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Medicare Drugs
Coverage
Medicare Cost SH
HIPAA
HIV/AIDS
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HCFA Regs
HRSA Loan
HCFA Iss.
HCFA Iss.
HCFA Iss.
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Gay Sperm Donors
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ospital Conversion rends

pital conversions from nonprofit to for-profit status receive most press. Hospital data, however, show that the switching s in many directions and is concentrated in just a few states.

ack Needleman, Deborah J. Chollet, and JoAnn Lamphere

TRACT: This DataWatch presents information on the extent, geographic ibution, and other issues related to hospital conversions during the 1980s 1990s. On average, 1 percent of hospitals convert each year. Many states erienced hospital conversions, but much of the conversion activity was centrated in California, Florida, Georgia, and Texas. While conversions of for-profit hospitals to for-profit status have received significant attention, iversions of public hospitals and for-profit hospitals raise complex policy ues, as well.

HUNDREDS OF PUBLIC AND not-for-profit hospitals converted to for-profit status during the 1980s and 1990s. In 1995 alone nearly sixty not-for-profit hospitals converted, ubling the previous year's transactions.[1] Hospital conversions ke many forms. In the case of a direct sale of a hospital, an amendent of incorporation (making the not-for-profit organization a r-profit corporation), or a merger of a not-for-profit with a forrofit corporation, a for-profit corporation takes ownership of the ospital's assets. Other forms of conversions (such as long-term asing and joint ventures) may not involve asset transfers. Converions without asset transfer became the more common form of hosital conversion in the 1990s.

Despite growing numbers of conversions and increasing public crutiny of these transactions in some states, information about onversions of not-for-profit hospitals to for-profit status is extremely limited and has improved little beyond the level observed by David Young a decade ago.[2] Neither a full count of conversions nor information concerning the conditions of conversions and the distribution of the not-for-profit assets is generally available.

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Study Methods

This DataWatch presents findings from a larger study of is arising from hospital conversions during the 1980s and 1990s was conducted for The Commonwealth Fund.[3] We compared ownership status of 5,768 hospitals in 1980 and in 1990. We ide fied these hospitals by matching all hospitals by hospital identif tion number in the 1980 and 1990 American Hospital Associa (AHA) annual surveys. We classified each of these hospitals as h ing the same ownership status in both years (public, not-for-pro or for-profit) or having changed ownership status between 1980 1990. To identify hospitals that had changed status between 19 and 1993, we undertook the same type of process using the 1990 1993 AHA annual surveys. Finally, we identified four states that h the greatest number of public hospital conversions (Georgia, Fl ida, and Texas) or not-for-profit hospital conversions (Califor Florida, and Texas) in the 1980–1990 period; we report the distrib tions of hospital conversions in those states separately from n national distributions. We also report some of the insights gained from interviews with a number of public officials and hosp tal representatives in those states about the possible reasons for t unusually large number of hospital conversions in their states.

In addition to the 5,768 hospitals that reported using the sa identification number in both 1980 and 1990 (the 1980–1990 group we identified 1,004 hospitals that participated in the 1980 AH annual survey but did not match to a hospital with the same iden fication number in the 1990 survey (1980-only group). Many hosp tals in the 1980-only group closed or converted to nonhospital stat during the decade (that is, no hospital existed at the location in t 1990 survey). Other hospitals were part of mergers, and the ne entity was assigned a new number. Most mergers were betwe hospitals of the same ownership type. In still other cases, mult campus hospitals operating under one number split, and each ne hospital was assigned its own number. We found virtually no cas in which a change in AHA number was associated solely with change in ownership.

We examined ownership conversions among hospitals in th 1980-only group prior to their closure, conversion, or merger an included them in state counts, but we excluded them from th analysis of pre- and postconversion characteristics of converted hospitals. Also excluded from the analysis are all federal hospitals (367 hospitals in 1980).

Public Hospital Conversions

Between 1980 and 1990, 9.2 percent of hospitals in the 1980–1990 group (532 hospitals) changed ownership status. An additional ninety hospitals (9 percent) in the 1980-only group also changed ownership status. Hospital conversions continued at about the same annual rate between 1990 and 1993: An additional 183 hospitals (3 percent) reported a change of ownership status during the three-year period (Exhibit 1).

Public hospitals were more likely than either nonprofit or for-profit hospitals to convert. Public hospitals accounted for 56 percent of all conversions in the 1980–1990 group; more than 15 percent of these public hospitals changed control over the decade. Similarly, 12 percent of the public hospitals in the 1980-only group converted. Between 1990 and 1993 public hospitals accounted for nearly 32 percent of all conversions, with another 3 percent of public hospitals changing control. In some cases, the conversion of a public hospital was described as an effort to improve efficiency by freeing the hospital from civil service and government procurement rules. Typically, however, the conversion of public hospitals was described as a response to the unwillingness of local governments and communities to provide continued tax support for the hospitals.

Most public hospital conversions were to nonprofit status (75

EXHIBIT 1
Number Of Hospital Conversions, 1980–1990 And 1990–1993

	Present In 1980 and 1990			Present In 1980, not 1990			Present In 1990 and 1993		
	Total	General	Specialty	Total	General	Specialty	Total	General	Specialty
Total hospitals	5,768	5,005	763	1,004	790	214	6,015	4,950	1,065
No conversion	5,236	4,506	730	914	704	210	5,832	4,791	1,041
Conversions	532	499	33	90	86	4	183	159	24
No conversion									
Nonprofits	2,903	2,647	256	442	384	58	3,181	2,855	326
Public	1,664	1,356	308	254	137	117	1,644	1,338	306
For-profits	669	503	166	218	183	35	1,007	598	409
Conversions									
Nonprofit to for-profit	110	95	15	27	26	1	37	31	6
Public to for-profit	73	72	1	16	16	0	7	7	0
For-profit to nonprofit	55	47	8	20	18	2	42	33	9
For-profit to public	6	5	1	2	2	0	14	13	1
Nonprofit to public	65	64	1	7	7	0	32	29	3
Public to nonprofit	223	216	7	18	17	1	51	46	5

SOURCE: Authors' calculations from American Hospital Association Annual Surveys, 1980–1990 and 1993.

percent in the 1980–1990 group and 53 percent in the 1980-only group). Thus, converting public hospitals that then closed or merged prior to 1990 were significantly more likely ($p = 0.02$) to become for-profit than were those in the 1980–1990 group. Between 1990 and 1993, 88 percent of public hospital conversions were to nonprofit status.

Nevertheless, public hospital conversions are an important source of growth for the for-profit hospital industry. The conversion of public hospitals to for-profit status accounted for 39 percent of all such conversions between 1980 and 1990 and 19 percent between 1990 and 1993.

Not-For-Profit Hospital Conversions

The second-largest number of conversions was among not-for-profit hospitals. In the 1980–1990 group, 175 not-for-profit hospitals (6 percent) reported changes in ownership status. Of these, 110 (63 percent) converted to for-profit status. Similarly, in the 1980-only group, thirty-four not-for-profit hospitals (7 percent) reported a change in ownership status, twenty-seven of these (79 percent) to for-profit status. As with public hospitals, converting nonprofit hospitals in the 1980-only group were significantly more likely ($p = 0.04$) to become for-profits than hospitals that operated through 1990. Between 1990 and 1993 the average annual rate of nonprofit conversions accelerated: 2.1 percent of nonprofit hospitals reported a change of ownership status over the period.

The high rate of public hospital conversions notwithstanding, a substantial number of not-for-profit hospitals in the 1980–1990 group (37 percent), 1980-only group (21 percent), and 1990–1993 group (46 percent) converted to public status.

For-Profit Hospital Conversions

For-profit hospital conversions represented 11 percent of the 1980–1990 group conversions, 24 percent of the 1980-only group conversions, and 31 percent of the 1990–1993 group conversions. Most conversions from for-profit status resulted in not-for-profit control of the hospital, but between 1990 and 1993, 25 percent of these conversions resulted in public control. The more recent acceleration of conversions from for-profit status may reflect an upsurge in community concerns about the long-term commitment of for-profit owners to maintaining community access to health care services and a desire by the community to retain some local influence on hospital policy.

State Experience With Hospital Conversions

Between 1980 and 1990 not-for-profit hospitals in thirty-seven states converted to for-profit status. In twenty-one states at least one public hospital converted to for-profit status. States' experience with conversions to for-profit status between 1990 and 1993 was similarly broad: Not-for-profit to for-profit conversions occurred in seventeen states, and public to for-profit conversions occurred in six states (Exhibit 2). However, much of this conversion activity was concentrated in only a few states. Between 1980 and 1990 more than half of all conversions (54 percent) occurred in just seven states. Ten or more hospitals converted to for-profit status in each of these states. Similarly, between 1990 and 1993 more than half of all conversions (55 percent) occurred in just four states, with each state experiencing at least five for-profit conversions (Exhibit 3).

Five states—Alabama, California, Georgia, Florida, and Texas—experienced unusually high rates of hospital conversions between 1980 and 1990. Interviews with officials in California, Georgia, Florida, and Texas disclosed that none of these states had any consistent process of public oversight to protect community benefits or to facilitate efficient change in the hospital sector. Health officials in each state remained uninvolved in the conversion activity, and attorneys general did not exercise their statutory authority. Because there was little public involvement, community concerns were likely to be poorly developed and expressed late in the transaction. In the absence of state regulatory standards, community issues in these states were resolved through the court system and typically posed no serious barriers to conversion. When public oversight occurred, it was usually initiated by local interests and remained local.

Also in these states, many conversions appeared to be structured to minimize oversight and maximize speed. For example, the Florida

EXHIBIT 2
Number Of States With At Least One Conversion, 1980–1990 And 1990–1993, By Type

	1980–1990	1990–1993
Type of conversion	**Number of states**	**Number of states**
Nonprofit to for-profit	37	17
Public to for-profit	21	6
For-profit to nonprofit	32	22
For-profit to public	7	8
Nonprofit to public	26	19
Public to nonprofit	39	24

SOURCE: Authors' tabulations from American Hospital Association (AHA) data. 1980–1990 data for hospitals present in 1980 without regard to 1990 status. 1990–1993 data for hospitals with same AHA identification number in both years.

EXHIBIT 3
States With Ten Or More Conversions To For-Profit Status In 1980–1990 Or Five In 1990–1993

State	1980–1990 Number of conversions	1980–1990 Conversion from nonprofit	1980–1990 Conversion from public	1990–1993 Number of conversions	1990–1993 Conversion from nonprofit	1990–1993 Conversion from public
Alabama	16	5	11	–[a]	–[a]	–[a]
California	16	13	3	7	7	0
Florida	21	14	7	5	4	1
Georgia	18	3	15	–[a]	–[a]	–[a]
Missouri	–[a]	–[a]	–[a]	5	4	1
Oklahoma	11	6	5	–[a]	–[a]	–[a]
Tennessee	11	1	10	–[a]	–[a]	–[a]
Texas	28	19	9	7	5	2

SOURCE: Authors' tabulations from American Hospital Association (AHA) data. 1980–1990 data for hospitals present in 1980 without regard to 1990 status. 1990–1993 data for hospitals with same AHA identification number in both years.
[a] Not available.

statute under which public hospitals are organized requires legislative authority for any public hospital to become a for-profit institution. Thus, to avoid the sale of public assets, most acquisitions in Florida have been structured as long-term leases. In one case, a public hospital transferred licensed beds to a for-profit corporation, then the corporation built new beds, delicensed the old beds, and transferred the original building back to the public.

Finally, the valuation and disposition of public or not-for-profit hospital assets varied among the states. Hospitals converting to for-profit status in California were required to transfer assets to a public trust in an amount equal to the "fair market value" of the transaction. Officials in Texas were unaware of the specifics of hospital asset valuation in cases of public or not-for-profit hospital conversion and presumed that practice varied widely. For-profit competitors for hospital lease arrangements in Florida occasionally questioned whether the hospital was "sold too cheaply," but no public bidding process occurred.

In Georgia, which had the highest percentage of public hospitals in the United States in 1980, 43 percent of all conversions between 1980 and 1990 were conversions of public hospitals to for-profit status. Many of these involved a lease arrangement rather than the sale of assets, and we found none that resulted in the endowment of a charitable trust or foundation.

Characteristics Of Converting Hospitals

Hospitals in the 1980–1990 group that changed ownership status were smaller on average than hospitals of the same type that did not convert (Exhibit 4). Except for public hospitals converting to non-

profit status in the 1990–1993 period, occupancy rates were somewhat lower as well.

In 1980–1990, and again in 1990–1993, changes in bed size were modest for nonconverting and converting hospitals of the same type among (1) not-for-profits and (2) for-profit hospitals converting to not-for-profit status. Between 1980 and 1990, nonconverting public hospitals and public hospitals converting to for-profit status both experienced sizable bed reductions. Hospitals converting from for-profit to public status showed substantial changes in bed size, but these changes varied in direction and magnitude between the 1980–1990 and 1990–1993 periods.

Nationwide, hospital occupancy declined sharply in the

EXHIBIT 4
Bed Size And Occupancy Of Hospitals Undergoing Conversions, 1980–1990 And 1990–1993

	1980–1990		1990–1993	
Type of conversion	**1980**	**1990**	**1990**	**1993**
Average bed size				
No conversion				
Nonprofits	215	205	203	200
Public	197	165	167	157
For-profits	125	132	121	119
Conversions				
Nonprofit to for-profit	141[a]	128[a]	126[a]	125[a]
Public to for-profit	101[a]	82[a]	82	88
For-profit to nonprofit	99[a]	96[a]	94[a]	100
For-profit to public	77	50[a]	85	116[b]
Nonprofit to public	89[a]	94[a]	114[a]	118[a]
Public to nonprofit	139[a]	131[c]	131	131
Occupancy				
No conversion				
Nonprofits	73.3%	63.1%	62.9%	60.4%
Public	65.3	57.3	57.2	56.9
For-profits	66.9	53.7	55.0	51.7
Conversions				
Nonprofit to for-profit	65.0[a]	51.7[c]	51.5[a]	48.9[a]
Public to for-profit	60.6[a]	45.3[c]	49.4	48.9
For-profit to nonprofit	60.9[a]	51.0	52.1	45.5[a]
For-profit to public	65.5	45.5	46.5	39.6[a]
Nonprofit to public	58.0[a]	47.7[a]	53.6[a]	54.1
Public to nonprofit	65.1	53.8[c]	59.4	57.2

SOURCE: Authors' calculations from American Hospital Association (AHA) Annual Survey, 1980, 1990, 1993. Based on hospitals with same AHA identification numbers in 1980 and 1990, and 1990 and 1993.
[a] Statistically significant difference at .05 level from nonconverting hospitals of original ownership type.
[b] Differences from pre- to postconversion years statistically different at .05 level from hospitals of original ownership type.
[c] Statistically significant difference at .05 level from nonconverting hospitals of original ownership type. Differences from pre- to postconversion years statistically different at .05 level from hospitals of original ownership type.

"Hospitals subject to conversion were generally smaller and appeared to have weaker market positions."

1980–1990 period, and moderately in 1990–1993. Hospitals co ing to for-profit status experienced steeper declines in occu than nonconverting hospitals experienced in the 1980–1990 p but comparable declines in the 1990–1993 period. Hospitals converted from for-profit status also generally experienced st declines in occupancy than nonconverting for-profit hospitals e rienced. The exception was hospitals that converted to nonp status in the 1980–1990 period. In sum, hospitals subject to con sion were generally smaller and appeared to have weaker mar positions judged on the basis of occupancy rates; conversion did substantially change these circumstances.

Policy Implications

Passions run deep, yet information is scant about the effects hospital conversion on access to care for charity patients, provisi of less-profitable services, and continuity of services to the comm nity. The few available studies of the dynamics of for-profit owne ship of hospitals suggest that communities should be concerne about continuity of service. In a study of HealthTrust and HCA aft HCA's leveraged buyout, Jan Clement and Michael McCue found n performance improvements among hospitals owned by these chain relative to other hospitals in their markets but that the chains ha downsized to achieve corporate financial goals.[4] Large for-profi chains also enter and exit markets more quickly than not-for-profit do.[5] Our findings regarding numbers of conversions to for-profi status, bed size, and occupancy changes are generally consistent with these studies.

However, our findings also indicate that the phenomenon of hos pital conversions is complex. The prevalence of public hospital con versions in some states reflects community decisions to relinquish public control of the hospital in favor of a lower tax burden. Con versely, for-profit hospitals converting to public or not-for-profit status make up a significant minority of all hospital conversions, especially in the 1990–1993 period. These conversions may reflect recognition of the unique place of mission-driven providers in these communities. They may also speak to for-profit hospitals' commit ment to meeting community needs when those needs conflict with profitability.

In light of these findings and concerns, greater public oversight of valuation and the development of strategies to stabilize access to

care and maintain community benefit seem warranted. The level of oversight that public officials exercised in 1980–1993 appears insufficient, as was the public disclosure that was required. Benign regulatory environments apparently supported large numbers of conversions in relatively few states between 1980 and 1990.

However, the development of appropriate public and community oversight of not-for-profit and public hospital conversions requires more information than we now have. Standards for the fair valuation of assets are needed, as is research appraising the effects of alternative standards. To develop standards for the disposition of community assets, we need to understand more clearly the impact of conversion on hospitals' financial stability, on the range of services they provide, and on access to care in the community. Most important, despite the large number of conversions that have occurred, we cannot yet answer the most fundamental question that should drive community decisions about public and not-for-profit hospital conversions: In a dynamic marketplace, are communities better or worse off when their hospitals change ownership?

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NOTES

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3. D.J. Chollet, J. Lamphere, and J. Needleman, "Conversion of Hospitals and Health Plans to For-Profit Status: A Preliminary Investigation of Community Issues" (Washington: Alpha Center, 1996).
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Conversion Of HMOs And Hospitals: What's At Stake?

The pros and cons of nonprofit conversions through the lens of public policy.

by Bradford H. Gray

PROLOGUE: "The debate about for-profit health care is fueled as much by values as by evidence," wrote Brad Gray and Walter McNerney in *The New England Journal of Medicine*. "Some objections to for-profit health care stem from the belief that it is fundamentally inconsistent with the values and purpose that should animate health care organizations . . . on behalf of the needs of patients and communities." Although these words were written in 1986, their veracity still resounds more than ten years later. In this paper Brad Gray frames the debate as it exists for the 1990s. He refrains from making a judgment on the desirability of nonprofit versus for-profit status and conversions from one to the other. Instead, he offers the health policy community a reasoned, well-organized framework within which to examine this often contentious issue.

Gray is director of the Division of Health and Science Policy at the New York Academy of Medicine. He came to the academy in 1996 after eight years on the faculty of Yale University, as a professor of public health and director of the Institution for Social and Policy Studies and the Program on Non-Profit Organizations. He received a doctoral degree in sociology from Yale. Previously he served as a senior staff member and study director at the National Academy of Sciences' Institute of Medicine (IOM). He edited the IOM's influential 1986 book, *For-Profit Enterprise in Health Care*, and has published extensively on matters pertaining to the ethics of human experimentation, for-profit and nonprofit health care, and the changing conditions of medical professionalism.

ABSTRACT: Because for-profit conversions of nonprofit organizations are regulated under trust law at the state level, their health policy implications have generally not been part of the process. This paper provides a health policy framework for assessing conversions of hospitals and health maintenance organizations (HMOs). It begins with basic differences in ownership forms and identifies considerations on both sides of the conversion question. The analysis turns on the extent of the social benefits of nonprofits: the regulatory tool provided by tax exemptions, trustworthiness in the presence of informational asymmetries, and community benefit activities. The analysis and the evidence suggest that the nonprofit form continues to hold significant advantages in health care that bear consideration by policymakers faced with conversion proposals.

FOR-PROFIT CONVERSIONS have been occurring among nonprofit hospitals and health maintenance organizations (HMOs) for many years without attracting much public attention.[1] Then the words "billions," "HMOs," and "conversions" appeared together in California, and Columbia/HCA began a highly publicized campaign of nonprofit hospital acquisitions.[2] Conferences on the topic suddenly became a small industry. Observers started using apocalyptic language, such as "the dissolving nonprofit sector" and "potentially the largest redeployment of charitable assets in history."[3] The parties to whom the topic is of great interest now include the entrepreneurs who hope to obtain nonprofits' assets, nonprofit boards that are trying to fulfill their responsibilities, the lawyers and consultants who advise both parties, existing nonprofits that hope to receive proceeds from conversions, policymakers, regulators, and researchers.

Interestingly, agencies with responsibilities for health care are not necessarily involved in the review of conversions, so hospital and HMO conversions have not generally been treated as a health policy matter. This paper provides a framework for assessing the desirability of conversions of nonprofit hospitals and HMOs from a health policy standpoint. I begin with a discussion of some specific implications of the basic ownership forms of health care organizations. I then discuss some of the reasons that conversions have been occurring and lay out arguments regarding the advantages and disadvantages of these transactions from a public policy perspective. I conclude by suggesting a public policy perspective from which conversions in health care might be viewed.

Basic Ownership Forms In Health Care

■ **Accountability issues.** Legal and economic comparisons of nonprofit and for-profit organizations have emphasized the absence of equity owners in the nonprofit form and the prohibition in nonprof-

its of the distribution of profits to owners or other private persons (what Henry Hansmann has called the "nondistribution constraint").[4] Also important is the related difference in internal accountability structures. Managers of for-profit organizations are ultimately accountable to owners, who generally seek to maximize the value of their investments, while nonprofit managers are accountable to boards of trustees, whose members lack an ownership stake and who may be chosen in a variety of ways and have a variety of values, motivations, and goals, including community service. Agency problems may exist on either the nonprofit or the for-profit side, with managers pursuing their own interests as they define them, rather than focusing primarily on the interests of stockholders or the values of trustees. But the for-profit health care companies use several devices to align the incentives of owners and managers. Senior executives commonly own large amounts of corporate stock, and companies often use large economic incentives to motivate executives toward corporate goals.[5]

■ **Economic performance and sources of capital.** Economic performance is important to both for-profits and nonprofits because both types of organizations in health care rely heavily on retained earnings and debt for new capital outlays. (Although there are important exceptions, charitable contributions are not now a significant source of capital for nonprofit hospitals and HMOs.) Despite their similarities, for-profit and nonprofit organizations do face differences with respect to sources of capital. Differences first arise at the outset of operations: Nonprofits usually begin with some mix of debt and donations or grants from private sources or government, whereas for-profits begin with a mix of equity capital and debt.

Public policies regarding capital have treated for-profits and nonprofits somewhat differently. Donations to charitable organizations [as defined by Section 501(c)(3) of the Internal Revenue Service Code] are tax deductible to the donor. (Of course, tax policy also has been used at times to stimulate capital investment—for example, by allowing accelerated depreciation expenses.) Among hospitals, Medicare return-on-equity payments provided a significant source of capital for for-profits that was not received by nonprofits and was an important reason for the growth of investor-owned hospital companies. Among HMOs, federal loans and grants from the HMO Act of 1973 were an important source of capital that was available, with narrow exceptions, only to nonprofits for a decade ending in the early 1980s.

Although many sorts of organizations may seek growth, equity capital provides special growth incentives. For organizations with growing earnings, equity capital can be much cheaper than debt.

The higher the stock price in relationship to earnings, the cheaper the organization's access to equity capital.[6] High price/earnings ratios result from investors' expectations of future earnings; such expectations can be fed by a history of earnings increases, a pattern that is achieved more readily via acquisitions and mergers than via improved performance of a fixed set of hospitals or health plans.

■ **Sources of revenue.** For operating revenue, nonprofit and for-profit HMOs and hospitals all rely heavily on payments for services rendered. Although there are again some exceptions, most nonprofit hospitals and HMOs do not have major sources of revenue other than those connected with the provision of services. As competitive pressures grow, the ability of nonprofits to use revenues generated from the sale of services to subsidize unprofitable mission-oriented activities may decrease. However, even relatively small amounts of nonservice revenues may prove to be important in differentiating nonprofits in a competitive era.

■ **Tax status.** A final point of contrast concerns nonprofits' exemption from a variety of federal, state, and local taxes that for-profits must pay. Estimates in the mid-1980s put the value of nonprofit hospitals' tax exemptions at about 5 percent of revenues, although these estimates were rough or were based on questionable extrapolations from a small number of financially healthy institutions during a brief period when hospitals had particularly healthy bottom lines as a result of the early implementation of Medicare's prospective payment system (PPS).[7] As an ownership-related matter, the tax-exemption issue has complexities. For example, at certain points in their histories, many for-profit health care firms have enjoyed significant tax breaks, designed to stimulate investment. Also, nonprofits are not exempt from all taxes. They pay payroll taxes and, in some states, taxes levied by the state on hospital admissions or payments to government in lieu of taxes; in some locales, nonprofit hospitals, because of their larger size and payrolls, actually pay more taxes on average than for-profits pay.[8]

Reasons For Conversions

Conversions take two general forms. One involves the acquisition of an organization or its assets by members of its management, board, or medical staff.[9] This often is a leveraged buyout, in which the purchasers borrow the money to purchase the organization's assets. The second form is the purchase of a nonprofit's assets (perhaps including its name) by an external organization. (There are, of course, mixed cases in which an insider is involved with an external purchasing organization.) It appears, although systematic data do not exist, that purchases by insiders have been common among

"Some HMO conversions have proceeded out of strength and strategy; hospital conversions have tended to occur out of fear."

HMOs, whereas the sale and conversion of nonprofit hospitals seem generally to involve an external investor-owned company.

A sale/conversion may be driven by positive organizational goals or by the absence of alternatives. That is, for trustees and those who influence them, the decision to convert may be driven by strategic considerations regarding improving access to capital, building market share, forming strategic alliances, and so forth—matters that can reflect a healthy organization that is trying to position itself to do well in the rapidly changing health care system. At the other extreme are organizations that are in trouble—unable to compete and lacking the capital and the vision to respond to health system change. Their trustees might be searching for a "white knight" to rescue the organization and relieve them of the problems that they face in trying to run it. Thus, conversions might occur in two very different situations—in organizations that believe their future is very bright and in organizations that are very troubled. Although systematic empirical data are lacking, I believe that some HMO conversions have proceeded out of strength and strategy and that hospital conversions have tended to occur out of fear, a choice from a list of unpleasant alternatives.

Policy Issues Raised By Conversions

Should public policy encourage or discourage conversions of nonprofit health care organizations to for-profit status? Arguments can be offered on both sides of the question.

■ **Reasons for encouraging conversions.** At least six reasons might be advanced for public policy that encourages conversions of nonprofit health care organizations. (I have not included the war horse about greater efficiency because its meaning is often murky in health care, and the preponderance of evidence does not suggest that for-profits necessarily have lower costs or are less expensive to either purchasers or society.)[10]

(1) To facilitate health coverage of the uninsured. The replacement of nonprofit health care organizations with for-profits, it might be argued, would hasten the end of the belief that the medical needs of the uninsured can be met adequately without governmental action to assure universal insurance coverage. The presence of a large "voluntary" sector was used as an argument against national health insurance in the 1930s, and it may account for the confidence some-

times expressed by conservative politicians today that America's forty million uninsured get Medicaid care when they need it.[11] That confidence might decline if nonprofit institutions were replaced by for-profits.

(2) To move more organizations onto the tax rolls. With concern about revenues in cities and states that rely heavily on property taxes for revenues, the conversion of nonprofits would have the beneficial effect of moving more organizations onto the tax rolls. (Taxes or payments in lieu of taxes by nonprofits might accomplish the same thing.) Federal and state taxes on corporate profits also would provide additional revenues for those governments, although this would result in a shift of resources from health care to other purposes.

(3) To put charitable assets to more productive uses. An enormous amount of capital is tied up in hospitals and HMOs that generate almost all of their revenues from the sale of services. If that capital were extracted, perhaps it could be used for services for which sources of payment are less readily available, such as care of the uninsured, prevention programs, or services deemed experimental by payers.[12]

what does this mean?

(4) To enhance access to needed capital. For hospitals and HMOs that are in financial difficulty, capital for modernization or expansion may be difficult to obtain. Sale or conversion to a for-profit organization may facilitate organizational survival by providing access to new sources of capital.

(5) To facilitate consolidation and capacity reductions. Surplus hospital capacity is a serious public policy problem. Insofar as nonprofits' boards view their responsibility as preserving their institutions, they may find it difficult to cease operations. Selling the assets may be a useful alternative for preserving value.[13] The sale of several hospitals in the same market to the same purchaser may hasten the closure of some facilities, since the market share of the acquiring organization would be enhanced. Depending upon one's perception of larger consequences (for example, the impact on safety-net hospitals), this may be a good idea.

(6) To end the "fiction" that nonprofits are more socially beneficial than their for-profit counterparts. Advocates of for-profit control commonly assert that nonprofits enjoy a halo effect and tax exemptions that are not justified by their performance (typically on narrowly defined criteria).[14] This is both a conceptual question (How might we expect nonprofits to differ from for-profits?) and an empirical one. I return to this issue later.

■ **Reasons for discouraging conversions.** There are at least three reasons for advocating public policy that discourages conversions of nonprofit organizations.

(1) Preserving the nonprofits' value in the nonprofit sector and preventing private inurement. Establishing the value of a nonprofit organization can be difficult. Windfalls by purchasers have been quite common, with a substantial net loss to the nonprofit sector. There are several reasons for this. Competitive bidding, and its benefit for establishing an organization's worth, is often missing in these situations. Moreover, the persons who know the organization best (such as the chief executive officer [CEO]) may be on both sides of the transaction. Particularly for HMOs, purchasers have frequently been insiders. But even when an outside purchaser is involved, financial payments or promises of future employment may be made to the nonprofit's managers.[15] Thus, in several common situations, those who are responsible for the nonprofit (as managers or trustees) may have an interest in minimizing the price paid for the nonprofit's assets.

In addition, because nonprofits have likely not been seeking to maximize profits, their revenue-generating potential may be difficult for a seller (or regulators) to assess. Purchasers—particularly those who have experience in buying nonprofits and operating them for profit—may have a major informational advantage over sellers in this situation. It is difficult to prevent purchasers from acquiring an organization at a bargain price, particularly since the financial details of such transactions often are not made public and thus do not inform future sellers of other nonprofits.

(2) Uncertainties about protecting the public interest. Neither the trustees of the converting organization nor the purchasers of their assets are responsible for considering the community impact of a conversion. As far as I can determine, often no one is. Even if legislation were to assign review responsibility to a state agency with substantive responsibility (for example, a department of health), no generally recognized conceptual tools exist for guiding reviewers regarding what information or potential consequences they should consider.

(3) Potential loss of social benefits of nonprofit health care. If substantial social or community benefits inhere in nonprofit organizations in health care, conversions could have significant disadvantages.

What Are The Social Benefits Of Nonprofits?

Proposals to convert nonprofits to for-profit ownership occur primarily in fields that already have a mixture of ownership forms. In fields where for-profit organizations can exist and prosper, what is the role or value of the nonprofit organization? Arguments on both sides of the conversion question rest heavily on nonprofits' social benefits (or lack thereof), so it is essential to consider carefully what

those benefits might be. I discuss three types of social benefits: regulatory benefits, trustworthiness, and community benefits.

■ **Regulatory benefits.** One reason for preserving a predominantly nonprofit health care system is the regulatory tool provided by the tax exemption. When faced with a public policy goal or challenge, government commonly faces a choice between using tax revenues or forcing (or encouraging) others to take action. These others might be individual citizens, lower levels of government, businesses, or nonprofits themselves. As with tax policy generally, nonprofits' exemptions provide policymakers with a lever to which they can attach a variety of conditions. In recent years all levels of government have become interested in attaching performance-related conditions—most commonly, charity care requirements—to tax exemptions for nonprofit health care organizations.[16] The wisdom of this approach is debatable, in terms of both efficiency and the desirability of governmental control of nonprofit organizations, but the tax exemption is nevertheless a tool that can be used to accomplish governmental purposes.[17] The disappearance of institutions that are subject to this tool, or to moral suasion regarding community responsibilities, would be a disadvantage of replacing nonprofits with for-profits.

■ **Trustworthiness.** Health care is characterized by serious informational asymmetries because of the vulnerabilities of patients and the use of third-party payment.[18] Parties that are at an informational disadvantage must trust that their vulnerability will not be exploited. Hansmann hypothesized that nonprofit organizations, because of the constraint on the use of surpluses, may be seen by purchasers as less likely than for-profit organizations to behave in an untrustworthy manner in the presence of an informational advantage.[19] He also suggested that in the health care context, patients' vulnerabilities are protected by their agency relationship with physicians and that the nonprofit form therefore is not needed to increase the trustworthiness of hospitals.[20]

There is, however, an extensive body of literature showing that physicians' patient care decisions are influenced by a variety of nonmedical factors, including economic incentives.[21] Moreover, many other parties in health care have economic interests that lead them to seek to influence physicians' patient care decisions. HMOs or hospitals may use methods that range from persuasion to finding ways to put money in physicians' pockets. Some past attempts have violated the fraud provisions that apply to Medicare (for example, the Paracelsus Health Corporation's scheme of a decade ago to split profits with doctors on Medicare patients admitted to the hospital under the diagnosis-related payment system).[22]

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Patient care decisions in hospitals. Not subject to the nondistribution constraint, for-profit health care organizations can enter into profit-sharing arrangements with doctors that may influence their patient care decisions. Columbia/HCA's strategy of forming local partnerships with physicians who admit patients to its hospitals is an interesting example.[23] According to Robert Kuttner, Florida's Agency for Health Care Administration found evidence that physicians are influenced by this arrangement. Medicare patients for whom hospitals receive fixed, diagnosis-related reimbursement and who were admitted to Victoria Hospital, a Columbia/HCA hospital in Miami, stayed an average of 8.48 days, whereas the same doctors' Medicare patients who were admitted to other area hospitals had an average length-of-stay of 13.5 days. This suggests that doctors either were steering their sickest patients to hospitals other than Victoria or were treating patients differently in the hospital in which they had a financial interest. The report, which was never released, talked of the "possibility of cream skimming" and the "possible adverse effects on a market of physician ownership in a hospital."[24]

Conflicts of interest in HMOs. HMOs have become the object of much distrust in recent years because of instances in which they seem to be simultaneously depriving patients of needed care, creating conflicts of interest for affiliated physicians, and profiteering at the expense of all other parties in the system. Critics of HMOs' practices often link their concerns to HMO owners' financial stake in limiting services for patients, suggesting that there may be a connection between the growing distrust of managed care and the prominent presence of for-profit HMOs. Perhaps this explains public perceptions regarding HMO ownership. In a national survey by Louis Harris and Associates in 1995, more than half of the respondents expressed a strong preference regarding the ownership form of HMOs; of these, more than 80 percent preferred a not-for-profit organization over a plan owned by a for-profit company.[25] In one of the few studies that has examined ownership and incentives in HMOs, Mark Pauly and colleagues found that the incentive devices used for primary care physicians by for-profit plans significantly affect physicians' patient care decisions, while this is not true of the incentives used by nonprofit plans.[26]

Whether there are systematic ownership-related differences in trustworthiness of HMOs is uncertain, but there is evidence that for-profits and nonprofits are at the opposite ends of some pertinent distributions. Thus, a Health Care Financing Administration (HCFA) review of disenrollment from Medicare risk contracts in 1993 found that the five HMOs with the highest disenrollment rates were all for-profit HMOs, and the five HMOs with the lowest disen-

"Trustworthiness problems may grow in concert with the growth of investor control of health care organizations."

rollment rates were all nonprofit HMOs.[27] A similar pattern has been reported in the appeal process for Medicare beneficiaries enrolled in HMOs, where the highest appeal rates were from for-profit plans, and the lowest rates were from nonprofits.[28] The rate of complaints per thousand enrollees ranged from 4.58 in Humana's for-profit Florida plans to 0.18 in the nonprofit Group Health Cooperative of Puget Sound. A third example comes from the 20,000 responses to a *Consumer Reports* survey of readers' experiences with and assessment of thirty-seven HMOs: An average of 12.2 percent of respondents from for-profit plans reported that they did not get care that they felt they needed because the plan discouraged it, compared with an average of 7.8 percent of respondents from the eighteen nonprofit plans about which data were obtained. The distribution of responses hardly overlapped.[29]

More systematic data on the relationship between trustworthiness and ownership form are needed before firm conclusions can be drawn. However, informational asymmetries and associated problems remain prominent in health care. There are theoretical reasons, and some evidence that is consistent with those reasons, to suggest that trustworthiness problems may grow in concert with the growth of investor control of health care organizations.

■ **Community benefits.** Nonprofits could provide valuable community benefits or public goods that are insufficiently available from for-profits. These might be tangible (offering unprofitable services or providing charity care) or intangible (the benefits, whatever they may be, of governance by local trustees who are free to make decisions that are relatively uninfluenced by self-interest).

Why might we expect ownership-related differences in the provision of public or collective goods? Economic theory predicts that market-driven organizations will not respond to wants or needs that are not accompanied by money demand, and nonprofit organizations are governed by and accountable to parties whose concern is not profit making.[30] Moreover, there are public expectations—somewhat inchoate but reflected in tax-exemption policies—that nonprofits will operate to serve the public interest. Even so, the adequacy of the community benefits provided by nonprofit health care organizations has been the subject of much controversy and attacks on nonprofits' tax advantages.

These attacks have been fed by a number of factors: dubious

performance by some nonprofits, skepticism from some legal analysts, governmental appetites for new revenue sources, the search by advocates for the uninsured for ways to enhance the ability of the poor to obtain medical care, and lobbying activities by the investor-owned health care industry.[31] There is a growing sense that nonprofits' tax exemptions in health care should be tied to an organization's community benefit activities. Discussion of this issue, however, is plagued by conceptual confusion regarding the meaning of community benefit.

Narrow view of community benefit. The narrow view of community benefit focuses on charity care for the poor. This focus has some policy appeal because it seems (misleadingly, unfortunately) to refer to something quite concrete and measurable and because it addresses an important problem (the uninsured) that lawmakers have not addressed more directly.[32] Moreover, most nonprofit hospitals and HMOs are tax-exempt as charitable organizations, although the Internal Revenue Service defines *charitable* not in terms of free care but in terms of community benefit.

For-profit advocates generally frame the community benefit issue in terms of charity care, perhaps because it suggests a narrow picture of the role of nonprofits and because the extent of charity care, generally measured as uncompensated care (deductions from revenues for bad debt and charity), varies widely among nonprofit hospitals (as it does among for-profits) depending on a variety of factors, including hospital location.[33] Many hospitals are located where the need for charity care is small. If charity care were adopted as the sole measure of community benefit for tax-exemption purposes, some nonprofits would fail the test.

National uncompensated care numbers based on hospital self-reports in surveys by the American Hospital Association show only slightly higher levels of uncompensated care in nonprofit than in for-profit hospitals, a pattern that has been persistent for many years.[34] Uncompensated care data for 1994 showed nonprofits at 4.5 percent of revenues and for-profits at 4.0 percent.[35]

This picture of comparative behavior is widely cited, but it may be misleading because of weaknesses in the measure used (unaudited self-reports by hospitals and some nonresponse problems) and because it ignores state-level differences. Nonprofits are found in large numbers in all states, including many that have low numbers of uninsured persons and, therefore, proportionately low levels of need for hospitalization among the uninsured. For-profits are concentrated in states that have growing populations and friendly regulatory environments; many of these states have relatively high numbers of uninsured persons.[36] In such states nonprofits tend to

provide much higher levels of uncompensated care than for-profits provide; this is true for Texas, Tennessee, Florida, and Virginia.[37] This pattern suggests that nonprofits may be more responsive than for-profits are to unmet needs for medical care. However, when the need for indigent care is relatively low, because of low numbers of uninsured persons or the availability of government-subsidized public hospitals, differences between for-profit and nonprofit hospitals are small, as is true in California.[38]

Research also has shown that nonprofit hospitals admit more uninsured and Medicaid patients than for-profits admit.[39] For-profit hospitals are also more likely than nonprofits are to pressure physicians not to admit uninsured and Medicaid patients, and physicians report conflict over the treatment of indigent persons more often in for-profit than in nonprofit hospitals.[40]

Broader view of community benefit. Community benefit can be viewed in much broader terms than indigent care. In work published elsewhere, Mark Schlesinger, Elizabeth Bradley, and I developed a more comprehensive set of measures derived from tax law, economic theories of nonprofits, and the work of scholars and hospital associations regarding community benefit.[41] We identified some thirty different dimensions, including activities that create positive externalities (such as contracting with essential community providers and reporting bad clinical practices to appropriate authorities), minimizing negative externalities (such as shifting the burdens of cost containment to providers or to patients' families), creation of public goods (such as involvement in research and educational activities), minimizing the exploitation of informational asymmetries, and various forms of community involvement.

The research on community benefits of different types of health care organizations has serious inadequacies, particularly regarding HMOs, but a variety of indicators suggest that nonprofits have substantial advantages over for-profits from a broadly defined community benefit standpoint. For example, local governance is much more typical among nonprofit hospitals than it is among for-profit hospitals; nonprofit hospitals are more likely than for-profit hospitals to be located in urban areas with large numbers of poor and uninsured persons; nonprofit hospitals and HMOs are much more involved in research and education than are for-profits; nonprofit hospitals offer a greater array of services, including some that typically lose money, than for-profit hospitals offer; nonprofit HMOs have been much more likely than for-profit HMOs to participate in the Medicare and Medicaid programs; and nonprofits are much less likely than for-profits to undergo recurrent changes of ownership and control.[42]

The advantage of a broad definition of community benefit is that

it more fully captures the benefits that nonprofit organizations might provide and that might be at stake when organizations convert. The disadvantage of the broad definition is that it is not based in a common metric that can be quantified and compared across organizations. Obviously, the breadth of the definition has both analytical and political consequences. There is no one correct answer to the question of which definition is "right," but a broad definition would seem desirable if one were to conduct an environmental impact assessment of potential conversions.

Most of the data on uncompensated care and other community benefit activities in nonprofit hospitals come from an era in which nonprofits were under little governmental pressure to provide and document their community benefit activities. In recent years nonprofit hospitals have experienced much additional pressure to serve the poor and uninsured to justify their tax exemptions. Some hospitals have begun to include such service in their budgets and to make public reports of their community impacts. How the new public pressures have affected the community benefit activities of nonprofit hospitals is not known. Research on psychiatric hospitals, however, has shown that public pressure on nonprofits is associated with greater differences with for-profits in indigent care.[43]

An Appropriate Public Policy Stance

The appropriate stance for public policy regarding conversions of nonprofit health care organizations depends on one's beliefs and values regarding several matters that cannot be wholly laid to rest based on available evidence. These beliefs or values relate to the following issues:

(1) Whether community benefits should be defined in narrow or broad terms. If only "charity care" counts, many hospitals and most HMOs provide very little. However, the number and magnitude of differences between for-profit and nonprofit health care organizations grow as the number of comparative dimensions is increased.

(2) Whether health care services are essentially private goods, and whether the community benefit aspects of health care (however they may be defined) are important. If one is highly confident that pursuit of economic incentives in health care will produce appropriate outcomes for patients and communities, one would have little concern about the possible negative effects of conversions because there is considerable evidence that for-profit behavior tracks economic incentives more closely than does the behavior of nonprofits.

(3) Whether performance measurement and reporting by purchasers are sophisticated enough to obviate the problems of trustworthiness that arise from the informational asymmetries between

provider and patient and between provider and payer, and whether purchasers serve as reliable protectors of patients' best interests.

(4) Whether tax exemptions should be used to advance public policy goals, and whether the performance of nonprofits on community benefit measures improves as a result of public scrutiny and pressure.

(5) Whether local control by voluntary trustees plays a valuable role in meeting community needs, and whether the stability of control of health care organizations is deemed important.

(6) Where one places the burden of proof: Should public policy support conversions as long as no one can show that conversions would be harmful to a community, or should conversions be discouraged until there is clear evidence that they produce beneficial change?

Conclusion

Policy arguments about the desirability of the conversion of nonprofits turn on the extent to which nonprofits offer community benefits and trustworthiness. Advocates of conversions see insufficient benefit in nonprofits, whereas opponents express concern about the loss of community benefits as a result of conversions. Many nonprofits do not provide as many of certain forms of benefits as critics would like, although the evidentiary picture itself has serious shortcomings. The focus of research has been rather narrow, and some aspects of community benefits and trustworthiness have received insufficient attention. Moreover, almost all research is cross-sectional, and almost all is focused on situations in which for-profits coexist with healthy nonprofits. Thus, we have no evidence about the consequences of the conversion of most of or all of the nonprofits in a particular market. We can only speculate about the potential consequences of conversions of nonprofits on a grand scale.

Investor-owned companies' acquisition appetites for hospitals seem to be fed by opportunities to make very cheap acquisitions because of nonprofits' uncertainties about the future, by lax regulatory oversight, and by the hope of obtaining sufficient market share that large purchasers will have to deal with them, even with high prices. Among HMOs, where the market continues to expand, conversions seem driven less by external suitors than by internal strategies. The opportunity to obtain a bargain is also a factor.

Conversions of nonprofits may help to preserve essential services in some instances, so a general policy of opposition to conversions seems undesirable. However, a sound process would protect the public interest by preserving the value of converting in the nonprofit

sector (in new or existing foundations); preventing private benefit (as occurs when assets are purchased for less than fair market value); minimizing the distorting effects of conflicts of interest; and assessing in a comprehensive way the community benefit dimensions that may be affected by a conversion.

As is discussed elsewhere in this volume, many states are developing legal provisions to ensure procedural integrity in conversion situations. It will be interesting to see if the wave of conversions continues under circumstances in which procedures are in place to bring public awareness to the matter, to ensure that a proper price is being paid, to make provisions for conflicts of interest, and to protect communities from the loss of community benefits. Perhaps the conversion phenomenon will retreat back into the obscurity that helped to facilitate it in the first place.

The author is grateful to Mark Schlesinger for collaborating on work that the author has adapted for parts of this paper and to Judith Feder for her suggestions for shortening a more lengthy paper prepared for "Changes in the Not-for-Profit Status of Health Care Organizations," a conference sponsored by The Henry J. Kaiser Family Foundation, George Washington University Conference Center, Washington, D.C., 30–31 October 1996. Portions of this paper are based on work that was supported by The Commonwealth Fund and the Milbank Memorial Fund.

NOTES

1. The earliest hospital conversion of which I am aware occurred prior to 1970. E. Hoy and B.H. Gray, "The Growth of the Major Investor-Owned Hospital Companies," in B.H. Gray, ed., *For-Profit Enterprise in Health Care* (Washington: National Academy Press, 1986), Table 5. The earliest HMO conversion to which I have seen reference occurred in 1978. See K.C. Dunn et al., "The Dynamics of Leveraged Buy-Outs, Conversions, and Corporate Reorganizations of Not-for-Profit Health Care Institutions," *Topics in Health Care Financing* (Spring 1986): 19–34.
2. D.M. Fox and P. Isenberg, "Anticipating the Magic Moment: The Public Interest in Health Plan Conversions in California," *Health Affairs* (Spring 1996): 202–209.
3. Ibid.; and C. McDermott, "The Changing Health Care Scene and Health Philanthropy: The New 'Conversion Foundations'" (Presentation at the Council on Foundations Annual Conference, Atlanta, Georgia, 23 April 1996).
4. H. Hansmann, "The Role of Nonprofit Organizations," *Yale Law Journal* 89, no. 5 (1980): 835–901.
5. In interviews at Humana in 1987, I was told that as much as 50 percent of the chief executive's compensation in Humana hospitals was in incentives tied to economic goals set by the corporation. Columbia/HCA establishes local joint ventures that own hospitals or other facilities, with local doctors and executives as investors. Robert Kuttner was told by a Columbia/HCA executive that hospital executives who fall short of the corporate goal of a 20 percent gross return on revenues are "regularly called to corporate headquarters in Nashville to explain and are ordered to redouble their efforts." See R. Kuttner, "Columbia/HCA and the Resurgence of the For-Profit Hospital Business" (Part 1), *The New England*

CONGRESSWOMAN ZOE LOFGREN

FAX TRANSMITTAL

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From:

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Michele Heller	Lily Toton ( )
Jason Mahler ( )	Lesley Williams ( )
Tom Oscherwitz ( )	Gregg Yates ( )

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Congress of the United States
House of Representatives
Washington, DC 20515-0516

October 26, 1998

Christopher C. Jennings
Deputy Assistant to the President for Health Policy
The White House
Washington, DC 20502

Dear Mr. Jennings:

I am writing to seek the Administration's assistance in combating a disturbing health care trend. In the past few years, non-profit hospitals with a tradition of community care are being taken over by for-profit hospital chains whose primary obligations are to their shareholders. For example, in the past few years, Columbia/HCA, the largest of the for-profit hospital chains, has negotiated more than 100 acquisitions or joint ventures with non-profit hospitals.

My community, San Jose, is currently at risk of losing a crucial non-profit hospital, Alexian Brothers Hospital. Columbia/HCA is proposing to take over the hospital in San Jose in exchange for two properties it owns in Illinois. Columbia has made no written commitment to continue Alexian's mission to help the needy and vulnerable in the community.

I understand that legislation is pending to ensure that the federal tax benefits enjoyed by non-profit hospitals accrue to the local community and not to private individuals. Moreover, this legislation also would require the details of proposed conversions be made available to the public.

As this legislation is being considered, the question of whether the Columbia/HCA transaction in San Jose and other similar deals deserve close regulatory scrutiny arises. These transactions do not just affect one community, but affect health care services in multiple states. Are there measures that the Executive branch can take to ensure that any conversions of non-profit hospitals to for-profit hospitals do not deprive the public of the valuable benefits conferred by these institutions?

Thank you for your attention to this request.

Sincerely,

Zoe Lofgren
Member of Congress

ZL:to

ZOE LOFGREN
16TH DISTRICT, CALIFORNIA

COMMITTEES:
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SUBCOMMITTEE ON COURTS AND INTELLECTUAL PROPERTY
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COMMITTEE ON STANDARDS OF OFFICIAL CONDUCT

Congress of the United States
House of Representatives
Washington, DC 20515–0516

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Thank you for your attention to this request.

Sincerely,

Zoe Lofgren
Member of Congress

ZL:to

CONGRESSWOMAN ZOE LOFGREN

FAX TRANSMITTAL

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Fax # 456-5557

From:

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Comments: Thanks for your interest.

— Tom —

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Congress of the United States

Washington, DC 20515

October 21, 1998

The Honorable Robert Pitofsky
Chairman
Federal Trade Commission
Sixth and Pennyslvania Avenue, N.W.
Washington, DC 20580

Dear Chairman Pitofsky:

We write to ask that the Federal Trade Commission (FTC) closely review the proposed "swap" of the Alexian Brothers hospital in East San Jose for two Columbia/HCA-owned hospitals in Illinois. This transaction raises serious antitrust concerns and could lead to a significant deterioration in the availability and quality of health care in Santa Clara County.

Columbia/HCA is currently the second-largest owner of hospital beds in the San Jose area. It owns the 388-bed Good Samaritan hospital in San Jose, the 327-bed San Jose Medical Center, the 93-bed South Valley Hospital in Gilroy, and Mission Oaks Hospital in Los Gatos. With this transaction, Columbia/HCA will become the largest operator of medical facilities in the region, controlling over 50 percent of all hospital beds.

Consistent with its past practices of buying multiple hospitals in an area and then shutting one or more down, Columbia has disclosed plans to consolidate Alexian Brothers hospital and another locally held Columbia-HCA facility, San Jose Medical Center. The end result is expected to be that San Jose Medical Center will close. This reduction in facilities threatens higher prices, poorer services, and an absence of choices for vulnerable health care consumers.

The public welfare is clearly at stake in this case. Since its founding, the Alexian Brothers hospital has filled a vital health care niche in Santa Clara County. Besides providing stiff competition to other local hospitals in the area, Alexian Brothers hospital has fulfilled its non-profit mission by caring for the needy and vulnerable in the community. The hospital has served thousands of individuals in the East Side of San Jose who otherwise would have no health care or inadequate care. It is principally because of the Alexian Brothers' humanitarian mission that community members donated funds for the construction of the hospital 33 years ago. Columbia/HCA has made no binding written commitments that it will continue Alexian Brothers hospital's high quality of health services or charitable mission.

Thank you for your attention to this matter, and for your ongoing action to protect health care consumers from unfair restraints on competition.

Sincerely,

Bill Delahunt

Anna G. Eshoo

Robert T. Matsui

Edward J. Markey

Sheila Jackson Lee

Nancy Pelosi

Dan Burton

Helen Chenoweth

Bob Filner

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Opinion

State looking @ non profit assets → charitable assets

Published Wednesday, October 7, 1998, in the San Jose Mercury News

BLANCA ALVARADO

County is right to examine deal with Columbia/HCA

10/31 deadline → 11/30; extension b/c state gov't concerned

Alexian's health care legacy must not be lost

BY BLANCA ALVARADO

WHEN Columbia/HCA and Alexian Brothers announced that for-profit Columbia would be taking over non-profit Alexian Brothers Hospital, I became alarmed. The mission of a non-profit hospital is to provide health care to the community -- including the poor -- and the mission of a for-profit hospital is to make profits for its shareholders.

My apprehension is shared by many community leaders and groups including Congresswoman Zoe Lofgren, Assembly member Mike Honda, San Jose City Council member Manny Diaz, Ed Alvarez (former Alexian Brothers board member), People Acting in Community Together (PACT), La Raza Roundtable, the Consumers Union, and the California Nurses Association.

agreed upon by Columb[illegible] & Alexian

The transaction was negotiated behind closed doors, and one of the most important parties to this transaction -- the public -- was in the dark. So, on Sept. 15, at my request, the Santa Clara County Board of Supervisors held a public hearing on this proposed deal.

Two major issues are at the heart of our concern:

- FTC won't do anything

- How will the transaction affect the community's health care?
- Does the deal protect charitable assets that belong in San Jose?

This deal could have a significant impact on health are in our community. Alexian Brothers is a trusted community institution that provides charity care to the poor and under-served, and it offers a wide variety of community benefit programs.

Although we've received verbal assurances from Columbia that it will maintain Alexian Brothers' charitable mission, the board has received nothing in writing that spells out the specifics of its commitment. Columbia officials also said that they would only guarantee their commitments for three years, but that's too few years and totally unacceptable.

Even though Alexian Brothers is incorporated in Texas, many of its assets were built in San Jose. Alexian Brothers was originally incorporated as a California non-profit corporation, and for many years, enjoyed the benefits of being a non profit in this state, including tax breaks and the ability to float tax-free bonds. Alexian Brothers Hospital was built in 1965 on land donated by a local resident and with funds raised directly from the community as well as with federal funds. The hospital was expanded over the years

with funds generated from the sale of tax-free state bonds. Its operations have also been subsidized by state and local property tax breaks. To the extent that Alexian's assets exist because of community contributions or subsidies, these are charitable assets which must, under California law, remain in the community.

To address these concerns, the board of supervisors passed a resolution asking the attorney general to carefully review the deal and make all transaction documents available to the public. We also sent letters to Alexian Brothers and Columbia, asking that they disclose the terms of the deal, submit to a thorough review by the attorney general, and participate in public hearings.

In a Sept. 30 editorial, the Mercury News erroneously concluded that the board's work has been fruitless. To the contrary, since we took this action, Columbia is now committed to involving the community in its planning. In fact, Columbia will participate in a community meeting that Manny Diaz and I are sponsoring, which will be held at 7 p.m. on Oct. 14 in the Santa Clara County Board of Supervisors' chambers. The attorney general's representative who will be reviewing this proposed deal will also be in attendance.

Our county attorneys have also been busy providing the attorney general with information, such as property tax records, so that we can protect charitable assets that belong here.

Through this public involvement, I hope that Columbia and Alexian Brothers will agree to spell out in writing and provide to the public their commitments to safeguard the community's health care and assets before the attorney general completes a review of the transaction. Columbia should also agree to carry these obligations for longer than three years. Finally, the county stands ready to work with Columbia to ensure that everyone in our community has access to health care.

Blanca Alvarado is chair of the Santa Clara County Board of Supervisors.

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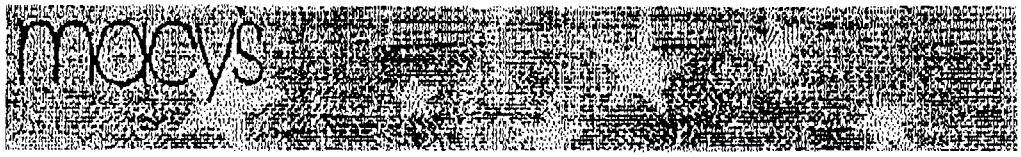

Local & State

Published Monday, October 19, 1998, in the San Jose Mercury News

Alexian Hospital trade causes worry

Charity: Joining for-profit chain could change traditional non-profit link with the community, some people fear.

BY LISA M. KRIEGER
Mercury News Staff Writer

Health care giant Columbia/HCA is assuring worried San Jose residents that non-profit Alexian Brothers Hospital will continue to provide charity care for three years if it becomes part of the for-profit chain at the end of this month.

But there is no guarantee that after three years Columbia will continue essential but unprofitable services such as emergency, trauma, prenatal and indigent care.

And although Columbia officials insisted the written promise was part of an agreement they may yet release to the public, as of Friday the California Attorney General's Office, which is reviewing the sale, could find no evidence of the offer in writing.

Residents, city officials, Alexian staff and others voiced their fear at a public meeting last week that the hospital, built on donated city land, will want to end unprofitable free services when it becomes part of the for-profit chain.

They argue that San Jose will be better served by a closer examination -- or even a rejection -- of the deal that could send Alexian Brothers, East San Jose's only hospital, into the nation's largest chain of for-profit hospitals.

That opinion is fed by reports that other communities have gotten wider concessions in similar deals, and by the private nature of the Alexian Brothers acquisition, in which both parties have refused to release any information.

"It is not public data," said William L. Gilbert, chief executive officer of San Jose Medical Center, representing Columbia/HCA. Although Columbia/HCA may consider releasing a binding agreement about its three-year commitment to charity care, he said, "it is not required, for the same reason that a person's individual taxes are not public."

Still, both he and the head of Alexian Brothers insist that care for the poor will continue. He says Columbia has provided millions of dollars in charity care at its many hospitals.

"I think Columbia is committed to the people of San Jose. . . . Let me assure you, we are confident Columbia will continue (Alexian) programs," said Lawrence Krueger, an Alexian brother.

Alexian Brothers Health System is proposing to swap its San Jose hospital for two Columbia-owned Chicago-area hospitals: Hoffman Estates Medical Center, worth $271 million, and Woodland Hospital, worth $10 million.

The proposed for-profit conversion of the Alexian Brothers Hospital will send the results of decades of public support into the hands of corporate Columbia/HCA and its investors, without any legal requirement for paying it back.

That support was repaid by free medical services to San Jose's poor over the years, according to Krueger, a member of the Catholic order that runs the hospital chain.

As Alexian Brothers seeks to consolidate its hospitals in the Midwest, Columbia has a growing interest in the Bay Area. Alexian Brothers would be Columbia's fourth San Jose-area hospital acquisition since 1996: It bought Good Samaritan in Los Gatos, Gilroy's South Valley Hospital and the San Jose Medical Center.

Swap, not a sale

Under the laws governing the purchase of Good Samaritan and the San Jose Medical Center, the health care company put millions into non-profit foundations that would carry on their traditions of charity and community service. Because the Alexian Brothers acquisition is a swap and not an outright sale, it isn't bound by those requirements.

The attorney general's office must approve the swap and is charged with protecting any public assets that are part of the deal. Deputy Attorney General Chet Horn said he may seek to have the deal's Oct. 31 deadline extended so his office has more time to review the acquisition.

Saying the deal is private, Columbia and Alexian Brothers have released transaction documents only to the attorney general's office, despite a number of requests from the community -- including Santa Clara County supervisors, employees and consumer activists.

"There is a lot of secrecy going on here," said Councilman Manny Diaz, representing East San Jose, in a community meeting Wednesday night. Agreed County Supervisor Blanca Alvarado: "Nothing is public. What we are asking for is fair, equitable and what the community deserves."

FTC review

U.S. Rep. Zoe Lofgren, D-San Jose, has asked Federal Trade Commission Chairman Robert Pitofsky to review the proposed swap. She believes the deal will end the historic, vigorous competition between Alexian Brothers Hospital and San Jose Medical Center for patients and services. As a result of this swap, Columbia/HCA will control both medical facilities.

If, as she predicts, San Jose Medical Center closes, she wrote that Santa Clara County residents will face higher prices, poorer services and fewer choices of health care.

The deal, increasingly seen in U.S. cities, is an outgrowth of dramatic changes in American health care. In the past, it was standard practice for communities to meet their medical needs by banding together and creating small charitable institutions, supported by neighborhood donations, tax money and bonds.

Nationwide, the number of non-profit hospitals merging with or being acquired by for-profit chains climbed from 18 in 1993 to 63 in 1996, the most recent year for which data is available.

The nation's largest for-profit hospital chain, Columbia/HCA, either purchased or merged with 33 non-profit hospitals in 1995, accounting for 57 percent of all non profit hospital conversions during that year. It purchased or merged with 17 hospitals in 1996.

It is unclear how conversions affect the U.S. health care system. Some studies have found non-profits to be more efficient. Others suggest that the profit motive is driving hospitals to cut corners.

Charity provision

In some cases, aggressive state regulation has affected some of the hospital deals,

according to the group Consumers Union. Some regulators demanded that hospitals converting to for-profit had to keep providing services, particularly to the poor, as a condition of approving the acquisition. For example:

- Louisiana regulators approved the merger of Columbia/HCA and a local non-profit hospital only after the new partnership agreed to continue providing as much charity care as the old non-profit hospital. The partnership was also required to maintain emergency rooms, promote wellness in the community, and participate in medical research, teaching and residency programs.

- In Florida, when Columbia/HCA purchased half of non-profit Winter Park (Fla.) Memorial Hospital, it contributed $18 million to complete an expansion and modernization plan and $29 million to a community foundation.

- Columbia/HCA abandoned a deal to buy a 50 percent stake in Sharp Hospital System in San Diego after the attorney general wrote a letter accusing the directors of Sharp of undervaluing the hospital chain by $100 million to $200 million and threatened to hold them personally liable.

- As part of a hospital purchase in New Hampshire, Columbia agreed to build a new hospital, retain employees and open its doors to all patients.

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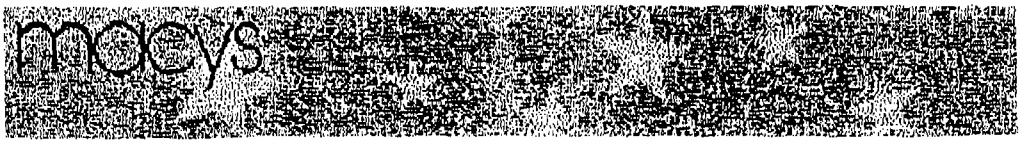

Proposed Guidelines for State Regulators' Oversight of Sale and Joint Venture Transactions in which the Assets of Nonprofit Hospitals or HMOs are Transferred to For-Profit Enterprises1

State charity regulators have strong authority for taking the position that where a nonprofit hospital or HMO corporation or holding company proposes to sell its assets or enter into a whole hospital joint venture, the nonprofit must obtain advance court approval in a cy-pres-type proceeding - a proceeding in which the attorney general is automatically a party.2

State regulators should publicly state that they will (1) oppose favorable court action on a cy pres petition, and (2) bring a breach of fiduciary duty action against nonprofit directors who consummate a sale or joint venture transaction without court approval, *unless* the parties to the proposed transaction have submitted the proposed transaction for advance review and approval subject to the groundrules outlined below.

The central objectives of the state regulator's oversight should be (1) safeguarding the value of the charitable assets, (2) safeguarding the community from loss of essential health care services, and (3) ensuring that the proceeds of the transaction are used for appropriate charitable purposes. The following procedures are designed to accomplish these objectives.

I. Safeguarding the Value of Charitable Assets

Independent review of the fairness of the transaction. Determining the reasonableness of a proposed hospital sale or joint venture transaction requires: (1) a thorough understanding of the terms of the terms of the proposed transaction and of all collateral arrangements, (2) careful assessment of the short- and long-term risks that the nonprofit would assume as a result of the transaction, (3) an independent determination of the value of the operations and assets being transferred by the nonprofit to the for-profit, and (4) a determination of the overall fairness of the transaction from the perspective of the nonprofit.

These are complex questions on which state regulators will need expert advice in order to reach an informed judgment. Accordingly, regulators should require the parties: (1) to disclose to the regulator the complete terms of the proposed transaction and all collateral arrangements, and (2) to fund the cost of an independent review, by experts selected by the regulator, of the fairness of the proposed transaction to the charity.

Submission of a valuation report. As a basis for this independent review, and as evidence of the exercise by the directors of their duty of care, the nonprofit hospital, HMO, or holding company should be required to submit a detailed written valuation report.

Degree of risk to charitable assets. A major focus of review should be to determine whether the proposed transaction exposes the nonprofit's assets to inappropriate economic risks associated with the future operations of the for-profit purchaser. This issue will be of particular importance in transactions in which the nonprofit becomes a passive investor in a joint venture transaction, and thus proposes to enter into a long-term economic relationship with the for-profit purchaser. It is also a major concern in asset sale transactions in which the charity does not receive the full purchase price at closing. Regulators should consider whether the nonprofit is adequately compensated, in the form of a higher rate of return, for

its assumption of significant economic risk, and whether, even where this is the case, the absolute level of risk being assumed by the nonprofit is greater than is prudent for a charitable investor.

Disclosure of conflicts of interest. In assessing the fairness of the proposed transaction to the charity, it is important that the regulator be aware of any conflicts of interest. Accordingly, the regulator should require the nonprofit to submit a conflicts disclosure statement identifying any officers, directors, or affiliates who have direct or indirect economic interests in the transaction and, for each such person, describing the nature of the interest. This required disclosure should include the disclosure of any promises or discussions of future employment.

Consideration of other offers. Where the directors of a nonprofit hospital or HMO corporation or holding company have decided to sell the hospital or HMO operations, they have a duty to give careful consideration to all competing offers. To stimulate multiple offers, the regulator should generally require the nonprofit to make a public announcement, at the time it provides initial notice to the regulator of the proposed transaction, that it is considering a possible sale or joint venture transaction and inviting other potential purchasers or joint venture partners to submit competing proposals. Further, where the nonprofit receives such competing proposals, the regulator should require the nonprofit to submit a written report explaining the grounds for the board's decision for selecting between or among these proposals. Finally, the independent analysis of the proposed transaction commissioned by the regulator should consider all competing offers.

II. Safeguarding the Community from Loss of Essential Health Care Services

Determination of appropriate safeguards for the continuation of essential health care services. The community served by a nonprofit hospital that proposes to enter into a sale or joint venture transaction may depend on the nonprofit for essential health care services. For example, the nonprofit may operate the only emergency room in the community or provide substantial amounts of uncompensated care. In determining whether to recommend approval of the proposed transaction, the regulator should consider whether it is appropriate to require the for-profit purchaser/joint venture partner to agree, as a condition for court approval, to continue to provide specified services. Where the for-profit agrees to such conditions, the regulator should consider establishing an appropriate enforcement mechanism, including requiring the for-profit to bear the cost of a periodic independent audit of its compliance with these conditions.

Public hearing and/or solicitation of public comment. To provide the basis for a more informed judgment about the transaction's effect on community access to essential services, the regulator should hold a public hearing and/or invite the submission of written comments on the transaction. The public statement announcing the hearing should provide the public with a summary description of the proposed transaction and invite comment on whether the transaction is in the best interest of the community.

III. Ensuring That the Proceeds of the Sale Are Used for Appropriate Charitable Purposes

Ensuring that the sale proceeds are not used for the private benefit of the for-profit purchaser. The regulator should ensure that the charitable entity that receives the proceeds of the transaction is not subject to direct or indirect influence or control by the for-profit purchaser. For example, the purchaser should not be represented on the nonprofit's board or have a legal right to require the nonprofit to fund the cost of uncompensated care or other services provided by the purchaser.

Charitable purposes for which the sale proceeds will be used. As a general matter, it is probably preferable to provide the nonprofit trustees considerable flexibility in using the sale proceeds to respond to changing community health care priorities. However, in some

cases it may be appropriate for the regulator to recommend that some or all of the sale proceeds be dedicated to quite specific needs. In addition, as noted above, the regulator should ensure that the sale proceeds are not subject to inappropriate risk with respect to the future operations or capital requirements of the for-profit purchaser.

Governance and oversight of the nonprofit entity that receives the sale proceeds. In addition to ensuring that the nonprofit entity receiving the sale proceeds is neither influenced nor controlled by the for-profit purchaser, the regulator may also find it appropriate to limit, both by number and length of service, the participation on the board of the successor nonprofit of persons who were involved in negotiating the sale transaction. Regulators should also exercise close continuing oversight over the operations of the successor nonprofit, including requiring it to prepare and submit to the attorney general, and make available to the public, an annual report describing its charitable and investment activities.

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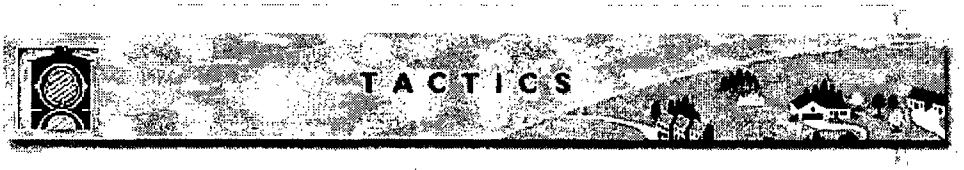

When Your Community Hospital Goes Up For Sale

A Publication of Volunteer Trustees Foundation for Research and Education

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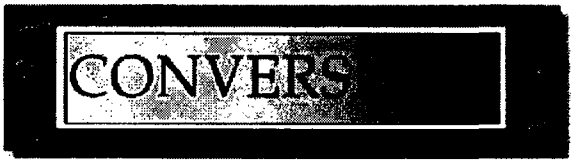

The Case for an Activist Approach by State Charity Regulators in Overseeing For-Profit Conversions of Nonprofit Hospitals and HMOs1

Magnitude of the Issue: An Unprecedented Number of Not-For-Profit Conversions

1995 has witnessed an unprecedented number of sales of not-for-profit hospitals to investor-owned chains -- and the resulting conversion of those hospitals to for-profit status. In the first six months, more than forty sales of non-profit hospitals were announced (either in negotiation or having signed a letter of intent) by Columbia/HCA alone, and most states are now party to some not-for-profit hospital or HMO conversion activity. This is a new phenomenon nationally, not only in terms of numbers and scope of conversions, but also with regard to the resulting structures.

Many of the conversions are "joint ventures", in which only a portion of the asset value is paid at the time of conversion. In some cases, the terms of the sale require as little as 50% of the asset value to be paid on conversion. The balance is held as an interest in the new for-profit venture, placing the charity at risk for the economic benefit of the for-profit purchaser.

In addition, these transactions frequently result in the creation of a new foundation with total assets of hundreds of millions of dollars, and the potential to reach into the billions. In California, we have just witnessed the creation of the tenth largest foundation in the nation through the conversion of Blue Cross. In Tennessee, the first and second largest foundations in the state have been created in the last two years by the sale of two not-for-profit hospitals. There is little in the way of legal precedent for these transactions, nor is there regulatory guidance as to the foundations' structure, board composition, or mission dictating distribution of funds.

Largely unsupervised, these transactions are paving new ground and dramatically stretching the bounds of previous -- and traditional -- models. They are establishing precedent and defining public policy by virtue of numbers and speed alone.

Implications for Communities

The public's stake in these conversions is substantial in that they represent not only the redeployment of billions of dollars in charitable assets, but also a fundamental change in the structure of the health care system. While the for-profit enterprises may prove valuable (e.g. to increasing competition) there is much at risk as well. Not-for-profit hospitals are community-owned institutions and the products of substantial community investment -- in terms of charitable contributions, taxes foregone, and volunteer time. They have provided services and access to them in response to community need, and profits are invested back into the community through expanded service. Studies demonstrate (e.g. Bradford Grey, "For-Profit Enterprise in Health Care"; "Setting the Record Straight&", *New England Journal of Medicine*, 1988) that distinct behavioral differences exist between the for-profit and not-for-profit hospitals -- with the not-for-profit sector providing the vast majority of teaching, research, education, and technological development, as well as a greater breadth and intensity of services (i.e., ICUs, neonatal units, burn centers, children's hospitals, etc.), and the majority of care for chronic illnesses and indigent populations. An investor-owned sector will look different by virtue of ownership, structure, and accountability. The changes

that will accompany such a transformation will reflect the differences between investor interests and community interests.

Policy Issues

A number of policy issues raised by the conversion of not-for-profit hospitals to for-profit enterprises argue for an activist approach to oversight by state charitable regulators. And because, in most cases, *the attorney general is the only party with standing* -- and therefore the sole representative of the community interest -- the argument is all the more compelling.

***Valuation of Assets and Disclosure Requirement** issues beg for some ground-rule guidance to not-for-profit boards. Can transactions be completed in secret without community knowledge or input? Is there an absolute duty to maximize financial return or is it mitigated by considerations of special needs of the community? Is there an obligation to shop the deal? How are competing bids from other hospitals evaluated?

As "joint venture" conversions become a dominant model, they are spawning in turn a variety of new and creative partnering arrangements. Should charitable assets be tied to and at risk with a dominant for-profit partner? Is the promise of some future profit-sharing an adequate substitute for payment of a full and fair price at the time of the conversion? When the non-cash balance is issued in shares in the new for-profit venture and held by a non-charitable entity, are those proceeds still in the charitable stream or are they accruing to the benefit of others?

Does the community have a right to know the terms of the venture? Is there a mechanism or formal process for comunity input? Are there financial and operational oversight mechanisms to assure compliance with promises made? What happens in the event of hospital closure, breach of contract, bankruptcy, or other events that may compromise the value of the non-cash assets, and more importantly, the community interest in the out years?

***Private Benefit** issues raise similarly compelling questions about the adequacy of oversight. There are now numerous examples of officers and directors who have negotiated the sale and conversion of a non-profit entity before moving to lucrative and highly-placed positions in the for-profit buyer or the foundation created with the proceeds. Absent IRS oversight, this practice makes a mockery of private benefit and private inurement rules and cries out for regulatory oversight. For-profit buyers demand and get confidentiality, while charitable assets appear to inure to the benefit of individuals. And, to the extent that non-profits are converted for less than maximally achievable value, is that not an inurement issue, in and of itself?

***Foundations:** Numerous questions also surface around the use of the proceeds of the sale and the establishment of new or the enlargement of existing foundations. Should there be a requirement for independence? From what? Are there rules -- or should there be, consistent with common law *cy pres* doctrines -- to govern the mission of these foundations and the use of their assets? How are the public benefit constraints on these hospital-dedicated funds defined? What ongoing oversight regarding distribution of funds is appropriate and manageable given the origin and size of these foundations?

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State Attorneys General's Legal Authority to Police the Sales of Nonprofit Hospitals and HMOs 1

by Robert A. Boisture and Douglas N. Varley
Caplin & Drysdale, Chartered September 19, 1995

I. Introduction

Nonprofit community hospitals have traditionally been the backbone of the American hospital system, accounting for substantially more than half of the nation's hospital capacity. However, over the past several years, powerful market forces reshaping the health care system have stimulated the rapid growth of large for-profit hospital chains.

While their initial growth was fueled by the consolidation of existing for-profit hospital companies, more recently the large for-profit chains have turned have turned to acquiring significant numbers of nonprofit hospitals. Most of these transactions are structured as asset sales, however, a significant minority are structured as joint ventures in which the nonprofit transfers its hospital assets to a for-profit joint venture, receives cash equal to a portion of the value of these assets, and retains a passive investment interest in the for-profit joint venture.

Nonprofit acquisition is a publicly announced strategy of the largest for-profit chain, and industry experts agree that the rate of for-profit acquisition of nonprofit hospitals and HMOs will continue to accelerate. These transactions promise to result in by far the largest redeployment of charitable assets in history, potentially involving tens of billions of dollars.

Given the sheer magnitude of these transactions and the obvious risks they entail for misuse or mismanagement of charitable funds, the case for aggressive regulation is clear and compelling. While the IRS has some authority in this area -- particularly in preventing private inurement and ensuring the adequacy of the purchase price -- it does not have the authority to require advance approval. Further, the resources it can devote even to *ex poste* review are quite limited relative to the magnitude of the task. Accordingly, the principal burden of protecting the public's interest when nonprofit hospitals go up for sale will necessarily fall to state charity regulators.

This memorandum examines the legal basis for, and scope of, state attorneys general's legal authority to oversee these transactions.2

II. Summary of Conclusions *Advance court approval required.* The directors of a nonprofit charitable corporation -- like the trustees of a charitable trust-- must obtain prior court approval in a *cy pres*-type proceeding for any fundamental change in corporate purposes. This advance approval requirement clearly applies where a nonprofit corporation whose dominant purpose has been the operation of a hospital proposes to sell its hospital operation and devote the sales proceeds to a fundamentally different use.3

While the courts traditionally offer a nonprofit's directors broad discretion in managing day-to-day operations, directors receive no such deference when the issue is a fundamental change in corporate purpose. Rather, the court reviewing a proposed nonprofit hospital sale or joint venture will make its own independent judgment about the appropriateness of the proposed change in use of the charity's assets. As the representative of the public interest,

the attorney general is automatically a party to any such court proceeding, and thus, has clear legal authority to undertake an independent review of the reasonableness and appropriateness of nonprofit hospital and HMO conversion transactions.

Where a nonprofit hospital corporation or holding company proceeds, without court approval, with a sale or joint venture transaction that will terminate the nonprofit hospital operations and redeploy its assets, state courts have the authority both to enjoin the transaction and to hold the nonprofit's directors liable for breach of fiduciary duty.

Director's duty of care. The directors of a nonprofit hospital corporation or holding company also have a duty to exercise reasonable care in reviewing and approving a sale or joint venture transaction. This duty of care requires the directors to employ a reasonable decision-making process directed toward ensuring that the transaction is in the best interest of the corporation. The nonprofit board's decision-making process will presumptively fail to meet this duty of care if the directors fail to obtain the assistance of competent experts and/or fail to consider competing offers. Nonprofit directors are entitled to the protection of the business judgment rule -- under which a court will decline to second-guess the objective reasonableness of the director's decisions -- only if the directors can show that they have met the process requirements imposed by the duty of care.

The attorney general's authority to require advance review and approval. The requirement that a nonprofit hospital corporation obtain advance court approval for a sale or transfer of its hospital operation, combined with director's personal exposure to suit for breach of their duty of care, give state charity regulators the practical leverage to require nonprofits to submit such transactions for advance review and approval. Click here to see the proposed guidelines. Faced with the prospect of a potentially protracted challenge by the attorney general to its petition for an authorization of new use, or a breach of duty action if it proceeds without court approval, nonprofit hospital corporations will almost certainly opt to comply with reasonable requirements for advance review and approval.

Leveraging state regulators' oversight capacity. It will be difficult within existing resource constraints for attorneys general and other state regulators to provide effective oversight for the increasing number of nonprofit hospital and HMO conversion transactions. Accordingly, regulators need to consider strategies to augment their existing regulatory capacity. In this regard, state regulators should consider requiring the parties to nonprofit hospital sale and joint venture transactions to fund the cost of an independent review of the fairness of the proposed transaction.

In addition, in appropriate circumstances, state attorneys general should consider authorizing private parties to bring relator actions challenging the terms of proposed transactions. Where state law permits such relator actions, the attorney general can exercise ultimate control over the action while requiring the private relator to bear the costs of the action.

III. Legal Analysis

A. The Requirement for Prior Court Approval of a Nonprofit Hospital Corporation's Sale of Its Hospital Operations

The directors of a charitable nonprofit corporation whose dominant purpose is the operation of a hospital must obtain prior court approval before selling the corporation's hospital operations and using the sale proceeds for other purposes. This obligation derives from the court's application to charitable corporations of fundamental trust law principles concerning changes in use of charitable assets.

The trustees of a charitable trust seeking to use trust assets for a purpose other than the stated purpose of the trust must, of course, obtain prior court approval in a *cy pres* proceeding.**4** In such a proceeding, to which the attorney general is automatically a party,

the trustee must establish that (1) it has become impossible, or at least impracticable, to accomplish the stated purpose of the trust, and (2) the proposed alternative use of trust assets comes as close as present circumstances permit to fulfilling the original intent of the donor. Consistent with trust law's strong emphasis on fidelity to the settlor's intent, courts historically have taken a quite strict and literal approach in applying these *cy pres* criteria in cases involving charitable trusts. However, the recent trend has been toward somewhat greater flexibility -- for example, courts have approved deviations from trust purposes without a showing of strict impossibility or impracticality where the trustee has made a credible argument that the settlor would have favored the proposed alternative use had he or she been able to take into account changed circumstances since the creation of the trust.**5**

While charitable corporations are not treated as trusts for all purposes,**6** courts and commentators have taken the position that the assets of a charitable corporation are impressed with a charitable trust limiting the purposes for which they can be used to the purposes of the corporation as those purposes were defined at the time the assets were given.**7** Thus, a charitable corporation's directors cannot authorize a fundamental deviation from those purposes without obtaining a prior court approval in a *cy pres*-type proceeding.**8**

The Supreme Judicial Court of Massachusetts, for example, has ruled that, although a charitable corporation has the power to amend purposes, it is not free to unilaterally apply pre-existing assets to the new purposes. In the court's view, such action would be a violation of the board's fiduciary duties to donors, and would potentially undermine the attorney general's power and responsibility to enforce the due application of [charitable] funds.'"**9** Thus, while the corporation in *Hahnemann* was authorized to sell its hospital facility, its use of the sale proceeds was limited to the purposes defined in its earlier governing instruments.

The clearest exposition of these principles can be found in *Queen of Angels v. Younger*, an important case in which a California Court of Appeals held that a nonprofit hospital corporation did not have the legal authority to lease its facilities to a for-profit concern and use the proceeds for other health-related activities. The court's analysis began with the proposition that:
the assets of a corporation organized solely for charitable purposes must be deemed to be impressed with a charitable trust by virtue of the express declaration of the corporation's purposes, and not withstanding the absence of any express declaration by those who contribute such assets as to the purposes for which the contributions are made.**10**

To determine the terms of that trust -- and hence the extent of the board's authority to authorize new activities -- the court looked not only to the corporation's articles of incorporation but also to the way it had held itself out to donors and the community at large. While the court recognized that the corporation's articles explicitly empowered it to engage in a range of health related activities, it found that all of those activities were predicated on the organization's running a hospital. The court went on to stress that the corporation had represented itself to donors, the public, and to state and federal tax authorities as a hospital. Thus, the opinion concludes that leasing the hospital to another organization constituted the abandonment of the organizationís corporate purposes and violated the trust imposed on its assets.**11**

In this regard, it is important to note that while the courts traditionally afford directors of a charitable corporation broad discretion in managing day-to-day operations, directors receive no such deference when the issue is a fundamental change in corporate purpose. The Supreme Court of Missouri has articulated this principle as follows in *Taylor v. Baldwin*: "The point of demarcation at which the courts will interfere with the discretion of those governing a public charity reasonably is the point of substantial departure by the governors (or Board) from he dominant purpose of the charity."**12**

In *Taylor*, the court considered a contractual affiliation between a nonprofit hospital and university medical center which involved selling the hospital's existing facility and buying a new one on the medical center campus. Although the court upheld the board's decision to

affiliate with the medical center, it did so only in light of several express findings indicating that the affiliation was not a substantial departure from the corporation's dominant charitable purpose. Indeed, the court found that, under the affiliation agreement, the corporation would maintain its independence and control over its hospital operations and would "continue to perform its present functions and render its present services without change."**13**

On the other hand, where a nonprofit corporation whose dominant purpose has been the operation of a hospital proposes to sell the hospital and use the sale proceeds for a fundamentally different purpose -- for example, to endow a grant-making foundation -- it finds itself clearly on the other side of the "point of demarcation" defined by the court in *Taylor*. In this situation, the nonprofit hospital corporation is not seeking merely to modify the circumstances under which it supplies hospital services, but rather is getting out of the hospital business altogether.**14** As the foregoing authorities make clear, the directors do not have the authority to make such a change with court approval.

There are as yet no reported cases applying the foregoing analysis to the relatively recent phenomenon of so-called whole hospitals joint ventures with for-profit hospital corporations. The terms of these joint venture transactions, including the degree to which the nonprofit will remain involved in managing the hospital once it is owned by the joint venture, vary greatly. However, the nonprofit typically gives up control of its hospital, transferring the hospital to the joint venture in return for cash plus a passive investment interest in the joint venture. In such cases, the change in use of the charity's assets is usually substantially equivalent to that involved in a traditional asset sale. Hence, the authority discussed above requiring prior court approval for fundamental changes in corporate purpose should be applicable to these joint venture transactions as well.

In sum, the directors of a nonprofit hospital corporation or hospital holding company do not have the authority to consummate a sale or joint venture transaction through which the corporation disposes of its hospital operations without obtaining prior court approval in a *cy pres*-type proceeding. Where a nonprofit hospital corporation proceeds with such a transaction without prior court approval, state courts have the authority both to enjoin the transaction and to hold the nonprofit's directors liable for breach of fiduciary duty.

B. Directors' Duty of Care in Approving Nonprofit Hospital Sales

Wholly apart from the duty of fidelity to the donors' intent imposed on them by the law of charitable trusts, directors of charitable corporations must fulfill their duty of care to the corporation. The standards applicable to directors of nonprofit corporations in fulfilling this duty are generally said to be the same as those applied to directors of for-profit corporations. In virtually all states, the duty of care for both nonprofit and for-profit directors requires that the director act with the care an ordinarily prudent person would exercise in similar circumstances.**15**

In the context of for-profit corporations, the courts have developed a strong policy -- known as the "business judgment rule" -- against second-guessing director's decisions. The business judgment rule raises a "presumption that in making a business decision the directors of a corporation acted on an informed basis, in good faith and in the honest belief that the action taken was in the best interest of the company."**16** This presumption does not mean, however, that directors' actions are not subject to judicial review. Indeed, in the leading case on the application of the business judgment rule to major transactions involving the sale of an entire corporation or its assets, *Smith v. Van Gorkom*, the Supreme Court of Delaware held that the rule does not protect decisions by board members who have breached their duty of care by failing to obtain sufficient information to make an informed business judgment.**17** Thus, while the board's substantive decision is generally insulated from judicial scrutiny, the business judgement rule leaves room for the courts, and consequently attorneys general, to review the process by which those decisions are made.

In *Smith v. Van Gorkom*, the court found that the directors of a business corporation had breached their duty of care when they approved a cash sale of their corporation which the corporation's chairman/chief executive officer had negotiated. In reviewing the board's action, the court stressed that: (1) the board had not adequately informed itself about the CEO's role in framing the deal and suggesting the purchase price to the buyer, (2) they had not adequately informed themselves about the value of the corporation, and (3) their decision had been made too quickly.**18**

In later cases, the Delaware court has continued to give special scrutiny to directors' decisions involving transactions in which control of the company will change hands.**19** The reason for this heightened judicial concern is, of course, the fear that the management and directors of a selling corporation will evaluate competing offers more in terms of the treatment they expect to receive personally from new management than in terms of the corporation's best interest. The case law in this area is clear that in any transaction involving a change in control "the duty of the directors is to get the highest value reasonably attainable for the shareholders."**20** At a minimum, this duty would require considering all available offers.**21**

From these general principles flow a series of more specific obligations that nonprofit hospital directors must meet if they are to discharge their duty of care with regard to a sale or joint venture transaction. First, directors must determine whether the officers on whom they rely for information about the transaction have any conflict of interest -- for example, a promise of future employment from the prospective purchaser -- that might color their judgment in recommending the transaction. Further, the directors must carefully ascertain the value of the assets they intend to sell or contribute to a joint venture. Given the complexity of this task, ordinary prudence clearly requires the directors to obtain an independent evaluation by a competent expert. **22** Moreover, the requirement that the directors maximize the value the corporation receives requires directors carefully to consider all competing offers and to either accept the highest offer or be able to demonstrate a principled reason, rooted in the charitable purposes of the organization, for choosing another buyer. Finally, decisions as momentous for the organization as the decision to terminate its dominant activity require considerable deliberation, and directors need to be able to demonstrate that they have duly considered the ramifications of any such transaction.

Where directors fail to meet their duty of care, they may be held personally liable for breach of fiduciary duty. Attorneys general have both the authority and the duty to initiate such actions for breach of duty.

C. The Attorney General's Authority to require Advance Review and Approval of Hospital Sale and Joint Venture Transactions.

Under the common law and by statute in many states, attorneys general are charged with the responsibility of overseeing the use of charitable assets. The authority vested in attorneys general to enforce charitable trusts and protect charitable assets is deeply rooted in the *parens patriae* power of the state to protect the public interest in assets pledged to public purposes. Thus, it is uniformly recognized that attorneys general have "an historic right and duty to supervise charitable trusts and to maintain such actions as may be appropriate to protect the public interest therein"**23** Indeed, in most states they are the *only* party authorized to fulfill this important role.**24**

As discussed in detail above, a nonprofit hospital corporation must obtain advance court approval for hospital sale or joint venture transactions, and the attorney general is automatically a party to such proceedings. Likewise, the attorney general has the authority to bring breach of duty actions against nonprofit hospital directors who fail to meet their duty of care in approving a sale or joint venture transaction.

The attorney general's legal authority to bring suit against nonprofit hospital directors who consummate a sale or joint venture transaction without court approval and/or without

meeting their duty of care provides the attorney general with substantial leverage to require the parties to proposed hospital conversions to submit such transactions to the attorney general for advance review and approval. Faced with the prospect of a potentially protracted challenge by the attorney general to its petition for an authorization of new use, or a breach of duty action if it proceeds without court approval, nonprofit hospital corporations will almost certainly opt to comply with reasonable requirements for advance review and approval.

Consistent with the attorney general's broad *parens patriae* power to protect the public interest, the attorney general's advance review of proposed hospital sale and joint venture transactions need not be limited to a review of whether the directors have met their duty of care or whether the technical requirements for *cy pres* approval of a change in use are present. On the contrary, the attorney general has both the duty and the bargaining leverage to require the parties to submit to a comprehensive advance determination of whether the proposed transaction is in the public interest.

The Central objectives of this advance review should be to: (1) safeguard the value of the charitable assets, (2) safeguard the community from loss of essential health care services, and (3) ensure that the proceeds of the transaction are used for appropriate charitable purposes. A set of proposed Guidelines for this advance review process is available here.

D. Leveraging the Attorney General's Oversight Capacity

In many states, charity regulators will have to deal simultaneoulsy with multiple hospital sale and joint venture transactions. In most states it will be difficult, if not impossible, for regulators to effectively police these complex transactions within existing budget constraints. Accordingly, regulators need to consider strategies to augment their existing regulatory capacity.

First, as suggested in the proposed Guidelines, the attorney general should consider requiring the parties to a proposed hospital sale or joint venture transaction to fund an independent expert, to be selected by the attorney general, to review the overall fairness of the transaction from the nonprofit's perspective. The cost of such a review, while substantial, will not be unduly burdensome relative to the overall transaction costs borne by the parties.

Second, where state law permits, the attorney general should also consider the use of relator actions to augment the attorney general's limited enforcement capacity. A relator is a private party authorized to bring suit in the name of the state or the attorney general when the right to sue is vested exclusively in the attorney general.**25** Although the rule appears to be that the ability to authorize relator actions exists only by statute, at least one leading case indicates that the attorney general can consent to a suit in the name of the people by a private party even in the absence of statutory authority and that such consent may be informal.**26**

From the perspective of an attorney general seeking a means of prosecuting charitable enforcement cases without depleting his or her litigation budget, the advantage of relator actions is that the relator bears the cost of the suit while the attorney general retains ultimate control of the litigation.**27**

IV. Conclusion

As a large and increasing number of nonprofit hospitals and HMOs enter into various types of sale, joint venture, and conversion transactions, state attorneys general face the challenge of policing the largest redeployment of charitable assets in history. The clear legal authority of state attorneys general to bring suit against nonprofit hospital directors who proceed with a sale or joint venture transaction without court approval -- combined with the parties' presumptive desire to avoid a prolonged legal challenge -- translates into substantial

leverage for the attorney general to require that the parties submit proposed transactions for advance review and approval and not to impose a variety of requirements as conditions for granting that approval. The goals of this review should be to safeguard the value of the charitable assets, protect the community from loss of essential health care services, and ensure that the proceeds of the transaction are used for appropriate charitable purposes. The Guidelines outline a process for achieving these important goals.

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