HEARING BEFORE THE
SENATE FINANCE COMMITTEE
(September 13, 2006)

COMMENTS OF PHILL KLINE, ATTORNEY GENERAL OF THE STATE OF KANSAS

*ON THE STATUS OF HIS OFFICE'S INTERACTION WITH THE
HEALTH CARE INDUSTRY IN KANSAS*

Chairman Grassley and members of the committee:

Good morning. My name is Phill Kline and I have the honor of serving as the Attorney General for the state of Kansas. I am honored to appear before this committee and thank you for the opportunity to discuss my review of the processes and policies relating to the billing and collections of the under and uninsured persons who obtain services from the non-profit health care delivery system in Kansas.

On the day that I was sworn in to office, a little less than four years ago, I was greeted with a lawsuit filed by a $1 billion tax-exempt, integrated healthcare delivery system serving Kansas and Missouri. That lawsuit sought to deny the Kansas Attorney General's office, and thereby the people of Kansas, of the authority to regulate Health Midwest's conversion of non-profit to for-profit status.[1]

We won that lawsuit. As a result the good citizens of Kansas now enjoy a brand new $110 million foundation that is currently providing grants assisting the medically indigent in Eastern Kansas. This timely litigation drove home the very important point that non-profit hospitals have -- no matter how successful they become or the median income of their communities -- a duty and social mandate to fulfill through charity care programs. In fact, it is the unique partnership that government exercises with non-profits and fidelity to their stated mission that serves as the

[1]For a more detailed description of the litigation, see Kline, Stephan, Holbrook, "*Protecting Charitable Assets in Hospital Conversions: An Important Role for the Attorney General*," 13 SPG Kan.J.L. &Pub. Pol'y 351 (2004).

foundation for the authority of my office to review such matters and that gives rise to the common law Cy Pres authority of the office of Attorney General. Before moving on to my review of our state's non-profit treatment of the medically indigent, I would like to review briefly one issue that arose in the Health Midwest conversion – excessive executive compensation.

In the Health Midwest conversion, the CEO of the non-profit hospital negotiated himself a $7 million "Golden Parachute." This remuneration package strikes me and my predecessor as unconscionable. It was unfortunate that the Kansas court concluded that it lacked jurisdiction to address our challenge to that Golden Parachute. The sale of that not- for-profit hospital to a for-profit corporation was consummated with the CEO receiving his $7 million benefit. The case was a great victory for Kansas except as to that sticking point. .

As the Committee is aware, recent studies have revealed health care costs to be a major cause of personal bankruptcies and family indebtedness across the country. As our population ages, the health care delivery system will play an even greater role in our economy. Kansas law affords the Attorney General Cy Pres authority and responsibility to ensure that charitable assets are utilized for their intended purposes. For the aforementioned reasons I established a Task Force dedicated to inquiring into the billing, charity care and collection practices of non-profit hospitals in Kansas. This action was also taken due to various complaints received by my office regarding such practices. I launched this Task Force with the goal of initiating a cooperative review of current practices and procedures and as an effort to avoid media sensation or litigation threats.

I have found that in almost all instances, those engaged in charitable health care have a strong dedication to the needs of those they serve and operate in a professional and appropriate manner. There are exceptions and as in all human endeavors, institutions sometimes develop practices and procedures that do not reflect their initial mission or the heart of those involved. It was my hope that in my approach I would avoid tarnishing an industry while identifying the obstacles and procedures to the fulfillment of the mission of non-profit health care systems. This is what we are now very close to achieving.

Our discussions were initiated and at one point in the process it was necessary to selectively auditing the largest non-profit hospitals in the state to afford me a better understanding of how billing and debt collection practices impact the uninsured and the under insured of Kansas.

Former Attorney General Robert T. Stephan is serving my office as a Special Assistant Attorney General and has been deeply involved in this process from the very beginning. He heads up the Task Force addressing the issue of non-profit hospital billing and collection practices. My office was fortunate to also have the cooperation of the Kansas Hospital Association. Former General Stephen worked with the KHA to conduct a survey of its entire membership. The results of that survey convinced me that a more formal methodology was necessary to fully investigate the processes and procedures being used by the non-profit hospitals of Kansas.

On April 25, 2006, my Consumer Protection Division served investigative subpoenas upon nine non-profit hospitals. I have included a copy of the subpoena that was delivered to this subset of Kansas hospitals in the materials filed with this Committee. This subpoena was designed to afford our Task Force a better understanding of how billing, charity care, and debt collection practices are managed at some of the larger non-profit hospitals in Kansas.

The immediate response to the subpoenas was a large gathering of hospital representatives in Overland Park, Kansas. These representatives of the nine subpoenaed hospitals were brought together through the leadership of the Kansas Hospital Association.

This proved to be only the first in a series of meetings that the subpoenas engendered. In the initial meetings my Task Force and representatives of the targeted hospitals discussed the sensitive nature of the information to be reviewed. Both privacy laws and the protection of pricing structures had to be agreed upon before the hospitals could respond to the formal inquiry. We have had numerous subsequent, individual meetings with representatives of the KHA and the hospitals. These discussions culminated in a Memorandum of Understanding which is included among the documents I have filed with the Committee this day.

Each of the nine hospitals that entered into the Memorandum of Understanding tendered a notebook of information responsive to the subpoena. This information was compiled into a database and processed on a spread sheet, allowing my Task Force the ability to efficiently compare data from each hospital against data from all hospitals. The analysis of this comparative data has proved quite useful in discussions with the individual hospitals.

Three of the subpoenaed hospitals voluntarily appeared, with their Chief Financial Officer, to discuss the subpoena responses and answer questions generated by the comparison of data. My Task

Force learned a great deal about the billing, charity care, and collection practices of representative Kansas hospitals during these productive meetings.

This eventual cooperative approach by the Kansas health care industry was not unforeseen. My office has generally received few complaints regarding non-profit hospitals when considering the nature of the services provided and the scope of this industry. I suspected that this was true because such hospitals in Kansas operate with a high degree of integrity and dedication to their core mission. This is the case. We have together, however, identified some practices, policies and procedures that should be utilized by all non-profit health care delivery systems in Kansas. We are formulating these changes, and in some instances current practices, into another agreement relating establishing a best practices model.

The "best practices" model formulated with the Kansas Hospital Association toward the goal of ensuring that all non-profit hospitals in Kansas treat the indigent and under insured in a manner consistent with their charitable mission while not forfeiting their ability to deliver services to the general population. This model strives to set a new, higher standard of care among Kansas hospitals when it comes to billing, charity care and collection practices. This model addresses issues such as excessive billing, consumer education, financial support, visitation and designation issues and services to the indigent and a prohibition on certain collection practices.

It is anticipated that this model will be promoted by both the Attorney General's Task Force and the Kansas Hospitals Association and will, due to its collaborative authorship, result in substantive improvements in a health care delivery system that is already functioning at a level better than the national average. I commend this collaborative and investigative model to any of my peers interested in a similar result. I have included in the attachments to this testimony a print out of the PowerPoint presentation demonstrating the evolution of this model as well as a copy of the current iteration of this model. The model included is nearly final. It has been approved by Former General Stephen and my Task Force. I have not yet given final approval and counsel for the Kansas Hospital Association has yet to review the document. It is very close to being approved, and a final, approved copy should be available by this time next month.

I want to thank the Committee for allowing me to present the fine work that my Task Force and the KHA has accomplished while addressing this important topic