WHAT EMPLOYMENT LAWYERS NEED TO KNOW ABOUT OTHER PRACTICE AREAS

ERISA FOR EMPLOYMENT LAWYERS

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In this article, we will discuss three of the most frequently discussed topics concerning the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and other related laws: (i) health care reform, (ii) due diligence in mergers and acquisitions, and (iii) multiemployer pension plans.

I. Health Care Reform –Compliance Challenges Ahead

Corporate compliance professionals will be facing historical compliance challenges as the U.S. Patient Protection and Affordable Care Act ("PPACA" or the "Health Care Reform Act") goes into effect. From now through 2014, employers of all sizes will find themselves subjected to new rules, regulations and penalties regarding health care benefits plans and administration. All employers will be required to make substantial changes to their group health plans' design, and they will need to provide summary plan descriptions ("SPDs") and other communication updates to their employees.

While many of the provisions of the Health Care Reform Act will not take effect until 2014, employers need to start now to assess their health care benefit plans and prepare for those plan design, communication and administrative changes that will be required in order to ensure they are in compliance.

A. Reform's Effect on Employer Group Health Plans

The Health Care Reform Act imposes many new rules and possible penalties on employers. Among the most significant are:

- Employers with more than 200 employees must automatically enroll their employees in the employer-sponsored group health plan.

- Employers with more than 50 employees – who do not offer minimum essential health benefits – will be subject to stringent penalties. If they have at least one employee who receives a federal premium tax credit because of coverage through an individual American Health Benefit Exchange, they will be assessed a fee of $2,000 per full-time employee, with a penalty exception for the first 30 employees.

- If the employer's group health plan requires contributions in excess of 9.8% of income for any employee, the employer will be assessed a penalty of $3,000 for each full-time employee who receives a premium tax credit, with a penalty exception for the first 30 employees.

- Employers with more than 50 employees may not have a group health plan waiting period of more than 90 days.

- Employers must offer a "free choice" voucher to an employee to help pay for coverage through an American Health Benefit Exchange, if the employee's income is less than 400% of the federal poverty level, and the required employee contribution for the employer's own group health plan is between 8% and 9.8% of the employee's income.

B. Immediate Reform Changes

Employers will start seeing some reform changes this year. These provisions, which are generally applicable for plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar years plans), may require changes in plan design or amendments to insurance contracts, as well as changes to summary plan descriptions, to ensure compliance. These changes will affect both insured and self-funded group health plans.

One caveat: Under the Act's "grandfather rules" not all provisions apply to all plans. A grandfathered plan is a group health plan that was in existence on March 23, 2010, and complies with certain notice requirements. However, grandfathered status is lost if the employer "enters into a new policy, certificate or contract of insurance" after March 23, 2010. (Special rules apply to collectively bargained plans.)

Grandfathered status can also be lost if the plan:
- eliminates substantially all benefits to diagnose or treat a specific illness;
- increases certain cost sharing requirements by a specified amount;
- decreases the employer contribution percentage by a specified amount; or
- imposes certain new annual limits on benefits.

Both grandfathered and non-grandfathered plans must comply with the following provisions as of the first day of the first plan year beginning on or after September 23, 2010. (Different effective dates apply to collectively bargained plans.):

C. Coverage of Adult Children

Under one of the most significant changes, all group health plans must make health care coverage available to children of plan participants until they reach age 26–whether they are married or single, and regardless of whether the child continues to be a "dependent" of the plan participant for federal income tax purposes.

For plan years beginning before 2014, grandfathered plans may exclude an adult child if the child is eligible to enroll in another employer-sponsored plan (other than that of the second parent).

The rules also require a special, one-time enrollment period for adult children who are currently not covered by the plan, including those who lost coverage because of age, those who are currently on COBRA and those who were never covered by the plan but who will become eligible because of the change in the law.

D. Restrictions on Annual and Lifetime Benefit Limits

For plan years beginning on or after September 23, 2010, all group health plans will be prohibited from imposing lifetime dollar limits on essential health benefits.

In general, group health plans will also be prohibited from imposing annual limits on essential health benefits. However, restricted annual limits may be imposed by grandfathered group health plans, until 2014.

Individuals who reached a lifetime limit under current plan provisions and who are otherwise still eligible for plan coverage must be notified that the lifetime limit no longer applies. If the individuals are no longer enrolled in the plan, they must be given a 30-day enrollment period before the first plan year beginning on or after September 23, 2010.

E. Pre-existing conditions

Under the Health Care Reform Act, group health plans cannot impose a pre-existing condition exclusion on a child under the age of 19. For plan years beginning on or after January 1, 2014, this prohibition will apply to *all* participants and beneficiaries.

F. Over-the-Counter Medications

Effective January 1, 2011, all Health Care Flexible Spending Account Plans and Health Reimbursement Accounts that currently cover over-the-counter medications will no longer be able to reimburse plan participants for expenses relating to non-prescribed, over-the-counter medications (with the exception of Insulin). Health Savings Accounts will not be able to reimburse the cost of these over-the-counter medications on a tax-exempt basis.

G. Other Important Provisions:

Non-grandfathered plans will also have to comply with the following provisions:

- Preventative Care Services: Certain preventative care services, including well child and well baby care, certain mammograms and services recommended by the U.S. Preventative Services Task Force or the Centers for Disease Control and Prevention, must be covered by the plan with no cost-sharing, such as co-pays or deductibles.

- Choice of Health Care Provider and OB/GYN Referrals: A plan participant or beneficiary must be permitted to select his or her primary care provider, and those of his or her dependents (including pediatric care providers) from any provider who participates in the

plan's network. In addition, a primary care provider's authorization or referral is not required for obstetrical or gynecological care provided by a network physician.

- Emergency Care Services: Participants and beneficiaries will be entitled to receive emergency care services without prior authorization and without regard as to whether the emergency health care provider is a participating provider in the plan's network.

- Internal and External Review Processes: Non-grandfathered group health plans must have "effective" internal and external appeals processes for coverage determinations and claims. ERISA-covered plans that comply with the Department of Labor's current claims procedures will only have to make minor adjustments to be in compliance with the new rules for internal appeals. Most insured plans are already required, through state insurance law, to provide a satisfactory external appeals process. The external review requirements for self funded, non-grandfathered plans have not yet been announced.

H. Communication Challenges

As overwhelming as these changes are to benefits professionals, they are even more confusing for plan participants. Employees will be looking to their employers to explain how health care reform affects them and their benefits.

By focusing attention on the provisions of the health plan(s) employers can improve employee understanding of what their plans cover and how they work—and help ensure that their employees are using the plans wisely.

Increased communication can have another positive effect. Recent studies by MetLife and Towers Watson have shown that employers with good benefits communications have more satisfied and engaged employees—and that typically means higher retention and productivity.

Reform is creating new decision points for employees. Good communication will help to facilitate decision making and avoid confusion. Some of these new choices are:

- Special enrollment periods for dependent children who had "aged out" under previous eligibility rules
- Special enrollment periods for participants who had hit the lifetime limit
- The automatic enrollment requirement—and the opt out process
- The elimination of over-the-counter medicines as covered medical expenses under account-based plans—which will affect how much to set aside in those accounts.

Further, some of these changes must be communicated now—before open enrollment—while still others have longer applicability (e.g., auto-enrollment). For these longer-term changes, employers will most likely need to issue new SPDs or summaries of material modifications ("SMMs").

I. What Employees Need to Know

The DOL requires employers to issue a new SPD at least every five years if there have been changes to the plan; if there have been no plan changes, a new SPD must be issued every 10 years. Employers who have not updated their SPDs recently may want to take this opportunity to do so, while they are incorporating changes required by the Health Care Reform Act.

With the volume, complexity and frequency of the information that must be communicated under the Health Care Reform Act, it's critical to create a robust communication plan that integrates required communications such as SPDs, SMMs and the four page summary required as of 2012, with other communication vehicles such as open enrollment materials, newsletters and emails.

An effective communication plan will map out:

- What needs to be communicated when—IRS, DOL and HHS has already specified many required changes and when they take effect
- When additional guidance is coming from IRS, DOL and HHS
- Who needs what information when—list out all constituents (management, supervisors, employees, retirees, dependents, new hires) along a timeline
- Who needs to review and approve what information—who internally (subject matter experts, legal, compliance, communications) and externally (vendors, legal counsel, administrators) will need to be involved
- What decisions will need to be made about benefit strategy and design
- What is the best timing and media to get messages across
- Who's going to do the work—are internal resources available, or does it make sense to outsource some or all of the effort.

Finally, think about how technology can help. If getting documents through the review process is a challenge, a technology-based, review management solution can help manage the flow of documents from one reviewer to another, and maintain an audit trail of who changed what. If you have many and/or especially complicated SPDs, an automated solution can dramatically speed up your update process, and reduce the likelihood of error.

J. Action Steps—Best Practices

Prepare for compliance *now***.** The effective date for many provisions is the first plan year beginning on or after September 23, 2010 – January 1, 2011 for calendar year plans. These notification requirements and special open enrollments should be completed during your next general open enrollment period.

After determining whether or not you have grandfathered plan protection, assess your group health plan to determine which of the new requirements will require plan changes. Also, you should assess your open enrollment procedures, to determine, for example, if your current system and open enrollment dates can support the additional special enrollments for adult children and for employees and beneficiaries who had previously reached their lifetime maximum benefits.

Then, look at your SPDs and amend SPDs and other communication materials to inform your employees – as early as possible – of upcoming changes.

K. More Regulations Ahead

The government will be issuing new rules and regulations on the Act and, most likely, changing the rules it has already made, based on employers' and insurers' comments. Health care reform will remain a moving target for the foreseeable future and the only way to ensure compliance is to be constantly up-to-date on all matters effecting group health plans, and communicate changes to employees, to ensure compliance.

II. Due Diligence in Mergers and Acquisitions

A. Introduction

Whether they are qualified retirement plans, health plans or executive compensation arrangements, the benefit programs of a company that is an acquisition target may be a source of significant liabilities. All such programs are promises that the target has made to its employees, and the buyer must ascertain whether it is liable to fulfill them and, if so, the dollar value of those promises. In addition, if the plans have been incorrectly drafted or operated, a buyer could find itself responsible for additional tax liabilities. Parties to a merger or acquisition should consider benefits issues early in the negotiations before the form of the acquisition has been resolved.

B. Structure of Transaction

1. Stock Purchase. In a stock sale or the merger of the target into the buyer, benefit liabilities remain with the target or automatically transfer to the buyer or its acquisition subsidiary. In a merger, all liabilities associated with the target's benefit plans will be assumed by the surviving entity. The buyer should know what liabilities it is assuming before the purchase is completed and preferably before a final determination of the purchase price.

    a. Benefits issues are frequently one of the last items considered by those negotiating the transaction. However, they will occasionally drive the form of the transaction, such as when a seller insists on a stock transaction where it would otherwise be required to pay a large withdrawal liability with respect to a collectively bargained multiemployer plan.

    b. The buyer in a stock transaction will expect extensive representations and warranties from the seller to the effect that

there are no material liabilities with respect to the seller's benefit plans. Representations as to the existence of or whether there has been a termination of a defined benefit plan governed by Title IV of ERISA are also typical. The breach of such representations and/or warranties can have varying consequences to the seller depending on the terms of the deal. If the representations and warranties are structured so that they do not survive the closing (a negotiable point), the due diligence phase of the transaction increases in importance.

2. Asset Sale. In an asset sale, the buyer does not assume any plans or plan liabilities unless it takes affirmative steps to do so. Because uncertainty has arisen over whether the buyer might be treated by regulators or the courts as a successor employer, some buyers will conduct due diligence on potential liabilities generated by the seller's plans and negotiate contractual protections similar to those in a stock deal. See item II.D.9.b, below for special rules relating to COBRA coverage by successor employers.

   a. Generally, an asset deal will require a less extensive review of a plan's operation and administration. However, this will not be the case if the buyer is assuming responsibility for the seller's plans.

   b. Unlike in a stock purchase, in an asset deal, the buyer can cherry-pick the benefit liabilities it wishes to assume.

C. Due Diligence

1. General Considerations. The buyer should review every current employee benefit plan, program or practice. This review should cover the documentation and form of a plan, as well as its operation. The objective is to discover hidden or contingent liabilities that should be covered by the seller's representations and warranties and by indemnification provisions.

2. Document Requests. The buyer will generally furnish the seller with a list of current plan documents that the buyer wishes to review. The seller will be asked to represent that it has furnished copies of such documents that are complete and up-to-date. For a stock transaction, the buyer should also examine plans, programs and practices that existed for a specified period of time before the acquisition. The list of requested documents should include the following:

   a. Qualified Plans. For a plan, such as a 401(k) plan, the plan document, including plan amendments; the trust agreement; Board resolutions approving the adoption of the plan and any

amendments; the summary plan description (referred to as the "SPD"); summaries of material modifications; any administrative services agreement; and, if applicable, a collective bargaining agreement. In addition to such plan documentation, the list of requested documents will cover IRS determination letters; annual reports on Form 5500; discrimination tests for the most recent 3 years; the plan's fiduciary liability insurance policy; forms relating to qualified joint and survivor annuities and qualified preretirement survivor annuities; any insurance company contracts; and for plans allowing plan participants to invest in employer stock, Forms S-8 and 11-K.

b. Health and Welfare Plans. The plan document; insurance contracts (including stop-loss policies) for health, life, dental, vision, accidental death and dismemberment and long-term and short-term disability coverage; summary plan description and summaries of material modifications; annual reports on Form 5500 for the most recent 3 years; COBRA notices, forms and written procedures; HIPAA certificates; if the plan is self-insured, information relating to claims experience; enrollment forms; and administrative service agreements.

c. Bonus and Incentive Plans. Plan documents.

d. Employment Agreements.

e. Employee Handbook.

f. Severance and Deferred Compensation Plans. Plan documents; insurance policies; rabbi trusts; and a schedule of participants and the amounts owed.

g. Change of Control Plans. All plans, agreements or arrangements providing benefits contingent on a change of control of the target.

h. IRS and DOL Correspondence. Correspondence, inquiries or examination notices to or from government agencies, such as the IRS, Department of Labor or Pension Benefit Guaranty Corporation.

i. Equity Compensation Plans. Copies of plan documents for stock option plans and employee stock purchase plans; the forms of agreement used with such plans; and shareholder consents relating to such plans.

j. Golden Parachute Information. A list of disqualified individuals for purposes of section 280G of the Internal Revenue Code; copies of their W-2s for the most recent 5 years; and spreadsheets covering stock options showing number of shares, grant date, strike price and vesting.

k. Worker Classification. List of consultants, independent contractors, leased employees and temporary employees who have worked at least 6 months for the company and the forms and agreements used for such workers.

D. Issues to Look For

1. Right to Terminate or Amend. Each plan, program or practice should be examined to ensure that it reserves to the sponsor the right to terminate or amend the plan. Otherwise, the buyer may be forced to continue providing benefits under the seller's plan indefinitely for those who were employees on the acquisition date. This is particularly important for retiree health plans which can represent a large unfunded liability of the target.

2. Acceleration of Benefits. The buyer will wish to know whether a plan, program or practice provides for accelerated vesting or any other consequence as a result of the transaction that could increase its costs. Stock option vesting and golden parachute payments would be typical examples.

3. Outstanding Participant Claims. The buyer should ask for information on such claims and how they are being handled.

4. Government Audits. The seller's representations should include information as to whether any audits are underway and, if so, what issues have been raised.

5. Qualified Plan Defects. The parties frequently discover one or more qualification defects relating to the seller's qualified retirement plans. Solutions range from correcting the defect through the IRS's voluntary correction program to restructuring the deal so that the buyer does not adopt or assume responsibility for the plan in question.

6. Pension Plan Termination Liability. If the seller maintains a defined benefit pension plan, the buyer should examine the amount of the plan's liabilities compared to the value of its assets. If there is underfunding, the buyer may seek an adjustment to the purchase price to reflect this fact.

Alternatively, the buyer may seek to restructure the transaction as an asset sale.

7. Multiemployer Plan Withdrawal Liability. Where the seller is obligated to contribute to a multi-employer pension plan, the buyer should determine the plan's unfunded vested liability and the portion of such liability allocable to the seller, as discussed in Part III, below.

8. Severance. Severance programs should be examined and, if necessary, restructured to ensure that they will not apply to employees of the target who continue to work for the buyer. Such plans are generally not subject to ERISA which makes it easier to change them.

9. COBRA. IRS regulations provide rules for determining the COBRA liabilities of buyers and sellers unless, as permitted, the parties reallocate these liabilities by agreement. If there is no agreement, the allocation of liability depends on the nature of the transaction.

    a. Seller Maintains Health Plan. If the seller or an affiliate continues to sponsor a group health plan after the sale, the selling group is required to offer COBRA coverage to "M&A qualified beneficiaries". M&A qualified beneficiaries include:

        i. Persons already on COBRA under the seller's plan who were formerly employed (or had a spouse or parent that was formerly employed) in connection with the assets being sold, and

        ii. Persons who lose coverage as a result of a sale.

    b. Selling Group Discontinues Health Plan - Asset Sale. In an asset sale where the selling group does not continue to maintain a group health plan after the sale, the buyer assumes COBRA liability if it is a "successor employer". A buyer is a successor employer if it continues the business operations associated with the assets purchased from the selling group without interruption or substantial change. Accordingly, such a buyer will be responsible for the COBRA coverage of former employees of the seller not actively employed as of the closing as well as actively employed persons that the buyer elects not to employ. If the buyer provides COBRA coverage in such a scenario, the seller will typically agree to assume responsibility for any losses incurred by the buyer as a result.

c. Selling Group Discontinues Health Plan - Stock Sale. In a stock sale where the selling group no longer maintains a group health plan, the buyer is automatically the successor employer and, consequently, assumes responsibility for COBRA coverage.

d. Penalties for Failure to Comply. $100 per day for each employee or qualified beneficiary. The buyer should seek a warranty from the seller that it has complied with COBRA.

E. Going Forward Alternatives in Dealing with Benefit Plans

1. Continue Seller's Plans. This is the least disruptive alternative for employees affected by the transaction, but its success depends on whether the seller's plans will continue to satisfy the coverage and nondiscrimination rules of the Internal Revenue Code when tested by considering the combined workforce of the buyer and former employees of the seller transferring to the buyer. The addition of a new group of employee's to the buyer's workforce may create coverage and/or discrimination problems if the buyer's plan has better benefits than the seller's plans. The converse may also apply, that is, if the seller's plans have better benefits and former employees of the seller that transfer to the buyer are highly compensated relative to the buyer's workforce, discrimination may result. The nondiscrimination rules give the buyer until the end of the plan year following the transaction to meet coverage requirements going forward.

2. Merge Buyer and Seller Plans. Plan mergers generally occur after the closing and are handled in a separate employee matters agreement. This is a typical strategy if the goal is to provide the same benefits to all employees. However, plan mergers must meet detailed requirements imposed by the Internal Revenue Code. In the case of ERISA pension plans, the buyer must be careful to preserve optional forms of benefits, as well as any early retirement options applicable to the portion of benefits attributable to the seller's plan. Before committing to merge plans, the buyer should assure itself that the seller's plan is fully compliant with the Internal Revenue Code's qualified plan rules. Otherwise, the qualified status of the surviving plan could be compromised.

3. Terminate Seller's Plans. This makes sense if the buyer will provide its own plans to former employees of the seller. A buyer may make termination of the seller's plans a condition to closing the transaction or the buyer may terminate the plans immediately after the transaction. (In the latter event, the qualified plans will have to satisfy coverage and nondiscrimination rules when considered as part of the buyer's controlled group.) Benefits are usually distributed from a terminated plan shortly

after the termination, although it is good practice to obtain a final determination letter from the IRS before doing so.

a. Generally, a defined benefit plan cannot be terminated until it is fully funded.

b. In a stock deal, where the parties desire to distribute 401(k) plan accounts, the seller should begin the termination process prior to closing. This may be accomplished by a Board resolution approving the plan's termination. If the seller fails to take such action, a successor plan rule will apply. This rule treats the plan as not having been terminated without the establishment or maintenance of a successor plan, the end result of which is that distributions will be prohibited. These concerns generally do not apply in asset sales.

III. Multiemployer Pension Plans – The Problems Surrounding Withdrawal Liability

One of the most frequently asked questions that we have received at the Wagner Law Group over the past three years relate to multiemployer pension plans. As one might expect, these questions have been driven in large part by the economic downturn starting in 2008 that has dramatically increased the underfunding of multiemployer pension plans and caused many contributing employers to question their withdrawal liability exposure to these plans. This exposure can be significant, and it can be challenging to quantify.

A. Background

For those unfamiliar with these types of plans, a multiemployer pension plan is a defined benefit retirement plan to which two or more unrelated employers contribute pursuant to collective bargaining agreements. Multiemployer pension plans are also known as "Taft-Hartley trust funds" because they are managed by a joint board of trustees whose duties and responsibilities are prescribed under the National Labor Relations Act § 302(c)(5)[1] as amended by the Taft-Hartley Act.[2] The multiemployer pension plan's contributing employers and union are equally represented on the plan's joint board of trustees.

As defined benefit plans, multiemployer pension plans are subject to minimum funding rules described in ERISA §§ 304 and 305 and Internal Revenue Code ("IRC") §§ 431 and 432. The minimum funding rules for multiemployer pension plans are generally more lenient than those imposed on single-employer plans.[3] If a multiemployer pension plan is underfunded when a contributing employer withdraws—completely or partially—the plan assesses withdrawal

[1] 29 U.S.C. § 186(c)(5).
[2] Officially, the Labor–Management Relations Act, Pub. L. 80-101 (June 23, 1947).
[3] A single employer pension plan generally must be funded over seven years under IRC § 430(c)(2)(B), while a multiemployer pension plan generally must be funded over fifteen years under IRC § 431(b)(2)(B).

liability against the contributing employer for its share of the plan's unfunded vested benefits. The withdrawal liability rules are described in ERISA §§ 4201 thru 4225.

B. Withdrawal Liability Estimate Requests

Since multiemployer plans are not under the control and management of the individual contributing employers, an employer must seek withdrawal liability information from the plan itself. What are the rules governing a contributing employer's request for a withdrawal liability estimate? In answering this question, it is worth discussing the rules in effect prior to the Pension Protection Act of 2006[4] ("PPA") was enacted, and those in effect thereafter.

ERISA § 4221(e). Even before the PPA was enacted, ERISA § 4221(e) required a plan to provide "general" information necessary to compute withdrawal liability without charge. However, plans were able to require an employer to pay the reasonable cost of providing a withdrawal liability estimate or other information "unique" to the employer, on the grounds that such information was not "general" in nature. In other words, ERISA § 4221(e) allowed a plan to charge for the actuarial work involved in calculating a unique withdrawal liability estimate for a contributing employer. For example, one of our clients paid $6,500 for its withdrawal liability estimate. We suspect that the bulk of the $6,500 was to cover the plan's cost for the actuarial work involved in calculating the withdrawal liability estimate.

The PPA added a new provision, designed to remedy this problem and cost for contributing employers. However, as a technical matter, the PPA failed to repeal ERISA § 4221(e), although that was what was clearly intended. It was not until the Worker, Retiree, and Employer Recovery Act of 2008[5] ("WRERA") was enacted, that this technical drafting error was corrected, by repealing ERISA § 4221(e), effective for plan years beginning on or after January 1, 2008.[6]

ERISA §101(l). The Pension Protection Act of 2006[7] ("PPA") significantly changed the rules for requesting withdrawal liability estimates. The PPA[8] added ERISA §101(l), which now requires a multiemployer pension plan to provide, upon request, a notice with a withdrawal liability estimate and an explanation of how the estimate was determined. More importantly, ERISA §101(l) allows the plan to charge only for "copying, mailing and other costs of furnishing such notice." Thus, by its literal terms, ERISA §101(l) does not allow a plan to charge for the actuarial work involved in calculating the withdrawal liability estimate because the actuarial costs or similar professional fees are significantly different from copying, mailing, or similar ministerial costs. Based on our recent experience requesting withdrawal liability estimates, multiemployer pension plans seem to accept that view.

C. Annual Withdrawal Liability Payment

[4] Pub. L. 109- 280 (August 17, 2006).
[5] Pub. L. 110-458 (December 23, 2008).
[6] See WRERA §§ 105(b)(2) and 112.
[7] Pub. L. 109- 280 (August 17, 2006).
[8] See PPA § 502, effective for plan years beginning after December 31, 2007.

A contributing employer's withdrawal liability is the liability imposed on the employer when it "withdraws" from the multiemployer plan. This liability represents the employer's proportionate share of the plan's unfunded vested liabilities. This withdrawal liability is to be assessed and collected by the plan, not by the PBGC. But once an employer withdraws and ceases participation in a multiemployer plan, the employer does not have to pay its withdrawal liability to the plan in an immediate lump sum. And in certain instances, the employer may pay substantially less than the full amount of the withdrawal liability.

Lump Sum Payment Not Required. Upon a complete or partial withdrawal, must a withdrawing employer pay the withdrawal liability in a lump sum? The answer to that question is "no" as long as the withdrawing employer pays the annual withdrawal liability payments or the equivalent quarterly or more frequent[9] installment payments. [10]

Contribution Rate and Base. That leads to our next question: Is there any relationship between (i) the amount of the annual withdrawal liability payment and (ii) the amount of the withdrawing employer's share of the unfunded vested benefits? Surprisingly, the answer to this question is also "no." The amount of the annual withdrawal liability payment depends solely on the statutorily-prescribed contribution rate and contribution base related to the withdrawing employer. To be specific,

- the contribution rate is the highest contribution rate during the last ten years, including the year of withdrawal, and
- the contribution base is the highest average annual number of hours (or other units used to measure the contribution base (e.g., tons of coal produced)) for three consecutive plan years during the ten plan years prior to the withdrawal.

In almost all cases, the current contribution rate will be highest during the last ten years, including the year of withdrawal. Determining the highest three-consecutive-year average in the 10-year look-back period requires the plan to keep track of hours worked. A contributing employer that has not been keeping track of hours but only the dollar amount of its contributions can determine the approximate number of its hours by dividing the contribution amounts by the contribution rate when the contributions were made. The point is that a contributing employer does not need to request a withdrawal liability estimate from a multiemployer plan in order to determine its annual withdrawal liability payment.

Amortization Period. After withdrawing employers determine their annual withdrawal liability payment, they frequently ask: how long must they pay the annual withdrawal liability payments? The answer to this question depends upon the amount of the withdrawing employer's share of the unfunded vested benefits. For example, if the plan is well-funded and allocates only a small amount of unfunded vested benefits to the withdrawing employer, the amortization period could be a few years. On the other hand, if the plan is severely underfunded, the amortization period could last indefinitely; particularly, if the plan has a high interest rate assumption and the

[9] ERISA § 4305(c)(3) authorizes a plan to require payment "quarterly, or at other intervals specified by plan rules."
[10] ERISA § 4305(c)(4) allows a plan to accelerate the payment of withdrawal liability only if the withdrawing employer defaults on its installment payment obligation.

withdrawing employer's annual withdrawal liability payment is relatively small in comparison to its share of the plan's unfunded vested benefits.

20-Year Cap. This leads to the next question: Does ERISA impose a cap on the number of annual withdrawal liability payments? The answer to this question is "yes." ERISA § 4219(c)(1)(B) limits the withdrawal liability amortization period to 20 years. This 20-year cap can significantly reduce a withdrawing employer's withdrawal liability.

Consider the following example. The withdrawing employer's annual withdrawal liability payment was $146,000 and the plan allocated $1.9 million in unfunded vested benefits to the contributing employer. Using the plan's 8.5% interest rate assumption, the present value of the 20 annual withdrawal liability payments was $1.5 million, which was approximately $400,000 less than the $1.9 million in unfunded benefits that the plan had allocated to the withdrawing employer. This example also illustrates that a withdrawing employer can estimate its maximum withdrawal liability under the 20-year cap without requesting a withdrawal liability estimate from the plan.

However, it should be noted that the 20-year cap does not apply if all of the contributing employers withdraw, resulting in the plan's termination under the law due to a "mass withdrawal."

Negotiating Lump Sum Payoff. The $1.5 million present value figure in the example also did not take into account the withdrawing employer's risk of bankruptcy. As long as the withdrawing employer makes its annual withdrawal liability payments, the plan's ability to collect the remaining withdrawal liability payments remains subject to the withdrawing employer's risk of bankruptcy. Thus, the joint board of trustees for the multiemployer pension plan should seriously consider exchanging the employer's obligation to make annual withdrawal liability payments over 20 years for a lump sum payoff that is significantly less than the $1.5 million.[11] Exchanging the 20-year payment obligation for a discounted lump sum payoff is an idea worth exploring by a withdrawing employer.

D. Partial Withdrawals

There are two types of withdrawals. A "complete withdrawal" occurs when the employer (including all controlled group members) permanently ceases to have an obligation to contribute to the plan or permanently ceases all covered operations under the plan. Special withdrawal liability rules apply to plans and employers in certain industries, such as construction, or less frequently, trucking.

A "partial withdrawal" generally occurs when there is a partial cessation in the employer's obligation to contribute to the multiemployer plan. The rules governing whether a partial withdrawal has occurred are extremely technical in nature, but they are based on two types of events: (i) one is based on a cessation of an employer's obligation to contribute to the plan through collective bargaining at some, but not all, of its facilities, and (ii) another is based on a

[11] ERISA § 4205(c)(4) allows a withdrawing employer to prepay its withdrawal liability payments without penalty.

decline in the employer's contributions to a multiemployer pension plan usually caused by difficult economic conditions.[12]

Non-Unionization. The first type of partial withdrawal would occur immediately by non-unionizing a facility that continues to operate. Thus, if the contributing employer ceases to contribute under a collective bargaining agreement for a facility but continues to operate that facility without an obligation to make contributions for the work at the facility, then a partial withdrawal will occur, regardless of the amount of contributions at the other facilities that remain subject to the contribution obligation under the collective bargaining agreement.

Decline in Hours. The second type of partial withdrawal would occur gradually by a decline in a contributing employer's hours covered by a plan to 30% or less of the high base year[13] in each year of a three-year testing period.[14] Thus, a partial withdrawal based on decline in contributions would evolve over three years. The key point is a contributing employer suffering an economic decline would not trigger a partial withdrawal even if its hours temporarily fall below or to the 30% threshold for one or two years. Rather, the contributing employer will trigger a partial withdrawal only if its hours fall below or to the 30% threshold in each of the three years in the testing period.

Withdrawal Liability for Partial Withdrawal. An employer's withdrawal liability for a partial withdrawal is a *pro rata* portion of the liability the employer would have incurred for a complete withdrawal. The partial withdrawal liability amount reflects the decline in the withdrawing employer's contribution base units, and it is calculated by multiplying the complete withdrawal liability by a fraction.

Conceptually, the partial withdrawal fraction reduces the amount of the unfunded vested benefits that a plan would allocate if the partial withdrawal were a complete withdrawal. The fraction is calculated as of the date on which the partial withdrawal occurs and is one minus another fraction whose:

- numerator is partially withdrawing employer's contribution base for the plan year following the plan year in which partial withdrawal occurred, and

- denominator is the average of partially withdrawing employer's contribution base for the 5 plan years immediately preceding the plan year in which the partial withdrawal occurs.[15]

The partial withdrawal fraction does not affect the amount of the annual withdrawal liability payment; it only affects how many payments that the partially withdrawing employer will make. That is to say, the annual payment for a partial withdrawal is the same annual payment amount

[12] ERISA § 4205(b)(1).
[13] The "high base year" is an average based on two of the five plan years preceding the testing period during which the hours were the highest.
[14] ERISA § 4205(b)(1)(A).
[15] ERISA § 4206.

that would have applied if the employer had incurred a complete withdrawal. However, the amortization period during which ongoing payments are made is reduced in the case of a partial withdrawal.

E. Business Sale Structure

If a contributing employer sells its business to an unrelated buyer, the transaction can be structured as either a stock sale or asset sale.

Stock Sale. If the transaction is structured as a stock sale, then (i) the contributing employer will continue to contribute to the plan albeit under the new ownership, and (ii) there is no withdrawal. However, the buyer inherits the contributing employer's complete contribution history and, thus, inherits potential partial or complete withdrawal liability based on the last ten years of that contribution history.

Asset Sale. If the transaction is structured as an asset sale, then it will trigger withdrawal liability unless (i) the contributing employer continues to contribute to the plan for sufficient hours[16] to avoid triggering a partial withdrawal as explained earlier or (ii) the contributing employer and the buyer comply with the asset sale rules in ERISA § 4204. Complying with asset sale rules not only avoids triggering a withdrawal but could also eliminate the contributing employer's potential withdrawal liability after five years.

Under the asset sale rules, the buyer would have to agree (i) to continue to contribute to the plan for substantially the same number of hours as the contributing employer did before the asset sale, and (ii) to post a bond (or deposit funds in escrow) in case the buyer withdraws from the plan during the five plan years following the asset sale. On the other hand, the buyer does not inherit the contributing employer's full 10-year contribution history, but only its last five years. This would enable the buyer to shed the highest contributions in the contributing employer's contribution history if the period of reduced hours is long enough. As a result, the buyer's potential withdrawal liability would be significantly reduced.

Under the asset sale rules, the contributing employer would also agree to be secondarily liable for the withdrawal liability that it would have had on the asset sale in the event the buyer (i) withdraws during the five plan years following the asset sale and (ii) fails to make its withdrawal liability payments. After five years, however, the contributing employer would shed its potential withdrawal liability to the plan.

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[16] While it would be unusual for a contributing employer to continue contributing on behalf of its former workers employed by an unrelated buyer after an asset sale, the ERISA withdrawal liability rules would not prevent such an unusual arrangement.