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ACQUISITIONS AND DIVESTITURES – PENSION AND HEALTH ISSUES

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Acquisitions and divestitures present unique challenges to actuaries, both before and after the sale. Our panelists will address the following issues, for pension as well as for health and welfare plans:

- What considerations are there when a company is being bought or sold?
- Can the buyer and the seller ever agree upon the retiree medical liability?
- Is the buyer interested in the income statement or the balance sheet?
- What are some of the hidden liabilities?
- What regulatory issues need to be considered?

MR. HOWARD J. SMALL: I think we have a very interesting program to present to you. Even though this is a session that frequently appears on the agenda for the Enrolled Actuaries' meeting and previously on Society meetings and CCA meetings, I think we have some new material that generally hasn't been presented before.

Let me introduce my panelists. Mike Nassau is an attorney with the law firm Kramer, Levin, Nessen, Kamin & Frankel in New York City. Mike has been practicing in the employee benefits area for about 30 years. He's written and lectured extensively on the subject.

Harvey Sobel is a principal in William Mercer's New York office where he consults for employers, Blue Cross/Blue Shield plans and HMOs in all areas of health and welfare. He has helped many companies in a merger or acquisition, and I'm very pleased to have him here. His health background should add a different perspective to our discussion.

I'm with Martin E. Segal Company in New York, and I'm doing a dual duty. I'm moderator and I'll make a short presentation after Mike and Harvey. I'll be discussing some of the pension issues that come under consideration in an acquisition or divestiture.

How many have had first-hand experience working with a client in a merger/acquisition deal? That's a very good showing. I think we have enough content here so that there's something for everyone. For those of you who didn't raise your hands, I think we can heighten your awareness of some of the issues that come under consideration, and for those of you who did raise your hands, I hope we can present some new issues that you may not have thought about or may not have encountered previously. Let me start with Mike and have him present some of the legal aspects that need to be addressed.

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MR. MICHAEL J. NASSAU: The first thing to be sensitive to in acquisitions and divestitures is what happens when meeting the coverage requirements under qualified plans, which have now become rigorous mathematical tests. Prior to 1989, transactions of size generally did not create a problem. A plan met coverage requirements if it covered a reasonable cross-section of employees. If you were acquiring a company, and by and large the plan covered the people at that company at the various levels of pay that you would find in a typical business, on a seat-of-the-pants judgment, the IRS generally did not question it. However, there is no longer a seat-of-the-pants-judgment approach. You in the audience by and large are with firms that have wonderful data collection and retrieval capabilities, and the IRS expects you to exercise those capabilities by collecting data, analyzing it, and determining whether various percentage tests are met. Whether these tests are met is determined by reference to what we call a controlled group, a parent and its 80%-or-more owned subsidiaries. There's a brother/sister controlled group configuration where five or fewer individuals own at least 80% of both entities. Counting any percentage ownership, and counting identical ownership in the two entities, they're over 50%.

So, let us assume that a buyer acquires a division or a subsidiary from a seller. Things happen to your compliance analysis. The seller is going to see a loss of the personnel of the entity sold. So, let us say that that entity was relatively heavy in nonhighly compensated employees (non-HCEs). Is the loss of demographics that was concentrated in the non-HCE level going to mean that the seller's plans that covered those non-HCEs are now going to fail to meet the required ratio tests? On the buyer's side, picking up non-HCEs is fine if you're going to bring them into your plans. If you don't want to bring them into your plans or you want to give them inferior plans, acquiring those non-HCEs can give a problem to existing plans that meet tests before the deal. If you are picking up a relatively high concentration of HCEs on the buyer's side, and you're going to give them your standard plans, that can give you a problem. Suppose the subsidiary you're buying is one where the non-HCEs are concentrated in union plans that don't count. Your HCEs are people whom you would normally give your regular salary plan to. That is a type of situation in which you can run into problems. Now, the question is how much breathing room do you have to deal with this kind of issue?

I would like to describe a transition rule that is in the statute, but before I deal with that let me mention a provision of the regulations under 410(b), which is in the old regulations as a final regulation and which is in the new regulations as a proposed regulation. It states that you only count employees based on an entity being a member of the same controlled group if it is a member of the group on one day of each quarter of the plan year. This is a rule whose operation is largely ignored in practice, but I think we have to deal with it and particularly in light of some of the ambiguities, the scope of the transition rule, we should consider what it does and doesn't do. First, it says you only count people based on their being members of a controlled group if the controlled group exists one day of each quarter. So, if what you are doing is acquiring a subsidiary that you immediately bring into your plan, those employees get counted but not because they are members of the controlled group. They are employees of an employer that's in the plan. If you buy assets, the issue is irrelevant because the employees will be directly on the payroll as those who have always been in the controlled group. However, if you were to acquire a subsidiary which you did not bring into the plan -- let's say it had no employees – the

exclusion of those employees could be disregarded for better or for worse if you acquire the subsidiary after the first quarter of the plan year, and you would only have to take them into account beginning the next plan year. Now, when I say for better or for worse, maybe you're for bringing that subsidiary into your own plan, but it has its own plan which is free-standing, and you're going to continue that. Here, if you read the regulation literally, that subsidiary, after the date of acquisition, would be tested separately for the rest of the plan year. Now, that can be good or bad. It may be that the subsidiary's plan was separately maintained while under the prior ownership, and when tested solely by reference to the demographics of the subsidiary would not pass muster. As to the subsidiary, the percentage of HCEs covered was too great in relation to the percentage of non-HCEs, but there were so many HCEs in the old group who are not in this plan, that when tested on a controlled group basis with the old group you were okay. Let us say the same thing would be true in the new group. Are we in a situation where suddenly for this year of sale we lose the ability at least to combine with the new group and maybe with the old group? That's a theoretical result under this regulation. As a practical matter, no one's ever applied it that way, but I think you have to be at least alert to the issue. Now, alertness to the issue includes having access to the data necessary to apply these rules, and access may be something that becomes particularly important when we look at the transition rule.

This is a new statutory rule that says that if a plan satisfies the 410(b) coverage requirements immediately before a change in the controlled group, then for a transition period beginning on that day and going to the end of the next plan year it will be deemed to remain in compliance with 410(b) if there's no other significant change during this transition period. In order for this rule to apply you have to satisfy these requirements immediately before the change. Now, the question is, is the data that you collect for your clients adequate for this testing? In theory, if you read the 410(b) regulations, you have to meet coverage tests one day of each quarter. I suspect that in many cases what happens is the data gathering is limited to the last day of the plan year, that as of the last day of the plan year you have to report 410(b)-type data for purposes of the annual report filing on Form 5500, the Item 22 test for coverage compliance. If you are only gathering up that data as of the end of the plan year, query whether you could demonstrate that if there's a sale -- we're talking calendar year plans to make an example -- if there's a sale in August, can you say that you're in compliance immediately before if the last date for which you have data is the preceding December 31, as opposed to data at least some time within the quarter in which the sale occurs and prior to the date of sale? So, if you have clients who are doing deals, it may be important for you to encourage them to have payroll and record systems that would enable you to get at that on a quarterly basis if, in fact, you needed to do that.

Now, passing the data collection problems, there's the question, can you get 410(b) relief if you're purchasing assets? Because what 410(b)(6)(C) says is, if there is a change in the controlled group and you bring in a new subsidiary, clearly there has been a change in the controlled group as to both the seller and the buyer, but if you simply buy a division, you buy assets, has the controlled group changed? Well, I think the IRS will ultimately conclude that. It makes absolutely no sense to make that distinction, and I think that there's enough leeway to construe language to get there. After all, the controlled group includes unincorporated trades or businesses, and the

division is an unincorporated trade or business. So, from that standpoint I think you could say there has been a sufficient change in the controlled group.

Assuming that you get over that hurdle, the question is, is the way you're handling your plans one that gets you the protection of this transition rule? If you have seller's plans and buyer's plans, and you are simply moving people from seller's plans to buyer's plans, it's clear that both plans would have the protection of the transition rule if both were in compliance with 410(b) immediately before, and that would be true whether or not you transferred assets and liabilities between the two plans. If you have a free-standing plan, you're buying a subsidiary that has its own separate plan, and that plan moves from seller's group to buyer's group, it is also clear that you have a plan that was in compliance immediately before, and so it would have the benefit of the transition rule.

But suppose you buy a subsidiary that was in the parent's plan, and what you do is have the parent spin off the assets and liabilities to a newly created, separate plan that you form for this purpose after the deal. Can that newly created plan have the benefit of the transition rule? We have this phrase referring to compliance immediately before the transaction. If the plan didn't exist immediately before, can it have been in compliance? I think there's enough play in the way the statute is phrased that you can conclude that that plan can also have the benefits of the transition rule, but it's far from a slam dunk, and so I think you have to be a little bit cautious of that kind of configuration.

Now, assuming we are meeting these various requirements that we've talked about, we now get to the question, is there going to be any other significant change in coverage? Obviously that's going to be a facts and circumstances thing, and there is authority in the statute for the issuance of regulations under which a significant change would not cause you to lose the benefits of the transition rule. Of course, there are no regulations on the subject at all at the present point. But let's consider the second deal that occurs within the transition period. First, there's the question, is that a significant change that louses up the first deal? And, second, if it's not, can you get similar transition rule relief for the second deal? I mean for the second deal to pass muster you must be in compliance immediately before that change. Are you in compliance immediately before the change if the way you get into compliance is by using the transition rule, or for the second deal to qualify must you show that, in fact, you comply without the transition rule? Reading it literally I would think you get the right to qualify so long as you're qualifying even under the transition rule, but whether the IRS will see it that way, I don't know. Obviously you have to proceed with caution here.

I've started with 410(b) because it indirectly a set of rules that qualifies you under 401(a)(4) for various nondiscrimination tests. We all know that the availability of optional benefit forms, rights and features and ancillary benefits, must be nondiscriminatory under 401(a)(4), and that means that it must be available to a group that meets a 410(b) coverage test. So, the question is, does compliance with the transition rule under 410(b) mean that you are in compliance with the 410(b) coverage test also for 401(a)(4) purposes? I would hope they would reach that result. Let's take a perfectly simple case where the plan involved is one that is completely uniform in all its optional benefits, rights and features and ancillary benefits. In other

words, every participant in that plan has the same, identical formula and rights in all respects. In that case if, in fact, the plan meets 410(b) as to coverage, automatically all of the rights and features will meet 401(a)(4). Let us say, however, that during a transition period the plan would not meet 410(b). However, you have the transition relief for 410(b) purposes as such. You're sort of undercutting the effect of the transition rule if it still fails to qualify because every single thing in that plan that's a right and feature is tested under 401(a)(4). If you don't extend the transition relief also to 401(a)(4), it doesn't do much good, and the Service has also recognized that 401(a)(4) and 410(b) really are two sides of the same coin. In fact, it has gone so far as to say if you flunk 401(a)(4), the disqualification sanctions are of the type that apply when you flunk 410(b). In other words, all HCEs are immediately taxable on the full value of their accrued benefits. So, that is why I have rashly said that the transition rules should apply for 401(a)(4) purposes as well.

Now, as to 401(a)(4) there are a couple of transition rules specifically made applicable for optional benefit forms. One exists in a final regulation, and that is a rule that if you eliminate an optional form with respect to future accruals, but at the time that you eliminated it you met the current availability test, which in effect meant that the group for whom the optional form was available met a 410(b) test, then you are forever in compliance with 401(a)(4) as to that right or feature. There is a second rule that is in a proposed reg that goes slightly further because this first rule relates to elimination of an optional form for future accruals while keeping it for current accruals; as you must because optional forms cannot be eliminated under the anticutback rule. So, if you're buying a subsidiary or a division and it is spinning off and you're receiving the assets and liabilities with respect to that group, and under the anticutback rule you have to preserve the optional forms for the benefits you're assuming, but you don't want to extend them to anyone else, this rule should permit you not to have to worry about whether later attrition in that group might cause the people who have this grandfathered accrual with the associated forms to fail to meet a 401(a)(4) test in the future. Now, that provision of the final regulations only deals with a frozen benefit and an optional form related solely to that.

Suppose you want to have an unfrozen benefit, that you're continuing to adjust the benefit for future pay increases or perhaps you're even continuing to accrue under that formula, and you transfer this living grandfather, we'll call it, from seller's plan to buyer's plan. Well, first of all, you have to deal with the nondiscrimination as to amount testing, but assuming you get over that hurdle, there is the question, do you have a 401(a)(4) problem as to rights and features and options? And there is a rule that if you meet 401(a)(4) immediately before and immediately after -- this is different from the final regulation rule that looked at it only before as you have to meet it after, but that's logical because this is one that is not limited to what was accrued up to the date of the deal – it allows you to continue it for the same deal going forward, so long as it remains available for the same group only, on the same terms. If you're talking about a defined benefit plan with early retirement subsidies and various benefit forms associated with it, you cannot continue to enjoy the protection of this transition rule if later you were to change the early retirement reduction formula. Obviously, you couldn't make it worse because of anticutback (at least for prior accruals), but if you wanted to improve it, you would lose that protection. So, if you do have a living grandfather for a group that you take over and you keep it going on the same basis

solely for that group, if you meet the 401(a)(4), which means a 410(b) test, just before and just after, you remain okay.

Those are the transition rules that we have, and they are applicable to qualified plans. Now, unfortunately, qualified plans are not the only group of plans for whom we have to worry about these requirements. Other categories of plans are subject to nondiscrimination requirements. There you have very little in the way of guidance, but I would be hopeful that the transition relief principles that are applicable for qualified plans would on an administrative basis be made applicable to these other situations.

At this point I want to call your attention to a couple of major developments that would affect the way you might do deals. The horizontal partial termination concept, which is sort of a relatively new term, was introduced into, I think, judicial literature (previously it's been in literary form) in a rather extraordinary way in the Gulf pension litigation, and that's a situation where the plans were handled in a way that's very common. You have the plan of the company you've bought. There's your own plan. You want to bring them together and have a uniform set of benefits going forward. In the Gulf plan, Gulf was acquired by Chevron, and the Gulf and Chevron plans were merged. Gulf had fully subsidized early retirement at age 60. It had social security supplements. It had disability benefits that were not reduced for early payment, and there was a subsidized spouse's benefit, 40% of the accrued. All of these four benefits were eliminated prospectively. Other goodies were given outside the plan. There were profit sharing plan enhancements for the Gulf people. There was some life insurance. What they lost on LTD in the plan was made up in LTD outside the plan. What the court held was there is a horizontal partial termination, under a reg that's been there for years but not widely applied, if the decrease in future accruals significantly increases a potential reversion. The Gulf plan was well overfunded before it embarked on this. The court identified millions and millions of savings from the elimination of these features and held that even though these features were ancillaries, they, nevertheless, came within the concept of elimination of future accruals for purposes of that regulation. The judge refused to give Gulf and Chevron credit for replacements for what was lost outside the plan, such as the qualified profit sharing plan or the LTD or some life insurance that was added, and decreed a horizontal partial termination which required full vesting. So, in a very standard exercise that you all go through when you're taking two plans and merging them together, and figuring out what benefit formula makes sense going forward, you have to be very careful now unless and until this is reversed that you're not going to trigger a partial termination, and maybe you will. Now, with accelerated vesting the costs of a partial termination are much less than they were in the Gulf case where you were still operating with 10-year vesting, and the value of the benefits that vested as a result of this were fairly hefty.

That, I think, is an overview of what I would call the most significant things and transitional problems in moving forward in a deal. At this point, I would like to enable Harvey to get started on the subjects of financial categories that concern liabilities and what's out there.

MR. HARVEY SOBEL: What I'm going to be doing is going over some of the basics of what I get involved with as a health care actuary, and that gets into some of the

health insurance and group insurance terminology. So, for those of you who are up to speed, you'll have to bear with me because some of it may be basic material.

I like to look at mergers and acquisitions in terms of three categories that a buyer might be interested in. One is the balance sheet. The other is the income statement. And the third is sort of a catch-all, a human resource side. Now, in terms of the balance sheet the buyer is very much concerned about the net worth of the company that's being acquired, and we, as actuaries, will be called upon to help primarily with the actuarial liabilities of the firm or of the company.

One of the most significant liabilities is retiree medical. I'm sure most of you have, if not directly, been involved with retiree medical. Perhaps you've seen some of your health and welfare actuaries involved with the retiree medical, and it creates the question, "Can there ever be a meeting of minds?" Now in some cases a buyer is going in and making a bid for a company, and so there is really no negotiation, but I've been involved in some situations where there is back and forth between the buyer and the seller, or it might be a joint venture and the retiree medical can be a very sticky point. So, what I've tried to do is list some approaches to retiree medical. I don't necessarily think it solves the problem, but it might be able to allow the buyer and the seller to move forward.

Obviously, the general approach the buyer would use is to adjust the purchase price for the retiree medical if the buyer is picking it up, and, of course, to the extent that your estimates are more conservative than either the seller or perhaps some other prospective buyer, that would still pose a problem because you can still lose out in the deal (since you won't have a deal).

In other situations we've seen, the buyer will not pick up the current retirees. The seller would retain the responsibility for current retirees. Again, it doesn't make the problem go away, but for a lot of companies, particularly some of the auto or steel companies, if they're trying to spin off divisions with large groups of retirees, it can help make some of the numbers a little more palatable.

The third approach is where the buyer would actually go in with the thought of trying to trim back or cancel benefits. Of course, that raises the issue, "Well, why doesn't the seller do that already?" Sometimes, as you're probably aware from reading the papers, many companies are distressed – in financial difficulty – and if a white knight comes in and is willing to infuse some capital into the company, it's perhaps a little more palatable for the employees to accept some sort of benefit cutback, particularly if they're not current retirees. There are some companies out there where this could work or has worked, but then, of course, you get into problems: will the unions buy off? Again, it gets into issues of what condition the selling company is in.

The fourth item on my list – hire a third actuary to arbitrate – is in a situation where the buyer and the seller are negotiating over the retiree medical. They can't reach an agreement. In some cases, a third actuary has been called in to pronounce Solomon-like judgment upon what the liability is. Of course, this can create problems if that actuary comes up with a range of numbers. If the range encompasses the seller's low number and the buyer's high number, it's not exactly clear how that third

actuary could reach a definitive number. But, of course, there is always a best guess, and this approach has taken place on one or two deals.

The next item is an approach that we're currently trying to work out which is the seller would indemnify the buyer if the results were bad. By bad, I mean if the retiree medical results come in worse than the buyer had anticipated. Now this approach, of course, still has a lot of problems because even if you wait five or ten years for some of the retiree medical claims to run out, you still may have a generation to go. But it would potentially allow the buyer and the seller to perhaps get by some sort of impasse, although it could still create problems down the road. It's not an end-all solution.

And the last item is stick-the-head-in-the-sand, which means just ignore it. With SFAS 106, this option is increasingly not available, but there are companies out there that we've dealt with where they just don't want to hear about retiree medical. They don't think that accrual accounting makes sense, and they have hired lobbyists to lobby for national health insurance. That's their way of getting out of the retiree medical problem.

The other major liability is for unfunded claims -- primarily medical claims incurred but not reported (IBNR). There are also dental claims. Primarily in evaluating this liability, we're more concerned if the plan is self-funded, because if the buyer is picking up this liability, it's a direct cost if the plan is self-funded. However, it doesn't minimize the need to look at the liability even if the plan is fully insured because if the seller's division is big enough, then the results would eventually be settled up in the dividend or refund accounting. So, if the liability for unpaid claims is too high or too low, it could eventually revert to the buyer. And we primarily would look at this liability, which is essentially the claims in the pipeline -- the claims that have not been settled at any point in time -- by doing some sort of triangulation or lag study. As a rule of thumb, the liability runs around three months of claims, but I caution you about a situation we came into where a buyer had acquired a company. We were not involved with the purchase, but after the fact we got involved, and we learned that the seller had instructed its claim administrator to slow down claim payments deliberately to make the medical expenses look better. What the buyer did was pick up a huge liability for incurred but unreported. It eventually litigated over that and other fraudulent misrepresentations, (nonactuarial ones), but it does point out the need to be careful. Of course, it's cleaner if you can strike a deal whereby the seller retains liability for all claims on an incurred rather than on a paid basis.

And the third major liability is for disability claims: the disabled life reserve which is the contingent liability for employees who are disabled and who will receive a disability income benefit while disabled in the future. You want to look at whether it's self-funded through some sort of voluntary employees' beneficiary association (VEBA) or if it's fully insured, because eventually the experience will come back. I'm involved right now with an interesting situation where it was not a merger and acquisition; it was a spin-off. But now, a few years later, we're looking at the disability reserves of a company that was spun off. Because during the spin-off there was a lot of turmoil -- divisions being closed -- a lot of people went on disability, and they qualified under what's called the "soft test," which is the inability to perform one's own occupation. Then after two years the test for disability changed to "any

occupation;" a lot of people were no longer considered disabled, and we had a nice healthy release of reserves. Which is saying that the reserves, when the employer was spun off, were overstated.

Now let's discuss what we call the other or hidden liabilities, and, of course, in some of these deals you have very little time to look at everything. Some of these other liabilities could get overlooked, but depending on your time horizons, you may have the ability to do due diligence on each and every liability. There is a liability for waiver of premium on group life insurance. In other words, somebody becomes disabled. They may go on disability, collect a disability income, but their life insurance benefit is preserved. The employer would not pay premium on them, and the insurance company would hold this liability -- generally on a fully insured basis. The interesting thing is here that while it's normally held by the insurance company, there can be situations for large employers where the employer and its consultants have negotiated a deal for the employer to hold this reserve. It gets to be a little tricky if a division is spun off, because then it is suddenly out in the marketplace trying to buy life insurance, and it has disabled employees, which is not exactly a risk that the insurance company wants to pick up. So, it's sort of important that you make sure that this liability is not ignored. It can be significant dollars, particularly if the company that's being acquired has been around awhile and built up a large number of disableds.

Usually there will be less disableds under this benefit than under a disability income benefit because the test for disability here is a very, very strict one. It's usually much more strict than a long-term disability plan benefit. Usually this one means that the person is totally and permanently disabled (i.e., can't do anything). For example, take someone who's a surgeon. Now a surgeon can qualify for long-term disability income benefits for the first two years because they cannot perform surgery. Then after two years, if they cannot provide any sort of service commensurate with their professional training -- for example, if they can't teach medical students -- then they would fail the "any occupation" test. For group life premium waiver, they would have to not be able to perform surgery, not be able to teach or not be able to do anything. So, to qualify for this benefit they would have to not be able to take a job at McDonald's.

My next liability is COBRA. Most of you are probably familiar with COBRA, which requires that employees and dependents upon termination of employment be offered medical and dental coverage on the same terms as while they were active, and they can pay no more than up to 102% of the active premium rate. Most employers have discovered that the costs of insuring their COBRA beneficiaries run two to three times the cost of the average active employee. So what happens is if the buyer is picking up a large contingent of COBRA beneficiaries, and whether they're known at the time of sale or whether they're going to happen as a result of the sale, the buyer can be picking up a very sizable liability which is essentially the present value of the COBRA beneficiaries' claims in excess of contributions.

On a related vein a lot of medical plans provide that if an employee terminates from the plan or if the plan terminates, the plan will provide continuing medical coverage to employees and dependents who are totally and permanently disabled. Now, this is the medical analog of that group life waiver of premium reserve. We're really talking about perhaps one or two big ticket claimants, and it's important that you think about

this as you evaluate the liability because there could be an obligation here. Sometimes this obligation is buried in with the unpaid claim liability. In fact, most insurance companies, when they perform a dividend accounting, bury this liability in there or they may separately identify it, but it's there.

We spend a lot of time thinking about retiree medical, but there are other post-retirement benefits. Life and dental are two. Sometimes there's a separate stand-alone prescription drug card benefit. You may be aware of it, and you may think that it's in your data, but then you find out, after you've done all your calculations, that someone failed to give you the prescription drug claims, which are being administered by some outside third-party administrator like Pharmaceutical Card System (PCS). So you have to be aware of it. You have to ask for it about five times. And then after you get it, you may find out that the plan has a mail-order drug plan administered by another TPA, and their claims are not in with the card drug claims. So, mail-order drugs could also be out there, and you must make sure that if you're doing a retiree medical valuation, you're picking it up because, for retirees, you're talking big dollars. Drugs can be up to half the cost of retiree medical for retirees 65 and over. There could also be separate vision and hearing plans, which usually are in with the medical, but sometimes they're not. And then some employers provide coverage that will pick up or pay for the Medicare Part B premium. This is a liability that needs to be valued, not overlooked. And, finally, beware of any "retiree-pay-all" coverages. I put that in quotes -- and I'm being very facetious -- because a lot of times people will swear that retirees pay the full cost ("Don't worry about it"), and as you look into it you find out that the cost they're paying is based on the active experience; it's really not indicative of retiree experience. So you have to just be careful that it truly is a retiree-pay-all-coverage and that the buyer is not acquiring a hidden liability.

Another type of liability is for vacation, sick pay and severance benefits. We had an employer that had a sick bank that needed to be valued, and depending upon the actuarial assumptions, you can actually get some big cost out of it.

Many insurance companies, if the company that's being acquired is conventionally insured, have arrangements that allow the insurance company to call up additional money if experience is bad. These are called retrospective or contingent premium arrangements. You need to be sure if you're working for the buyer, that the buyer is not picking up what we would call a retro call, which would mean simply that after the sale goes through, the insurance company presents the buyer with a bill for 10 or 20% of premium, because claim experience is bad. What you want to do is make sure you do a sort of mini-settlement on the date of the sale to make sure that you've accounted for any monies due the insurance company -- over and above the traditional premium. And in the same vein there are some very, very sophisticated funding arrangements out there, particularly under minimum premium plans, whereby additional money is owed the insurance company. Again, you have to make sure you're not missing anything.

I think I've covered all the balance-sheet-type items, but sometimes buyers are more concerned about the income statement. They and their investment bankers are doing a projection of the revenue and expenditures of the company that they're considering acquiring, and they need a benefit cost figure to go into the pro forma financial statements. They want to know if the revenues of the company can support the

expenditures, including benefits. Sometimes the investment bankers will not be that aware that benefits are not like any other expense because benefits, at least on the medical side, are continuing to go up at 15-20% a year. Most of the companies being acquired are not projecting such increases in terms of their unit sales. So, there can be a real problem in terms of the ability of the company to cover the ever-increasing medical burden.

When I'm involved with income statement projections -- projections of benefit costs -- one thing you have to be cognizant of is, are we working with cash or are we working with accrual accounting? Because in that first year, when the buyers take over, there could be less claims in the first year because of the claim runout, if the seller assumes the liability for claims incurred but not reported. Some investment bankers like to do discounted cash-flow analysis. They're more concerned with the incidence of the cash rather than the accrual accounting. So, it's something you need to be aware of, and if you're going to do a cash projection, you need to make sure everybody's aware of all of the liability, not just for the time period you're projecting.

This brings me into what I call the "tail." Many times the investment bankers will have a five- or a ten-year time horizon, and they will project the company's revenue and expenditures over that time horizon. Then they'll have some residual factor for the years beyond the projection. Say if they're doing a 10-year projection, they may have a column for the 11th year, but they'll take that 11th year and multiply it by some factor to account for the fact that the company will go on beyond 11 years. What I found, if you look at it carefully, is a lot of times what they're assuming implicitly, since they're discounting the net income, is that the employee benefit expenses will grow at the same rate as the other expenses and revenue, and that the profit margin will be preserved. Those of us involved with the medical side are aware that the medical is growing quite rapidly, and particularly if this projection is including the retirees, you'll see the retirees come in 20-30 years. So, it's very important that you make your client aware that they have to have a long enough time horizon in order to properly pick up the tail.

The internal rate of return is not necessarily something that you have to be worried about, but it's something you might need to talk to your client about. Your client is probably evaluating cash flows for the enterprise using some pretty high interest rate, which might be a risk-free-type rate plus some sort of risk margin. I was recently involved in a deal where we were discounting the retiree medical at 9%, but the client was discounting cash flows at 15% because it wanted that as its benchmark hurdle rate. We got into some discussions about the appropriateness of whether we should be valuing retiree medical at 15% or 9%. We didn't really reach a satisfactory conclusion, but if you think about it, the buyer is using a higher rate not because of its retiree medical, but because of the uncertainty of the net revenue, not the net expenses. So, you can make an argument that you really shouldn't be discounting retiree medical at 15%. If anything, it should be going the other way.

Sometimes when we're given data, we're not necessarily given data based upon the current plan. Are you pricing today's benefits plan? If you're working with historical data, you're properly adjusting it for any benefit changes that have taken place since the time period of the data. You also want to make sure you're factoring in any

benefit changes that have been negotiated with the union that have yet to show up in the plan data.

Another consideration is administrative expenses. Frequently the buyer is looking to take the seller and absorb its employees into the buyer's benefit plan. This will create generally lower administrative expenses because the buyer now has one benefit plan, and the expenses for administering the plan are spread over more employees. So, the unit cost could drop. If you're doing a projection, you might want to factor that in. On the other hand, we've been in the situation where -- in a joint venture -- the seller wanted to spin off a division, and in that case the administrative expenses for administering the plan would be higher because we would be losing the seller's economies of scale.

Sometimes in some of these deals the buyer says, "Well, I'm going to jack up employee contribution rates to help offset the costs of the medical program, whether it's the active plan or the retirees." If the game plan is to jack up contributions high enough, you can get into adverse selection, and you want to make sure that you factor that into your calculations. We've been in situations where the buyer says, "I'm going to turn the retiree medical plan into a retiree-pay-all plan" or "I'll have retirees pay half the cost." You'll lose retirees, but the retirees that you keep will cost you a lot more because only the less healthy retirees or the retirees without coverage under a spouse's plan will elect to be in the plan.

Finally, I have sort of a catch bucket of what I call human-resource-type issues. Sometimes we're asked not so much to tell balance sheet numbers or income statement projections, but help in terms of consolidating the plans. When we're asked to do this, sometimes we'll set up a little worksheet that'll show the buyer's plans and the seller's plans -- this is if the buyer's going to be consolidating benefits with one benefit plan for all employees. We'll compare the benefits, and we'll make recommendations in terms of areas where the plans can be consolidated -- where the employees in the seller's division are not really being asked to give up too much. We may want to quantify the costs of doing that. Sometimes you get into issues of whether there is going to be major loss of types of benefits or, going the other way, there could be situations where the buyer, by virtue of moving the seller's employees into its plans are actually giving the seller's employees a better deal. We had that recently where the buyer had no contributions for being in the medical or dental plan, but the seller had a very large contribution required for coverage of dependents. So, moving the seller's employees into the buyer's plan was a windfall for the dependents.

I've had the pleasure of actually going to the seller's insurance companies and terminating coverage. That's sort of one of the aftermaths of merger and acquisition, and it creates some interesting problems that you need to look at. First of all, you want to make sure there's no penalty for terminating off of the policy anniversary. There are some insurance companies where, if they have an August 1 policy anniversary, and you terminate August 1, there'll be a settlement; if there's any favorable experience, your client will get a refund. However, if you terminate December 31, you're out of luck. Off-anniversary terminations do not require the insurance company to refund any surplus, and, in fact, there's one company out there that I'm aware of that has the very draconian requirement: It is saying basically, "We provide

coverage based upon an annual policy year, and if you terminate off anniversary, that's nice, but you owe us a year's worth of premium." So, you want to make sure that if you're terminating coverage off anniversary, you don't get into one of those situations. We successfully were able to negotiate with them to terminate off anniversary, but we did it before we actually issued the notice of termination. You also get into issues of negotiating rates for partial policy years. We talked about some of the sticky liabilities, like liabilities for disabled people, and you want to make sure that you've identified potential problem claimants so that it's clear which carrier has the liability.

I would like to remind everyone about compliance. Mike really covered this in great length in his talk, but there are questions such as: Is the seller filing its Form 5500s properly? Is it properly notifying employees of COBRA? You want to make sure that your client is not coming into a situation where there are going to be penalties assessed because the seller did not properly administer the plans.

MR. SMALL: I want to discuss some of the pension issues. Let me start by giving you the analogy that I like to refer to in any of these merger acquisition deals. It's sort of like a chess game. There are some standard opening moves that we can talk about, and then as you go through this discovery stage you move into a game that takes on its unique identity; these are the issues that become the discussion items in the deal. And then, one by one these issues may be put to rest. Finally, you move into the end game where there are certain transition issues that need to be addressed.

Starting at the beginning, the opening moves generally start with a short trip to a data room where there are many documents for you to review. You can look at 5500s, actuarial valuation reports, plan documents, financial statements, and numerous other items that are included in the data room for your review, but so what? Unless something really jumps off the page, it would be very difficult for you to really spot issues that you'd want to bring to the attention of your client. So, I would like to share with you some experiences that I've had in some of the deals that I've been involved with, and having been primed with some of the issues, now you can review documents with an eye towards answering some probing questions.

Certainly as a result of Statement 87, we now have pension disclosure that appears on corporate financial statements. So, you may well start with looking at pension liability and see how it's being disclosed. The first apparent item to be looking at might be the interest rate being used for discounting the pension liabilities. Suppose you find liabilities are being disclosed at 12%. Maybe I'm exaggerating, but the point is if liabilities are being disclosed on the seller's balance sheet at a higher discount rate than the buyer would be willing to assume or willing to disclose and compute pension expense, this means something to you in reporting back to your client. Another item to pay attention to is not only the discount rate itself, but has it changed recently? And if it has, is there some justification for it? Hopefully, no one was just making the balance sheet look pretty.

You'll also want to look at actuarial valuation reports as another item. What are you going to pay attention to? You should look at the funding method. I've personally been involved in a situation where the funding method is projected unit credit, and I read the description contained in the report, and I've concluded that the methodology

that was being described is not the methodology that was being followed. In fact, the way we at our firm would follow the projected-unit-credit-type method, it would lead to higher funding than what the seller has been putting in, and that's quite important.

You'll want to pay attention to plan experience. That, of course, is always to be found in the valuation report. Maybe it's complete enough to give you experience by source. If not, you can generally try and get a sense of asset experience versus all other plan experience. That's certainly quite doable. When you have a chance to look at your plan documents, together with the valuation report, you'll want to look and see how the benefits are being valued for the valuation purposes. Some plans have certain early retirement subsidies or enhancements that are in addition to the regular early retirement, but then if you leave under special circumstances or downsizing, there may be some better early retirement benefits. Are those being reflected in the valuation? Suppose, as you're going through your review, and I'm being pessimistic -- they go the other way. Suppose you go through your review and you find the plan is very well funded. (This is similar to a situation that I got involved with about a year ago.) The buyer is contemplating taking the plans, and they'll continue the plans. The sale price is going to be quite significant, and we're looking at these excess pension assets. Now, that's been a big item for companies maintaining plans that have surplus assets. I don't know how often it's been thought through in a buy-sell deal, but this is a situation where maybe you can put the seller in a very fair position so that together with the purchase price you negotiate, it is possible to leave some pension surplus behind with the seller and the buyer assumes the pension plans with less surplus going forward. That is a very creative way to finance a deal, and in doing something like that you want to work with your client, give them some sensitivity parameters. If they leave $50 million of surplus behind, and you continue the plans, obviously your funding is going to be higher than the seller's, but there's a cash flow implication. If you don't have to finance the deal, but you pay for the deal in higher pension contributions, maybe that's a fair way to strike an arrangement.

If the buyer's assuming the pension plan of a subsidiary of the seller, the buyer may be assuming the liabilities, and there's going to be a transfer of assets over. The two parties will want to strike a common agreement as to how much assets will be transferred over, and it's usually related to the liability. So, how you value the liability for transferring assets means deciding on an interest rate. Again, I've seen the situation where the assets according to the sale agreement were transferred at 9%, then as actuaries we were using an 8% valuation interest rate, so right away there was an immediate funding requirement, and also on the Statement 87 side that had a similar impact. Sometimes there may not be any assets to transfer. Maybe the seller will continue to be responsible for the accrued benefits that have been earned up to the sale date. They'll keep the assets. Now the buyer says in order to be fair to the employees we'll establish an identical or very similar pension plan so that from the employees' standpoint they're whole. It would be transparent to him that he'll get perhaps two checks at retirement, one from his former employer and one from the new employer. The new employer's pension plan might provide a carve-out feature so that they'll just carve out the accrued benefit from the prior employer. Simple enough concept, but you want to be sure that buyer and seller have a mutual understanding of the pension terms. I mean it's certainly possible that that buyer

might think they were entitled to the pension benefits, but the seller says no. They are not eligible for those pension provisions. The buyer at this point is going to have a sense of responsibility to the employee, and they may find themselves on the hook to pick up additional benefits that they hadn't thought about. Along the same line, suppose a few years later the buyer wants to do some downsizing and wants to offer an early retirement incentive, and suppose it's a five-plus-five type deal so that a 53-year-old employee is now entitled to early retirement. Under whose plan? The seller's plan has early retirement of 55. Now, the buyer is in a situation of providing an early retirement enhancement, and there may not be a valid carve-out in a situation like that.

Turning the focus just a little bit, as you have the opportunity to review plan experience, you'll want to pay attention to employee turnover. There's an interesting story here, of my perspective versus someone who has more of a human resource's approach. We were involved in a situation where the turnover was very low. So, what does one conclude? No turnover. I guess people are very happy. A good place to work. But maybe the human resource person says turnover is low. Maybe people work only three or four hours a day. Maybe the company is overstaffed. Obviously this is a completely different twist from what I've been talking about, but that could be very interesting to discover.

Does anybody have clients who are defense contractors? I don't think you need to be reminded that defense contractors are subject to their own scrutiny by the Department of Defense, and there may be many other defense issues that enter into the discussion when it comes to an acquisition. You should make sure you're well aware of any preexisting situations or any situation that may be triggered as a result of the sale.

MR. MATTHEW J. SHERWOOD: I just have a quick question for Harvey Sobel. You mentioned that COBRA claims generally run about two times, two-and-a-half times, what the premium is. Is it just because terminating employees tend to be in worse health or are there other reasons for that?

MR. SOBEL: The terminating employees that can afford or want to pay $100, $200, $300 a month, maybe even $600 a month for family coverage, are going to be the ones who tend to need coverage. It's not that a terminating employee, per se, is less healthy. The ones who elect COBRA coverage are less healthy.

FROM THE FLOOR: Along those lines, the employee has such a long lead-in time to make his first payment that he can wait to see if he actually needs to make the payment. (Am I going to get better coverage or should I just go ahead and pay the claim?) They have about 60 days after they've left to make their first payment, and so they have two months to incur the claims, and they know what they have incurred versus what they have to pay, and it's the real reason there is a lot of antiselection there.

MR. SOBEL: I would second that. When I once changed jobs, I was afraid that I might incur medical expenses during that transition period, so I notified the old employer that I wanted the COBRA option. By the time I got all the paperwork, I was working at the new employer. Had I had a medical condition in the interim, I

could have retroactively taken out the COBRA option. There are time lags and legal requirements that the enrollee must be given.

MS. JUDITH E. LATTA: A couple of comments on things that I've seen that seem to come up, and a question probably for Mike. Certainly we always come up to the issue of to merge or not to merge plans before we go into a sale. To the extent there are any surplus assets, we have certainly discussed whether strategically we want that surplus to continue to be associated with that particular group or to become part of the whole controlled group and, therefore, more negotiable. Along those lines, we don't always put the actual valuation report in the data room and make that available. Very often we do an abbreviated report that produces accrued liabilities and normal costs, which is really all the ongoing buyer needs to assess the ongoing implications of continuing the pension plan. Certainly in negotiations when push comes to shove later and you get your "real" buyers as opposed to your array of buyers, you can only be so hard-nosed in those negotiations, but you don't always have to ante-up the standard stuff if, in fact, it may not put you in the best position. You may want some sort of an abbreviated report. We've gotten into big issues between validates, dates of sale and dates of transfer. I caution all of you that when you're talking about liabilities and liabilities only, they do change between our dates very often because we're dealing with funded plans, and we see benefit payments affecting both the asset and the liability side. We forget that if we're just negotiating liabilities and numbers and we negotiate based on a number as opposed to a conceptual basis for the valuation, those numbers change over time based on the number of benefit payments that you've released, as well as the additional accruals. So, those can make significant differences in your numbers, and you should be cautious about that. Thank goodness I've been on the good side of that particular negotiation but certainly learned my lesson from it. The one issue that I've struggled with is I've seen companies really want to transfer the obligation. Very often we end up in a fall-back position of keeping everything.

It's just like when we're going to sell a company. Sell it, keep the assets, and stop arguing about who gets the surplus or what the valuation basis is. I've had one situation where the seller had a defined-benefit (DB) plan and the buyer had a defined-contribution (DC) plan. The seller wanted to preserve that asset accumulation and would have very much been willing to do distributions as long as they could be rolled into the DC plan and required to be rolled into the DC plan as opposed to making it an option. Is that something that you've been able to construct or come across? Are you able to transfer your obligation to a DC plan and take away the employees' ability to take it in any other form other than roll it right into that DC plan?

MR. NASSAU: I think it should be doable. The IRS finally clarified its position on the same desk rule. If it must go into the DC plan, we have regarded this as not conceptually a rollover but a direct plan-to-plan transfer, and you have very serious anticutback rule problems in a plan-to-plan transfer unless you come under an exception that allows the money, when it winds up in the DC plan, to be viewed, in effect, as starting afresh in terms of what you must give when the individual leaves. The money started in the DB plan. In the DB plan there were annuity rights and features and the joint and survivorship (J&S) implications. There is a provision in the anticutback regulations that says that if a distribution is permitted under the terms of a DB plan, and the individuals could have taken a distribution under which all of the

rights as to form and the like were available to them, then if with spousal consent they elect an alternative, you can start fresh. Now, if you're buying assets, what you've got is a termination of employment. A pension plan that ordinarily could not pay out in service is permitted to pay on a termination of employment, and so if on termination you offer the individuals annuity forms, but they can elect instead the direct transfer, and they choose that, it can go over.

There is one feature, though, of the annuity option you offer that you should be aware of. You can only offer the direct transfer if there is a waiver of the Qualified Joint and Survivor Annuity (QJSA), and the final Retirement Equity Act (REA) regulations that came out say the waiver of the QJSA has to be a waiver of an immediate QJSA. So, let's take someone age 40 in a DB plan that only pays at 55, early retirement age. Normally they could not leave at 40 and get an immediate annuity. If the person at 40 is to be given an option to move it to the DC plan, they must also be given the option of an immediate annuity beginning at age 40. Now, as I say, in an asset sale situation there's no question it's a termination of employment, and, therefore, you satisfy the requirement of the regulations for relief from anticutback restraints, that the DB plan be permitted at that point to make a distribution under which all of the protected features under the anticutback rule can be taken advantage of. In a stock sale historically there was a concern, Is there a termination of employment where you're selling stock and the individual's still working for the employer? and I think the same desk rule would yield the result that we don't make distinctions between asset and stock deals. If you're no longer working for any employer maintaining the DB plan or for any member of a controlled group maintaining that plan, then you should be able to do it, I would say.