

Hospital Merger and Acquisition Transactions: A Focus on Retiring Liabilities

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The volume of business combinations involving non-profit hospitals is at the highest level of the last decade. The macro-economic forces spurring industry consolidation and rationalization are weighing heavily on management teams and boards around the United States. There is broad consensus that the fragmented ownership structure of the acute-care industry is, in part, responsible for the ineffectiveness of medical outcomes. The presence of a large number of small hospital companies has contributed to the widely held view that our hospital industry, in aggregate, delivers mediocre quality care at an extremely high cost. For these reasons, hospitals are attempting to form larger enterprises to create scale, expand geographically, manage risk, access capital, contend with the changing regulatory environment, improve operating skill, and to more effectively manage the health of the populations they serve.

Despite these strategic and financial imperatives, completing change-of-control transactions has become increasingly difficult. This is due, in part, to the level of financial liabilities found at many selling institutions. Regardless of transaction structure, satisfying liabilities has become an onerous part of completing merger and acquisition (M&A) transactions for both buyers and sellers. These challenges typically include: 1) retiring funded debt, 2) unwinding interest rate swaps, 3) satisfying defined benefit pension plans, and 4) the cost of tail insurance. Today's historically low interest rate environment is partially to blame for the increased cost and complexity associated with satisfying these obligations at the closing of transactions. This article seeks to clarify these challenges and to provide recommended solutions to them when completing M&A transactions.

1. Retiring Funded Debt

The municipal bond market is the most common form of external capital utilized by non-profit hospital systems. This \$3.7 trillion market is by far the most developed in the world, allowing government entities, schools, utilities, and hospitals to finance their operations and capital expenditures. Investors in these tax-exempt debt instruments are attracted to the strong credit and

tax-advantage characteristics of issues in this market. Despite certain high-profile bankruptcies in the past few years (Detroit, MI; Stockton, CA; Jefferson County, AL; Harrisburg, PA), investors have largely remained confident in this market and have shrugged off the default risk forecasted by Meredith Whitney over the last several years. Moody's cites that only 71 of the roughly 17,000 bonds (i.e., 0.4 percent)¹ they have rated since 1960 have defaulted. This compares favorably to the 1.5 percent default rate in the corporate bond market.² This investor confidence can be observed in the reduced spreads that A-rated municipal bonds trade compared to AAA-rated Treasuries, as shown in Exhibit 1.³

Exhibit 1: U.S. A-Rated Municipal-Bond Spreads over AAA-Rated Municipal Bonds (Percentage Points)



Historically, retail clients were the primary investor base for municipal bonds. However, the proliferation of mutual funds and exchange-traded products has increased the role of institutional buyers. Most underwriters believe this trend will instill more selection discipline and require larger offerings. In turn, this could stimulate the formation of larger, vertically integrated healthcare companies.

- 1 Todd Ganos, "Whatever Happened to the Muni Bond Implosion," *Forbes*, April 12, 2013.
- 2 Kay Giesecke et al., "Corporate Bond Default Risk: A 150-Year Perspective," *Journal of Financial Economics*, Vol. 102, Issue 2, November 2011.
- 3 "America's Municipal Bond Market," *The Economist*, June 22, 2013.

While complex in execution, there are conceptually only two broad ways that funded debt (whether municipal bonds, directly placed bank notes, or private placements with institutions) can be handled in a merger or acquisition. Typically, the transaction structure determines the approach.

Purchase of Stock

In a transaction structured as a purchase of stock (as opposed to assets, see below), the target's legal entity remains intact and the buyer "steps into the shoes" of the seller and becomes liable for its financial obligations, including its funded debt. Liabilities of the new subsidiary either remain in place by being *assumed* or *guaranteed* by

the new parent company (as part of the obligated group), or are *retired* via refinancing. This form of merger, in which both legal participants survive, usually occurs between two non-profit systems. These are referred to as "membership" or "sponsor" substitutions since there are no clear equity holders in community non-profits. Note, this is not the case with for-profit, religious-sponsored, or publicly owned hospitals that have clearly defined shareholders. Procter & Gamble's acquisition of Gillette represents a corporate analogy to these member substitutions. Procter & Gamble, as the new owner, became explicitly liable for the debt obligations of Gillette upon acquiring Gillette's stock.

The same principal is true in the hospital industry.

Purchase of Assets

In a transaction where the acquirer purchases the assets of the target, the buyer is obtaining ownership of select assets and requires that the seller delivers the business "free and clear of encumbrances" at the closing. Asset sale transactions typically occur between non-profit hospital sellers and for-profit buyers and are referred to as "conversions" by regulators because the tax status is changing.

In these situations, the seller collects a purchase price from the buyer, retains cash and other financial assets, and utilizes

continued on page 2

Hospital Merger and Acquisition Transactions...

continued from page 1

the economic outcome of the transaction (the “gross proceeds”) to *call*, *defease*, or *tender* for the bonds. The IRS requires the retirement of tax-exempt debt in a conversion because for-profit companies cannot hold tax-exempt debt. *Calling* bonds from investors (usually at par) is straightforward and follows a prescribed formula laid out in the bond indenture. *Defeating* the bonds is more complicated and necessary when the bonds are in the “no-call period,” typically six to 10 years following issuance.⁴ Defeasance involves purchasing a laddered portfolio of U.S. Treasury securities that will generate a yield sufficient to pay the bonds’ principal and interest payments until the no-call period has elapsed and the bonds can be retired. Defeasance has become more costly recently due to the low interest rate environment. *Tendering* for the bonds is rare and involves negotiating with institutional holders to accept a price less than par. In our experience, this is achievable only during major economic disruptions or in response to the threat of bankruptcy proceedings. For example, in fall 2008, following the collapse of Lehman Brothers, fear motivated some investors to exit securities at less than par. In today’s environment, it is difficult to achieve agreement among bondholders for a tender because reinvestment opportunities in replacement securities with a similar yield are limited.

From these two examples, it is easy to see that selling the stock of a business has certain advantages to sellers related to simplifying the handling of funded debt in a transaction. Conversely, buyers prefer to acquire assets as it limits future legal obligations they must become responsible for (more on this in parts three and four).

4 *Redemption Provisions*, Municipal Securities Rulemaking Board, 2013.

Exhibit 2: Declining Underwriting Spreads

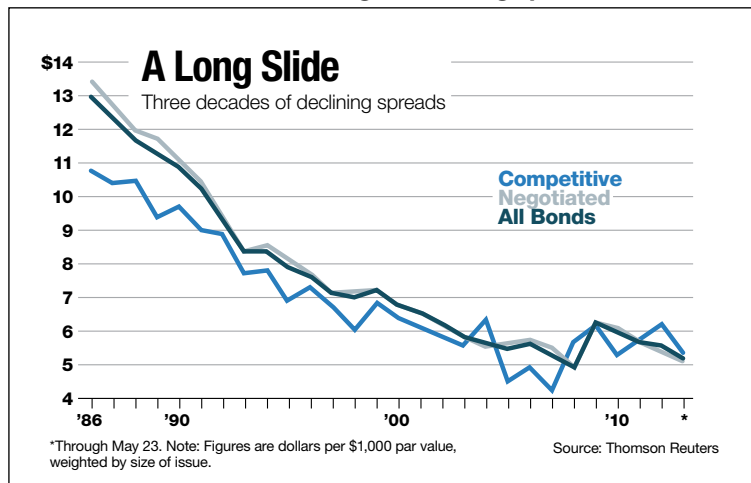
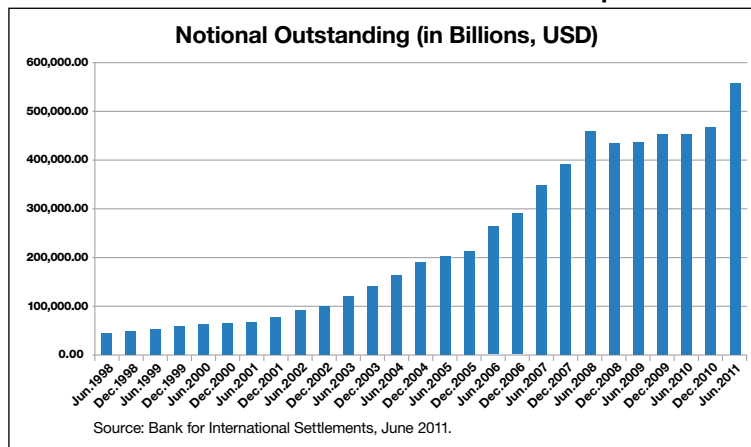


Exhibit 3: Growth and Size of the Interest Rate Swap Market



2. Unwinding Interest Rate Swaps

Interest rate swaps are derivative contracts that synthetically convert an issuer’s interest payment to either a fixed or floating rate. Non-profit hospital systems have utilized interest rate swaps to a dramatic extent following the market exuberance of the mid-2000s.

Critics of the bulge bracket investment banking business might attribute this trend to declining underwriting spreads on municipal issues. The average spread in 1986 was \$12.92 per \$1,000 bond; in 2012, the average was \$5.52 (see **Exhibit 2**).⁵ Swaps, then, can serve as an additional, high-margin financial

5 Tonya Chin, “Muni Underwriting Fees Continue to Decline,” *The Bond Buyer*, May 28, 2013.

product for the sales force (see **Exhibit 3**).⁶

Trading desks formerly arranged interest rate swaps on an *agency* basis between two client companies with opposing needs (e.g., an insurance company hedging duration risk that sought a floating rate and a manufacturer that sought cash flow stability from a fixed rate). However, banks now trade more on a *principal* basis and act as the counterparty. Floating rate payments are pegged to major worldwide benchmarks (e.g., LIBOR or SIFMA) and fluctuate with those indices. Having entered into fixed-to-floating contracts, many hospital systems are now confronting a scenario where their speculation is significantly “out of the money.”⁷

Similar to the discussion regarding bonds in part one, interest rate swaps must be terminated in an *asset sale transaction* to achieve the “free and clear” requirement of the buyer. Commonly, the face value of the bonds is the notional amount on which the interest rate is swapped. To unwind, a broker will price the

cost to terminate the swap with the counterparty. Over-the-counter swap market volume exceeds \$2.7 trillion per day,⁸ so these are quite liquid and easy to exit, albeit for a cash payment out of the transaction proceeds.

3. Satisfying Defined Benefit Pension Plans

Moody’s Investors Service reports that approximately 72 percent of the 460 not-for-profit hospitals that it rates offer

continued on page 3

6 *Growth and Size of the Interest Rate Swap Market*, Bank for International Settlements, June 2011.

7 Liz Capo McCormick, “Funding Pressures Mixed as Dollar Libor at Almost Two-Year Low,” *Bloomberg*, July 12, 2013.

8 “Cleared OTC Interest Rate Swaps,” CME Group, August 16, 2013.

Hospital Merger and Acquisition Transactions...

continued from page 2

defined benefit plans to their employees (referred to herein as “pension plans”).⁹ According to Standard and Poor’s, the median funded status of defined benefit plans for hospitals was 69.4 percent in 2012, down from 72.6 percent in 2011.¹⁰ If a pension plan is significantly underfunded, that is to say that the benefit obligations under the pension plan exceed the assets held in trust used to settle the accrued benefits, the pension plan represents a concern both from a liability and cash flow perspective. Following the implementation of the Pension Protection Act of 2006, a pension plan that is 60 percent or less funded is considered “severely at risk,” and a pension plan funded between 60 percent and 80 percent is considered “at risk.” Although the Moving Ahead for Progress in the 21st Century Act will help reduce the amount hospitals have to contribute to their pension plans in 2013 and 2014, this will not change a hospital’s total liability—thereby only providing temporary financial relief.

Underfunded pension plans present an issue when negotiating change-of-control transactions. In a stock or membership substitution transaction, the affiliating party may adjust its other commitments to the hospital in light of such liability (underfunding can have a negative credit impact on the entities going forward). In an asset sale, the buyer will likely exclude the underfunded pension plan from the transaction so that it is not legally obligated to

maintain or fund the pension plan following the closing. This will require the seller to either maintain the underfunded pension plan, or alternatively, fully fund and terminate the underfunded pension plan (which in most cases is prohibitively expensive).

4. Acquiring Tail Insurance

The operation of a hospital leads to a large number of potential liabilities in the form of medical malpractice claims. A buyer of a hospital will have significant concern that it is not inheriting all of the historical and potential medical malpractice liabilities incurred by the target. Therefore, most buyers will require that a target obtain an insurance policy (or an endorsement to an existing policy) that provides coverage for past known and unknown medical malpractice claims. This type of policy is commonly known as a “tail insurance” policy.

The cost and structure of a tail insurance policy can vary widely. One of the key influencing factors on the cost of such a policy is the cost of errors and omissions insurance in the state in which the hospital operates. If a hospital that is being acquired maintains its own captive malpractice insurance or is “self-insured,” it may complicate the approach to tail insurance and there will be a need to purchase tail insurance for the captive’s reinsurer. Finally, different features of the tail insurance policy itself (such as whether the policy includes demand or incident triggers) can influence its cost.

The cost of tail insurance and the arranging for coverage for historical malpractice liabilities is an important consideration on a potential transaction.

Conclusion

Some basic arithmetic illustrates how these four issues have caused problems for independent hospitals determining whether they can afford to sell. Consider a \$150 million revenue stand-alone 501(c)(3) hospital with \$50 million in cash and equivalents. Due to changing industry demands inherent in healthcare reform, this hospital implemented a competitive process to find a partner. The hospital received competing proposals and, for sound fiduciary reasons, has decided to sell to a for-profit company. The for-profit partner is willing to pay the hospital \$100 million in cash at closing for the equity of the business. Combined with its \$50 million of retained financial assets, the hospital now has \$150 million to work with to address these four liability issues. If we assume the following: 1) the cost to defease the bonds is \$80 million, 2) out of the money interest rate swaps requires \$10 million, 3) fully funding and freezing the pension with the PBGC will require \$50 million, and 4) tail insurance is \$5 million—this totals \$145 million. So \$150 million of gross proceeds less \$145 million in expenses (before any transaction costs) narrowly nets a \$5 million foundation. Many sellers are now in this type of predicament where the strategic logic of a transaction is enormous, but the ability to sell and margin for error is extremely thin. ●

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9 “Moody’s Identifies Top NFP Hospital Strategies for Mitigating Rising Pension Burdens,” Moody’s Investors Service, May 21, 2013.

10 Ron Shinkman, “S&P: Pension Costs a Fiscal Drag on Hospital Systems,” Standard and Poor’s, April 23, 2013.