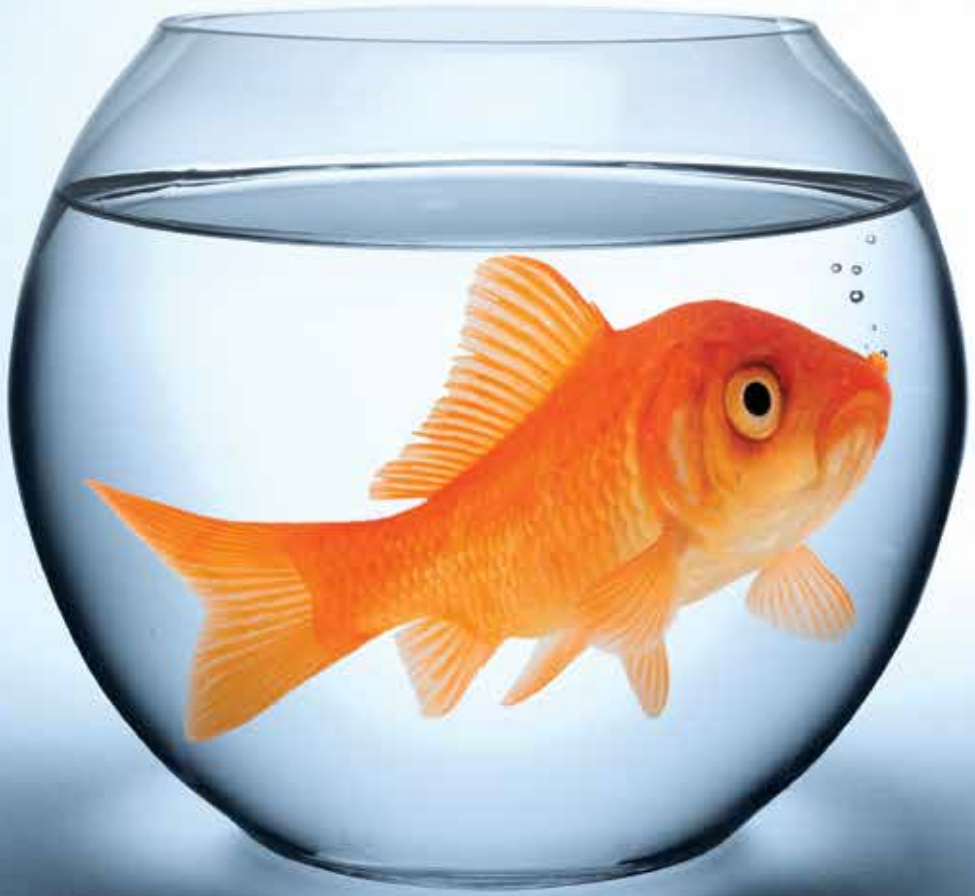
Multiemployer Health

Assessing When Bigger May Be Better

by | **Megan Kelly**



Plan Mergers:

benefits
MAGAZINE

A plan merger may help multiemployer health plans maintain financial sustainability, but drawbacks can include loss of autonomy and changes in benefits for plan participants. Trustees must focus on their fiduciary responsibilities and regulatory compliance.

Medical trend drivers, such as price inflation and increases in the cost of specialty drugs, have resulted in higher medical costs which, in turn, makes health plans both more important as well as more expensive to maintain.[1] And recently, the economic downturn as a result of the COVID-19 pandemic has put a strain on workhours in some industries, resulting in fewer dollars to pay for those increasing costs. Seeking strength in raw numbers, multiemployer plan trustees might consider a health plan merger with a counterpart as a way to leverage economies of scale and perhaps secure better prices for plan participants. However, when considering a merger, trustees that neglect the nuances and details of how these plans should come together will face considerable complications.

Why Merge Health Plans?

When it comes to maintaining the financial sustainability of health plans, bigger can often be better. Trustees may take comfort at the prospect of having a larger, more geographically diverse pool of participants to support a health plan. A merger allows trustees to instantly increase the number of people in the plan, which improves administrative efficiency and risk management.

For example, suppose the trustees of a plan in the Midwest face a challenge with their health plan's solvency. The local economy is struggling and, due to reduced workhours, the plan's participants decide to pay some long-overdue visits to their health care professionals. The increased use of the health benefits—combined with the reduced fund income from low workhours—places significant stress on the fund. As a result, trustees begin to contemplate decreasing health benefits or raising the standards for plan eligibility.

takeaways

- Health plans can merge for a variety of reasons, but most of them revolve around remaining financially solvent for participants.
- Mergers can result in the loss of autonomy for some plans, depending on the structure of the merger.
- Plans can agree to a partial merger, but this can lead to a contentious atmosphere among trustees if they don't establish trust and clear lines of communication.
- Trustees thinking about a merger need to check with their attorney to review the compliance implications and make sure they are fulfilling their fiduciary duty to their participants.

However, the trustees see potential salvation in the form of an opportunity to merge their health plan with a plan in a neighboring city. The health plans offer similar benefits to their participants, but the financial health of the neighboring plan is much stronger because of that area's booming economy.

By fully merging the two health plans, the trustees may reduce many administrative expenses. The larger and more geographically diverse pool of participants also helps protect the new fund's assets from swings in a local economy (or catastrophic high-cost claim events) and results in financials that are more predictable.

What Are the Overlooked Drawbacks to Merging Health Plans?

The example above, in which two health plans merge to the benefit of participants in both, represents the best-case scenario. But, as some trustees discover when attempting a merger, such a major structural change presents difficult challenges for both participants and trustees. Overcoming them requires skillful planning and execution.

Trustees must act consistently with their fiduciary duties to plan participants when deciding whether to merge and when implementing a merger. They should make sure that their professional staff and legal counsel are involved. Consequently, all mergers start with a due diligence review and eventually proceed to a merger agreement that addresses the terms and conditions of the merger. However, sometimes the hardest challenges go beyond the words on the pages. These include loss of autonomy, underestimating financial challenges and finding hidden liabilities.

Some trustees on health plans may lose autonomy and control of how a fund is managed after a merger. This could occur either when two health plans merge or when multiple smaller plans decide to combine. Trustees may see new voting blocks or factions, or trustees from a small plan could be outvoted on contentious issues. Planning for new roles can help avoid difficult dynamics after the merger. One action a fund can take to promote harmony is adding new trustees to the board by changing the trust agreement. Alternatively, former trustees could be enlisted to serve as liaisons between the members they used to represent and the new health fund.

Mergers may solve some financial challenges, but others may arise. Trustees may look to the combined plan's negotiating power to help decrease medical spending and ob-

tain better contracts with insurers and third-party administrators. However, the expected cost decrease might not actually materialize. Trustees should ask their professional advisors up-front what fund expenses will vary based on volume and determine whether having more participants will actually result in significantly lower administration expenses. Counting on cheaper rates to make the math of the merger work without planning will likely mean disappointing results.

Finally, the possibility exists that one party may have hidden liabilities that come to light only after the parties have committed substantial resources to the merger process. Learning that a potential merger partner has debt—perhaps from physical plan expenses or a poor settlement with a carrier—can lead to disappointment and an ultimately unsuccessful merger. A due diligence investigation is critical to understanding the financial situation of the parties. But even if these concerns arise, understanding them in advance of when the merger agreement is signed can allow the parties to work through the issues and determine whether the merger can be accomplished with the right conditions.

Trustees Don't Always Have to Go All In

Mergers between health plan funds with huge wealth discrepancies usually cause too many complications to make the combination financially worthwhile. But when the decision has been made to merge despite the difference in wealth, trustees may want to consider a partial merger. This allows the funds to pool their assets together while still retaining plans with separate benefits and accounting for each plan's participants. The table shows the differences between full and partial mergers.

TABLE

Comparing Full and Partial Health Plan Mergers

Full Merger	Partial Merger
Trust assets for both plans merged	Trust assets merged but financials tracked separately
Benefits, eligibility rules modified for all participants	Benefits, eligibility rules determined separately
Uniform contribution rates	Contribution rates may vary depending on plan unit.
Administration under one fund	Administration under one fund

A partial merger may grant some of the advantages of a full merger while mitigating drawbacks, but it also comes with its own issues. Specifically, these partially merged health plans can devolve into finger-pointing between the trustees of the different funds should the overall finances suffer. Given that benefits, contribution rates and more remain separate, it's easy for these mergers to fail as trustees divide into factions. It's for this reason that it may be a good idea to merge financial expertise and refrain from tracking financial information that's organized by the former funds making up the new, partially merged fund. Maintaining trust and open communication among all trustees is paramount to the success of a partial merger.

Another alternative to a full or partial merger is a "buy-in" merger. This typically works when one fund is larger than its partner in the merger, with the smaller fund moving all (or the majority) of its contributions to the larger fund. Participants in the previous plans gain eligibility into this new plan based on contributions on their behalf. After a year, any assets from the previous plans that haven't been reconciled—such as health reimbursement arrangement (HRA) and health savings account (HSA) funds, for example—should be addressed.

Important Compliance Considerations When Merging Plans

Trustees and their professional advisors must address compliance considerations at the beginning of the merger process in order to assure that fiduciary obligations are met and applicable legal and regulatory guidance is considered. Three important elements of the merger process where compliance comes into play include (1) who makes the decision to merge and how it is paid for, (2) whether the merger study takes all issues into consideration and (3) whether the merger has been implemented appropriately.

The decision to merge and whether the merger work is paid for through fund assets is a process that should be discussed among trustees and the fund professionals. Counsel should review trust documents to determine how the

merger decision is made and whether there are special requirements in either the trust agreements or collective bargaining agreements. Trustees will want to be cognizant of the fee to perform this work and who will pay for it: either the fund requesting the merge, the fund being solicited to merge or an equal split between the two. They should carefully review whether there are any plan withdrawal penalties should a fund want to exit the merger in the future. At all times, trustees must act solely in the interests of the participants and beneficiaries of the plan.

The merger study needs to consider a wide range of financial and legal issues but also administrative compatibility and technology. It also needs to look at previous mergers, whether a plan has grandfathered status under the Affordable Care Act and whether there are any restrictions on changing benefits or eligibility.

Finally, the merger agreement needs to be carefully drafted to address procedural requirements (such as administration of employer contribution remittance and how long it will take to process eligibility) for the new trust, how service providers will be addressed and the impact on insurance arrangements. Examples of these arrangements include whether any insurance carriers will be terminated due to the merger and whether those carriers have early termination penalties. Covered individuals such as beneficiaries qualified for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and retirees will need to be addressed. If an HRA is in place, the agreement will have to address use of those funds. Any applicable tax filings should also be considered.

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John C. Garner, CEBS. 2015. International Foundation.

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The Questions Trustees Should Ask Before Merging

Merging health plans will always come with some risk, but a successful merger can ensure the security of participants' health coverage for decades. With so much at stake, it's tempting for trustees to find themselves looking at a deal through rose-tinted glasses, but trustees owe it to themselves and their participants to consider the following:

- Will eligibility requirements for participants change after the merger? How will trustees deal with members who suddenly find themselves ineligible for health care?
- Will benefits in the new plan change from the previous plans? Do the trustees have the authority to make those benefits changes?
- Are there special voting requirements in either of the merging plans? For example, sometimes each trustee counts as an individual vote, and other times labor and management vote in blocks. Are there any other unusual policies that trustees should examine?
- Have trustees examined the other health plan's financials thoroughly? Did the professionals who reviewed the financials possess relevant experience in this sort of work, or could they have overlooked liabilities that will be discovered later after the merger?
- Will the combination of fund administrative staff result in some jobs being eliminated or reassigned?
- Have trustees reviewed projections for the health of the combined fund?

These questions are just the tip of the iceberg when it comes to what trustees need to cover before moving ahead with a health plan merger. It can seem like a daunting amount of work, but it is less painful than realizing after a merger that it was a bad decision for plan participants.

Breaking the News to Participants

Trustees should keep plan participants informed about why a merger is in their best interests. A merger may look great on paper, but if participants fail to buy into the reasoning behind it, it will likely end in failure. Trustees should keep these five key points in mind to craft a communications strategy that will leave participants educated and excited about the new merged plan.

1. Begin the communications process as soon as possible—especially before the rumor mill takes over. Dis-

close what can be disclosed, explain what cannot be disclosed and provide a road map for ongoing communications.

2. Give participants the whole picture, including an explanation of the factors that have an impact on the plan's situation. People are more likely to accept the outcome if they understand the context that produced it.
3. Honesty is the best policy. Avoid making the picture rosier than it is. Communicating gives plan sponsors an opportunity to remind participants what the plan has accomplished in the past and assure them that the trustees are working hard on their behalf to ensure a sound future.
4. Help participants understand the dollars-and-cents implications of cost-related decisions. Make numbers personal by putting them into terms participants can understand, using graphics wherever possible.
5. A variety of constituencies—participants, spouses, fund office staff, trustees, business agents—may need to get different, yet consistent, messages. Media such as newsletters, email, etc. should be targeted to ensure that each audience gets the message they need when they need it and in the most appropriate way.

bio

Megan Kelly is senior vice president and national multiemployer health practice leader at Segal, where she leads strategic planning initiatives for multiemployer services and product development. She has more than 20 years of experience consulting to numerous multiemployer health and pension clients on a wide variety of benefits issues.

Merging health plans won't be easy—But armed with the right information and expertise, trustees have a greater chance of emerging from the merger with a stronger plan than ever.

Endnotes

1. *2020 Segal Health Plan Cost Trend Survey,* Segal, accessed February 27, 2020. Available at www.segalco.com/consulting-insights/2020-segal-health-plan-cost-trend-survey.