MERGERS & ACQUISITIONS:
DEALING WITH KEY RISKS
DECEMBER 4, 2013
Presenters

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  – Managing Director, Central Zone Healthcare Practice – Marsh Chicago

• Jeremy Brigham, FCAS, MAAA
  – Towers Watson
Agenda

- Identification of Deal Risks
- Deal Process and Due Diligence
- Legal / Regulatory Risks
- Insurance / Quality of Earnings Risks
- Q&A
The Risks that Can Impact the M&A Transaction

- Letters of Credit / Collateral
- Open Litigation
- Insolvent Insurers
- Fraudulent Conveyance
- Reputation Risk
- Corporate Governance
- Compliance
- Environmental
- Key Employee Retention
- Long- and Short-term Incentive Comp.
- Regulatory Approvals
- Organizational Change
- Reimbursement
- Impaired Credit
- Captive Insurance Programs
- Tax Issues
- International Transactions
- Successor Liabilities
- Purchasing of High Yield Debt
- Under Insured Risk
- IBNR Claims
- Materiality
- Workforce Strategies
- Under Funded Liabilities
- Political Risk
- FIN 47
- Economic Risk
- Sources of Capital
- Organization Culture
- Coverage Gaps
- Prior Indemnity Agreements
- Exit Strategy
Deal Process

SELLER’S DUE DILIGENCE

BUYER’S DUE DILIGENCE

Planning / Strategy
Confidentiality / Nondisclosure Agreement
Assemble Advisory Team
Term Sheet / Letter of Intent
Transaction Documents
Satisfaction of Closing Conditions
Closing
Post-Closing Obligations

Financial / Accounting
HR / Benefits
Insurance
Legal
Deal Process
Due Diligence

• Why Due Diligence?
  – Know your company/the target
  – Evaluate investment/disposition decision
  – Establish/support value
  – Determine appropriate deal structure
  – Negotiate purchased and excluded assets; purchased and excluded liabilities; representations and warranties; conditions to closing; pre-closing and post-closing covenants
  – identify issues / assessing risk
    - financial
    - business
    - strategic
    - legal / regulatory
    - Insurance / risk management
### Why Insurance Due Diligence is Relevant

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<th>Typical Issues</th>
<th>Solutions</th>
<th>Benefits / Value</th>
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<td>Increase in post completion insurance costs</td>
<td>Develop pro-forma insurance costs projections to ensure risk management budget is not under-estimated.</td>
<td>Lowers the level of uncertainty and reduces the risk of “surprises” after the deal closes.</td>
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<td>Inadequate or no provisions for self-funded losses in the opening balance sheet.</td>
<td>Identify any insurance related one-off costs</td>
<td>Assists clients to obtain a truer picture of the value of liabilities and assets to be acquired and can result in:</td>
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<td>Uninsured or underinsured legacy exposures.</td>
<td>Evaluate seller’s pre-transaction insurance policies to determine if they will protect the buyer against post-transaction liabilities.</td>
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<td>Uninsured liabilities assumed in prior acquisitions.</td>
<td>Determine whether finite policy limits have been impaired by other claims.</td>
<td>– Smoother, faster integration</td>
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<td>Incompatible risk profile.</td>
<td>Assess current and historic liability exposures and claims experience.</td>
<td>– Operational cost/synergies</td>
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<td>Not achieving the expected synergy savings.</td>
<td>Review sale and purchase agreement</td>
<td>– Improved Corporate Governance</td>
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<td>Provision for access to historic coverage addressed in the Purchase Agreement (SPA).</td>
<td>Tailor made solutions that address specific transactional related issues</td>
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<td>Known tax litigation or environmental issues</td>
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Regulatory Risks

- Governmental Approvals
- Reimbursement
- Compliance
Regulatory Risks
Government Approvals

- Does company have requisite licenses and approvals?
- Any corporate practice issues?
- Does deal structure minimize exposure to regulatory and financial liability?
- Does deal structure require regulatory approvals or trigger change of control provisions in contracts?
Regulatory Risks
Reimbursement

• Reimbursement changes on horizon?
• Reimbursement implications of transaction?
• Successor liability for assumed provider agreements and payor contracts?
Regulatory Risks
Compliance

• Anti-kickback, Stark, False Claims, HIPAA exposure

• Government investigations and inquiries

• Financial arrangements with physicians, vendors, referral sources
  – management services agreements
  – consulting and royalty arrangements
  – joint ventures
  – medical director and physician agreements

• Compliance plan and program
Insured and Self-Funded Liabilities Risks

- Quality of earnings
  - Treatment of retained loss costs on financial statements
- Captive arrangements
- Successor liabilities for prior M&A transactions
- Collateral requirements
- Uninsured liabilities
Treatment of Insurance and Loss Costs on P&L and Balance Sheet

• How are insurance and retained losses expensed on P&L?
• What is the company accruing for historical liabilities on balance sheet?
• How is the company accounting for Claims Made insurance coverages?
Captive Risk

- Captive Review – if captive is part of acquisition
  - Compliance with regulations in country/state of domicile
  - Does captive satisfy “insurance requirement” in contracts
  - Adequacy of reserves / quality of seller’s actuarial reports
  - “Confidence Level” used for funding
  - Tax treatment of premiums
  - Captive may not fit buyer’s strategic approach to risk (exit issues)
Collateral

• Impact of transaction on collateral obligation

• Collateral requirement under deductible programs may increase
  – “Ramp up” as claims develop
  – Insurer requirement for increased collateral due to debt structure

• Post-closing interventions to reduce collateral obligations
Addressing Deal Risks

• Assess Scope and Severity of Risks

• Develop Strategies
  – Terminate negotiations / agreement
  – Negotiate purchase price adjustments
  – Address through Purchase and Sale Agreement
    - assumed and excluded liabilities
    - representations and warranties
    - post-closing covenants
    - indemnity
    - indemnity escrow
  – Transaction risk solutions / insurance to resolve deal obstacles
THANK YOU!
APPENDIX
Some Quick Definitions

• Total Cost of Risk (“TCOR”): The estimated “all in” annual cost for insurance, including
  – Insurance premiums or “fixed costs”
  – Self-funded losses or “variable costs” (under loss sensitive programs involving large deductibles/retentions)
  – Miscellaneous costs (claims handling & brokerage fees, taxes & surcharges, etc.)

• Variable costs are frequently significantly more than fixed costs for HC organizations. Therefore, insurance premiums are only the “tip of the iceberg”

• Buyer and Seller often have widely divergent assessment of ultimate cost of self-funded losses
  – Independent actuarial review is strongly recommend
Definitions

• “Claims Made” v. “Occurrence” (Coverage Triggers): ascertaining whether coverage is claims made or occurrence determines what policy covers a claim and when the claim must be reported

• Occurrence Coverage: policy that responds to a claim is the policy in effect at time of underlying injury, regardless of when claim is ultimately asserted in the future
Definitions

- Claims made coverage: policy that responds to a claim is the policy in effect when claim is “asserted,” so long as underlying injury took place after retroactive date on the policy and circumstances were unknown as of the time of policy inception
  - Insured generally has to purchase tail insurance if business is sold, physicians retire, etc. to claims asserted after policy term
  - Insured must expense cost of tail each year because there is no certainty that insurance will be purchased in future
  - Premiums “step up” for 3-5 years after policy inception, as policy matures and losses develop
  - The existence of an insurance policy is no assurance that the risk of financial loss has been transferred
  - Under a claims made policy there is no transfer of risk for claims that have not been reported to the insurer during the policy period
FASB Audit and Accounting Guide for Health Care Organizations

• Accounting for claims made insurance
  – HC organization must recognize the estimated cost of losses under policy retentions related to claims that occur and are reported to the insurer during the policy period as an expense on its Income Statement
  – Organization must also recognize the estimated costs of unasserted/unknown (Incurred but not reported/"IBNR") claims that have occurred during the policy period, regardless of when these claims may be made and reported in the future
  – The estimation of IBNR claims must be made unless the organization has bought Tail insurance and included the cost of the premium as expense on the financial statements for that period
  – Organization must post reserve on its Balance Sheet for outstanding historical unpaid liabilities (both known and IBNR) within its SIR
Overview of Collateral

• Why is collateral required?
  – Under a deductible program, an insurer pays all claims “on behalf” of the insured; then seeks reimbursement from the insured.
  – The insurer is legally responsible for these payments, even if the insured cannot or will not reimburse the insurer.

• A collateral position is built over the course of several policy periods until the amount of historic liabilities being completely paid and closed is approximately equivalent to the amount of new liabilities that will be incurred in conjunction with the next policy period. This process can be lengthened by a number of factors, including:
  – Deteriorating loss experience
  – Deteriorating financial performance
  – Growth in exposures
  – A change in insurers

• A self insured retention (“SIR”) does not have the same legal implications (since it does not have “pay on behalf language”), therefore there is no corresponding securitization risk to the insurer and no need for collateral.

• Most common form of collateral = letter of credit
ASCENSION CASE STUDY FOR CAYMAN CAPTIVE FORUM

Sandy Boillot
Vice President, Risk Management
Case Study Discussion Outline

• Ascension Overview

• Ascension M&A Activity
  – 2012 Activity
  – 2013 Activity – Integration of Marian Health System

• Ascension Insurance Organizational Structure

• Captive Consolidation Considerations

• Captive M&A Activity

• Captive Consolidation Lessons Learned

• Future Plans
Our Vision Calls Us to Strengthen the Catholic Health Ministry

**OUR MISSION**
Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.

**OUR VISION**
We envision a strong, vibrant Catholic health ministry in the United States which will lead to the transformation of healthcare. We will ensure service that is committed to health and well-being for our communities and that responds to the needs of individuals throughout the life cycle. We will expand the role of the laity, in both leadership and sponsorship, to ensure a Catholic health ministry of the future.

**OUR VALUES**

**Service of the Poor**
Generosity of spirit, especially for persons most in need

**Reverence**
Respect and compassion for the dignity of diversity of life

**Integrity**
Inspiring trust through personal leadership

**Wisdom**
Integrating excellence and stewardship

**Creativity**
Courageous innovation

**Dedication**
Affirming the hope and joy of our ministry
About Ascension

- Largest Catholic health system
- Largest private nonprofit system
- Third largest system (based on revenue)
- Currently operate in 23 states and the District of Columbia

FACILITIES AND STAFF
- Locations: 1,500
- Acute Care Hospitals: 103
- Long-term Acute Care Hospitals: 3
- Rehabilitation Hospitals: 3
- Psychiatric Hospitals: 4
- Available Beds: 23,569
- Associates: 150,000

FINANCIAL INFORMATION (FY 13) (in millions)
- Total Assets: $30,047
- Operating Revenue: $17,097
- Operating Income: $397
- Excess of revenue and gains over expenses and losses, controlling interest: $3,013

Care of Persons Living in Poverty and Community Benefit Programs: $1.3 Billion
Daughters of Charity Health System is an affiliate of Ascension Health
2012 Merger Activity

Merger Completed January 1, 2012

Alexian Brothers Health System

- 4 Hospitals including 2 acute care, a behavioral health and a rehabilitation (Illinois)
- 13 Senior Service facilities in Missouri, Tennessee, & Wisconsin {including 2 Continuing Care Retirement Communities (CCRC)}
- 14 Primary Care locations
- 7 Occupational Health locations
- 7 Immediate Care Facilities
- $990M Total Revenues
2013 Activity: Marian Health System

**Ministry Health Care**

**Milwaukee**
Central, northern and northeastern of Wisconsin and eastern Minnesota; complete continuum of care

**St. John Health System**

**Tulsa, Okla.**
Nine hospitals in northeastern Oklahoma and southern Kansas; includes primary care and multi-specialty physician group practices

**Via Christi Health**

**Wichita, Kan.**
Largest provider of healthcare services in Kansas, also serving northeastern Oklahoma; includes physicians, hospitals, senior villages and other health services

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<td>• $271 million</td>
<td>Charity Care</td>
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<tr>
<td>• $3.1 billion</td>
<td>Total Revenue</td>
</tr>
<tr>
<td>• $4.5 billion</td>
<td>Total Assets</td>
</tr>
<tr>
<td>• 3.9%</td>
<td>Operating Margin</td>
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<tr>
<td>• 30 hospitals</td>
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Ascension Insurance Organizational Structure

- Ascension
- Ascension Risk Insurance Services
  - 1st Party Captive (AHIL)
  - HPL/GL Trust
  - WC Trust
  - 3rd Party Captive (Sunflower)
Captive Consolidation Considerations

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<tr>
<th>Considerations</th>
<th>Specific Issues</th>
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| Legal/State Insurance Regulations | • Domicile regulatory concerns  
                          • Healthcare legal concerns, i.e., Stark violations  
                          • State insurance regulations – particularly where Patient Compensation Funds exist  
                          • Risk Purchasing Group structure of independent physician program requires state-by-state filings |
| Tax Position            | • Captives generally not considered insurance companies for tax position due to non-profit ownership  
                          • Extent of third-party premiums is a consideration                                                                                                                                                   |
| Financial               | • Potential for significant savings  
                          • Capitalization and funding philosophy of owners  
                          • Investment strategy/restrictions  
                          • Commitments regarding tracking of surplus/deficit from prior programs                                                                                                                                  |
## Captive Consolidation Considerations

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| **Domicile Choice**       | • Relationships with regulators  
                            • Domicile regulatory environment  
                            • Geographic proximity  
                            • Captive service providers |
| **Insurance Program**     | • First Party vs. Third Party risks  
                            • Risk appetite/retentions  
                            • Supporting risk management functions – loss prevention and claims |
| **Governance**            | • Board membership – internal management vs. outside  
                            • Participation of service providers  
                            • Frequency of meetings |
| **Management Reactions**  | • Control/ownership  
                            • Resistance to change |
Historical Captive M&A Activity

1986
- DCNHS merged with another Catholic health system and became Ascension Health (AH).
- AH became shareholder of a Barbados captive.

2000
- Additional Catholic health system and its Cayman Islands captive joined AH.

1999

2001
- Barbados captive transferred by way of continuation to Cayman Islands.

2002
- All three captives were merged by statutory amalgamation under Cayman law.

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012
- AHA holding company formed; became shareholder of AHIL.
- Co-sponsorship of additional health system resulted in AHA’s ownership of a Bermuda based captive.

- Bermuda captive was also merged into AHIL.

- DCHS Insurance, Ltd. (later AHIL) captive formed in Cayman Islands by Daughters of Charity National Health System (DCNHS).
2013 Captive M&A Activity

- Marian Health System entities join Ascension
- Via Christi owned Cayman Captive with USVI Branch
- St. John owned Hawaii RRG

- CIMA approval to change shareholder, board members, and captive manager for Sunflower

- Novation of prior Sunflower 1st party risk to AHIL
- Novation of prior Hawaii based RRG (PMI RRG) to AHIL

- Closure of PMI RRG

- Captive Board approves captive consolidation plans
Ascension Insurance Organizational Structure

- **Ascension**
- **Ascension Risk Insurance Services**
  - **1st Party Captive (AHIL)**
    - Umbrella/Excess PGL
    - Buffer layer excess
    - Reinsurance of fronted liability in PCF states
    - Employer Stop Loss
  - **HPL/GL Trust**
  - **WC Trust**
  - **3rd Party Captive (Sunflower)**
    - Primary coverage for Affiliates (< 50%)
    - Reinsurance of independent physician program
    - Tail and prior acts coverage
    - Reinsurance of benefits
    - Managed Care/ACO coverage
    - Provider Stop Loss
    - Governmental/Regulatory
Captive Consolidation Lessons Learned

• Start early – don’t underestimate the length of time involved, particularly if multiple domiciles involved
• Stay focused on the strategic purpose for consolidation of captives and the desired impact on the organization’s insurance program
• Communicate openly with regulators, business partners, service providers and reinsurers
• Build strong partnerships with trusted advisors and carriers
Future Plans

• Consolidation will continue within healthcare

• There are significant opportunities for cost savings through integration of risk and insurance programs

• Captive(s) will be instrumental in Ascension achieving its Mission, Vision and Values as well as Strategic Direction
  – We are positioned to handle new and different risks as healthcare moves outside of acute care setting
Questions?

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In response to health care reform, hospital executives increasingly cited physician-hospital integration through physician employment as key to preparing for expected Medicare payment reforms, including bundled payments, accountable care organizations (ACOs) and penalties for preventable hospital readmissions.

- Physician employment typically is one of many strategies to gain market share by increasing admissions, diagnostic testing and outpatient services
- Increase negotiating leverage with insurance plans

Some relevant statistics:
- A 2012 study by the American Medical Association found that 29% of physicians worked in practices that were either directly or partly owned by a hospital
- A survey of physicians conducted by Jackson Healthcare found the percentage of hospital-employed physicians increased from 20% in 2012 to 26% in 2013
- The number of physicians employed by hospitals grew by 32 percent from 2000-2012 according to a 2012 study by the American Hospital Association
Trends in Physician Employment

• What types of acquisitions we see:
  – Solo physicians or small group practices aimed at ensuring availability of coverage in certain areas or building out capabilities
  – Large single or multi-specialty practices aimed at cornering significant market share in a particular service offering (cardiology, orthopedic, radiology) or building out the referral networks (primary care)

• For the most part the really large (150+) physicians groups are remaining independent but partnering with health systems in ways that they haven’t in the past
  – Outpatient joint ventures
  – Insurance contracting
  – Credentialing
Role of Risk Management in the Acquisition

• Facilitating vs. due diligence
  – If risk management’s role is exclusively due diligence then they are often not getting involved until the 11th hour

• If you can become more active in facilitating it will put you in a better position on the due diligence
  – Perception of solution vs. road block

• Role of risk management in evaluating physician risk is an area we see opportunity for continued improvement
  – What is the issue that physician insurer CEO’s are worried about at this moment?
  – Who will be filling their shoes?
  – What often times is the factor gets physician insurers in financial trouble?
  – Who is more sophisticated in their underwriting practices – physician insurer or a health care system?
Facilitating the Acquisition
Dealing with Tail Exposures

• Across the country claims made coverage is most prevalent
  – Leaves physician with a tail exposure that is uninsured

• Physician insurers price tail coverage punitively
  – Adverse selection – physician needs tail because they are being non-renewed for poor claims experience
  – No competitive pressure – physician is leaving so why try?

• Using your captive to cover the tail can save you 20-40% off the commercial premiums
  – 20% on the front end/20% on the back end

• Some keys to success:
  – Know your docs and underwrite
  – Report, report, report to incumbent carrier

• We have seen increased activity from non-traditional markets looking to write this business
  – Confirmation that it can be done at a lower cost and profitably
Facilitating Deals/Relationships

- Traditional uses of captive are still relevant
- Captives and provide coverage for joint venture relationships
  - Cost
  - Control
  - Consistency
- Captives can provide coverage for physicians before they become employed
  - Another tool to tie the physician to the hospital
  - Soft vs. hard market
Due Diligence on Physician Acquisitions

• If you feel risk management issues are not a priority you are not alone

• Unlike hospital acquisitions it is rare to have a physician group that is retaining material risk
  – You will not be inheriting existing claims liabilities other than perhaps the tail exposure

• If you do acquire a physician group that is retaining material risk (usually only large groups) it is prudent to be cautious
  – Physician groups don’t tend to fund/reserve their programs as conservatively as hospitals; they also tend to have sophisticated/confusing reinsurance programs

• Does the acquisition include physicians with elevated risk levels that ultimately will undermine their value to the system?
  – Past: focus on revenue
  – Future: focus on revenue/quality
Identifying Physicians With Elevated Risk Levels

• Qualitative vs. quantitative

• Qualitative needs input from local hospital staff

• Quantitative focuses on the physician’s claims history
  – When you look at physician loss histories there is a lot grey
  – But we are focused on identifying the flashing red not the grey

• For a typical hospital attending staff (employed and non-employed) here’s what we find:
  – 5% of physicians account for 55% of the claim dollars
  – 10% of physicians account for 80% of the claim dollars

• The top 5-10% are dominated by OBGyn’s, general surgeons, etc. which we know are high risk/high cost specialties
  – Should we reject all OBGyn acquisitions and support all allergist acquisitions?
Identifying Physicians With Elevated Risk Levels (cont’d)

• To determine if a physician presents an elevated risk level you need to compare them to their peers (specialty) and consider their length of practice

• With this approach for a typical hospital attending staff here’s what we find:
  – 5% of physicians account for 40% of the claim dollars
  – 10% of physicians account for 62% of the claim dollars

• This approach is still powerful in identifying cost outliers but allows you to be more even-handed in evaluating a wide variety of specialties
Summary Observations on Physician Acquisitions

• Overall the trend towards more employed physicians is not a bad thing for your malpractice program
  – While your costs will increase $1 + 1 \neq 2$; opportunity for cost savings
  – Preliminary indications from our Towers Watson study indicates health systems with a greater mix of employed physicians tend to have better loss experience

• Important for risk management to have a role in identifying the 5-10% of physicians that we should be worried about

• Evaluating physician risk is not only an issue at the time of acquisition – it’s a risk we face every day

• The cost of physician risk is not limited to employed physicians – non-employed physicians have a clear impact on system malpractice costs

• Opportunity for improved performance if we can identify/remediate physicians with outlier results
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