self-employment income subject to employment taxes and deemed to be a guaranteed payment. The Tax Court explained that its decision was influenced by the fact that the partners made a nominal investment into the partnership, but nearly all of the income earned by the partnership was derived from hours of service contributed by its partners.[29] This contribution of hours of service fundamentally defined the relationship between the partners and partnership, evidenced by the tax treatment of income earned by the partners.

[24] *See e.g.*, *Nationwide Mutual Insurance Company v. Darden*, 503 U.S. 318 (1992).
[25] *See* section 707(c) of the Internal Revenue Code ("Code").
[26] *See* H. Rept. 95-702 (Part 1) at 11 (1977).
[27] *See* Code section 1402(a)(13).
[28] 136 T.C. 137 (2011).
[29] *Id*. at 139, 150.

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As previously noted, LP's business model is based on the generation, aggregation, and sale of data from its userbase of LPartners. LP cannot sustain operations or profitability without contributions of data from LPartners. Contributions of data are not achieved without work. Specifically, contributing data requires actively using devices or performing activities from which data can be generated. A leading media research firm – Nielsen – has found that the average American spends approximately 254 minutes per day on internet-based activity from which data can be generated, or 4 hours and 14 minutes of activity per day.[30]

An argument can be made that the value of this data may not be worth the hours of service taken to generate the data. However, the data demonstrably has value. The largest tech companies in the world would not exist otherwise. Based on the foregoing, LPMS believes it has demonstrated that there is a substantive service-related obligation by each LPartners, evidenced by the fact that income received for the hours of services provided to LP will be reported as guaranteed payments as that term is used in Code sections 707(c) and 1402(a)(13) which specifically address the taxation of limited partners. As such, the income will be subject to employment taxes. Under Code section 1402(b), self-employment income is subject to Social Security taxes and in other important ways is treated as *de facto wages*.[31] This tax treatment, of course, is the hallmark of services performed by an employee on behalf of an employer, thus proving that an employment relationship between LPartners and LP exists.

It is important to note that whether an entity is a "partnership" – and whether an individual is a "partner" – is governed by State law. Thus, if the State law definitions of "partnership" as well as "partner" are satisfied, satisfaction of these State law requirements should control the determination as to whether an employment relationship exists. As the Tax Court explained in *Renkemeyer,* States, not the Federal government, determine and then directly regulate these hybrid corporate structures. As a result, LPMS believes that the Department must defer to the States to determine the threshold question of whether an employment relationship exists. In the case of LP, the partnership structure satisfies the State laws in which health coverage offered through LP's single-employer self-insured plan will be offered. As a result, whether an employment relationship between LPartners and LP exists cannot and should not be questioned. State law already confirms that such a relationship exists.

[30] *See* https://www.nielsen.com/us/en/insights/news/2018/time-flies-us-adults-now-spend-nearly-half-a-day-interacting-with-media.print.html.

[31] While partners are considered to be self-employed, when those partners are providing services on behalf of a partnership and paid for those services by the partnership, there is no functional difference between this partner and a common-law employee providing services for which they receive income. In fact, both the employee and the partner are subject to Social Security taxes on the income received for providing services on behalf of the entity to which they are related. There is no tax policy reason and no reason under ERISA to treat partners, limited or otherwise, differently from common-law employees under these circumstances.

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D. Tax Considerations

The IRS has for decades maintained and enforced a clear set of regulations regarding tax treatment of partners in all health and welfare benefit plans, including group health plans. The Internal Revenue Code (the "Code") does not comment on the ability of a partner to participate in a group health plan. However, once a partner becomes a participant, the IRS treats that participant differently than common law employee participants. For the purpose of tax treatment, said partners are treated as independent contractors by the IRS. As previously explained, LPMS will report income distributed to LPartners for services performed on behalf of the partnership as guaranteed payments.

Withholding from guaranteed payments to pay premiums for a group health plan on a pre-tax basis is not possible for partners.[32] Thus, partners are not allowed to join a section 125 cafeteria plan in order to pay premiums in a group health plan on a pre-tax basis. A further consequence of this rule is that Health Savings Accounts ("HSAs"), which are typically offered through cafeteria plans, are also not available (with a meaningful tax benefit) to partners participating in a plan sponsored by their partnership. LPMS acknowledges these standards and does not seek special or separate tax treatment for its partners. Inasmuch as LP does not pay wages to its partners, no pre-tax payment of premium could be available to partners participating in LP's plan. Finally, LP does not sponsor and does not plan to sponsor either a cafeteria plan or an HSA.

While the benefit of pre-tax payments of premium is not available to partners, such payments could under certain limited circumstances be deductible as an ordinary and necessary business expense.[33] The Code provides that if a partner qualifies as a working owner with earned income, said partner may deduct the cost of premiums for a group health plan against their earned income from the same source that sponsors said group health plan.[34] This regime both acknowledges that a plan sponsor of a group health plan may have participants who are partners and that a limited scope deduction should be available in said circumstances. With respect to LP's plan, as with any other partnership, this deduction would only be available if LP distributed income to partners participating in LP's plan which was then used to pay for premiums from LP's plan. (In the event that LP distributed funds to a partner insufficient to pay said partner's premium, any deduction would be limited to the amount distributed). LPMS is not seeking special or separate treatment with respect to this deduction. Other rules and limitations also apply and are acknowledged.[35]

[32] *See* Code section 125(d)(1)(A).
[33] *See* Code section 162(l).
[34] *Id*.
[35] *See* Code section 162(l)(2-5). *See also* 83 Fed. Reg. 28912, 28932 (June 21, 2018) (Where the Department noted in the preamble that deductibility under Code section 162(l) "informed" its view in support of establishing it regulatory framework for owner-employees.)

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The IRS has comprehensive, existing rules in place with respect to partners participating in a group health plan, within which LP's plan is regulated in similar fashion to any other partnership. No special treatment or extralegal tax benefit is sought by or available to partners participating in LP's plan.

III. Request for Determination

Based on the foregoing, Renfro respectfully asks that the Department to confirm that:

(1) The single-employer self-insured group health plan sponsored by LP is an "employee welfare benefit plan" within the meaning of ERISA section 3(1).

(2) LPartners participating in LP's single-employer self-insured group health plan are "participants" within the meaning of ERISA section 3(7).

(3) The single-employer self-insured group health plan sponsored by LP is governed by Title I of ERISA.

Thank you in advance for considering this request. Please do not hesitate to contact me with any questions, or with any request for additional information.

Respectfully submitted,

Alexander Renfro

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Employee Benefits Security Administration
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January 24, 2020

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2020-01A
ERISA SEC.
3(1)
29 CFR 2510.3-3

Dear Mr. Renfro:

This is in response to your request on behalf of LP Management Services, LLC (LP Management), for the Department's views on the regulatory status under the Employee Retirement Income Security Act of 1974 (ERISA) of health benefit programs that the LP Management limited partnerships may choose to offer to their "limited partners." In particular, you ask whether the Department would consider LP Management's limited partnership programs to be employee welfare benefit plans within the meaning of section 3(1) of ERISA, and, if so, whether the arrangements constitute single-employer group health plans sponsored by the limited partnerships as an "employer."

After submitting your request, you filed a complaint for declaratory and injunctive relief against the Department in *Data Marketing Partnership, LP v. United States Department of Labor,* Civil Case No.4:19-cv-00800-O United States District Court for Northern District of Texas (filed October 4, 2019). The complaint included allegations regarding a currently operating limited partnership program. The summary of facts and representations in this letter is based on the materials you submitted in support of your request as well as the information alleged in the complaint.[1]

As discussed in more detail below, ERISA does not sweep so broadly as to regulate the commercial sale of insurance in the manner proposed by LP Management. ERISA regulates the provision of *employee* benefits by employers and employee organizations, not the commercial sale of insurance outside the context of employment-based relationships. Based on your representations, in the Department's view, the limited partners as described in your request are not employees or bona fide partners of the limited partnerships; they do not work for or through the partnership; and they do not receive income for performing services for or as partners of the partnership. In sum, you have provided no facts that would support a conclusion that the limited

[1] The summary does not include representations you provided about the financial and reinsurance safeguards adopted by the limited partnership, *e.g.*, use of a licensed and bonded third party administrator, reinsurance supported by retrocessionary coverage, and a trust to hold plan assets, because those representations and allegations were not relevant to the Department's decision on the foundational question you posed about the status of the limited partnership health coverage program under the definition of "employee welfare benefit plan" in section 3(1) of ERISA.

partners are meaningfully employed by the partnership or perform any services on its behalf. The purported and sole "service" that the limited partners would appear to perform for or through the partnership would be to install specific software on their personal electronic devices that capture data as they browse the Internet or use those devices for their own purposes. If LP Management's arguments were accepted, marketers could sell any health insurance package as a single ERISA-covered plan, as long as their buyers had smartphones, the contract papers included "limited partnership" provisions, and the customers assented to the installation of tracking software (much as numerous firms, such as internet browsers and social media companies, already track consumers' activities on the Internet without claiming that the tracked consumers work for them). Accordingly, in the Department's view the limited partners are not participants in a single-employer group health plan or in an ERISA plan at all.[2]

According to the information you submitted and the representations you made in support of your request, LP Management proposes to serve as general partner of various limited partnerships and manage the day-to-day affairs of these partnerships. The limited partnerships' business would be to capture, segregate, aggregate, and sell to third-party marketing firms, electronic data generated by individuals who become limited partners and install on their personal electronic devices specific software which, among other things, captures the data tracking of other companies as the individual partners use their devices and surf the Internet. LP Management represents that individuals would obtain a limited partnership interest by executing a joinder agreement with LP Management, which would serve as the general partner. You assert that limited partners would participate in global management issues through periodic votes of all partners, but you provided no information on such votes. You assert that each limited partner agrees to contribute more than five hundred (500) hours of "work" per year through the generation, transmission, and sharing of their data, but you provide no information on how that "work" differs in any meaningful way from the personal activities individual limited partners would otherwise engage in while using their personal devices. Neither you nor LP Management representatives have suggested that individual limited partners will have any meaningful equity interest in the limited partnership or that they can expect any appreciable financial benefit for their participation in the partnership, except for the health coverage for which the limited partners pay separate premiums.

Apart from permitting LP Management to track the use of their personal electronic devices, it does not appear that the limited partners perform any work for or through the partnership. According to the representations you have provided in support of your request, limited partners do not appear to report to any assigned "work" location or otherwise notify the partnership that they are commencing their work; and they are not required to possess any particular work-related skills. In fact, the limited partnership agreement does not appear to require that a limited partner perform any service for or through the partnership apart from permitting tracking of the limited partner's use of the Internet on a personal device, as the limited partner sees fit. It appears that the limited partners would generate economic value for the partnership in much the same way that visitors to websites generate value for the entities that track consumer traffic every day for marketing and advertising purposes. In our view, there is no employer-employee relationship between the partnership and the limited partners, and as a matter of economic reality, it does not

[2] Requestors of advisory opinions may withdraw requests only "prior to receipt of notice that the Department intends to issue an adverse opinion[.]" ERISA Procedure 76-1, §9, 41 Fed. Reg. 36281, 36283 (Aug. 27, 1976). Because you received such notice, the request may not be withdrawn.

appear that the limited partners depend on the limited partnership as a source of business revenue. Indeed, it appears from your representations that the revenue that a limited partner could reasonably expect from the limited partnership will typically be approximately zero. Based on the representations and materials that you have provided, in operation, the primary reason for an individual or employer to participate as a "limited partner" in the arrangement appears to be to acquire health coverage.

Notwithstanding the absence of factual representations supporting an actual employment or working owner relationship between the individuals participating in the arrangement as limited partners and the limited partnerships, you argue that the limited partnership health benefit programs should be deemed to be single-employer plans because the partnership itself would have a small number of common law employees (possibly only one, as compared to thousands or tens of thousands of non-employee limited partners who could potentially acquire coverage through the arrangement). You argue that the presence of a single employee participant is sufficient to extend ERISA coverage to all the limited partners, without any stated limit.

This position cannot be squared with ERISA's text. The term "employee welfare benefit plan" is defined in section 3(1) of ERISA, in relevant part, as "any plan, fund, or program … established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise … medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment …." In addition to providing the types of benefits described in section 3(1) of ERISA, a benefit program must, among other criteria, be established or maintained by an employer, an employee organization, or both, to provide the specified benefits to participants or their beneficiaries to be treated as an "employee welfare benefit plan" within the meaning of ERISA.[3] Section 3(7) of Title I of ERISA, in turn, provides, in relevant part, that a "participant" is any employee or former employee of an employer who is or may become eligible to receive a benefit of any type from an employee benefit plan that covers employees of such employer.

These provisions, like the title of the law itself — the *Employee* Retirement Income Security Act (emphasis added) — are replete with references to the employment relationship, and ERISA's coverage expressly turns on the provision of benefits in the employment context. As the above quoted language demonstrates, ERISA covers *employee* welfare benefit plans sponsored by an *employer* or *employee* organization for the benefit of plan participants who are themselves *employees* or former *employees*. The arrangements proposed by LP Management meet none of these criteria, inasmuch as the partnership is not the limited partners' employer, and the partners are neither employees nor employers with respect to the partnership.

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[3] There is no indication that an employee organization within the meaning of section 3(4) of ERISA is involved in the limited partnerships or their health benefit programs. Section 3(4) of ERISA defines "employee organization" as "any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan."

Nevertheless, LP Management points to ERISA regulation at 29 CFR § 2510.3-3(b), which, in relevant part, states:

> **(b) Plans without employees.** For purposes of title I of the Act and this chapter, the term "employee benefit plan" shall not include any plan, fund or program, other than an apprenticeship or other training program, under which no employees are participants covered under the plan, as defined in paragraph (d) of this section. For example, a so-called "Keogh" or "H.R. 10" plan under which only partners or only a sole proprietor are participants covered under the plan will not be covered under title I. However, a Keogh plan under which one or more common law employees, in addition to the self-employed individuals, are participants covered under the plan, will be covered under title I.

You argue, by implication, that the limited partnership benefit program can be treated as a single ERISA-covered plan because it would cover at least one common law employee of the partnership itself, and therefore, fall outside the exclusion for "plans without employees," even if its predominant purpose is to provide health benefits to individuals who are not employees of the partnership, do not look to the partnership for work-based earnings, and are classified by the sponsor as "limited partners"—and even if the single common law employee is outnumbered by thousands or tens of thousands of "limited partners" who obtain health coverage through the arrangement.

The text of the regulation will not support your expansive claim of ERISA coverage. As discussed above, ERISA regulates employment-based benefit programs and 29 CFR 2510.3-3(b) must be read in that context. The fact that one common law employee participates in a purported partnership program does not mean that everyone covered by the arrangement is participating in an ERISA plan. Rather, the regulation must be read in light of the Department's authority under ERISA to regulate the provision of employee benefits offered in the context of a genuine employment relationship. *See*, for example, ERISA sections 3(1) and 3(4) (limiting coverage to plans maintained by employers or employee organizations), section 3(7) (defining participant in terms of an employment relationship), and section 2 (declaring ERISA's purpose as "in the interests of employees and their beneficiaries"). Consistent with these statutory limitations, limited partners must participate in the plan as "working owners" to be covered as plan participants within the meaning of Title I of ERISA. The limited partners here are neither employed nor self-employed with respect to the partnership, but rather are merely consumers purchasing health coverage in exchange for premiums and an agreement that the partnership can track their personal activities on their electronic devices.

You additionally argue that ERISA section 732(d) supports LP Management's position, but this argument too is unpersuasive. Section 732(d) provides "for purposes of this part," [*i.e.*, Part 7 of ERISA] that "[a]ny plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (2)) as an employee welfare

benefit plan which is a group health plan."[4] Paragraphs (2) and (3) provide that, in the case of a group health plan, the term "employer" also includes the partnership in relation to any partner and the term "participant" also includes, in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership.

The regulations emphasize the need for an employment or self-employment services-based relationship with respect to the partners participating in a group health plan maintained by a partnership. Specifically, the regulations clarify that, for purposes of Part 7 of ERISA, a partner must be a "bona fide partner" in order to be considered an employee, and the partnership is considered the employer of a partner only if the partner is a "bona fide partner." 29 CFR 2590.732(d)(2), (d)(3). The regulation also states that whether an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership. *Id.*

The limited partners here are not "bona fide partners" within the meaning of ERISA section 732 because they do not work or perform services for the partnership; they have only a nominal (at best) ownership interest in the partnership; and they do not earn income based on work performed for or through the partnership that is a material income-producing factor for the partnership. If the limited partners worked for or through the partnership, had a material ownership interest in the partnership, and earned income for work that generated material income for the partnership, it would be plausible to treat them as employed by the partnership in the relevant sense. In such circumstances, the partners could have dual status, like self-employed individuals who earn income from their self-employment with respect to a group health plan (*i.e.*, the partner could be both an "employer" for purposes of the partnership's sponsoring the group health plan and an "employee" for purposes of participating in the partnership's group health plan).

As discussed above, however, the limited partners in the arrangement merely obtain health benefits through the partnership and permit it to capture data based on their personal use of their personal devices. Their nominal ownership interests do not appear to have economic or operational substance; they do not appear to perform labor for the partnership in any meaningful sense; there is no basis to conclude the limited partners will derive any income from the partnership for the performance of services; and the limited partners neither give nor take directions in a work context from the partnership. They are simply purchasers of health coverage who, like other purchasers of individual health insurance, are responsible for paying all of the health care premiums for their coverage under the limited partnership arrangement. To treat them as employee participants in an ERISA-covered plan would effectively read the employment-based limitations on ERISA coverage out of the statute. As noted at the beginning of this letter, any marketer could claim coverage of any arrangement as a single ERISA-covered plan, as long as the buyer had a smartphone, signed a "limited partnership" agreement, and was willing to permit the marketer to track the buyer's activities on the phone (just as numerous firms already track a buyer's activities on the Internet, without claiming any employment relationship).

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[4] The Department's regulation at 29 CFR 2590.732 expressly states that its provisions on the treatment of partnerships are "[f]or purposes of this part." The parallel Department of Health and Human Services regulation at 45 CFR 146.145(c) and the Department of the Treasury regulation at 26 CFR 54.9831–1 similarly limit the application of those provisions for purposes of certain requirements applicable to group health plans.

Such a reading and result is insupportable under the clear employment-based language of the statute.

For the foregoing reasons, and based on your representations, information in the complaint you filed against the Department, and the materials we reviewed, it is the Department's view that the proposed LP Management health benefit programs would not be single-employer group health plans or ERISA plans at all.[5] To the contrary, treating the limited partnership program as a single ERISA plan would effectively eliminate ERISA's important statutory distinction between offering and maintaining employment-based ERISA covered plans, on the one hand, and the mere marketing of insurance and benefits to individuals outside the employment context, on the other.[6] We have consulted with the Departments of Health and Human Services and the Treasury. They have advised the Department that other than to the extent that the LP Management has established a separate welfare plan for the partnership's common law employees, the limited partnership programs described by LP Management would not be a group health plan within the meaning of 45 CFR 146.145(a) or 26 CFR 54.9831–1, and thus, the limited partnership programs would generally be subject to regulations applicable to the individual market, and not the small or large group markets.

This letter constitutes an advisory opinion under ERISA Procedure 76-1. Accordingly, it is issued subject to the provisions of that procedure, including section 10 thereof, relating to the effect of advisory opinions. This opinion relates solely to the application of the provisions of Title I of ERISA addressed in this letter. Further, this letter is not determinative of any particular tax treatment under the Internal Revenue Code and does not address any issues arising under any other federal or state laws.

Sincerely,

John J. Canary
Director, Office of Regulations and Interpretations

[5] To the extent the limited partnership program covers common law employees of the partnership, the Department would consider the limited partnership to have established a separate welfare benefit plan for those employees. That plan would be subject to ERISA, and the persons responsible for operating the plan would be subject to the reporting, disclosure, fiduciary, group health, and enforcement provisions in Parts 1, 4, 5, 6, and 7 of ERISA.

[6] You did not ask and this letter does not address the status of the limited partnership programs as multiple employer welfare arrangements (MEWAs) within the meaning of ERISA section 3(40). In light of our conclusion that the programs are not ERISA-covered plans, the programs would be subject to broad state insurance regulation regardless of whether they were multiple employer welfare arrangements (MEWAs) within the meaning of ERISA section 3(40) and ERISA section 514(b)(6).

State of Louisiana
DEPARTMENT OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL
P.O. BOX 94005
BATON ROUGE
70804-9005

Jeff Landry
Attorney General

February 21, 2019

The Honorable Alexander Acosta
Secretary of Labor
200 Constitution Ave. NW
Washington, DC 20210
executivesecretariat@dol.gov

Dear Mr. Secretary:

We, the undersigned Attorneys General of Louisiana, Arkansas, Georgia, Indiana, Nebraska, S. Carolina, and Texas, have recently become aware of a request for an Advisory Opinion ("AO") made to the Department of Labor ("DOL") on behalf of LP Management Services, L.L.C.

We are interested in this request and encourage the DOL to respond as soon as possible. The AO sought by LP Management Services provides an alternative for expanded access to ERISA plans. We support the intent behind the request and find its legal arguments well-reasoned and thorough, but interpretation and enforcement of ERISA falls under the exclusive authority of the DOL Guidance from DOL would, nevertheless, provide much needed direction to states assessing applicability of their own insurance regulations in similar circumstances. States would retain meaningful regulatory oversight, because so long as the McCarran Ferguson Act of 1945 remains law, states will have primary authority over insurance business conducted within their borders. We do not seek or support repeal of McCarran Ferguson, inasmuch as ERISA-subject plans have worked well alongside it for more than forty years.

We have a strong interest in the DOL's response to the AO request for three principal reasons:

- More than fifteen million Americans who are self-employed or work for small businesses and earn too much to qualify for Patient Protection and Affordable Care Act ("ACA," or "Obamacare") subsidies are currently uninsured or under-insured due to the unavailability of affordable coverage. The considerable efforts by the Administration to bring relief to these people have thus far been of limited effect, primarily due to the actions of obstructionist states.

- An AO confirming the validity of the structure described in the request would add much-needed health coverage options for these hard-working Americans, and would not negatively impact anyone. No plan offered in reliance on the proposed AO could discriminate against people with pre-existing conditions or fail to offer dependent coverage through age 26. Although some (likely including the plaintiffs in the anti-AHP suit) will claim that anything which provides an alternative to ACA is a threat to those people who have benefitted from it, we strongly disagree. Younger, healthier people who pay for their own health coverage cannot be "lured away" from ACA because they have already left -- by the millions. And people whose combination of health and economic status make them ACA "winners" will continue to enjoy its protections and subsidies, unless and until Congress passes an alternative.

- Because the demand for affordable health coverage is so acute, many non-ACA "solutions" have already appeared in the nationwide marketplace. We put "solutions" in quotes, because we believe many of these alternatives are ill-conceived, underfunded, and in some cases constitute outright consumer fraud. The bulk of LP Management's AO request is not spent asking the DOL to relax its regulatory authority. To the contrary, asks the DOL to establish solvency and fiduciary requirements where none currently exist for ERISA-subject plans and makes specific recommendations for these protections. With such specific requirements in place, the DOL and state Departments of Insurance could focus their resources on needed enforcement actions against ill-funded plans and bad actors. Safe harbor guidelines for solvency and fiduciary requirements will also encourage more reputable and financially-stable companies to enter the expanded ERISA market - which will in turn increase competition and choice, and drive down costs.

We believe a timely and favorable response to the AO request could provide a valuable and much-needed alternative for those citizens adversely impacted by the ACA. While providing government-paid health care to certain citizens, Obamacare stripped away coverage from many millions of working Americans who formerly paid for their own health insurance but can no longer afford it due to ACA-driven premium increases in excess of 200%. We attach for your reference a recent opinion column written by former New York Lieutenant Governor Betsy McCaughey, which concisely articulates this dilemma as well as the hurdles faced by those of us who are trying to do something about it.

In the absence of legislative solutions to this crisis, various other measures have become necessary. Ours are among the twenty states that joined as plaintiffs in *Texas, et al. v. United States, et al.*, and we were very gratified by the recent ruling by District Judge Reed O'Connor in the Northern District of Texas finding that ACA is unconstitutional. It is our hope and expectation that this decision will be upheld. Congress will thus be compelled to find a solution which, while preserving some of the positive aspects of ACA (including protections for people with pre-existing

medical conditions), will once again allow self-employed middle-class Americans to access quality, affordable health coverage.

But Judge O'Connor's ruling has been appealed, and appeals take time. It could take years for the case to run its course. For this reasons and others, we find it unlikely that a constructive and successful ACA replacement process can take place in Congress sooner than 2021. We must therefore continue to search for interim solutions.

We strongly supported the October 2017 Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States and the regulatory actions that followed. We were particularly encouraged by the DOL's Rule expanding access to Association Health Plans (AHPs) because ERISA-subject plans are proven solutions that have largely spared more than 160 million Americans from the negative impacts of ACA. But we were disappointed when twelve of our fellow Attorneys General sued the DOL seeking to block the AHP Rule, despite the great deference shown in it to the individual states as to how - and whether - they may allow AHP expansion in each of their jurisdictions. It is apparently not enough for these states to block AHP expansion within their own borders; they seek to prevent all other states, including ours, from accessing solutions to a problem that no one can deny exists.

Based upon the questions and comments from Judge Bates at the January 24 hearing, along with the determination of the plaintiffs to accept nothing less than complete rescission of AHP expansion, it appears likely that the DOL will be forced to continue defending the Rule for some time. Our states include those that filed an *amicus* brief in support of the DOL, and we will encourage additional Attorneys General to join us in subsequent actions.

Thank you for your consideration.

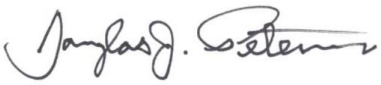
Respectfully yours,

Jeff Landry
Louisiana Attorney General

Chris Carr
Georgia Attorney General

Leslie Rutledge
Arkansas Attorney General

Curtis T. Hill, Jr.
Indiana Attorney General



Doug Peterson
Nebraska Attorney General

Ken Paxton
Texas Attorney General

Alan Wilson
South Carolina Attorney General

Attachments:

- LP Management Services LLC Advisory Opinion Request, 1/15/2019
- Betsy McCaughey, "Democrats Are Waging War Against Affordable Health Insurance," 12/18/2018 New York Post

November 8, 2018
Revised as of January 15, 2019

Submitted Electronically via email

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

RE: Request for Advisory Opinion Concerning a Limited Partnership and Its Sponsorship of a Single-Employer Self-Insured Group Health Plan

Dear Director Canary:

The Law Office of Alexander Renfro ("Renfro") makes this request for consideration and possible issuance of an Advisory Opinion on behalf of our client, LP Management Services, LLC, a Georgia Limited Liability Company ("LPMS"). The primary business purpose of LPMS is to serve as General Partner of various Limited Partnerships and manage the day-to-day affairs of these Partnerships. At least one of these Limited Partnerships (the "LP") desires to sponsor an "employee welfare benefit plan" as defined under section 3(1) of the Employee Retirement Income Security Act ("ERISA"). The plan will be organized as a single-employer self-insured group health plan that will provide major medical health benefits to LP's eligible employees, along with LP's limited partners. On behalf of LP, Renfro hereby seeks confirmation from the Department of Labor, Employee Benefits Security Administration (the "Department") that:

(1) The single-employer self-insured group health plan sponsored by LP is an "employee welfare benefit plan" within the meaning of ERISA section 3(1).

(2) The limited partners participating in LP's single-employer self-insured group health plan are "participants" within the meaning of ERISA section 3(7).

(3) The single-employer self-insured group health plan sponsored by LP is governed by Title I of ERISA.

Renfro and LP recognize that any contemplated expansion of the traditional scope of ERISA, even if permissible under the existing statutes, may raise concerns at the Department as to the potential for plan failure(s), whether due to ill-conceived structure, inadequate (re)insurance reserves,

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fraud, or some combination of these and other factors. We share these concerns, and LP has strong safeguards - which are described in detail below - in place to address each partnership plan vulnerability. LP anticipates that if the Department provides the confirmations requested above, it will do so in explicit consideration of all the specific facts and circumstances provided herein, and that neither LP nor any other ERISA plan sponsor will be able to rely upon a favorable Advisory Opinion unless all such safeguard standards are met or exceeded.

Further, while Renfro and LP have gone to considerable effort to foresee and guard against all possible causes of plan failure, we welcome input from the Department as to any additional areas of concern and solutions thereto. Such solutions could be incorporated into LP's manual of Standard Operating Procedures, as well into a further revision of this request (and any subsequent Advisory Opinion). Finally, we believe that while an Advisory Opinion is the appropriate first step toward defining allowable uses of partnerships as ERISA plan sponsors, it should perhaps be followed by informal Department guidance, and/or rulemaking in accordance with the Administrative Procedures Act, primarily in order to strengthen the enforceability of the safeguard requirements.

I. Background

A. Statement of Facts Concerning Corporate Structure of LP

LP is a Limited Partnership duly registered and formed in the State of Georgia. LP's Partnership Agreement appoints LPMS as General Partner and delegates day-to-day business management decisions to LPMS, including but not limited to the execution of rental agreements, employment contracts, distribution of revenue producing agreements, and grantor decisions to form a group health plan. LP's Limited Partners ("LPartners") are individuals who have obtained a Limited Partnership Interest ("LPI") through the execution of a joinder agreement with LP. LPMS, as General Partner, correspondingly counter-executes such agreements, files a resolution on the addition of a new LPartner, and updates LP's partnership information to include the addition of a new LPartner. LPartners participate in global management issues through periodic votes of all Partners, as well as contribute time and service to revenue-generating activities of LP. Together, LPMS, as General Partner, and LPartners wholly control and operate LP.

LP's primary business purpose and main source of revenue is the capture, segregation, aggregation, and sale to third-party marketing firms of electronic data generated by LPartners who share such data with LP. Participating LPartners install specific software which, among other things, tracks the capture of such data by other companies, such as Google or Facebook, and provides access of such data to LP. LP then decides how such data is used and sold to third-party marketing firms, generating revenue. LPartners control and manage the capture, segregation, aggregation, and sale of

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their own data, empowering LPartners in a manner not otherwise available to them when they utilize services over the Internet through their computers, phones, televisions, and other devices.

As discussed above, LPartners all gain status as a limited partner in LP by executing a joinder agreement, establishing each LPartner's rights. These rights are subsequently exercised on a regular basis through votes on how aggregated data will be sold or used by LP as well as votes on other partnership matters. Finally, through the sharing of data, LPartners are committing time and service to revenue-generating activity on behalf of LP.

LP also employs at least one common law employee to assist the partnership with administrative and/or revenue generating services.

B. Statement of Facts Concerning LP's Single-Employer Self-Insured Group Health Plan

In an effort to attract, retain, and motivate talent in service of LP's primary business purpose, LP will establish a single-employer self-insured group health plan (the "Plan"). Since this Plan is formed and sponsored only by LP – and not in concert with any other employer – the Plan is a single-employer self-insured group health plan. LPMS, as the General Partner, serves as the Named Fiduciary and Plan Administrator of the Plan.

The Plan has a number of third-party vendors which LPMS engages on behalf of LP to administer the Plan. First, LPMS hires a consulting and benefits design firm for guidance and assistance with fulfilling plan requirements pursuant to the ERISA and related statutes. Second, LPMS appoints a licensed and bonded Third Party Administrator ("TPA") to collect funds and allocate funds, adjudicate claims, manage claims' appeals, execute the payment of claims for benefits under the Plan, and perform other traditional services performed by a TPA. Third, LPMS appoints a benefits administrator to assist its staff in managing eligibility data and plan participant customer service issues on an ongoing basis. Fourth, LPMS creates a Trust to hold any plan assets related to the Plan. Finally, LPMS obtains a reinsurance policy for the Plan. This reinsurance policy is of a comprehensive and specific nature, as described more fully below.

The terms of the Plan are outlined in a Plan Document. This Plan Document contains information on the benefits provided by the Plan to Plan participants, eligibility information, instructions on claims for benefits, claims appeals information, coordination of benefits provisions, disclaimers concerning certain federal statutes, and other information. With respect to eligibility, the Plan Document notes that both employees and partners are eligible to participate in the Plan. As discussed above, at least one common law employee participates in the Plan, as well as a number of LPartners, although not all LPartners participate in the Plan. LP will pay 100% of the premiums for coverage under the Plan for LP's employees. LPartners will be 100% responsible for paying their own premiums for coverage under the Plan. According to the enrollment procedures as outlined in the Plan

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Document, annual Open Enrollment periods, as well as Special Enrollment periods as required by law, are utilized to permit eligible plan participants to join the Plan.

The aforementioned third-party vendors service the Plan as their delegated duties require. For example, the TPA collects monthly premium payments from the Plan's participants. The TPA allocates these funds appropriately, routing plan assets to the Trust (which is solely controlled by a Directed Trustee), paying vendors their fees, and ensuring premium payments are timely made to the reinsurance carrier underwriting the Plan's reinsurance policy. The TPA withholds a certain amount of premium due to the reinsurance carrier covering the Plan in order to expedite payment of claims for benefits. With respect to paying claims for benefits, in cases where the TPA has received and approved a claim, the TPA will access the plan assets held in Trust to pay said claim. Should a claim require a payment in excess of the funds available to the TPA on an immediate basis, the TPA coordinates with the reinsurance carrier covering the Plan for transmission of additional funds to the TPA's claims-paying account. Once received, the TPA will continue paying claims.

C. Additional Plan Features

LP is sensitive to prospective concerns with respect to the solvency of its Plan as well as the need for credibility of its Named Fiduciary. To that end, LP has obtained comprehensive and extremely well-funded layers of reinsurance policies, and LPMS – as General Partner and Named Fiduciary – has obtained a fiduciary liability policy.

With respect to the primary reinsurance policy covering the Plan, coverage is obtained from first-dollar and to an unlimited degree per the terms of the reinsurance policy. This policy is supported by multiple layers of retrocessionary coverage without a risk corridor by retrocessionaires with an excess of $7,000,000,000 in assets to cover risk with respect to the Plan. LPMS requires the following features of any policy it obtains to cover the Plan now or in the future:

> Any group health plan sponsored by LP, or by any other entity managed by LPMS and which offers ERISA plan participation to its eligible plan participants, including certain employees and partners, must first obtain Qualifying Reinsurance Coverage. "Qualifying Reinsurance Coverage" means excess/stop loss insurance, indemnity insurance for a self-insured plan or employee benefit trust, insurance for a self-insured plan or trust, or reinsurance coverage purchased from an excess/stop loss, indemnity, insurance, or reinsurance carrier that meets the following requirements:
>
> - The carrier providing Qualifying Reinsurance Coverage must provide the following information to LPMS:
>
> - The name, address, and phone number of the carrier;

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- Statement(s) certifying compliance with all requirements described in below;
- A statement of compliance with the reserve requirements described below;
- A notification of any material changes to the Qualifying Reinsurance Coverage.

- The Qualifying Reinsurance Coverage:

  - Must (re)insure, without limitation, all benefits covered by the Group Health Plan which it (re)insures. Plan and Reinsurance coverage must be identical as to benefits and limitations.
  - May only be issued by a carrier which establishes and maintains retrocessionary coverage from one or more (re)insurer(s) with at least $100,000,000 in aggregate equity for any claims which the plan is unable to satisfy by reason of a solvency event affecting said carrier's ability to pay claims, to an unlimited degree;
  - Must note on any contract for coverage a definite starting or attachment point of such coverage which is conspicuous and clear to the plan member(s) prior to purchase of such coverage, and qualifying (re)insurance coverage issued on a non-stop loss (re)insurance basis must have a first-dollar starting point;
  - Must note on any contract for coverage an unlimited liability of the carrier issuing such coverage for benefits covered by such coverage which is conspicuous and clear to the plan member(s) prior to purchase of such coverage;
  - Must have been approved by one or more regulatory body or bodies duly authorized to license and regulate the business of insurance within the United States and/or a member of the National Association of Insurance Commissioners, for a minimum of twenty-four months, and been issued to at least one insured party for the direct and/or indirect coverage of health and/or medical benefits, and in force throughout said period;
  - May only be issued by a carrier which establishes and maintains reserves with respect to covered benefits, in an amount recommended (or the mid-point of multiple recommendations) by an actuary certified by the American Academy of Actuaries, consisting of reserves sufficient for:

    - Unearned contributions;
    - Benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and

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for expected administrative costs with respect to such benefit liabilities;
- Any other obligations of the plan; and
- A margin of error and other fluctuations, taking into account the specific circumstances of the plan.

- May only be issued by a carrier which establishes and maintains additional reserves of at least $500,000 above the reserves noted above.

- Carriers issuing Qualifying Reinsurance Coverage may demonstrate compliance with the reserve requirements described above with alternative reserves in the form of a contract of indemnification, lien, bonding, (re)insurance, letter of credit, or security.

- Any business of insurance, including but not limited to the obtaining of Qualified Reinsurance Coverage, conducted in any State must comply with the insurance laws of said State, and obtain all required State approvals.

II. Law and Analysis

A. Treatment of a Partner Under ERISA

ERISA provides specific rules and regulations applicable to (1) an "employee welfare benefit plan," (2) "employees," and (3) "participants" that may participate an "employee welfare benefit plan."

An "employee welfare benefit plan" is defined as:[1]

"any plan, fund, or program…established or maintained by an employer…for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits…"

An "employee" is defined as:[2]

"an individual employed by an employer."

[1] Section 3(1) of the Employee Income Retirement Security Act ("ERISA").
[2] ERISA section 3(6).

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A "participant" is defined as:[3]

> "any employee or former employee of an employer…who is or may become eligible to receive a benefit…from an employee benefit plan which covers employees of such employer."

On its face and without further context provided elsewhere in ERISA, it appears that a partner in a partnership is not an "employee" within the meaning of ERISA section 3(6). Relying on the common law definition of an "employee," a partner also would not be considered an employee.[4] If a partner is not considered an "employee" for ERISA purposes, a partner cannot be considered a "participant" in an ERISA-covered "employee welfare benefit plan."

DOL Reg. section 2510.3-3(b) confirms that, for limited purposes, a partner is not considered an "employee" for purposes of determining the existence of an "employee benefit plan," which includes an "employee welfare benefit plan." DOL Reg. section 2510.3-3(b) further explains that a "plan without employees" is excluded from the requirements under Title I of ERISA (i.e., a plan covering partners is not considered an ERISA-covered plan).

B. A Partner May Be a "Participant" In an ERISA-Covered Single-Employer Plan Alongside At Least One Common Law Employee

The Department, however, has concluded that if a partner participates in an employee benefit plan along with at least one common law employee, DOL Reg. section 2510.3-3 does *not* exclude this plan from being covered by Title I of ERISA.[5] Specifically, the Department has found that a plan covering partners (who are considered "working owners") as well as their non-owner employees clearly falls within ERISA's scope.[6] The Department explained that "[t]he definition of 'plans without employees' in DOL Reg. section 2510.3-3(b) simply defines a limited circumstance in which the only parties participating in a benefit arrangement are an individual owner/partner…and declines to deem the individual[], in that limited circumstance, as [an] employee[]…for purpose of the regulation."[7] The Department explains further that DOL Reg. section 2510.3-3(b) "does not apply, however, outside

[3] ERISA section 3(7).

[4] In accordance with the Supreme Court's ruling in *Nationwide Mutual Insurance Company v. Darden*, the Department has found that the common law standard for determining employee status is whether someone is hired by an employer, with the employer having the "right to control and direct" the individual's work. [*See* DOL Information Letter (May 8, 2006); DOL Advisory Opinion 95-29A (Dec. 7, 1995); DOL Advisory Opinion 95-22A (Aug. 25, 1995)].

[5] 83 Fed. Reg. 614, 621 (Jan. 5, 2018).

[6] *Id*.

[7] *Id*.; *see also*, 83 Fed. Reg. 28912, 28930 (June 21, 2018).

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that limited context and, accordingly, does not prevent sole proprietors or other working owners – [including partners] – from being participants in broader benefit plan arrangements…"[8]

The conclusion that partners can participate in an ERISA-covered plan so long as the plan also covers at least one common law employee is consistent with the finding of the courts. For example, the Supreme Court in *Yates v. Hendon*[9] found that a plan covering both a "working owner" – including a partner in a partnership – and at least one common law employee is governed by ERISA.[10] In other words, in cases where a benefit plan covers both partners and common law employees, the plan will be covered by Title I of ERISA.[11]

The Fifth Circuit Court of Appeals, in *House v. American United Life Insurance Company*, also concluded that ERISA applies to a benefit arrangement that provided coverage to a firm's partners that also covered the firm's common law employees without reliance on whether said partner was a "working owner."[12] In *House*, a partnership established a plan that provided disability benefits to both employees of the partnership, as well as the partners. The partnership – as the employer of the employees – paid 100% of the premiums for the disability coverage for its employees and automatically enrolled them in the plan. The partners, on the other hand, were responsible for 100% of their own premium payments. The Circuit Court found that despite the differences in the manner in which premiums were paid, the partnership established a comprehensive employee welfare benefit plan covering both partners and employees, thus creating a single-employer ERISA-covered plan.[13]

In our opinion, *House* is instructive because of its similarities to our facts described in Section I.B. above, where LPartners will be required to pay their own premiums for the self-insured group health plan coverage sponsored by LP, while LP will pay 100% of the premiums for eligible employees, who are automatically enrolled in the plan. Based on the conclusion in *House*, the Supreme Court in *Yates*, and the Department's interpretations as set forth in proposed and final regulations, it is clear that LPartners may permissibly be considered "participants" in an ERISA-covered plan so long as at least one common law employee participates in the plan.

It is also clear that the single-employer self-insured group health plan sponsored by LP – acting in the capacity of an employer – to provide medical health benefits to LP's common law employees and limited partners is an "employee welfare benefit plan" within the meaning of ERISA section 3(1).

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[8] *Id*.
[9] 41 U.S. 1 (2004).
[10] *Id.* at 9.
[11] *Id.*
[12] 499 F.3d 443 (5th Cir. 2007).
[13] *Id.* at 451-452.

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As a result, because both LP's employees and LPartners may permissibly participate in this single-employer ERISA-covered "employee welfare benefit plan," the plan would be governed by Title I of ERISA.

C. A Partner Has Dual Status as an "Employer" and "Employee" and Thus May Be Considered a "Participant" In an ERISA-Covered Plan

In line with the reasoning discussed above, the Department has concluded that a partner may have dual status as an "employer" and an "employee," and thus, permissibly be considered a "participant" in an ERISA-covered plan.[14] Specifically, the Department opined that ERISA section 401(a)(2), ERISA section 403(b)(3)(A), ERISA section 408, ERISA section 4001(b)(1), ERISA section 4021(b)(9), and ERISA section 4022(b)(5)(A) all serve as indications that "working owners" – including partners – may be considered "participants" for purposes of ERISA coverage.[15] The Department has found that there is a clear Congressional design to include "working owners" – including partners – within the definition of "participant" for purposes of Title I of ERISA.[16]

Based on the foregoing, it is clear that LPartners may permissibly be considered "participants" in LP's single-employer self-insured group plan. In addition, because the Plan is considered an "employee welfare benefit plan" within ERISA section 3(1), the Plan would be governed by Title I of ERISA.

D. For Purposes of ERISA, a Partner Should Be Defined as an Individual Who Commits Time to and Performs Services on Behalf of the Partnership

The fact that a partner is considered a "working owner" must not be confused with the definition of a "working owner" under the Department's final association health plan (AHP) regulations.[17] Under the final AHP regulations, a "working owner" – which in the case of the final AHP regulations is a self-employed individual with no employees – means an individual who (1) has an ownership right in a "trade or business," regardless of whether the "trade or business" is incorporated or unincorporated, (2) earns wages or self-employment income from the "trade or business," and (3) works at least 20 hours a week (or 80 hours per month) providing personal services to the "trade or business" *or* earns income from the "trade or business" that at least equals the "working owner's" cost of the health coverage.[18]

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[14] DOL Adv. Op. 99-04A (Feb. 4, 1999).

[15] *Id*.; *see also*, 83 Fed. Reg. at 621 (Jan. 5, 2018) and 83 Fed. Reg. at 28930 (June 21, 2018).

[16] *Id*.

[17] *See* 83 Fed. Reg. 28912 et. seq. (June 21, 2018).

[18] DOL Reg. section 2510.3-5(e)(2).

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As discussed above, the Department and the Supreme Court have concluded that a "working owner" may also include a partner in a partnership. Although the term "partner" is not specifically defined in ERISA, ERISA section 732(d) contemplates a partner participating in a group health plan. Section 732(d) is relevant in cases where partners are the *only* participants in a group health plan, which would cause the plan to fall outside of Title I of ERISA (as required under DOL Reg. section 2510.3-3(b)). However, ERISA section 732(d) is also guiding on how a partner should be defined for purposes of participating in a group health plan, regardless of whether the plan is governed by Title I of ERISA or not. Stated differently, ERISA section 732(d)'s reference to and description of a partner serves to define a partner participating in a "plan without employees," as well as a partner who may permissibly participate in an ERISA-covered plan alongside at least one common law employee.

The regulations implementing ERISA 732(d) provide that for purposes of treating a partner as an "employee" – and thus a "participant" in a group health plan subject to the requirements under Part 7 of ERISA – the "the term employee includes any bona fide partner."[19] The implementing regulations go on to state that "whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual *performs services on behalf of the partnership*."[20]

Although a "bona fide partner" is not further defined in ERISA or its implementing regulations, the term "bona fide partner" can be found elsewhere in federal law, specifically in guidance from the Internal Revenue Service ("IRS").[21] According to the IRS, a bona fide partner is an individual with rights in a partnership, who exercises said rights, and who *commits time and service to the partnership*.[22] The consistency between the IRS's definition of a bona fide partner and the manner in which the Department described a bona fide partner in ERISA section 732(d) implementing regulations supports the interpretation that for purposes of ERISA, a partner should be defined as "an individual who commits time to and performs services on behalf of the partnership."

In our opinion, LPartners satisfy the definition of a "bona fide partner." LPartners have actual rights in LP as dictated in both LP's Partnership Agreement and the joinder to said agreement signed by each LPartner. LPartners regularly exercise these rights in periodic votes on partnership business. Finally, LPartners contribute time and energy to LP by sharing data and assisting in LP's primary business purpose and revenue generation activity. The time and services contributed by LPartners comprise the sole means of revenue generation of LP. In other words, without this activity, LP would

[19] DOL Reg. section 2590.732(d)(2).
[20] *Id*.
[21] *See* Rev. Rul. 69-184.
[22] *Id*.

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not earn revenue or survive as an entity. By these acts, LPartners meet both the IRS's and the Department's standards to qualify as bona fide partners.

E. Tax Considerations

The IRS has for decades maintained and enforced a clear set of regulations regarding tax treatment of partners in all health and welfare benefit plans, including group health plans. The Internal Revenue Code (the "Code") does not comment on the ability of a partner to participate in a group health plan. However, once a partner becomes a participant, the IRS treats that participant differently than common law employee participants. For the purpose of tax treatment, said partners are treated as independent contractors by the IRS.

Wage withholding for the payment of premiums for a group health plan on a pre-tax basis is not possible for partners.[23] In other words, partners are not allowed to join a §125 cafeteria plan in order to pay premiums in a group health plan on a pre-tax basis. This prohibition likely exists because of the difficulty in distinguishing a partner's wages from a partner's distributable income (which might be considered earned income) from a partnership. As a result, such funds cannot be used for the payment of premiums for a group health plan on a pre-tax basis through a cafeteria plan. A further consequence of this rule is that Health Savings Accounts ("HSAs"), which are typically offered through cafeteria plans, are also not available (with a meaningful tax benefit) to partners participating in a plan sponsored by their partnership. LPMS acknowledges these standards, does not seek special or separate tax treatment for its partners. Inasmuch as LP does not pay wages to its partners, no pre-tax payment of premium could be available to partners participating in LP's plan. Finally, LP does not sponsor and does not plan to sponsor either a cafeteria plan or an HSA.

While the benefit of pre-tax payments of premium is not available to partners, such payments could under certain limited circumstances be deductible as an ordinary and necessary business expense.[24] The Code provides that if a partner qualifies as a working owner with earned income, said partner may deduct the cost of premiums for a group health plan against their earned income from the same source that sponsors said group health plan[25]. This regime both acknowledges that a plan sponsor of a group health plan may have participants that are equity partners and that a limited scope deduction should be available in said circumstances. With respect to LP's plan, as with any other partnership, this deduction would only be available if LP distributed funds to partners participating in LP's plan which was then used to pay for premiums from LP's plan. (In the event that LP distributed funds to a partner insufficient to pay said partner's premium, any deduction would be limited to the

[23] See IRC § 125(d)(1)(A).
[24] See IRC § 162(l).
[25] Id.

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amount distributed.) LPMS is not seeking special or separate treatment with respect to this deduction. Other rules and limitations also apply and are acknowledged.[26]

The IRS has comprehensive, existing rules in place with respect to partners participating in a group health plan, within which LP's plan is regulated in similar fashion to any other partnership. No special treatment or extralegal tax benefit is sought by or available to partners participating in LP's plan.

III. Request for Determination

Based on the foregoing, Renfro respectfully asks that the Department to confirm that:

(1) The single-employer self-insured group health plan sponsored by LP is an "employee welfare benefit plan" within the meaning of ERISA section 3(1).

(2) LPartners participating in LP's single-employer self-insured group health plan are "participants" within the meaning of ERISA section 3(7).

(3) The single-employer self-insured group health plan sponsored by LP is governed by Title I of ERISA.

Thank you in advance for considering this request. Please do not hesitate to contact me with any questions, or with any request for additional information.

Respectfully submitted,

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[26] See IRC § 162(l)(2-5).

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Democrats are waging war against affordable health insurance

By Betsy McCaughey, *New York Post*

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A federal district judge in Texas struck down the Affordable Care Act as unconstitutional Friday. The lawsuit was brought by Republican officials from 20 states, who want their residents to have more insurance choices and lower premiums.

Though the suing states won in Texas v. Azar, their victory won't help consumers reeling from ObamaCare sticker-shock anytime soon. ObamaCare will stay on the books while the decision is appealed, which could take more than a year. The outcome is uncertain.

Fortunately, President Trump is using his regulatory power to accomplish precisely what these states want: relief from ObamaCare's rigid regulations.

One of Trump's most helpful moves is to allow the sale of "short-term plans," renewable for up to three years, in any state that permits them. These plans cost 80 percent less than ObamaCare plans, on average, according to ehealthinsurance.com.

Short-term plans omit maternity coverage and don't cover pre-existing conditions. They're not for everyone, but for many middle-class buyers, they're a good deal.

In Tampa, Fla., a short-term plan for a family of three costs $1,169 a year, less than one-tenth the $12,071 sticker price of an ObamaCare plan.

The outrage is that people who live in New York, New Jersey, California and other states dominated by Democrats can't take advantage of these deals. Blue states are doubling down on ObamaCare, refusing to allow consumers other choices.

Welcome to the Democrats' health care prison.

Gov. Andrew Cuomo even wants the New York Legislature to copy all of ObamaCare's federal regulations into state law. Yikes — those regulations have caused premiums to more than double in five years.

In Congress, Democrats are pushing a bill to outlaw short-term plans everywhere. They've titled it the "Undo Sabotage" bill. As if allowing an exit ramp off ObamaCare is sabotage. Dems would rather prop up the Affordable Care Act than ease the pain of middle-class consumers.

Last week, former President Barack Obama made a video to coax people to buy his signature health plans, promising that for most of them, the plans wouldn't cost more than a cellphone bill.

But that's only true for low-income buyers getting taxpayer-funded subsidies. Single adults earning more than $48,560 are considered middle class, and they're on their own.

Obama wasn't talking to them. Some 4 million ObamaCare customers who paid full freight have dropped their coverage. They can't afford the soaring premiums. The middle class are becoming the new uninsured in this country.

What's to blame for the huge premiums? According to McKinsey consultants, it's because ObamaCare forces healthy buyers in the individual market to pay the same as people with serious illnesses.

But 5 percent of the population uses nearly 50 percent of the health care. To make everyone pay the same is sheer extortion.

Democrats and Republicans agree that people with pre-existing conditions must be protected. But the lie perpetuated by the Democrats is that ObamaCare is the only way to do it. In truth, it's just the least fair way.

The Trump administration is encouraging states to do it in a fairer way, by departing from ObamaCare rules and allowing insurers to charge healthy buyers less than sick ones.

That doesn't mean people with pre-existing conditions are abandoned. The cost of their care is paid for out of general state revenues, spreading the burden widely instead of skewering buyers in the individual insurance market. Alaska, one of the first states to try it, was able to lower ObamaCare premiums by double digits in 2018.

When the Texas v. Azar decision was announced on Friday, Obama called it “scary,” warning that it “puts people’s pre-existing-conditions coverage at risk.” That’s the same demagoguery Democrats used in the midterm elections.

Don’t fall for it.

With help from the Trump administration, some states are forging better ways to make health insurance fair to the sick and affordable for the middle class. Regardless of the fate of ObamaCare.

Betsy McCaughey is a former lieutenant governor of New York.