JOHNSON & KROL, LLC

Taft-Hartley Report

VOLUME 1, ISSUE 3 OCTOBER 2008

The Department of Labor Clarifies its Position on Fiduciaries Accepting Gifts from Plan Vendors

The Department of Labor (DOL) recently issued guidance clarifying what DOL will consider insubstantial and not an ERISA violation regarding a plan fiduciary's acceptance of gifts and gratuities from a party dealing with the plan. This guidance is provided in the Employee Benefits Security Administration (EBSA) Enforcement Manual (Manual) which assists EBSA employees in carrying out their enforcement responsibilities. In addition to its administrative value to EBSA, the Manual provides employee benefit plans a sense of how DOL interprets and enforces the various applicable employee benefit-related laws.

History

DOL has varied its intensity in its concern about fiduciaries receiving routine marketing courtesies from vendors that deal with the plan. For many years, DOL failed to provide any guidelines regarding what, if anything, was acceptable and within the ERISA prohibited transaction provisions regarding fiduciaries receiving gifts or entertainment.

Under ERISA Section 406(b)(3), it is considered a prohibited transaction for a fiduciary to receive any consideration for his own personal account from any party dealing with the plan in connection with a transaction involving the plan's assets. For years, the only action DOL took on this issue consisted of DOL bringing suit against various fiduciaries for their acceptance of extremely lavish gifts – such as motorcycles, use of vacation homes rent-free and trips to New York City. These extravagant gifts were clearly "in connection with a transaction" involving plan assets. However, in regard to fiduciaries receiving routine marketing courtesies, DOL continued to be silent.

In 2004, EBSA began making informal interpretations of the prohibited transaction provision during plan audits and at public forums stating that when a fiduciary receives *anything* of value from a plan vendor, it is considered a prohibited transaction. This coincided with the Office of Labor Management Standards (OLMS) tightening its own enforcement of the reporting provision of the Labor Management Reporting and Disclosure Act of 1959 (LMRDA) which requires union trustees to report gifts and entertainment from plan vendors on an LM-30 form.

Initially, OLMS took the position that a trustee must report everything he receives on the LM-30 form. The main concern was that the filed LM-30 form was available online for EBSA to access and review. The dilemma was that on one hand, failure to report on the LM-30 could result in criminal penalties and on the other hand, reporting any gift or entertainment may open the plan up to allegations of the trustees engaging in prohibited transactions in light of EBSA's zero tolerance position.

OLMS's position to require disclosure of all things of value was short-lived. They realized how burdensome this was for both the trustees and OLMS. They quickly changed their stance and advised trustees that they were now only required to report anything they received that totaled more than $250 in the aggregate per calendar year. OLMS had adopted a de minimus position; however, EBSA continued to maintain their zero tolerance policy. This split between two Department of Labor agencies furthered the confusion and the concern regarding this issue. During this confusing time, many plans adopted their own zero tolerance policies that prohibited trustees from accepting any routine marketing courtesies regardless of value.

However, Johnson & Krol (J&K) openly took the position that DOL's zero tolerance policy ignored the plain language of the prohibited transaction provision of ERISA, which provides that the consideration must be in "connection with a transaction" involving plan assets. It was J&K's opinion that when a vendor provides its current and potential clients with sporadic meals, golf or tickets to a sporting event as part of its marketing, the provision of such items without some "connection to" a specific plan transaction, the prohibited transaction provision was not triggered so long as it did not exceed the value and type of entertainment that is in line with industry norms. J&K advised its clients that unless there were facts or circumstances that indicated otherwise, a trustee's acceptance of a routine marketing courtesy was not related to a transaction involving plan assets and, as a result, was not a prohibited transaction.

Continued on Page 2—**Fiduciaries**

INSIDE THIS ISSUE:

Fiduciaries *continued from page 1*

Explanation of Recent Department of Labor Guidance

This EBSA Manual is the first guidance that DOL has given since its informal zero tolerance application of the prohibited transaction provision. Now, DOL provides fiduciaries a sense of understanding as to how DOL will review the receipt of gifts and services from plan vendors in the event the plan is being investigated or audited.

The new language provides guidelines to DOL investigator/auditor with respect to gifts and entertainment offered to fiduciaries of plans. The guidelines instruct the investigator to first determine if the facts support an allegation that the fiduciary receiving gifts were received in connection with a transaction involving plan assets. Additionally, the investigator will determine if the fiduciary violated any plan procedure or policy. This guidance parallels J&K's prior analysis of the prohibited transaction provisions of ERISA.

Further, the guidelines instruct the investigator to generally not treat a fiduciary's receipt of items or services from any one individual or entity as a prohibited transaction so long as the aggregate annual value is ***less than $250*** and their receipt does not violate any plan policy or provision. The guidance states that any gift ***less than $250*** should be considered ***insubstantial.*** However, though a gift may be less than $250, this will not protect fiduciaries if there are clear facts or circumstances that indicate that the fiduciary received the gift in connection with a transaction involving plan assets. A dinner with a plan vendor can be considered a prohibited transaction if there are clear facts that would show this connection. Additionally, the Manual recognizes that items and services which are included in these circumstances are: gifts, gratuities, meals, entertainment, reimbursement of expenses associated with educational conferences or other consideration.

Accordingly, if a plan fiduciary receives less than $250 in the aggregate per calendar year in items or services from a plan vendor, DOL will generally consider this insubstantial and not a violation of ERISA, absent facts or circumstances that indicate a connection to a plan transaction. Further, if a fiduciary does accept something for $250 or more from a plan vendor, it will not be an inherent violation of ERISA's prohibited transaction provision, but it may be scrutinized more closely to ensure that it did not influence the fiduciary. This guidance confirms J&K's previous position regarding DOL's overreaching zero tolerance policy, as well as DOL's recognition that nominal marketing courtesies are part of the business world and they do not inherently mean that fiduciaries can be unduly influenced.

Conclusion

In light of this clarification from EBSA, trustees should now feel comfortable accepting routine marketing courtesies from plan vendors so long as the aggregate value of those courtesies is less than $250 per year and the acceptance is not connected to any plan transaction. Also, trustees should not accept any gifts from plan vendors that exceed $250 or more. Though it may not be deemed an inherent violation of ERISA, the gift may be scrutinized more closely and it is unnecessary to bring this unwelcome attention to the plan.

Also, in response to EBSA's former zero tolerance position, many plans adopted policies strictly prohibiting fiduciaries from receiving services or gifts from plan vendors. Based on this most recent guidance, if your plan has such a policy or provision, you should seriously consider repealing the provision as it is stricter than is necessary by law.

If your plan has a strict prohibition policy and the trustee accepts even a lunch from a plan vendor, the trustee would be in breach of his fiduciary duty for violating the policy, but would be well within the parameters of the new EBSA limitations. Therefore, these overreaching policies are no longer necessary in consideration of this recent guidance and can be replaced with a simple code of conduct policy requiring the fiduciaries to abide by all local, state and federal laws.

Contractor Pleads Guilty to Making Illegal Payment to Union Official

A Philadelphia electrical contractor recently pleaded guilty to making an unlawful payment to a union official in connection with renovation work that the contractor completed at the IBEW Local 98's business manager's house.

The contractor admitted that he did not prepare or submit a bill to the business manager for the work his firm performed on the house until the contractor was already being investigated by federal agents. After the contractor's house and business were searched by federal agents, the contractor issued the business manager a bill for $115,600 for materials, labor and related costs that his company incurred in connection with the renovation.

Federal law bars employers from offering anything of value to an officer of a labor organization that represents the employer's workers. In this case, the contractor's employers were represented by IBEW Local 98. Though the Taft-Hartley Act permits financial transactions between an employer and a union official, the transaction must be made at prevailing market price in the regular course of business.

The contractor may be sentenced up to 51 months in prison under the federal guidelines for making unlawful payments to a union official.

Using Mechanic's Liens in the Collection Process

There are several advantages and disadvantages to using mechanic's liens to collect delinquent contributions. The process of filing a mechanic's lien can be somewhat cumbersome and requires careful documentation of project-specific dates, times and hours worked by employees. In most cases, there is typically very little time to gather the necessary information before the filing deadline. However, when used under the right circumstances, a mechanic's lien can be a very powerful and effective collection tool.

Mechanic's liens are governed by the law of the state in which the property is located. The process for filing a mechanic's lien is generally a complicated "one-size-fits-all" law for all of the trades entitled to a lien and for all of the circumstances that can arise in the construction industry. The deadline for filing a mechanic's liens is typically 60 to 90 days following the last day in which work was performed on the project. The strict deadlines create special obstacles in the ERISA context when the contractor has failed to report the hours worked by its employees.

In order to meet the stringent deadline for filing a valid mechanic's lien, having an accurate record of the hours worked on the project is critical. Keep in mind that additional time is typically needed to conduct title searches for the subject property and the specific deadlines may vary depending on whether the project is public or private.

In order to file a valid lien, the property owner must be verified through a title search, which can take up to three weeks to complete. Generally speaking, a lien cannot be filed against property that has been sold by the owner to a third party purchaser. This creates special problems for projects involving subdivision developments that include multiple pieces of property. As a result, mechanic's liens may not be feasible in all cases and should be considered on a case-by-case basis.

Under the appropriate circumstances, a mechanic's lien can be an effective method for collecting delinquent contributions. In order to preserve the right to file a mechanic's lien, the Union and the Fund Office should consult with counsel early on to ensure compliance with all important dates and deadlines.

Illinois Insurance Law Amended To Cover Dependents Until Age 26

Plans subject to Illinois insurance law may be required to cover dependents until age 26 under legislation expected to become effective January 1, 2009. Under this law, an insured plan would be required to cover dependents regardless of their student status until age 26, or if they are in the military, until age 30.

Although self-insured multiemployer health and welfare plans are generally not subject to state insurance law, this change is of note because multiemployer plans generally strive to provide coverage at least as generous as that provided by other employers in the area. Thus, the state required level of coverage is often treated as a floor when deciding the level of participant benefits.

Plans that may be interested in mirroring the Illinois law should be aware of the potential tax consequences. Employer provided coverage is excluded from taxable income only if it meets the requirements of the Internal Revenue Code (Code). Section 152 of the Code has a dependent age maximum which provides that an unmarried individual may be covered as a dependent until the end of the calendar year they attain age 18, or if a student, until the end of the calendar year they attain age 23 if he/she is a full-time student. Special rules apply to children who are permanently and totally disabled.

This means that coverage mandated under the Illinois law for an individual who is not a dependent under the Code would likely be taxable to the employee. As such, an employer that pays for medical coverage would have to include the value of such coverage as taxable income on the employee's Form W-2 and payroll taxes (FICA and FUTA) for the employer and the employee must be paid. Alternatively, an employer could require the employee to pay for dependent coverage after the dependent meets the Code's age maximum with after-tax self-payments.

This change to the Illinois insurance law was effectuated through an amendatory veto by Governor Blagojevich and may be subject to a constitutional challenge based on the argument that creating this major insurance program changes the fundamental purpose of the original legislation. Although business groups have threatened such litigation, the new law will go into effect January 1, 2009, barring any new developments.

Multiemployer welfare plans that are interested in increasing the limiting age for dependents would have to either: 1) issue a Form W-2 reporting the additional income to the participant in a manner similar to that used for short term disability payments or 2) charge the participant an after-tax self-payment amount to pay for dependent coverage that exceeds the age maximum of the Code.

For plans that are interested in increasing the limiting age for dependents but are not subject to the Illinois insurance law, our recommendation is to wait to see if the legislation becomes law effective January 1, 2009, and then evaluate the experience of plans that are required to comply with Illinois insurance law before taking any action.

For plans that are interested in providing such dependent coverage as soon as it applies to insured plans effective January 1, 2009, we are available to work with you to navigate through these difficult compliance issues.

Following the Plan's Claims Procedures is Essential to Ensuring Discretionary Authority

In a string of recent district court decisions, the federal courts are cracking down on plans that do not follow the plan's written claims procedures. In *Tinker v. Versata Inc. Group Disability Income Insurance Plan*,[1] the court held that a decision denying benefits by a disability benefit plan administrator with discretionary authority to make benefit determinations was not entitled to deferential review because the administrator violated ERISA in failing to adhere to ERISA's procedural requirements regarding denied claims.

Typically, if the plan so provides, all benefit determinations are given a discretionary standard of review in the event a participant brings suit in federal court. With this more favorable discretionary standard, the reviewing court will not disturb the plan administrator's decision if it was reasonable. However, in *Tinker*, the court used the de novo standard of review because the plan administrator did not provide the participant with sufficient notice of why it was denying her claim and misstated the review procedure requirements. The de novo standard of review allows the court to not give weight to the plan administrator's decision when making its decision.

In *Tinker*, the participant worked for Versata and ceased working because of Meniere's disease, which caused her to have severe vertigo attacks. Tinker received long-term benefits under Versata's group plan, which provided benefits if a participant is continuously unable to perform the material duties of his or her regular occupation.

Eventually the plan administrator terminated the participant's benefits, basing the decision on a letter from the participant's doctor stating that her condition had improved and on a functional assessment tool in which Tinker's doctor responded affirmatively to the statement that Tinker could perform her job. The termination of benefits letter from the plan administrator stated that Tinker could request reconsideration of its decision within 60 days and that if it decided not to reconsider her claim, she could appeal within 60 days of that decision.

Four days after her benefits were terminated, Tinker sent the plan administrator a letter requesting reconsideration in which she stated that her doctor's report was incorrect and her condition had worsened. The plan administrator upheld the initial decision. A few months later, Tinker's doctor requested reinstatement of benefits because Tinker was indeed still suffering from this disease. The plan administrator responded that Tinker had exhausted her administrative remedies and her benefits would not be reinstated. In turn, Tinker filed a lawsuit challenging the termination of her benefits.

The court found that the plan administrator had violated the plan's written claims procedures under ERISA and therefore, the abuse of discretion standard was not warranted. Under ERISA, a plan must provide a claimant with written notice stating the specific reasons for the denial, the plan information needed to perfect the benefit claim and information as to the steps a claimant must take for review of the denied claim. Further, the court said that the plan administrator prevented the full development of the administrative record because it did not provide adequate notice informing Tinker of what information she needed to provide to perfect her claim. The denial letter also did not correctly state the steps Tinker needed to take to submit a claim and it incorrectly advised that she had 60 days to appeal, when she actually had 180 days to appeal under the plan.

This failure to follow the plan's claims procedures allowed the court to abandon the abuse of discretion standard and apply the de novo standard. Ultimately, the court retroactively reinstated Tinker's benefits.

In light of this case and many other recent cases providing the same outcome, it is essential that your plan's claims procedures are in accordance with ERISA and more importantly, that the procedures are being properly followed.

[1] *Tinker v. Versata Inc. Group Disability Income Insurance Plan*, E.D. Cal., No. 2:06-CV-02906, 7/13/08.

We encourage you to contact

JOHNSON & KROL, LLC

if you have any questions regarding the articles contained within this newsletter.

(312) 372-8587

johnson@johnsonkrol.com • krol@johnsonkrol.com

US Supreme Court Weighs in Twice on Employee Benefits Issues

LaRue v. DeWolff

Earlier this year in *LaRue v. DeWolff*,[1] the U.S. Supreme Court issued its decision on whether a plan participant could sue to recover losses that did not affect all or a large number of plan participants in an individual account defined contribution plan. Since the Court's ruling, there has been extensive commentary weighing in on the breadth of this decision and how it will affect employee benefit plans. After reviewing the decision and reading various opinions regarding this case, J&K is of the opinion that the *LaRue* decision will not have a substantial impact on Taft-Hartley funds and the manner in which they would handle a similar situation as in *LaRue*.

The plaintiff, Mr. LaRue, participated in a 401(k) plan that allowed him to direct the investment of his account balance. Mr. LaRue alleged that he instructed an employee of the plan over the phone to make a particular investment adjustment; however the adjustment was never made. He alleged that the plan's failure to carry out his instructions rose to the level of breach of the plan's fiduciary duty and he alleged losses of $150,000.

The main issue in this case was whether a plan participant could sue a plan administrator to recover losses that did not affect all or a large number of plan participants. The Supreme Court held unanimously that an individual participant could bring suit against the plan for injuries that occur to the individual's account.

When this decision first came out, the commentators feared that this would open the flood gates for participants to sue plan administrators. This fear was largely stirred up by single employer plans. Prior to *LaRue*, single employer plans were more likely to argue that a plan participant did not have a right to file a lawsuit under ERISA. Single employer plans have operated under the assumption that unless the plan as a whole was injured, an individual participant did not have a remedy.

In our experience, Taft-Hartley funds have generally worked under the assumption that if a plan participant alleged that he had been wronged, he would be able to bring suit against the plan under ERISA. Additionally, Taft-Hartley funds would generally try to resolve similar problems with participants on their own—before any lawsuits are filed—regardless of whether the participant had the right to sue.

While the decision may mean a change from business as usual for the single employer industry, it generally confirms the Taft-Hartley fund approach to individual account defined contribution plans.

[1] *LaRue v. DeWolff, Boberg &Assocs., 128 S. Ct. 1020 (2008).*
[2] *Metro. Life Ins. Co. v. Glenn, 128 S. Ct. 2343 (2008).*

Metropolitan Life v. Glenn

In *MetLife v. Glenn*,[2] the Supreme Court ruled where an employer both administers benefit claims and pays for the benefits in question, thus facing a conflict of interest, a reviewing court must take the conflict of interest into account in deciding whether the administrator abused its discretion. As in *LaRue*, J&K is of the opinion that this decision affects single employer plans far more than Taft-Hartley funds.

Wanda Glenn was an employee of Sears, Roebuck & Co. and was covered by a long-term disability insurance plan offered by Sears. Metropolitan Life ("MetLife") was both the plan administrator and the insurer of the plan, which gave MetLife the discretionary authority to determine whether an employee's claim for benefits was covered under the plan. Ms. Glenn filed a claim for long-term disability and MetLife denied her claim. Glenn sued MetLife stating there was a conflict of interest based on MetLife having the authority to deny claims that it also pays.

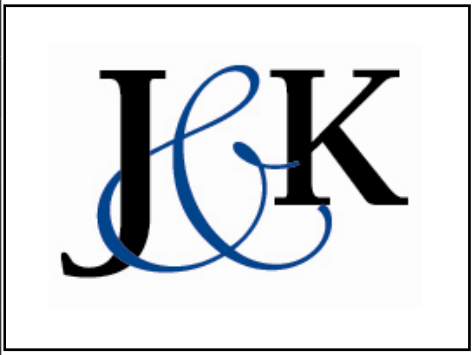
A federal district court held that MetLife did not abuse its discretion in denying the claim. On appeal, the Sixth Circuit determined that MetLife's dual role as administrator and payor of claims was a conflict of interest and that fact should be treated as a relevant factor in deciding whether MetLife abused its discretion. The Sixth Circuit set aside MetLife's denial of the claim and ordered that Ms. Glenn's benefits be reinstated.

The Supreme Court decided that the dual role of deciding benefit claims and paying the benefits creates a conflict of interest. The Court held that reviewing courts should consider the conflict as one factor among all of the other factors when a court is reviewing the lawfulness of the benefit denial.

This decision does not represent an earth-shattering change for Taft-Hartley health and welfare funds because there is minimal conflict of interest when deciding claims. Traditionally, with a joint Board of Trustees in a Taft-Hartley fund, any conflict is mitigated because both the union and the management weigh in on the appeal decision, and it is typically the union trustees' goal to ensure its members' claims are being handled fairly, without primary consideration being given to the bottom line. Additionally, the contributions for the plans come from all employers, not just one single employer; therefore, the effect any single claim has to the bottom line of any single employer or employer trustee is fairly remote in most cases.

The *Glenn* decision does however have a more substantial impact on the appeals process for single employers where there is an inherent conflict of interest between the participant's interests and the bottom line. The Court recognizes that an entity that both pays the claim and makes the benefit decision has an inherent conflict of interest and the reviewing courts must take this conflict into consideration when deciding whether the administrator abused its discretion.

Although the *Glenn* decision has not yet been applied to a Taft-Hartley fund, it is our opinion that courts will not view the typical Taft-Hartley arrangement as creating a conflict. If we are correct on how the courts will apply this decision, the *Glenn* decision will not significantly affect Taft-Hartley funds.



U.S. Postage Here

JOHNSON & KROL, LLC

Johnson & Krol, LLC
208 South LaSalle
Suite 1602
Chicago, IL 60604

Phone: 312.372.8587
Fax: 312.255.0449

JOHNSON & KROL, LLC

(312) 372-8587

johnson@johnsonkrol.com • krol@johnsonkrol.com

Federal Government Implements Program to Protect Nation's Maritime Transportation System

In an effort to ensure that individuals that pose a threat to our nation maritime transportation system do not gain access to secure areas, Congress enacted the Maritime Transportation Security Act and the Security and Accountability for Every Port Act (MTSA). The MTSA created the Transportation Worker Identification Credential (TWIC) program which is administered by the Transportation Security Administration and the U.S. Coast Guard.

TWICs are tamper-resistant cards that will be issued to workers who require unescorted access to secure areas of ports, vessels, credentialed merchant mariners and Outer Continental Shelf facilities. Employees interested in participating in the program must enroll and be vetted by the Coast Guard and TSA before they will receive their TWIC.

Though possessing a TWIC may not be essential to conducting work in these secure areas, it is tremendously beneficial for employees to enroll in the program. If an employee does not have a TWIC, he will have to be escorted through the secure area by a TWIC holder in order to access the area to perform his job.

Currently, the TWIC program only applies to certain facilities depending on the cargo the facility handles. Some of the Chicago-area facilities that must be compliant with the TWIC program by October 31, 2008, include: Exxon Mobil (Channahon, IL), Citgo Lemont Refinery (Lemont, IL), BP Whiting Refinery (Whiting, IN), Illinois International Port District (Calumet, IL) and Arcelor Mittal Steel (East Chicago, IN).

Enrolling in the TWIC program now may be beneficial for all union members. Though the program only applies to certain facilities, the program could eventually expand to include power plants, water reclamation facilities and even high-rise buildings located along the waterfront.

For more information, please do not hesitate to contact Johnson & Krol, LLC.