SPECIAL SECTION

LEGAL ISSUES IN MERGERS AND ACQUISITIONS

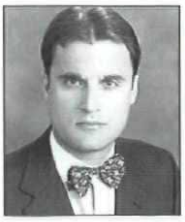
Several Noteworthy Legal Developments Have Arisen Since the Last Wave of Merger Activity

BY MICHAEL W. PEREGRINE

Not-for-profit health care providers embarking on a merger/acquisition strategy should be sensitive to a series of significant new legal developments that may affect transaction plans and should pause to evaluate how the legal landscape has changed over the past several years before pursuing a specific transaction strategy. Since the last period of heavy health care merger/acquisition activity (in the mid to late 1990s), a number of noticeable trends have developed that should be considered by any not-for-profit provider investigating such a major business transaction. These trends include:

- Much greater review at the state level
- Tax and antitrust developments affecting certain traditional structures
- The impact of community opposition on the transaction time frame
- The practical importance of incorporating "exit" or "unwind" provisions in the definitive agreements (due to the increase number of failed corporate relationships)

In most cases, these problems are not insurmountable. They can be addressed with appropriate foresight and planning by the not-for-profit provider. Nevertheless, settlement of some of the issues (particularly state law "community asset" concerns) may prove to have a significant impact on the transaction timetable and thus must be recognized at a very early stage in the process. Both parties to the transaction should be aware of the potential for these issues to affect the ultimate closing date and, in the extreme case, the basic legal feasibility of the underlying transaction. When necessary, steps should be taken to help address these potential problems, including a possible change in the form of transaction or by addition or alteration of proposed key agreement terms.



Mr. Peregrine is a partner, Gardner, Carton & Douglas, Chicago.

GREATER STATE REVIEW

Perhaps the most significant legal development since the last wave of merger/acquisition activity has been the marked increase in the review of such transactions at the state level (particularly by the state attorney general). This review has come principally in the form of new or expanded statutes and/or protocols requiring additional notice to state authorities as well as specific state oversight and approval of major business transactions by not-for-profits. Of particular importance is the fact that these new or expanded statues often extend to transactions between not-for-profits, not just to transactions between a not-for-profit and a for-profit.

Although naturally differing by state, these laws and protocols generally have several consistent themes. First, they share an unusually broad scope. In most cases, they apply to any type of fundamental change in the ownership or structure of a not-for-profit health care entity, regardless of whether the other party or parties to the deal are not-for-profit or for-profit. Indeed, in some cases the law applies to the sale or transfer of less than all of a hospital's assets. For example, California law requires approval of transactions in which 20 percent or more of the assets of a not-for-profit hospital (or $15 million, whichever is less) is transferred. Thus, such a statute could conceivably cover the sale of a discrete hospital unit (e.g., hemodialysis, home health) in addition to a sale of the entire facility. Furthermore, in some states, the scope of

the law may be broad enough to cover transactions involving parent corporations or controlled subsidiaries.

Second, these laws typically require an extensive filing with and approval of (rather than merely advance notice to) the attorney general. The review process may be lengthy—even open-ended—and will likely allow the attorney general's office to involve its own consultants and experts (usually at the parties' cost) to review the information submitted with the application. Public notice or hearing is usually part of any statutory process. Some statutes clearly specify the attorney general's authority in the event that office chooses not to approve the transaction (e.g., injunction, voiding the transaction).

Third, in many cases, such as in Pennsylvania, the documentation requested together with the state filing is extensive and could include basic corporate organizational documents and related board records, all relevant transaction documents, information regarding the "successor party," and information relating to the impact on employees and other participants (e.g., physicians) in any related integrated delivery system. Some states, such as California, actually require the submission of a "health impact statement" measuring the transaction's likely effect on the availability and accessibility of health care in the related community. Furthermore, the focus of any such state review is similarly extensive, emphasizing such matters as the economic fairness of the transaction, the absence of self-dealing, the impact on charitable donations, due diligence exercised by the board, and the reasonableness of related party transactions (executive termination and other "golden parachute" type arrangements).

The practical impact of these new statutes, as well as of related increased attorney general involvement, is that they will add a substantial amount of time and expense to most transactions and will require a more intense emphasis on the transaction process by the board and senior management. In a sense, a map must be followed to obtain state approval, and it does not allow for many shortcuts from the prescribed route. Both parties to the transaction must carefully identify and plan for the satisfaction of these state law requirements at the earliest possible stage (including preparation of requested material and structuring deal terms to comply with the scope of review) or risk substantial delay in receiving approval.

Along the same lines, state attorneys general, as well as interested third parties such as community groups, can be expected to review more closely the organization and subsequent operation of charitable conversion foundations and similar entities (i.e., foundations formed with the proceeds from the sale of a not-for-profit hospital) created as part of the core transaction, to ensure consistency with not-for-profit corporate and tax exemption principles. A significant level of notoriety has been associated with the operation of some of these newly created entities, and the IRS, for example, has set forth specific guidelines on how they may relate to a for-profit purchaser of a hospital and how they may qualify for tax-exempt status. Accordingly, the organization and intended operation of the foundation are likely to be part of any state review process.

These new statutes will add a substantial amount of time and expense to most transactions.

The Community Asset Controversy

Closely related to the trend of increased state review is the community asset controversy. Parties to transactions that contemplate (1) the change in status or level of service at a community-based hospital and/or (2) the transfer of control over such a hospital to an organization headquartered out of state should give close attention to the community asset controversy and how it could affect a given situation. The controversy relates to the series of challenges instituted over the last several years by community groups, donors, and/or the state attorneys general regarding the ability of a not-for-profit health system to exercise authority over an individual hospital affiliate. The central theme of these actions is that the best interests of the health system as a whole are subordinate to the wishes of the local community and that system decisions contrary to such wishes are violations of the public trust. In several of the actions, the state has alleged that the underlying assets were held in a charitable trust and required specific judicial approval before the requested corporate actions could be pursued.

The most notorious application of the community asset controversy in the merger/acquisition scenario was the June 2000 dissolution under substantial attorney general pressure of a 1994 merger between a Catholic hospital and a community-based hospital in Manchester, NH (the creation of Optima Healthcare). In 1998, the New Hampshire attorney general challenged the transaction on the basis of three specific findings:

- That the parties should have sought judicial approval for the transaction, given what it perceived as three fundamental changes to the charitable missions of the two hospitals (one of which was the termination of the Catholic hospital's role as an acute care provider)
- That the record did not support a finding that Optima would have been successful had it actually sought judicial approval for the merger
- That Optima parties failed to satisfy their

"duty of inclusion" by not including the community in the decision-making process that led to the merger

The controversy surrounding the attorney general's challenge led to the ultimate demise of the merger, which, in turn, has emboldened other attorneys general to apply other innovative legal theories to challenge other major corporate transactions of not-for-profit health systems. The most notable related challenges have been to proposed hospital closures in Long Beach, CA, and West Palm Beach, FL (both owned by Intracoastal Health System). Of particular interest in this regard is the attempt of the Florida attorney general in the West Palm matter to question the corporate legitimacy of the merger that created the underlying health care system. In that matter, the attorney general also sought to improve a "constructive trust" on the subject hospital assets, which would have involuntarily transferred control of the hospital to a new community-based board. The Intracoastal controversy was resolved by settlement, in which Intracoastal agreed to sell *both* of its area hospitals. In addition, the Long Beach inquiry has led to a statewide attorney general review of a large not-for-profit system's compliance with charitable trust obligations. Other prominent examples of the community asset controversy include the Rhode Island attorney general's twin 1998 challenges and proposed transactions involving Life Span Corporation and Care New England Health System.

Of importance is that the "community" referred to in the concept includes not only health care consumers, but other interested third parties such as labor unions, charitable donors, and the medical staff. All these groups have attempted to institute community asset-type litigation.

The concept of the community asset controversy should be taken seriously by not-for-profit health care providers planning a major corporate transaction such as a merger or acquisition. Diversionary considerations include whether legal merit to a particular investigation or challenge exists or whether substantial political factors are at play. Any community asset-based challenge to a transaction can have deleterious effects on the timetable and ultimate transaction feasibility. When any community opposition exists, project planners should give special effort to address in advance the issues most likely to generate controversy in the interested community groups. Although such special planning efforts may not ameliorate all community concerns, such efforts at inclusion may go a long way toward reducing the threat of litigation or attorney general investigation.

Related to the community asset controversy is a prominent 1999 New York state court decision in which the state attorney general successfully challenged the sale of Manhattan Eye, Ear & Throat Hospital to a real estate development company, principally because of its view that the board failed to satisfy its duty to find a purchaser that would have preserved the charitable mission of the hospital.

In this case, the trustees had justified their decision to accept the most attractive financial offer, based in part on the advice of independent investment bankers, who advised the board that the long-term prospects for the hospital were negative given decreasing reimbursement rates for services. The court expressed concern with the process by which the board reached its decision. The court concluded that the success-based fee arrangement with the investment bank resulted in a potential conflict (to the board's detriment). The court also concluded that the decision to sell the assets to the developer (and the subsequent plan to use the proceeds to develop ambulatory clinics) was not based on any strategic evaluation, but rather that the sale offer had prompted the change in purpose. The court was highly critical of the board's failure to adequately consider the various, but less lucrative, proposals from other not-for-profit hospitals that would have preserved the hospital's mission.

As such, this case serves as the dominant statement of the fiduciary duty of obedience to corporate purpose of not-for-profit directors. This case will probably be cited by other parties attempting to challenge a merger/disposition transactions believed to be inconsistent with the charitable purposes of the organization.

State attorneys general are also particularly sensitive to situations in which control of hospital assets passes in a merger/acquisition transaction from a domestic corporation to a "foreign" corporation (i.e., an out-of-state system taking control of an in-state hospital or health system). A particular concern will be the potential for charitable assets received through fund-raising in one state to be used for the benefit of organizations (charitable or not) in another state. This concern was manifested in two highly publicized 1998 merger challenges brought by the Rhode Island attorney general.

State attorneys general are sensitive to situations in which control of hospital assets passes from an in-state system to an out-of-state system.

Regulatory Guidance on Certain Traditional Structures

Another important development is the extent to which federal tax and antitrust enforcement positions and activity have provided additional guidance (and, in certain instances, placed a cloud over) the use and feasibility of certain traditional merger/acquisition structures.

Related Tax Guidance For example, the IRS recently set forth with some degree of clarity its tax exemp-

tion guidelines on how to establish a hospital affiliation through a centralized parent holding company entity or through the establishment of a joint operating agreement. These guidelines emphasize the establishment of "absolute financial and structural control" by the parent over its affiliates in the parent holding company model or of "other explicit manifestations of control" in the joint operating company model. The level of structural guidance provided by the IRS in this regard is substantial, and any not-for-profit health system considering one of these transaction options should closely consult these guidelines when developing the framework of a proposed relationship.

Similarly, the IRS has in the past year provided a similar level of guidance on the ability of not-for-profit hospitals to participate in whole hospital joint ventures with for-profit hospitals. A whole-hospital joint venture involves a transaction in which the entire assets of the tax-exempt hospital corporation are transferred to a joint venture to be operated by the venture and not the exempt corporation. The IRS guidance has taken the form of a detailed chapter in its fiscal-year 1999 "Continuing Professional Education Textbook" for field agents as well as in a 1998 Revenue Report. This guidance addresses how these types of joint venture arrangements may affect an exempt hospital's tax-exempt status and its foundation classification or result in unrelated business income tax to the organization. The ruling does not prohibit all joint ventures between not-for-profit and for-profit hospitals. Rather, in venture design it requires that:

- Charitable purposes supersede profit maximization purposes
- Health care services benefit the community as a whole
- Exempt hospitals must ensure that the partnership furthers charitable purposes and does not result in prohibited private inurement or private benefit to third parties.

The IRS approach was recently upheld by the U.S. Court of Appeals in the Redlands Surgical Services case. Accordingly, a not-for-profit hospital or health system considering entering into a whole hospital joint venture would greatly benefit from applying the IRS standards in the structure development phase.

Furthermore, a recent exempt status and intermediate sanctions enforcement action brought by the IRS in the sale of a series of tax-exempt home health agencies has served to underscore the importance of a properly prepared fair market value analysis in a sale of assets involving an exempt organization. In the cases at hand, the appraisals performed for the home health care taxpayers showed that each organization's liabilities exceeded the fair market value of its assets, so that the value of the net assets of each organization was less than zero. The IRS appraisal determined that fair market value for each organization's assets substantially exceeded its liabilities, so that the value of the net assets of each organization was significantly more than zero. The gap between the appraisals served as a basis from which the IRS has pursued enforcement action seeking revocation of exempt status and application of excise tax liability.

Transactions that depend on acquisition financing should be structured carefully in terms of interlocking board relationships so that parties are viewed as "unrelated."

The current series of IRS audits of tax-exempt health care acquisition financings also can be expected to have an impact on the structuring of any financing related to certain types of merger/acquisition transactions. These audits have focused on two specific scenarios: when a purchaser buys or assumes control of hospital assets and in exchange therefor either (a) agrees to assume liability for the tax-exempt debt of the seller (which is then refinanced or defeased by the purchaser with the proceeds from acquisition bonds) or (b) provides cash consideration to the seller (which then defeases the tax-exempt debt with the cash consideration).

Of all of the requirements for acquisition financings, the one most relevant to hospital transaction structuring is that the purchaser and seller must be unrelated before and after the closing of the merger/acquisition transaction (i.e., the purchaser must not be a related person to, under the common control with, or part of the same controlled group as the seller.) *Relatedness* principally depends on the controlling party's right or power to approve, and to remove without cause, a majority of the board of directors/trustees of the controlled party, or if the controlling party has the right or power to require the use of funds/assets of the controlled party for any of its own purposes. If such relatedness exists, the transaction will not qualify for acquisition financing treatment. This consideration is important in many transaction arrangements between not-for-profit hospitals, where interlocking board seats and explicit manifestations of corporate control through director nomination power are frequently applied terms and conditions. Accordingly, in transactions that depend on acquisition financing, great care should be taken to structure interlocking board relationships, board appointment powers, and similar relationships so that the parties are viewed as unrelated to one another (particularly as interpreted by bond counsel).

Antitrust Guidance Joint operating agreements are always a somewhat controversial transaction structure because of the complexity of their financing and severance agreements. Recently, the feasibility

of joint operating companies has become even more clouded by virtue of the 2000 decision of a federal district court that the participants to a joint operating relationship (two Poughkeepsie, NY, state health systems) were engaged in a *per se* unlawful price fixing and market allocation in violation of the federal Sherman Act and New York state law. This decision underscores the vulnerability of the joint operating agreement structure to antitrust challenge, in large part because of a lack of economic and structural integration between the participants arising from the nature of the corporate relationship.

The Poughkeepsie decision is also symbolic of an additional trend, which is the increased enforcement of antitrust laws by state, rather than federal, regulators. Indeed, in both the Poughkeepsie and a subsequent California hospital merger case (California vs. Sutter Health System), the state antitrust enforcement agency instituted the challenge even after the underlying transaction was reviewed by the federal antitrust enforcement agencies, which failed to object to the transaction. This development is significant, particularly given that the federal agencies have lost their two most recent hospital merger cases (e.g., Butterworth, Health Corp., Grand Rapids, MI, and Doctors Regional Medical Center, Pine Bluff, MO).

Also of importance is a private antitrust action recently filed against a hospital merger in Pennsylvania. This action is particularly significant because it was filed by a payor. If successful, the case could signal a trend in which private litigants and state agencies supplant the federal government as the principal antitrust enforcement sources.

Along the same lines, collaboration/affiliations that feature an exchange of directors (i.e., "interlocking directors") may also trigger antitrust concerns under the federal Clayton Act if the participating hospitals are competitors and their combined capital exceeds a certain dollar amount.

These new developments underscore the fact that antitrust implications remain a significant consideration in planning for any merger/acquisition activity.

"Exit" or "Unwind" Provisions

The recent dissolution or breakups of many health industry mergers and acquisitions have been highly publicized (e.g., *The New York Times*, March 14, 2001). The cost of such breakups, in both economic and emotional terms, is usually enormous. The volume of breakups and the related costs are both significant enough to suggest that the appropriate standard of case in negotiating and drafting merger/acquisition transactions requires that the not-for-profit board consider incorporating termination (e.g., "exit" or "unwind") provisions as part of transaction terms.

Clearly, no one wants to anticipate future problems in a transaction, and even fewer transaction team leaders will eagerly authorize the expenditures of material amounts of legal and management time to develop transaction terms addressing such an unattractive possibility. Furthermore, some such transaction terms may actually create legal problems (e.g., antitrust concerns if the parties maintain some close affiliation subsequent to the termination of the original transaction).

Nevertheless, the cost of a transaction, and the potential for its occurrence, merit some attention to the issue by those responsible for structuring the transaction. The most appropriate exit provision depends, of course, on the nature of the parties and the type of transaction involved. A key factor in evaluating termination options is whether the proposed transaction structure would readily allow for an unwinding. An important issue in this regard is whether the party that is requesting dissolution is in a corporate or legal position to operate hospital assets. (i.e., it continues to operate one or more other hospitals and could be capable of reassuming operations of the transferred hospital if the original transaction were to be rescinded). For that reason, corporate affiliations and membership transfers, joint ventures, and joint operating agreements often offer the most practical opportunity for an "unscrambling of the [merger] eggs" that would place the parties in as close to their preclosing position as possible. In other situations where unwinding may be less practical, options or rights of first refusal or operating restriction may be viable options.

All these new developments can affect the transaction time frame and, in some cases, the ultimate legal feasibility of the transaction.

In any event, key concepts to consider in developing an exit strategy include the anticipated postclosing relationship capability of the parties, the event(s) that could trigger an unwinding, any arbitration or mediation related to implementation of the unwinding, the time period in which the trigger would remain effective, and the actual form or mechanism by which the unwinding is to be implemented.

A substantial number of recent legal developments have occurred that merit close attention by not-for-profit health care providers considering a merger/acquisition transaction. These developments can involve both the transaction time frame and, in some cases, to the ultimate legal feasibility of the transaction. Partly because they were not prominent during the last merger period, and partly because of their overarching significance, they should be given close scrutiny by deal planners for not-for-profit hospitals. □

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, May-June 2001