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Valuation of Health Business for Mergers and Acquisitions (M&As)

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Summary: As nonprofit health insuring organizations convert from nonprofit to for-profit status, and with the flurry of health maintenance organization (HMO) M&A activity in the past year, the valuation of health insurance lines of business has become increasingly visible to the public eye. In this session, panelists address actuarial techniques used to measure "value" and the issues surrounding such valuation.

Mr. Timothy F. Harris: For a while, there were consolidations primarily in the indemnity area. Now, a lot more is happening in the managed health care area, and some combinations are involving some organizations that were previously thought to be untouchable. Also, combinations with Blues and other organizations can create problems in the area of equity.

We have three panelists who are experts in this area. Bob Dobson is a consulting actuary with Milliman and Robertson in Tampa. I'm also with Milliman and Robertson in St. Louis, and I've done quite a bit in the health care merger and acquisition area myself. As I said, Bob is in our Tampa office, and he has been involved in many and I've seen his resumé because we've worked together on some proposals—M&As of managed health and indemnity-health-related organizations. He will talk a little bit about the nuts and bolts of the actual process that actuaries go through when helping clients or employers on appraisal assignments.

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Mr. Robert H. Dobson: As Jim said, a lot of activity is going on in this area. One of the things that I think is interesting about this panel is that we have a regulative representative, Mr. Fickes; we have a for-profit company representative, Mr. Nelson; and we have a consulting actuary, which is me.

In any event, one of the things you should know is that a lot of M&As that get announced don't actually come to pass. I've been involved in at least one of those and I want to read a couple of headlines to you about the types of people who get involved in reviewing planned M&As, and why some of these don't come to pass. Here's one headline that Jerry Fickes is involved in, and we'll perhaps talk about it: "National Association of Insurance Commissioners (NAIC) Committee to Analyze Insurer Restructuring Activities Including Those of HMOs, Mutual Insurers, Nonprofits, Public and Mutual Benefit Corporations." Another headline reads "State Attorney General Adopts Proposal on Nonprofits." Another is "Legal Regulatory Hurdles Spoil New Jersey/Delaware Blues Merger." These deals don't always go through, and the reasons they don't always go through often have to do with regulatory issues. Other issues are often present as well, but it means that as you go through a merger or acquisition, you always need to keep your options open. Don't assume that it will go through and that it's necessarily going to happen.

Some of you may have been at the Colorado Springs meeting. We had a session such as this, and I did some role-playing. I played the "Rich Old Guy," the chairman of the board who was trying to push through a merger on behalf of his company. It was going to perhaps help him financially, but there were other good reasons to do the merger. It turned out that because of the regulator disapproving the merger and the for-profit entity that was going to be involved in the purchase pulling out, the deal didn't go through. I'm back this time, no longer the "Rich, Old Guy" but "Old, Poor Guy," trying to make a living as a consultant. I'm now forced to talk about the nuts and bolts of doing appraisals instead of having to do real work.

Actually, the comments we received on that Colorado Springs meeting were somewhat favorable overall, but many people commented that they wanted to know more about the actual appraisal activities, what detail was needed to go into it, and what you needed to go through. I'm going to cover that, but I'm going to do this fairly quickly because I do want to allow time for both the other speakers and for some questions and answers.

Of the three areas that I will cover, first and foremost is doing an actuarial appraisal, and that's what I will talk about the most. Second is reading the report because I think the report is a critical part of an appraisal, and people should pay more

attention to the content of the report. Third, I will comment on the definition of market value as opposed to an actuarial appraisal value.

When doing an appraisal, the steps you have to go through are as follows. First you have to build a model, you have to choose many assumptions, and as consultants we find writing the report ends up taking perhaps a disproportionate amount of time, much more time than we ever think. But I think that the report is a very valuable tool and that people reviewing the M&A, either because they're either potential buyers or regulators, really have to pay more attention to the content of the report. In terms of market value, I think everybody has been through the process of selling or buying a house. You know you can get an appraisal for a particular amount, but that doesn't mean you can sell it for that amount. I want to comment briefly on appraisals, but first we'll talk about actually doing the actuarial appraisal.

One document that I found very interesting is the *Actuarial Standard of Practice (ASOP) No. 19*; its subject is actuarial appraisals. It gives a lot of background and a lot of information, so I would encourage anybody who really wants to know about the nuts and bolts of actuarial appraisals to read this. In fact, I was looking at the standard of practice in preparation for this presentation, and it reminded me of one point I had intended to mention, which was the "as of" date. One of the important things in doing an appraisal is to decide what the effective date of your appraisal will be. Often, particularly with regulatory reviews, you end up going through reviews after the fact, but going back and referencing what that date was is always important.

The next thing you have to think about is the purpose and basis of the appraisal. This is the starting point. You might be representing a buyer who is looking at a particular book of business or a particular company, and that would affect how you would approach everything. The buyer may want you to substitute in certain assumptions that would differ from the company's current operations. If you're working for the seller, you might want to present us with what I call a continuity of management or continued assumptions operating as they have been.

A third potential purpose for doing the appraisal would be a value-added type of analysis, or perhaps management incentives based on the appraisal value of the company over time and how it might change. All those would affect the type of basis you would do. If you're doing it for a buyer, things that might change would be administrative expense levels, if the company is going to assume some cost efficiencies, or it might think it can get better provider deals, so it could affect the claim cost assumptions. It might put in bigger premium rate increases. It could affect many assumptions.

Once you decide on the purpose and the basis you will use, then you need to deal with the issue of how many cells to model (i.e., how you will break down the business in creating your models). There are many trade-offs. It's usually easiest if you use fewer cells because you can concentrate more on the reasonableness of the overall results and not get lost in the forest-for-the-trees-type situation. But the problems you run into are being able to make the model adequately reflect reality if you're dealing just with a small number of broad-based cells. Sometimes it's necessary to do more cells, but you have to be careful and not get too bogged down in the details.

When you combine cells into categories that are too broad, sometimes you run into problems with premium change methodology. We usually try to have enough different cells to at least reflect the different types of premium change methodologies. There are three major types I would mention—the first I refer to as monkey cells because a consultant I worked with a long time ago said that even a monkey could forecast these cells. These are the ones where premiums change all at once. Perhaps it is a Medicare block of business or a community-rated cell of some type, or a cell that consists of one large group, say a state group. It's anything where the premiums will change one time a year and one time only.

The more common and more complicated situation, of course, is when you have phase-in by renewal date and then you have to build in the mechanism to reflect the distribution of business by renewal dates. This makes the model a lot more complicated.

Then the third type of cell, which is actually fairly easy also, is claims reimbursement cells. The reimbursement will just be the amount of claims plus some sort of administrative add-on. Those are fairly easy from the premium change methodology standpoint.

Medical expenses have gotten more complicated over time because there are so many different reimbursement arrangements out there now. One of the things that has complicated the process a lot is capitation arrangements. Obviously, capitation rates will tend to change differently from your normal underlying claim cost trends and have different impacts; therefore, they require a different methodology.

Another important thing, of course, is linking the trends to the premium change rates and to the interest rates. I've seen many projections done where the premiums are increasing considerably more than the claims. It's fairly easy to make a book of business that's profitable and valuable if you do that. But certainly if you're in a situation reviewing it, that would be a critical thing to question.

The reasonableness of the resulting loss ratio is obviously something that you need to review whether you're doing the appraisal or reviewing it. Often it's important to look at historical results from a company. Generally, I would say, you should not just look at the most recent historical results, but try to look at the results over at least one or two underwriting cycles.

Continuing on with the list of detail-type things you need to worry about, one is the number of years you will include in the projection. I've seen some done with as few as five years. I think I actually saw one done with just three years. We tend to use ten, although there's no real magic about that and some people use more. Of course, with life company appraisals, typically you do it into perpetuity. With the health care area changing as rapidly as it does, many people take the position that anything that happens beyond five or ten years will really be a result of the current management at the time and shouldn't be reflected in the value of the appraisal time.

The discount rate is a critical assumption that we usually believe is not ours to set. We would set a range, but the buyer really needs to determine what risk-adjusted rate of return it wants to achieve from the investment. Often investment bankers might get involved to specify the discount rates to be used.

In terms of administrative expenses, sometimes people use a flat-dollar amount that they would increase with inflation. Other times it is easier to use a percentage of premium, even though people make the argument that health care costs might inflate quicker than general administrative expenses. We haven't noticed many decreasing percentages in terms of administrative charges. With lower trend rates now, it probably isn't as true anyway, so assuming a percentage of premium really works fairly well.

One issue we've run into on administrative expenses is that sometimes the company has a budget. But you might look at past performance and see that they will spend 110% of the budget, so it's hard to justify using their budgeted numbers going forward.

Finally, in terms of the real detail-oriented things, one of the up-front decisions you have to make in building a model is whether you will separately reflect new business or use just a net growth assumption. With group insurance and health company appraisals, we've tended to use a net growth assumption. If you're dealing with group insurance, new business can be expansions in an existing group. You can be getting, if you're an HMO, greater penetration of the groups you already have as well as new business sales. Though if you do separate out new business,

then sometimes you use a shorter period for the new business, or you use a higher discount rate to reflect the fact that it's less certain.

You can get really complicated at this point, because if you're building in a lapse rate, you can actually have the lapse rate vary by how much the premium rate increase will exceed the claim cost increases. In other words, if the company is trying to bump up premium rates more than claims cost inflation, you would assume people would shop and get better deals elsewhere. If you do this, you can then build in some adverse selection on those people who remain. As you can see, it can get really complicated. We've also done at least one where we've done a transition lapse in which a certain percentage was assumed to lapse because of the deal itself. So you can get fairly sophisticated, but I'm not sure how much impact that has on the ultimate value.

Back to some of the bigger picture items. Regarding investment income, if you read the actuarial standard, you should be looking at the company's investments and the rate of return it has been getting on them. We've found with health business that the investment income isn't always that material, so we haven't done as much work on that side as I think many life actuaries might do.

Taxes, particularly for not-for-profit companies and the Blues, in particular, where there's a grandfather provision from the 1986 tax law, gets complicated. The end result in taxes might depend on the transaction itself, so we generally look to the accountants whom we'd be working with to tell us which tax rates to use.

Cost of capital has become an extremely important thing to use with all the move toward risk-based capital. It had a drastic effect on the barriers. It tends to lower the barriers significantly. I've seen two different approaches. One is where the cost of capital is built into each of the cells. I think the one that I might prefer is where you do each of the cells without the cost to capital and then do a separate calculation for the cost of capital. It shows its impact directly, but either approach works and they should be mathematically equivalent.

Other things that you need to do, either because it's helpful to the readers or because it's required by actuarial standards, are as follows. Sensitivity testing is where you vary one or more assumptions to show its impact on the valuation. I found that this is very important in helping people understand the results. We always show a range of discount rates, but we do sensitivity testing on things such as interest (i.e., investment income) rates, loss ratio, expenses, and growth. You can do a number of them. Cash-flow testing is required by the actuarial standard, but I have found that it is usually not a big issue in most of the situations in which I've been involved.

With adjusted book value you usually start with statutory surplus, and the reason to use statutory instead of generally accepted accounting principles (GAAP) is because somebody purchasing a book of business is interested perhaps in how much earnings can immediately be released. The buyer can't take out earnings that would result in surplus levels below statutory surplus requirements. We generally start with statutory surplus, but then we would want to increase this if the nonadmitted assets have a real market value. The result is the adjusted book value. In some cases, I've seen people put in the value of a license so that if a company is licensed in many different states, there might be some value attached to that.

I'm going to say a few words about reading the report. Many people look at actuarial appraisal reports and see all the caveats and disclaimers and tend to think that they're boilerplate and that you should ignore all that. I strongly disagree with that—particularly a section we've put in that we call "Issues of Note." We point out some things that we think are particularly critical about the particular appraisal we're doing. I would say to people who would be looking at an appraisal report because they're the purchaser or the seller and certainly to the regulator, that reading the report and reading those sections and seeing what the actuary is really saying can be very important. If you're preparing a report, being very clear about what the purpose is and what the basis are very important and should be spelled out very clearly, in my opinion.

Finally, I have just a couple comments on market value. I know Dave will talk a bit about market value as well. Everything I've said so far relates to actuarial appraisals. I think actuarial appraisals are critical to most transactions, but in reality the market value will be assessed by a buyer and a seller. We have some wording that we include in our reports specifying that the market value should be determined by a willing buyer and a willing seller and not under undue, unreasonable restraints in terms of time. Given all that, it really will be a negotiation process, and the actuarial appraisal is one of a number of tools people would consider in determining what that value is.

I mentioned earlier the cost of capital. That tends to depress the value a lot—though if a company has a lot of capital, it might not care about it so it might want to not consider that as much as the actuarial appraisal does. It might particularly be interested in market entry, getting into a particular market, and that might raise what it would consider the perceived value to be. A for-profit company that has earnings-per-share projections out there might need to increase the earnings-per-share, so it would look for the growth, and therefore, attach more value to it than somebody else might. That's an interesting thing, too, because I tend to think in the past in terms of percentage margin, and many people think that way. But if you get into the full process mode where you're dealing with earnings per share, you can

actually acquire some business with a lower percentage margin. But if it will add earnings over the shares that you have outstanding, it still might be a good transaction for you.

The lesser of evils is where I refer to a situation in particular in which a not-for-profit company might merge with one of two partners. I guess it could be a for-profit company for that matter. Management might think it has a much better chance of retaining its positions with one partner versus the other, so it might choose the lesser of the evils.

There are some common rules of thumb: dollars per member and percentage of annual premium. Again, I know Dave will talk about that a little bit. A report called the *Sherlock Report* publishes information on for-profit health companies, and it gives a dollar-per-member value. It's interesting because the values vary from anywhere in the low $100 range up to $3,000 or so. So there's lot of variation in those numbers.

One comment I will make about it is that you'll see a couple of cells with a negative value. When we first started doing some of these, we spent a lot of time thinking about what it means when you get a negative value for a cell. That really results from the cost of capital that I mentioned several times. You have an assumed interest earnings rate that you're getting on that capital and a discount rate. The discount rate, of course, would normally be a good bit higher than that assumed earnings rate, so that particular cell has to throw out enough earnings to be able to cover that difference. You could have a cell which is profitable which could still generate a negative value just because of the discount rate you're assuming.

Mr. Harris: Dave Nelson is a graduate of the University of Wisconsin in Madison and is chief actuary with Humana in Louisville. He is quite familiar with some of the consolidations that have been going on in the managed health care organizations. Actually, he has been involved on both sides of these transactions.

Mr. David R. Nelson: I have some experience in companies that have been acquired, and I've worked for companies that have acquired others, and I now work for a company that sees itself as a consolidator in the health insurance industry. So I have a view with respect to acquisitions.

My remarks will take a little different tact. I will not spend a lot of time on the present value of profit or whether the transaction will be accusative or dilative, or what the methods are to value a company. I will take a different approach. I will take a look at what it takes to do a transaction and look at the pressures that people face on both sides of the transaction. I'd like to start out with a quick review of

some of the recent transactions. Then I will quickly move into how and why transactions are done.

Table 1 shows nine major transactions that have happened in the last three or four years totaling $17 billion. The point here is that a lot of activity is affecting some huge companies. This does not show Blue Cross/Blue Shield organizations. It's pretty much for-profit companies. The other point that I'd like to make here is that some of the values of these companies are quite high. The value per member is more than $1,000 in a number of instances. The point here is that there's a lot of activity. If you work in the managed health care industry, you will probably be affected by an M&A in some way.

TABLE 1
SUMMARY OF MANAGED CARE TRANSACTIONS

DATE	BUYER	SELLER	VALUE*	VALUE/ MEMBER
2/28/97	CIGNA Corporation	Healthsource	$1,500	$1,091
8/5/96	PacifiCare	FHP International	2,100	826
4/1/96	Aetna	US Healthcare	9,000	3,3400
2/1/96	United Healthcare	Healthwise	300	1,9799
10/95	Humana	Emphesys	650	650
4/3/95	WellPoint	Health Systems	1,900	1,1699
7/29/94	Foundation Health	Intergroup	700	1,5499
1/10/94	FHP International	TakeCare Inc.	1,100	1,4311
5/13/93	United Health Care	HMO America	400	1,3988

*Millions

Merger and acquisition work is really difficult. It's crunch time. Big decisions have to be made with little information and little time. Not that long ago I was talking to my boss about a newly announced M&A, and he told me I would be living in dog years for the next few months. He was right. When you're involved in an M&A, the available time is really short. That's why it's so important to plan. It's critical to have a plan—to get the M&A done and then to make the M&A work.

An M&A involves several steps. It starts with courtship, negotiation, and due diligence. Then there is the deal. Then, comes monitoring the material adverse change clause. Finally there is the close, and all that is just the start of the real work—the actual integration of the companies. If you don't have a plan for due diligence, you will bring people into the process too late. You will annoy your

target and end up with a decision that's made based upon insufficient information. If you don't have a plan for integration, you will waste the true value of the company.

Both the buyer and the seller need a plan. The buyer needs a plan because it has to protect its investments. The seller needs a plan because it has to protect the future. It has to build a role for itself and its employees in the new company.

All this calm, rational planning needs to take place in a highly charged emotional environment. People's careers and fortunes are on the line. Time is short and the longer that the negotiations go on, the higher the risk increases that rumor or uncertainty will spoil the deal.

You will not be able to change the pressure-packed nature of the M&A, but you can make sure that you add value and that what you do is not just a flurry of activities. It's hard to get the facts. You can't base the valuation of the company on the published financial results of the company. You must get the true reserves and the true earnings of the company.

Undervalued reserves for spent margin can significantly distort the true value of the company. You must dig below the surface to find out about recent rate changes, recent underwriting changes, recent changes in the capitation rates or other deal features so that you really know what is going on in the company. The scary fact is that you may need to know more about the company that you're trying to acquire than the management of that company itself.

As I mentioned before, M&As embody change and uncertainty. You must be on your best behavior. For your own sake, treat people with common courtesy. There's often a reason a company is for sale, but it could just as easily be you that's in the ineffective system. Not everyone has the authority to change the old system. Not everyone has the authority to make it better. Don't hold people accountable for something that they can't change. Most of the time, momma's old rule—if you don't have anything good to say, don't say it—applies.

Why would anyone put themselves in a pressure-packed situation such as this? The answer is because there are big rewards. There can be huge advantages to the buying company. The first three reasons—to increase market share and gain leverage, to acquire a profitable book of business, to forestall a competitive threat—are all standard, straightforward reasons to acquire a company. The fourth and fifth points concerning learning and generating synergies are more subtle points that really depend on the value-added management of the acquiring company. It will take some work to actually make those points come true.

The reasons not to buy a company are straightforward as well. Obviously, it will be hard to go to glory paying too much. It's also a problem if you don't have the bench strength in your organization to both deal with the issues in your own company and deal with all the issues that go along with an acquisition. People must be in place to be able to acquire a company and do that smoothly.

Acquisitions can be good for all concerned: (1) the stockholders in the buying company; (2) the selling company that typically gets a 20–40% increase in stock value; (3) the buying company that can get an early pick-up, particularly with learning and synergies; and (4) the employees. Don't be scared. If you're involved in an M&A, no matter what, you will learn a lot about yourself. You will learn a lot about your colleagues and you will learn about your business. You may just find yourself with a role in a larger, more viable organization.

Mr. Harris: Jerry Fickes is the chief actuary for the New Mexico Insurance Department. He is also past president and chief executive officer (CEO) of an insurance company, which he says was sold six times. (That could be a record.) As a consultant he was also involved in acquisitions and mergers. He's chair of the NAIC Accident and Health Health Working Group and chair of the Annuities Working Group. He is also active on the special committee on Blue Cross/Blue Shield plans.

Mr. Jerry W. Fickes: What action does the department take when it's confronted with a merger or an acquisition? Acquisition to us, and this is straight out of the New Mexico law book, means any agreement, arrangement or activity, the consummation of which results in a person (person can mean individual, company, or anything else) acquiring directly or indirectly the control of another person and includes, but is not limited to, the acquisition of voting securities of assets, bulk reinsurance and mergers. By the way, this can also mean a management contract. This can mean a franchise agreement or a licensing agreement or anything that actually transfers the control. You will find this in our Holding Company Act, because this is the thing that we normally have to get into if there will be one of these acquisitions or mergers.

Actually, we have three things that we're really concerned with, and these are the three main things that we must consider anytime an acquisition or a merger comes into the department. These are the regulator's concerns, and the first two are those that have always been there. First is protection of the consumer. Consumer means primarily the policyholder and the subscriber if you want to look at an HMO or Blue Cross. Second is solvency of the insurer. By the way, many people don't understand that is a rule in regulation. It doesn't do us any good just to look strictly at what the consumer is getting if there isn't going to be a company around to

provide it. So we have to look at the solvency issues. With the change for nonprofits going to a for-profit status, we have the third one—the public interest.

What would happen if a big merger suddenly came in and we had to look at it? I have a fax that was sent to me last night. I thought I was going to tell you that this came over the wire at the same time I was standing here, but Mr. Dobson spoke a little longer than we expected, so about 30 minutes ago this was announced on the AP wire. "PacifiCare Systems," the second name in Table 1 has entered into a long-term licensing agreement to offer Secure Horizon programs with Presbyterian Health Care Services." What does that mean? Presbyterian Health Care Services is an organization in New Mexico. It has 11 hospitals, 155,000 individuals who are insured. It actually has 400,000 people who go through the hospital system, 1,500 physicians, contracts with 82% of our state's 32 hospitals. As a part of this alliance and long-term strategic relationship, Presbyterian will acquire 58,000 commercial and Medicare members of PacifiCare FHP of New Mexico. Thirty minutes ago this merger acquisition, was announced.

I'm the regulator. I'm going to have to look at this basically to see what would be there after. After all, many people are involved. In New Mexico we only have 1.6 million people. A big share of our population will be affected by this. Only about 75% of that population is insured. Then if we take out another 30% that's on Medicaid, and Presbyterian will get 100,000 of those people effective July 1, we have one big organization there all of a sudden, don't we?

What are we going to look at? This is basically a little paraphrasing of our statute, but these are the things that require us to hold the hearing and require us to look at this M&A. When this is over will the insurer still satisfy the requirements for certificate of authority? In other words, will it still be able to operate in our state? Will the competition not be lessened substantially? That will be a question right here. Does this particular merger lessen the competition? The financial condition of the acquisitor does not jeopardize the insurer, the interest of the policyholders or the remaining unaffiliated security holders, if there were any. In this case there will be because it's basically private to private.

We want to make certain that there are not any plans to liquidate, sell assets, consolidate, merge with another company, or make a material change in the business corporate structure or management that may be unfair or unreasonable to the policyholders of public interest. That's a lot to look at. This doesn't say they can't do it. It says it can't be unfair. The question is, why didn't PacifiCare mention this about four or five months ago when it acquired Family Health Plan (FHP) International, of which New Mexico was a part of that acquisition?

Competence, experience, and integrity of those in control are primarily characteristics of the ownership, and of the management. In other words, we aren't going to let this company go to somebody who just got out of jail for defrauding the public so that the person can have another opportunity.

The acquisition cannot be hazardous or prejudicial to the insurance-buying public. We can't put a little stamp on the side of a cigarette package when buying a policy from this company stating that the company, after the merger, may be hazardous to your life. Maybe we can put a stamp on the policy, but I don't think anybody really wants to go that far.

In the old days we used to see only certain types of mergers—publicly held to publicly held. We didn't have to be too concerned as regulators because these were two entities that were dealing with each other, and they could take care of themselves as far as the financial M&A. The only reason for normally going into any form of a real valuation or determining a good price was a dissident shareholder. During a hearing, a shareholder or two would complain that they were not being treated fairly, so you would have to make certain that there was a proper valuation made so that the price or the exchange amount would be such that you could say this person was being treated fairly.

Then we started running into a new thing about 15–20 years ago called demutualization. Demutualization now took policyholders' companies and moved them very often to private entities. Some of the insurance departments had to start looking at the way these were put together. Laws had to suddenly be written, and really the laws still are not good for demutualization; but they had to be put together so that somebody could protect the rights of the policyholders if this was sent to some form of a stock ownership, management, or individual ownership.

The general marketplace, normally, will set the acquisition price. But if interested parties are involved, you have to make certain that price is fair.

Now during the last few years, we've had the introduction of something new, and that's what we're here about, nonprofits—nonprofits going to private corporations, nonprofits going to public corporations, businesses, franchises being involved, and nonprofits going to nonprofit organizations. Something new is now introduced on these three unknown fronts. It's not just a concern for the subscriber or the policyholder. Who's the owner of the nonprofit? Who's the person who has the right to say that it should sell this? Who should be the recipients of the funds when it is sold, and how much should they receive? We're now into a whole new field of valuation. An insurance department is having to step in to protect the rights of the citizens of its state because if you really check the laws from coast to coast, you will

find that almost all of them really state that nonprofits are owned by the state. They're the property of the citizens of that state and, as a result, it's their interest that you have to protect.

Many other things have come up in trying to change nonprofits into for-profits. These include the creating of subsidiaries, the movement of funds, management contracts, licensing agreements, and franchise agreements. All these play in this acquisition valuation role.

When you're in the insurance department you have to examine the filing of the holding company to determine how the valuation is done. We mainly would request the classic method. The classic method is basically what Bob was talking about: simply put, the present value of the business at a given earnings rate.

What is the regulatory effect on such streams? Bob said he looks at ten years when performing the valuation. I'm wondering what the regulatory and governmental effect will be on health care for ten years, especially medical health care. Will it even be around ten years from now? I would hate to be the one to try to predict. I just hope I get to be around to work on it, that's all.

Values of intangibles are big things that you have to look at because this is how money is moved from one source to another. It is net worth or equity considerations, as Bob said. Statutory net worth is what you normally look at because statutory net worth is what you end up paying dividends with. There are dividends (I'll get to where the money comes from in a minute), value of control, and market value adjustments for the assets so you can really see what it might be worth in the market.

I think another method was already talked about, which is really what I call the investment banking approach. You use comparable values that compare the value with other mergers that have occurred. You look at the different things. It's almost like appraisals for real estate. Sometimes these are made as instructive.

With market acceptance of similar companies, plus the value of control, you always have to look at control because it does have a very definite value. How much are you paying for control of a company (Control of what's going on)?

Regarding earnings, specifically dilution of earnings (when dealing with many corporations and when one is merging into another one, you always have to look at the earnings stream and the book value as to how they might dilute it in the survivor or how they would improve it. This is one of the reasons for the acquisition. This is more relevant in a profit-to-profit acquisition. When looking at it from a nonprofit-

to-a-profit situation, you look at the earnings stream from the perspective of where it is going in the new stock entity or in some of the people who have created it and what it might be worth to them.

My third method is what I call the regulatory approach. You make certain that at least one of the methods that I gave you before is used. If it's really going to be a hotly contested type of an acquisition, you'll probably get into more than one. By the way, it might be necessary for a department that's a small department to hire outside consultants to do this. The nice thing is that we can hire them and make the acquiring company pay for it, so we can always go for the best that way.

Our purpose is very simple. Determine that all parties have the opportunity to a fair valuation and that the policyholders will not be placed at risk now or in the future. It's a simple guideline.

We go back in this holding company document and to try to ensure that we look at who has the money. Where's the money coming from? There are so many ways to finance an acquisition. One of the reasons I got into this is they said that I know where most of the bones are buried, because I buried most of them when I was back there in the consulting field. You can hide things in stock swaps. I was in a merger once that was a cash offer against a stock offer, and the cash offer jumped up $5 a share. The guy with the stock reprinted more shares and increased the offer by $10. The other guy bet another $10 cash. The guy printed more stock and upped his offer an additional $10. Of course, he was diluting the value of the stock every time he did this. You know the poor guy with cash was having a real tough time. His was real money. The rest of this was just from a little printing press. Where did the cash come from? Was it laundered into this country? We've seen it that way. Was it brought in from some other industry—I won't mention any industries—and would we just as soon not have this money buy a company that's going to handle insurance business?

Regarding leveraged buyouts with secondary financing, or mezzanine financing, how will indebtedness be paid off? Why are we concerned with that? When you're in a leveraged buy-out, that money is coming out of that company. When it comes out, where will the policyholders be?

We used to do a lot of reinsurance contracts where we could do some creative financing by taking the reinsurance contract over to the bank and borrow money on it. We'd get money to buy a block of business for which we would just be holding the money. It's tricky work, but that's the way we do things.

Bootstrapping is getting the selling company to buy back some of the stock of the company, which then reduces the amount that you have to pay to buy it. Where does the money come from? Are we diluting the interest of the policyholders?

A great way to get money in the future is to set up a management contract. You sell the company. In the future you have to pay this to the person who has just sold the company. This is the way that you get the company to basically finance your own purchase. You can do it with blocks of business with commission contracts also. These are things that we have to look at. The newest ones are franchise agreements. I just read one, didn't I. That was a real example that I read. That is on the wire.

Special business concerns sales of blocks. Will this sale cause block isolation, which will cause spiraling of premium costs basically into a death spiral? Is the purchase price leveraged by anticipated rate increases? If so, is it properly reflected? Does it overstate the premium? Does it understate it?

You cannot change the reserve basis when you have sold a block of business. This can release funds to the surplus of the company, which can be used for a commission. All of a sudden you start running the business, you find out you need a rate increase, which you would have offset from these reserves. One of the things we try to look at is that the block history should remain with the block of business.

There are nonprofit owners' concerns. Who really owns the assets and the right to sell them in either mutuals or nonprofits? One of the things that we've been told over and over again is that the board has to fight it. In some companies the board is selected by the members. The members are selected by the board. The board must be from the membership. The membership can only be appointed by the board. Blessed are they who run in circles because they shall be known as wheels.

Can the management and the directors of nonprofits or mutuals profit from the M&A and represent full value, or is the conflict of interest too great? Management can make money through underwriters' shares, through stock options, through many different ways. Colorado just recently, out of our special committee on Blue Cross, passed a new law that basically prohibits any officer/director from making a profit on this type of an acquisition or merger. Does the law actually allow a merger? We probably turn down three or four acquisitions every year of nonprofits in our state because our law says that a nonprofit in our state must be a domestic company. When an outside company tries to buy one, it makes it a little different. Also, outside nonprofits have tried to come into our state for the purpose of acquiring them. They can't—they're not domestics. We have to look at many rules. All we're concerned with is fairness, but the nonprofit has introduced fairness to a third

group of people—the citizenry of our state. There is setting up foundations, setting up places where the money can go, and then determining the valuation as to what should be in there.

Ms. Cynthia S. Miller: Our main claim to fame is that we own Blue Cross licenses in the states of Indiana, Kentucky, and Ohio. We've been in the press recently because we've announced a merger with Blue Cross/Blue Shield of Connecticut and also New Jersey. I don't know if this is a question more than a point. The media recently has tended to lump all the Blues plans together, saying that they're all not for profit. If you want to mutualize or merge with the mutual for profit, what you need to do is pay over your assets or your net worth into a foundation. That simply is correct. It's important for everybody to realize that we're all incorporated differently. It was a state-by-state incorporation and so you really need to look at the laws and the history of the plan in the particular state before you make sweeping generalizations such as those. The other thing to realize is that if you don't allow these mergers to go forward, some of the plans are facing a tremendous amount of pressure from the market and the large HMOs. They're probably not going to survive because I think you need to look for long-term viability to the people in the state. If that plan goes away, have you really done a service to the citizenry and the policyholders? I think that's something that many people have missed in this whole dialogue.

Mr. Fickes: You're absolutely correct. Every state basically has different laws, and you have to look at the law of each state. Not all states' Blues plans are nonprofits. Many of them are mutuals. Many of them are nonprofit mutuals and some are actually for-profit companies. Each state has a different way in which it should be handled. Most of the laws for nonprofits do get down to the foundations. Let me make one point, which I know I didn't make up there. We do not oppose Blue Cross's going for profit and being able to raise capital for competition. That is not what is behind the special Blue Cross committee. We want to make certain that the proper people receive the funds when these do become for-profit, and that nobody is actually hurt for the sake of some person's profit. The subscribers and the true owners should receive what they are due.

Mr. James P. Galasso: In evaluating acquisitions and mergers, evaluating the companies, you mentioned the cost of capital and risk-based capital. What are you doing if there is risk-based capital in evaluating companies, given what the uncertainties are in my mind—the uncertainty of what the risk-based capital requirements are for health care companies in particular?

Mr. Dobson: That's a good point. You're talking about the fact that there's a big issue about the health organization risk-based capital and where it will end up. I think the ones I've been involved in most recently have been Blue Cross plans so

we've tended to use the Blue Cross Association's target benchmark, but we really considered that you needed to look at both. If it is an NAIC life company, a life and health company, you would have to look at the existing requirement compared with the Blue Cross Association requirement, and then use the higher of the two. They need to be in good standing in the state and in good standing with the association, but we have not done any where we tried to use the proposed new health organization risk-based capital. From what I've understood, and I haven't checked into it recently, there are many obstacles that arise.

Mr. Robert C. Tookey: I want to compliment this panel on the job that was extremely well done. I just want to say you gave every reason for people wanting to merge and be acquired. I'm working on two deals—in one case it's the buyer and in another case it's the seller. I have a question on assessing the buyer—probably to Bob Dobson. Do you ever get into a situation where a company is so far behind (and I'm finding this to be the case) and it simply can't get its rate increases through to catch up to an acceptable loss ratio with special approval as far as Medicare is concerned?

Mr. Dobson: Yes, certainly you can see that situation. The one situation I was in where it might not have been quite that bad, but where significant rate increases were necessary, is where we built in those transitional lapses and then the shock lapses from premium rate increases above claim cost trends and adverse selection. Obviously, it's hard to make the book look very attractive or profitable when you start building in a lot of those assumptions, but it's way underpriced. Currently, I don't know what choice you have in doing the pricing. You need to reflect the reality, I think.

Panelist: Bob, in the first acquisition that we did, we ran into a block that was in a big loss cycle. We put a negative value into the value of that company because we knew it had a loss that could never be made up with rate increases. The buyer was just going to have to accept the fact that this was going to be a loss while this block actually ran off. Actually, we wrote down the value by more than 10% in that particular company just for its block of health insurance.

The other example of a block that's really hard to turn around and make profitable would be an individual book of business in which there are many individual policyholders and you're way behind on your premiums because there's a lot of selection. You get a rate increase and the good risks can go out and get health insurance from someone else, and you're left with an ever-increasing need for rate increases. So that would be the other area that you need to really watch out for.

From the Floor: Was your acquisition successful?

Mr. Fickes: Yes, my acquisition was successful. Not only was it successful, but nine years later I became president of that company for ten years. By the way, that company was then sold six times. Each time it received more money for it and the people kept turning to me as president, could I return on the amount that they had paid a certain return? I kept saying, "Hey, it's the same company. You're just changing the denominator in this equation." They'd say please, could you do a little bit more?" We were in that Getty oil thing that rolled around, so we saw Getty Oil, Pennzoil, Texaco, and General Electric. We got spun down to Temple Inland, Great American Reserve, so I feel very successful. I survived five of six.

From the Floor: Could you please comment on statutory versus GAAP financial statement values, as they pertain to valuing a company?

Mr. Nelson: I really didn't say much about that. I personally think you need to look closely at the GAAP value of the company. That is how we traditionally look at transactions. Make sure that you know what your reserves and what your true earnings are. Go beyond the financials of the company and into your own estimates of what you think the true incurred earnings and true reserves are.

Mr. Dobson: I guess the standard of practice mandates the statutory approach to appraisals. We start out with expert advice because the value of anything that you're buying—whether it's stock or bonds or an insurance company—is derived from the value that you're going to take back from it, and that's going to come from statutory earnings. Specifically what it comes down to, especially when you take it from the company's cost of capital, is you're looking at the present value of reasonable statutory earnings, plus the market value of capital surplus and any examples at that point in time. That's typically the value of the company. Then we will turn around and do purchase GAAP analysis because historic GAAP doesn't mean anything. But we will turn around then and use co-purchase GAAPs to see that the new buyer, as a publicly held organization, will give the required return on equity (ROE) that is needed but there is very little demand.

Mr. Donald T. Weber: One of the things that hasn't been mentioned at all in terms of the value of companies, when looking at something other than a true stock company and the value of the ownership isn't really well defined from the law or regulation, is the value that management or employees have generated in the past and also the value that the management or employees have the right to in the future. Look at what is fair value to perhaps the value related to the policyholders who are currently insured under the plan as well as the value that's related to what's been generated by the management or the employees. I wonder if anyone would like to comment a little bit on that as to what's fair. The second part, I guess relating to it, is that what generally triggers many merger activities or availability of the

nonprofit arena, so that these values may not be well defined, is the willingness of some managements to step down for merger, consolidation, and golden-parachute-type arrangements, and what is fair along that line. That's what is needed to get the efficiencies that might be available in the future mergers.

Mr. Fickes: A management team very definitely has a value, plus or minus, in any purchase. I mean that—plus or minus. Remember, if this is the company that's not doing too well, the last thing you want to do is put more money in so it can do more of not doing very well. So if you're going to have to get rid of them, that means severance, that means several things of this sort. I've probably seen more parachutes in Blue Cross companies than the U.S. Air Force has, but the management certainly is a value. It's a value to the company, which means that it should be a value to the ownership. The fact that management has served well and done well is wonderful. If Bob owned a company and I was president of it and I continued as I used to, 22–23% returns on equity, hey, I've done well, that doesn't give me a right to the ownership of the company unless I buy stock. Now it might give me a stock option in the future, but it is not an ownership right. There are really owners in a nonprofit, even if they're just citizenry of the state. Or they might be some other group that is so named, and they should reward good management with contracts, with bonuses, etc., but that doesn't give them an inherent right, at least in my opinion, to a value of that company.

I usually find my attention span is limited to two or three questions. When there are four, I have some difficulty, but I think I remember. Dave mentioned the claims lag, and I thought it was an excellent point. You need to look into whether there's more or less conservatism in the claim liability and that would get into the claim lag evaluation. We generally try to use data where we have some amount of run-out. For example, we're doing an appraisal as of December 31 in a given year. We might be doing it a little bit after December, but we might use claims experience through June with six months of run-out. So in the model itself, we're not too dependent on claim processing or what the incurred but not reported (IBNR) was. But, of course, it impacts the adjusted book value so that's something you might want to adjust when figuring out what the surplus is. You certainly would want to know whether there had been a significant change in the margin from one year to the next. We've also tended to look at multiple years of past experience, so you would need to worry about the beginning and end points. But the interim years would wash out if you were looking at the combined profitability for a long period. Is there more or less conservatism in the buyer/seller approach? One key thing is to make sure that the report clearly states what the assumptions are. Some of the differences you would have would be the point of view. For example, and I mentioned this, the buyers might think they're going to change provider arrangements, or they might think they're going to reduce expense levels. So you

might reflect that in a buyer's appraisal, whereas you wouldn't in the seller's appraisal. Sometimes there might be some assumptions that are provided by management that you would clearly state, such as growth, for example. If you're doing a seller's appraisal and it is assuming some sort of growth level, we might make a comment about whether we think it's reasonable, based on past results, or we might use the seller's level and clearly state it. I think there could be some differences.

We do that in terms of discount rates. We generally don't do it in terms of the other sensitivity tests, so I like that approach. But generally we show three different discount rates and then show sensitivity testing by plus or minus 1% of the interest earnings rate, plus or minus 1% loss ratio, etc., so a reader can determine different values from what we present.

The final one you wanted all our comments on was postmortem. We can only do what somebody wants to bring us in and pay us to do. We would love to do those, but we don't always get called in and get asked to do them. I think it would be a good idea to look at things after the fact. We certainly have been involved in situations, where regulatory and other approvals have dragged out over a long period of time. We know that the intervening period would not have tied in very closely to what our appraisal is based on, but you have to remember that the appraisal is usually intended to be throughout different portions of the underwriting cycle. So even though it shows specific years, it's really not intended to predict that year, but be an average. So even though a year might have passed and you might look and say—you projected a $10 million gain for this period and had a $10 million loss, that doesn't necessarily negate the value of the appraisal.

If you've been involved with an acquisition and you ended up with the company, you'd want to hope that we don't do a postmortem, because that means exactly what it implies. The company probably died and we're back in there working on it. No, we really do not go back. The main thing is, we're more worried about the fairness at the time of the problem. We do look at business plans. In fact, all the domestics that we review have to file a business plan with us, and that includes those that have just completed acquisitions. We do go back and look at the business plans. In fact, this is part of the accreditation of the NAIC. We look at these things every year to see how well that company is doing with its plan. Then we call the people in if they're not doing what they said, not necessarily because it's wrong, but because we want to know why it changed. At least we haven't had any companies go down in the last nine years in New Mexico (at least not any life or health companies).

Mr. Paul E. Stordahl: Bob, I have a question regarding the level of discount rates. You mentioned the prudence of the range of discounts in which the buyers determine the reasonable rates of the buyer. However, the relative magnitude of the risk should be reflected in the range of discount values provided. This is a source of an internal struggle. There are those who believe that health insurance, because it is inherently riskier than life insurance, requires a higher rate of return, which I agree with. However, managed care, because of the inherent controls that can be used to limit risk, implies less risk than traditional indemnity health insurance, and therefore, the risk-adjusted rates of return should be lower. Could you comment on this?

Mr. Dobson: I think I tend to agree with what you just said. I tend to be on the side that wants to use higher discount rates. Generally, through peer review and through the company's investor banker comments, they've come down. I think the ones we've done recently have been something like 10%, 12%, and 15%, to present a range, whereas I might have started with 12%, 15%, and 18%. But you have to remember that interest rates have been down for a while, and inflation rates have been down for a while, too. I've seen some cash-flow projections done by investment bankers. I think the highest rate I saw was perhaps in the low 20s. But I also agree with your comment that if it were a purely managed care organization it might be less risky and you might use a number on the low end of those ranges.

Mr. Nelson: Yes, you might also vary it based on the quality of the management of the firm that you're looking at. If you have a real strong group, you might have lower risk, justifying lower discount rates.

Mr. Fickes: As we were looking at some of these in the Blue Cross committee, from the investment banker approach, we saw changes from $400 per unit up to as high as $2,000–3,000 per unit. We were not using a discount rate but using the rule of thumb of so much value per insured member. There's one caution I would like to throw into this. We have just passed a new managed care regulation in New Mexico. In this managed care regulation we require more of the managed care organization and less of the profit or the risk-taking or risk transference to the physician or the hospital. This is becoming a trend now in the U.S. As it comes into effect, I think you will see the value of some of the managed care business start to deplete.