Strategic Options for Hudson Health System

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Executive Summary

Hudson Health System ("Hudson") recognizes that health care reform has shifted the balance of risk and reward between payors and health care providers. Health systems will no longer be rewarded for providing repeated, high volume care. Moving forward, the reward will be found through coordinated, value-based health care centered on population health management. Hudson is conscious of this change and recognizes the need to adapt to remain successful in the evolving health care marketplace under the Patient Protection and Affordable Care Act ("PPACA").

Hasch & Tagg, LLP ("H&T") believes the shifting insurance marketplace offers Hudson an opportunity to broaden its operations to participate in the market for insurance products. This move may even be necessary so Hudson does not find itself at the mercy of payors who are constantly seeking to drive down reimbursement rates, causing financial pressures that cannot be addressed solely through more efficient health care delivery. Hudson also faces the possibility of network exclusion as payors begin to narrow provider networks to maintain lower costs.

Hudson is equipped and ready to expand its role in the continuum of care, and to deliver an insurance product that is financially viable and able to meet the demands of the consumer market. Hudson already has the integral components of a successful clinical care model in place given its foothold in areas from primary care to long-term care and home health. In addition, Hudson has a strong foundation of knowledge due to its experience with self-insurance and familiarity with the insurance marketplace. Given the foregoing considerations along with other industry insight to be discussed further in this memo, H&T has identified the following three strategic options for Hudson:
• **Option 1 - Renegotiate Existing Payor Contracts to Include Greater Risk-Sharing:** Hudson already has a relationship with Blue Cross/Blue Shield (“BC/BS”) and presumably other payors in the market, along with experience running a clinically integrated network through its Accountable Care Organization (“ACO”). Hudson can leverage this experience to negotiate greater risk-based contracting arrangements with payors. However, payors will still have the upper hand in controlling rates.

• **Option 2 - Collaborate with an Existing Payor through a Joint Venture:** Pursuing a collaborative partnership with an existing payor could provide Hudson with new growth opportunities to expand the depth of its care continuum. A joint venture would allow Hudson to establish a mutually beneficial business relationship with an existing payor, and still retain its independent identity. H&T believes entering the insurance market will require Hudson to transform its role from that of a “price-taker” to that of a “risk-taker.”

Establishing a strategic relationship through a collaborative pursuit such as a joint venture allows Hudson to take on this transformation without assuming the risk alone.

• **Option 3 - Acquire/Create a Wholly-Owned Payor Subsidiary:** Hudson has a strong reputation and provider network in its market, and can potentially attract the right patients to sign up for a Hudson-branded insurance plan. According to a survey conducted last month by the Advisory Board, 18 percent of hospitals currently own insurance companies, and the number is growing. While Hudson stands to gain the most with this option, downsides of full integration include cost, risk assumption and lack of enough familiarity with the insurance business to be able to compete with established payors like BC/BS.

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1. **STRATEGY&,** *Several Hundred Health Networks will become Payors,* 2013, available at http://www.strategyand.pwc.com/media/file/Strategyand_Health-Networks-Become-Payors.pdf

The three options above represent different points along a spectrum of integration (See Figure 1). Ultimately, the further Hudson moves to the right on the integration spectrum, the more financially accountable it will be for patient health. Integration poses a great opportunity for Hudson to control and manage all of the premium dollars. Integration will also allow Hudson to invest and maintain independent financial stability rather relying on payors who implement unfavorable reimbursement terms. H&T further believes that a Hudson insurance product will promote patient loyalty and will prevent its already strong consumer base from eroding.

**Figure 1. Spectrum of Integration**

II. Scope of Representation

Hudson has retained H&T to address the business, legal and strategic advantages and disadvantages of expanding Hudson’s line of business into the insurance market. A natural tension exists between health providers and payors – providers make money by delivering care, and payors make money by reimbursing providers as cheaply as possible. Removing this dichotomy and collaborating towards a common goal is not only a potentially lucrative business step, but may be necessary to survive sharp industry changes. Therefore, H&T has identified
three viable strategies for entering the insurance market. Hudson must determine how far along the integration spectrum it desires to plunge.

In this memo, H&T will examine market and industry trends impacting the Pearson area and will form its recommendations based upon these movements. H&T’s strategic transaction recommendations arise in the context of the two major trends: (1) declining reimbursement with emphasis on value over volume, and (2) narrowing provider networks.

III. Insurance Industry Background

The first trend H&T has identified is declining reimbursement and move toward value-based payment. The PPACA has placed significant funding pressures on government spending for Medicare and Medicaid in an effort to combat the steeply rising cost of health care.³ Commercial payors are also facing these same pressures and have responded by lowering reimbursement rates, draining provider budgets with few resources and options to provide “greater care at lower cost” to consumers.

However, the PPACA also provides new mechanisms to emphasize value over volume, such as ACOs, where providers who manage patient care more effectively and efficiently stand to share in cost savings arising from the same. Hudson already combats declining reimbursement rates through its ACO and its efforts to coordinate care for patients, yet it is unclear how successful its efforts have been thus far. In terms of moving towards value-based care, Hudson has the advantage of a large multi-specialty physician network in the Hudson Physician Group,⁴ a home health agency, as well as several outpatient primary care clinics. If

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⁴ H&T assumes that Hudson Physician Group-affiliated physicians are employees of Hudson.
Hudson is not already tracking data and coordinating patient care across the entire spectrum of care for its patients, it is poised to do so almost immediately.

Hudson’s integrated delivery system could capture financial and steerage benefits as well as a better clinical experience for patients. Further, moving into the insurance industry can allow Hudson to have more control over the entire continuum of care, and to get ahead of declining reimbursement rates. Hudson also has the opportunity to keep patients within its robust care network, and focus efforts on building the right technology to capitalize off of payor integration efforts. Ultimately, Hudson’s mission of providing quality care for patients is what is at stake if Hudson does not adapt to the changing market.

The second insurance industry trend H&T identified is the narrowing of provider networks in payor arrangements. The PPACA has expanded access to health care through the individual mandate and other accompanying mechanisms to make health insurance coverage both mandatory and more affordable for consumers.\(^5\) Regardless, with health insurance premiums growing by 8 to 10 percent annually, and employer-offered plans increasingly shifting health plan costs onto employees, health care consumers are increasingly seeking less expensive options.\(^6\) In response to growing premiums, many payors have begun offering “narrow network” insurance plans which provide employers and consumers with lower premium payments in exchange for access to a more restricted network of hospitals and physicians.

Reducing the breadth of patient choice to a more exclusive set of providers is emerging as a popular method for payors to bring down costs. This concept is not new; many hospital-run

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\(^5\) The constitutionality of the PPACA’s individual mandate was upheld by the Supreme Court in National Federation of Independent Business v. Sebelius, 567 U.S. ____ (2012). King v. Burwell, a case regarding insurance subsidies on the exchanges, is set for argument in front of the Supreme Court on March 4, 2015. The outcome of this case could possibly change the projected breadth of expansion of insurance coverage.

\(^6\) Cliff, *supra* note 2.
health plans folded in the mid-1990s following the “HMO movement,” when patients revolted against the bureaucracy and the special authorizations necessary to see a specialist or go outside the network. Due to growing health care costs, many national-scale payors such as Aetna, Cigna and UnitedHealth Group are exploring the narrow network concept again.

While the HMO movement was largely a failure in the 1990s due to rising costs and consumer frustration, H&T believes the current narrow network movement is different and will not meet the same demise. The previous HMO movement propagated models that paid providers a predetermined amount and required all care to be administered within a fixed budget. Current narrow networks offer more flexibility in terms of physician compensation, including pay-for-performance mechanisms. While consumers may have less choice in terms of providers, they will benefit from lower out-of-pocket costs and greater care coordination and efficiency due to the availability and utilization of electronic health records (“EHRs”) to chart patient health and pinpoint specific care needs. The new iteration of the narrow network will offer a more efficient and coordinated-care experience for both the patient and provider.

Narrow networks focus on keeping care “in the community” and represent a divergent path from current industry trends focused upon mergers and acquisitions aimed solely at enlarging a health system’s “geographic footprint.” H&T believes Hudson can benefit from participating in a narrow network as it moves towards a more integrated payor role, especially given that Hudson is interested in better serving the needs of people in the Pearson community. Narrow networks tightly maintain costs, and incentivize enrollees to receive care only from in-network providers, with significantly higher deductibles and copays applied to out-of-network
Narrow networks also enable providers to capitalize on the provision of quality care; since enrollees receive their care exclusively from network providers, costs associated with duplicative or unnecessary procedures can be minimized and presents an opportunity for Hudson to increase the value of its health care dollars.

While federal health law requires insurance policies to include a standard set of “essential benefits” in an insurance product, it is less prescriptive about the size of a policy’s network of participating doctors and hospitals. Hudson therefore has some flexibility in designing the product it will offer on the market. However, the insurance product offered must meet minimum network adequacy standards mandated by PPACA if the insurance product is to be sold on the exchange. In addition to PPACA requirements, the National Association of Insurance Commissioners (“NAIC”) has also weighed in on network adequacy and its proscriptions should be kept in mind when designing an adequate insurance product and network.

Because narrow network plans obtain deep discounts from health systems, those systems must be able to control utilization costs, quality, and ultimate outcomes. To achieve such control, health systems must be tightly integrated and have its systems aligned, especially when it comes to physicians; physicians must be willing to work cooperatively within the network and not refer out of it. In addition, the health systems must have an adequate distribution system

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10 Kaufman, supra note 7.
11 Id.
and possess the capabilities to offer care sufficient to cover the defined geographic region where the network intends to target potential consumers—both individual and group purchasers.\textsuperscript{12}

IV. Strategic Options for Hudson

After reviewing Hudson’s position and the current payor mix in the Pearson and surrounding metropolitan area market, H&T believes Hudson should consider pursuing one of the following transactional options to implement its desired insurance product: (1) Renegotiate Existing Contracts to Include Greater Risk Sharing, (2) Pursue a Collaborative Relationship with an Existing Payor (Joint Venture), and (3) Acquire or Create a Wholly-Owned Insurance Subsidiary.

(IV)(a) Option 1: Renegotiate Existing Contracts to Include Greater Risk-Sharing

Hudson already has a relationship with payors in the market, along with experience running a clinically integrated network through an ACO. Hudson can leverage this experience to negotiate greater risk-based contracting arrangements with payors, and shift to performance-based compensation for providers. This involves negotiating payment arrangements with payors wherein Hudson and its affiliated entities would be responsible for delivering defined services to a specific population at a predetermined price and quality level. The arrangements would largely be fee-for-service based, but with Hudson assuming more financial risk for providing care. One example would be negotiating bundled arrangements with payors, where Hudson receives a fixed amount for providing defined services required by a patient during an entire episode of care (i.e., joint replacements and coronary bypasses).\textsuperscript{13}

Success in risk-based contracting comes down to (1) sophisticated information technology and data management, and (2) contract planning and management. Under the

\textsuperscript{12} Id.
Medicare Shared Savings Program, the federal government sets quality measures and performance standards for providers participating in ACO arrangements.\textsuperscript{14} Presumably, Hudson physicians are already familiar with these measurements. However, with 33 quality measures and reporting requirements, and various other measures imposed by private payors in similar risk-sharing arrangements, physicians may not be sold that risk-based contracting is the most efficient way to transition for a fee-for-service environment. In fact, hospitals have already expressed the sentiment that they are not seeing much upside in the ACO risk-sharing model.\textsuperscript{15} Ultimately, if Hudson renegotiates payor contracts to include greater risk-sharing, Hudson still does not have direct access to consumers.

Further, H&T identified another strategy on the lower side of the integration scale that can move forward almost immediately, within any of the following recommendations. If it is not already doing so, Hudson should work to get more patients enrolled in Medicaid so they can lower unreimbursed care. A health care system with a vested interest in the surrounding community, such as Hudson, could bolster its presence in the community by outreach and educating patients on the new coverage opportunities, while at the same time decreasing uncompensated care losses.\textsuperscript{16} H&T believes this practice would not run afoul of fraud and abuse laws as long as there is no fraudulent intent or patient inducement to use Hudson facilities.

(IV)(b) Pre-Transaction Considerations

The following considerations apply to H&T’s final two recommendations for Hudson, centered around integrating with payor partners. While there are numerous issues Hudson must


\textsuperscript{15} Cliff, supra note 2.

consider before entering into any type of transaction with another party, H&T believes there are four critical issues which Hudson must give special consideration. As market forces continue to require health systems to modify their operations, consideration of these four issues will be key in determining whether or not Hudson should pursue a collaborative relationship, when to pursue, and how that relationship will be structured.

(b)(1) Issue 1: Mission and Goals

Hudson is a non-profit, tax-exempt organization. As such, Hudson carries with it a 501(c)(3) designation. Hudson must be cautious with whom it considers partnering; Hudson’s 501(c)(3) cannot be compromised. Any transaction Hudson participates in must operate in a manner that furthers Hudson’s charitable purpose. This does not mean Hudson cannot partner with a for-profit entity; it simply means that whomever partners with Hudson must be willing to cooperate and align its mission with Hudson’s overall charitable mission.

(b)(2) Issue 2: Level of Integration

Hudson must determine what level of integration it is comfortable establishing with a potential partner. Both parties should identify the objective of the relationship and what level of integration is appropriate to accomplish those objectives. Regardless of the transactional structure, both parties must be willing and comfortable to cede a certain amount of control to accommodate the transaction. Further, Hudson must consider what level of structural and/or operational integration is appropriate for its business objectives and financial bottom-line.

(b)(3) Issue 3: Resources and Risk Sharing

The success of any transaction will depend on each party’s willingness to dedicate time, expertise and financial capital. Hudson should only engage in a transaction with an entity that will complement its current assets and financials strengths. An entity with a strong pre-existing
internal infrastructure pre-designed to deliver insurance products to large populations will be most advantageous to Hudson. Strong assets in information technology and underwriting capabilities will also be important in the delivery of an insurance product. In addition, any potential transactional partner must be financially capable of absorbing its own financial risk.

(b)(4) Issue 4: Market Response

Hudson should also consider the potential market response that any collaborative venture or acquisition may have upon the Pearson market. Market response should be evaluated in both a general and service-specific context (e.g., acute care vs. skilled nursing facility). While Hudson is considered the market leader in Pearson and independently possesses a strong reputation, it remains unclear how the Pearson market-competitors would respond to a Hudson-insurance product, especially on the payor side of the market. Ultimately, Hudson may not have the scale required to rely solely upon its own insurance product for sufficient revenue; therefore, Hudson must continue to accept competing insurance products to remain financially viable.

(IV)(c) Option 2: Joint Venture to Deliver Hudson Branded Insurance Product

Joint ventures between health systems and payors have become an increasingly popular trend in the industry. Due to rapid industry change, payors and health systems are seeking out new business relationships that help both parties deliver quality, low-cost care to consumers. A joint venture is often an attractive model because it allows separate entities to combine resources in pursuit of a common business goal, yet retain their own independent identities.

Typically, participants pool capital and resources related to their venture to form a new entity to carry out the purpose of the joint venture. This new entity is typically operated either as an LLC or in a general or limited partnership form. While the participants surrender certain managerial functions and powers to that new entity, they still retain their own individual board,
system and identities. These agreements permit collaboration without sacrificing individual operational independence. The level of integration and control exerted by the joint venture varies depending on the participant’s goals; some agreements may require parties to operate as if they have actually merged while other agreements are more limited and only involve partial integration of certain operations.

Unsurprisingly, the PPACA is responsible, at least in part, for incentivizing payors to pursue this collaboration model. Most notably, the medical loss ratio (“MLR”) requirement under the PPACA, mandates payors spend 80%-85% of the premium that they receive on medical benefits or quality improvement expenditures; if payors fail to meet this requirement, they must rebate excess premiums to consumers.17 The cap on payor premium retention has motivated many payors to play a more significant role in the delivery of health care and transform their role from that of payor, to that of a “wellness company.”18 Combining resources and aligning interests with a leading health system such as Hudson through a collaborative venture will be an attractive option to many payors.

H&T therefore presents the option of a joint venture collaboration between Hudson and an existing payor in the Pearson market. Through the venture, Hudson and its partner would combine capital and resources to create a new entity to facilitate the offering of a Hudson-branded insurance product that utilizes Hudson providers and the Hudson network. Modeled after the Aetna and Inova joint venture formed in 2012, a proposed structure would take the following form (See Figure 2 on following page).

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This ancillary joint venture would be structurally and legally beneficial to Hudson for several reasons. First, with certain structural elements put into place, Hudson will be able preserve its 501(c)(3) status regardless of the type of entity (non-profit v. for-profit) with whom it partners. Hudson may share 50/50 ownership and governance of an ancillary joint venture with a for-profit entity without jeopardizing its exempt status and without incurring any unrelated business income tax (“UBIT”) on its share of income from the joint venture, so long as the activity conducted by the venture is conducted in a manner that contributes importantly to Hudson’s exempt purpose and only incidentally for the benefit of the for-profit member.\textsuperscript{19}

Because the venture’s activities will be imputed to Hudson, it is important that the entity’s organizational purpose explicitly denotes the promotion of Hudson’s charitable, tax-exempt purpose. In addition, Hudson must exercise sufficient control over the operation of the venture so it will not be viewed as a “passive investor” which could jeopardize its tax exempt-status.

Another benefit is the minimal antitrust risk the venture poses. Vertical joint ventures typically attract less scrutiny and raise fewer antitrust issues than horizontal collaborations between competitors. Because vertical joint ventures involve entities at different levels of competition there are few, if any, competitive overlapping issues that will arise. Because of this, vertical joint ventures are less likely to create, increase or facilitate the exercise of market power the could foreclose market entry by third parties, drawing antitrust scrutiny. However, the parties must be sure to implement appropriate safeguards to prevent improper exchanges of competitively sensitive information unrelated to the collaboration to avoid any allegations of collusive activity.

Aside from legal considerations there are also several strategic issues Hudson must weigh when selecting a joint venture participant. For example, partnering with BC/BS could be beneficial because of its predominant presence in the Pearson market, its strong brand reputation and its proven ability to deliver an insurance product to a large population. However, that predominant presence could also become a conflict as BC/BS may choose to devote less time and effort to a Hudson insurance product in a market it already dominates. Hudson may find a

20 PROSKAUER ROSE, supra note 19.
more appealing partner in a payor with a smaller market presence, who may be looking to gain a foothold in the Pearson insurance market.

Although Hudson has prior experience in the delivery of a health insurance, Hudson does not have experience insuring a population broader than its current employee base. Collaborating with an existing payor will allow Hudson to combine its expertise in the delivery of health care with a payor who has expertise in underwriting, financing, administering and delivering a final insurance product within the regulatory bounds of the broader insurance industry. Collaboration with an existing payor provides strategic benefits for both parties. Hudson and its partner both gain an opportunity to more efficiently manage population health, coordinate care on a larger scale, closely monitor and track patient health, and increase information exchange between physicians across Hudson’s continuum of care. Combined participation in the management of population health by payor and provider will eventually create more predictable health outcomes and translate into overall cost savings.\(^{23}\)

(IV)(d) Option 3: Wholly Owned Insurance Subsidiary

Having its own insurance subsidiary exposes Hudson to the greatest risk, but also positions Hudson to achieve the greatest rewards in entering the insurance market. This corporate structure can be achieved through either acquisition or creation of an insurance company. While several of the drawbacks and advantages of these two options are identical, each option presents unique challenges and benefits. This memo first discusses the drawbacks and advantages common to both options, followed by an analysis of the unique issues presented by each option.

Unlike self-insurance, the regulation of which is predominantly preempted by the 1974 Employee Retirement Income Security Act (“ERISA”), payors are regulated at the state level.

Perhaps most pertinent in this consideration of Loyola’s laws is the significant capital and surplus requirement. This requirement protects enrollees, assuring that their payor will have sufficient funds to cover medical expenses. Practically, compliance locks up a considerable amount of Hudson’s assets, and limits risky endeavors through assessments of risk-based capital. Even if Hudson chooses to acquire an existing payor, any existing capital reserves that are transferred will certainly be factored into the transaction price, costing Hudson in one way or another. In a time of rapid technological development and market pressure to maintain state of the art facilities and IT infrastructure, the requirement to amass these capital reserves withdraws funding and restricts other critical capital projects. Hudson, then, must weigh the potential advantages of offering insurance to the public against its other strategic and innovative plans that require access to this capital. Nonetheless, Hudson is already a distinguished industry leader, and is already self-insured; the balance of needing capital for new projects versus needing capital for insurance may tip in favor of the insurance product.

Another consideration to be weighed is potential antitrust violation. Hudson must ensure that its size and actions remain pro-competitive, or that the pro-competitive advantages of a plan outweigh any anticompetitive effects. However, an antitrust analysis of an amalgamative transaction between Hudson and a payor, or of an organic expansion of Hudson into the insurance market, poses a different question than that raised by a joint venture. Because a wholly owned subsidiary and its parent corporation are a single economic unit, there is no possibility of collusion for Sherman Act §1 violation. The analysis, then, is one of monopoly power. Given the diverse payor mix in the Pearson market, with seven participants each enjoying between three and twenty-one percent of the market, Hudson’s market share will be far from monopolistic.
Two other significant drawbacks of Hudson having its own insurance product relate to risk bearing and administration. Risk forecasting interfaces with administrative experience in the process of setting premium rates. This poses a barrier to entry into the insurance market; if premiums are too high, individuals and employers will not opt for the product, whereas if the premiums are too low, Hudson risks not being able to cover its own costs. Because Hudson is already self-insured, it likely already understands the process of underwriting, and is adept at bearing risk. Hudson likely has already substantially overcome this barrier because of its familiarity with self-insurance. Still, if Hudson is currently utilizing stop-loss insurance through its third party administrator ("TPA"), shifting away from such a safety net may require considerable analysis.

The conundrum of marketing a competitive insurance product is further complicated by network appeal. As alluded to in Section III infra, Hudson has strong incentive to limit its network to eliminate "patient bleed" and manage quality along the continuum of care. Narrower networks also reduce expenses, which pass on to the consumer as lower premium prices. This strengthens the product’s marketability to potential enrollees. However, narrow networks limit the options of enrollees, and individuals shopping for insurance products are likely to eliminate networks that do not include preferred or esteemed providers.

While setting the premium and bearing risk pose challenges, they position Hudson to capitalize on efficiencies and quality of care. Economically, the most efficient way to benefit from increased efficiencies is to insure risk. In a subsidiary model, Hudson obtains premiums directly from the insured, establishing its own risk pool. This has the potential to benefit Hudson for the same reason that it is risky: because Hudson is the only party responsible for the risk. While downside risk could prove perilous, the upside benefit does not have to be shared. If
Hudson can provide care at a cost below the premiums it charges, then Hudson – not a third party – keeps the difference. This is distinguishable from shared savings models of reimbursement because the savings are not shared. Hudson keeps it all. Also, given the profit caps initiated by the PPACA, a payor that is integrated with the providers can operate with a larger medical loss ratio, since payment of claims goes to an affiliated organization.\(^\text{24}\)

This, of course, is a radical departure from the incentive alignment established by a fee-for-service reimbursement model. While many systems may be ill-equipped to make such dramatic changes, Hudson’s recognized quality, local footprint, and experience with ACO reimbursement structures make it a strong candidate to benefit from owning its own insurance company. Unlike fee-for-service models, a provider system that is integrated with a payor covers its costs of care with the entire premium dollar. The source of revenue is not payments received from billed services, but premiums. Revenue, then, is not dependent on quantity of services provided, but is a function of lives covered by the insurance plan. In this model, a provider like Hudson that 1) is providing quality care, 2) is capable of coordinating care, and 3) has enough physical locations and range of services to encompass the entire continuum of care, can benefit from keeping enrollees healthy. Of course, Hudson is best positioned to coordinate with its enrollees to keep them healthy and out of the hospital, especially with regards to preventative services, behavioral health, and management of chronic conditions.

In this regard, the benefits of integration are largely dependent on integrated management of the two systems. An insurance subsidiary should not operate independently from the health system, since the two are symbiotic. An effective management structure, then, ensures

\(^{24}\) See, e.g., OREGON DEP’T OF CONSUMER & BUS. SERV’S, Health Insurance in Oregon, 26 (January 2010) (Comparison of top seven insurer’s medical loss ratio averages from 2004-09 shows Kaiser at 94-96%, while other insurers operate in the eighties).
communication and coordination of functions between the systems. H&T recommends a structure whereby the CEO of the insurance subsidiary reports directly to the CEO of Hudson. This chain of command and coordination can be simulated by all executives of the respective entities.

While Hudson will face significant administrative expenses in operating a subsidiary insurance company, the scale will enable net benefits. Hudson benefits from net reduced overhead expenses, a result of bringing the insurance company under the same administrative framework as Hudson. Hudson can share certain expenses with the insurance company. Common departments of human resources, accounting, and information technology systems can serve both entities while respecting the separation of entities. The shared costs result in less expenses than if the two entities were independently operated.

Notably, an insurance product offered by Hudson would not preclude Hudson from accepting reimbursements from other payors (See Figure 3 below). Hudson would continue to contract with Medicare, Medicaid, and other private pay payors. Maintaining relationships with commercial payors,
which tend to offer reimbursement rates above the cost of care, is critical to maintaining sufficient revenues to continue Hudson’s charitable mission of providing affordable, high-quality health care.

While Hudson stands to benefit from managing the entire premium dollar on enrollees in its own product, the system will continue to negotiate rates and receive reimbursements from other payors. As Hudson’s insurance product grows and comprises more of Hudson’s payor mix, the efficiencies of aligned incentives will increase. Note also that this corporate structure does not preclude alternative options, such as contractual arrangements with third party payors for shared savings and bundled payments.

However, negotiating with these private payors may be complicated by the fact that Hudson will be in direct competition with them. Hudson’s entry into the public insurance market may tarnish longstanding relationships with reputable payors like BC/BS. Hudson may consider probing the potential for continued relationships upfront, before it launches into competition with its sources of revenue.

If Hudson chooses to operate its own insurance company, the company should operate as a distinct entity from Hudson. The importance of this distinction is twofold. First, the separation of entities shields Hudson Health Systems from liabilities arising from its insurance operations. Short of piercing the corporate veil, liabilities will be limited to the assets contained in the insurance entity. Second, the separation will provide some ease for navigating regulatory and compliance issues as the entities straddle two distinct, legally complex bodies of law. In addition to separating the insurance operations from the health care operations for state regulatory
compliance, separation of entities defends Hudson’s 501(c)(3) status, thus ensuring the system’s tax-exempt status independent of the insurance company’s status.

The tax status of separately incorporated entities depends on the entity’s own merits.\textsuperscript{25} Insurance entities, much like hospitals, can operate for profit or as tax exempt not-for-profits. Notably, tax-exempt status will require Hudson to focus its insurance product on insuring the indigent and uninsured. Insuring the indigent and uninsured will drive up premiums to spread the cost of care, and may even preclude Hudson from the market, since its product will not compete with more affordable plans that give access to a broader network. Operation as a not-for-profit also precludes Hudson from accepting capital investments, which will require the payor to maintain a larger surplus. Nonetheless, many large successful payors are tax-exempt, not-for-profit entities.

Also, Hudson’s not-for-profit status will not be ‘infected’ by a subsidiary for-profit corporation. The corporate entity doctrine treats distinct entities as separate inasmuch as corporate formalities are respected. It is important, then, for an insurance subsidiary to have a distinct board of directors with distinct meetings and minutes. Equally important is separate accounting and allocation of costs and income, especially to prove that no earnings of the not-for-profit enterprise inure to the benefit of the for profit enterprise (or any individual).

Hudson may consider acquiring a commercial payor as a subsidiary organization to the System. This would provide Hudson with the benefits and risks of managing premiums, and ease of market entry as it piggybacks on a payor’s experience and human as well as capital resources. However, such acquisitions are costly, and Hudson’s options will be limited to willing partners.

By acquiring an experienced payor, Hudson can capitalize on the underwriting experience of the functioning payor rather than relying on its own limited experience of self-
insuring. Drawing on the experience and resources of the existing payor enables Hudson to immediately offer an insurance product that is attractive to consumers, and functions with an appropriate medical loss ratio. An acquisition can also ease market entry by a gradual shift in branding from a trusted, known product (e.g. BC/BS) to the name of Hudson, an unknown name in the insurance market. This garners the trust of consumers, and guarantees Hudson a portion of the market.

Acquiring an existing organization also minimizes potential damage to revenue streams caused by hostile competition. As alluded to, entering into direct competition with other payors may harm Hudson’s relationships with reliable payors. However, by acquiring one of these reliable payors, Hudson can capture that stream of revenue and ensure its health system is not excluded from that network. While Hudson may still face exclusion from other networks that are hostile to Hudson’s entry into the public insurance market, acquiring an existing health plan allows Hudson to participate in at least some share of the market, as opposed to relying on its own patient base to cover costs and sufficiently utilize facilities.

However, acquiring an insurance subsidiary will be costly to Hudson. If the target entity is a not for profit entity, the transaction may be structured as a cash sale of assets (with the proceeds likely benefiting a foundation or other tax exempt cause), or as a membership substitution (with a likely capital commitment). A for-profit target, however, may also be acquired through a stock purchase.

With sufficient funds to acquire an existing entity, Hudson still faces the challenge of finding a willing and suitable partner. While the tax status of the target will not “infect” that of Hudson (as noted previously), the tax status will likely be an important factor in considering a partner, and may limit the options. Other considerations include compatibility of mission and
values, management structure and philosophy, sufficiency of due diligence review, and business success. Also, acquisitions generally require consent of both parties (with the exception of hostile stock acquisitions). Even if Hudson finds its ideal partner, it risks unwillingness from the target to consummate the transaction. Finally, acquiring an entity may limit Hudson’s control of its subsidiary, at least for the first few years while the board and executive positions turnover. Hudson may face diplomacy challenges in communicating its mission and goals to senior executives of the payor.

While Hudson seeks a potential partner with which to enter the insurance market, beginning Hudson’s own insurance subsidiary may be a viable backup option. Other hospital systems have embraced this strategy when attempts to partner with insurance companies failed. Starting from scratch gives Hudson more flexibility and freedom to structure particular plans as it sees fit, without the shared opinions of others and without the necessity of negotiation. This may be the only option that gives Hudson full control of a subsidiary insurance company if no potential partners can be found.

The significant drawback to Hudson in creating its own insurance would be administrative processes and expenses. Because Hudson currently outsources much of the administrative processes – such as membership, claims processing, etc. – to a TPA, establishing its own insurance subsidiary would necessitate an overhaul. Because this is entirely new for Hudson, the growth would likely be slower and more cumbersome than if Hudson were to acquire or partner with an existing payor.

V. Durable Medical Equipment Supplier Relationship with Home Health Care

26 Cliff, supra note 2. (Noting that the partnership between Piedmont and WellStar in Atlanta, GA spawned from failed attempts to partner with health insurance plans).
The predominant issue surrounding any prospective relationship with Home Care Plus ("HCP") will center around Hudson’s recommendation/referral policy for durable medical equipment ("DME") suppliers to its patients. While antitrust laws do not prohibit a health system from utilizing its own affiliated company, the process in which referrals and recommendations are made will make the difference between a successful referral and an expensive antitrust suit. Any policy that blatantly restricts patient choice or forecloses competition in the DME market could invite antitrust litigation.

From a risk-management perspective, implementing clear policy guidelines over the DME referral process will be essential in rebutting allegations of anticompetitive conduct. The referral policy should affirmatively state that patient choice predominates over all other concerns. In cases where a patient may not have a preference, a statement disclosing the affiliation should be disclosed to the patient and upon request, the provider should give the patient information regarding alternative options to the Hudson-affiliated DME supplier. For example, courts have declined to find antitrust liability where hospital personnel have honored patient choice expressed in a referral policy and upon request, supplied the names and telephone references of competitors to the patient. In absence of any showing of increased price, reduction in supply or decrease in quality, courts have found that simply encouraging, but not

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27 Mark L. Mattioli, “Does a Hospital Have a Duty to Cooperate with Downstream Providers?, AMERICAN HEALTH LAWYERS ASSOCIATION, Member Briefing, June 2008, available at https://www.healthlawyers.org/Archive/PG/Member_Briefings/Antitrust%20%20Member%20Briefings%20Does%20a%20Hospital%20Have%20a%20Duty%20to%20Cooperate%20with%20Downstream%20Providers,%20June%202008.pdf

28 Id.

forcing patients to choose one home health care agency over another does not in and of itself, make out an injury to competition.\(^{30}\)

Hudson must keep in mind the potential risk for violations under the Anti-Kickback Statute (“AKS”) and even the False Claims Act that could occur based on its relationship with HCP. DME supplier relationships are a frequent target of government investigations and any affiliation between Hudson and HCP should be modeled as closely as possible to an applicable AKS safe harbor exception. Hudson could pursue (1) the safe harbor exception for small investments by entering a joint venture with HCP pursuant to the harbors requirements, (2) a contractual arrangement whereby HCP provides items for Hudson’s inpatient use provided that HCP not bill Medicare or Medicaid for such services, or (3) pursue a supplier convenience and consignment closet arrangement pursuant to the safe harbor exception.\(^{31}\)

VI. Due Diligence And Regulatory Considerations

As insurance is mostly a state-regulated industry (PPACA considerations aside), Hudson must comply with the state of Loyola’s regulatory and state licensing guidelines in terms of its final insurance product offering. These guidelines typically cover areas affecting minimum capitalization requirements, underwriting practices, rating methodology, advertising, marketing, rescission of coverage and payment of claims. Because Hudson is seeking a payor partner, there are other special considerations Hudson must consider throughout the process, such as detailed analysis of current patient enrollees and complaints, accuracy and timely payment of claims, and

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\(^{30}\) Home Health Specialists v. Liberty Health Sys., 1994 U.S. Dist. LESIX 11947, 15 (E.D. Pa. Aug. 23, 1994) Although this ruling relates to home health care and not DME, it applies a similar line of reasoning that could apply in the DME-health system context.

financial accounting. H&T will shepherd Hudson through these regulations as a final determination is made as to Hudson’s insurance presence.

Before transacting with any entity, an exhaustive due diligence process must be performed. Because the due diligence process is a two-way street both parties will be expected to disclose information to one another to effectuate the proposed transaction. Prior to disclosing any documents or information, Hudson should execute a confidentiality agreement to protect information disclosed by itself and by the other party. Hudson should also consider incorporating a “no-shop clause” if a definitive agreement is reached to prevent the acquisition target from “shopping” during the due diligence and negotiation process. Information gathered during the due diligence process will assist Hudson in identifying risks inherent in the acquisition process.

Because Hudson is a non-profit, tax-exempt organization it should also consider obtaining an independent fairness opinion. A fairness opinion is a professional evaluation as to whether the terms of a transaction are fair from a financial standpoint. Obtaining this opinion aids in demonstrating the board has complied with its fiduciary duties in negotiating the transaction and that the transaction is fair to the community and will not place Hudson’s 501(c)(3) status at risk. Hudson should also seek an independent, professional valuation opinion to ensure the transaction is carried out at fair market value.

The due diligence process will form the basis of the relationship between H&T as counsel and Hudson as client throughout the transaction process, and will be the bulk of H&T’s work moving forward. That said, one legal issue that H&T believes will form the basis of due diligence with a payor partner is assessing compliance with the HIPAA Security Rule and HITECH compliance. The future success of the acquisition depends on cohesive care coordination efforts and accompanying patient data sharing; assessing the level of risk and
potential liabilities in this area will be key to Hudson’s future success. Therefore, H&T will work with Hudson to request and analyze information to ensure any acquisition target has implemented procedures regarding information security - including audit logs, access reports and security incident tracking.\footnote{42 C.F.R. 164.} H&T also presents the following items as a roadmap of the due diligence process:

**General Corporate Matters:**
- Board Minutes/Major operating committees for the last 5 years
- Articles of Incorporation Bylaws/Amendments
- Detailed organizational & Operational chart
- Mission/Vision/Purpose Statement
- Internal Governance policies eg: conflict of interest

**Financial Disclosures:**
- Audited financial statements for at least the past 5 years
- Forecasted Financial Performance/Future Trends for next 3-5 years
- Annual volume of Insureds/Consumers
- Market Presence; Demographic Data
- Summary of Known Liabilities
- Other Unrecorded Liabilities or Off Balance Sheet Liabilities
- Summary of Medicare and Medicaid Cost Reports; Program Reimbursement Summaries

**Compliance and Regulatory Disclosures:**
- State Insurance License
- State Accreditations
- Disclosure of Any Past or Pending Governmental Investigations (Federal or State)
- Copy of Correspondence with Regulatory Authorities (State Agencies, CMS, Medicare Intermediaries for past 5 years)

**Contracts:**
- Existing Contracts of Any Kind, Including Those Under Default;
- Descriptions of Other Partnerships/Alliances and Entity Identification (non-profit/exempt v. for-profit)
- Contracts with any TPA
- Contracts and Documents Regarding Arrangements with Marketing Agents, other Contracting Entities

**Employees:**
- Compensation Agreements
- Summary of all Employment Lawsuits of Any Kind for Previous 5 years
- Employee Policies & Procedures
- Collective Bargaining Agreements
- Labor Union Affiliations
- Employee Benefits

**Information Technology:**
VII. Final Recommendation and Conclusion

While each of the three presented options enable Hudson to benefit from increased risk-sharing and incentive alignments with quality of care, H&T believes that Hudson is sufficiently integrated along the entire continuum of care to offer its own insurance product through acquisition of an existing health plan. Hudson’s market share, availability of facilities throughout the region, and recognized quality and patient satisfaction make Hudson a desirable network for any health plan. The system’s financial strength and quality should enable both the purchase of an existing health plan and the surplus requirements for operating an insurance plan. Hudson’s diversity of care along the continuum of care, from its multispecialty physician group, to its skilled nursing facilities, acute care hospitals, outpatient primary care clinics, and home health agency enable the system to manage costs and ensure quality and coordination of care. Further, Hudson’s EHR interoperability and ability to coordinate care is demonstrated through its participation in the ACO program. In the midst of health care reform, diversification of Hudson’s portfolio by entry into the insurance market best positions Hudson to benefit from restructured payment systems, and defends against increasing pressures on margins from regulators and insurance plans.