Approved: March 31, 1997
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Don Steffes at 9:00 a.m. on March 25, 1997 in Room 529-S of the Capitol.

All members were present except: Senator Biggs, Excused
Senator Corbin, Excused

Committee staff present: Dr. William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Honorable Carla Stovall, Attorney General
Marni Vliet, Kansas Health Foundation
Kenneth P. Stewart, Columbia Wesley Medical Center
Steven Potsic, M.D., Ph.D.
Kevin Gross, Midwest Division of Columbia
Tom Bell, Kansas Hospital Association

Others attending: See attached list

Hearing on SB 372 -- Nonprofit hospital sale act
Senator Praeger discussed the community hospital's role in changing health care, definition of its assets in the determination of value, and the community's involvement in its formation and possible sale.

Attorney General Stovall informed the Committee that this bill would codify common law. Only the Attorney General can speak for a not-for-profit entity so it becomes her responsibility to assure the valuation of such an entity is appropriate. (Attachment 1) The importance of the bill was stressed as it explicitly lists the nine powers of the Attorney General in the sale of of a not-for-profit hospital to a for-profit organization. The bill requires disclosure to the public prior to the sale. She suggested that the bill also apply to the sale of not-for-profit hospitals to another not-for-profit hospital. The Attorney General already has the power to block through the courts any sale of not-for-profit hospitals if the valuation is assumed to be incorrect. Committee questions included whether the inclusion of the suggested amendment by the Attorney General would grant her authoritative and veto powers in any hospital transaction. Independent experts on valuation are usually hired to ascertain the valuation of not-for-profit hospitals in sales negotiations.

Tom Wilder, Kansas Insurance Department, presented written testimony only. (Attachment 2)

Marni Vliet, President of the Kansas Health Foundation, presented testimony on the history, development, and current activities of the Foundation. (Attachment 3) The definition of "health" has been expanded to include education, jobs, quality of life issues, general environment, etc. Committee discussion included questions of whether communities have lost control of their health dollars and is the Kansas Health Foundation the best authority to handle these dollars.

Kenneth P. Stewart, counsel to Wesley Medical Center, reviewed for the Committee the history of the sales transaction of Wesley Medical Center to Columbia/HCA Healthcare Corporation and the creation of the Kansas Health Foundation. (Attachment 4) The proposed sale was widely publicized prior to the actual sale.

Dr. Steven Potsic, Kansas Department of Health and Environment, explained that the proposed bill would establish a joint KDHE-Attorney General review process related to hospital acquisitions. (Attachment 5) Inasmuch as KDHE has not been involved in such activity before, he suggested that an interim study be conducted to address issues such as the types of standards proposed, analysis of existing health care market and community services, and exact responsibilities of the Attorney General and KDHE in this process.

Kevin Gross, President of the Midwest Division of Columbia/HCA Healthcare Corporation, reviewed the operations of their four hospitals in Kansas which employ 4800 people. (Attachment 6) Many of the existing not-for-profit and for-profit hospitals in Kansas need to consolidate with some larger type of network system in order to remain financially viable. Ninety-two percent of the mergers last year were between not-for-profit hospitals. The proposed bill would put an enormous burden of increased government regulation on hospitals

seeking to affiliate, merge, or otherwise join systems. He urged the Committee to include not-for-profit hospitals being acquired by another not-for-profit hospital to be subject to such review process also. Tax status should not be a criteria for reviewing such transactions. He requested to be included in the interim study if one is established. Committee discussion included: the need for reinstatement of Certificates of Need before a hospital could be established in an area; the question of clinics carving out part of the once dedicated hospital business.

Tom Bell, Kansas Hospital Association, spoke in opposition to the bill as it would make the Attorney General the decision maker in determining valuation of not-for-profit hospitals in sales transactions to for-profit entities. (Attachment 7) The state's role should be to assist the community in making the decision and not become a barrier to negotiation.

Senator Praeger recommended the bill be placed in an interim committee for further study.

The meeting was adjourned at 10:02 a.m. The next meeting is scheduled for March 31, 1997.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 3/25

NAME	REPRESENTING
Ken Stewart Boyd, Davidson & Stewart	The Wesley Sale
Mari Ulit	Kansas Health Foundation - "conversion"
KEVIN GROSS	Columbia / HCA Healthcare Corp
Ron Hein	Columbia / HCA Healthcare Corp.
Diana Gross	Columbia / HCA Healthcare Corp
Susan Baker	Hein + Weir, Columbia/HCA
RICH VLIET	KANSAS HEALTH FOUNDATION
Rick Guthrie	Health Midwest
Roger Fauske	Nationsbank
Greg Rosen	KDHE
Don Wilson	KHA
Tom Bell	KHA
Carla Stovall	AG
Kevin Case	AG Office
Chris Burger	AG
Nancy Lindberg	Atty Gen
Linda McCluskey	KS Insurance Dept
Tom Wilder	Kansas Insurance Dept -

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Office of the Attorney General
301 S.W. 10TH AVENUE, TOPEKA 66612-1597

CARLA J. STOVALL
ATTORNEY GENERAL

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TESTIMONY OF ATTORNEY GENERAL CARLA J. STOVALL BEFORE THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE, MARCH 25, 1997 REGARDING SENATE BILL 372, THE KANSAS NONPROFIT HOSPITAL SALE ACT.

Because I believe we need to clarify the process by which state officials enforce state law regarding the sale of nonprofit hospitals in Kansas, I am here to testify in support of Senate Bill 372, the Kansas Nonprofit Hospital Sale Act.

Nationwide, hundreds of nonprofit organizations are deciding to sell off their hospitals to large health care corporations. Kansas is no exception to this national trend. My staff is already reviewing such a proposed acquisition between Bethany Medical Center of Kansas City, Kansas and Columbia/HCA HealthCare Corporation of Nashville, Tennessee. In this proposed acquisition, Columbia/HCA intends to purchase the majority of the Medical Center's assets and in turn, a charitable foundation will be created from the sale proceeds. SB 372 recognizes this nationwide trend has come to Kansas and establishes a more coherent, more efficient process by notifying nonprofit hospitals how I am to enforce Kansas law relating to such acquisitions. SB 372 improves the current law without creating new regulatory burdens on nonprofit hospitals.

Senate F.I.I
Attachment 1
March 25, 1997

SB 372 provides a reasonable mechanism for ensuring that existing Kansas laws relating to corporations, charities and trusts is enforced. SB 372 requires me, if I would determine that I need to review the proposed transaction, to approve the transaction unless I find that the acquisition is not in the public interest. To do this, I must determine whether, for instance:

1. The acquisition is permitted under the laws of Kansas governing nonprofit entities, trusts or charities;

2. The nonprofit hospital is exercising due diligence;

3. Expert assistance is being used;

4. Conflicts of interest are disclosed; and,

5. Reasonably fair value will be received.

This legislation does not allow me to substitute my judgment for that of the nonprofit board of trustees. That determination, at all times, remains with the board of trustees. The Attorneys General of other states such as Nebraska, Missouri, Michigan, California, Florida, and Massachusetts have been faced with similar acquisition issues like I am facing now.

The types of issues that all Attorneys General confront in this area may best be illustrated by the following not-so-hypothetical situation. Assume a constituent came to you to recount this situation. The constituent had elderly parents who over the course of several years had made contributions to a favorite charity -- a charity whose mission was to provide medical services for the indigent. The charity relied on donations and payment for services to provide their charitable services. During their lifetimes, the constituent's parents supported the charities' fund drives. They attended charitable auctions. Maybe the constituents even walked door to door with their parents to raise money for the charity. Convinced that the charity was a worthy cause, in their Wills, the constituent's parents even left a modest sum of money to the charity. But suddenly

something changed. Without notice, it was discovered that the current directors of the charity decided that they could no longer operate their charity, and for some unknown reason, had decided to sell off all the charitable assets to a for-profit corporation who intended to use the assets, including the name of the charity in a new business, but now the former charity would be operated for a profit. Your constituents parents' efforts, donations and bequests were now to be used to nurture an on-going private business. Their efforts, donations and bequests had been radically transformed, and their original charitable intentions frustrated. Worse yet, imagine your constituent lacked any means to question the sale of the charitable assets. Imagine if your constituent lacked the security that any state law enforcement official had any efficient mechanism to prevent this scenario from happening again.

Kansas law relating to corporations, trusts and charities currently provides that the Attorney General is responsible for seeing that this scenario does not occur without oversight. However, current law fails to provide a efficient, meaningful process to prevent scenarios like what I have just set forth from reoccurring. Nonprofit hospitals fall within the same category as other charities. Because nonprofit hospitals are some of the largest of our charities and a vital part of our communities, they are necessarily included in the oversight that my office provides. This Act gives nonprofit hospitals the notice they need to understand how they can comply with Kansas law.

I support the Kansas Nonprofit Hospital Sale Act as the establishment of a meaningful process to prevent the loss of charitable assets.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: Senate Financial Institutions
and Insurance Committee

From: Tom Wilder

Re: S.B. 372 (Nonprofit Hospital Sale Act)

Date: March 25, 1997

I am appearing today in support of Senate Bill 372 which will establish procedures for the review by the Attorney General and the Department of Health and Environment of the sale of nonprofit hospitals. Nationally, about 85 percent of hospitals are classified as nonprofit institutions. Over 90 percent of the 159 hospitals in Kansas are nonprofit. These institutions have a strong commitment to provide service to their communities including patients who are uninsured and "underinsured" and those who rely on government sponsored insurance programs such as Medicaid.

The conversion of a nonprofit health care organization into a for-profit entity raises important policy questions. First, a for-profit hospital does not have the same community focus and may not provide the same type of essential services or serve vulnerable populations such as low income or uninsured people. In addition, nonprofit institutions usually receive tax advantages because of their charitable nature. There is the issue of whether the assets of the nonprofit hospital should be returned to the community as part of the conversion process.

The legislation requires that notice be given to the Attorney General and Secretary of the Department of Health and Environment of any sale of a nonprofit hospital to a for-profit entity. The Attorney General must give notice of the transaction to the community

Senate F & I
Attachment 2
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Topeka, Kansas 66612-1678

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Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

2-2 2-2 2-3

The National Academy for State Health Policy

Table 2

Characteristics of Recently Enacted State Health Plan Conversion Laws

State (state law citation)	Conversion defined	Advance state approval	Agencies involved	Public hearing	Key criteria for approval	Conditions for foundation	Use of outside experts
California (Health & Safety Code 1399.70-1399.76)	transformation of NP to FP or transfer of substantial amount of NP assets to FP (applies to mutual plan with assets subject to charitable obligation)	yes	Corporations Commissioner (foundation must report annually to Commissioner and AG)	yes	no private inurement or conflict of interests mechanism to continue charitable purpose and public benefits obligations	independent board; without conflicts; experienced directors; purpose: serve Californians' health care	yes (may charge costs to plan)
Colorado (C.R.S. 10-16-324)	change of ownership to stock company	yes	Insurance Commissioner	yes	plan is fair & reasonable not contrary to interests of subscribers or public assets used to promote or serve health needs of Coloradans	independent of plan's board limits on lobbying, self-dealing	yes (may charge costs to plan)
Georgia (H.B. 669, 1995)	change of ownership of NP to FP health care corporation or creating a FP subsidiary	yes	Insurance Commissioner (notice to AG)	yes	none	none (no assets required to be set aside for public benefit)	no
New Jersey (C.17:48E-45 — 48)	change of ownership of health services corporation to mutual insurer	yes	Insurance Commissioner	yes	no prejudice to interests of subscribers	none (no assets required to be set aside for public benefit)	no
Virginia (art. 1, ch. 10 sec. 38.2-1005.1)	change of mutual insurer to stock insurer	yes	Insurance Commission	opportunity for policy holders to be heard		none (no assets required to be set aside for public benefit)	no

The National Academy for State Health Policy

Table 1

Characteristics of Recently Enacted State Hospital Conversion Laws

State (state law citation)	Applicable transactions defined	Advance state approval	Agencies involved	Public hearing	Key criteria for approval	Conditions for foundation	Use of outside experts
California (Corp. Code 5913 - 5919)	Conversion: disposal of material amount of assets to FP or mutual benefit corporation or transfer control, responsibility or governance of material amount of assets to FP or mutual benefit corporation	yes	Attorney General (may consult with and receive advice from any state agency)	yes	-fairness of terms and asset value -no private inurement -proceeds to be used consistent with assets' charitable trust -no breach of trust -no significant impact on availability or accessibility of local health care -transaction is in the public interest	none	yes (may charge costs to nonprofit hospital)
Nebraska (Legislative Bill 1188, 1996)	Acquisition: change of ownership or FP controlling interest in a NP hospital of 20% or more or where acquiring firm controls 50% or greater interest in the hospital	yes	Attorney General Department of Health	yes	-due care by NP in decision & process of sale -fair market value of NP's assets -avoidance of conflicts of interest -risk to charitable funds -continued access to affordable care & for disadvantaged people	broadly based in community	yes (may charge costs to nonprofit hospital)

KANSAS HEALTH FOUNDATION

Testimony, Senate Financial Institutions and Insurance Committee
Tuesday, March 25, 1997
Marni Vliet, President of the Kansas Health Foundation

Kansas Health Foundation

About the Foundation:

- A private philanthropy based in Wichita.
- Total assets: $370 million
- Annual grant-making: $15 million
- Mission: To improve the health of all Kansans.
- Funding categories: Public health, rural health, primary care education, health promotion and disease prevention, health policy.
- Funding partners: Regents institutions, Kansas Department of Health and Environment, county health departments, individual communities, etc.

History:

1978: Wesley Medical Endowment Foundation
1985: Wesley Medical Center sold to Hospital Corporation of America (Wesley Foundation begins)
1991: Public to private foundation; name changed to Kansas Health Foundation
1995: Kansas Initiative, a listening tour to 27 communities
1997: A focus on children and leadership

A Focus on Community

NAME OF PROJECT	AMOUNT	TERM
Integrated Community Health Development Project (ICHD)	**$1.3 million**	**6 years**

- *To provide rural communities with the opportunity to design an integrated system serving the area's health care needs in a more coordinated and cost-effective manner.*

  Communities: Ottawa, Geary, Clay, Wilson and Cloud & Republic counties, Wellington and Marysville

Leadership Institute	**$1.1 million**	**6 years**

- *To develop the skills of community health leaders in the state.*

Kansas SmokeLess Kids Initiative	**$300,000**	**4 years**

- *To support the development of a statewide agency dedicated to tobacco use prevention and control. Matching funds from the Robert Wood Johnson Foundation: $873,000.*

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Healthy Start Plus $766,000 3 years

- *To replicate a successful program for preventing child abuse and neglect by working with parents at the time their child is born and providing the family with intensive home visitation services.*

  Pilot site: Hutchinson

Personal Actions to Health (PATH) $665,000 4 years

- *To support a program that assists communities in developing health promotion activities for older adults.*

  Partner: Kansas State University Cooperative Extension program. Mini-grants to more than 60 communities.

Project Freedom $1.5 million 4 years

- *To support the replication of a community-based model that reduces and prevents adolescent substance abuse.*

  Communities: Leavenworth, Junction City, Lawrence

Adolescent Pregnancy Prevention $2.3 million 4 years

- *To support replication of a previously successful model aimed at reducing unwanted adolescent pregnancies.*

  Communities: Wichita, Ottawa, Junction City

Kansas LEAN (Low-fat Eating for America Now) School Health Project $821,000 4 years

- *To reduce the consumption of dietary fat in an effort to reduce the incidence of heart disease and cancer among Kansans.*

  Partner: Kansas Department of Health and Environment

  Communities: Winfield (USD 465), Pierceville (USD 457), Holcomb (USD 363), Arkansas City (USD 470), Rose Hill (USD 394), and Andover (USD 385)

Adolescent Physical Education Project $911,288 4 years

- *To support the expansion of an integrated health and physical education course in 80 school districts. The course provides high school students with the health/fitness skills needed to assume responsibility for their own health and well-being throughout life.*

  Partners: Kansas State Board of Education, state university physical education departments, local school districts

Community Partnerships for Health - Schools and Public Health $325,000 2 years

- *To promote partnerships between schools and local public health departments, so communities can address social factors that influence the health of children.*

  Communities: Atwood, Dodge City, Hoyt, Wichita, Great Bend, Kansas City, Hutchinson, McPherson, Arkansas City, Winfield, Oskaloosa, Pratt

"Red Blood and High Purpose: Crumbine in Kansas" $82,000 2.5 years

- *To write, produce and stage a play based on the life of Samuel Crumbine, M.D., a noted national public health leader and former director of health in Kansas.*

A Focus on Systems

NAME OF PROJECT	AMOUNT	TERM
Kansas Public Health Association (KPHA)	$427,000	5 years

- *To develop and implement a strategic plan to allow KPHA to become a more effective advocate for primary prevention and population-based approaches to health.*

Kansas Department of Health and Environment (KDHE) strategic plan $149,400 2 years

- *To provide strategic planning expertise for the state health department.*

Master's in Public Health $2 million 4 years

- *To support the development of a collaborative master's of public health degree program at Wichita State University and the University of Kansas School of Medicine campuses in Wichita and Kansas City.*

Epidemiology $1.2 million 4 years

- *To support the development of data collection and analysis within the state.*

  Sites: KDHE, University of Kansas and WSU

Kansas Health Institute $5.4 million 5 years

- *To develop an independent health policy institute based in Topeka with the purpose to provide analysis of health issues in Kansas for legislators and other decision makers in the state.*

Distinguished Professorship in Public Health $1.6 million

- *To support an endowed position within the Department of Preventive Medicine at the University of Kansas School of Medicine in Wichita.*

Distinguished Professorship in Community Health $1.6 million

- *To support an endowed position at Kansas State University that would finds ways to bring health promotion programs to rural communities through the Cooperative Extension network.*

Telemedicine $193,000 2 years

- *To evaluate how telecommunications and telemedicine could affect the delivery and cost of health care in Kansas.*

  Partners: Kansas Medical Society, State Board of Emergency Medical Services, KDHE

Behavioral Risk Factor Surveillance Survey $750,000 3 years

- *To initiate a health risk data collection system for Kansas.*

Public Health Continuing Education $922,00 5 years

- *To provide continuing education opportunities for all county health departments in Kansas.*

  Communities: Every county in Kansas

Kansas Public Health Information System $721,000 2 years

- *To support the development of a computerized public health information system in the state.*

  Communities: Wichita-Sedgwick County, Douglas County, Lyon County, Shawnee County, Northwest Kansas (Decatur, Logan, Rawlins, Sheridan, Sherman, Thomas and Wallace), Southcentral Kansas (Barber, Comanche, Edwards, Harper, Kingman, Kiowa and Pratt)

Healthy Kansans 2000 at KDHE $970,000 5 years

- *To participate in a Centers for Disease Control (CDC) program that provides the expertise needed to measure Healthy People 2000 goals.*

A Focus on Primary Care

NAME OF PROJECT	AMOUNT	TERM
Primary Care Physician Education Initiative	$15 million	5 years

- *To restructure medical education to focus on community-oriented primary care.*

Community Health Project at KU School of Medicine $120,000 3 years

- *To support a student-run summer internship program that places first-year medical students in public health and social service agencies.*

Physician Assistant program $1.6 million 10 years

- *To increase the number of physician assistants providing care in rural underserved communities in Kansas.*

Partner: Wichita State University

Nurse Practitioner program $1.4 million 4 years

- *To develop and implement a collaborative nurse practitioner program that increases statewide distribution of primary care providers in underserved areas of Kansas.*

Partners: University of Kansas, Wichita State University, Fort Hays State University

Remarks of Kenneth P. Stewart regarding the sale of Wesley Medical Center to Hospital Corporation of America

I have been asked to relate to you some of the facts of the transaction by which the assets of Wesley Medical Center and affiliated entities were sold to Hospital Corporation of America in 1985.

First, allow me to identify myself and my part in that transaction. My name is Kenneth Stewart. I have been an attorney in private practice in Wichita for over four decades. As a substantial part of my legal practice, I served as counsel to Wesley Medical Center for many of those years, and our firm represented the hospital in general. This legal representation encompassed the span of time following the decision of the Kansas Supreme Court in Noel vs. Menninger Foundation in 1954. The significance of that case is that it illustrates an ongoing change in the manner in which hospitals operated, were publically perceived, and became engaged in an essentially competitive business. What that case did was abolish the doctrine of charitable immunity under which charitable institutions, including specifically hospitals, were immune from liability for injuries caused by their negligence. Kansas was not alone, as abolishment of this doctrine was an ongoing process nationwide. Abolishment of the charitable immunity doctrine was not the cause of the changes in the manner of operation of hospitals, but certainly had some effect thereon.

In our representation of Wesley Medical Center, we assisted the hospital in many facets of its continuing ongoing struggle to obtain access to capital and to enter into arrangements by which it could become more efficient and competitive. There was a series of industrial revenue bond issue transactions to raise capital, commencing in 1969 and continuing right up to 1984. There was restructuring of the hospital corporations themselves and the formation of Wesley Medical Endowment Foundation to separately receive and administer all the charitably endowed funds for the hospital. There was participation in large group buying associations. There were organizations formed to provide a network of managements with other hospitals. There were undoubtedly many other actions which do not immediately come to my mind. Suffice it to say there were continuing major efforts expended on these matters in order to stay abreast and continue to provide competitive, high quality hospital and medical care.

Our firm was not involved in the initial actions or contacts which eventually led to the entry into and completion of the sale. Thus, I am unable to detail these actions for you. All that I can relate is that it is my understanding that some of the members of the executive committee of the Board of Trustees and some of the professional administrators of the hospital became quite concerned about the continued ability of the hospital to obtain the tremendous amounts of capital and methods of operation necessary to continue to provide quality care and compete in what had become a competitive marketplace. These board members and professionals became aware of various national studies and reports indicating the possibility that some of the larger for-profit companies had so much better capabilities for obtaining capital and efficiency and sharing of operations that they could provide better quality and more

Senate H.D.S.
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competitive health care than many of the non-profits could. Out of these concerns, the executive committee of the Board of Trustees set up a task force to explore the possibility of sale. The executive committee included senior and experienced corporate executives, successful businessmen, lawyers, senior and experienced bankers and entrepreneurs, so that it operated with a wealth of experience and knowledge. Ultimately this committee decided that the possibility of a sale should be explored, and appointed a negotiating team comprised of a business entrepreneur, a senior real estate development executive, and a banker/industrialist. All were experienced and knowledgeable.

There are hospital consultants who specialize in the process of appraisals of hospitals. An appraisal was obtained. Negotiations for a possible sale were conducted by the negotiating team with Hospital Corporation of America, which was one of the larger, more well known national companies. In that process, it is my understanding that there were not only considerations of price, but there were visits to hospital facilities, to corporate headquarters, and consultation of various sources of information to assess the manner in which Hospital Corporation of American ran its health care facilities, provided health care, and its general methods of operation and reputation. While this process was ongoing, our office made a study of the technical legal requirements and possibilities to actually accomplish a sale. We determined that the sale could be made after full consideration by the various boards and upon their determination that such action was appropriate, proper and necessary in the interest of the health care mission of Wesley Medical Center. It was necessary that the proceeds resulting from the sale be devoted to a consistent charitable use, which in this instance was obviously the existing vehicle, the Wesley Medical Endowment Foundation.

The negotiating team and Hospital Corporation of America executives continued their process of negotiation. By November of 1984, they had achieved sufficient agreement to present a letter of intent proposal to the Boards of Trustees of Wesley Corporation and the Wesley Medical Center. Wesley Corporation was a parent, not-for-profit 501(c)(3) tax exempt organization with several subsidiaries, including the Wesley Medical Center, the hospital operating company. The letter of intent was presented to the boards of both those entities, and after a full consideration thereof, they made their decision that the letter of intent should be executed. As with all letters of intent, the parties agreed in principle to make a good faith effort to reach a definitive agreement, but the parties recognized and agreed that there would be no binding agreement until a formal written agreement was executed. These letters of intent commonly include major items to be included in the ultimate transaction, and in this case included:

1. Wesley agreed to sell all of the assets owned by Wesley Corporation and its subsidiaries except a subsidiary known as Wesley Medical Research Institutes. All assets were to be free and clear of any liens or encumbrances. Allow me to note here that Wesley Medical Research Institutes remains an existing separate entity and continues its good work of receiving, processing and administering grants in the medical research area.

2. Hospital Corporation of America agreed to pay Wesley at closing the sum of $250,000,000 less the balance of any liabilities assumed by HCA. The purchase price was to be paid forthwith. It was also to be adjusted upward or downward at the closing by the amount of any difference between the book value of the total assets shown on the audited financial statement as of the closing date and the book value of the assets on the September 30, 1984 interim financial statement from which the purchase price had been negotiated. I am not any kind of an expert on valuation, but allow me to point out here that the purchase price was approximately twice the gross book value of Wesley's assets, and we understand around twice the appraised value. Hospital Corporation of America was also obligated to acquire other assets for $15,000,000.

3. The letter of intent was conditional upon:

   A. The parties reaching a mutually satisfactory definitive agreement;

   B. Receipt of a Certificate of Need;

   C. Receipt of federal and state tax clearances or opinions that the proposed transaction would be tax-free to Wesley and its subsidiaries and would not adversely affect the tax exempt status of Wesley and its subsidiaries, nor the tax exempt status of Wesley Medical Endowment Foundation, nor the tax exempt status of the outstanding hospital revenue bonds and interest paid thereon;

   D. Compliance with all applicable laws, rules and regulations;

   E. Approval by the proper boards of trustees and, if necessary, memberships; and

   F. Obtaining all necessary consents required by law or contract.

The letter of intent also committed Hospital Corporation of America to not resell the assets within a ten-year period without extending a first right of refusal to Wesley.

Wesley Medical Center itself had been begun by the Kansas West Conference of the United Methodist Church and had operated throughout its years with the support of the church. Wesley's assets were held not only for the health care mission of the Wesley Medical Center, but also recognized the health care mission of the church. In recognition of the existence of these ties, a reporting process regarding the sale was engaged in by some of the negotiating team, hospital administrators and counsel, and members of the Board, to report to various churches and membership areas throughout the region of the Kansas West Conference. Extensive presentations regarding the purpose and the need for the sale were made. As part of this process of dealing with the church and its mission, it was ultimately agreed that some $33,000,000 of the sales proceeds would be paid in installments to the Kansas West

Conference to recognize and carry out its specific health care missions.

In the meantime, the substantial task of arriving at a definitive agreement and also clearing all the hurdles of tax exempt status and regulation from our side of the transaction were undertaken. Although large portions were performed by our office, together with the professional administrators, it was necessary to employ a variety of outside expert consultants in the legal and accounting field. An extremely critical area of this entire process was assuring the continuing 501(c)(3) tax exempt status of all of the entities involved, and that there would be no income tax consequences to those entities nor to those persons who had purchased the hospital industrial revenue bonds. In this connection, in lieu of the expensive and drawn out process of obtaining IRS determination letters or private letter rulings, it was decided to rely upon opinions from two prominent and respected firms regarding each of the two tax exempt areas involved.

With respect to the continued tax exempt status of the Wesley Corporation and its subsidiaries, the Wesley Medical Endowment Foundation, and the effects of the transaction itself upon those entities, we selected Foulston, Siefkin law firm of Wichita, and Peat Marwick & Mitchell, CPAs, a national accounting firm. These two firms conducted their own due diligence investigations of the entire transaction in order to arrive at their opinions. The major portion of their investigations and their opinions are devoted to two of the Internal Revenue Code 501(c)(3) requirements that the organization be operated exclusively for charitable purposes and that no part of its earnings inure to the benefit of any private shareholder or individual. This latter requirement is really related to the first and is what is being referred to in general discussions as "inurement" questions. Also looked at but less emphasized are the purpose of the sale and the purchase price. Private inurement can occur in a multitude of ways, depending on the transaction. In this instance, there were particulary examined inurement issues involving the purchaser HCA, involving officers, directors and employees of Wesley, and third party service providers. Both opinions concluded that the transactions allowed the organizations to remain tax exempt and that there was not created unrelated business income.

The second set of opinions concerning tax exemption related to the hospital revenue bonds which were outstanding. There were in excess of some $40 million in bonds outstanding, and the interest to the bondholders was tax exempt. Hospital Corporation of America could not assume this obligation and it was necessary that the bonds be "defeased". This process meant substituting a series of United States government bonds, notes and other obligations for the hospital's stream of revenue which had previously served as security for the bonds. In order to assure the continued tax exempt status of the interest paid on the bonds and the non-realization of taxable income by the defeasance of the bonds, a Wall Street law firm, Brown, Wood, Petty and Mitchell, was consulted, and King & Spaulding, a national firm, also rendered an opinion. The Brown, Wood firm came to Wichita and made their due diligence investigation to support their opinion. They concluded that the bond interest would remain tax exempt. Ernst & Whinney, CPAs, were consulted to create the structure of the bond's

defeasance fund of U.S. government bonds and to assure that the manner of this structure would not create a tax liability through being classified as "arbitrage" bonds, a rather technical concept.

The foregoing opinions were in regard to and based upon the final definitive agreement for purchase and sale which was achieved after a long negotiation process in May of 1985. This contract and the sale was a relatively large business transaction. As a result, we were engaged in or involved in a rather large number of legal aspects common to any regular business transaction involving ordinary companies. The other aspects which would appear to be of more interest to this committee would appear to be:

1. The right of first refusal to repurchase the assets which was granted to Wesley for a ten-year period if Hospital Corporation of America desired to sell the assets. This did come up a few years after the sale when Hospital Corporation went private in a leveraged buy-out. It was quite debatable whether this triggered the right of first refusal, but Wesley was notified by HCA of this transaction. In its notification, HCA submitted its financials, showing what portion of the leveraged buy-out would be attributed to Wesley assets. The calculation involved the relation to the total HCA assets and included those which had been added by HCA at Wesley. Although the triggering of the right of first refusal was doubtful, the Board, in the exercise of their responsibilities, considered the matter, had a CPA review the determination of the price, had a consultant give a brief opinion of value, and declined to exercise the right of first refusal subject to the condition that HCA recognize that the right of first refusal continued in the future.

2. An option to reacquire the hospital assets was created to allow a repurchase of the assets in the 5th to 6th year after the sale, in the event it were felt that HCA was not providing quality medical care and meeting its obligations. The price to be paid was determinable by the original assets adjusted for inflation, additional assets, and income tax consequences to HCA. The Board exercised its responsibility to examine both the price and the performance of HCA, and elected not to exercise this option.

3. Hospital Corporation of America undertook to continue certain programs at the hospital, including the chaplaincy program, indigent care, the volunteer program and medical education. It also committed up to $7 million for construction of a wellness center.

4. There was created a Board of Advisors who were selected from the former Wesley Trustees Board to monitor the performance of Hospital Corporation of America, including but not limited to the above programs, and to retain a community monitoring of the health care service. This board has been created and has functioned throughout the period since the sale occurred on July 11, 1985.

By way of summary, the sale was conducted under a great deal of scrutiny over a relatively short period of time. The tax exemption requirements of the Internal Revenue Service themselves are sufficient to inspire a great deal of caution in conducting such a sale. The considered decision of the Board of Trustees was made and subjected to this various scrutiny. What would have happened had they not made this decision is unknown. What we do know is that we continue to have an excellent health care facility at the Wesley Medical Center, the Kansas West Conference of the United Methodist Church has received $33 million to devote to its health care mission, and the Kansas Health Foundation currently has assets in excess of $300 million to devote to health care in Kansas after expending millions of dollars toward Kansas health care in the interim.

Thank you for your courtesy.

F:JOW:jrh wesley sale history

State of Kansas

Bill Graves Governor

Department of Health and Environment
James J. O'Connell, Secretary

Testimony presented to

The Senate Committee on Financial Institutions and Insurance

by

The Kansas Department of Health and Environment

Senate Bill 372

Thank you for the opportunity to provide testimony on SB 372. Passage of this bill would create the Non-profit Hospital Sale Act and empower the Attorney General and Secretary of Health and Environment with new authority to review the acquisition of non-profit hospitals by any person. KDHE does support the need to assure that the public's health interest is considered when a major acquisition occurs. Where the local community has supported a non-profit hospital as a community asset and service, it should be entitled to assurance that it will continue to receive the services and benefits of that asset, though its legal form may change.

This bill would give new authority to the KDHE Secretary regarding such acquisitions. Currently only very broad authority is available to the Department under the provisions of KSA 65-429, which requires written approval of the licensing agency for transfers of licenses to other entities. Federal Medicare requirements related to change of ownership involves only the completion of forms to transmit the change to the Health Care Financing Administration and fiscal intermediaries.

It is difficult to project how many of these types of acquisitions may occur in the future. On one hand, Kansas has well over 90 percent of its 143 acute care hospitals owned by not-for-profit or government entities. This might indicate that there are potentially a large number of transactions which might be subject to review. On the other hand, since many of these facilities are supported by local communities, it is not certain how many might be viewed as attractive acquisitions by potential purchasers.

The bill establishes a review process related to hospital acquisitions for which the Department has no previous experience. During his review, the Secretary must utilize criteria established in Section 8 of the bill. These include: whether sufficient safeguards are included to assure the affected community continued access to affordable care, whether a commitment to provide health care to the disadvantaged has been made, whether the purchaser has made a commitment to provide benefits to the community to promote improved health care, and others. This section also limits the Secretary from applying higher standards to hospitals covered by the bill than those applicable to other hospitals. These established criteria relate to community financial obligations, economic support of targeted groups and services, and projected values rather than health care quality standards. Although

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the standards for the covered hospitals can not be greater than for other hospitals, the Department has not established these types of standards for any hospitals.

The Secretary and Attorney General are to jointly review applications, hold hearings, and approve/disapprove applications in short time frames. For example, the Attorney General must decide within 20 days whether to review an application; a hearing must be held within 30 days after receipt of the application, and there must be ten days notice of the hearing given. This leaves only ten days for the Department to review the application and prepare for a public hearing. In order to do an effective review, additional time would be necessary.

The Department believes that the types of standards proposed and the necessary analysis of the health care market and community services have not been sufficiently addressed and would be an important topic to consider for interim study. In addition, some provisions of the bill should be reviewed to assure a well-coordinated, non-duplicative process is created between the Attorney General and the Secretary.

Presented by: Greg L. Reser, Director
Hospital and Medical Programs
Bureau of Adult and Child Care

Date: March 25, 1997

Testimony Regarding Senate Bill 372

Senate Financial Institutions and Insurance Committee

Kevin Gross

March 25. 1997

Ladies and Gentlemen, my name is Kevin Gross. I live in Wichita, Kansas and am appearing here today in opposition to Senate Bill No. 372. I am the President of the Midwest Division of Columbia/HCA Healthcare Corporation and I am responsible for my company's operations in Kansas and Missouri. We have four hospitals in Kansas employing over 4800 people.

As you know, the health care industry is in the midst of rapid change. The rate of change we see today is unprecedented and shows no signs of slowing down. If anything, the rate of change will likely increase in the future.

One result of these rapid changes is that hospitals are forming and joining systems. The ability of free-standing hospitals to continue to compete and to survive is very limited. Hospitals need the ability to organize into networks. As members of the Legislature, you are experiencing these issues in a very real way today in your stewardship role at the KU Medical Center.

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The formation of provider networks presents hospitals the opportunity to gain economies of scale, which lead to reduced cost of operations in the area of supplies and other operating expenses. These networks allow the individual hospitals, and the other health care providers associated with those hospitals, to have more ability to negotiate with managed care companies for the provision of patient services. Networks also allow the hospitals within them greater access to capital to continue to keep up to date with ever expanding technology. Finally, forming networks allows hospitals to rationally and compassionately deal with the issue of excess capacity. With the national average hospital occupancy at 55%, it is obvious that hospitals in many areas must consolidate services. This is a difficult and emotional issue that must be addressed. The only way for hospitals to effectively deal with excess capacity and duplicative services is to join networks that allow the individual hospitals the opportunity to consolidate services within the network.

Our company owns and operates Columbia Wesley Medical Center in Wichita. Wesley was acquired by our predecessor company, Hospital Corporation of America, in 1985. The result of this sale was the creation of the Kansas Health Foundation, which is being addressed today by other speakers. My message is that this sale occurred thirteen years ago, so it has a long standing history of success. Columbia Wesley Medical Center delivers high quality care to its patients, provides its fair share of charity care, employs over 2500 Kansans, and pays $12 million in taxes in this state. Wesley is better positioned to weather the changes in the industry as part of a large and successful company like Columbia. The Kansas Health Foundation today is an extremely important

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community foundation that has accomplished much in the State of Kansas since its inception.

Senate Bill 372 appears to head in the opposite direction of the changes in the industry. S.B. 372 would put an enormous burden of increased government regulation on hospitals seeking to affiliate, merge, or otherwise join systems. It would require not one, but two approval processes involving both the secretary of health and environment and the attorney general. The attorney general's office believes they already have the authority necessary to review the conversion of tax-exempt entities and to ensure that the interests of the citizens are protected. The attorney general's office has not investigated hospital transactions in the past and has not, until very recently, expressed an interest in doing so. I know of no hospital sale or merger in the state that has resulted in any issues that S.B. 372 would seem to be designed to address. There have been at least five major acquisitions or mergers of hospitals in the last three years in Kansas. These have been completed successfully without governmental review. The most highly visible transaction to date, the sale of Wesley, has been extremely successful over a long period of time.

If you decide that S.B. 372 is good public policy, I urge you to closely examine and modify certain components of the bill. First and most importantly, S.B. 372 as currently drafted would exempt from review a transaction involving a non-profit hospital being acquired by another non-profit hospital. To preferentially exclude a transaction based on the ownership of the acquiring entity is absurd. In the United States, in 1996, there were 705 mergers or acquisitions between tax-exempt hospitals and only 63 involving investor owned companies. Put another way, publicly-held hospitals represent 15% of all

hospitals in the country, yet they were involved in only 8% of the mergers/acquisitions. If it is even appropriate for the state to review these transactions, why should 92% of these transactions be exempted from review simply because the acquiring entity is a tax-exempt organization. There is no rational basis to exclude similar transactions based on the tax paying status of the acquiring corporation.

Section 7 of S.B. outlines issues for review including: due diligence, fair value, utilization of outside expert assistance, conflict of interest among board members, rights of first refusal, and others. Again, if these issues are important when a hospital sells to an investor owned corporation, why are they not important when a hospital sells to a tax-exempt organization. The only conclusion that can be drawn from the ownership discrimination of S.B. 372 is that tax-exempt organizations are inherently perfectly able to deal with these issues and that tax-paying organzations are not. This makes no sense and is not supported by experience in Kansas, nor throughout the country.

Secondly, if you adopt this type of legislation, we believe that the attorney general should look as carefully at the foundation that results from the acquisition of a tax exempt hospital. S.B. 372 attempts to address issues of process, fair market valuation, and fiduciary responsibility of board members. However, we believe that this process virtually ignores the value of the resulting foundation and the on going charitable work that is accomplished. Our experience in these transactions is that communities gain benefits when a tax-exempt hospital merges with a tax-paying hospital. The hospital continues to grow and succeed as part of a larger network Debt of the tax-exempt hospital is frequently retired in a transaction with a tax-paying hospital. The tax base in the community is dramatically increased. S.B. 372 appears to concentrate its review,

approval, and punitive actions on the purchaser of the hospital, and only if that purchaser is a tax paying corporation.

These are only several of the issues we think are important in understanding these complicated transactions. In the limited time available today, I have attempted to provide a brief outline to the most significant issues. We understand that the committee may consider an interim study to fully analyze all the issues. As the only tax-paying hospital system in the state, Columbia would welcome the opportunity to be involved in these interim discussions.

I urge you to let free market forces continue to work well and not to attempt to impose this additional regulatory burden on hospitals where it is not needed. I appreciate the opportunity to be here today and would be happy to answer any questions.

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

March 25, 1997

To: Senate Financial Institutions and Insurance Committee

From: Kansas Hospital Association

Re: **Senate Bill 372**

The Kansas Hospital Association appreciates the opportunity to comment regarding Senate Bill 372. While we cannot support the specific provisions of this proposal, we think it raises an important public policy issue. Our comments will concentrate on that policy issue, although we will discuss some of the specifics of the bill.

BACKGROUND

The health care system is currently undergoing massive changes on virtually every front, and the pace of change is unprecedented. This is most visibly felt by hospitals, who must cope simultaneously with changes brought about by competition, managed care, government cutbacks, new technologies, work force dynamics, and a myriad of social problems. Today's hospitals are seeking to be more efficient--to "do more with less." As a result, the pace of mergers, consolidations, and collaborative activity in the health care sector has quickened. In those instances where hospital ownership has changed from one entity to another, some policymakers have raised questions about whether the public good continues to be served.

PRINCIPLES TO GOVERN THE PUBLIC POLICY DEBATE

Nonprofit hospitals are required to be governed by a board representing the community. Such governing bodies are comprised of individuals from all parts of the community's economy and social structure. These persons have a fiduciary obligation to the institution they govern. Their priority must be to maintain the community benefit provided by the hospital. One of the state' priorities, then, should be to avoid second guessing legitimate business decisions made by such boards.

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At the same time, when a nonprofit hospital undergoes a change in ownership, it is appropriate to examine whether the community benefit will continue under the new structure. As donors and beneficiaries, the public has an interest in this question. Any examination conducted by the state, however, should be done in the least regulatory manner possible--state action should not serve as a barrier to the creation of efficiencies in health care service delivery. For example, the competitive bid process can be a very reliable tool to aid in the determination of the value of an asset. The state should recognize this and avoid the creation of artificial barriers to such a determination. Ultimately, the decision regarding the future of a community hospital rests with the community. The state's role should be to assist to community in making an informed decision, not to stand in the way.

Any necessary state oversight of hospital restructuring should be vested in a single state agency, such as the Office of the Attorney General. The review standard to be utilized during this oversight should be simple and clearly articulated in statute. In general, they should include the following:

1. notification to the Attorney General of the proposed transaction;
2. review by the Attorney General in a timely manner;
3. independent valuation of charitable assets being restructured;
4. disclosure of the essential terms of the agreement;
5. avoidance of conflicts of interest and private inurement;
6. any new nonprofit health care organization or foundation created should serve the same general service area and patient populations as the nonprofit organization prior to restructuring; and
7. application to all acquisitions involving the community benefit, regardless of purchaser.

SENATE BILL 372 RAISES TOO MANY UNANSWERED QUESTIONS

In our opinion, Senate Bill 372 is not the best solution to the Legislature's search for simple but meaningful legislation that would protect the public interest. Numerous procedural and policy questions are raised by this proposal. First, the definition of "acquisition" is confusing. Section 2 (c) refers to "an ownership or controlling interest in a hospital, whether by purchase, merger, lease, gift, or otherwise, which results in a change of ownership or control of 20 percent or greater or which results in the acquiring persons holding a 50 percent or greater interest in the ownership or control of a hospital." It is unclear to us what is meant by a change of control of "20 percent or greater." It is also unclear whether this language would apply to situations

in which a small hospital enters into a contract with another company for management services. That is already the case in numerous situations in rural Kansas. We question whether the Legislature should be involved in this type of micro-management.

The structure of the bill does not make it applicable to the lease of a county hospital. It seems to us that other types of governmental hospitals should be included in this exception. At the same time, the bill does not seem to apply to any purchase of a psychiatric hospital because it uses the definition of hospital in KSA 65-425.

SB 372 sets up a dual track of investigation and enforcement involving both the Attorney General and the Department of Health and Environment. In numerous instances, the bill applies different rules and time frames to these agencies. We think this could lead to a very confusing situation.

Senate Bill 372 lists criteria for both the KDHE and the Attorney General to apply during their investigations. These criteria are, in many cases, quite broad. In some instances, they are confusing, especially considering the fact that different criteria are to be applied by each agency. In addition, they raise questions about Senate Bill 372's consistency with current law in the area of referrals under the Medicare/Medicaid anti-kickback statute.

Finally, the appeal mechanism delineated by the bill references the Kansas Act for Judicial Review but some sections appear to be inconsistent with that state law.

CONCLUSION

Hospitals need to maintain flexibility in this changing environment, but also must remain accountable to the public for the proper use of charitable assets. Policymakers must seek to strike the appropriate balance between the rights and qualifications of those responsible for hospital governance to make decisions about the partnerships in which they may wish to participate, with the interests of those responsible for overseeing the use of charitable assets and the public who should benefit from those assets. The Kansas Legislature has a good chance to accomplish this after careful consideration of all the issues involved. Further study of other state experiences and the specific provisions of SB 372 is warranted.

Thank you for your consideration of our comments.