SYMPHONY RISK

Executing a Successful Acquisition:

Your Guide to Navigating Risk in Healthcare M&A

Industry-wide consolidation has caused rapid change across the healthcare landscape, requiring a sophisticated approach to risk management enhanced by the best practices engaged in by private equity firms and their portfolio companies.

Table of Contents

SECTION 1

Two into One: Horizontal and Vertical Consolidation **03**

Finding a Balance Between Risk and Reward **04**

Healthcare Professional Liability Claims, Defined and Measured **05**

SECTION 2

Growth Plans and Venue Considerations: High-risk States for Healthcare Professional Liability **06**

How Some States Are Protecting Patients and Doctors with Patient Compensation Funds **09**

SECTION 3

Formulating a Comprehensive Strategy to Address Total Cost of Risk **10**

Staffing for Growth **16**

Upgrading Technology **17**

SECTION 4

Going Forward **18**

Considerations for Future Transactions **18**

About Symphony Risk **19**

Our Team **20**

SECTION 1

Two into One: Horizontal and Vertical Consolidation

Mergers and acquisitions unify organizations to become greater than the sum of their separate parts. This trend of **horizontal consolidation**, or the joining of two like organizations, is only accelerating. Between 1998 and 2021, over 1,800 hospital mergers were reported.[1] Healthcare provider groups are also experiencing consolidation. 2020 marked the first time less than half (49.1%) of patient care physicians worked in private practice, an 11% drop in less than ten years.[2] In just two years, between 2018 and 2020, the percentage of physicians in practices with at least 50 physician peers jumped to 17.2%.[3]

Healthcare organizations have been looking to add more types of services to their portfolios as well.[4] **Vertical consolidation**, or the consolidation of different types of healthcare organizations, bring physician groups, private practices, and other acute care providers into more integrated healthcare networks.

The 10 biggest players in the latter scenario grew to be nearly a quarter of the market in the 2010s.[5] Private equity investment in domestic healthcare organizations has nearly tripled during the same time frame,[6] with a focus on slightly larger institutions in more populated areas of the southern United States.[7]

Health services deal volumes over the last few years demonstrate a continued appetite for change and reinvention, with 2023 volumes holding strong at nearly twice the levels in recent years.[8] Since 2022, industry EBIDTA multiples have been steady, with a large portion of this deal volume being driven by smaller value roll-up and add-on transactions versus transformational platform or megadeals (valued $5 billion or greater).[9]

Finding a Balance Between Risk and Reward

>55% More than half of hospitals targeted for a merger or acquisition between 2010 and 2019 were located in a different geographic market than the acquirer, and 21% of these were located in different states.[10]

Consolidation is trending for a reason. For larger healthcare systems, consolidation can lead to greater cost savings, optimization of resource allocation, and the ability to build greater negotiating power with suppliers in greater numbers.

While simple in theory, executing consolidation strategies is often wrought with challenges. What works for a small hospital or group of physicians may not work for larger groups. Or, what is successful for an organization in one jurisdiction could present a major risk in another. Certain healthcare entities may find themselves restricted from even practicing medicine in particular geographic markets due to intricate legal constraints and the spider web of organizational structures.

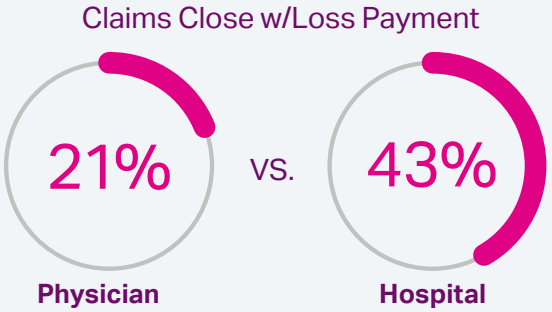
Just like the healthcare landscape, the professional liability claims environment has been rapidly changing, with escalating claims frequency and severity. Both economic and social inflation factors have converged to create increased litigation, a broader definition of *duty of care*, and normalization of nuclear or higher than expected verdicts. These factors in turn impact the average cost of a claim, which is estimated to be increasing at about 5% per year for hospital professional liability (HPL) claims.[11] And when the cost of claims increases, so does the cost of coverage for all.

Healthcare Professional Liability Claims, Defined and Measured

The cost of risk is complicated and hard to predict, which makes it even more impactful. The two most fundamental metrics that can be used to evaluate a market risk in a particular specialty or jurisdiction are claims frequency and claims severity. Understanding these terms and how they relate to medical professional risk can significantly enhance the ability to manage and mitigate potential liabilities.[12]

Claim Frequency

Claims frequency is the number of non-zero claims filed in a given period for the unit of exposure. The unit of exposure for hospital professional liability is often occupied bed equivalent (OBE). For employed physician professional liability (PPL), it is a full-time Class 1 physician equivalent who is employed for a full year.



Claims frequency is hovering around 1.50% for HPL and 3.75% for PPL. Only 21% of physician claims close with a loss payment, compared to 43% for hospitals.

Claim Severity

Claims severity is the monetary loss associated with the claim, inclusive of any payment to the plaintiff and/or cost to defend the claim.

The severity of claims has been approximately **40%** ***lower for employed physicians than HPL claims.***

Severity for both employed physicians and HPL are projected to increase at an annual rate of **3%**

SECTION 2

Growth Plans and Venue Considerations: High-risk States for Healthcare Professional Liability

While cross-market mergers may lead to competitive advantages, each geographic market has its own risk considerations. Healthcare claims frequency and severity varies across the U.S. depending on the litigation culture and laws in each region. The following maps give a comprehensive view of claims severity across the U.S., from January 2016 to July 2023.* Dive deeper into six high-risk regions for examples of the impact of litigation trends on healthcare professional liability.

Georgia**

23
Nuclear Verdicts

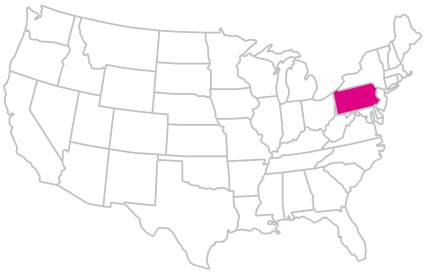
$655.3M
In Total Awards

Georgia recently claimed the top spot in the American Tort Reform Foundation's annual list of challenging litigation districts for defendants,[13] in large part due to its massive nuclear verdicts and liability expanding rulings, which forces defendants to pay as much as double the plaintiffs' attorneys' fees if they lose. In the 2010s, 53 nuclear verdicts were reported in Georgia, totaling $3 billion in awards for plaintiffs — and 21% of these verdicts were for medical liability claims.[14] Georgia is also one of a handful of states that have codified a rule allowing plaintiffs' lawyers to seek any amount of damages for pain and suffering, "no matter how extraordinary."[15]

* Healthcare Liability Market Update, Source: Various internet articles with publication dates between 01/01/2016 and 11/03/2023.

** Nuclear verdicts are those greater than $10 million.

Pennsylvania



23
Nuclear Verdicts

$662.9M
In Total Awards

Medical malpractice liability and product liability cases account for more than 60% of nuclear verdicts in Pennsylvania.[16] In 2022, the Supreme Court of Pennsylvania relaxed venue restrictions for plaintiffs' lawyers filing medical liability lawsuits, no longer restricting venue to where the treatment occurred. This poses a risk to healthcare providers as lawyers can now choose jurisdictions where they expect a more plaintiff-favorable jury.

Illinois

30
Nuclear Verdicts

$910.8M
In Total Awards

Medical liability trials resulting in nuclear verdicts are nearly twice as common in Illinois as they are throughout the rest of the U.S. Two-thirds of Illinois's nuclear verdicts are issued by the Cook County Circuit Court.[17] Cook County is also a hot spot for Biometric Information Privacy Act (BIPA) cases. In February 2023, a ruling decided that BIPA claims accrue each time a biometric identifier is unlawfully collected and disclosed, rather than just the first time.[18] State healthcare organizations are particularly vulnerable as Illinois law requires them to perform fingerprint-based background checks on their employees. While a bill was filed in January 2023 to amend BIPA and carve out an exemption for healthcare employers, even under this change, healthcare employers would need to maintain strong operational practices to ensure they follow the proper procedures to remain exempt.

California

14
Nuclear Verdicts

$465.1M
In Total Awards

California's A.B. 35 went into effect in January 2023, raising the $250,000 cap on noneconomic damages — otherwise known as pain and suffering — in medical liability cases to $350,000.[19] This legislation also provides for future increases that will eventually reach $750,000. While only 7.6% of the state's nuclear verdicts resulted from medical liability claims, this makes medical professionals more vulnerable to nuclear verdicts.[20]

New York

30
Nuclear Verdicts

$969.9M

New York is one of the most challenging states for doctors due to high malpractice award payouts and expensive malpractice liability insurance rates.[21] With no cap on pain and suffering awards, New York lawyers are known to "anchor" or start with an extremely high figure when requesting an award. Unlike medical expenses, pain and suffering cannot be objectively measured, and this tactic often leads to nuclear verdicts. In fact, in 90% of cases where over $20 million is requested, at least that amount is received.[22]

Florida

20
Nuclear Verdicts

$561.7M
In Total Awards

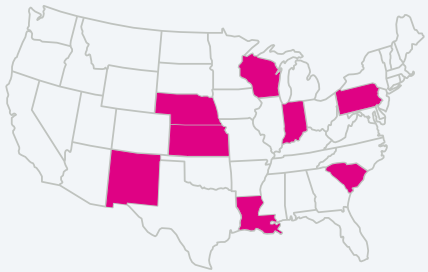
With the most nuclear verdicts per capita, and 40% including a punitive damage element, Florida's judicial environment has been hard on businesses for years. [23] Broward County and Miami-Dade County are known to issue nuclear verdicts most often. In 2023, Florida started to take steps to reduce the severe risk on businesses including a reduction on the statute of limitations and more regulations on the evidence admissible to prove the amount of a plaintiff's damages for past or future medical care.

How Some States Are Protecting Patients and Doctors with Patient Compensation Funds

Patient compensation funds (PCF) are state-operated programs that cap the healthcare provider's exposure per claim at an amount specified by the state. Designed to protect both the patient and the doctor, PCFs lower the total cost of risk for doctors and healthcare systems by supplementing medical professionals' coverage over a certain limit.

> *For example, if a doctor participating in a state-led PCF program is sued for $400,000, but their medical liability policy provides only $200,000 in coverage, the PCF will cover the remaining $200,000.*

Eight Active PCF States



Indiana	New Mexico
Kansas	Pennsylvania
Louisiana	South Carolina
Nebraska	Wisconsin

Each state varies in management of the PCF.

> *For example, while PCF is mandatory for physicians in Pennsylvania and covers claims beyond $500,000 against doctors, the state of Indiana does not absolutely require PCF but any physician who opts to partake must have malpractice insurance coverage of $250,000 per patient.* [24]

SECTION 3

Formulating a Comprehensive Strategy to Address Total Cost of Risk

The consolidation of healthcare entities creates a multitude of new challenges to overcome, ranging from regulatory compliance and financial alignment to cultural integration and patient care continuity. Rushing into a cross-market transaction without a well-structured strategy can result in substantial operational disruptions, financial instability, and reputational damage, all severely impacting the total cost of risk.

Focusing and safeguarding the health of the business does not equate to deprioritizing patient safety and care. In fact, a robust risk management approach enhances the ability to provide top-quality healthcare services by mitigating potential pitfalls and uncertainties, which allows the organization to allocate resources more efficiently, invest in the latest medical technologies, and maintain the highest standards of patient safety and care.

The path to this level of successful consolidation is a meticulously crafted strategy that embraces the three pillars of protection and resilience: due diligence, insurance, and risk management.

1. Due Diligence - Market, Legal and Regulatory

The journey to successful consolidation or acquisition does not start at the time of purchase. Once the papers are signed, the acquirer may be responsible for all of the risks and liabilities associated with its new entity — previously known or otherwise. Think of due diligence as the road to purchase, with stops along the way to ensure the decision is right for the business. During due diligence, all internal and external factors that create risk are identified, and the questions asked during the process will help focus the strategies of the risk management team after acquisition.

The complexity of the healthcare market makes the due diligence process even more important, and it may require experts from several fields to appropriately answer the following key questions.

What is the new company's market and specialty?

Remember, there are two main types of healthcare consolidations: horizontal and vertical. Horizontal consolidations in the same region are the most simplistic as the two organizations are similar in market and specialty. If the target company's specialty is different from the acquirer's (a vertical consolidation) this will necessitate a distinct decision-making and assessment process that requires a closer look at litigation trends and regulatory environments. Even if the specialty is the same but the practice is in a new geographic jurisdiction, the evaluation should consider the regulatory and legal differences in that area. In some cases, a holding company may be established to oversee and manage the financial aspects of multiple physician practices, which introduces its own set of risks and complexities to be assessed.

What is the regulatory environment associated with that specialty and jurisdiction?

It can be tempting to assume that any well-established company is inherently compliant with all the regulatory requirements of its trade and jurisdiction. However, both parties will be responsible once the two are combined, and if businesses are to cross state lines, each party should understand the implication to their operations. In some instances, regulations can restrict certain acquisitions. For example, corporate practice of medicine regulations are developed primarily at the state level, and in some states hospitals or corporate entities cannot own physician groups. This legal due diligence, along with understanding of the litigation and regulatory environment of a new jurisdiction, will also help an organization select the right coverage and prevent high losses after merger.

How will the acquisition impact coverage retention?

The company's coverage retention limit is based on its risk profile. As the new risk profile of the combined entities is uncovered through the due diligence process, it may impact the amount to be paid by the company before its insurance coverage is activated. If the retention limit significantly increases due to higher risks in a new jurisdiction, will the company need to find alternative ways to finance its risk? Due to the litigious environment of the new jurisdiction, will new or different limits or additional policies need to be acquired?

What is the payor environment?

Resource utilization, quality of care, and profitability are all dependent on the organization's ability to maintain a healthy cash flow. Beyond understanding the financial health of the new company, one must be aware of how the company's payor environment will impact the cash flow of the entity. This bleeds into insurance coverage as well. What is the reimbursement and negotiation structure of insurance companies in the new jurisdiction? How will the company get paid in the event of a claim?

Is this a joint venture?

If more than one acquirer is involved, the parties must assess and strategize for an added layer of contractual risk. Decisions between the two acquirers will need to be made, such as how will they structure the new company and whose insurance will apply to the new venture? When it comes to litigation, joint defense is not implied but would need to be written into the contract.

2. Insurance

It is not a question of whether or not insurance belongs in an M&A strategy, but rather what type of coverage is right for the situation based on the findings of the due diligence process. Each state may have unique requirements and regulations, which can impact the type and extent of insurance coverage required. Additionally, factors such as whether the state has implemented tort reform should influence insurance decisions. In some states, traditional insurance or being self-insured might be a viable option, while in others, setting up a captive insurance arrangement could lead to more reasonable rates.

The key to navigating healthcare consolidation successfully lies in tailoring the coverage to the deal structure, which requires careful assessment of what to do with existing liabilities. For healthcare professionals, is a tail policy needed to cover past liabilities, and if so, who will be responsible for acquiring that coverage? The deal structure itself can take various forms, such as asset acquisitions (where the business takes over specific operations) or stock acquisitions (the business assumes control of the entire entity).

Working closely with an insurance broker can help avoid creating gaps in coverage that can arise specific to the unique deal, the location of the new entity, and the existing entity. Ultimately, the goal is to find insurance solutions that strike a balance between risk transfer and affordability.

Alternative insurance structures

Healthcare organizations may want to consider creating a captive insurance subsidiary to better handle and reduce risks, particularly when it comes to healthcare professional liability. Captives work like a type of self-insurance, except the healthcare organization owns the insurance company entirely.

One of the key advantages of a captive lies in the transformation of traditional insurance expenses into a potential asset class. When executed correctly, a captive has the potential to evolve into a profit generator. Beyond financial gains, captives can provide healthcare systems with potentially reduced operating costs, access to reinsurance markets, and the ability to tailor insurance coverage to meet an organization's unique needs.

For example, an organization can use captive insurance to manage run-off liability versus a more traditional tail policy. In some cases, acquiring companies can explore the legacy insurance market, where other capital entities may purchase the precedent captive. This creative approach can be a viable alternative to the conventional insurance market's premium-based tail coverage, ultimately streamlining the run-off management process while optimizing financial outcomes.

Is my organization a
Good fit for captive insurance?

Use the following five questions to determine if your healthcare business is well-suited for captive insurance.

Current insurance costs:

>1M

1. Are you spending over $1 million on malpractice insurance annually?

Desire for autonomy:

2. Do you want more control over your insurance decisions?

Flexibility in coverage:

3. Do you desire flexibility in choosing what specific risks or areas to insure?
4. Is your goal to smooth out financial performance and eliminate unexpected losses or surprises for shareholders?

Current insurance costs:

5. Is predictability within your organization's finances and balance sheet a priority?

3. Risk Management

As an organization grows, its risk mitigation strategy should adapt to the unique challenges presented by the different scenarios that arise and new market entrants. For example, managing risk in a Texas hospital might require different resources and expertise compared to a patient compensation state or one with a high frequency and severity rate. The organization will need dedicated individuals, robust policies and procedures, and ongoing education to address diverse risk landscapes effectively. The policies and education would then look different if the Texas organization was to acquire a urology clinic in Philadelphia, for example. No matter the expansion, it's essential to have someone on the ground with the expertise to manage risk specifically in that region, along with the necessary infrastructure to support them.

Measuring outcomes and improving quality are central to effective risk management. By identifying best practices and consistently reinforcing them, organizations create a culture of risk awareness and mitigation. Leadership plays a critical role in instilling this culture, as they set the tone and prioritize risk management as a cultural imperative. Developing this kind of risk-conscious DNA takes time, but it's a repetitive protocol that ensures the organization remains adaptable and resilient in the face of evolving liability.

Staffing for Growth

Any healthcare organization that expands its operations must ensure it has the right people in the right places to manage risk and maintain quality of care. If an expansion involves inheriting another company's staff and hiring practices, the process becomes more complex.

Making the wrong hiring decisions can lead to exposure and liability at the holding company level. Organizations should conduct clinician audits to assess the accuracy of documentation, patient care, and hiring practices prior to transaction. Evaluating the historical performance of any acquired practices will help determine if the organization is inheriting any potential liabilities. Reviewing claims history, comparing it to local standards, and identifying any frequency issues with specific doctors through resources like the National Practitioner Data Bank also helps in risk assessment.

When moving into a new market, take time to understand staffing availability, turnover rates, and local pay scales. High turnover may indicate underlying issues, such as culture problems or burnout, which could lead to increased Workers' Compensation claims and other costly issues. Additionally, assessing lines of coverage and the company's claims history related to employment issues can highlight any red flags.

The shortage of healthcare workers is a pervasive issue across the industry. Addressing this issue is crucial to help minimize risks associated with understaffing and turnover. Organizations can explore compensable insurance products, such as disability insurance, to make compensation packages more enticing. Distinguishing yourself in a competitive labor market, including implementing deferred compensation programs, can help attract and retain skilled professionals.

Upgrading Technology

U.S. healthcare organizations were the most compromised by data breaches for the third year in a row with 344 breaches in 2022.[25] This number was surpassed in the first half of 2023. [26]

As part of the due diligence process for mergers and acquisitions, organizations should not only conduct a comprehensive security analysis of the new company but require adherence to industry best practices such as multi-factor authentication and cloud-based security solutions, which are vital in safeguarding sensitive patient data and maintaining operational continuity.

During an M&A, especially when governed by transition service agreements, the complexity of cybersecurity risk management intensifies. A breach during this period can have dire implications, underscoring the necessity of stringent cybersecurity assessments and regulatory compliance evaluations.

Even outside of these scenarios, cybersecurity threats are a growing concern that can disrupt operations and financial stability for healthcare facilities — and their impact is even more wide-reaching. Over 26 million people were impacted by the 344 breaches that occurred in 2022. [27] The insurance underwriting market therefore places a premium on differentiating organizations that have robust cybersecurity measures in place to prevent such disruption.

SECTION 4

Going Forward

The consolidation of healthcare entities, including cross-market mergers can reduce costs, optimize resources, offer greater negotiating power with suppliers and vendors, and ultimately has the potential to offer a higher quality of care. And yet, healthcare organizations are not exempt from the rapidly evolving high stakes claims environment in which frequency and severity continues to climb.

The risk of litigation is greatest for six states in particular — California, Florida, Georgia, Illinois, New York and Pennsylvania, where nuclear verdicts are more common and state legislatures have been forced to enter the debate on one side or the other.

Having a comprehensive master plan to address total cost of risk when executing transactions requires due diligence, risk transfer to insurance, and a playbook to manage costs into the future.

Considerations for Future Transactions

The key to a successful consolidation of healthcare entities is having a partner with deep knowledge of best practices and risk management strategies. Thousands of healthcare organizations have consolidated, and most of them have not done so alone. There are numerous stakeholders in a single consolidation, and those that are successful utilize the right partners to conduct each step of the process.

Risk management advisors with knowledge of and experience in the healthcare market can provide benchmark data, evaluate and mitigate potential risks, connect the organization with a network of specialists such a legal counsel, and provide guidance through post-merger risk management. By consolidating the knowledge and experience of multiple entities and past mergers, it is possible to create a unified approach built on historical best practices and lessons learned, leading to better outcomes, improved patient care, long-term success, and overall organizational harmony.

About Symphony Risk

Symphony Risk Solutions is a next generation, full-service insurance, risk management, and employee benefits advisory firm. Symphony Health is the specialty business of Symphony Risk Solutions dedicated to the healthcare marketplace, with an innovative and client-centric approach to insurance placement and risk financing. Features that make Symphony unique in the marketplace:

Barrier-free Structure

Symphony's flat organizational structure and shared P&L means that clients have seamless access to experts within our business verticals, including Symphony Transact for acquisition due diligence and integration, and Symphony Consulting for employee benefits and human capital support.

Market Knowledge and Global Reach

With Symphony leading the brokerage process, clients have access to any coverage, with any insurer, anywhere in the world. The firm currently has placements with 130 insurers in 14 countries and has exclusive brokerage partnerships with firms representing 46 countries.

Team Experience

Averaging 25 years of experience, our team of industry experts provides global reach, sophisticated risk management, and unlimited market access.

Placement and Advisory Expertise

From traditional insurance placement to tailored risk financing solutions, clients benefit from innovation and deep expertise. Symphony exceeds the traditional broker standards to deliver custom solutions that clients can employ to create value, avoid uncertainty, and plan for growth.

External Industry Partnerships

Symphony's "best in class" model encourages client service teams to partner with industry experts, both inside and outside of our firm. Symphony constructs and places the best insurance and risk-financing solutions for its healthcare clients using the best in the industry, both inside and outside the firm.

Our Team

Frank McKenna

President, Symphony Health

Frank has been a leading expert in the healthcare brokerage industry for over 35 years. He began his career in the 1980s in Los Angeles at the Sullivan Companies, a leading broker of hospital professional liability coverage. Frank was responsible for the employee benefits business. With the emergence of managed care, Frank was an early innovator and provider of managed care capitation stop loss / reinsurance solutions. He later founded McKenna and Associates, which was acquired by Aon in 2000.

Before joining Symphony, Frank was the National Healthcare Practice Leader with Woodruff Sawyer. Over the course of his career, Frank led both Beecher Carlson's and Aon Risk's Healthcare Practices.

Daniel Schmidt

Managing Director, Symphony Health

Dan is the co-leader of the Symphony Health business within Symphony Risk Solutions. He is responsible for providing strategic direction for the business as well as critical risk financing advice to Symphony's healthcare clients. Dan also directs risk advisory services for many of Symphony's major clients.

Dan's expertise is designing and implementing customized programs to finance client risk, including complex alternative risk financing mechanisms. A seasoned professional with 40 years dedicated to risk management and finance, he began his career at a large teaching hospital. Experience managing the rigorous self-insurance programs there launched his successful career in healthcare risk finance, one that spans several major insurance brokers and many high-profile healthcare clients, including Stanford University, The University of California, and The George Washington University. Dan has been nationally recognized by his peers and his partners for his business production success and his ability to develop unique and creative solutions for his clients.

Dan holds a degree in Business Administration with an emphasis in Management from Pacific Union College and has completed extensive credits at the Drucker School of Business at Claremont Graduate University. He is a Chartered Property & Casualty Underwriter and a member of the American Society of Healthcare Risk Management.

Our Team

Liz Spink, CIC, RN, BSN

Director, Symphony Health

Liz is responsible for creating strategic and tailored risk financing solutions for our Symphony Health clients. Liz provides day-to-day exceptional service ensuring our clients are free to care for their patients and manage their healthcare organizations. Liz is well versed in all forms of risk transfer and risk financing for healthcare organizations, from Provider to Payor.

Liz brings over two decades of brokerage experience to Symphony Health as well as a clinical background. Most recently, Liz spent 21 years with a national brokerage as Senior Vice President & Healthcare & Higher Education Practice Leader serving clients worldwide. Client profiles include hospitals and health systems, senior living, physician groups and behavioral health. Prior to her brokerage career, Liz cared for patients in a Pediatric ICU setting.

Liz is a Registered Nurse in Missouri. Liz earned her BSN from Deaconess College of Nursing and her B.A (Business & Human Resources) and M.A (Human Resources Development & Organizational Development) from Webster University.

Steve Pelletier

Senior Principal, Symphony Health

Steve is a seasoned insurance professional with almost 30 years of sales, marketing, and consulting experience with Prudential, Mercer, The Hartford, ELM Exchange (now Med-IQ), Coverys, and Gallagher Bassett.

Steve helped grow ELM Exchange from a small, family-owned business—dedicated to training healthcare providers on risk avoidance in their clinical practice—into a nationally-known company in the hospital risk and medical professional liability marketplace.

He is an active member of the American Society for Healthcare Risk Management (ASHRM), as well as a participant and supporter of industry associations and events, including the Vermont Captive Insurance Association, Cayman Captive Forum, and Medical Professional Liability Association.

Steve earned a B.A. at the University of Wisconsin-Madison and M.S. at Northwestern University.

Sources

[1] RAND Corporation "Health Care Consolidation: The Changing Landscape of the U.S. Health Care System," May 17, 2023.

[2] American Medical Association "Policy Research Perspectives," May 2021.

[3] American Medical Association "Policy Research Perspectives," May 2021.

[4] Deloitte Insights "The potential for rapid consolidation of health systems," December 10, 2020.

[5] Deloitte Insights "The potential for rapid consolidation of health systems," December 10, 2020.

[6] RAND Corporation "Health Care Consolidation: The Changing Landscape of the U.S. Health Care System," May 17, 2023.

[7] Harvard Business Review "Research: What Happens When Private Equity Firms Buy Hospitals?," March 20, 2023.

[8] PwC "Health services: US Deals 2023 midyear outlook," May 2023.

[9] PwC "Health services: US Deals 2023 midyear outlook," May 2023.

[10] FIERCE Healthcare "Cross-market hospital consolidation is on the rise and understudied, researchers say," November 7, 2022.

[11] Aon "2021 Aon/ASHRM Hospital and Physician Professional Liability Benchmark Analysis," 2021.

[12] Aon "2021 Aon/ASHRM Hospital and Physician Professional Liability Benchmark Analysis," 2021.

[13] American Tort Reform Association "Nuclear Verdicts Explode in No. 1 Judicial Hellhole Georgia," December 6, 2022.

[14] U.S. Chamber of Commerce Institute for Legal Reform "Nuclear Verdicts: Trends, Causes, and Solutions," September 2022.

[15] U.S. Chamber of Commerce Institute for Legal Reform "Nuclear Verdicts: Trends, Causes, and Solutions," September 2022.

[16] U.S. Chamber of Commerce Institute for Legal Reform "Nuclear Verdicts: Trends, Causes, and Solutions," September 2022.

[17] U.S. Chamber of Commerce Institute for Legal Reform "Nuclear Verdicts: Trends, Causes, and Solutions," September 2022.

[18] JD Supra "Illinois Biometric Privacy Law Developments May Increase Risk to Businesses Generally But Protect Healthcare Employers from Suits," February 21, 2023.

[19] State of California "Governor Newsom Signs Legislation to Modernize California's Medical Malpractice System," May 23, 2023.

[20] U.S. Chamber of Commerce Institute for Legal Reform "Nuclear Verdicts: Trends, Causes, and Solutions," September 2022.

[21] WalletHub "Best & Worst States for Doctors," March 20, 2023.

[22] New York Civil Justice Institute "New York's Nuisance Nuclear Verdicts," May 4, 2022.

[23] U.S. Chamber of Commerce Institute for Legal Reform "Nuclear Verdicts: Trends, Causes, and Solutions," September 2022.

[24] Gallagher "Basics of Patient Compensation Funds By State," April 29, 2015.

[25] Identity Theft Research Center "ITRC Annual Data Breach Report," 2023.

[26] Identity Theft Research Center "The Weekly Breach Breakdown: An Apple a Day Keeps the Doctor Away – The Rise in Healthcare Data Breaches," July 28, 2023.

[27] Identity Theft Research Center "The Weekly Breach Breakdown: An Apple a Day Keeps the Doctor Away – The Rise in Healthcare Data Breaches," July 28, 2023.

SYMPHONY RISK

To learn more visit:

SYMPHONYRISK.COM/HEALTH