

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

DATA MARKETING PARTNERSHIP,)	
LP,)	
)	
Plaintiff,)	
)	Civil Action File No.
v.)	_____
)	
UNITED STATES DEPARTMENT OF)	
LABOR, EUGENE SCALIA,)	
<i>in his official capacity as Secretary of the</i>)	
<i>United States Department of Labor, and</i>)	
UNITED STATES OF AMERICA,)	
)	
_____ Defendants.)	

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

COMES NOW the Plaintiff Data Marketing Partnership, LP (“DMP”) and file this, its Complaint for Declaratory and Injunctive Relief against Defendants United States Department of Labor (“DOL”), Eugene Scalia, solely in his official capacity as Secretary of the United States Department of Labor, and the United States of America, and show the Court as follows:

INTRODUCTION

1. This lawsuit seeks a declaratory judgment to settle an immediate and ongoing controversy caused by DOL’s refusal to act on the advisory opinion request filed by LP Management Services, LLC (“LPMS”) on November 8, 2018, revised as of January 15, 2019, and further revised as of February 27, 2019 (the “Request”). A true and correct copy of the Request is attached hereto as Exhibit A.

2. The Request was submitted because LPMS, as plan administrator and named fiduciary of the self-insured health plan that DMP maintains for its common law employees and limited partners (the “Plan”) as an adopting employer, seeks to confirm that DOL will not classify

the Plan 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”). LPMS is the general partner of DMP.

3. According to the Request, while neither DMP nor LPMS believes the Plan is a MEWA, because the applicable statutory terms set forth under ERISA are ambiguous and a limited partnership is a potentially novel sponsor of a health plan, LPMS has sought an advisory opinion pursuant to ERISA Procedure 76-1 in order to achieve finality on this issue and to assuage the concerns of DMP’s current employee, limited partners and potential limited partners.

4. 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 MEWAs and in its actions issuing approximately 140 advisory opinions and information letters on issues concerning MEWAs.

5. As with private parties such as LPMS, States have also routinely filed advisory opinion requests with DOL, similar to the 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.

6. While not filing their own advisory opinion request, several States have submitted a letter in support of the Request to DOL. 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 Request (the “State AG Letter”). A true and correct copy of the State AG Letter is attached hereto as Exhibit B.

7. In the State AG Letter, the respective Attorneys General stated “[w]e are interested in this request and encourage the DOL to respond as soon as possible. The [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 the DOL.*” See Exhibit B, p. 1 (emphasis added).

8. Guidance from DOL on the Request is critically important because its response informs DMP as to which regulatory authority controls the administration of the Plan. A determination that the Plan is a MEWA immediately causes a cascading set of regulatory compliance hurdles mandated by statute in each State concerning MEWAs that conduct business within their borders. That regulatory enforcement obligation is a heightened concern here because the Plan is self-insured. The regulatory requirements and burden imposed on self-insured MEWAs are substantial and varied from State to State. Should DOL determine that the Plan is not a MEWA, DMP would not be subject to such varied and burdensome MEWA regulations of the States.

9. The delay from DOL and the subsequent confusion created in the several States where DMP currently seeks to do business as to the status of the Plan under ERISA actively undermines DMP’s ability to do business throughout the United States. This harm to DMP occasioned by DOL’s unreasonable inaction is further detailed below.

10. DMP faces catastrophic regulatory penalties and enforcement actions as a sponsor of a Plan with limited partners and Texas employees due to the inaction of DOL. Should DOL determine that the Plan is a MEWA, then DMP will have no choice but to dissolve the Plan. In such event, the participants would lose their health insurance and access to health care.

11. Perhaps worse than the impending regulatory burden, the lack of clarity on this fundamental issue 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 major incentive for limited partner membership is the Plan offered by DMP.

12. Each limited partner that refuses to join for the reason set forth in Paragraph 11 limits the scope of the data pool that DMP can offer to potential customers, thus undermining DMP's overall business purpose and directly siphoning off revenue and profits that would have been had but for DOL's inaction.

13. Plaintiff accordingly asks that the Court to declare that the Plan is not a MEWA and award other relief as set forth below.

JURISDICTION AND VENUE

14. The Court has subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331 and 2201(a) and 29 U.S.C. §§ 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).

15. 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

16. Plaintiff is aggrieved by the unreasonable delay in agency action by the federal Defendants and have standing to bring this action.

17. 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).

18. Defendant Eugene Scalia (“Secretary”) is the Secretary of Labor and is sued solely in his official capacity.

19. Defendant the United States of America is sued as permitted under 5 U.S.C. § 702.

FACTS

20. 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 Request to DOL. LPMS is the general partner of DMP. 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 DOL’s failure to respond to the Request. The stipulated facts presented in the Request are hereby incorporated by reference and are the stipulated facts on which the Plaintiff relies.

21. 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.

22. 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 who in turn files a resolution adding the new limited partner and updates DMP’s partnership information to include this information.

23. 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.

24. DMP'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 limited partners who transmit such data with DMP.

25. In addition to certain other management rights, limited partners have a say in how aggregated data will be sold or used by DMP.

26. Each limited partner agrees to contribute more than five hundred (500) hours of work per year through the generation, transmitting, and sharing of their data. Thus limited partners are active, committing time and service to the revenue-generating activity of DMP which, among other things, makes them "working owners."

27. Income distributions by DMP to limited partners resulting from such revenue-generating activities will be reported as guaranteed payments and subject to employment taxes.

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

29. To attract, retain, and motivate talent in support of DMP's primary business purpose, DMP established the Plan. The Plan Document of the Plan will state in its "Eligibility" section that only eligible plan participants of which DMP is an employer, as defined by ERISA § 1002(7), including certain employees and partners of DMP, are eligible to participate in the Plan.

30. The Plan automatically covers all common law employees of DMP. The Plan is available to provide coverage to limited partners if they choose to participate. No other persons are eligible to participate in the Plan.

31. 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.

32. 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.

33. 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. 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.

34. DMP recognizes that there are many potential 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. DMP has established strong safeguards as a commitment to employees and partners – which are described in detail in Paragraphs 35 through 39 – 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.

35. The Plan has a number of third-party vendors LPMS engages on behalf of DMP to administer. First, LPMS hires a consulting and benefits design firm for guidance and assistance with fulfilling plan requirements pursuant to 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.

36. These 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 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.

37. 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.

38. 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 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 key requirements.

39. 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.

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.

40. 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.

41. 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.

42. 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).

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).

43. A 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).

44. While ERISA § 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 ERISA § 1002(7).

45. 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.

46. 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).

47. 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

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

that to treat such working owners different 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.”).

48. 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.

49. DMP employs common law employees and those employees along with the limited partners are eligible to participate in the Plan. 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.

50. With respect to DMP, limited partners will 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).

51. 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

52. 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 distributed income. 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.").

THE ADVISORY OPINION INACTION HARMS THE PLAINTIFFS

53. As detailed in the preceding paragraphs, the failure by DOL to take any action on the Request harms the economic and proprietary interests of Plaintiff.

54. The requested relief, if granted, will redress the injuries to the interests of Plaintiff caused by DOL's failure to issue an Advisory Opinion Ruling in a reasonable timeframe.

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 the DOL.

CAUSES OF ACTION
COUNT ONE
DECLARATORY JUDGMENT

55. Plaintiff incorporates each of the foregoing paragraphs by reference as if they were fully set forth herein.

56. Under 29 U.S.C. §§ 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...”

57. Plaintiff brings this suit in its capacity as fiduciary of the Plan, and requests that this Court declare the limited partners of DMP are “employees” and “participants” in an ERISA covered employee welfare benefit plan, and prohibit the Secretary from ruling otherwise because such a ruling would be an “action contrary to the provisions of” ERISA.

58. Plaintiff further request this Court declare and the Plan is not a MEWA as that term is defined from ERISA, and similarly prohibit the Secretary from ruling otherwise because such a ruling would be an “action contrary to the provisions of” ERISA.

COUNT TWO
INJUNCTIVE RELIEF

59. Plaintiff incorporates each of the foregoing paragraphs by reference as if they were fully set forth herein.

60. 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 at-issue Advisory Opinion while this case is pending.

61. The Plaintiff respectfully requests the Court issue such injunction at the earliest possible time in order to prevent continuing and irreparable harm to the Plaintiff.

62. The Plaintiff 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 Plaintiff's Complaint.

63. The Plaintiff further respectfully requests the injunction apply with equal force to the several States' respective departments of insurance or similarly charged administrative bodies. Broad federal preemption applies to single employer ERISA plans. Because interpretation of ERISA is inherently a federal prerogative, permitting the states to engage in a patchwork interpretation landscape on a question that is purely federal in character and still pending before this Court would unduly burden Plaintiff is manifestly unjust.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests 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 is not a MEWA as that term is defined under ERISA;
- c. Declare that DOL failed to timely respond to the Advisory Opinion request and, therefore, in the interest of judicial economy, neither DOL nor any state agencies may opine on or take any action whatsoever on the substance of the Request but rather must await the final disposition of this action before taking any independent course of action with respect to the issue of whether the Plan is a MEWA;
- d. Enjoin DOL and all its officers, employees, and agents, and anyone acting in concert with them, from implementing, applying, or taking any action in any State that is contrary to the findings of this Court;
- e. Award Plaintiffs costs, expenses, and reasonable attorneys' fees; and,

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

Respectfully submitted,

TAYLOR ENGLISH DUMA LLP

/s/ Reginald Snyder _____

Reginald Snyder

Texas Bar No. 24030138

Bryan Jacoutot (*Pro Hac Vice Pending*)

Georgia Bar No. 668272

1600 Parkwood Circle, Suite 200

Atlanta, Georgia 30339

Telephone: (770) 434-6868

Facsimile: (770) 434-7376

rsnyder@taylorenghish.com

bjacoutot@taylorenghish.com

Counsel for Plaintiffs

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

I. (a) PLAINTIFFS

(b) County of Residence of First Listed Plaintiff (EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys (Firm Name, Address, and Telephone Number)

DEFENDANTS

County of Residence of First Listed Defendant (IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- 1 U.S. Government Plaintiff, 2 U.S. Government Defendant, 3 Federal Question (U.S. Government Not a Party), 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)

- PTF DEF Citizen of This State, Citizen of Another State, Citizen or Subject of a Foreign Country, Incorporated or Principal Place of Business In This State, Incorporated and Principal Place of Business In Another State, Foreign Nation

IV. NATURE OF SUIT (Place an "X" in One Box Only)

Table with columns: CONTRACT, REAL PROPERTY, CIVIL RIGHTS, TORTS, PRISONER PETITIONS, FORFEITURE/PENALTY, LABOR, IMMIGRATION, BANKRUPTCY, SOCIAL SECURITY, FEDERAL TAX SUITS, OTHER STATUTES. Includes sub-sections like PERSONAL INJURY, PERSONAL PROPERTY, LABOR, SOCIAL SECURITY, FEDERAL TAX SUITS.

V. ORIGIN (Place an "X" in One Box Only)

- 1 Original Proceeding, 2 Removed from State Court, 3 Remanded from Appellate Court, 4 Reinstated or Reopened, 5 Transferred from Another District, 6 Multidistrict Litigation - Transfer, 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity):

Brief description of cause:

VII. REQUESTED IN COMPLAINT:

CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P., DEMAND \$, CHECK YES only if demanded in complaint: JURY DEMAND: Yes No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE DOCKET NUMBER

DATE SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # AMOUNT APPLYING IFP JUDGE MAG. JUDGE

Case 4:19-cv-00800-O Document 1-1 Filed 10/04/19 Page 2 of 2 PageID 19
INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

- I.(a) Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.
- (b) County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)
- (c) Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".
- II. Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
 United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
 United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
 Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
 Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below; **NOTE: federal question actions take precedence over diversity cases.**)
- III. Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.
- IV. Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: [Nature of Suit Code Descriptions](#).
- V. Origin.** Place an "X" in one of the seven boxes.
 Original Proceedings. (1) Cases which originate in the United States district courts.
 Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441. When the petition for removal is granted, check this box.
 Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
 Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
 Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
 Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
 Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.
- VI. Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service
- VII. Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
 Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
 Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.
- VIII. Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If a related case exists, whether pending or closed, insert the docket numbers and the corresponding judge names for such cases. A case is related to this filing if the case: 1) involves some or all of the same parties and is based on the same or similar claim; 2) involves the same property, transaction, or event; 3) involves substantially similar issues of law and fact; and/or 4) involves the same estate in a bankruptcy appeal.

Date and Attorney Signature. Date and sign the civil cover sheet.

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

**DATA MARKETING PARTNERSHIP,)
LP,)**

PLAINTIFF,)

v.)

**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,)

DEFENDANTS.)

CIVIL ACTION NO.

CERTIFICATE OF INTERESTED PERSONS

Pursuant to Fed. R. Civ. P. 7.1 and LR 3.1(c), LR 3.2(e), LR 7.4, LR 81.1(a)(4)(D), and LR 81.2, Plaintiff Data Marketing Partnership, LP by and through its undersigned counsel of record, provides the following information:

(1) The undersigned counsel of record for Plaintiff Data Marketing Partnership, LP certifies that the following is a full and complete list of all parties in this action, including any parent corporation and any publicly held corporation that owns 10% or more of the stock of a party:

- Plaintiff Data Marketing Partnership, LP;
- Defendant United States Department of Labor;
- Defendant Eugene Scalia *in his official capacity as Secretary of the United States Department of Labor*; and
- Defendant United States of America.

(2) The undersigned further certifies that the following is a full and complete list of all other persons, associations, firms, partnerships or corporations having either a financial interest in or other interest which could be substantially affected by the outcome of this particular case:

- Georgia Data Partners, LLC;
- American Marketing Partnerships LLC; and
- Randall Johnson.

(3) The undersigned further certifies that the following is a full and complete list of all persons serving as attorneys or the parties in this proceeding:

Counsel for Plaintiff:

Reginald L. Snyder
Bryan Jacoutot
TAYLOR ENGLISH DUMA LLP
1600 Parkwood Circle, Suite 200
Atlanta, GA 30339

Respectfully submitted this 3rd day of October 2019.

s/ Reginald L. Snyder

Reginald L. Snyder
Texas Bar No. 24030138
Bryan Jacoutot (*Pro Hac Vice Admission in Process*)
Georgia Bar No. 668272
TAYLOR ENGLISH DUMA LLP
1600 Parkwood Circle, Suite 200
Atlanta, Georgia 30339
Phone: 404.434.6868
Fax: 770.434.7376
Email: rsnyder@taylorenghish.com
bjacoutot@taylorenghish.com

Attorneys for Plaintiff

EXHIBIT A

The Law Office of Alexander Renfro

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
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 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:

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

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.

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 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.*

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

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.

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 its 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

ALEXANDER T. RENFRO, JD, LLM

EXHIBIT

B



Jeff Landry
Attorney General

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

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.

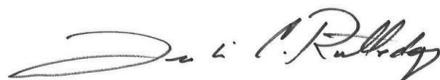
Respectfully yours,



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

The Law Office of Alexander Renfro

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

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

- 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 in 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).

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

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.*

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 plan²⁵. 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,



ALEXANDER T. RENFRO, JD, LLM

²⁶ See IRC § 162(l)(2-5).

Democrats are waging war against affordable health insurance

By Betsy McCaughey, *New York Post*

December 18, 2018 | 10:26pm | Updated

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.