Preventing Employee Benefits from Tarnishing a Deal

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April 2013

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In the world of mergers and acquisitions, both sides of the due diligence process often overlook the impact on their company's benefits plan. There are three fundamental positions to consider:

1. What will happen to the seller's existing plan?
2. What hidden costs are lurking for the buyer?
3. How will the buyer's and seller's plans integrate?

Without performing a thorough analysis you can't answer these questions. The good news is that you don't have to have the answers immediately; you just have to recognize the need and rely on your advisers to consider and report on the impact to your organization.

Seller's Plan

There are several ways a seller's plan can be impacted. In some cases, the selling organization ceases to exist while in others, only pieces of the organization are sold.

Ceases to Exist

Assuming a total sale under which all employees and assets are transferred to the buyer, any employees or owners that did not transition to the new ownership group would cease to have access to coverage- even at their own expense through COBRA. In the event the bought out owner still needs health insurance, this should be a major consideration.

Example

Consider a family-owned business. The employees of the business transition to the buyer, but the sellers do not intend to make the transition. In some cases there might be three generations of family members that will not be employed but will still need health insurance. While the senior family members would likely have access to Medicare, the junior members would still need coverage. This concern is finite, as healthcare reform will re-create the individual insurance marketplace, but until the exchanges are at full speed, this remains a consideration.

Recognizing the need for coverage, many contracts contain a provision that requires the buyer to continue to offer coverage to the sellers for a pre-determined amount of time. While perfectly legal, from an insurance standpoint it can create problems. Nearly all insurance contracts and now the Affordable Care Act (ACA), require that anyone enrolled on the plan must be working full time for the employer. Even if the insurance companies will allow it, creating a special class of employees to maintain coverage for the sellers could create a discriminatory plan in the eyes of the Department of Labor as it relates to the ACA.

Continues to Exist

If the seller continues to operate a business and maintain a group plan, COBRA dictates that the plan must continue to fulfill its COBRA obligations to anyone on COBRA at the point of sale. From a practical perspective, it may be very hard to find affordable coverage for a small group that includes several COBRA continuees. Also speaking practically, as groups shrink they can lose access to economies of scale in the insurance companies' eyes and both terms and pricing can adjust significantly.

Hidden Liabilities

Analyzing and quantifying any unfunded liabilities in a benefits plan is paramount to the buyer. The most common form of unfunded liability in self-insured plans is "Incurred But Not Reported" claims. These are those doctor and hospital visits that people have made, but haven't been submitted or processed by the claims payer. A good rule of thumb is that there is a two month claims lag, so if a plan is terminated on July 31st, there would still be two solid months of claims being processed and paid. For a two million dollar annual spend, the IBNR claims can vary greatly but should be somewhere between $250,000 and $350,000.

To prevent a large claims spike IBNR claims are traditionally covered with "tail coverage". Tail coverage is a form of insurance that prevents a plan from having claims in excess of a set limit even after the plan is terminated. While tail coverage is important to have in place and understand, there is still a claims threshold- deductible- that must be met before the coverage triggers. This threshold for a two million dollar plan could be $240,000, so asking if there is an estimate of "incurred but not reported" claims, if there is tail coverage, and if there is an accrual that has taken place for this contingency is key.

Other Items to Note

Occasionally savvy buyers will insert a clause in the purchase agreement that requires the seller to maintain liability for the current COBRA enrollees. As mentioned prior, if the seller has no intention of keeping a group health plan in place there is no place for the COBRA enrollees to maintain coverage. The concern is not that these people will not have coverage, their rights will transfer to the buyer's plan, but it would create a contractual breach that--in the event of high claimants--could easily reach hundreds of thousands of dollars in unintended liability per person! Depending on your perspective, knowing what COBRA liability there is and who will maintain it should be carefully vetted.

Finally, it is important to ask some basic questions about any requests for information from the DOL or IRS and performing a review of benefits practices. The penalties and fines associated with COBRA, HIPAA, ERISA, and the ACA can all be substantial. Performing a review of all documents and procedures should be performed by any prospective buyer.

Plan Integration

Buyer's and seller's plans seldom have the same network, coverages, out of pocket expenses, or payroll deductions. In the event they do not have identical plans and costs, there will be a significant amount of cross-referencing that will need to take place. Contrasting the two plans and understanding and communicating the differences for the new employees will be an early indication of how well the new employer is perceived. And beware; the ACA requires that all employees are treated equally, so even if the new employer is tempted to grandfather the new employee's former plan, there is no legal way to do that. Getting a handle on how different the benefits plans are, whether there is coverage in any new locations, and how different the payroll deductions are, will go a long way in making sure the new employees feel valued and appreciated.

Conclusion

There are a number of financial, legal, and morale based considerations that need to be understood before making or accepting a final offer. Attempting to understand the three fundamental questions without a detailed understanding of employee benefit plans can be extremely challenging. Bringing in knowledgeable strategic partners can prevent a good deal from turning to a bad one.