
The Transfer of a Health Insurance/ Managed Care Business

John N. Gavin, George Goodman, and David B. Goroff

The owners of a health insurance/managed care business may want to sell that business for a variety of reasons. Health care provider systems may want to exit that business due to operating losses, difficulty in complying with regulations, the inherent conflict in operating that business as part of a provider system, or the desire to focus on being a health care provider. Health insurers/HMOs may want to sell all or a portion of their business due to operating losses, difficulty in servicing a particular market, or a desire to focus on other markets.

No matter what reason prompts a seller to undertake a sale, a sale of health insurance/managed care business can be a complicated transaction involving a multitude of issues. This article will focus first on the ways in which such a sale may be structured. The article will then discuss some transactional issues that may arise in the negotiations for the sale of a health insurance/managed care business. The article will then focus on some particular legal issues that arise in each sale—e.g., antitrust, HIPAA, regulatory approvals, and charitable issues. Finally, this article will provide an overview of tax structuring considerations. Key words: *merger, assumption reinsurance, migration, indemnity reinsurance, antitrust, HIPAA, DOI regulatory approvals, and charitable issues.*

Structural Issues

In any of these transactions, the parties need to determine what structure best achieves their business goals and meets legal requirements. Several different transaction structures are available to transfer health insurance/managed care businesses. They include:

- Merger;
- Purchase of stock;
- Assumption reinsurance/transfer of assets;
- Migration of business; and
- Indemnity reinsurance/administrative service agreements.

Each structure has advantages and disadvantages, and the following discussion will attempt to briefly discuss those. Like many issues that arise in business transactions, no one structure may be ideal for both the buyer and the seller, and so compromises may be necessary.

Merger

A merger transaction is one of the simpler types of structures that may be used. In this transaction, the target may merge into the acquirer (or vice versa). A possible alternative is to merge the target into a subsidiary of the acquirer (or vice versa) in a “triangular” merger.

A merger has substantial advantages because:

- One combined entity will be best able to consolidate operations and expenses;
- The consolidated entity will have a larger surplus;

John N. Gavin is a partner in the law firm of Foley & Lardner LLP, Chicago, IL.

George Goodman is Of Counsel to the law firm of Foley & Lardner LLP, Chicago, IL.

David B. Goroff is a partner in the law firm of Foley & Lardner LLP, Chicago, IL.

*J Health Care Finance 2007;34(2):10–37
© 2007 Aspen Publishers, Inc.*

- The transaction is relatively easy to execute;
- The transaction avoids the need for multiple third-party consents (but the target's contracts must still be examined to see if the proposed merger will violate broad anti-assignment or change of control provisions);
- It is specifically authorized by statute (in most states); and
- It allows an acquirer to acquire 100 percent of the target, even if some shareholders of target object to the transaction.

On the other hand, this approach has significant disadvantages because:

- It only works if all health insurance business (and only health insurance) is in the merging entity;
- All liabilities of the target continue and remain (which could include liabilities for such matters as malpractice liability, Medicare fraud and abuse, etc.). If the acquirer forms a subsidiary to enter into the transaction, the liabilities will continue in the subsidiary;
- Target's shareholder/member approval may also be required, for example:

There also exists a possible need to secure a shareholder vote of the acquirer's shareholders. The use of a merger subsidiary by the acquirer may avoid the need to secure any such vote

- The acquirer must administer all target's policies on an ongoing basis;
- If the target merges into the acquirer (or its subsidiary), the target will lose its separate identity/licenses. The acquirer

will then need to secure a certificate of authority/other approvals in the target's state(s) in order to do business there. In order to avoid this result, a subsidiary of the acquirer could merge into the target (with target's stock converted into stock owned by the acquirer.);

- Some third-party consents may be required (*e.g.*, if there exist change of control provisions or broad anti-assignment provisions in contracts); and
- There is the possible exercise of dissenters' rights by shareholders of the target.

Note that, in contracts involving a proposed merger between different types of entities (*e.g.*, stock and non-profit), the parties must review the applicable state statutes to determine whether such a merger is permitted and, if so, the actions necessary to effect such a merger. If any such merger is not permitted, the parties must consider other possible structures (discussed below).

Sale/Purchase of Stock

Another relatively straightforward transaction is a sale and purchase of the stock of the target company. In this transaction, the acquirer acquires the stock of the target (which is in the health insurance/managed care business). If the target is a mutual insurer or other form of non-stock company, the target will first have to convert to a stock company or transfer assets into a stock company.

Again, this approach has substantial advantages because:

- A stock sale may simplify the transaction, for example:

It may avoid the need for multiple consents from third parties (but again the target's contracts need to be reviewed to see if there are change of control provisions);

- The target retains its separate identity;
- The target maintains its licenses;
- The acquirer may not need to secure a separate certificate(s) of authority; and
- The liabilities of the target are held in an entity that is separate from the acquirer.

By the same token, this approach has significant disadvantages because:

- The transaction only works if all health insurance business (and only health insurance business) is in the entity whose stock is being acquired;
- The acquirer owns a company with all target's liabilities;
- The acquirer must administer the target's policies on an ongoing basis;
- The acquirer may not be able to acquire 100 percent of the stock of target, if some shareholders do not want to engage in the transaction;
- It may be necessary to obtain some consents, *e.g.*, due to change of control provisions;
- It may be necessary to review and comply with existing shareholder/voting trust agreements; and
- If a conversion of the target company is required, some difficulties may arise, for example:

Applicable statutes may not allow conversion or demutualization because:

- The conversion may require Department of Insurance (DOI) approval;

- A policyholder vote may be required for target's conversion;
- A conversion to a stock company may entitle policyholders or charitable interests to a distribution of cash/stock/other consideration; or
- The conversion process may be lengthy.

Assumption Reinsurance

In an assumption reinsurance transaction, (i) the target transfers subscriber contracts and other specified assets (*e.g.*, computer systems) to the acquirer, and (ii) the acquirer assumes the liabilities under these contracts (and other specified liabilities of the target). If the target is transferring liabilities that are incurred prior to the closing, the target must transfer to the acquirer assets approximating the amount of these liabilities. As part of the transaction, the acquirer will ordinarily pay the target a purchase price for the business transferred. The target will usually remain in existence.

The advantages of this approach are as follows:

- The acquirer may be able to leave behind unrelated business and/or specified assets and liabilities;
- The acquirer need not pay for surplus (which could be left behind);
- The transaction may be the only authorized mechanism;
- The parties may possibly avoid demutualization/conversion issues because:

- The transaction allows acquirer to pay the purchase price and leave target/regulators to determine disposition of funds; or

- The target’s status (*e.g.*, as a charity) does not apply to acquirer’s operations.

The disadvantages to this approach are as follows:

- There may be a possible requirement that individual or group policyholders consent to novation of their contracts because:
 - Some states will require that each policyholder consent to a transfer; and
 - Some court decisions hold that no novation occurs if no consent is obtained;
- It may be cumbersome to transfer other assets and liabilities because:
 - There may be a need for consent of holders of other types of contracts (*e.g.*, software licenses, leases);
 - It may be difficult to separate the business being sold from the business being retained by the target (*e.g.*, due to the shared space or systems or suppliers);
 - The transfer of some assets (*e.g.*, Medicare receivables) may be prohibited; and
 - Separate transfer documentation may be necessary for some specific assets—*e.g.*, real estate deeds, title to vehicles, and the license of intellectual property rights;
- The acquirer may not succeed in leaving liabilities with the target;
- The acquirer must administer target’s policies on an ongoing basis;
- The role may be unclear for continuing shell of the target. For example:

- What is the disposition of remaining assets?
- What is the future role of the target (*i.e.*, can the target compete with the acquirer)?

- There may be regulatory issues, such as:
 - Licenses are not transferable, as a general matter. The acquirer will need to secure license(s) in the target’s state(s) in order to do business there; and
 - The acquirer may need to effect other regulatory approvals/filings (*e.g.*, products and rates, agent appointments);
- A shareholder vote by the target’s shareholders may be required if “all or substantially all” of the assets are being sold;
- In some states, the target’s shareholders may have “dissenter’s” rights; and
- There may be a possible need to comply with “bulk sales” laws and asset transfer taxes.

Migration

One of the disadvantages to the previous approaches is that, once the acquirer acquires the subscriber contracts of the target, the acquirer is required by HIPAA (and possibly state law) to continue to renew the contracts unless it meets one of the HIPAA exceptions (*see* the HIPAA discussion beginning on page 27). As a result, an acquirer may be required to administer these contract forms for a substantial period of time—something the acquirer may not want to do, given the inefficiencies and cost of administering policy forms that its computer system is not set up for.

To avoid this situation, the parties may undertake a “migration” transaction. In this type of transaction, (i) the target cancels or does not renew its business; (ii) the policyholders are offered a new contract by the acquirer (on its policy forms) (without underwriting and generally at the same premium rates for a specified period); (iii) the policyholder must consent to the cancellation or non-renewal of the old contract and apply for the new contract; (iv) the acquirer pays the target an amount (typically predicated on the policyholders that migrate and stay with the acquirer for a specified period); and (v) the parties may agree whether other specified assets/liabilities are to be transferred to the acquirer.

This approach has some substantial advantages, as follows:

- The acquirer avoids the need to renew and administer the target’s contracts;
- The acquirer administers the business on its own systems;
- The acquirer may be able to leave behind specified assets and liabilities, including licenses;
- The acquirer need not pay for surplus (which could be left behind); and
- The parties may possibly avoid demutualization/conversion issues. For example:
 - The parties may possibly avoid charitable foundation issues; and
 - The transaction allows the acquirer to pay an amount and leave the target/regulators to determine the disposition of the funds.

This approach also has some significant disadvantages because:

- The acquirer needs consents/applications from policyholders to obtain the business;
- It is cumbersome to transfer assets and liabilities. For example:
 - The acquirer may need consents of holders of other types of contracts to be transferred;
- The acquirer may not succeed in leaving liabilities with the target.
- The role is unclear for continuing shell of the target. For example:
 - What is the disposition of the remaining assets?
 - What is the future role of the target (*i.e.*, can it compete with the acquirer)?
- There may be regulatory issues, such as:
 - The existing company will most likely require DOI approval of termination/nonrenewal/transfer;
 - Termination/nonrenewal must comply with the law;
 - The acquirer will need a license in the target state(s) in order to do business there; and
 - The acquirer will need to effect other regulatory approvals/filings (*e.g.*, products and rates, agent appointments.)

The requirement that each policyholder group consent to the termination of its existing contract, and apply for a new contract, may at first seem daunting. However, keep in mind that the policyholders may have good reason to leave their existing insurer; that insurer most likely has announced that it is exiting the market, and may be in financial difficulty. Further, the parties may be able

to arrange the paperwork to impose minimal burdens on the policyholder. And these policyholders may be offered an incentive (*e.g.*, a stronger insurer, premium guarantees for a specified period) to transfer their business to the acquirer. Even in these situations, the acquirer must launch an aggressive and comprehensive marketing effort to secure as many policyholder consents/applications as possible. If this is done, our experience is that the acquirer may be able to achieve a very high success rate (*e.g.*, over 90 percent) in migrating the business to the acquirer.

One issue which may arise in these transactions is whether the acquirer's new contracts are a close "match" to the contracts issued to the group by the target. In particular, the DOI, in reviewing the transaction, may inquire whether policyholders are losing a substantial amount of benefits in connection with the transaction. With this in mind, the acquirer may wish to compare its contracts with the target's contracts, and then offer to the policyholders the contract(s) that provide the closest "match" to their old contracts.

Indemnity Reinsurance/ Administrative Services

Finally, acquirers can use another form of transaction to "acquire" health insurance/managed care business. Acquirers could enter into an indemnity reinsurance agreement with the target, which reinsures 100 percent of the target's subject business. Frequently, in this type of transaction, the acquirer would also be granted the right to administer the business. Although the acquirer does not actually "acquire" the underlying business, it gets 100 percent of the profits (and losses) after taking into account commissions and other amounts payable to the target, and it

controls the administration of the business. Conceivably, this sort of transaction may precede another type of transaction which effects an actual acquisition.

Again, there are some advantages inherent in this approach, as follows:

- The transaction is less of an "acquisition;"
- The transaction leaves the target in place;
- The transfer of financial results of the target's operations through reinsurance:
 - Secure economic benefit without paying a substantial acquisition price; and
 - May mean being able to use future profits to fund subsequent acquisitions;
- The transaction allows for a more gradual integration of functions;
- The acquirer administers business and may therefore attain some degree of control over operations;
- The target remains in place, and so:
 - There are no transfers of assets or numerous third-party consents;
 - Existing licenses remain in place and in effect;
 - The acquirer may not need to secure a separate certificate of authority;
 - Subscriber agreements/provider agreements remain in place;
 - Management/employees/employee benefit structure may remain in place;
 - The transaction leaves liabilities in place;
 - Charitable conversion issues may be avoided. For example:

- It may be able to avoid or delay payment to a charitable foundation.

However, some significant disadvantages are incurred in this type of transaction. For instance:

- The transaction will be cumbersome in governance/management. For example:
 - The acquirer will likely not be able to achieve full control; and
 - The acquirer may not want to assume full risk without control.
- It may be difficult to integrate operations, and so the transaction may not achieve efficiency in operations;
- It is difficult for the acquirer to realize or retain long-term value. For example:
 - Arrangements are likely to have specified time limits (*e.g.*, five to ten years);
 - The arrangements may build up value and either (i) pay more later, or (ii) lose the plan to another bidder later;
- Once implemented, the transaction may be difficult to unwind;
- The transaction require negotiation of complex allocations;
- There may be regulatory issues, such as:
 - The ceding company will most likely require DOI approval of reinsurance and management agreements;
 - The acquirer may need a license in the target state (or may have to provide some security) in order to allow the target to take credit for the reinsurance on its financial statements; and
 - The acquirer may need a third-party administrator (TPA)/other licenses in the target state; and
- The continuing entity may have charitable obligations

Final Comments on Structure

Some final comments on structural issues may be useful.

Some transactions may use a combination of the foregoing approaches. For example:

- In some cases, the parties may agree to use assumption reinsurance for some subscriber contracts (*e.g.*, large governmental contracts), and use a migration approach for all other subscriber contracts; or
- The parties may agree initially to use an indemnity reinsurance/administrative service approach, and then decide to replace it with an assumption reinsurance or migration approach when regulatory approvals/policyholder consents are received.

Any decision on structure must take into account tax considerations (*see* “Tax Issues,” which begins on page 32) and possibly other issues (*e.g.*, regulatory approvals, charitable issues), which are also discussed below.

Again, any determination on structure must take into account a variety of factors—some of which may argue for different and competing structures. Indeed, the acquirer and the seller may have very different views on the best structure to facilitate the transaction and meet their respective objectives. In the end, the resulting structure will reflect the negotiations of the parties—and may take into account other considerations, such as adjustments in the price.

Transaction Issues

Once the parties agree on a structure, the parties must then address a number of issues that will arise in a transfer of health insurance/managed care contracts. Some of the issues that typically arise are as follows:

Communication with Policyholders

The parties must address the timing and substance of any communication to the target's policyholders (or any other public announcement). The target will most likely insist that any announcement be delayed as long as possible, and certainly until after agreements have been negotiated and signed and the regulators advised of the transaction. The target will not want any premature announcement to be made, for fear that any such announcement will encourage other competitors to "raid" the target's groups and may encourage those groups to think about transferring to those competitors—all without compensation to the target. Even when an announcement is to be made, the target (or the seller) will want to be very careful in how policyholders are advised and the substance of any communication with policyholders.

Prior Health Insurance Liabilities

In the cases of a merger or a stock transaction, the acquirer is taking on all liabilities—even for health care costs prior to a closing. In other sorts of transactions (*e.g.*, assumption reinsurance), a question will arise whether the acquirer is assuming liability for health care costs incurred prior to the closing. The seller frequently wants to transfer these liabilities, on the ground that it wants to be out of the insurance business altogether (at least in the market involved). The acquirer may have some reason to take these

liabilities, since it wants to ensure that the acquired groups' claims are paid promptly. And the DOI may have a preference that all prior health care liabilities transfer to the acquirer, for the reasons that (i) the seller (or target) may be in financial difficulty, or (ii) the transaction will be less confusing for policyholders.

If these liabilities are transferred, the parties must agree on the funds to be transferred to the acquirer to support these liabilities. Needless to say, the acquirer is taking on some risk that, if a fixed sum is transferred, that amount may not be enough to cover liabilities. To cover that risk the acquirer may demand an indemnity, possibly secured by an escrow or holdback of consideration.

Even if the acquirer is not assuming these liabilities, the seller (or target) may want the acquirer to administer the "run-off" of these liabilities. If the acquirer is willing to do so, other questions will arise—*e.g.*, its use of the target's systems (discussed below), and the fees/charges for performing the administration.

Transfer of Systems

Another issue that frequently arises is the transfer of the computer systems that are used to administer the business being transferred. In many cases, the acquirer may need to buy/lease these systems, at least for a temporary period while it is transferring the business onto its own systems. Of course, one issue that must be addressed here is whether any such purchase/lease requires any consent or payment to the owner/licensor of such systems.

One advantage of the migration approach discussed above is that the acquirer does not need to use the target's systems (except possibly to administer pre-closing claims, if the

acquirer has agreed to do so). Even in the case of a merger or stock transaction, the transfer of systems may need to be discussed. For example, the seller (or target) may administer the administration of the business not through the use of its own system, but through an affiliate or a TPA.

Employees/Employee Benefits

In a number of these transactions, questions will arise regarding the parties' respective allocation of responsibilities regarding employees and employee benefits. For example, will the acquiring party hire some or all of the target's employees? If employees are to be not retained, who is responsible for severance benefits? What is to be done regarding the target's employee benefits and plans? Which party is to be responsible for particular benefits—*e.g.*, accrued vacation?

Health Care Providers

In many of these transactions, questions also arise regarding the target's contracts with providers of health care—*e.g.*, hospitals, doctors, pharmacies, etc.

If the acquirer does not already have a sufficient network in the applicable geographic area, the acquirer may wish to acquire the provider contracts held by the target. In such cases, questions will arise such as whether the contracts may be assigned without the consent of the providers. If a consent is required, the providers may well wish to adjust other terms of their contracts—particularly the price paid for health care services.

The acquirer may already have a network of providers in the geographic locations, and so may not need to acquire the target's provider contracts. In transactions where the target's provider contracts are nonetheless being transferred to the ac-

quirer (*e.g.*, through a merger), the parties must address which of the provider contracts (*i.e.*, the acquirer's contract or the target's contract) are to apply to future health care services.

Note that, in these situations, the DOI may well wish to inquire as to how many subscribers are going to be required to change primary care providers as a result of the transaction. It is always an advantage in these transactions if the regulator may be advised that the great majority of subscribers will not need to change primary care providers.

Other Types of Contracts

The target most likely will have other types of contracts in place—*e.g.*, software contracts, administrative service contracts, and leases. In these situations, parties must negotiate (in transactions other than possibly the purchase of stock and mergers) as to the contracts to be assigned and the terms of any assignment. In case of assignments, the question will arise whether a consent is required from any of these vendors.

One word of caution here is that the acquirer should avoid contracts with restrictive covenants—*e.g.*, non-competes and exclusive dealing contracts. For example, pharmacy benefit managers may have contracts requiring that the other party deal only with that pharmacy benefit manager. If that contract is acquired by the acquiring party, the acquiring party may then be subject to these restrictive covenants—in situations where they may not want to or even be able to comply.

Insurance

Another issue that typically arises is whether to transfer to the acquirer general

liability/malpractice insurance carried by the target. Note that, even in merger or stock transactions, the target's insurance may not be carried directly by it but through an affiliate—and that insurance may terminate once the affiliation terminates.

In these situations, the acquiring party must review its own existing insurance policies to see whether it is covered in connection with liabilities that it may be assuming. In most cases, the acquiring party will not be covered by its existing carrier for such liabilities. In such cases, the acquiring party must either negotiate with its existing carrier for an endorsement to cover those liabilities, or it could seek a transfer to it of the insurance carried by the target. Note that many insurance policies contain anti-assignment clauses, and so any transfer may require the consent of the insurer.

Indemnity

As in any transaction, indemnity matters must be addressed and can be difficult to negotiate. These negotiations must first cover the matters subject to the indemnity. In this regard, the seller will likely resist an indemnity for pre-closing health care claims, on the ground that it wants to end all health care liability.

Once the issue of matters covered by the indemnities is resolved, the parties must necessarily address other sorts of matters that arise in any indemnity negotiation—*e.g.*, the deductible, the maximum dollar amount of the indemnity, the time limit for asserting indemnity claims, and a gross-up to take taxes into account, etc.

Telephone Number

One item frequently that is neglected in these transactions is the transfer of the tele-

phone number(s) used by the target for communication with policyholders. In many cases, the target will have an 800-type telephone number that its customers are used to calling. In fact, that number may be set forth on insurance policies, claims literature, etc. If the acquirer desires to continue that method of communication, the acquirer should negotiate for rights to the transfer of the telephone number(s).

Non-Compete

If the target survives as a separate independent entity, the acquirer will most likely want to seek a non-compete provision in the acquisition agreement. In particular, the acquirer may wish to do so if the target is part of a health care delivery system. In light of its existing provider network being still in place (and the possible retention of its licenses), that system may be able to reestablish a health insurer/managed care entity with relative ease—which the acquirer almost certainly would not welcome.

In negotiating any non-compete, the parties must address several issues common to all non-compete provisions—the services involved, geographic scope, and time duration. The acquirer should carefully review the local state's law to determine the limits that the law/court decisions impose on allowable non-competes.

Policyholders That Do Not Transfer

In some of the transaction structures discussed above, (*e.g.*, assumption reinsurance and migration), policyholders may have a choice whether to transfer to the acquirer. In these transactions, the question arises how to treat the policyholders that reject a transfer (or who just may fail to act in connection with a proposed transfer).

In the negotiations, the target will likely not want to continue to be responsible for these policyholders. After all, the target wants to get out of this business (at least in this market), and it does not want to have to insure/administer a lingering small block of business.

One possible way to address this issue is for the acquirer to 100 percent indemnity reinsure and to administer this business, until the target is able to terminate/non-renew it in accordance with the law and contract terms.

One issue the parties should explore is whether the target will be able to terminate/non-renew the business within a relatively short period of time (*e.g.*, 12 to 18 months) under existing federal and state law and under the terms of the contracts. If the target is exiting the market, some of the laws mandating renewal may no longer apply. (*See* the discussion under “HIPAA,” which begins on page 27.) If that is the case, and if the target commits to a prompt non-renewal in accordance with law and contract terms, the acquirer may be willing to undertake to 100 percent indemnity reinsure and administer the business for the necessary period of time.

One caution here is that the terms of the existing contracts must be reviewed to ensure that a cancellation or non-renewal is allowed. Our experience has been that some targets’ contract forms may not allow or provide for cancellation or non-renewal—in which case an acquirer may not want to have to deal with the long-term nature of these contracts.

Other Standard Terms

Of course, the parties must also agree on other terms that are customary in almost all acquisition transactions—*e.g.*, representations and warranties, pre-closing and

post-closing covenants, conditions to the transaction, possible termination events, closing documents/requirements (*e.g.*, required transfer documents, resignations, ancillary agreements, opinions), and exclusivity, etc.

Regulatory Issues

In these transactions, several major legal issues can arise—*e.g.*, antitrust, HIPAA, DOI regulatory approvals, and charitable issues. We will briefly discuss each separately.

Antitrust

From the time a transaction is contemplated until the time it is consummated (and perhaps even after), antitrust issues are ever-present in health plan mergers and related transactions. This includes the possible need for regulatory approval for a merger; the possibility that due diligence will run afoul of antitrust limitations; and the concern that companies will “jump the gun” and begin to coordinate activities prior to regulatory approval. Each of these risks should be considered through the lens of what is the appropriate antitrust market for evaluating the competitive effects of a transaction.

Identifying the Relevant Market

Many transfers of health insurance and/or managed care businesses will be subject to antitrust scrutiny or challenge. A key element of any antitrust inquiry will be determining what product and geographic markets are relevant to the transaction. The US Supreme Court has specifically held that a determination of a relevant product and geographic market is a “necessary predicate” for analyzing a claim under Section 7 of the Clayton Act¹ that a merger may have a

substantial adverse effect on competition.² The relevant market for antitrust purposes often will be the subject of debate. Generally, those seeking approval for a transaction will argue that the transaction should be viewed as part of the broadest possible market with the largest number of competitive alternatives, while those opposing a transaction will argue that a narrower market applies where the transaction, if approved, could have anticompetitive consequences.

Product Market

The relevant product market consists of those entities which compete with the product in question. The central factor is what alternative providers a consumer might reasonably turn to as a substitute for the product. In *Brown Shoe Co. v. United States*,³ the US Supreme Court outlined factors that may be considered in determining the relevant product market (or submarket):

The outer boundaries of a product market are determined by the reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it. However, within this broad market, well-defined submarkets may exist which, in themselves, constitute product markets for antitrust purposes. The boundaries of such a submarket may be determined by examining such practical indicia as industry or public recognition of the submarket as a separate economic entity, the product's peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes and specialized vendors.⁴

Other relevant indicia include how the parties to a transaction describe themselves and the transaction at issue in correspondence

and other documentation, including tax and regulatory filings. For instance, the Standard Industrial Classification (SIC) Code data reflected in a party's tax or accounting filings may indicate that that firm participates in the same product market as other companies who identify the same SIC Code in their filings.

More recently, the FTC and the Antitrust Division of the Department of Justice (DOJ), in their jointly issued 1992 Horizontal Merger Guidelines (Merger Guidelines), illuminated the way today's federal regulators approach the issue of markets. They defined "market" to mean a product and the geographic area in which it is produced or sold such that a hypothetical profit-maximizing firm, with monopoly power and not subject to price regulation likely would impose at least a "small but significant and nontransitory" increase in price, assuming all other market terms held constant.⁵ Other market participants include those firms currently in the market and those that likely would enter if there were a "small but significant nontransitory price increase."⁶ To determine such a price, the FTC and DOJ (collectively, the Agencies) rely on a "5 percent test." This identifies those firms that would enter a market if there were a 5 percent hypothetical price increase for the product in question that held for the foreseeable future.⁷ The 5 percent approach has been specifically applied by courts in analyzing transfers related to managed care plans.⁸

With regard to health plans specifically, one of the central questions is whether different types of insurance products such as HMOs, PPOs, POS plans, and indemnity plans constitute a single product market or multiple markets. Regulators also have questioned whether those who are self-insured

should be viewed as part of the same market as commercial and health insurers.⁹ Another important question is who is the relevant “consumer” for purposes of the analysis, as this may include hospitals, physicians, and other medical service providers, or patients themselves.

Courts have reached inconsistent outcomes. For instance, the US Court of Appeals for the Seventh Circuit in *Blue Cross & Blue Shield United v. Marshfield Clinic*¹⁰ found that HMOs should not be viewed as a separate market because they competed with non-HMOs. As the Seventh Circuit stated there, “the services offered by HMOs and by various fee-for-service plans are both provided by the same physicians, who can easily shift from one type of service to another if a change in relative prices makes one type more lucrative than others.”¹¹ The court further stressed that the physicians in a single HMO were permitted to join other HMOs as well as other types of plans and that the market included physicians who had not affiliated with any plan.¹²

By contrast, in *United States v. Aetna, Inc.*,¹³ the DOJ challenged a merger between Aetna and Prudential in Texas. In doing so, the DOJ concluded that PPOs and indemnity plans would not be a reasonable substitute for HMO and HMO-POS products based on the facts that employees who left one HMO plan chose another HMO plan rather than a PPO for their next plan. The DOJ also concluded that a small but significant increase in the price of HMO and HMO-POS products would not cause consumers to shift to a different form of plan.¹⁴

Geographic Market

Identifying the relevant geographic market depends on the area of effective compe-

tion for a product. The US Supreme Court has defined this as “the area in which the seller operates and. . .the purchaser can practicably turn for supplies.”¹⁵ The geographic market can be as narrow as a single city or county, as broad as an entire region, or even as big as the United States as a whole. In *Aetna*, the DOJ noted that most patients sought to receive treatment close to where they work or live and therefore, employees required managed care companies to offer a network that contained a certain number of health care providers within a specified distance of each employee’s home. The DOJ concluded that the relevant geographic markets were in the Houston and Dallas-Fort Worth area.¹⁶ Therefore, as part of its consent decree approving the merger, the DOJ required the acquirer to divest HMO businesses in these markets in order to establish viable competitors in the development, marketing, and sale of HMO and HMO-based POS plans.¹⁷

Market Power

The concern with mergers is that by raising the market share of the acquirer, the transaction creates or enhances “market power,” or the ability to maintain prices above competitive levels for a significant period of time,¹⁸ to the detriment of consumers. Market power may also take the form of “monopsony,” where a single buyer has the ability to depress the price for a product below competitive levels and thereby decrease output.¹⁹ The concern for market power will be greater where there are high barriers to entry to the market or where there has been a trend toward concentration with the observance of corresponding anti-competitive effects. The concern will also be greater where market conditions facilitate the

lessening of competition through coordinated interaction, such as where key competitive information is not readily available in the market or where there is greater homogeneity among firms.²⁰ Health industry representatives have advised the Agencies that the more similar the merging firms are in terms of their product offerings and areas where they compete, the greater the possibility that market power may be misused.²¹

The Agencies use the Herfindahl-Hirschman Index (HHI) to gauge market concentration, which is calculated by adding together the squares of the market shares of the individual participants. Generally, where there is a post-merger HHI above 1,800 and the merger causes the HHI to increase (the “delta”) more than 100 points, it is considered likely to enhance market power and therefore generate further scrutiny.²²

By contrast, concerns of anticompetitive effects may be rebutted by the showing that the merger creates the potential for pro-competitive efficiencies, including lower prices, reduced costs, economies of scale, better regulatory compliance, increased output, technological innovation, greater choice, easier administration of claims, improved financial stability, better quality of care, and other positives.²³

The Agencies suggest that they will follow the Merger Guidelines in reviewing health care mergers and conduct a fact-intensive, case-specific assessment of whether a particular transaction will have anticompetitive repercussions.²⁴

Parties contemplating a transfer or merger should consider what regulators will likely consider to be the relevant market and how, assuming such a market, they may justify the transaction as efficient, beneficial to consumers, and pro-competitive. They also

should consider what challenges are likely to be raised and how best to combat those challenges.

The FTC’s ENH Decision

The FTC’s recent *In re Evanston Northwestern Healthcare Corp. (ENH)* decision gives substantial insight into the current approach that federal regulators take toward health-care industry mergers.²⁵ In *ENH*, the FTC, in finding that the merger caused Evanston Northwestern Healthcare Corp. (Evanston) to possess market power in violation of Section 7 of the Clayton Act, gave significant weight to anecdotal testimony by witnesses from managed care organizations (MCOs) that they feared that the merger would force MCOs to pay higher costs and cause them to lose bargaining leverage.²⁶ While in *ENH* the MCOs were claiming to be injured parties, their approach may easily be used by those who would challenge future managed care mergers and related transactions. The evidence relied on by the FTC in *ENH* also serves as a reminder that merging parties must be careful about how they frame and document transactions, as the FTC, in finding the Evanston merger to be anticompetitive, emphasized statements made by executives of Evanston and Highland Park Hospital (Highland Park) and their consultants that had predicted how the merger would give the merged entity greater leverage in negotiating with MCOs.²⁷

In *ENH*, Evanston, which already owned Glenbrook Hospital (Glenbrook), merged with Highland Park. The FTC thereafter challenged this under Section 7 of the Clayton Act.²⁸ The evidence was undisputed that Evanston’s prices increased substantially following the merger.²⁹ At issue was whether these price increases were caused by the

merger. The matter was referred to an administrative law judge (ALJ), who in 2005, found that the merger was anti-competitive in violation of the Clayton Act, following an eight-week trial during which 42 witnesses testified and 1,600 exhibits were admitted.³⁰ The ALJ ordered Evanston to divest Highland Park.

On August 2, 2007, the FTC, in an Opinion written by Chairman Deborah Platt Majoras, generally affirmed the ALJ's finding that the merger was anticompetitive and violated Section 7, but ordered a far less harsh remedy. The FTC let the merger stand, but ordered that Evanston should establish two separate and independent contract-negotiating teams—one for Evanston and Glenbrook and the other for Highland Park—that would allow MCOs to negotiate separately for the competing hospitals.³¹

Certain of the factors emphasized by the FTC in reaching its finding of anti-competitiveness are unexceptional. The FTC found that the change in HHI caused by the merger—from 2,355 to 2,739 (a delta of 384)—made it presumptively anti-competitive.³² The FTC found that econometric evidence and expert testimony supported this.³³ The FTC also noted that senior officials at both Evanston and Highland Park and their outside consultants had, in statements and written correspondence, predicted prior to the merger that it would improve the hospital's bargaining position in negotiating managed care contracts.³⁴ The FTC emphasized that one Highland Park officer, in particular, had noted that because there are so many executives who live in Chicago's north suburbs—where Evanston, Glenbrook, and Highland Park are located—that employers would

have difficulty in trying to avoid doing business with Evanston.³⁵

Other findings by the FTC in *ENH* are more unusual. For example, the FTC found that the Evanston merger would create the potential for market power even though there were numerous other strong hospital competitors in the market and even though Evanston, even after the merger, was far from a monopolist.³⁶ Of equal significance was the FTC's reliance on anecdotal testimony by MCO officials, who have an interest in preserving their own negotiation strength, that they believed the merged entity would impair their bargaining power and give Evanston undue leverage.³⁷

Finally, the FTC's focus in *ENH* was on the velocity of price increases—how fast Evanston raised prices after the merger—rather than on how the hospital's pre- and post-merger prices compared to prices established by comparable hospitals in the market for comparable services.³⁸ The FTC specifically rejected the argument of one of Evanston's experts that data suggested that Evanston after the merger may have just been trying to bring its prices in line with other "academic hospitals." The FTC found this data to be unreliable and of no benefit to Evanston because the data were equally consistent with Evanston's post-merger exercise of market power.³⁹ The FTC's approach suggests that a hospital trying to bring its prices into line with competitors' prices may nonetheless face a challenge if payers complain about the velocity of its price increases.

Completing the Pre-Merger Review Process

Under the Hart-Scott-Rodino Improvements Act of 1976,⁴⁰ each party to a merger must file a pre-merger notification with both

the FTC and DOJ when three tests are met:

1. *The “in commerce” test.* This considers whether either of the parties is engaged in US interstate commerce or in an activity that “affects” interstate commerce. The answer to this will often be yes, especially with regard to larger plans.
2. *The size of the transaction test.* This requires that, as a result of the acquisition, the acquirer would hold voting securities or assets of the acquired person with a total value in excess of an inflation-adjusted multiple of \$50 million.⁴¹
3. *The size of parties test.* This requires that either the acquirer or the acquired person have annual net sales or total sales of at least an inflation adjusted multiple of \$100 million (\$119.6 million as of February 2007) and that the other has annual net sales or total assets of at least an inflation-adjusted multiple of \$10 million (\$12 million as of February 2007). Where the first two tests are met, the size of parties test does not apply, and a filing is required when transactions are valued above an inflation-adjusted multiple of \$200 million (\$239.2 million as of February 2007).

Filing fees for a pre-merger notification filing vary depending on the size of the transaction. At present, pre-merger notification filings for transactions of less than \$120 million in size cost \$45,000 to file. Those for transactions between \$120 and \$598 million in size cost \$125,000 to file and those for transactions above \$598 million cost \$280,000 to file.

A merger may not be consummated until 30 days after notice is given to the Agencies, unless the waiting period is waived by the Agencies, which parties may request. While the pre-merger notification process takes place, the parties must behave as separate entities and may not coordinate their activities.⁴² Once notice is given, the Agencies have the power to request additional information, a so-called “second request.”⁴³ After such additional material is received, the Agencies may extend the waiting period for 20 additional days.⁴⁴ However, parties may ask for an accelerated time for consideration.

Should the Agencies decide to investigate a merger further, the DOJ may issue Civil Investigative Demands—which are administrative subpoenas—to obtain documents or testimony from the parties, or from others in the industry.⁴⁵ The FTC likewise may issue subpoenas or take depositions as part of a pre-merger investigation.⁴⁶ In certain instances, parties may be able to avoid the possibility of a second request or investigation in advance by identifying areas of possible controversy and discussing a resolution of such issues with Agency representatives prior to the time of filing.

Most transactions that are subject to pre-merger review are ultimately approved. In some instances, the regulators identify a problem area and propose a fix, such as that a certain line of business or geographic area be carved out from a transaction or sold to a third party, as *United States v. Aetna, Inc.*, illustrates.

However, the fact that regulators approve a merger does not preclude them from challenging a transaction once it is consummated should it prove anti-competitive in practice. Nor does such an approval preclude

challenges by state regulators, competitors, disappointed suitors, consumers, or other parties.

In contemplating a transaction, it is good to ask who is likely to complain about the transaction and what about the transaction they will challenge. By doing so, one can muster the best arguments and collect the best data to rebut such challenges.

Avoiding Pre-Merger Coordination

It is essential that the parties to a transaction avoid coordinating their activities until such time as the regulators have finally approved their merger. Those who “jump the gun” and begin coordinating activities prior to this time face stiff penalties of up to \$11,000 each day a violation continues.⁴⁷

Examples of unlawful pre-merger coordination resulting in sanctions include where a target agreed to obtain the acquirer’s approval before entering into, among other things, obligations of more than \$75,000 or matters regarding intellectual property rights or before presenting business proposals to customer and prospects;⁴⁸ where a target’s agreement to limit discounts until after a merger is approved and to obtain the acquirer’s consent before offering discounts above 20 percent;⁴⁹ and where an acquirer began to assign the employees to be acquired to new positions at its offices and gave them new business cards with the acquirer’s name.⁵⁰

In the *Gemstar* case,⁵¹ the court levied a \$5.67 million fine where the merger participants, among other things, began to jointly set prices and other customer terms and acted jointly on numerous business decisions.

Minimizing Antitrust Issues Arising During Due Diligence

A merger or other transfer of business usually will require that the parties conduct due diligence. During due diligence, those who have competed with a firm may receive access to competitively sensitive information about that rival. This may be especially problematic if a transaction never materializes, as often happens. Generally, however, such information exchange should not pose an antitrust risk where the parties act in good faith as part of a legitimately contemplated transaction and where the information exchanged is reasonably related to that transaction.

Some kinds of information exchanged are less likely to pose an antitrust risk than others. Thus, aggregate data generally poses less of an antitrust risk than do individual data. Historic data are less risky than current or future data. Cost information, while possibly a problem, poses less of a risk than does price information. Present and future price information and marketing or strategic plans are especially problematic.

To minimize risk in connection with due diligence, it is important that parties agree to keep any information exchanged confidential and not to make competitive use of such information and to put teeth into such agreements to make these prohibitions meaningful. Nonetheless, it is hard to police effectiveness of such agreements. To limit the risk posed by competitively sensitive information, it is helpful to filter such information through a third party, such as an accountant, lawyer, economist, or other professional. If this is not possible, it also may minimize the risk to have such competitively sensitive information reviewed by a company representative who works in a department generally unrelated to the transaction

or the rival and who may be in some sense “walled off” from colleagues who do.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) raises several issues in connection with the transfer of health insurance/managed care contracts.⁵² These issues include:

1. The guaranteed renewal of the health insurance contracts;
2. Guaranteed availability of health insurance contracts;
3. Pre-existing condition exclusions; and
4. Disclosure of protected health information to the acquirer, both in due diligence and in the transfer of policy files.

Guaranteed Renewability

HIPAA provides for the guaranteed renewability of health insurance coverage in both the small and large group market and for individuals (with exceptions). If an acquirer acquires health insurance contracts from another insurer, the acquirer must continue to renew those contracts unless one of the specified exceptions applies.

The difficulty an acquirer may have, in acquiring and renewing such contracts, is that its systems and personnel may be set up to administer only the contracts it has issued—and not contracts issued by others. Of course, systems can be adjusted or altered to administer the newly acquired contracts, but the acquirer may incur substantial expense in doing so. And in light of the inefficiencies of maintaining a separate relatively small block of contracts, the acquirer may not want to do so for the long term.

As such, the acquirer must evaluate its options as to how to deal with the guaranteed renewability requirements of HIPAA. These options include:

Migration

Instead of assuming contracts issued by the other insurer, the transaction may be structured as a migration transaction. (See the discussion that begins on page 13, under the heading “Migration.”)

Relief Under HIPAA

HIPAA also offers some possible modes of relief. First, HIPAA allows an acquirer to discontinue a particular type of coverage if the acquirer so acts in accordance with state law and meets other specified requirements—*i.e.*, the acquirer must (i) give notice to each plan sponsor provided such coverage (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of discontinuation; (ii) offer each plan sponsor the option to purchase all (or in the case of the large group market, any) other health insurance coverage currently being offered by the acquirer to a group health plan in such market; and (iii) act uniformly without regard to claims experience of those sponsors or any health status-related factors relating to participants or beneficiaries. Similar requirements exist in the case of individual coverage.

HIPAA’s requirement that the acquirer act in accordance with state law will require the acquirer to adhere to the state law in each state where coverage exists. That state law may impose other procedural or substantive obstacles to any termination of a particular type of coverage—*e.g.*, a specified time for

prior notice to the DOI or other applicable authority, or a requirement that any termination take place on a policy anniversary. The cumulative effect of such requirements could result in a substantial period of time being taken to effect a discontinuation of a particular type of coverage.

Second, an acquirer may modify coverage at the time of coverage renewal (i) in the large group market, or (ii) in the small group or individual market if such modification is consistent with state law and effective on a uniform basis among health plans with that coverage. An acquirer may possibly use this provision to modify the policies acquired by it so as to allow the acquirer (and its systems) to more effectively and economically administer the business acquired.

Several matters should be noted here. First, HIPAA allows for a modification only at the time of coverage renewal. Second, HIPAA's requirement of acting in accordance with state law requires the insurer to meet the various procedural and substantive requirements regarding modifications of coverage in each state where coverage exists—which could include requirements such as notice to the DOI or other applicable authority, advance notice to the insured (or the participants and beneficiaries), or allowing a modification only on the policy anniversary. As a result, an acquirer may be able to put modifications in place only after a substantial period of time. Third, the acquiring insurer must determine whether modifications to the target's forms are sufficient to allow it to administer the business efficiently and economically. If an insurer engages in a large number of "modifications," the acquirer may face objections that a proposed modification is in fact a termination of the prior coverage and issuance of a new prod-

uct (which is subject to the rules noted on page 27, under the heading "Relief Under HIPAA").

Another possibility to seek relief from the guaranteed renewal provisions of HIPAA may be to discontinue all coverage in the market in a state. In order to do so, a plan must:

1. Provide 180-day advance notice to the appropriate state authority and each plan sponsor (and all participants and beneficiaries) of the discontinuation; and
2. Discontinue all health insurance policies in the state in the market (or markets). HIPAA allows this to occur both in the group and individual markets.

Several substantial disadvantages inhere in any such approach:

1. Any such discontinuance must be in accordance with applicable state law. The state law in this context may not only impose the sorts of requirements noted above (*e.g.*, notice, discontinuance only on an anniversary date), but may also impose other sorts of requirements (*e.g.*, filing of an exit plan with the state authorities).
2. All health insurance policies issued in the state in the market must be discontinued. Ordinarily, a health insurer that recently acquired business in the market would presumably not want to discontinue all business in the market—unless the business and market were peripheral to its overall business and a minor part of an acquisition of business in other markets.
3. If an insurer discontinues all coverage in a market (or markets), HIPAA prohibits the insurer from issuing coverage in the market (or markets)

and state involved during a five-year period after the discontinuation.

Given these disadvantages, insurers will not often take the approach of discontinuing all coverage in a market.

In each case involving a termination or modification, care must be taken to comply with the requirements of the contracts being terminated or altered. In some cases, those contracts may preclude termination or modification, or may impose procedural or substantive requirements in order to effect such termination or modification. Any such requirements must be met, in addition to the requirements of law set forth above.

Guaranteed Availability

HIPAA contains provisions requiring health insurers that offer insurance coverage in the small group market to offer coverage to any small group in a state (and to accept every eligible individual who applies for enrollment under such coverage). A similar requirement exists for insurers that offer coverage in the individual market.

If an acquirer already offers coverage in the markets where it acquires health insurance or managed care contracts, these HIPAA rules will have little if any effect (since the acquirer is already subject to these rules in that market). However, if an acquirer acquires health insurance or managed care contracts in areas where it had not previously extended coverage, these HIPAA rules will extend the locations where the acquirer will be mandated to offer coverage in the small group and individual markets.

Pre-Existing Condition Exclusions

In any transfer of health insurance contracts, questions may arise regarding pre-existing condition exclusions. Generally, a health insurer offering group health

insurance may impose a pre-existing condition exclusion only if:

1. The exclusion relates to a condition for which medical advice or treatment was recommended or received within the six months ending on the enrollment date; and
2. The exclusion extends no more than 12 months (18 months in the case of a late enrollee) after the enrollment date (reduced by creditable coverage).

Notably, both of these requirements pertaining to pre-existing condition exclusions are dependent on the “enrollment date.” In the context where one insurer acquires another insurer’s business, the acquirer must recognize that the enrollment date is *not* the date that the acquirer begins coverage. Rather, the enrollment date will be the first day of coverage under the policy of the target (or even a predecessor of the target).

Two different rationales support this conclusion. First, if the acquirer assumes the seller’s contracts, the acquirer would assume all obligations of the target under those contracts—including those relating to pre-existing conditions. Even if the new insurer replaces the target’s contracts, HIPAA regulations specify that “if the plan changes group health insurance issuers, the individual’s enrollment date does not change.” Under either or both of these rationales, the acquirer’s pre-existing condition exclusion will be dependent on the enrollment date which applied to the predecessor insurer(s).

In any case, the enrollment date will not often in this context be a crucial issue in determining the applicability of a pre-existing condition exclusion. In most cases involving the transfer of health insurance/managed care contracts, the creditable coverage provisions (due to the prior insurance

coverage) will eliminate the exclusion for a pre-existing condition.

Disclosure of PHI

HIPAA (and regulations issued thereunder) contains privacy rules that limit the ability of covered entities (such as health insurance companies) to use and disclose certain individually identifiable information called “protected health information” or PHI. PHI includes the names, addresses, Social Security numbers, and claims information pertaining to insured individuals.

Generally, covered entities may use or disclose PHI without an individual’s authorization only as permitted under the privacy rules. Among other things, the privacy rules permit a covered entity to use and/or disclose PHI for “health care operations.”

Health care operations include, in pertinent part, the sale or transfer of all or a portion of the covered entity’s business (and due diligence related to such activity). These provisions afford a substantial amount of protection to both:

- Disclosure of PHI in connection with due diligence regarding a proposed sale or transfer of a covered entity (or part thereof); and
- If the sale proceeds, the transfer of policy files to the acquirer to carry out its health care operations such as underwriting and premium rating functions.

The rules thus take into account issues that arise in the sale or transfer of health insurance/managed care contracts.

Several cautions must be noted here, however:

1. Permitted disclosure is limited by the “minimum necessary” standard, which requires covered entities to make rea-

sonable efforts to disclose only the minimum amount of PHI necessary to accomplish the intended purpose of the disclosure. In addition, the minimum necessary standard mandates that the covered entity requesting disclosure of PHI request only the minimum amount necessary for the intended purpose of the disclosure. As a practical matter, in the context of acquisitions, these rules may require an acquiring party to seek only aggregate or summary or de-identified information in due diligence—since that information may be sufficient to allow the acquiring party to ascertain what it needs to know before proceeding with the transaction.

2. The acquiring plan may obtain only those policy files of the persons whose contracts are being transferred to the acquiring plan.
3. If the transaction is not closed, the plan acquiring PHI in due diligence is prohibited from using or disclosing PHI, except as may be required by law.

One final caution is that, in these transactions, the parties must also review other applicable federal law and state privacy law—which may impose additional or more strict requirements on the disclosure of PHI.

DOI Regulatory Approvals

In these transactions, the parties must identify and address the required DOI regulatory approvals. The types of required regulatory approvals will depend on the following:

1. The type of transaction being effected;
2. The magnitude of the transaction (compared with the magnitude of the target and the acquirer); and

3. The laws of the state(s) where the target is domiciled, where the target does business, where the acquirer is domiciled, and possibly where the seller (if different than the target) is domiciled.

First, it may well be necessary to obtain DOI approval for the transaction in the state where the target is domiciled. For example, if the target's stock is being transferred, or if the target is involved in other types of transactions described above (*e.g.*, merger, assumption reinsurance, migration, indemnity reinsurance/administrative), the approval of the DOI of the target's domicile may well be required.

Second, the parties may also have to secure DOI approval of the transaction in the state(s) where the target does business. For example, such approval may be necessary for assumption reinsurance or migration transactions.

Third, the parties should examine the laws of the domicile of the seller (if different than the target) and of the acquirer. Depending on the nature or size of the transaction, the DOI of the acquirer's domicile may need to approve the transaction—*e.g.*, in cases of a merger, or in cases of indemnity or assumption reinsurance (particularly if the size of the transaction exceeds specified thresholds). And even the laws of the seller's domicile (if different than the target) should be reviewed to determine if the parties need the approval of the transaction by the DOI in that state.

Finally, the parties may need other types of approvals in states where the target's business is located and being transferred. As noted above, in some sorts of transactions, the acquirer may need to secure a certificate of authority to do business (if it does not

already have one). The acquirer may also have to secure other types of approvals or make other filings in those states—*e.g.*, policy form or rate approvals, approval of the form of assumption certificate (if applicable), and agent appointments.

Charitable Issues

In some cases, one of the entities involved may be considered a charity. For example, if the target is part of a system formed by a charitable hospital, that system may be (or may be claimed to be) a charity. As another example, the target may have been formed under a state law that provides that the target is a charity.

In these cases, the parties must review the applicable law (both statutes and common law) to see if a report to or approval by the state attorney general or a court is required. The states' laws in this area will vary greatly, but many states have adopted laws to protect charitable assets in those states.

In this regard, it is possible that the transaction could be challenged by interested parties in those states—*e.g.*, by the attorney general, or by interested consumer groups. The basis for the challenge could be that the price does not reflect the market value of the charitable assets, or that the parties have failed in some other way to comply with state law.

It is also possible that some states have adopted similar laws even in cases when the target (and the seller) are not a charity but are non-profit entities. These laws may be adopted to ensure that the non-profit entities are not transferring assets that may be charitable, or to ensure that these entities are fulfilling their non-profit obligations. Again, the parties must review applicable state law to determine whether

they or their transaction is subject to such laws.

Other Possible Issues

There are other sorts of regulatory issues that the parties should consider. For example:

Medicare/Medicaid

If a portion of the business being transferred is Medicare or Medicaid business, the transaction may well require the approval of the Centers for Medicare & Medicaid Services (CMS). The parties should seek such approval promptly, since it may take a lengthy period to secure that approval.

Other Forms of Government Business

The transaction may involve other forms of government business being transferred—*e.g.*, Federal Employee Health Benefit Program, Indian Health Service, Military, or state/city government entities. While generally the transfer of such business is permissible, the parties must review the applicable regulations, and contact the applicable governmental authorities, to determine what approvals may be necessary.

Blue Cross/Blue Shield

If the business being transferred is Blue Cross/Blue Shield business, the parties will need to consider what approvals/licenses they may be required to seek from the Blue Cross Blue Shield Association.

Securities Laws

If a transaction involves securities, the parties must necessarily ensure that federal and state securities laws are followed. Of course, if the securities are publicly held, compliance with the securities laws will require

substantial time and expense. Even if the securities are not publicly held, the parties must still ensure that the applicable requirements of such laws are complied with.

Tax Issues

Both the seller and the acquirer need to consider the treatment of the transaction under federal, state, and local income and other tax laws. In addition to the taxation of the transaction itself, the parties also need to address responsibility for filing and paying current tax returns and obligations, and for past deficiencies that may be assessed on audit. The following provides a high-level overview of some of the principal tax considerations.

Federal Income Tax Treatment

Normally, the federal income tax treatment is the most important tax factor in shaping the transaction. The Internal Revenue Code (IRC) does not contain extensive provisions designed specifically to cover transfers of health insurance/managed care businesses. As a result, such transactions are governed primarily by the provisions and principles applicable to mergers and acquisitions transactions generally, and the parties are left to determine how those will apply. The transfer of a health insurance/managed care business may present some unique issues, however, and there are a few specific regulations, rulings, and cases pertinent thereto. Transactions involving Blue Cross and Blue Shield organizations may present issues under IRC Section 833, which are beyond the scope of this general discussion.

In some situations, such as a staff model HMO where the taxpayer itself provides the

health care through a staff of doctors and nurses, there may be a question as to whether the business primarily entails risk shifting and thus constitutes an insurance business for federal income tax purposes, or is primarily a service provider business. If the business is not considered an insurance business, then the special considerations pertinent to insurance companies would not apply.

In the discussion, it is assumed that the business is conducted through a stock, mutual, or similar C corporation. For federal income tax purposes, the policyholder members of a mutual company are generally considered stockholders to the extent they have voting, dividend, and liquidation rights in the organization.

The following discussion analyzes the tax treatment of each of the transaction structures outlined above on pages 10 through 16.

Merger

As long as at least about 40 percent of the consideration paid to the stockholders of the target consists of stock in the acquirer, it should be possible to structure the transaction as a tax-free reorganization under IRC Section 368(a)(1)(A). This is so even if the target merges with a subsidiary of the acquirer, although additional requirements apply. Care needs to be taken in dealing with mutual companies. While a merger of mutuals, or a merger of a mutual into a stock company in which the mutual policyholders receive stock for their equity interests, can qualify as a tax-free reorganization, a merger of a stock company into a mutual generally would not since the target stockholders' equity interest would not be considered to continue sufficiently. In a tax-free reorganization, the target stockholders, the target, and the acquirer would generally not recog-

nize any taxable gain or loss, and the acquirer would succeed to the tax basis and other tax attributes of the target (subject to change in ownership limitations such as Code Section 382).

If a forward merger is not tax-free, then the target would be deemed to sell its assets in exchange for the merger consideration (including assumption of liabilities) in a taxable transaction (including a deemed assumption-reinsurance transaction), and then liquidate. The target's tax liability on its deemed sale of assets could be very large, and would be inherited by the acquirer in the merger. Thus, if that is what the parties want to do, provision would need to be made in the transaction terms and documents to cover that liability. In addition, the target stockholders would be taxed on their receipt of consideration in the deemed liquidation. Because of the two levels of taxation, taxable forward mergers are relatively rare.

By contrast, taxable reverse triangular mergers in which a subsidiary of acquirer merges into the target and the target becomes a subsidiary of the acquirer are common. However, these are treated for tax purposes as stock acquisitions, and are covered in the discussion below.

Stock Acquisition

As in the case of a merger, a stock acquisition can be effected as a tax-free or taxable transaction. If the consideration to the target stockholders is solely voting stock of the acquirer, the stock swap may be a tax-free section 368(a)(1)(B) reorganization. Or, if the acquirer forms a subsidiary that merges into the target, effectively causing a stock swap by operation of the merger laws, the transaction may qualify as a tax-free Section 368(a)(1)(A) and (a)(2)(E) reorganization;

under that structure, up to 20 percent of the consideration to the target stockholders could be cash or property other than acquirer voting stock. In a tax-free reorganization, the target stockholders, target, and acquirer would generally not recognize any taxable gain or loss, and the target would retain its historic tax attributes (subject to change in ownership limitations such as IRC Section 382).

If the stock acquisition is taxable, then the analysis depends on whether the target is an ultimate parent or stand-alone corporation, or a subsidiary. In the first case, the transaction would typically be a simple taxable stock purchase. Although a Section 338(g) election may be available to treat the transaction as also involving a deemed sale of the target's assets, the election is normally not made due to the immediate tax triggered by the deemed asset sale. Absent the election, only the selling stockholders are taxed on their sale of stock and the target retains its historic tax attributes, including basis in assets (subject to change in ownership limitations such as Section 382).

If the target is a subsidiary, then it typically does make sense to make a Section 338(h)(10) election to treat the transaction as though the subsidiary sold its assets and then liquidated into its parent in a tax-free Section 332 liquidation. The difference here is that the seller corporate group may pay the same tax whether it is considered to sell the target subsidiary stock without the election, or the subsidiary's assets with the election, making the selling group largely indifferent. However, the buyer would normally want to make the Section 338(h)(10) election if it would step up the tax basis in the subsidiary's underlying assets to produce greater tax deductions going forward. Note that the Section 338(h)(10) election would

cause an assumption-reinsurance transaction to be deemed to take place.⁵³ The Section 338(h)(10) election would cause the target to be treated for most tax purposes as a new corporation with a new, deemed cost basis in its assets. Any historic attributes such as NOL carryovers would (to the extent not used to offset the deemed asset sale gain) remain with the selling group, except that the target would remain legally liable for tax deficiencies in years ending prior to or including the closing.

Assumption Reinsurance/Transfer of Assets

If substantially all the target insurance company's assets are acquired in exchange solely for voting stock of the acquirer and the acquirer's assumption of target liabilities (plus potentially a limited amount of cash or other property under the so-called "boot relaxation rule"), and the target liquidates and distributes the acquirer stock received and any other properties it has to its stockholders, then the transaction would normally qualify as a tax-free Section 368(a)(1)(C) reorganization. As in the tax-free merger, the target equity owners, the target, and the acquirer would generally not recognize any taxable gain or loss, and the acquirer would succeed to the tax basis and other tax attributes of the target, including its insurance-related tax items such as tax reserves (subject to change in ownership limitations such as IRC Section 382).

If the target has valuable insurance licenses, an Internal Revenue Service (IRS) letter ruling could be obtained to permit the target to retain the licenses and the target stockholders to sell their target stock to an unrelated buyer in a separate transaction. To satisfy the Section 368(a)(1)(C) liquidation requirement described above, the target would be deemed to liquidate and

distribute the retained licenses out to its stockholders, who would be deemed to contribute the licenses to the target as a new corporation.

If the assumption reinsurance/transfer of assets does not qualify as a tax-free reorganization, then the treatment will depend on whether the transaction is limited to an isolated assumption reinsurance of contracts, or is part of a larger transaction involving a transfer of other assets. If it is solely an assumption reinsurance transaction, it should be accounted for as such. But if the acquirer also acquires significant business assets of the target, in addition to the insurance contracts, to which goodwill and going concern value could attach, then the transaction would be an applicable asset acquisition (including the assumption-reinsurance transaction) governed by IRC Section 1060, and reportable to the IRS on Form 8594, *Asset Acquisition Statement*.⁵⁴ In either case, IRC Section 197(f)(5) would apply to determine the acquirer's tax basis in the insurance in force (excess of amount paid for the book over the amount, if any, required to be capitalized under IRC Section 848), which would be amortizable over 15 years.⁵⁵

Migration of Business

The tax characterization of a migration transaction is somewhat open-ended and may depend on the particular facts and circumstances. Because the target may retain contracts (until cancelled or not renewed), and the acquirer would merely offer to enter into new contracts with the insureds, assumption reinsurance treatment may not be appropriate. An alternative approach may be for target and acquirer to each account for its own respective contracts based on its own receipts of premiums, reserves, payments,

and other items, all as allocated under the migration agreement. However, if the acquirer pays for the business, that payment would have to be accounted for. In any case, if the acquirer acquires significant business assets to which goodwill or going concern value could attach, besides the insurance contracts, then the transaction would likely be an applicable asset acquisition under IRC Section 1060 and reportable to the IRS on Form 8594.

Indemnity Reinsurance/Administrative Services Agreements

An indemnity reinsurance arrangement would generally be treated in a manner similar to an assumption reinsurance transaction. However, IRC Section 197(f)(5) does not apply to indemnity reinsurance, leaving a question as to the applicability of IRC Section 197 to any ceding commission.

Other Taxes

The parties should consider the applicability to and effect of the transaction with respect to other taxes as well, including state income taxes, sales taxes (if tangible personal property is transferred), property taxes (including not only transfer taxes but impact on assessment values), employment taxes (*e.g.*, whether successor employer treatment is available), unemployment taxes, excise taxes, and premiums taxes.

Tax Compliance and Responsibility

The transaction documents should provide for reporting in accordance with the desired tax treatment, and for making any agreed upon elections; designate which parties are responsible for filing which tax returns and paying which taxes, and handling tax audits and proceedings; and require

the parties to cooperate with respect to tax matters.

Conclusion

As is evident from the above discussion, the parties to a transaction involv-

ing the sale of a health insurance/managed care business must consider and resolve a number of different types of issues. But while these transactions are complex, our experience is that these transactions may be successfully negotiated and implemented.

REFERENCES

1. 15 U.S.C. § 18. This provides, in relevant part, that "No corporation. . .subject to the jurisdiction of the Federal Trade Commission ("FTC") shall acquire the whole or any part of the assets of another corporation also engaged in commerce, where in any line of commerce, in any section of the country, the effect of such acquisition may be substantially to lessen competition or to tend to create a monopoly.
2. See, e.g., *United States v. E.I. DuPont de Nemours & Co.*, 353 U.S. 586, 593 (1957).
3. 370 U.S. 294 (1962).
4. *Id.* at 312.
5. See 1992 Horizontal Merger Guidelines jointly issued by the Federal Trade Commission (FTC) and the Antitrust Division of the United States Department of Justice (DOJ) (the Merger Guidelines) at § 1.0.
6. *Id.*
7. *Id.* at § 1.11.
8. See *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1078 (N.D. Cal.), *aff'd*, 217 F.3d 846 (9th Cir. 2000). In a later decision in that case, the Court noted that consolidation among various health care plans, in addition to the strong emergence of IPAs—*independent practice associations* that negotiate with plans on behalf of groups of physicians and medical groups—had led to a competitive health care market that had reduced costs and resulted in significant financial pressures on both health plans and providers. *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1114–1115 (N.D. Cal. 2001).
9. "Improving Health Care: A Dose of Competition," (*Improving Health Care*) A Report By The FTC and DOJ, July 2004 at Ch. 6, p. 2.
10. 65 F.3d 1406, 1411 (7th Cir. 1995) (that case did not address a merger but provides insight as to how the Seventh Circuit would view the health plan marketplace in the merger context.)
11. *Id.* at 1411.
12. *Id.* at 1410. See also *Ball Mem. Hosp. v. Mutual Hosp. Ins. Co.*, 784 F.2d 1325 (7th Cir. 1986) (merger of two plans of non-profit providers of health care financing did not pose antitrust risk where firms offered complementary products and had been run *de facto* as a single firm for 30 years).
13. 1999–2 Trade Cas. (CCH) ¶ 72,730 (N.D. Tex. 1999).
14. *Id.*
15. *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1967).
16. *Improving Health Care*, Ch. 6 at 6.
17. *Aetna*, 1999–2 Trade Case, ¶ 72,730.
18. Merger Guidelines at p. 1.
19. *Id.*
20. Merger Guidelines at §§ 2.0–3.4.
21. *Improving Health Care*, Ch. 6 at 7.
22. Merger Guidelines at §§ 1.5–1.51.
23. *Improving Health Care*, Ch. 6 at 11–13.
24. *Improving Health Care*, Ch. 6 at 13.
25. *In re Evanston Northwestern Healthcare Corp.* (ENH), Docket No. 935, Opinion of the FTC dated Aug. 2, 2007
26. ENH Op. at 18–25, 67.
27. *Id.* at 15–16.
28. *Id.* at 5.
29. *Id.*
30. *Id.* at 5–6.
31. *Id.* at 5, 88–91.
32. *Id.* at 6.
33. *Id.* at 26–47, 64–78.
34. *Id.* at 15–16.
35. *Id.* at 66. ("The bottom-line conclusion of Highland Park's Spaeth was that the way to 'push back on the managed care phenomenon and get rates back to where they ought to be [was to become] big enough,' at which point 'it would be real tough for any of the Fortune\break 40 companies in this area whose

CEOs either use this place or that place to walk from Evanston, Highland Park, [and] Glenbrook'. . . . It is difficult to imagine on a clearer example of an executive using everyday language to explain how a merger will produce a firm that can exercise market power and whose services constitute a relevant antitrust market.")

36. *Id.* at 6, 13–14.
37. *Id.* at 18–26, 67.
38. *Id.* at 16–18, 31–47.
39. *Id.* at 47.
40. 15 U.S.C. § 18a.
41. 15 U.S.C. § 18a(a). Many of the statutory thresholds are now revised annually to account for changes in the gross national product. *Id.* § 18(a)(2). Beginning February 2007, the size of the transaction test is \$69.8 million.
42. The dangers of pre-merger coordination are discussed below.
43. 15 U.S.C. § 18a(g)(1).
44. 15 U.S.C. § 18a(e) and even beyond this if the Agencies receive District Court approval.
45. 15 U.S.C. § 1311(c).
46. 15 U.S.C. § 46.
47. 15 U.S.C. 18a(g)(1).
48. United States v. QUALCOMM Inc., 2006–1 Trade Cas. (CCH) ¶ 75,195 (D.D.C. 2006).
49. United States v. Computer Associates Int'l, 2002–2 Trade Cas. (CCH) ¶73,883 (D.D.C. 2002).
50. United States v. Input/Output, Inc., 1999–1 Trade Cas. (CCH) ¶ 72,528 (D.D.C. 1999).
51. United States v. Gemstar-TV Guide Int'l, 2003–2 Trade Cas. (CCH) ¶ 74,082 (D.D.C. 2003).
52. This part regarding HIPAA has been adapted with permission from an earlier version published in BNA's *Health Law Reporter*, vol. 16, no. 23 (June 7, 2007). Copyright 2007 by The Bureau of National Affairs, Inc. (800-372-1033) <http://www.bna.com>.
53. See Treas. Reg. § 1.338-11, *Effect of section 338 election on insurance company target*.
54. See Treas. Reg. §§ 1.1060-1(b)(9) and (c)(5).
55. See Treas. Reg. § 1.197-2(g)(5).

Reprinted from *Journal of Health Care Finance*, Volume 34, No. 2, Winter 2007, pages 10–37, with permission from Aspen Publishers, a Wolters Kluwer Company, New York, NY 1-800-638-8437, www.aspenpublishers.com