

PITFALLS IN HEALTHCARE MERGERS AND ACQUISITIONS – EMERGING ISSUES

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Mergers and acquisitions in any industry present challenges for both buyer and seller. With the passage of healthcare reform legislation,¹ the ongoing publication of its implementing regulations, and increased scrutiny from both state and federal enforcement agencies, healthcare mergers and acquisitions present additional risks and pitfalls. The current trend in the healthcare industry is toward consolidation, emerging from incentives to form accountable care organizations (“ACOs”), intensive capital requirements for providing healthcare (such as those relating to electronic health record (“EHR”) systems), reimbursement changes from fee-for-service to bundled and global payments, and new prohibitions on physician ownership, among other factors. Consolidation is driven by both healthcare reform and an industry desire for scale.² But without proper planning, integration, and attention to risks, mere consolidation is not a solution. There are a few tools that parties and attorneys should keep in mind when dealing with the new dangers in healthcare mergers and acquisitions.

New Pitfalls in Healthcare Transactions

Despite a degree of stagnation in health industry transactions in the months leading up to the passage of The Patient Protection and Affordable Care Act (“PPACA”) and during the months of constitutional challenges winding their way to the Supreme Court, the eventual passage and Supreme Court confirmation of healthcare reform legislation has not

drastically altered the way deals are done. There certainly are areas of increased risk – many of them enforcement-related – but most of the risks are not new. Rather, these are areas that have experienced renewed importance and, in some cases, increased scrutiny under the Obama administration.³ Arguably, the most significant pitfall for current healthcare transactions is the not yet finalized regulations to implement PPACA. While the government agencies work through the regulatory process and continue to piece these rules together, market participants will labor to lower costs and increase value and accountability, all while attempting to comply with an ever-evolving regulatory landscape.

Healthcare has long been a highly regulated arena, and enforcement agencies are increasing their focus on the healthcare industry across the board. With the ongoing evolution of PPACA regulations as an overlay, regulatory compliance is even more difficult for healthcare providers, payors, and vendors, while at the same time buyers are focused particularly on regulatory compliance during due diligence. There are federal and state reimbursement conditions and requirements, state licensing and certification issues (for individual professionals and entities), quasi-governmental inspection agencies and accreditations, and payment regulation affecting both payors and providers. There are also federal and state anti-kickback statutes, prohibitions against physician self-referrals and beneficiary inducement, and corporate practice of medicine prohibitions. Under PPACA, both the anti-kickback statute (“AKS”) and the False Claims Act (“FCA”) now reach even further, lessening the government’s burden on proving intent for AKS violations, linking AKS violations to violations of the FCA, and

providing enhanced civil and criminal penalties for violations, to name a few changes.⁴ Because the penalty of exclusion from federal healthcare programs can be an effective death sentence for a healthcare company, it is important to know that a business has been operated within the scope of the law.

Beyond the uncertainty caused by changing rules and regulations under PPACA, healthcare transactions face increased scrutiny by antitrust enforcement officials under the Obama administration. Although a review of current antitrust enforcement and prosecution activities is beyond the scope of this article, the Federal Trade Commission (“FTC”) and Department of Justice (“DOJ”) are increasing their scrutiny of transactions that “appear to have a competitive concern.”⁵ But antitrust considerations are also not new to the healthcare industry, and the FTC and DOJ use the same analytical framework to scrutinize a healthcare transaction’s effects as they do for other mergers. In any event, buyers, sellers and potential partners should familiarize themselves with the antitrust laws and guidelines when considering a merger, acquisition, or any other transaction that may have anti-competitive effects.

Another area of increased risk in healthcare transactions involves data privacy and security issues. Covered entities have been guarding protected health information under the Health Insurance Portability and Accountability Act (“HIPAA”)⁶ for well over a decade. Now, under the Health Information Technology for Economic and Clinical Health (“HITECH”) Act,⁷ business associates are directly subject to the HIPAA privacy and security requirements for health information. Along with the broader reach of HIPAA, there has been and will

continue to be an increase in providers' use of EHR systems, now that the Department of Health and Human Services ("HHS") opened registration for the Medicare and Medicaid EHR system incentive programs in January 2011.⁸ As of the end of August 2012, CMS reported that 271,105 eligible professionals and hospitals have registered and more than \$6.9 billion in incentive payments has been awarded to providers.⁹ Additionally, as of July 2, 2012, 44 states have brought Medicaid programs online.¹⁰ On the flip side, eligible providers will be subject to a one percent payment adjustment on their Medicare Part B services provided January 1, 2012 through December 31, 2012 if they are not successful electronic prescribers under CMS's e-prescribing incentive program in 2012.¹¹ With these incentives come increased use of electronic data storage and transmission, and with that, an increased risk of data breaches, theft, accidental disclosures and losses. Covered entities and business associates face civil and criminal liabilities for noncompliance, with HHS's Office of Civil Rights ("OCR"), The Centers for Medicare & Medicaid Services ("CMS"), and state attorneys general authorized to enforce HIPAA.¹²

All told, buyers in healthcare industry mergers and acquisitions generally are more risk averse than in the past. This creates a need for various and increasingly creative tools to get the transaction over the finish line. The industry has seen more conservative revenue projections in business appraisals, with buyers and sellers anticipating that a business's past performance may not be a clear indicator of its future. Additionally, buyers are conducting more thorough due diligence reviews and requiring broader seller representations and warranties, more earn-outs, escrows, and holdback provisions.¹³

Although a number of questions remain about the specific structures that will be allowed under PPACA as

entities consolidate, the legislation is clear that one major goal is to promote and reward lower cost, higher quality care, and greater accountability across providers for patient health.¹⁴ With the creation and expansion of ACOs, it is also clear that consolidation and affiliation among healthcare providers will continue, whether through mergers and acquisitions contemplated in this article, or other joint ventures and strategic affiliations. Consolidation provides both opportunities to thrive and pitfalls that can have a negative impact on newly merged or affiliated entities.

Recent Trends and Tools for Mitigating Risk in Healthcare Transactions

Just as many of the pitfalls in healthcare mergers and acquisitions are not new, many of the solutions are tried-and-true. Whether one is representing a buyer, seller or a future partner in a joint venture, consider the following tools as one navigates towards closing.

Address Regulatory Compliance in Representations and Warranties

Due to healthcare's complex regulatory framework and the increasing enforcement risks, parties to these transactions should always require representations and warranties regarding the other parties' compliance with healthcare laws. Noncompliance can impose long-lasting successor liability for buyers and surviving entities, and there are high-dollar penalty assessments for fraud and abuse violations.

Focus on Security and Privacy Compliance

All covered entities and business associates should have the proper safeguards and security systems in place, along with a comprehensive set of HIPAA compliance policies that are clearly organized and well understood by everyone in the organization. Disorganized or incomplete documentation presents risk in the event of a

privacy- or security-related complaint or an OCR audit under the HITECH Act standards: regulators will assume that a lack of documentation is equivalent to a lack of compliance. Not only should sellers be proactive to assess and confirm they are operating with adequate HIPAA compliance programs, buyers should conduct thorough diligence to probe whether a target has any existing HIPAA breaches, since these may result in post-closing liabilities for the buyer or surviving entity. Regardless of what is found, there are solutions to keeping a deal moving forward and to limit liability, including: increasing due diligence review of a target's IT security practices; carving out HIPAA privacy- and security-related incidents from the indemnification cap and basket (so these losses are covered from the first dollar); delineating which liabilities are excluded (e.g., all liabilities arising from incidents prior to the closing); and limiting the amount of private information transferred to the buyer from the target (e.g., transfer medical records only for patients who are currently being treated).

Review and Assess Organization Fit and Plan for Transition Issues

Companies seeking to grow by acquisition or merger should carefully consider their service lines, core competencies, the cultural fit with a target entity, and the long-term goals of the transaction, whether it is a merger, acquisition, joint venture, change to physician employment, or affiliation arrangement.¹⁵ In addition, acquisition-minded companies should ensure that they have an effective transition team in place. Realizing the benefit of synergies between an acquirer and target relies in large part on how the target is integrated once the transaction closes.

Address Risks Associated With Noncompliance

In some instances, a target will remediate noncompliance with healthcare laws or private billing and

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coding requirements before closing, to avoid a reduction in or holdback from the purchase price or ongoing liability, or because the buyer requires remediation as a pre-condition to closing. In the merger context, attempts are made to resolve problems found during diligence as part of the integration process. When not prohibited by anti-kickback and physician self-referral requirements, a buyer can use purchase price earn-outs, escrows, or holdbacks tied to performance, revenue, or compliance benchmarks.¹⁶ Alternatively, a buyer may require the seller to retain an equity interest in the target or resulting entity. As long as equity retention is not prohibited by law, a buyer can reduce the purchase price and the seller still has some “skin in the game” to encourage a successful ongoing relationship.

Over the past few years, buyers in particular have turned more frequently to a number of tools to mitigate the risk of acquiring and/or merging healthcare companies. Although not new, their more frequent use suggests trends, and even standards, in healthcare transactions that are worth noting.

Enhanced Seller Representations and Warranties

Buyers are requiring more from sellers’ representations and warranties. One example is the “No Undisclosed Liabilities” representation, which has become standard to include. This representation was included in 99 percent of public target merger and acquisition (“M&A”) transactions announced in 2009,¹⁷ an increase from 94 percent of similar transactions announced in 2008. These representations are increasingly crafted to be more favorable to the buyer (e.g., not qualified by seller’s knowledge, and/or covering all liabilities as opposed to just “GAAP Liabilities,” etc.). For private target M&A transactions, the representation

was included in 96 percent of transactions completed in 2010, 97 percent in 2008, and 93 percent in 2006.¹⁸

Another representation included in transactions with increased frequency – and with a broader scope – is the “Compliance with Law” representation. For public transactions included in the ABA, 2010 Deal Points Study that were announced in 2009, the target’s “Compliance with Law” representation had no time constraint in 18 percent of the transactions, contained a specific look-back date (such as three years prior to closing) in 50 percent of transactions, and applied to current violations only in 32 percent of the transactions.¹⁹ For similar transactions announced in 2008, 22 percent had a “Compliance with Law” representation with no time constraint, 35 percent had a specific look-back date, and 43 percent applied only to current violations.²⁰ In addition, the authors have seen an increased focus on compliance with non-healthcare laws, since non-compliance can have a significant impact on patient health and safety, or on a healthcare provider’s ability to seek federal reimbursement for services.²¹ For example, Occupational Safety and Health Administration (“OSHA”) and environmental non-compliance can be costly to remediate, and often requires an interruption in operations, resulting in lost revenue and patient migration to other facilities.²²

Indemnification

Sandbagging

Indemnification continues to be an important tool in mergers and acquisitions. One tactic that allows a party to press an indemnity claim for losses arising from inaccuracies in a representation or warranty is known as “sandbagging.” A pro-sandbagging provision requires a party’s representations and warranties to be accurate, regardless of whether another party seeking indemnification has knowledge of the

inaccuracy. That is, a party’s knowledge of a breach or inaccuracy does not affect its right to seek indemnification. In other words, if an item is not set forth in a seller’s disclosure schedule, it does not limit or modify the representation or warranty. On the other hand, under an anti-sandbagging provision, if a party knew (or sometimes even should or could have known) about a breach or inaccuracy of another party’s representation or warranty, its indemnity claim is barred.²³ In these days of electronic data rooms and email transmission of diligence information, a pro-sandbagging provision protects an acquirer against being barred from recovery due to constructive knowledge of items buried within a “diligence dump.”

Caps and Baskets; Survival Periods

Indemnification provisions can be crafted to use caps, baskets and deductibles on recovery amounts, as well as limits on representation and warranty survival periods, to create an indemnification scheme tailored to the risks of a particular deal.²⁴ While a seller will want to apply an indemnification cap and basket or deductible to all potential future losses, a buyer will seek to limit such caps, baskets and deductibles and apply them only to certain representations and warranties. For example, a buyer might require full indemnification for all losses arising from a breach of any covenant, especially restrictive covenants, and from liabilities arising from a seller’s operation of the business pre-closing, because they are deemed to be fully within the seller’s control. The parties also can create “classes” of representations and warranties, using scaled caps, baskets, and survival periods. For example, “standard” representations and warranties may be subject to the cap, basket and deductible, and have a 12 month survival period; “fundamental” representations and warranties

(such as taxes, employee benefits, and title to stock representations) may be excluded from the cap, basket and deductible, and have a longer survival period; and healthcare representations and warranties might be excluded from the cap, basket and deductible and have a survival period that runs to the full statute of limitations.

Representation and Warranty Insurance

Given their increased aversion to risk, buyers are looking for more ways to protect their investment against the unexpected breach of a key covenant or seller representation or warranty. As mentioned above, use of earn-outs, escrows, and holdbacks can mitigate some buyer risk, but are not always viable solutions. Representation and warranty insurance may be an option when the risks are unknown or difficult to quantify, or when there is a specific representation that buyer and seller wish to insure. This tool has been discussed more frequently in recent transactions, but it is still rarely pursued. The coverage tends to be limited, and cost continues to be a barrier unless the parties are willing to limit the scope of coverage. And because the insurer will conduct its own due diligence, it may also increase the parties' transaction costs. However, this tool should be considered as a supplement to traditional indemnification.

Alternative Dispute Resolution ("ADR")

While there has not been a drastic change to the use of ADR provisions generally, when they are used there appears to be a trend toward binding arbitration. In the ABA 2011 Deal Points Study, for 2010 transactions that included a general ADR provision, those using binding arbitration increased from 77 percent in 2006 to 89 percent (down from 92 percent in 2008), while those using mediation followed by binding arbitration decreased from 18 percent in 2006 to 11 percent (up from three percent in

2008).²⁵ None of the deals with general ADR provisions provided solely for mediation.²⁶ The authors believe that this trend results from the parties' desire to limit the expenses associated with protracted dispute resolution and litigation and create more certainty with respect to the timeframe for an outcome.

Conclusion

The biggest pitfall in healthcare transactions in the current environment is the assumption that there is a one-size-fits-all strategy or solution. For a healthcare entity to realize the benefits of its deal, it must know its core competencies, culture, capabilities and needs, current and future market considerations, and its options for mitigating the risks, before it pursues a merger, acquisition, partnership or other strategic arrangement.

The information, opinions and advice offered by Ms. Daccord and Ms. Irving in this article are those solely of the authors, and do not in any way convey or represent the opinions or advice of their firm, Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C. This article originally was prepared in connection with the American Bar Association Health Law Section's Emerging Issues in Healthcare Law 12th Annual Conference held February 23-25, 2011, and has since been updated.



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Ms. Daccord has spoken and published on healthcare mergers and acquisitions, strategic joint ventures, incentive compensation arrangements, and other topics. She has presented at numerous healthcare events and seminars, including "New Pitfalls in Health Care Transactions" (February 2011), "Comparative Effectiveness Research: Implications for Healthcare" (March 2010), and "What's Happened and What's Next for the Health Care Industry" (April 2010, Boston and San Diego).

In recognition of her expertise in healthcare law, Deborah was selected by her peers to be included in *The Best Lawyers in America* for 2012 and 2013. She also has been named one of *Nightingale's Healthcare News' Outstanding Healthcare Transaction Lawyers*, and is recognized as a leading healthcare lawyer in Massachusetts by *Chambers USA: America's Leading Lawyers for Business*. Additionally, she serves on the boards of Big Sister Association of Greater Boston, Brookline Community Mental Health Center, and on the Board of Visitors of Fenway Health.

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Ms. Irving has published articles on a variety of healthcare topics, including; Medicaid and Medicare certification and payment, special considerations in healthcare mergers and acquisitions, fraud and abuse regulations, and the corporate practice of medicine. She has represented a variety of pro bono clients at the firm.

Prior to joining Mintz Levin, Rachel was a law clerk for the Illinois Attorney General and worked for the Massachusetts Medical Society in its Membership and Legal Departments. While a student prosecutor at Boston University School of Law, she successfully briefed and argued against a motion to suppress evidence in a criminal hearing.

Ms. Irving is admitted to practice in Massachusetts. She is a member of the Massachusetts and Boston Bar associations and the American Health Lawyers Association. She is an officer for the Boston Chapter of the BU Law Young Alumni Council and was a member of the 2011–2012 Women's Leadership Program with the Greater Boston Chamber of Commerce. Rachel received her BA from the University of Illinois (2002) and her J.D. from Boston University School of Law (2008).

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Endnotes

- 1 President Obama signed the Patient Protection and Affordable Care Act on March 23, 2010, and the Health Care and Education Affordability Reconciliation Act of 2010 on March 30, 2010 (collectively referred to herein as "PPACA"). After numerous constitutional challenges, the United States Supreme Court upheld the constitutionality of PPACA on June 28, 2012.
- 2 Christopher Y. Chi and Leigh Walton, Reform Could Spur Consolidation in the Health Sector, *Nat'l L.J.* 11, Col. 1 (7/26/2010). One draw of larger scale operations is that healthcare providers and vendors may benefit from smaller 'per-unit' costs by lowering supply prices (for example, through bulk drug pricing) and lowering per-employee/per-patient administrative costs.
- 3 Healthcare fraud enforcement is a top priority for the Obama administration, with an additional \$350 million appropriated to a separate Health Care Fraud and Abuse Control Account by PPACA, creation of the Health Care Fraud Prevention and Enforcement Action Team ("HEAT"), and mandatory compliance programs for enrollment in government payment programs. See C. Stephen Redhead, Congressional Research Service, Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act, CRS-9 (12/10/2010); Thomas S. Crane, et al., Risky Business: Health Care Reform's Fraud-Fighting Provisions Increase the Potential for All in the Health Care Industry, *Health Care Fraud Report*, 14 HFRA 312 (4/7/2010) (analyzing the broadening of healthcare fraud statutes, expansion of enforcement efforts, and enhanced penalties for healthcare fraud under PPACA).
- 4 Crane et al., *supra* note 3.
- 5 Assistant Attorney General Varney's Healthcare Antitrust Speech Emphasizes Health Insurance Industry Enforcement and Offers Supportive Remarks on Clinical Integration, Mintz Levin Health Care Antitrust Advisory, May 26, 2010, available online at <http://www.mintz.com/newsletter/2010/Advisories/0429-0510-NAT-AFR/web.html>. See also, DiVarco, Sandra, The Top Five Traps in Health Care M&A Transactions, November 8, 2010, *Mondaq*, 2010 WLNR 22290160.
- 6 The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (Pub L 104–191, 110 Stat 1936).
- 7 The Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), part of the American Recovery and Reinvestment Act of 2009 ("ARRA") (Pub L 111–5, 123 Stat 115).
- 8 Press Release, CMS and ONC, Electronic Health Record Incentives Registration Starts Jan. 3, 2011, online at <http://www.cms.gov/apps/media/press/release.asp?Counter=3887&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cbOrder=date>.
- 9 CMS EHR incentive payments flirt with \$7 billion, Sept. 6, 2012, available at: <http://www.govhealthit.com/news/cms-ehr-incentive-payments-flirt-7b>.
- 10 See CMS info sheet re State Medicaid program registration in Medicaid EHR Incentive Program, online at: <https://www.cms.gov/apps/files/statecontacts.pdf> (last accessed 7/8/2012).
- 11 See CMS E-Prescribing Incentive Program website, online at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html> (last accessed 7/8/2012).
- 12 See, e.g., Cynthia Larose, HITECH: Business Associates Beware – New Rules, Audits and Enforcement on the Horizon!, <http://www.privacyandsecuritymatters.com/2012/06/hitech-business-associates-beware-new-rules-audits-and-enforcement-on-the-horizon/> (6/22/2012); Cynthia Larose, The Rising Cost of HIPAA Violations: \$100,000 Fine Levied on Physician Group, *Privacy and Security Matters Blog*, <http://www.privacyandsecuritymatters.com/2012/04/the-rising-cost-of-hipaa-violations-100000-fine-levied-on-physician-group/> (4/19/2012); Cynthia Larose, WellPoint Sued by Indiana AG for \$300K, *Privacy and Security Matters Blog*, <http://www.privacyandsecuritymatters.com/hipaahitech/> (11/1/2010); and Dianne Bourque, First Ever State-initiated HIPAA Enforcement Action Settled, *Privacy and Security Matters Blog*, <http://www.privacyandsecuritymatters.com/2010/07/first-ever-state-initiated-hipaa/> (7/8/2010).
- 13 An earn-out provides for a portion of the purchase price to be paid post-closing upon satisfaction of certain benchmarks (financial or otherwise). An escrow or holdback provision holds back a certain portion of the purchase price for a period of time to protect against obligations of the seller like indemnity or tax; an escrow is held by a third party while the buyer keeps the funds in a holdback.
- 14 See, e.g., PPACA, Title III entitled "Improving the Quality and Efficiency of Health Care" with numerous provisions regarding quality reporting and improvement, and value-based purchasing programs, Title VI entitled "Transparency and Program Integrity" with numerous provisions regarding provider reporting, transparency and accountability.
- 15 See, e.g., HealthLeaders Media Breakthroughs: Hospital Merger and Acquisition Strategies, PricewaterhouseCoopers, for examples of four different hospital/health system growth strategies, available online at: <http://www.healthleadersmedia.com/breakthroughs/257025/Hospital-Merger-and-Acquisition-Strategies>.
- 16 For example: percentage (or total) compliance with certain billing and coding metrics, obtaining a clearance letter after a state

inspection survey and plan of correction, and/or issuance of license or determination of need authorization.

- ¹⁷ American Bar Association, 2010 Strategic Buyer/Public Target Mergers & Acquisitions Deal Points Study, M&A Market Trends Subcommittee of the Committee on Mergers & Acquisitions, <http://www.abanet.org/dch/committee.cfm?com=CL560003> (2010) (hereinafter, “ABA, 2010 Deal Points Study”). The ABA, 2010 Deal Points Study analyzed publicly-available acquisition agreements for acquisitions of U.S. publicly-traded targets by publicly-traded and other strategic acquirers for transactions announced in 2009 (private equity buyers’ acquisition agreements were not included among the agreements analyzed), and although it is not specific to the healthcare industry, its results are often used as a datapoint.
- ¹⁸ American Bar Association, 2011 Private Target Study, M&A Market Trends Subcommittee of the Mergers & Acquisitions Committee, <http://www.abanet.org/dch/committee.cfm?com=CL560003> (2011) (hereinafter “ABA, 2011 Deal Points Study”). The ABA, 2011 Deal Points Study analyzed

publicly available acquisition agreements for transactions completed in 2010 that involved private targets being acquired by public companies, and although it is not specific to the healthcare industry, its results are often used as a datapoint.

- ¹⁹ ABA, 2010 Deal Points Study, *supra* note 18.
- ²⁰ *Id.*
- ²¹ For example, a seller may be required to represent that it is not in violation of any laws relating to terrorism or money laundering, laws comprising or implementing the Bank Secrecy Act, and laws administered by the United States Treasury Department’s Office of Foreign Asset Control.
- ²² An asbestos or mold remediation, for example, may require complete evacuation of a healthcare clinic, and patients requiring ongoing treatment will seek care at other facilities. These patients may be less likely to return to the buyer’s facility once remediation is completed.
- ²³ ABA, 2011 Deal Points Study, *supra* note 18. The Study provides the following pro-sandbagging sample provision: “The right to

indemnification, payment, reimbursement or other remedy based upon any such representation, warrant, covenant or obligation will not be affected by... any investigation conducted or any Knowledge acquired at any time, whether before or after the execution and delivery of this Agreement or the Closing Date, with respect to the accuracy or inaccuracy of, or compliance with, such representation warranty, covenant, or obligation.” and anti-sandbagging sample provision: “No party shall be liable under this Article for any Losses resulting from or relating to any inaccuracy in or breach of any representation or warranty in this Agreement if the party seeking indemnification for such Losses had Knowledge of such Breach before Closing.” (Emphasis in original.)

- ²⁴ For example, the parties may agree not to seek indemnification until losses reach \$50,000 (the basket) and to cap their obligations at the purchase price; if there are any known compliance issues, existing litigation activities or union negotiations, any loss related to those issues may be excluded from any limitations on basic indemnification.
- ²⁵ ABA, 2011 Deal Points Study, *supra* note 18.
- ²⁶ *Id.*

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