

Benefits: A Key Player in Mergers

By Patrick J. Haraden

Employee benefits can affect purchase price, operating efficiency and employee relations in a merger or acquisition.



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More hospitals are merging or acquiring other health care providers to take advantage of economies of scale. But employee benefits are often one of the last areas evaluated in any merger and acquisition (M&A) transaction—if they're considered at all—despite the potential land mines.

After a merger, a health care organization may find itself saddled with hidden costs or liabilities. Its employees may become unhappy with their new benefits and leave. But with proper planning, a merger or acquisition can improve benefits and reduce costs.

Uncovering Hidden Liabilities

Benefits are usually evaluated only in terms of cost savings related to layoffs or attrition after the merger. This approach is unfortunate, as benefits can affect the purchase price (or true cost of the combination), operating efficiency and post-merger employee relations.

Due diligence should encompass all benefits—medical, dental, life, disability, time off, retirement and voluntary benefits. But the primary focus should be on medical and dental benefits as these usually have the greatest impact on costs, opportunities and employee relations.

Health care organization leaders should assess all medical and dental plans, including any "grandfathered" plans, retiree benefits (including FAS 106 liabilities for postretirement benefits besides pensions) and severance plans that provide for the continuation of medical or dental coverage. This review should focus on coverage eligibility, employee-contribution schedules, funding, contract provisions and compliance requirements, such as plan documents, IRS Form 5500 filings, and required COBRA and HIPAA notifications.

Self-insured plans are the most common source of big hidden costs or liabilities in medical or dental plans. There are two main areas to review—reserves and stop-loss claims. The reserve is the amount an employer sets aside when the plan is first implemented. The reserve will pay "run-out" claims and administration when a plan is eventually terminated, as in a merger or acquisition. If a plan's reserves are not adjusted each year for inflation, enrollment, plan design and differences in annual claim-lag (payment timing) factors, the plan could be underfunded and/or under-reserved.

The due diligence should include reviewing annual reserve-setting calculations and factors. Stop-loss problems can occur when large claims have been authorized and approved as part of a case-management or pre-certification process but have not yet been submitted for payment. Such claims could later be rejected, subject to coordination of benefits, subrogation or retrospective audit. Claims also may be awaiting reimbursement from the stop-loss carrier. Your benefits adviser should review a listing of all open authorized and reinsurance claims. Pharmacy rebates, performance-guarantee payments and other fees should also be reviewed for self-insured plans.

Continuing COBRA Coverage

For any business reorganization—whether a stock or asset sale—if the seller maintains health insurance coverage after the sale, it also must continue COBRA coverage to affected employees under the federal law that requires employers to extend coverage to former employees up to 36 months. The parties involved in such a transaction can assign responsibility for providing this coverage in a purchase agreement. However, if that party fails to meet its obligations under the contract terms, responsibility and liability revert to the party with the obligation under IRS regulations—which might be your organization.

In a stock sale, if the seller stops providing health benefits to employees connected with the sale, the buyer must continue COBRA coverage to M&A-qualified beneficiaries. Similarly, in an asset sale, if the seller cancels health coverage to employees and the buyer continues business operations without interruption or substantial change, the buyer is considered a successor employer and therefore must continue COBRA coverage for qualified beneficiaries.

In any type of merger or acquisition, employers should create contract provisions for all parties to access each other's COBRA-eligible plan documents and records—including notifications, eligibility, elections, waivers and payments—for at least 36 months after the sale date.

In states like Massachusetts and California that have different or supplemental COBRA-continuation regulations, organizations must address state responsibilities, too.

Unique Hospital Opportunities

Hospitals and health care systems are unique when it comes to benefits evaluations in mergers and acquisitions. Their dual roles as employer and provider of health care services for employees make for an interesting and challenging analysis.

Health care workers traditionally have higher utilization rates of health care services. The reasons most often cited for this include:

- greater knowledge of available technology;
- better education about courses of treatment;
- familiarity with insurance company billing procedures;
- higher rates of illness from attending to sick patients;
- access to care;
- confidence with certain providers; and
- age and demographics.

Additionally, health care employers tend to have more generous benefit plans—both in terms of lower employee cost and higher level of benefits—even without a union presence.

Some health care organizations have taken advantage of their dual role. In a merger, these advantages can be magnified or modified to achieve the goals of both human resource

departments and the CFO. Examples of unique benefit designs include:

- lower office visit co-payments with affiliated physicians;
- waived or lower deductibles with system facilities;
- waived or lower co-payments at an on-site pharmacy;
- higher visit limits or maximums on services;
- lower employee contributions for the plan that includes these design elements; and
- tiering of co-payments and deductibles based on providers selected.

The design elements can be enhanced in a merger or acquisition as the potential network of providers expands and the volume of patient services increases. All these types of plans must include nonsystem providers for services in which confidentiality is a greater issue for employees (for instance, mental health and substance abuse). Self-insured health insurance plans can also benefit from the increased volume of claims staying within the system.

The savings and benefits associated with such arrangements also can be accomplished without a merger or acquisition by using agreements with affiliated local providers. The employees of the affiliated providers would also be able to benefit from these arrangements.

Health care executives uniquely understand increases in technology, labor and fixed costs that contribute to more costly health insurance for employers. In their dual role, they are well positioned to provide solutions to this ongoing problem.

The Benefits of Evaluating Benefits

If M&A due diligence regarding the employee benefit programs is thorough and considers all of the post-combination effects on all stakeholders, the transaction should close and appear seamless. Leaders may even get a pleasant surprise. The resulting employee program may produce economies and advantages that weren't anticipated. Your strategy and actions will determine whether you get an unexpected bonus or a rude shock.

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