HEALTH BENEFITS COMPLIANCE CONSIDERATIONS IN MERGERS AND ACQUISITIONS: A GUIDE FOR EMPLOYERS

Employers considering a merger or acquisition should be aware of the numerous health and welfare benefits plan compliance issues that can arise in such a transaction.

Numerous health and welfare benefit compliance issues arise during business reorganizations, such as mergers and acquisitions. Ideally, benefits compliance concerns are addressed early in the process (e.g., at the due diligence stage) so the transacting parties can plan accordingly. It is always advisable to engage counsel familiar with the transaction in the benefit aspects to ensure that potential liabilities, reporting, and administrative obligations are negotiated and addressed contractually.

In the absence of contractual provisions, the law may assign responsibilities to the parties by default as of the transaction date (also called the closing date). This publication provides a high level overview of some of the health and welfare benefit compliance considerations that may arise with a business reorganization and the applicable defaults under the law.

Of course, the application of particular laws depends upon the transaction structure, benefit offerings, employer size, and plan funding, among other items. Federal laws often implicated in the merger and acquisition context include, but are not limited to, the ACA, COBRA, ERISA, and IRC Sections 105 and 125. Because the application of these laws varies widely based on the specifics of the merger or acquisition, employers should work closely with legal counsel for exact answers. However, to help at a high level, considerations that arise under these laws are discussed below.

ASSET VS. STOCK TRANSACTIONS

As a preliminary matter, it is important to understand the legal structure of the potential transaction. There are two basic types: asset purchases and stock purchases.

Asset Purchases

In an asset purchase, the buyer is purchasing some or all of the seller's assets (and may also be assuming certain liabilities). With an asset purchase, the employees of the purchased entity are normally considered terminated employees of the seller. Often these employees are hired by the buyer, in which case they become new employees of the buyer.

Generally, the parties in an asset purchase should be careful about an arrangement in which the seller agrees to provide benefits to former employees hired by the buyer for a transitional period after the transaction date. Because the seller's former employees become new employees of the buyer, the seller's extension of benefits beyond the transaction date may result in the inadvertent creation of a multiple employer welfare arrangement (MEWA). In order to avoid this unintended consequence, the seller will typically want to relinquish responsibility for providing benefits to former employees as of the transaction date (except as required by COBRA, as explained further below).

To explain further, MEWAs have additional compliance obligations (and potential liabilities) under both state and federal laws. For example, certain states may require that a MEWA be licensed, registered, have a minimum number of participating employers, or obtain an actuarial opinion confirming it can pay promised benefits. The DOL may

require a MEWA to file an annual report using Form M-1. However, there is a limited exception to the Form M-1 filing requirement for a MEWA that provides coverage to employees of two or more employers due to a change in control of businesses (such as a merger or acquisition) that does not extend beyond the end of the plan year following the plan year in which the change in control occurs. See the Form M-1 Instructions for further details on this filing exception.

Accordingly, the parties should always consult with counsel well in advance of the transaction date before allowing former employees to remain on the seller's plan. Counsel can determine if a MEWA is permitted under applicable laws and, if so, can confirm the specific requirements that must be met. Further, if an asset purchase is structured to proceed over a period of time rather than on a date certain, the client's counsel or tax advisor will also need to determine whether and when there is sufficient common ownership between the client and related entities to form a controlled group, as the controlled group status of the entities will affect the timing of various benefit transitions.

Stock Purchases

In a stock purchase, the buyer is purchasing all of the stock or ownership in the seller's business (or a unit thereof). As a result, the buyer assumes the seller's obligations and liabilities with respect to the acquired entity on the transaction date as a matter of law (which is generally not the case with an asset purchase). With a stock purchase, employees of the purchased business remain employed by the same legal entity. (That is, the employees are not terminated as a direct result of the transaction.) However, the ownership of that entity is transferred from seller to buyer. A merger, in which the businesses of the two parties merge into a single business, usually occurs following or in connection with a stock purchase. As will become evident in the next sections, the asset vs. stock distinction affects the application of many benefit-related laws.

ACA PROVISIONS

Although many ACA provisions apply broadly to most group health plans, certain obligations attach specifically to applicable large employers (ALEs), i.e., employers with 50 or more full-time equivalent employees (FTEs). This FTE count includes full-time employees and part-time employees converted to full-time equivalents using a special calculation method for this purpose. When determining whether an employer (or successor employer following a merger or acquisition) has 50 or more FTEs, all employees of related entities under common control must be counted. As defined under Section 414, this would include a controlled group of corporations, a group of trades or businesses under common control, an affiliated service group, and certain other arrangements. So, it is always important to review the post-transaction entity with counsel to determine if it falls into one of these categories.

An entity determined to be an ALE must comply with the ACA's employer mandate. Specifically, ALEs must extend an offer of health insurance coverage to at least 95% of full-time employees and dependent children up to age 26. Additionally, the coverage offered to the full-time employees must be affordable and of minimum value (i.e., must pay at least 60% of the cost of covered services). Coverage is considered "affordable" if employee contributions for self-only coverage do not exceed a certain percentage of an employee's earnings as determined under three affordability safe harbor options. A failure to satisfy the employer mandate requirements could subject the ALE to potential penalties if a full-time employee purchases marketplace coverage and receives a tax credit. For further information about determining an employer's ALE status as well as liabilities associated with failure to offer coverage to an employer's FTEs, see the PPI publications **ACA: Applicable Large Employers** and **ACA: Employer Mandate Penalties and Affordability**.

Timing of Offers of Coverage

When an ALE acquires a smaller entity that is not an ALE, one question that arises with a stock transaction is whether the acquired entity becomes subject to the employer mandate requirements as of the acquisition date. Unfortunately, the available guidance is not entirely clear on this issue. However, the general view is that the mandate would apply at the time of the acquisition. The rationale is that if the buyer is an ALE, then the acquired employees become employees of the acquiring ALE immediately as of the transaction date. By contrast, with an asset purchase, employees hired by the acquiring ALE would be treated as new hires and could be subject to any waiting period that applies to similarly situated employees.

If two non-ALEs merge together to form an ALE, there may be additional time before the newly created entity becomes subject to the employer mandate obligations. The determination of ALE status is normally based upon the size of the employer's workforce in the prior calendar year. So, if two non-ALEs merged in Year 1 and the combined entity employed 50 or more FTEs, the new entity would be subject to the employer mandate in Year 2. Additionally, if both entities were previously non-ALEs, a limited three-month penalty non-assessment period would apply to the first year in which the employer is subject to the employer mandate. In other words, there would be no ACA penalty for not offering coverage in January, February, or March of Year 2.

Measurement Methods and Periods

A key issue in complying with the employer mandate is identifying employees who are considered full-time (i.e., generally those who work or are paid for an average of 30 or more hours per week). An employer determines an employee's full-time status using either the monthly measurement method (i.e., counting the employee's service hours for that same month) or the look-back measurement method. Under the look-back measurement method, an employer averages the employee's hours of service during a measurement period of 3 to 12 months to determine the employee's full-time status for a subsequent stability period. For example, an employee who averages 30 or more hours of work in a 12-month measurement period would be entitled to an offer of coverage for the duration of the corresponding 12-month stability period, regardless of hours worked during that stability period. For further information about ACA measurement periods and methods, see the PPI publication **ACA: Employer Mandate Look-Back Measurement Periods**.

With the merger of two ALEs, questions can arise if the parties to the transaction use different measurement methods or different measurement periods under the look-back method. IRS Notice 2014-49, although not primarily intended for the merger and acquisition context, provides some preliminary guidance to address these situations.

Under this notice, one option is to treat acquired employees as if they transferred to a new position with different measurement and stability periods. Applying this approach, if an acquired employee has been employed by the seller for a full measurement period at the time of the transaction, the employee will retain the status determined by that measurement period through the end of the seller's corresponding stability period, after which the buyer's measurement and stability periods apply. If an acquired employee has not yet completed an initial measurement period at the time of the transaction, the employee's status will be determined using the buyer's measurement and stability periods, but taking into account hours of service with the seller.

Another option is to continue to apply the seller's measurement methods and periods to the acquired employees during a transition period following the transaction date. If the acquired employees' status was previously determined using the monthly measurement method, the transition period begins on the transaction date and ends on the last day of the first calendar year that begins after the transaction date. If the acquired employees' status was previously determined using the look-back measurement method, the transition period instead begins on the transaction date and ends after the completion of a full measurement period and stability period, using the seller's measurement and stability periods. After the transition period ends, the buyer's measurement method, including the buyer's measurement and stability periods, would apply.

Ultimately, each employer should work with their legal counsel to determine the appropriate approach for their particular circumstances. Regardless of the chosen option, the buyer will need to be provided with information regarding the acquired employees' status and hours of service prior to the transaction date.

Employer Reporting Obligations

Unfortunately, there is no specific guidance on how to address employer mandate reporting requirements in the context of mergers and acquisitions. The information reporting required of ALEs under Section 6056 applies on an entity level — that is, per Employer Identification Number (EIN) — rather than on a controlled group level. So, each entity with employees during the year must file a separate information return.

Because there is no explicit regulatory direction for a stock transaction (e.g., merger or acquisition), several reporting approaches could be considered. One approach would be for the buyer to treat itself as a continuation of the seller and file reporting information on the acquired employees under the buyer's EIN for the entire calendar year that includes the transaction date. Another approach would be to file two separate returns for the acquired employees; one would be filed under the seller's EIN and cover the period prior to the transaction date, and the second would be filed under the buyer's EIN for the period following the transaction date.

With an asset transaction, the buyer purchases the assets of another entity, but there is no transfer of stock ownership. So, in an asset sale, if employees are part of the acquired assets, the seller's employees become part of the buyer's payroll; they are newly hired employees of the buyer as of the transaction date. In such case, the buyer becomes responsible for the applicable reporting on those employees from the hire date, as they would with any other newly hired employees. For example, the buyer would complete a Form 1095-C for each new FTE. (But the seller would typically remain responsible for the employer mandate reporting for those employees for the period prior to the transaction date.)

Since the IRS maintains authority for several years to investigate employer mandate compliance and review filed returns, it is recommended that the seller provides sufficient information to the buyer to assist the buyer in any future claims. This is particularly important in the context of a stock purchase. For further information about reporting requirements, see the PPI publication **ACA: Employer Mandate Reporting Requirements**.

Employer Disclosure Obligations

Additionally, with a stock purchase, the buyer may have summary of benefits and coverage (SBC) disclosure obligations. In other words, if the buyer will be making material modifications to the health coverage provided to the acquired employees, 60-day advance notice is normally required if these changes occur outside of the acquired plan's annual open enrollment. It is also advisable to verify the accuracy and timely distribution of prior SBCs by the acquired entity, as SBC failures can result in potential penalties. With an asset purchase, the acquired employees would generally be treated as other new hires and provided the SBC with the enrollment materials upon eligibility for coverage. For further information about SBC requirements, see the PPI publication **ACA: Summary of Benefits and Coverage Requirement**.

Grandfathered Plans

Special considerations should be given to transactions involving grandfathered health plans, which are exempt from certain ACA requirements. Generally, a buyer may add acquired employees to an existing group health plan without affecting the plan's grandfathered status. However, in some cases, it may be necessary to maintain separate plans for existing and newly acquired employees in order to preserve such status. See under the Nondiscrimination Considerations section below for further discussion of allowable benefits eligibility distinctions among different employee groups in the context of nondiscrimination rules.

COBRA

In the context of mergers and acquisitions, the COBRA regulations provide default rules regarding COBRA responsibilities. Of course, the parties in a transaction are generally free to negotiate COBRA liability (and health plan obligations), provided that COBRA-qualified beneficiaries receive any required offers of continuation coverage. Such COBRA qualified beneficiaries, often referred to as merger and acquisition (M&A) qualified beneficiaries, may include those receiving COBRA coverage under the seller's plan at the time of the transaction, as well as individuals whose employment is terminated, or who lose benefits eligibility with the new employer, as a result of the transaction. If COBRA is not addressed in the transaction agreement, then the default COBRA rules apply.

COBRA Qualifying Event

COBRA entitlement results from a loss of group health coverage due to a COBRA triggering event. In the acquisition context, the triggering event is typically a termination of employment. With stock transactions, if all of the employees continue employment with the buyer after the stock sale, there is no COBRA qualifying event. In such case, the employees of the acquired division may experience a loss of coverage under the seller's plan, but are not necessarily entitled to an offer of COBRA as a COBRA triggering event did not occur. However, if some benefits-enrolled employees are terminated or suffer a reduction in hours below the benefits eligibility threshold as a result of the sale, these individuals would experience a COBRA qualifying event and thus must be offered COBRA.

By contrast, employees who lose group health coverage due to an asset sale typically experience a COBRA qualifying event. In other words, the employees have a termination of employment with the seller, even if hired (and offered coverage) by the buyer. For example, assume a seller sells one of several divisions to a buyer and the buyer hires all of the division's employees and offers them coverage under the buyer's group health plan. Those employees (and their spouses or domestic partners and dependents) who were previously covered under the seller's plan immediately prior to the transaction date would be entitled to an offer of COBRA. (Note that domestic partners are not qualified COBRA beneficiaries with independent COBRA election rights, but they can continue to be covered as dependents per the employee's COBRA election. For further information about domestic partner benefits, including COBRA entitlement, see the PPI publication **Domestic Partner Benefits: A Guide for Employers.**)

Party with COBRA Obligation

Regardless of whether the transaction is an asset or stock transaction, the COBRA liability generally defaults to the seller. Specifically, if the seller (as defined on a controlled group basis) maintains any group health plan after the sale, then the seller has the obligation to make COBRA coverage available to covered employees, spouses or domestic partners, and dependents who lost coverage as a result of the sale (and also to the current COBRA participants). For entities that are part of a controlled group, this is true even if the plan related to the sold entity has been terminated. In other words, a plan of an entity in the seller's controlled group must extend the coverage to the beneficiaries, although they were not previously covered by that particular plan of the seller. If such plan is a fully insured plan, the seller should consult with the carrier to ensure the M&A COBRA qualified beneficiaries will be covered, even though they were not previously enrolled in that plan.

By contrast, different COBRA obligation rules apply to asset versus stock transactions if the seller ceases to provide any group health plan. In a stock sale, a group health plan maintained by the buyer has the obligation to make COBRA coverage available, but only if the cessation of the seller's plan was "in connection with the sale." The determination of whether a plan cessation is in connection with a sale is based upon all facts and circumstances. Thus, even if the plan termination occurs after the actual sale date, the termination can still be considered "in connection with" the sale (assuming the facts and circumstances support such a finding).

In an asset sale, the buyer's group health plan may also be obligated to make COBRA coverage available if the seller ceases to maintain any plan in connection with the sale. However, this responsibility arises only if the buyer continues the business operations associated with the purchased assets without interruption or substantial change. In such case, the buyer is considered a successor employer. For a successor employer, the buyer's obligation should be satisfied if active coverage is offered to the acquired employees of the seller under the buyer's group health plan, and if COBRA coverage is also made available to the M&A COBRA qualified beneficiaries under the plan.

If COBRA liability attaches to the buyer, the obligation to make coverage available begins on the later of 1) the date that the seller ceases to provide any group health plan or 2) the date of the sale. The buyer's obligation extends only to the COBRA beneficiaries with respect to the transaction (i.e., the COBRA beneficiaries related to the purchased entity, but not to other entities owned by the seller).

COBRA Disclosure Obligations

The parties should be attentive to COBRA disclosure obligations related to the transaction. If the seller maintains a group health plan for a period after the acquisition date, then the seller is responsible for providing COBRA election notices to the COBRA qualified beneficiaries who became employees of the buyer. If the seller ceases to provide any group health coverage, the seller must provide a notice of cessation of coverage (e.g., a summary of material reduction in benefits for an ERISA plan; or an SBC) to any remaining active employees. If COBRA liability attaches to the buyer, the buyer is responsible for sending the COBRA election notices. Additionally, the existing COBRA participants under the seller's plan must be notified of the change in the group health plan coverage (including any change in the COBRA administrator and premium payments).

The buyer is obligated to provide SBCs and summary plan descriptions (SPDs) to hired employees and qualified beneficiaries offered coverage under the buyer's group health plan. The buyer must also provide newly hired employees with a COBRA initial notice for the buyer's plan.

Merger of Small Employers

Although most group health plans are subject to COBRA, the IRS regulations provide an exception for a group health plan maintained by an employer that normally employed fewer than 20 employees during the preceding calendar year. For purposes of determining whether an employer (or successor employer following a merger or acquisition) qualifies for the exception, all employees of all related employers under common control must be counted.

When two small employers that were previously excepted from COBRA merge together, the merged entity may employ 20 or more employees. The question then arises as to when the COBRA obligation commences. IRS Revenue Ruling 2003-70 provides guidance to address this concern.

With a stock transaction, the employees of both entities in the prior year must be counted as of the transaction date. For example, Company A merges into Company B on October 1, 2024. Each company had 12 employees in 2023. The surviving Company B is subject to COBRA as of October 1, 2024, because the combined employee total in 2023 was 24 (i.e., 20 or greater).

With an asset sale, the parties do not become related entities as a result of the transaction, so their employees in the prior year are not counted together. For example, Company A purchases Division C from Company B on February 1, 2024, and hires all 10 Division C employees. In 2023, Company A had 15 employees and Company B had 18 employees, including the 10 in Division C. In this situation, Company A remains exempt from COBRA in 2024, but ceases to be exempt from COBRA beginning January 1, 2025 (because Company A employed 20 or more employees on at least 50% of its typical business days in 2024).

Accordingly, small employers previously not subject to COBRA should be aware of when the COBRA obligations may attach following a merger transaction. Employers of all sizes should work with the insurer or stop-loss carrier and any TPAs to ensure the coverage and communications are coordinated before, during, and after the transaction period.

ERISA

ERISA applies broadly to most employer sponsored welfare plans regardless of size. In the merger and acquisition context, compliance with ERISA (and other benefit related laws) should be reviewed at the due diligence stage. At this point, the buyer

is identifying and evaluating potential risks and liabilities associated with the seller's plan(s) and how these may impact the transaction. Such review is particularly important with a stock purchase because the buyer is generally assuming the liabilities of the seller.

Potential liabilities may arise due to special coverage obligations (e.g., retiree benefits) or past compliance oversights (e.g., failures to adhere to plan document terms or file Forms 5500). Accordingly, the potential buyer should request copies of the seller's ERISA plan documents, including any SPDs. Particularly with a stock transaction, the buyer may also want to request verification that all required Forms 5500 have been timely filed. In some cases, the seller may have filed Forms 5500 for the group health plan, but failed to file the forms for other ERISA benefits, such as disability plan coverage. If such a failure is discovered, the terms of the buy/sell transaction may require the seller to correct the failure through the DOL's voluntary correction program. Prospectively, buyers that previously relied upon the small plan exemption from the Form 5500 filing requirement (due to less than 100 participants at the plan year start) should reassess whether the exemption still applies if newly acquired employees will also be participating in their plan(s).

ERISA plan documents should be carefully reviewed. The buyer in a transaction will often need to consider whether to continue to maintain the seller's plans, create new plans, or cover the acquired employees under its own existing plans. So, especially in the event of a stock transaction, the buyer will likely want to compare its own ERISA plans to the seller's plans. If the intention is to cover the employees under one plan, the buyer may need to amend its existing plan to accommodate the newly acquired employees. Additionally, the buyer should understand that ERISA provides protections to plan participants with respect to benefits previously promised (including claims incurred prior to any change in plan options or benefits).

With an asset purchase, the seller's former employees may become new hires of the buyer. In such case, there still may be concerns regarding the extension of the buyer's group health plan coverage to these new employees, particularly if they are located in a different geographic region. So, the buyer will need to carefully review the coverage options with the carrier(s), service providers, and counsel to determine if changes to the coverage and/or amendments to the ERISA plan documents are necessary.

The parties should also keep in mind their ERISA fiduciary obligations as plan sponsors and administrators. Among other duties, plan fiduciaries must ensure that they operate each ERISA plan in accordance with the written document and that they use plan assets for the exclusive benefit of the plan participants. Plan assets include any participant contributions in addition to any amounts not paid from an employer's general assets (e.g., through a trust). Accordingly, the parties should ensure that any plan assets (e.g., participant salary deductions taken by the seller) are appropriately applied to the transitioning plan. If the seller held plan assets in a trust (which is atypical in the welfare plan context), the buyer should ensure that it satisfies ERISA's fidelity bond requirements (to protect such amounts from risk of loss due to theft).

ERISA fiduciaries who breach their duties can be personally liable for damages to the ERISA plan and for DOL penalties imposed in connection with fiduciary breaches. Accordingly, the buyer should review the terms of any existing fiduciary liability coverage to determine whether changes will be necessary as a result of the transaction. Particularly with a stock purchase, the buyer should also understand how fiduciary liabilities related to the seller's plans prior to the transaction will be addressed.

Of course, employees must be notified of their benefit entitlements and any changes to benefits, which would include disclosures provided in SPDs and summaries of material modifications (SMMs). Generally, plan administrators should seek to provide as much advance notice of benefit changes as is possible, since employees are otherwise relying upon the information previously provided to them in making their benefit decisions. For specific information regarding disclosures and other ERISA obligations of plan sponsors, see the PPI publications **ERISA Compliance Considerations for Health and Welfare Benefit Plans** and **ERISA Fiduciary Governance: A Guide for Employers**.

SECTION 125 CAFETERIA PLAN REGULATIONS

Plan Transition

The Section 125 cafeteria plan rules apply if employees can elect to pay for plan benefits (e.g., medical and dental coverage, health FSA) on a pre-tax basis through salary reductions. Although the Section 125 regulations do not specify how cafeteria plans should be addressed in a merger or acquisition, the IRS has provided some guidance that may be instructive. As with the application of other rules, whether the transaction is structured as a stock sale or an asset sale affects the available options.

With a stock transaction, the buyer typically assumes sponsorship of the seller's plans. In such case, the employees' participation and existing cafeteria plan elections would continue because the employees are continuing their employment and are bound by their prior elections. The buyer may prefer to terminate the seller's plan as of the transaction date; in such event, it is unclear whether new midyear benefit elections would be permitted under the buyer's cafeteria plan. Additionally, issues may arise with a midyear plan termination if participants are not provided with sufficient advance notice. (We cover use of health FSA balances in the next section.)

In the event of an asset sale, employees of the acquired business terminate their employment with the seller. Their participation (and elections) in any cafeteria plan (and component benefits) maintained by the seller would typically terminate on the transaction date. Those employees hired by the buyer may be offered participation in the buyer's existing cafeteria plan (and component benefits) or a newly established cafeteria plan and would be given the opportunity to make new elections.

Flexible Spending Accounts (FSAs)

With an asset sale, if the seller offered a health FSA, the transaction and resulting employee terminations could create potential forfeitures (as well as COBRA rights) for affected employees under the seller's FSA plan.

However, if the parties wish to allow for the transfer of existing health FSA balances under the seller's plan following the transaction date, the IRS has provided guidance in the form of Revenue Ruling 2002-32. This ruling outlines two possible approaches, which would apply if the seller continues its business operations and health FSA after the asset sale, and the buyer either has or will create a cafeteria plan that offers health FSA coverage.

Under the first approach, the parties could agree to have the transferred employees continue to participate in the seller's health FSA plan for a period of time, such as through the end of the plan year. Their existing salary reduction elections would also continue for the same duration, but as if made under the buyer's plan.

Under the second approach, the buyer could agree to cover the transferred employees under its health FSA for the remainder of the plan year. The employees' account balances (whether underspent or overspent) under the seller's health FSA would be rolled over to the buyer's health FSA. Claims for reimbursement after the asset sale would be submitted to the buyer's health FSA (including claims incurred before the asset sale that were not yet reimbursed). The transferred employees' salary reduction elections would continue for the balance of the plan year under the buyer's plan.

The guidance does not specifically extend to dependent care FSAs. However, in the event of an asset sale, the seller could consider adopting a spend-down feature, which would allow terminated employees to be reimbursed from their dependent care FSA balances for eligible expenses incurred during the remainder of the plan year or, if applicable, the grace period. (Absent such a spend-down provision, plan documents often only permit employees to request reimbursement for expenses incurred prior to termination, although employees can continue to submit such requests through the runout period.) So, a spend-down provision would allow employees to be reimbursed for eligible dependent care FSA expenses incurred while working for the buyer (or another employer) following the termination date.

With a stock purchase, if the acquired business maintains its own cafeteria plan, the buyer may assume sponsorship following the transaction; in such case, the employees' existing health FSA elections would continue.

Alternatively, a decision may be made to terminate the plan prior to the transaction date. In such event, the employees should be given as much advance notice as possible, so they have a chance to use their existing account balances and avoid forfeitures. (There are no FSA COBRA rights in the event of a stock transaction because there is no termination of employment and therefore no COBRA qualifying event.) However, the parties could agree for the seller to arrange to provide some type of COBRA-like coverage to the affected employees.

In some cases, the acquired employees may participate in a cafeteria plan sponsored by an affiliate of the purchased entity (such as a parent company). The question then arises as to whether their FSA account balances and elections could be transferred on the transaction date from the affiliate's FSA plan to the buyer's FSA plan. Unfortunately, there is no formal guidance that permits such a transfer for a stock transaction. However, the IRS has informally commented that such an FSA account balance transfer may be permissible in a merger and acquisition context (following the second approach referenced above for asset sales under Revenue Ruling 2002-32). Given the informal nature of this guidance, employers considering this possibility should consult with counsel.

The agreed upon approach for the transition of FSA balances should be incorporated in the transaction agreement, so each party's obligations are clearly defined. Both the seller and the buyer will likely need to adopt amendments to their respective cafeteria plans.

HEALTH SAVINGS ACCOUNTS (HSAs)

As noted in previous sections, any post-transaction changes in the group health coverage (e.g., coinsurance, deductibles) available to acquired employees should be communicated by means of an SBC and SPD or SMM. One question that may arise is whether acquired employees can receive a midyear credit under the buyer's group health plan for an amount previously applied towards satisfaction of the deductible under the seller's group health plan. This may be particularly important to employees if the plans involved are intended to be qualified high deductible health plans (HDHPs) offered in conjunction with HSA programs.

Unfortunately, there is no direct guidance as to whether such a midyear credit to an HDHP deductible is permissible as a result of an acquisition. However, in Notice 2004-50, the IRS indicated that such a credit may be allowed when an employer makes a midyear change in group health plans. In other words, the new HDHP can take into account amounts applied towards the deductible during the prior plan's short plan year without jeopardizing the HDHP plan status. Of course, employers interested in providing such a credit should discuss the possibility with counsel.

With an asset purchase, if the buyer is allowing employees to make pre-tax contributions to an HSA through the cafeteria plan, the employees will need to be given the opportunity to make HSA contribution elections under the buyer's plan. The buyer should be sure the HSA eligibility requirements are clearly explained in the enrollment materials. This is particularly important if the seller did not offer an HSA program or will be offering COBRA under a group health plan that is considered "impermissible coverage" for HSA eligibility purposes. If the seller offered an HSA program to the employees, it may be possible to directly transfer the existing balances to the buyer's HSA program, but only if the affected employees affirmatively authorize such transfers.

With a stock purchase, if the seller offered an HSA program, it may be possible for the buyer to continue that program. However, the seller's contractual arrangements with the HSA custodian may need to be reviewed and updated to reflect the buyer as the contracting employer. Any changes to the program (including available investment options) should be clearly communicated to employees. If the buyer assumed sponsorship of the seller's cafeteria plan, the HSA elections could continue; however, employees must have the option to change their HSA elections at least monthly. For further information about HSAs, see the PPI publication **Health Savings Accounts: A Guide for Employers**.

NONDISCRIMINATION CONSIDERATIONS

The effect of the business transaction on Section 125 nondiscrimination testing (applicable to cafeteria plan benefits) and Section 105 nondiscrimination testing (applicable to self-insured group health plans) should also be considered. When the buyer acquires the stock (or assets) of a business, the inclusion of the newly acquired employees and structure of their benefits can potentially impact nondiscrimination test results.

With business reorganizations, questions often arise as to whether the buyer or merged entity can vary benefits and related costs for different groups of employees. For example, if one entity merges with another and each sponsors a group health plan, can both plans be maintained by the surviving merged entity despite differences in the benefits? If a buyer purchases an entity in another state, can the buyer maintain the acquired company's group health plan separately from its own existing plan, which provides more generous benefits?

Generally, employers are not required to offer the same benefits to all employees. Variances in benefits based upon certain bona fide employment-based classifications are permissible, provided these are consistent with the employer's usual business practice (i.e., the employer is not making the distinction solely for the purpose of the benefit offerings). Distinctions that are normally permissible include those based upon full- or part-time status, current or former employee status, occupation, hire date, geographic location, or membership in a collective bargaining agreement. Thus, employers can vary benefits based upon these classifications, provided similarly situated individuals in a class are treated in the same manner. For further information about nondiscrimination rules, see the PPI publications **Sections 105 and 125 Nondiscrimination Rules: A Guide for Employers**, **Section 129 Dependent Care Assistance Program Nondiscrimination Rules: A Guide for Employers**, and **Quick Reference Chart: Nondiscrimination Rules**.

Section 125 Nondiscrimination Rules

Section 125 nondiscrimination rules must be considered in connection with mergers and acquisitions, and these rules apply on a controlled group basis. So, if a stock purchase results in the acquired business becoming part of the buyer's controlled or affiliated service group under the applicable Section 414 rules, then the acquired business must be included in the buyer's Section 125 nondiscrimination testing. In the welfare plan context, the IRS has not specified a time frame for such inclusion nor provided a transition grace period. So, employers should consult with counsel for guidance. With an asset transaction, any employees of the acquired entity hired by the buyer would be included in the buyer's nondiscrimination testing (as newly hired employees of the buyer).

At a high level, the Section 125 nondiscrimination rules prohibit variances in benefits that disproportionately favor highly compensated employees (HCEs) and key employees. An HCE is defined as an officer, a more-than-5% owner in the current or preceding plan year, or an employee with compensation in excess of an indexed threshold in the prior year (or in the current plan year, if a new hire). (For details of HCE thresholds, see Appendix A, **IRS Limits on Retirement Benefits and Compensation**.) A key employee is an officer with annual compensation greater than a specified threshold that is indexed annually (see Appendix A), a more-than-5% owner, or a more-than-1% owner with annual compensation over $150,000. (Note that, in general, compensation means total compensation from the employer, including bonuses or commissions as well as contributions made through a 401(k)

plan or similar retirement plan or through a cafeteria plan or qualified transportation benefit plan.) The Section 125 nondiscrimination tests focus on eligibility, benefits, and key employee concentration. There are also specific tests conducted for component benefits (e.g., health and dependent care FSAs) offered under the cafeteria plan.

Accordingly, although employers can vary benefits or cost structures among or even within plans, all plans and tiers must be tested together for Section 125 nondiscrimination purposes. So, if the differentiation results in the HCEs and key employees receiving disproportionately richer benefits than the rank and file employees (i.e., the non-HCEs), the plan could fail one or more nondiscrimination tests. Generally, such test failures result in the HCEs having taxable income relative to the discriminatory benefits they receive.

Section 105 Nondiscrimination Rules

Additionally, self-insured group health plans (including HRAs) are subject to Section 105 nondiscrimination rules. As with Section 125 rules, Section 105 rules are designed to prevent discrimination in favor of highly compensated individuals, which are defined more broadly under the Section 105 rules to include not only the five highest-paid officers and a more-than-10% owner but also those among the highest-paid 25% of all employees (other than excludable employees who are not participants). The component tests focus on discrimination in eligibility and benefits in plan operation as well as design. Issues can arise, for example, if newly acquired employees are subject to different waiting periods or offered different benefits than other employees covered under the buyer's plan.

Therefore, a party to a possible merger or acquisition may want to review the proposed benefit plan structures of the post-transaction entity with the party responsible for their nondiscrimination testing in advance of the transaction. In any event, nondiscrimination testing should be conducted as soon as possible following the transaction date so that potential test failures are promptly identified and any necessary corrections are timely applied.

REQUIRED GROUP HEALTH PLAN NOTICES

In addition to the special considerations that arise for both sellers and buyers in connection with a business reorganization, it is important to note that employers of all sizes that sponsor group health plans are responsible for providing certain notices to employees during different periods of an employee's employment cycle. In the context of mergers and acquisitions, buyers in particular need to be mindful of notices, such as the CHIP Notice, the HIPAA Notice of Special Enrollment Rights, and the Medicare Part D Creditable/Non-Creditable Coverage Notice, that must be distributed to employees upon hire or upon eligibility for the employer's health plan. For further information, see the PPI publications **Required Group Health Plan Notices Overview** and **Required Group Health Plan Notices Chart**.

SUMMARY

Employers considering a merger or acquisition should be aware of the numerous health and welfare benefit plan compliance issues that can arise in such a transaction. A benefit compliance review should be incorporated into the due diligence process. Early planning enables the parties to address the benefit related obligations and liabilities of the parties in the transaction agreement.

The impact of requirements under federal laws, including the ACA, COBRA, ERISA, and the Internal Revenue Code, should be reviewed. State law compliance obligations may also arise. Therefore, it is imperative for employers to consult with counsel for guidance regarding the interpretation and application of such laws to their specific situation. It is also important to engage carriers and service providers to ensure that the transition process is coordinated and communicated clearly to affected employees.

RESOURCES

IRS Notice 2014-49

IRS Revenue Ruling 2003-70

DOL Technical Release No. 1992-01

DOL Voluntary Correction Program

IRS 2007 Proposed Cafeteria Plan Regulations

IRS Revenue Ruling 2002-32, pg. 1069

IRS Notice 2004-50

IRS Notice 2021-15

PPI BENEFIT SOLUTIONS

APPENDIX A

IRS Limits on Retirement Benefits and Compensation

	2026	2025	2024
401(k) and 403(b) plan elective deferrals	TBD	$23,500	$23,000
Catch-up contributions (age 50 and older)	TBD	$7,500*	$7,500
Annual compensation limit	TBD	$350,000	$345,000
Highly compensated employee threshold**	TBD	$160,000	$155,000
Key employee compensation threshold**	TBD	$230,000	$220,000
Defined contribution plan limit under Section 415	TBD	$70,000	$69,000
Defined benefit plan limit under Section 415	TBD	$280,000	$275,000
SIMPLE employee contribution limit	TBD	$16,500	$16,000

See www.irs.gov for more information.

*New effective 1/1/2025: individuals who attain age 60, 61, 62, or 63 in 2025 can make catch-up contributions up to $11,250 in 2025.

**In general, compensation means total compensation from the employer, including bonuses or commissions as well as contributions made through a 401(k) plan (or similar retirement plan) or through a cafeteria plan or qualified transportation benefit plan.

The chart above is excerpted from the PPI publication **Employee Benefits Annual Limits**. See that publication for other annual limits that affect group health plans.

PPI BENEFIT SOLUTIONS