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For Your Benefit

A newsletter on current legal issues impacting employee benefits and executive compensation

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Asset Sale Results in Unanticipated Pension Liabilities for Purchaser

By Brian D. Sullivan

In January 2011, the Third Circuit Court of Appeals expanded the circumstances under which a purchaser in an asset sale can be liable for the seller's employment-related obligations. The court held that such a purchaser can be liable for the seller's delinquent contributions to a multiemployer benefit plan, if the buyer had notice of the delinquency prior to the sale of assets and if there is sufficient evidence of continuity of operations between the buyer and the seller to justify imposing such liability. The holding, in *Einhorn v. ML Ruberton Construction Company*, follows similar rulings in four other federal appellate courts.

The seller in *Einhorn* was party to a collective bargaining agreement that required it to contribute to multiemployer pension and welfare plans on behalf of its unionized workforce. Prior to the asset sale, the purchaser negotiated with the union and agreed to hire the seller's employees, observe the existing collective bargaining agreement on an interim basis and negotiate a new union contract that would cover all of its employees. The purchaser was aware the seller owed the plan $600,000 in delinquent contributions, and this fact was discussed during the pre-sale negotiations with the union. However, the resulting agreement was silent as to what responsibility, if any, the seller would bear for those delinquent amounts.

Following the asset sale, the purchaser took over several of the seller's existing projects and subcontracted with the seller to provide labor on other projects retained by the seller. The purchaser leased, and later bought, real estate from the seller. The purchaser also began contributing to the multiemployer pension and welfare plans on behalf of employees who now were covered by its agreement with the union.

When the seller failed to pay its delinquent contributions to the benefit plans, the plan administrator filed suit alleging the purchaser was a successor in interest to the seller and, therefore, liable to the plan for the delinquency. The district court dismissed the suit and granted summary judgment in favor of the purchaser. However, the Third Circuit reversed, holding that the purchaser in an asset sale may be liable for the seller's delinquent ERISA fund contributions if the buyer had notice of the liability prior to the sale and provided there is sufficient evidence of continuity of operations between the buyer and the seller.

Noting that the inquiry regarding continuity of operations must be made on a case-by-case basis, the Court of Appeals sent the case back to the district court to apply the "substantial continuity test" and determine whether there was sufficient evidence of continuity of operations between the buyer and seller to justify imposition on the purchaser for delinquencies incurred by the seller prior to the sale of assets. In applying the substantial continuity test, the factors to be considered include continuity of the workforce, management, equipment and location, completion of work orders begun by the predecessor, and constancy of customers. Commonality of ownership is not required.

Although the court determined that imposition of such liability is necessary to vindicate important federal statutory policy as reflected in ERISA, there is no specific provision in ERISA that requires such a result. To the contrary, the statute implicitly acknowledges the traditional common law rule that an entity purchasing the assets of another is responsible for the seller's liabilities only if the buyer expressly or impliedly assumes those liabilities. The court invoked its authority under ERISA to develop a federal common law of employee benefit plans, noting a central policy goal underlying the law's enactment was the protection of plan participants and their beneficiaries. It concluded this remedial legislation should be construed liberally in order to protect these participants and beneficiaries from the harm that would result from the seller's failure to pay contributions.

In This Issue:

Federal courts have modified the traditional common law rule in other circumstances in which it was deemed necessary in order to effectuate national labor policy. It has long been the case that liability for a predecessor company's unfair labor practices could be imposed on a subsequent purchaser of its assets under certain circumstances because the successor company "is generally in the best position to remedy" the violation of its predecessor. More recently, federal courts have expanded the potential liability of a successor employer to include employment discrimination claims under Title VII and analogous state and local laws prohibiting discrimination in employment. Thus, the holding in *Einhorn* and in other federal appellate cases reaching similar results can be seen as a further expansion of the willingness of federal courts to modify the traditional common law rule regarding allocation of liabilities in connection with the sale of assets by businesses in order to effectuate national labor policies.

Einhorn holds that a purchaser cannot be found liable for the seller's delinquent contributions unless the purchaser is aware of the delinquency prior to the sale. Thus, the issue here is not due diligence in discovering the liability, but rather, determining prior to the sale, what steps, if any, the prospective purchaser can take to insulate itself from such liabilities. Employers that are party to multiemployer pension plans already face potential exposure for circumstances often beyond their control, such as withdrawal liability, mass withdrawals and liability resulting from rehabilitation plans and surcharges imposed pursuant to the Pension Protection Act of 2006. Businesses considering transactions that will result in their becoming contributors to a multiemployer plan should fully investigate the actuarial and financial condition of the plan and the ramifications of becoming a contributing employer.

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Reminder: Notice Requirements Under the Patient Protection and Affordable Care Act

By Sarah Ivy

As you likely are aware, Congress passed the Patient Protection and Affordable Care Act (PPACA) effective March 23, 2010. Many of the PPACA's provisions became effective in 2011 (depending on your group health plan's "plan year"), which include the notice requirements imposed on plan sponsors and requiring revisions to enrollment materials, summary plan descriptions (SPDs) and other plan documents related to employer-sponsored group health plans.

We recommend that the following required notices be incorporated into 2011 open enrollment materials or, if open enrollment materials have already been distributed, sent to plan participants in the form of an addendum to the open enrollment materials.

Applicable to All Group Health Plans

Special Enrollment Notice for Dependant Coverage of Children Up to Age 26

Effective beginning on the first day of the plan year beginning on or after Sept. 23, 2010, group health plan coverage must be offered to dependents up to the age of 26 (to the extent your group health plan covers dependents). The regulations implementing mandatory dependent coverage of children up to age 26 require plan sponsors to provide a special enrollment notice, which provides dependents an opportunity to be covered by the plan up to age 26 (e.g., children who graduated in May, aged out and have not been covered, are on COBRA on account of aging out, or never were eligible on account of age when the participant was first eligible for plan coverage). If the plan is grandfathered and chooses to utilize the rules pertaining to grandfathered plans, the notice should explain that, until the plan year beginning on or after Jan. 1, 2014, **only** adult children who are not eligible for their own employer-sponsored group coverage may enroll as dependents under their parents' plan.

Notice Regarding Plan's Grandfathered Status

A group health plan in effect as of March 23, 2010, that has not been substantially changed so as to affect its grandfathered status will avoid immediate application of some of the provisions of PPACA. In order to maintain grandfathered status, the plan sponsor is required to include a statement, in any plan materials provided to participants, describing the benefits provided under the plan that are considered grandfathered. If the plan has lost its grandfathered status or was never grandfathered, disclosure that the plan is **not** a grandfathered plan is not necessary.

Special Enrollment Notice for Individuals Who Have Reached Lifetime Limit

Effective the first day of the plan year after Sept. 23, 2010, lifetime limits are eliminated. As a result, plan sponsors are required to give a special enrollment notice to individuals who have reached

the lifetime limit under the plan but otherwise are eligible for coverage. Only individuals who have reached the lifetime limit are required to receive the notice.

Notice of Rescission of Coverage

Plan sponsors now are required to give notice 30 calendar days in advance before coverage can be rescinded (i.e., revoked retroactively). PPACA limited the circumstances under which coverage can be rescinded to cases involving fraud or intentional misrepresentation or cases in which premiums are not paid timely. Plan sponsors may need to revise the plan document and SPD provisions describing how benefits can be lost due to rescission as limited by PPACA.

Applicable to Non-Grandfathered Plans

Patient Protection Disclosures

Plan sponsors are now required to provide a notice regarding participants' rights to: (1) choose a primary care provider or a pediatrician when designation of a primary care physician is a plan requirement, and (2) obtain obstetrical or gynecological care without prior authorization. This notice should be incorporated in the SPD or provided as a separate amendment whenever the SPD is distributed. Grandfathered plans are not subject to these requirements immediately and, thus, disclosure is not applicable.

Conclusion

While the PPACA is intended to give every American equal access to health care coverage, many of its requirements impose additional administrative burdens on employers sponsoring group health plans. We are able to assist you in determining whether your group health plan is grandfathered, and in preparing the required notices plan amendments and updating SPDs as necessary to comply with the PPACA in general.

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Qualified Charitable Distributions Live On

By Susan Foreman Jordan

Based on a provision in the Pension Protection Act of 2006, an individual who is age 70-1/2 or older may make a tax-free donation of up to $100,000 directly from his or her individual retirement account to a qualified charity. Initially, this option was available only in 2006 and 2007, but it was extended through 2009 by provision in the Emergency Economic Stabilization Act of 2008. On December 17, 2010, President Obama signed into law the Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010, which contains a provision that extends the option for making qualified charitable distributions through 2011.

In order to qualify, the payment must be made directly by the IRA custodian to the charity. These disbursements are neither taxable nor deductible. However, qualified charitable distributions will satisfy required minimum distributions.

An IRA owner who has received his or her required minimum distribution may not recontribute that distribution to the IRA to have it be redistributed to the qualified charity. However, if an IRA owner has received a distribution in excess of the required minimum amount, the excess distribution may be rolled back into the same IRA or to another IRA within 60 days of the distribution and have the funds then be paid directly to the charity as a qualified charitable distribution.

The qualified charitable distribution option is available only for amounts accumulated in an individual retirement account. Distributions from employer-sponsored qualified retirement plans, savings incentive match plan for employees (SIMPLE) IRAs and simplified employee pension (SEP) plans are not eligible for this treatment. Moreover, not all charities are eligible recipients. Donor-advised funds and supporting organizations are ineligible, and any distributions made to these charities will be fully taxable to the IRA owner.

A qualified charitable distribution made by January 31, 2011, may be deemed to have been made in 2010 for purposes of satisfying 2010 required minimum distributions. The IRS web site confirms that in such a situation, the amount of the 2011 required minimum distribution is to be determined by subtracting from the individual's December 31, 2010, IRA account balance, the full amount of the qualified charitable distribution made in January 2011.

The Congressional Research Service has suggested that qualified charitable distributions are most valuable to taxpayers who do not itemize their tax deductions and to taxpayers whose charitable contributions exceed 50 percent of gross income. According to the report, other taxpayers can achieve the same result by including the IRA distribution in gross income, donating the distribution to charity and, then, taking a tax deduction for the donation.

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DOL Broadens Definition of Fiduciary

By Theresa Borzelli and Mary Andersen of ERISA Diagnostics, Inc.

In October 2010, the Department of Labor (DOL) issued proposed regulations expanding the definition of fiduciary. Investment advisers and service providers will have to examine the proposed rules to determine whether they fall under the broadened definition. This article provides a brief overview of some of the major provisions of the proposed rules. You should consult your attorney or service provider regarding the impact of the proposed rules on your arrangements.

Background

ERISA currently defines a fiduciary as a person who exercises any discretionary authority or control with respect to plan management or disposition of assets, renders investment advice for a fee or other compensation or has any authority or responsibility to do so, or has discretionary authority or responsibility in the administration of the plan.

DOL regulations provide a five-part test (all of which must be satisfied) that defines the circumstances under which a person is deemed to render investment advice under ERISA. The test considers whether a person renders advice: (1) as to the value of securities or other property or makes recommendations as to the advisability of investing in, purchasing or selling securities or other property; (2) on a regular basis; (3) pursuant to a mutual agreement, arrangement or understanding with the plan or a plan fiduciary; (4) that will serve as a primary basis for investment decisions with respect to plan assets; and (5) that will be individualized based on the particular needs of the plan.

What Are Some of the Major Differences?

The proposed rules would:

1. Define certain advisers as fiduciaries even if they do not provide advice on a **regular** basis;
2. Eliminate the requirement that the parties have a **mutual** understanding that the advice will serve as a **primary** basis for plan investment decisions;
3. Include advisers who perform appraisals and fairness opinions concerning the value of securities or other property. (which activities currently are excluded);
4. Provide exclusions if:
    a. The recipient of the advice knows or should reasonably know under the circumstances that the person is providing advice in his or her capacity as a purchaser or seller, whose interest is adverse to the interest of the plan as well as its participants or beneficiaries and that the person is not undertaking to provide impartial investment advice. To comply with this exclusion, the person seeking to avoid fiduciary status must demonstrate compliance with all the applicable requirements.
    b. Defined contribution service providers who "simply" make available a platform of services and investments from which the plan fiduciary chooses with or without the assistance of the investment provider and discloses in writing to the plan fiduciary that they are not undertaking to provide impartial investment advice.

Why Is the DOL Proposing the Change?

Among the reasons provided is the fact that the rules haven't been changed since 1975, while the retirement plan community has changed dramatically, particularly shifting from defined benefit plans to defined contributions plans. The DOL regulations issued in 1975 narrow the definition as provided in ERISA, making it time-consuming for DOL agents to substantiate fiduciary status. Additionally, the types and complexities of investment practices lend themselves to conflicts of interests that plan sponsors should understand. Changing the rules to add additional circumstances in which investment advice providers are subject to ERISA's fiduciary standards would protect plan participants and beneficiaries.

The DOL also believes that amending the current regulation to define the circumstances under which a person is an ERISA fiduciary will discourage conflicts of interest, improve service value and enhance the government's efforts to allocate its resources effectively. The preamble to the proposed regulations cited a 2005 Securities and Exchange Commission study that revealed that 50 percent of pension consultants examined - or their affiliates - had undisclosed conflicts of interest. The study also revealed there were a number of relationships with broker-dealers that raised various concerns regarding potential harm to pension plans.

What It Means to Plan Sponsors

Initially, service and investment providers will bear the brunt of dissecting the proposed regulations and determining whether their current plan contracts/arrangements make them fiduciaries. The preamble indicates the government expects more service providers will be determined to be fiduciaries under the proposed rules. These service providers could experience higher costs of doing business, which could result in higher fees as well as service providers leaving the market.

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IRS Grants Reprieve To Use of Debit Cards for Over-the-Counter Drugs

By Susan Foreman Jordan

Prior to 2011, the cost of over-the-counter (OTC) medications and drugs was deemed to be a medical expense eligible for tax-free reimbursement under employer-sponsored health plans, including a flexible spending arrangement (FSA) or health reimbursement arrangement (HRA). That changed when the Patient Protection and Affordable Care Act of 2010 redefined "medical expenses" to include only those OTC medicines and drugs for which the individual has a prescription and insulin.

This past September, the IRS issued Notice 2010-59 with additional guidance for implementation of the new rule. Among other things, that Notice defines "prescription," for this purpose, as "a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state." In addition, the Notice provides that effective for expenses incurred after January 15, 2011, FSA and HRA debit cards may not be used to purchase OTC medicines and drugs because current debit card systems are "incapable of recognizing and substantiating that the medicines or drugs were prescribed." On December 23, 2010, the IRS issued Notice 2011-5, modifying that earlier guidance and reinstating the permitted use of debit cards to pay for OTC medications and drugs from certain types of vendors, subject to very specific restrictions.

Importantly, after January 15, 2011, FSA and HRA debit cards may be used to purchase OTC medications or drugs at drug stores and pharmacies, at non-health care merchants that have pharmacies and through mail order and web-based vendors that sell prescription drugs, if (1) prior to purchase, the prescription is presented to the pharmacist and the pharmacist dispenses the OTC medication in accordance with applicable law and assigns an Rx number; (2) the pharmacy retains a record of the Rx number, the name of the purchaser and the date and amount of the purchase and does so in a manner that meets IRS recordkeeping requirements; (3) the pharmacy makes these records available to the employer upon request; (4) the debit card system is designed so that it will not charge for OTC medications or drugs unless an Rx number has been assigned, and (5) the other existing rules applicable to the use of debit cards are satisfied. Notice 2011-5 also permits the use of FSA and HRA debit cards for the purchase of OTC drugs from other vendors that use health-related merchant codes, as long as the vendor retains records of the purchaser, as well as of the date and the amount of the purchase, makes these records available the employer on request and otherwise satisfies existing rules applicable to the use of debit cards.

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Multiple Plan Loans – Don't Forget To Check the Plan!

By Seth I. Corbin

In December, the IRS published guidance in its *Employee Plans News* publication regarding participants requesting multiple plan loans. Unfortunately, plan sponsors often overlook the requirements regarding plan loans, which can lead to several issues for the plan and its participants, including taxable distributions and operational failures that can threaten the tax-qualified status of the plan. Specifically, plan sponsors often forget to check the plan document to determine whether multiple plan loans are permitted. Additionally, calculations must be performed to determine the maximum amount available to a participant in the event multiple loans are permitted under the terms of the plan. The following example was provided by the IRS:

> A retirement plan participant, X, has requested a second plan loan. X's vested account balance is $80,000. He borrowed $27,000 eight months ago and still owes $18,000 on that loan. How much can X borrow as a second loan? Would it benefit X to repay the first loan before requesting a second loan?

As noted above, X will only be able to take a second loan if the plan allows it. Internal Revenue Code Section 72(p) controls the limits on plan loans and, most of the time, those provisions are incorporated either into the plan or a separate loan policy referenced in the plan. Sometimes a plan may contain more restrictive loan provisions. Therefore, it is critically important to confirm the terms of the plan because any plan loan in excess of the permissible amount is treated as a taxable distribution from the plan.

Looking at the example provided by the IRS and assuming the plan permits multiple loans, the second plan loan, when aggregated with the highest outstanding balance of all other plan loans during the previous 12-month period cannot exceed

the lesser of: (1) $50,000, reduced by the excess of the highest outstanding balance of all of X's loans during the 12 months preceding the day before the new loan over the outstanding balance of X's loans from the plan on the date of the new loan; or (2) the greater of $10,000 or 50 percent of X's vested account balance.

As noted above, X's current loan balance is $18,000. Assuming the highest outstanding balance of all of X's plan loans over the previous 12 months was $27,000, the maximum amount X could take as a second loan if X still owes the balance on the first plan loan is calculated as the lesser of:

$50,000 – ($27,000 - $18,000) = $41,000 **OR** $80,000 x .5 = $40,000

Therefore, the maximum amount available to X is $40,000, of which $18,000 is an existing loan balance. This means X can take a new loan of no more than $22,000.

However, if X repays the existing loan before taking out the second loan, there is a different result. Specifically, if X repaid the existing loan ($18,000) before applying for the second loan, X would be limited to the lesser of:

$50,000 – ($27,000 – 0) = $23,000 **OR** $80,000 x .5 = $40,000

In which case, X could take a new loan of up to $23,000.

Plan sponsors need to be mindful of the limitations set forth in Section 72(p) as well as the specific provisions of the plan document to ensure the issuance of multiple plan loans does not result in taxable distributions to participants and possible plan qualification issues.

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Rollovers for Business Startups: A New Wrinkle

By Susan Foreman Jordan

In 2009, the Employee Plans Unit of the IRS initiated a ROBS (rollovers for business startups) Compliance Project to monitor general compliance among ROBS plans. (See our July 2010 newsletter for a detailed discussion of the ROBS strategy.) The IRS found many ROBS plan sponsors were under the mistaken assumption they were not obligated to file an annual report/return (Form 5500-EZ), at least for the first year or few years after the plan was implemented.

Simplified reporting through Form 5500-EZ is available when an individual (alone or with his/her spouse) owns the entire business and the qualified retirement plan provides benefits to no one other than the owner (and/or the owner's spouse). Moreover, a special exemption from the filing requirements applies when the value of the plan assets at the end of the year does not exceed $250,000.

In a ROBS arrangement, the qualified retirement plan invests in employer stock, and while the shares held by the plan may be held as earmarked investments of the owner's account, it is the plan **and not the individual** that is the owner of record.

The entire business, then, is not owned by the individual, and the ROBS plan does not qualify for Form 5500-EZ or the filing exemption. Consequently, in virtually all cases, a ROBS plan is obligated to file an annual Form 5500.

For more information regarding this topic, please contact Susan Foreman Jordan at 412.391.1334 or sjordan@foxrothschild.com or any member of the firm's Employee Benefits & Compensation Planning Practice Group.

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