THIS SEARCH	THIS DOCUMENT	GO TO
Next Hit	Forward	New Bills Search
Prev Hit	Back	HomePage
Hit List	Best Sections	Help
	Doc Contents	

GPO's PDF version of this bill	References to this bill in the Congressional Record	Link to the Bill Summary & Status file.	*Full Display* - 9,841 bytes.[Help]

Medicare Nonprofit Hospital Protection Act of 1997 (Introduced in the House)

HR 443 IH

105th CONGRESS

1st Session

H. R. 443

To amend part A of title XVIII of the Social Security Act to deny Medicare payment with respect to non-profit hospitals that transfer assets or control to for-profit entities without approval.

IN THE HOUSE OF REPRESENTATIVES

January 9, 1997

Mr. STARK (for himself, Mr. FILNER, Mr. KENNEDY of Rhode Island, Mr. BROWN of Ohio, Mr. WAXMAN, Mr. MCDERMOTT, and Mr. LEWIS of Georgia) introduced the following bill; which was referred to the Committee on Ways and Means

A BILL

To amend part A of title XVIII of the Social Security Act to deny Medicare payment with respect to non-profit hospitals that transfer assets or control to for-profit entities without approval.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Medicare Nonprofit Hospital Protection Act of 1997'.

SEC. 2. DISQUALIFICATION FROM MEDICARE PAYMENT OF NON-PROFIT HOSPITALS THAT TRANSFER ASSETS OR CONTROL TO A FOR-PROFIT ENTITY WITHOUT APPROVAL.

(a) IN GENERAL- Part A of title XVIII of the Social Security Act is amended by adding at the end the following new section:

`DISQUALIFICATION OF CERTAIN NONPROFIT

HOSPITALS FROM PAYMENT IF ASSETS OR CONTROL TRANSFERRED TO A FOR-PROFIT ENTITY WITHOUT APPROVAL

`SEC. 1821. (a) REQUIREMENT- No payment may be made under this part with respect to inpatient hospital services of a hospital if the hospital, on or after January 7, 1997, was owned or controlled by a nonprofit entity and there is an impermissible transfer (as defined in subsection (b)) with respect to the hospital or the entity.

`(b) IMPERMISSIBLE TRANSFERS-

`(1) IN GENERAL- For purposes of this section, the term `impermissible transfer' means any covered transfer (as defined in paragraph (2)) that has not been considered to be approved in accordance with subsection (c).

`(2) COVERED TRANSFER DEFINED- For purposes of this section, the term `covered transfer' means, with respect to a hospital that is owned or controlled by a nonprofit entity--

`(A) the sale, transfer, lease, exchange, option, conveyance, or other disposition of, the assets of the hospital (or of the entity in relation to the hospital) to a for-profit entity, if a material amount of the assets relating to the hospital are involved in such disposition; or

`(B) the transfer of control, responsibility, or governance of a material amount of the assets or operation of the hospital (or of the entity in relation to the hospital) to any for-profit entity.

Transfers described in this paragraph may be effected through sale, joint venture, joint operating agreement, or any other means.

`(3) OTHER DEFINITIONS- For purposes of this section:

`(A) The term `acquired hospital' means, with respect to a covered transfer, the non-profit hospital the assets or control of which are the subject of the transfer.

`(B) The term `acquiring entity' means, with respect to a covered transfer, the for-profit entity that is involved in the transfer.

`(c) CONDITIONS FOR APPROVAL- Subject to subsection (d)--

`(1) IN GENERAL- A covered transfer with respect to an acquired hospital owned or controlled by a nonprofit entity is not considered to be approved in accordance with this subsection unless--

`(A) the acquiring entity has disclosed to the Secretary, in a form and manner specified by the Secretary, the information described in paragraph (2) relating to the transfer;

`(B) there has been an independent fairness review conducted of the proposed transfer and the report on the review concludes that no assets of the acquired hospital in relation to the nonprofit entity have inappropriately benefited any private parties; and

`(C) the Secretary has approved the transfer.

`(3) INFORMATION TO BE DISCLOSED- The information described in this paragraph is a complete description of the terms of covered transfer, together with a description of all

collateral arrangements, including information describing--

`(A) the acquired hospital and the nonprofit entity that owns or controls the hospital;

`(B) the acquiring entity;

`(C) other parties to the transfer;

`(D) terms of the proposed transfer;

`(E) the value of consideration to be provided in connection with the transfer (including details as to the basis for the valuation);

`(F) copies of documents relating to the transfer;

`(G) the identity of individuals and persons who are officers, directors, or affiliates of the nonprofit entity and whether they have any direct or indirect economic interest in the transfer (including any promise or discussion of future employment); and

`(H) such other information as the Secretary may require.

`(3) PUBLIC DISCLOSURE- The Secretary shall provide for public disclosure (including disclosure through electronic means on the Internet) of information described in paragraph (3) provided under paragraph (1)(A) and the report on the transfer described in paragraph (1)(B).

`(4) CONDITIONS FOR APPROVAL OF TRANSFERS- The Secretary may not approve a covered transfer relating to an acquired hospital owned or controlled by a nonprofit entity unless, after completion of the public hearing described in paragraph (6), the Secretary determines that the following conditions are met:

`(A) Due care was exercised by the nonprofit entity in deciding to enter into the transfer, selecting the acquiring entity, and negotiating the terms of the transfer.

`(B) The nonprofit entity sought appropriate expert assistance in making decisions in relation to the transfer.

`(C) The nonprofit entity took all reasonable steps to avoid conflict of interests.

`(D) The nonprofit entity will receive fair market value for its assets transferred in connection with the covered transfer.

`(E) No charitable funds are placed at risk in connection with the covered transfer.

`(F) The amount of any compensation under any management contract entered into in connection with the covered transfer is fair.

`(G) The proceeds to the nonprofit entity in connection with the covered transfer will be used only for appropriate charitable purposes consistent with the entity's non-profit charter and for the promotion of health in the affected community and such proceeds will be controlled as charitable funds independent of the acquiring entity.

`(H) Any charitable corporation established to hold proceeds of the acquired hospital in connection with the covered transfer will be broadly based in the community.

`(I) There are sufficient safeguards to assure the affected community continues to have access to affordable hospital services.

`(J) The acquiring entity has made a commitment to provide comparable care to the disadvantaged, the uninsured, and the underinsured, and to provide benefits to the affected community.

`(K) The acquiring entity has no contractual right to receive or direct future grants in relation to the acquired hospital.

`(L) The acquiring entity has paid the Secretary, with respect to the covered transfer, a fee sufficient to cover the costs of the Secretary in administering this section in relation to such transfer.

`(6) PUBLIC HEARING- Before approving a covered transfer, the Secretary shall provide for notice and a public hearing to take place in the community of the acquired hospital concerning the transfer and publication of a public report on testimony received at the hearing.

`(d) APPLICATION OF ALTERNATIVE STATE LAW REQUIREMENTS- A covered transfer is deemed to meet an applicable requirement of subsection (c) relating to the transfer to the extent that the Secretary determines that there is a State law that imposes a requirement at least as stringent as the requirement involved with respect to the transfer.

`(e) DELEGATION OF AUTHORITY- The Secretary may exercise the Secretary's authority under this section through any appropriate official in the Department of Health and Human Services.

`(f) NO EFFECT ON OTHER RIGHTS- The fact that the Secretary has approved a covered transfer under this section shall not supersede other rights that any entity (including the federal government or a State or local government) may have to challenge the transfer on any grounds.'.

(b) EFFECTIVE DATE- The amendment made by this section shall apply with respect to covered transfers for which agreements or transactions are entered into on or after January 7, 1997.

THIS SEARCH	*THIS DOCUMENT*	*GO TO*
Next Hit	Forward	New Bills Search
Prev Hit	Back	HomePage
Hit List	Best Sections	Help
	Doc Contents	

Bill Summary & Status for the 105th Congress

Item 2 of 62

PREVIOUS BILL | NEXT BILL
PREVIOUS BILL:ALL | NEXT BILL:ALL
NEW SEARCH | HOME | HELP

H.R.443
SPONSOR: **Rep Stark** (introduced 01/09/97)

Jump to: Titles, Status, Committees, Amendments, Cosponsors, Summary

TITLE(S):

- SHORT TITLE(S) AS INTRODUCED:
  Medicare Nonprofit Hospital Protection Act of 1997

- OFFICIAL TITLE AS INTRODUCED:
  A bill to amend part A of title XVIII of the Social Security Act to deny Medicare payment with respect to non profit hospitals that transfer assets or control to for profit entities without approval.

STATUS: Floor Actions

NONE

STATUS: Detailed Legislative Status

House Actions

Jan 9, 97:
Referred to the House Committee on Ways and Means.
Jan 21, 97:
Referred to the Subcommittee on Health.

STATUS: Congressional Record Page References

01/09/97 Introductory remarks on Measure (CR E82-83)

COMMITTEE(S):

- COMMITTEE(S) OF REFERRAL:
  House Ways and Means

- SUBCOMMITTEE(S):
  Hsc Health

AMENDMENT(S):

NONE

19 COSPONSORS:

Rep Filner - 01/09/97
Rep Kennedy, P. - 01/09/97
Rep Brown, S. - 01/09/97
Rep Waxman - 01/09/97
Rep McDermott - 01/09/97
Rep Lewis, John - 01/09/97
Rep Norton - 02/11/97
Rep Dellums - 02/11/97
Rep Rush - 02/11/97
Rep Weygand - 02/11/97
Rep Pelosi - 03/05/97
Rep Barrett, T. - 03/05/97
Rep Kennedy, J. - 03/20/97
Rep Wexler - 03/20/97
Rep Gejdenson - 03/20/97
Rep Kucinich - 04/17/97
Rep Gutierrez - 04/17/97
Rep Gonzalez - 04/30/97
Rep Sanders - 05/15/97

SUMMARY:

(AS INTRODUCED)

Medicare Nonprofit Hospital Protection Act of 1997 - Amends part A (Hospital Insurance) of title XVIII (Medicare) of the Social Security Act to disqualify for Medicare payment any non-profit hospital that transfers assets or control to a for-profit entity without appropriate approval by the Secretary of Health and Human Services.

State Experience In Regulating A Changing Health Care System

The differing politics, experience, and legislative backdrops in states around the country lead to substantial variation when it comes to regulating nonprofit conversions.

by Donald Shriber

PROLOGUE: The recent wave of conversions of nonprofit health plans to for-profit status has brought new challenges to state officials whose job it is to keep an eye on such transactions. States traditionally have regulated insurers and hospitals; often their capabilities are stretched by the complexities surrounding nonprofit-to-for-profit conversions, and the magnitude of the dollars involved raises the stakes still higher. Chief among states' duties is to protect consumers, who often fail to grasp the significance of a plan's conversion until the deal is in its final stages.

In this paper Donald Shriber examines four areas of law that apply to conversions: corporate law; laws that govern the powers of the attorney general or insurance commissioner in a state; laws governing health maintenance organizations (HMOs), insurance, hospitals, or Blue Cross/Blue Shield plans; and charitable trust law. Because the policies and environments of the states differ, experiences with nonprofit conversions also have varied greatly among the states that have seen such activity. Conversions taking place in California, Colorado, Maryland, Massachusetts, Missouri, and Ohio stand out as most instructive and in some cases have made national headlines.

Shriber holds the position of associate director of the U.S. Centers for Disease Control and Prevention in Washington, D.C. He served for eight years as counsel to the Commerce Committee of the U.S. House of Representatives, where he devoted much of his time to legislative and regulatory reform of private health insurance, managed care, and the pharmaceutical industry. He holds law and master of public health degrees from the University of California, Los Angeles.

ABSTRACT: Conversions of nonprofit hospitals, health maintenance organizations (HMOs), and Blue Cross and Blue Shield plans to for-profit status have tremendous social and economic consequences for communities. Although some consensus exists on the legal principles governing hospital conversions, a coherent legal framework for processing many other conversions is often lacking. Rapid changes in the configuration of health plans and providers complicate the situation. Litigation will provide some resolution of the issues but is not an optimal way of making policy. Some state legislatures are stepping into the fray with differing solutions. Currently, the approach of a particular regulator is often the most important determinant of a given conversion.

As CONVERSIONS OCCUR around the nation, state officials are responding in a wide variety of ways. This paper examines the range of state responses, analyzes why and how they arise, and highlights some of their strengths and weaknesses. The discussion draws upon interviews with regulators of and stakeholders in conversions that have occurred in several states. Regulation of the conversion process is an art, not a science, and is influenced as much if not more by the perspective and environment of state regulators as by any body of law.

Current Regulatory Authority

The task of intervening in conversions is complicated by two basic deficiencies in the law: the absence of a clear statement of who owns nonprofits, and the lack of a clear definition of charity that includes a requirement to register with the state.[1] Almost every state is deficient with regard to the former; only some, with regard to the latter.[2] With no definition of ownership, one must search for clarity among abstruse legal concepts (such as charitable trusts) and governing legal theories. Without a definition of charitable law, regulators have too many authorities and too little guidance.

There are at least four major and potentially overlapping areas of law that apply to conversions: corporate law; laws speaking directly to the powers of the attorney general or insurance commissioners; health maintenance organization (HMO), insurance, hospital, or Blue Cross–specific law; and charitable trust law. Within these there is significant variation among the states. There are a number of other sources of authority that states may use with conversions, including state constitutions; for-profit and not-for-profit laws (governing charter, formation, dissolution, merger, sale, and joint ventures and partnership); holding company and mutual insurance statutes; certificate-of-need statutes; charities laws; codes of civil procedure; tax (state and federal) and property laws; and statutes for public records; and false statements.[3] Much authority is based on

common-law doctrines (developed through the decisions of court

The list of authorities is long because conversions involve ma issues. More importantly, often no one statute provides enoug guidance on how to consider a conversion. Until political consensu develops, lawyers will be free to develop new theories to add to th list above.[4] Only by laying broad common-law principles over patchwork of state laws can one assert that a harmonizing princip exists among the states. For now there is limited harmony. Mos people agree that in straightforward sales of charitable hospitals attorneys general may intervene and use charitable trust principles But many regulators are nervous about asserting charitable doctrine as the governing principle where the nature of the transaction is muddled and statutory law is relatively undeveloped, and they are even less comfortable with charitable doctrine as a basis for review of Blue Cross plans.

■ **Hospital conversions.** The most common authority for viewing hospital conversion cases is charitable trust doctrine. Under this doctrine, the nonprofit entity is viewed as belonging to the public, with the directors and the state's attorney general acting as its representatives. If the doctrine applies, a series of important consequences will flow: The government will have a clear basis for intervening in the transaction. It will measure the conduct of the corporation's "insiders" (trustees, managers, or other persons who operate inside the nonprofit entity on its behalf). It will try to ensure that the transaction was carried out to forward the mission of the nonprofit, that adequate value was received in the transaction for anything transferred, and that a foundation or other entity is established to carry on the original mission of the entity.

The best articulation of this basis for intervention appears in Robert Boisture's work on the sale of nonprofit hospitals and HMOs.[5] Boisture argues that the authority is clear under common and statutory law in virtually every state. It rests, in his view, on the broad common-law authority of the attorney general to review charitable organizations and on two related principles.

The first principle is the requirement of court approval for a change in the corporate purposes, the so-called *cy pres* doctrine. Under *cy pres*, charitable organizations are impressed with a trust that survives anything that happens to the organization. Historically, *cy pres* was applied when it became impossible for a charity to carry out its mission (for example, the "further" eradication of smallpox). It provides that the charitable assets then should be devoted to carrying out a purpose as near as possible to the entity's original mission. Should these conditions be violated, the attorney general would have the authority to hold directors personally liable and to

enjoin violative activities.

The second principle is that the entity's directors have a duty to act as fiduciaries and to exercise care in their dealings on behalf of the nonprofit corporation. The directors must act in the interest of the nonprofit corporation, avoiding conflicts that might compromise that interest, and must exercise reasonable judgment in carrying out their duties. Thus, they would undertake a conversion only if they viewed it as the only or best alternative for continuing to carry out the purposes for which the hospital was established.

Boisture's articulation of how hospital conversions should be handled reflects prevailing practice in states with very aggressive regulators and approximate practice in many other states. Although Boisture's theory could become the basis for handling conversions nationally, not all attorneys general are equally confident in asserting these principles. Many feel that they need to harmonize charitable trust law with other state laws. Some believe that they lack the clear authority, particularly in statute, to process even certain hospital cases. In addition, although *cy pres* is often cited by regulators, they rarely use it to mean the same thing, and they rarely enforce it strictly.[6]

■ **Blue Cross/HMO conversions.** The most contentious battles over ownership and definition are occurring with respect to Blue Cross and Blue Shield plans.[7] The ambiguity in the law has produced a surfeit of legal theories. Some theorists have taken the position that chartering legislation defines the plans as having a charitable mission.[8] Others insist that the key to understanding the plans' ownership lies in their articles of incorporation.[9] Others argue that Blues plans have metamorphosed so many times and are such unique creatures that their ownership is unclear. Still others insist that Blue Cross plans are not-for-profit corporations subject to the common-law doctrine of charitable trusts. In contrast, plans such as Blue Cross in Missouri and Ohio insist that they are not subject to charitable law. They, like many Blues plans, assert that ownership can be determined by the terms of the latest transaction.

There is no consensus among state regulators with regard to the governing authority for Blue Cross/HMO conversions. The most comprehensive examination of the issue is by Eleanor Hamburger and colleagues.[10] It rests on the view that charitable law is the governing doctrine through which state statutes should be read. The authors report that forty-eight states have laws that specifically regulate nonprofit corporations, but some do it through nonprofit corporation laws and others through regular corporate law.[11] Moreover, nearly every state has a sale, merger, or dissolution statute. The statutes may permit, forbid, or be ambiguous regarding the merger

"Today's transactions do not fit into the categories typically found in most nonprofit statutes."

of a nonprofit with a for-profit and the conversion of the resulting corporation to for-profit status.

Corporate statutes do not anticipate the multilayered transactions that have taken place or been proposed in several states, including those involving Blue Cross plans in Missouri, Maryland, California, and Ohio. Further, while state provisions governing dissolutions might be used to implicate charitable trust principles, it is often unclear precisely when a dissolution has occurred or should occur. Hence, consumer groups have argued in Ohio, Missouri, and elsewhere that conversions are covered by these provisions, while Blue Cross plans have claimed that their transactions are distinct from those contemplated by the state statutes.

Many states have specific laws that regulate both HMOs and Blue Cross plans, but the laws seldom provide clear guidance as to how conversions should be processed, or how those laws should be read in conjunction with other state statutes and common law. In North Dakota proposed mutualization of the Blue Cross plan has highlighted the lack of clarity in the law.[12] There overlapping corporate and insurance statutes confuse the situation. Under nonprofit corporation law, a nonprofit may not be able to distribute its income. However, some have argued that to mutualize, a corporation must trigger dissolution statutes, which in turn might trigger the need to distribute assets under a charitable trust theory. Meanwhile, experience with the *cy pres* doctrine in North Dakota is very limited.[13]

■ **Growing complexity.** Complicating the issue of authority to regulate transactions are the constant consolidation and changes in the enterprises being governed. As the Ohio Blue Cross conversion shows, the line between hospitals, HMOs, and health plans is becoming blurred. Many regulators have said that the increasing complexity of today's health care transactions is requiring increasingly more subtle, complex, and time-consuming analyses to determine whether regulators even have jurisdiction over the transactions.

A recent conversion of the Blue Cross plan in Virginia was described as a "reverse triangular merger." In Maryland, Ohio, California, and Missouri Blue Cross transactions are multifaceted and highly complex. They often involve the creation of subsidiaries and changes in the nonprofit that are so fundamental as to render them shell entities. "Downstream subsidiaries" (entities that are offspring of the converting organization), joint ventures, leases, and limited partnerships are replacing old-fashioned sales in other states. Fu-

ture transactions promise to become increasingly complex.

Today's transactions do not fit into the categories typically found in most nonprofit statutes. Typically, these statutes describe categories of transactions (for example, sales, dissolutions, and mergers), and they often elaborate different standards and procedures governing each category. For example, Ohio law provides that a not-for-profit corporation can only merge with another not-for-profit, but the law does not prevent a dissolution or sale. Similarly, most statutes do not address what occurs when there is a sale and a merger or a merger and a dissolution.[14] Consumer groups in many states, including Missouri, have invoked dissolution statutes, arguing that de facto dissolutions have occurred along with other kinds of transactions. However, in doing so they are forced to rely on a body of law that is not well defined.

Complicating matters further, some categories of transactions are exempt from review as conversions. Regulators report that they are sometimes constrained from looking at conversions labeled as "joint ventures" because underlying state law either does not authorize such review or forbids it. Others operating without such constraints look to see whether the joint venture implicates elements of trust law, such as a fiduciary duty or public benefit.[15] The issue of joint ventures strikes at the heart (and soul) of the conversion issue. A marriage between the Sisters of Charity chain in Cleveland and Columbia/HCA (in which the latter purportedly bought half of the former) has drawn much attention and controversy.

In short, most state nonprofit laws are based more on the form of the transactions than on their function. They provide an incentive for making transactions overly complex and confusing, since a conversion that is structured or labeled in a more straightforward manner may be easier to regulate. Regulators therefore face a dilemma: Should they examine the form of the transaction and what it purports to do or look at what it really accomplishes? Although many regulators feel constrained in their efforts to do what corporate lawyers call "piercing the veil" (looking beyond the label of a transaction to see what it really accomplishes), some are moving toward a more functional approach. In Ohio, for example, the attorney general's office asserts that if charitable assets are involved, the attorney general will intervene—the form being secondary. However, Ohio insurance officials were slow to assert this kind of functional approach to the proposed Blue Cross conversions.

Some Examples: State Overview

To gain insight into state regulators' experience with conversions, we interviewed officials in state offices of attorneys general. Their

responses illustrate the great variety in law and practice that exists.

In California and Massachusetts aggressive attorneys general believe that strong common-law authority exists for asserting charitable trust principles but that it must be used or interpreted in light of clear statutes.[16] These offices are scarcely alone in this assertion, but their comprehensive and unyielding assertion of that authority distinguishes them from other states. The attorneys general in Massachusetts and California are also unusual because they have developed written protocols for the charitable principles under which they will assert authority and review conversions.[17] These protocols represent strong assertions of power that govern how transactions will be processed. They rest heavily on the beliefs that nonprofit entities belong to the public and that the public is represented by the attorney general.

Other states demonstrate unique statutory schemes or interpretations. In New York a statute governing not-for-profit corporations is used to regulate the conversions of HMOs. However, operating a hospital as a for-profit stock corporation is effectively forbidden, so conversions of hospitals to for-profit status are generally not an issue.[18]

In Maine, where experience has been limited to the proposed conversion of the state's Blue Cross plan, the attorney general's office had cited a single statutory sentence giving the attorney general the right to supervise charitable trusts.[19] The office also may look to the legal theory of *ultra vires* (the performance of unauthorized acts by a corporation), for which Maine law permits injunctive relief.[20] The Blue Cross case is now before the insurance department. Under petition from Blue Cross, the insurance department is considering whether to allow operation of downstream for-profit HMOs, jointly owned by Blue Cross and private hospitals.

In New Hampshire, common law, including cases dating back to 1901, is the primary basis for intervention.[21] The attorney general's office also relies on a *cy pres* statute, which recently was modified to place all such proceedings before the probate court.[22]

In Virginia, the attorney general's office, although taking a relatively modest view of the obligations of the converting Blues plan, ran into a legislature that was anxious to leave its own imprint. Ultimately, the legislature effectively determined the amount of the valuation—a gross understatement in the view of some critics—but directed the money toward the state's coffers, rather than toward medical purposes, as the attorney general had sought.

■ **Texas.** Texas is likely to have dozens of hospital conversions in the coming years, and the state's Blue Cross plan is involved in merger discussions with the Illinois plan. (The Texas Blues plan

already operates four for-profit subsidiaries, and many regard the merger as a prelude to a for-profit conversion.)[23] The relevant authorities identified by the Texas attorney general's office are exceptionally complicated. According to the attorney general's office, a major source of authority is the Miscellaneous Corporations Act, which permits the attorney general to investigate the books and records of any corporation doing business in Texas. Further, the property code requires that the attorney general must be notified if there is a proceeding involving a charitable trust. It permits voiding an action for which notice is not given. The not-for-profit statute never mentions the need to notify the attorney general, but it appears to govern the conduct of the not-for-profit health care entities. Another provision of the Texas codes permits the attorney general to revoke the authority of an entity to function if the entity has violated any Texas law. The attorney general may seek receivership to rehabilitate an errant corporation, but this extreme measure is difficult to use. Most importantly, the attorney general asserts common-law authority to sue for breach of fiduciary duty, and this use of authority has never been seriously challenged. The attorney general may impose a "constructive trust" where charitable principles have been violated.

Ironically, none of these laws was the basis for the Texas attorney general's recent role in blocking a conversion of St. Luke's Hospital. In that case, the relevant issue was enforcement of a fiduciary duty contained in a deed restriction, which limited the entity to not-for-profit uses. The attorney general won the case. More recently, the Texas attorney general, citing multiple grounds, filed suit to block the possible merger of the Texas and Illinois Blues plans.

■ **Maryland.** The rejection of a proposed reorganization of Maryland's Blue Cross plan by that state's insurance commissioner demonstrates how fluid the authority of that office can be, and how it can be affected by public opinion. When the conversion was first announced, the commissioner of insurance seemed to embrace it and find no apparent obstacles.[24] After great public opposition and numerous investigative articles in *The Sun* (Baltimore, Maryland), he found a clear basis for objecting to the conversion.[25]

In December 1995 the Maryland Blue Cross plan sought approval from the state Department of Insurance for its proposed "reorganization." The plan involved the creation of a new for-profit health insurance company, a new general insurance agency, and a new downstream holding company; the reactivation and expansion of a charitable foundation; and the transfer to a managed care company of all the nonprofit's ownership in five HMOs, a third-party administration company, its real and personal property, and the vast major-

ity of its functions and employees. Blue Cross took the position that this was not a conversion. Consumer groups disagreed.

Maryland law provides specifically for the conversion of a nonprofit health care service plan to for-profit status, upon submission of a plan to and approval by the insurance commissioner.[26] Maryland law also provides for distribution of assets upon dissolution. But Maryland corporate law prohibits nonstock corporations from operating as for-profit corporations. Moreover, the attorney general has written that a nonprofit corporation may not engage in for-profit activity that may "become so substantial that [it] may no longer be characterized as . . . operating a nonprofit health service plan" and "would result in it being characterized as for-profit." The question in Maryland was how the Blue Cross transactions should be characterized and treated.

The commissioner of insurance refused to approve the proposal to "restructure" because it did not accord with state law. The commissioner relied on the attorney general's opinion and found that "the profit-making aspects of the entire enterprise would be so substantial that BCBS [Blue Cross/Blue Shield] would lose its character as a nonprofit health services plan." The commissioner eschewed a rigid legal analysis to determine which narrow category of Maryland law applied to the conversion structure and affirmed the need for a more functional approach: "I have concluded that the proposed reorganization is in reality more than a mere reorganization but is instead tantamount to a conversion to [a] for-profit enterprise."

Factors Affecting Regulation Of Conversions

A number of practical matters may profoundly affect how and when a conversion is regulated. These include how much regulators know about possible pending conversions (through either formal notice, discussions with other regulators, or other means) and whether regulators have sufficient resources and expertise to carry out their responsibility to protect the public trust. Other important issues are the sometimes overlapping missions of regulators in a state and the philosophy and approach of particular regulators.

■ **Knowledge of pending conversions.** Regulators agree that if they are to become involved in a conversion, it is best to do so early. Early intervention prevents disrupting a transaction that is nearly complete (and wasting the resources that have gone into it), permits adequate time for review, prevents unlawful conflicts of interest, allows the use of experts on matters such as valuation, and improves the chances of a cooperative relationship between the regulator and the entity undergoing conversion. It also allows the regulator time to anticipate the future and to help structure a surviving or new

"A striking number of regulators received notice from entities of their intent to change their status but did not comprehend the significance."

entity while involving interested parties in the community.

Regulators learn of potential conversions in a variety of ways, which may or may not be related to statutory notice requirements. In some states word-of-mouth serves adequately to apprise regulators of potential conversions. In New Hampshire, for instance, the law does not require notice to regulators, but the attorney general's office reports that attorneys representing health care providers do so much other business with the attorney general's office that they cannot pass a conversion by them without timely notification. In Ohio the attorney general's office complains of learning of hospital conversions through the media, as there is no requirement of notice. The attorney general there has asked the Ohio Hospital Association (on behalf of its members) and Columbia/HCA to approach its office early with conversion proposals. They have met with some success, perhaps because the attorney general's office appears prepared to enjoin any transaction it has not reviewed.

In Texas, because there is no statutory notice requirement, regulators often learn of transactions close to the point at which they are scheduled to be consummated (and sometimes from the media). Regulators report that a large number of transactions have already passed them by, and they may not be able to review them. Regulators are willing to reopen transactions that have already been approved.[27] However, the absence of a clear notice requirement can create a political and economic dynamic that makes it difficult to slow down or reopen transactions and to review them thoughtfully.

The power of a regulator to hold up a transaction can be even more important than a notice requirement. For example, California has a notice requirement for converting hospitals, but hospitals enter into negotiations with the attorney general long before giving notice. The parties do this because they know that the attorney general has sufficient power to hold up a transaction by seeking more information, issuing subpoenas, or delaying approval.

Indeed, in most states parties to conversions enter into discussions with regulators well in advance of giving notice. They know that notice could help a regulator who is lacking political or other power to hold up a transaction. It also could blunt the tactic used by some for-profit entities of developing political or community support for a transaction to undercut a regulator's legal objections. Ultimately, the dynamic of power in what are often private discus-

sions may foretell more than the existence of a notice requirem does about the outcome of a conversion.

Notice is of little value if a regulator is not prepared to thoughtfully and decisively and does not understand the potent impact of a conversion. A striking number of regulators report th they received notice from entities of their intent to change the status but did not comprehend the significance of the change. Pa ticularly with regard to Blues plans, regulators have failed to com prehend fully the implications of certain actions that may have bee preludes to conversions. According to an official at the Nation Association of Insurance Commissioners (NAIC), over the past sev eral years several Blues plans were successful in effecting legislativ changes that permitted them to change to mutual status, often with clear notice to regulators. Many regulators and legislators did not understand that these changes could portend additional moves to for-profit status, so they paid little attention to the proposals. Con sumer groups have sought to educate regulators in many states about the importance of incremental changes to corporate status.

Many regulators report that it is only the observation of what plans in other states have done that has put them on notice that any proposed change in the regulation of a Blues plan might portend a wholesale conversion to a stock company. With regulators from twenty-six states now sitting on a special NAIC committee on Blues conversions, regulators are likely to be better informed. Nonetheless, in South Dakota a recent conversion of a Blue Cross plan arose with relatively little attention or notice.

■ **Sufficiency of resources.** Many state agencies lack the resources to devote to conversions. This affects how and when regulators intervene. Some report giving smaller cases relatively little scrutiny. Many are unable to study the implications of subtle or complex transactions and thus allow them to go forward without study. Many rely on staff attorneys or other officials who have little time to devote to these highly complex matters. They report extreme frustration at having limited resources to face what they see as the near-infinite resources of the private entities that are seeking to convert. Often they must rely heavily on the representations of the regulated entities because of a lack of resources or expertise. Some worry that with new legislation they will be given new responsibilities but not the resources needed to carry them out.[28]

Intervening in the outcome of a conversion is the most visible part of a regulator's job, but an equally significant challenge is overseeing conversions as they unfold, foundations as they form, and for-profit entities as they evolve. Because converting entities rely on experts in finance and law, and government resources often are unavailable or

nonexistent, many regulators are looking to outside experts to advise them on any or all of these matters. In California, for example, the Department of Corporations (DOC) hired an investment banker, Bear Sterns, and a foundation and public health expert, Nancy Kane, to advise it on the Blue Cross/WellPoint conversions. In Virginia, Texas, and around the nation attorneys general and insurance departments are hiring consultants with distinct expertise in conversion law. In the midst of litigation in Ohio, the Department of Insurance has retained Alex Brown, Inc., to advise it on valuation. Selecting and interpreting the work of experts is itself time-consuming and complex, and the ability of regulators to work effectively with experts varies greatly from state to state.

Most regulators assess the parties for the services of these experts—sometimes as much as $100,000. In many cases, regulators have simply made the payment of such fees a condition of their approval of a deal. The requirement of payment of fees is typical of many issues in the regulation of conversions: They are less important as matters of law than as a reflection of the balance of power between regulators and the entities concerned. So far, relatively little controversy appears to have attended this area. However, some new and proposed legislation includes provision for payment by parties to the transaction for experts to advise regulators. This legislation reflects a fear in some states that regulators will be challenged if they seek to obtain expert advice or require payment from the parties without explicit statutory authority.

■ **Ambiguity of jurisdiction.** State law often lacks clear guidance on the precise roles of regulators in health care conversions, particularly those involving the Blues. Offices of attorneys general are traditionally the lead agency in interpreting and enforcing charitable law and hospital conversions; insurance departments typically oversee the Blues.[29] But an attorney general may pursue other theories of law, while an aggressive insurance commissioner may pursue a charitable doctrine. The contentious nature of conversions may force legislators to define the roles of regulators more neatly. Some are reluctant to do this because they do not want to tamper with what they perceive to be broad authority derived from common law, practice, or inherent power to enforce statutes.

The regulatory tangle can be exacerbated by politics. Insurance commissioners and attorneys general may be elected officials who regard themselves as wholly independent of one another and even of the state's governor. Conversions in Maryland, California, Ohio, and Tennessee have become hot political issues.

The complexity of the roles played by attorneys general and insurance commissioners also affects regulatory effectiveness. For in-

stance, an attorney/client relationship may exist between these tw entities, so that the attorney general must represent the insuranc department in court. The role of the attorney general's office when is counsel to a state agency may be quite different than when it acting on its own. Theoretically, the client should give instruction t the attorney as to the course it wants to take, but political realit may dictate otherwise. Many insurance commissioners and attor neys general are unclear as to what their role is, particularly vis-à-vi one another. One insurance department official reported that hi department must serve as a judge of the appropriateness of an in surer's action. Hence, he claimed, it cannot advocate for the public Many attorneys general reported that they too wear many hats advocate for the public but also arbiter of whether the public has been protected, attorney for their own offices and other state agencies, and negotiator and litigator.[30]

In many states regulators are just beginning to define their respective roles. In some states efforts to clarify jurisdiction have been undertaken through legislation. For instance, in Colorado the insurance commissioner is deemed the lead in the Blue Cross conversion. In Nebraska both the attorney general and the director of health are given lead roles in hospital conversions. In California a demarcation is made between HMO conversions, for which the DOC is given the lead (except with respect to foundation oversight, which falls to the attorney general), and hospital conversions, which are under the purview of the attorney general.

It is possible that a constructive sorting out of roles is taking place. The confusion arises in part from lack of experience and uncertainty about what is the relevant theory in the case. When this uncertainty surrounds a transaction, it creates inefficient regulation and obstacles to timely and thoughtful intervention. The question of who should regulate is an important one. Officials in offices of attorneys general assess their own ability to evaluate health policy issues (such as the ability of institutions to adequately serve the health needs of communities) very differently. Some argue that conversions present unique health policy questions and cannot be handled adequately by professional public prosecutors. Others believe that attorneys general are perfectly capable of analyzing the health policy issues involved in conversions.

The health policy issues that arise in conversions might be best dealt with by a team of state experts that includes health officials. So far, this approach has been slow to develop, but some regulators are looking increasingly to others in government for assistance.

■ **Regulatory will.** Virtually every person consulted for this paper agreed that the single most important determinant of the

outcome of a conversion is the regulator—in particular, his or her philosophy, politics, political independence, aggressiveness, commitment, and willingness to take risks. The law is in a sufficient state of flux and confusion that a regulator's interpretation and stance will often be the critical factor.

Changes in political administration that bring into office leaders with new philosophies of regulation can have profound consequences. Massachusetts Attorney General Scott Harshbarger has brought an aggressive and personal approach to conversion regulation. Many commentators have noted as well that the single most important determinant of the outcome of the Blue Cross conversion in California was that the new DOC director, Gary Mendoza, had an intense interest in and commitment to this matter. Under Mendoza, the conversion's yield to the public escalated from $100 million to more than $2 billion. By contrast, observers point to a series of earlier conversions in which regulation was far less aggressive and foundations were vastly undervalued.[31]

Not discussed in this paper but critical to the outcome of a conversion is the degree to which regulators consult with and involve community and consumer representatives in the decision-making process. In virtually every state in which conversion activity has occurred, consumer representatives have sought to educate both the public and regulators about the implications of conversions. The response of regulators and the ultimate outcome of a conversion often reveal much about the degree to which the regulator was receptive to this input.

Litigation

Disputes over the applicability of statutory and common-law authorities to conversions are being played out at the state level in the courts. Lawsuits have been brought by state regulators (or by conversion parties attempting to enjoin the actions of regulators) in several conversion cases. Three current cases show how judges have responded to the various parties' arguments.

Michigan. In June 1996 the Michigan attorney general brought suit to enjoin a proposed joint venture between Columbia/HCA and the Michigan Capital Medical Center.[32] The joint venture provided for Columbia/HCA to own one-half of the health care system and granted primary control over many essential functions to that for-profit concern.

The attorney general asserted a variety of theories to block the transaction, including breach of fiduciary duty, improper valuation, failure to gain a tax law ruling, and violation of the state's nonprofit law, which prohibits for-profit hospital ownership. The judge re-

jected the first three theories but accepted the last. He appeared to be most comfortable relying on a specific provision of statute. He formally held that the joint venture was *ultra vires* (beyond the authority) and that the nonprofit had exceeded its purpose as a hospital under the state's nonprofit corporation law.

■ **Missouri.** In 1994 Missouri's Blue Cross plan underwent a "reorganization" under which it created a for-profit subsidiary, RightCHOICE, in which it received shares of stock in return. Blue Cross sought and received approval from the director of insurance for that transaction. Subsequently, Blue Cross sold 20 percent of the stock at a public offering and retained the rest.

The director of insurance subsequently alleged that Blue Cross had withheld from him material details of the transaction. These included amendments to its articles of incorporation allegedly removing its original purposes and altering the scheme for asset distribution on dissolution, as well as information showing that all of its business would be transferred to RightCHOICE. The director subsequently adopted the position that the reorganization was a conversion not permitted under Missouri law and that if the conversion was to occur, charitable trust principles should apply.

Blue Cross filed a preemptive lawsuit attempting to block the director from proceeding against it and seeking a declaratory judgment that it had no charitable obligation. Consumer groups then filed an administrative petition with the Department of Insurance asking the department to force Blue Cross to turn over its assets to the public. Blue Cross obtained a temporary restraining order to keep the department from proceeding against them and to block any action on the consumers' petition. The Department of Insurance and the attorney general counterclaimed (with respect to the Blue Cross suit), with the department asserting charitable trust principles and the attorney general relying on a narrower doctrine that Blue Cross had violated the purposes of the state's health services corporation statute by operating outside its scope as a nonprofit.

The judge in the case has issued two very different decisions in the case, demonstrating just how volatile conversion cases can be. In the first ruling, the judge held that under Missouri law, the attorney general, not the director of insurance, would have jurisdiction over the conversion. The judge has yet to rule on the attorney general's claim or on an amended claim of the Department of Insurance asserting a new theory.

About one month later, however, the judge asserted from the bench that his September order was an interim ruling, not a final one. In December he effectively reversed himself, ruling on behalf of the attorney general that Blue Cross's conversion was impermissible

and ordering that there be a dissolution of the corporation. The judge indicated that he would look to reasonable alternatives to the initial conversion. Blue Cross has since entered into talks with a nonprofit, BJC Health Systems, for a new and permissible merger arrangement.

■ **Ohio.** Pending lawsuits in Ohio over Columbia/HCA's proposed joint venture with Blue Cross/Blue Shield of Ohio (BCBSO) are significant because they raise all of the important issues related to conversion policy and because the marriage formed in the transaction may represent a new and important form of health care finance and delivery.

Under a proposed transaction in Ohio, BCBSO would form a stock company subsidiary, BlueCo, to which it would transfer 85 percent of its business and assets. BCBSO would own BlueCo, which would then be acquired by Columbia/HCA, or a newly created subsidiary, in return for $299.5 million. Of that, $77 million would go to Blue Cross, and the remainder, to a new for-profit company owned by Columbia/HCA. BCBSO would be BlueCo's reinsurer, and BlueCo would provide administrative services to BCBSO. BlueCo would later be able to purchase the portion of BCBSO still held for one dollar. BCBSO is required to pay $25 million to Columbia if it accepts another offer to convert and to contract at Blue Cross's highest reimbursement rates with certain Columbia/HCA hospitals. Some of BCBSO's executives reportedly would receive lucrative contracts for consulting and noncompetition arrangements.[33] Blue Cross has applied to the state's Department of Insurance for approval of the transaction.[34]

A suit was brought on behalf of policyholders against Blue Cross to recognize the interests of the policyholders in the conversion and to recognize the transaction as a conversion under Ohio law. The attorney general successfully intervened in the policyholders' suit and sued Blue Cross and its trustees for breach of fiduciary duty in not to protect the charitable assets held by Blue Cross. The policyholders' suit was stayed pending a review (now under way) by the Ohio Department of Insurance. The attorney general's suit has gone forward. Blue Cross filed a motion to dismiss the suit, alleging that there are no charitable assets, and the attorney general has filed a response. In addition, Consumers Union, Families USA, and the American Association of Retired Persons (AARP) have filed amicus briefs supporting the attorney general's position. A lawsuit by the National Blue Cross Association to block the Ohio plan's use of the Blue Cross logo has been stayed.

The attorney general has asserted a charitable trust theory and will likely look at inurement issues. The Department of Insurance,

by contrast, appeared initially to claim that charitable trust law w not operative and that it would look only at whether policyhold were protected. It is unclear whether that is still true. It also unclear whether the department is viewing the transaction a demutualization or mere restructuring, and whether departme policy is being informed by the view that the Blues plan may fa financial pressures that it cannot bear in the future.

An independent valuation might be the easiest answer to th claim, and, under some public pressure, the Department of Insuran ultimately retained the services of an investment bank to undertal one. A petition arguing that the case is a clear conversion, requirin a demutualization and implicating charitable trust principles, before the department.

The lawsuits in Michigan, Missouri, and Ohio expose unresolve issues and provide a process for addressing them. However, litiga tion is a lengthy process, and, given the important legal principle and the enormous amounts of money involved, appeals to highe courts are inevitable. It could be several years before a clear pictur emerges of the legal authority of regulators and responsibilities o converting through the courts. To date, not every case has bee tested in this forum. However, unless the underlying issues are han dled in another forum, many more cases can be expected.

Legislation

State legislatures provide another arena for dealing with issues o authority and responsibility for conversions. In the past two years many state legislatures have considered, and a few have passed, legislation to govern conversions.

■ **Nebraska.** In April 1996 Nebraska's governor signed the Non profit Hospital Sale Act into law.[35] It arose in response to a proposed acquisition by Columbia/HCA of Clarkson hospital and the commu nity's and state assembly's fears that local interests would lose con trol over health care services to non-Nebraskans.[36]

Under the new law, persons engaging in acquisitions of hospitals must apply to the attorney general and the director of the Depart ment of Health for approval. The regulators have ninety days follow ing receipt of a complete application to approve or disapprove the acquisition. Although the new statute has not been tested, it has likely served to deter proposed mergers. Consumer groups point to it as containing language that could form the basis of a national model.

■ **California.** On 1 January 1996 a new California law went into effect governing conversions of nonprofit health care service plans.[37] The law was enacted following great publicity about the conver-

sions of enormous entities such as Blue Cross and Health Net and claims that those conversions were processed without consistency or reason because of ambiguity in the law.[38] The law's enactment also was influenced by claims that the conversions had resulted in gross undervaluations and enrichment of certain persons.

The new law requires that covered plans file applications with the commissioner of corporations to establish their compliance with the law. The commissioner is empowered to disapprove applications if the law is not followed and may consult other branches of government in reviewing an application for a conversion. The new law is clearly rooted in charitable-trust principles and requires converting HMOs to donate assets equal to their fair market value to an independent foundation. The foundation must use those assets for serving the health care needs of the people of California, be free of conflicts of interest, and file postapproval reports showing continued compliance with state law. The attorney general is charged with overseeing the new foundations.

■ **Colorado.** When the Colorado Blue Cross plan first contemplated conversion, it sought and gained passage of a law permitting it to mutualize. But, in 1995, beleaguered by bad press and lost accounts, the plan expressed interest in figuring out a direct path to becoming a stock company. It conveyed that interest to the insurance department, and negotiations began. The Blue Cross plan eventually conceded the application of charitable trust issues and the necessity of establishing a foundation for its assets.

In June 1996 the governor of Colorado signed into law an act codifying negotiations between insurance officials, legislators, and the state's Blue Cross plan. This law requires Blue Cross to file a conversion plan with the commissioner for approval. The conversion plan must meet prescribed criteria relating to the transaction, the obligations of the Blue Cross plan, valuation, and inurement. The commissioner must approve the completed plan if he or she finds that it meets the statutory criteria. However, the law gives much discretion to the commissioner. Among the criteria for the commissioner's review is that the plan "will not be prejudicial to the subscribers of the corporation or the citizens of the State of Colorado."

After state officials in Nevada approved a merger of that state's plan with the Colorado plan, the Colorado plan filed with its state officials to convert formally to a stock company. The Colorado law provides for the value of the assets of the Colorado plan to be devoted to public purposes. Therefore, the citizens of that state may reap a windfall with the inclusion of the Nevada plan's assets in any valuation.

The laws adopted in Nebraska, California, and Colorado settle

many of the important issues raised by conversions, including authority of regulators to review proposed transactions, the pro for review, and the charitable and fiduciary obligations of the par to conversions. The apparent success of these states in clarify these issues may mean that their laws will become models for ot states as they grapple with proposed conversions.

Conclusion

Substantial variation among the states in the processing of conv sions reflects a diversity of experience, expertise, and politi power. It also reveals an area of law that is not clear enough to de with a contentious social issue involving hundreds of billions dollars and the future delivery and financing of health care. T courts are a particularly poor place in which to resolve these issue Legislation has no guarantee of being rational, but it does perm discussion of a broader range of social and economic issues. Mo states could benefit from legislation that clarifies the issues. Unle that legislation is aimed at a particular transaction, it will need to b based on a functional approach that gives regulators some discretion

At a minimum, new laws should address the following issues: way to ascribe ownership to nonprofit entities; a delineation of th applicable theory (charitable trust or another doctrine); harmoniza tion between conversion law and all other outstanding laws; clarifi cation of the role of public officials; a statement of who is entitled to the assets of the converting entity and the method by which they should be valued; a description of the responsibilities of the result ing nonprofit or foundation; and a statement of rules governing inurement. The legislation also should include an enumeration of the procedural rights to which members of the public are entitled in the conversion process. The critical role that particular regulators play should be encompassed in a framework that includes broad public participation in resolving issues.

NOTES

1. As we shall see, the decision over whether a nonprofit is a charity will fundamentally affect the outcome of the conversion.
2. Interestingly, some attorneys general have expressed the concern about enacting "clarifying" legislation. They fear that legislation that defines their powers with respect to charitable entities might only constrict what they regard to be singularly broad common-law authority. For that reason, they often have sought to insert into proposed legislation a clause stating that nothing in the legislation interferes with or diminishes their common-law authority.
3. Federal tax law is an important adjunct to state law for many conversion issues, particularly those related to foundations. Its enforcement may, however, fall through the cracks as state officials oversee conversions but can seldom seek to enforce federal tax law.
4. Not surprisingly, no independent writer has yet tackled the job of producing

ABSTRACT: The increasing number of nonprofit hospitals and health converting to for-profit enterprises, public concern, and media attention brought conversions to the top of state policy agendas. Conversions raise policy issues because nonprofit corporations' legal status obligates the operate in the public interest, their tax subsidies should not inure to the be of private interests, and they often represent unique community resou providing valuable services. This paper describes legal authority that states use to oversee conversions and outlines several policy issues facing regulators that could be addressed by new legislation.

DESPITE LONG-STANDING AUTHORITY over charita trusts, attorneys general and insurance regulators have o recently begun to examine conversions of nonprofit hospit and health plans to for-profit status. This paper describes existi and newly enacted legal authority that states can use to overs conversions and outlines fifteen policy issues facing state regulato that could be addressed by new legislation.[1]

Traditional State Regulatory Authority

State attorneys general historically have been responsible for enfor ing the body of law that applies to nonprofit hospitals and healt plans, including enabling statutes for nonprofit corporations tha exist in most states and the common-law doctrine of charitabl trusts.[2] According to common law, the creation of a nonprofit or ganization with charitable or other social welfare purposes result in a charitable trust that is irrevocably dedicated to the organiza tion's original mission.[3] The organization's trustees are supposed to seek court approval if they wish to deviate from these purposes.[4] On behalf of the general public, attorneys general may sue to safeguard the value of charitable assets and ensure that charitable organiza tions maintain their intended community benefit, such as the con tinuation of essential services.

Application of some of these laws is sometimes unclear. For example, although Blue Cross and Blue Shield plans were originally nonprofit corporations, they might not be chartered to serve "charitable" purposes, which makes it less certain whether they should be regulated under common-law charitable trust principles. In joint ventures, in which a nonprofit and a for-profit appear to contribute and govern equally, the for-profit can actually gain control, but such ventures may not be defined as conversions under existing law.

Several attorneys general have become involved in hospital conversion cases. For example, the Michigan attorney general recently obtained an injunction to prohibit Columbia/HCA from consummating a joint venture with a nonprofit hospital.[5] In addition to requiring creation of a charitable foundation, the Massachusetts

attorney general has ordered for-profit successors acquiring nonprofit hospitals to provide charity care and emergency services to the community for specified periods of time and payment for his staff to monitor compliance with these obligations.[6] The Tennessee attorney general entered into a consent decree with parties proposing the sale of a nonprofit hospital to a for-profit firm that included creation of a charitable foundation and established conflict-of-interest protections and accountability requirements for the foundation's board.[7] And in Texas the attorney general helped to negotiate an agreement under which hospitals in Houston's Texas Medical Center must obtain permission from both the center's board and the attorney general before entering into joint ventures with for-profit corporations.[8]

Somewhat less successful attempts have been made by state regulators to supervise conversions of Blue Cross or Blue Shield plans to for-profit firms. After several years of negotiations, in 1996 the California commissioner of corporations required Blue Cross to create two foundations with combined assets of $3 billion.[9] The Missouri insurance director recently won a case against a Blue Cross mutual benefit plan that transferred most of its assets into a for-profit subsidiary (a part of which was sold to the public).[10] On the other hand, the Virginia legislature voided negotiations between the attorney general and Blue Cross to create a community foundation when the plan converted first to a mutual benefit corporation and then to a for-profit firm; the legislature instead required that stock be issued to policyholders and a payment made to the state treasury.[11]

Recent State Legislation

Although common law and existing state nonprofit corporation laws provide regulators with general jurisdiction to oversee many hospital conversions, some state regulators have found that their authority over conversions is unclear. For example, some attorneys general believe that their authority is limited to litigation to stop conversions that are under way rather than issuing advance approval. Furthermore, Blue Cross conversions sometimes raise unique jurisdictional issues. Also, authority for oversight of hospital conversions does not necessarily include authority over advance notice, public hearings, or the use of resources for an independent valuation, or the right to impose specific community obligations on either foundations or the successor for-profit entities. Consequently, several states have enacted explicit laws to prescribe procedures to review conversions; and other laws are under consideration.

■ **Hospital conversion laws.** In 1996 the California legislature enacted a statute confirming the attorney general's jurisdiction over

plan to inform the general public and the plan's subscribers. After a public hearing, the commissioner may approve the plan if it is fair and reasonable and not contrary to law or the interests of subscribers, contract holders, or the public. The fair market value of the assets must be conveyed to one or more foundations, which are independent of both the new stock corporation and the former nonprofit's officers, directors, or staff, and must be used to promote or serve the health needs of Coloradans.[21] Blue Cross directors, officers and employees cannot receive any compensation related to the conversion. For three years after the conversion, the new corporation is prohibited from lowering the value of any stock held by the foundation by issuing stock with greater dividends or voting rights.

Conversion Legislation: Policy Issues

Explicit statutory authority can help to resolve ambiguity in common-law standards or states' nonprofit corporation codes, which often address sales or dissolutions but not partial transfers or multistage arrangements. Clarification is particularly useful in the case of Blue Cross conversions because of these plans' varying tax status and different structures (nonprofit or mutual) in many states. However, while specific statutory standards can guide regulators (for example, to assure that all conversions actually are reviewed), it may be useful to provide regulatory flexibility on some issues (for example, in determining exactly what constitutes a conversion, imposing conditions on successor for-profit organizations, or valuing assets) in view of the widely varying arrangements likely to emerge in the unpredictable and fast-changing health care environment. I set out here fifteen policy questions for consideration.

■ **What entities should be subject to a conversion law?** Most statutes have been drafted to address hospital and health plan conversions separately, perhaps because of the kinds of conversions that have received most attention in the state. Separate laws may be appropriate, for example, in California, where different agencies are responsible for supervising each type of organization. But because health plans may acquire interests in hospitals and hospitals may acquire or create health plans, conversion laws should be drafted, as proposed in Ohio, to apply to relationships among all types of health care entities that ever had a federal tax exemption (including Blue Cross and Blue Shield plans, which lost their federal tax exemptions in 1986).[22] Because tax-exempt health plans have had different public missions than most nonprofit hospitals have had, a regulator might impose different obligations on one type of organization than on the other but should have the authority to review all of them.

■ **How should conversion be defined?** A fundamental issue in

enacting a conversion law is defining the activities subject to the review procedure. Conversion occurs when a nonprofit provider or plan changes its form of ownership to for-profit status or cedes a considerable amount of control over its assets or activities to a for-profit firm (even if a nonprofit shell remains). Because of the varied ways in which conversions can be designed (including not only mergers and total acquisitions but creation of a for-profit subsidiary and various levels of joint ventures), a functional definition may be more useful than a narrow structural one. For example, the definition of conversion in California's hospital conversion law (a sale of or transfer of control over a material amount of assets to a for-profit corporation or mutual benefit plan) allows an examination of the actual effect of a proposed change. On the other hand, the Nebraska law's definition (ownership change of at least 20 percent or the purchaser owning at least 50 percent of the hospital) requires less regulatory discretion but is easier to evade by a transaction that transfers just less than the defined amounts of control. Furthermore, to apply to a hospital or health plan conversion that occurs in a series of small steps, a definition should include all transactions over several previous years. California's health plan conversion law, for example, appears to allow the corporations commissioner to treat a series of related actions as a restructuring.

With respect to health plans such as Blue Cross, policymakers should decide whether becoming a mutual insurer constitutes a conversion subject to state review (as California's law provides). This issue is important because mutualization may precede change to for-profit status, at which point it may be much more difficult to require a set-aside of assets, because a mutual benefit company may not be viewed as having a "charitable" purpose or obligation.

■ **Which agency or agencies should regulate conversions?** Attorneys general historically have been responsible for supervising changes of mission and dissolutions of nonprofit organizations. Although some have been more active than others, there does not appear to be any justification for changing their traditional role.[23] It may, however, be appropriate to add review responsibilities for other state agencies with more expertise on issues raised by health care organization conversions. For example, insurance regulators have experience in overseeing the operation of health plans, including Blues plans, and should be involved in reviewing proposed health plan conversions. Because conversions may raise issues of health care access, costs, and financing, departments of health or other agencies with expertise in these matters, including certificate-of-need review, could be charged with reviewing such aspects of proposed hospital or health plan conversions. The lead agency could

be authorized to consult with all interested state agencies, althou
timely cooperation is most likely to occur if each agency's respon
bilities are set out in the law (and if, as discussed below, sufficie
resources are provided to carry them out). Unfortunately, st
agencies may have conflicting political interests, as, for examp
when an attorney general and the governor or an elected insuran
commissioner come from different political parties.

A related issue is whether private parties, such as policyholde
potential beneficiaries of a charitable foundation, or members of t
general public, should be given authority to enforce charitable tru
obligations or state conversion laws if state officials fail to do s
Some state laws allow individuals to act as "private attorneys ge
eral" and bring lawsuits in the public interest, usually after provid
ing the attorney general an opportunity to pursue the case.[24]

■ **Should an informal review process be available befor
public review?** A prime objective of recently enacted conversio
laws is to bring these proposals to public attention because of th
broad community interest in nonprofit provider and health pla
assets and activities. Parties to these transactions may seek informa
discussions with state regulators, particularly to explore whether
the proposed action would constitute a conversion and examine
other matters that may be controversial. One precedent for informa
review preceding the public process is antitrust enforcement, where
the federal and many state enforcement officials will discuss pro-
posed transactions and even issue formal opinions (business review
letters). On the other hand, such an informal review of conversion
proposals should not in any way be allowed to nullify or dilute the
process of public scrutiny.[25]

■ **What provisions should be made for advance notice to
regulators and the public?** One of the reasons for enacting explicit
conversion laws is to assure that regulators are aware in advance of
proposed conversions so that they can conduct a meaningful review
and inform interested members of the public. The California hospi-
tal conversion statute requires sixty days' advance notice; other
recent laws require advance notice but do not specify a time frame.
The attorney general's inherent power to supervise charitable trusts
is meaningless without advance notice because it is very difficult to
undo these arrangements after contracts have been signed.

■ **What conversion information should be made public?** Be-
cause conversions are often conducted behind closed doors, an im-
portant issue is the extent to which details of the plan are matters of
public record. Parties to a transaction tend to argue for secrecy in
order not to jeopardize the deal (and attorneys general's investiga-
tional files often are exempt from state public record acts). But

consumers assert that the purchase price, governing arrangements, and use of sale proceeds should be public. Recent conversion laws, such as those in California, Colorado, and Nebraska, state that all documents submitted in the conversion application (including details of the proposed transaction) must be in the public record. (Unless explicitly addressed in law, however, conversion plan records still may be exempt from disclosure as state investigational files or proprietary information.) California law also specifically provides that these records must be made available at least one month before the public hearing on the conversion plan.

■ **What opportunities should be made for public input into the conversion review?** In several states, such as California, Colorado, and Massachusetts, consumer advocates have actively encouraged and supported state regulatory review of hospital and health plan conversions as well as legislation to clarify the review process.[26] Although state attorneys general are explicitly charged with representing the public interest, and other regulators generally have similar responsibilities, a specific role for public input into the conversion process is important for several reasons. First, there are likely to be many "publics" with different interests (beyond the "general public," there may be potential beneficiaries of a foundation, persons served by different activities of a converting nonprofit hospital, a plan's policyholders, or a provider's or plan's employees), and their diverse views are more likely to be heard through a public hearing. Second, the large amounts of money involved in these transactions may create the appearance of a conflict of interest (if not an actual one), and fully open proceedings can encourage regulators to scrutinize these proposals carefully and reassure the public that they are fair.[27] Although some details of conversion proposals may be proprietary, offices of attorneys general report that they are likely to be few.[28] An open process provides an opportunity for policymakers to discuss and receive feedback on the implications of the proposal for health care access and costs. Another value of public input is that some national and local consumer groups have developed considerable sophistication and expertise in reviewing conversions and can provide useful technical input to state regulators.[29] Finally, a public process may encourage other prospective purchasers to bid for the nonprofit, which makes it easier to value the assets.

■ **What type of public hearing should be required?** A technical issue that may have important consequences for the conversion review process is the nature of the public hearing. An opportunity for interested persons to comment and ask questions, similar to a legislative hearing, can be useful for obtaining input from a broad spectrum of the public. A more formal ("quasi-judicial") hearing

involving prepared statements by designated parties, invited
nesses, and cross-examination (often the model used when in
ance regulators are investigating insurer misconduct) may pro
more focused information to the decisionmaker, but it may re
the opportunity for input from the general public. The type of h
ing also is likely to determine who has a right to appeal the reg
tor's final decision and whether an appeal can be made to a cou
another administrative agency.

■ **What authority should regulators have to impose co
tions on the parties to a conversion?** In addition to supervis
the disposition of the nonprofit provider's or plan's assets, st
regulators may want to impose conditions on the nonprofit (i
continues to exist in some form) or the for-profit successor.
example, a for-profit hospital could be required to provide a cert
amount of charity care or to maintain an open emergency depa
ment (as the Massachusetts attorney general has required in so
conversions).[30] A health plan might be required to continue to
community-rated policies. One criterion the state can use under t
Nebraska hospital conversion law is the purchaser's continued ob
gation to serve disadvantaged and uninsured persons.[31] Althou
such obligations might not be needed in all cases, authority to im
pose them should be included in a conversion law, because witho
explicit jurisdiction, an attorney general may feel unable to regula
the for-profit successor.[32]

■ **How should the converting nonprofit provider's or plan'
assets be valued?** One of the most contentious issues in a conve
sion review is the valuation of the nonprofit's assets, which dete
mines the amount of resources that must be set aside in a foundatio
or other organization to continue the nonprofit's mission and, in th
case of mutual insurers, transferred to policyholders. The extent t
which the nonprofit is undervalued eventually will inure to th
benefit of private individuals. When several nonprofit Californi
HMOs became for-profit firms in the 1980s, their successor founda
tions received a fraction of the value that shareholders held after the
conversion.[33] Consequently, the proposed purchase price should not
be taken as the best measure of a nonprofit's value. Regulators
should be encouraged to consider multiple approaches to valuation,
including the value of assets (both tangible and intangible, such as
trademark, reputation, provider contracts, subscriber lists, and gen-
eral benefits to the community), multiples of earnings over several
years, discounted cash flow, and future cash-flow projections that
take changing market conditions into account.[34] The price that the
nonprofit would bring in an open, competitive market is difficult to
determine because there are often no competing bidders, but the

potential for competition is another reason that the conversion review process should be public.[35]

Because few state officials have expertise in valuing these types of assets, they will need the assistance of consultants such as investment bankers, accountants, and actuaries. Conversion laws should authorize the use of such outside experts and the ability to charge their costs to the nonprofit applicant (as provided in the California, Colorado, and Nebraska laws).

■ **What entity should receive the former nonprofit's assets?** The typical model is to create a new charitable foundation to receive the assets of the former nonprofit entity and use them for continued public benefit. Other possible recipients are an existing community foundation or a government agency. A key consideration in deciding which type of organization can best carry on the nonprofit's mission is how to ensure that the funds are used for the desired purposes. For example, to reduce the costs of administrative duplication, assets could be transferred to an existing community foundation with the same objectives as the former nonprofit organization and earmarked for specific purposes, perhaps with some commitment to report to state agencies on their use. Alternatively, a government health program might be an appropriate recipient, since foundations rarely fund direct services, which might be the desired use of funds (for example, from a hospital that provided a large amount of charity care). Because public agencies do not generally use the interest from an endowment and might consume the assets more quickly than a foundation would, assets could be set aside in a public program that is responsible for preserving the principal and using the interest for the designated health care purpose.

■ **How should a successor foundation be structured?** One way to ensure that the new foundation remains independent from both the nonprofit and for-profit entities would be to engage separate counsel to represent the foundation during its initial development and to help the foundation to define its purpose, tax status, and board membership.

Purpose. Should the foundation have the same purpose as the nonprofit, or a different purpose? By common law, a nonprofit organization whose purpose became impossible or impractical was required to adopt a purpose as close as possible to its original mission. This approach may be undesirable in health care organization conversions because of the difficulty of determining the nonprofit's precise missions and because the community may not need hospital care, for example, because of overcapacity. A successor foundation could be authorized to serve a broader mission (promoting the health needs of state or community residents, health professional training, or

public health education) or a narrower one (charity care to uni
sured or underinsured persons or health care services to children
Because some foundations have been created from hospital sales
include nonhealth missions, a conversion law should define accep
able parameters for the foundation's activities.[36]

Tax status. Federal charitable tax-exempt status as an Intern
Revenue Code section 501(c)(3) private foundation is advisable b
cause of its limits on political activity and private inurement and i
requirements for public accountability. On the other hand, the
organizations may not hold more than 20 percent of a corporation
voting stock, and it may be desirable to transfer the assets of th
nonprofit in the form of the new organization's stock as a way t
ensure that they are fairly valued.[37] For this reason, California
health plan conversion law permits the temporary use of a 501(c)(4
organization (whose stock ownership is unlimited) to graduall
monetize the value of the stock, but it imposes restrictions on th
501(c)(4) entity (regarding political activity, self-dealing, and publi
reporting) similar to those under 501(c)(3).

Board membership. Some successor foundations have been manage
by board members of the former nonprofit and/or the successo
for-profit enterprise.[38] However, these persons may have little expe
rience in making grants. Furthermore, close ties with the for-profi
firm may lead to conflicts of interest. Conversion laws in Californi
and Nebraska require independent foundation directors with ap
propriate philanthropic experience, although defining what consti
tutes an independent board can present a challenge. Other ques
tions regarding board composition are how many directors th
board should include (some general state nonprofit laws permit a
few as three, which may be too few to carry out the foundation'
responsibilities), and how they are selected both initially and there
after. An outside expert might be engaged to recruit and recommen
membership for the first board.

■ **How can private inurement from the conversion be avoided?** In addition to transferring assets to an entity such as a foundation that is totally separate from the nonprofit and for-profit entities, the conversion should not enrich individuals, such as em
ployees, board members, or fiduciaries (attorneys, accountants, or other consultants) of either the nonprofit or for-profit parties to the conversion. Previous conversions have resulted in private inurement to stockholders when assets are undervalued and to employees and board members who receive consulting fees, low-price stock op
tions, or employment in the successor for-profit entity or founda
tion. Some foundations have given grants or other subsidies to the for-profit purchaser that also suggest conflicts of interest or private

inurement. Health plan conversion laws in California and Colorado (driven by publicity over high compensation to nonprofit board members approving these transactions) prohibit private inurement and conflicts of interest, as does Nebraska's hospital conversion law.

■ **How should conversions be monitored over time?** Establishing that a conversion meets common law or statutory requirements for fairness to the public is not the only responsibility for state policymakers. Regulators also need to monitor whether the parties to the conversion have met required conditions, such as the prohibition on private inurement and self-dealing or any charitable obligations, and whether the successor foundation maintains independence and carries out its mission. Enforcement of these conditions is another important but potentially underfunded longer-term function that could involve various state agencies. Remedies such as fines and license revocation could be useful enforcement tools. It seems likely that an attorney general or insurance regulator can require reports on these matters under his or her inherent oversight authority and as a condition for approving a conversion. To avoid any uncertainty over this authority, state conversion laws should include an explicit reporting requirement, like those in California and Nebraska.

■ **What resources might state regulators need to implement a conversion law?** Because of the expertise and time needed to adequately review a proposed hospital or health plan conversion and to monitor compliance with the conditions of approval, state regulators are likely to need additional resources to carry out their responsibilities under both current and newly enacted laws. In states with a great deal of conversion activity, attorneys general, insurance commissioners, and state departments of health may need additional staff to process applications and evaluate their impact on affected communities. They also will need proficiencies not generally used in state agencies, particularly to assess the fairness of the nonprofit's asset valuation. Such competence is especially important given the high level of expertise that the parties to a conversion can afford to hire. In view of state budget constraints, it seems most appropriate to permit state regulators to assess the nonprofit organization applying for conversion or the for-profit purchaser for both the costs of engaging outside experts and the reasonable direct costs of reviewing and evaluating the application. Colorado's health plan conversion law permits charging the cost of hiring experts, whereas California's hospital and health plan conversion laws provide the broader authority to charge all reasonable agency review costs to the applicant. An alternative under consideration in Massachusetts would permit charging costs to the for-profit purchaser to

preserve the nonprofit's assets.

Conclusion

Conversions of nonprofit hospitals and health plans pose a ma challenge for state health policymakers, who are obligated to ens that charitable assets remain to serve the public. The public inter in a nonprofit hospital or health plan's assets justifies a fair and op public process to review conversions. While public attention often piqued by the media's focus on windfall gains to nonpro board members or executives, the real focus should be on how achieve sound health policy for the communities served by organi tions proposing to convert. For-profit organizations may add val by improving efficiency and paying taxes, but at the cost of losing institution that is uniquely dedicated to serving community nee These discussions can become contentious because they invol often strongly held views (not easily grounded in scientific eviden on organizational performance) about the value of for-profit or no profit organizations. Yet philosophical debates may be moot if t increasingly competitive U.S. health care environment is discoura ing both nonprofit and for-profit hospitals from providing unprofi able services that benefit the community or from serving perso who are unable to pay.

In drafting legislation and defining transactions subject to publi oversight, policymakers need to be vigilant for new arrangement that may fall just outside legal boundaries. One of the few certaintie in the unpredictable and fast-paced health care marketplace is tha plans and providers will try to craft ventures to meet both explici and implicit corporate goals while avoiding regulatory oversight.

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NOTES

1. See P.A. Butler, *Profits and the Public Interest: A State Policymaker's Guide to Non Profit Hospital and Health Plan Conversion* (Portland, Maine: National Academy fo State Health Policy, 1996).
2. D.M. Fox and P. Isenberg, "Anticipating the Magic Moment: The Public Inter est in Health Plan Conversions in California," *Health Affairs* (Spring 1996): 202–209; E. Hamburger, J. Finberg, and L. Alcantar, "The Pot of Gold: Moni toring Health Care Conversions Can Yield Billions of Dollars for Health Care," *Clearinghouse Review* (August/September 1995): 473–504; and A.W. Scott and W.F. Fratcher, *The Law of Trusts* (Boston: Little Brown, 1989), sec. 399.
3. 18 Am. Jur. 2d *Corporations*, secs. 32–33 (1985); *Greil Memorial Hospital v First Alabama Bank*, 387 So. 2d 778 (Ala. 1980); and *Queen of Angels Hospital v Younger*, 136 Cal. Rptr. 36 (Cal. App. 1977).
4. In a proceeding called *cy pres*, a court must determine that it is impossible or

ABSTRACT: Conversions raise two critical policy questions: First, does ownership form (nonprofit or for-profit) make any difference to delivery of health care? Second, when conversions occur, how are charitable assets and purpose preserved? This paper addresses both questions, based on a review of evidence and experience. On the first question we conclude that, overall, nonprofit ownership enhances the potential for community benefit. However, that potential may be better realized by requiring nonprofits to meet minimum community benefit standards and possibly by mitigating pressure on institutions to convert. On the second question, we conclude that more states should take legislative action to establish a formal oversight process for conversions. Without public consideration of how much money to set aside and for what purpose, conversions pose the risk that communities will lose significant services and resources.

PERHAPS NO HEALTH SYSTEM change arouses more emotion and less rational policy discussion than the conversion of hospitals and health plans from not-for-profit to for-profit status. Although the nation's hospitals and hospital beds remain overwhelmingly not-for-profit and only a handful of Blue Cross/Blue Shield plans have actually converted to for-profit status, nonprofit hospitals and health plans confront an increasingly competitive marketplace and aggressive acquisition strategies by for-profit chains. Furthermore, the magnitude of the dollars at stake ($3 billion in one Blue Cross conversion alone) makes the amount of public attention both understandable and appropriate.

Attention, however, is not the same as thoughtful consideration. The purpose of this paper is to encourage a thoughtful public dialogue by providing an overview of the issues that conversions raise for the health care and health insurance systems. Our aim is to clarify what public policy issues are at stake. The paper addresses two fundamental questions. The first is whether tax status makes any difference to the delivery of health care or health insurance. If not, tax policies conferring nonprofit status may warrant adjustment or reconsideration. If so, the desirability or the terms of conversions come into question. The second question is how to regulate the conversion process to protect charitable assets. When charitable organizations convert to for-profit status, charitable trust law requires that the value of those assets be set aside for charitable purposes (usually in a foundation) and not inure to the benefit of individuals. But who is subject to charitable trust law, how much money is set aside, and how those funds are used are public policy issues of major procedural and substantive concern.

Background

We define *conversion* as any type of transaction that results in the shift of all or a substantial portion of the assets of nonprofit health

care organizations to for-profit use. Conversions range from relatively simple transactions in which nonprofits' assets are exchanged at arm's length for cash to far more complicated transactions involving multiple organizational components, interlocking organizational structures, and complex financial arrangements. The following are some examples of the possible types of transactions.

Asset sales. A common and straightforward form of conversion is asset sales. In such arrangements a nonprofit organization typically sells its physical assets (such as a hospital plant), its name, and its accounts to a for-profit purchaser in exchange for cash, stock, notes, or other property. The proceeds of such a sale are generally received by a nonprofit foundation, which may be the original organization or a new nonprofit entity established to receive the proceeds of the sale.[2]

Joint ventures. A more complicated type of transaction that may result in a conversion is a joint venture. For example, a nonprofit hospital and a for-profit hospital organization might form a for-profit partnership whose purpose is to offer hospital services. The nonprofit contributes its hospital assets to the partnership in exchange for cash and an ownership interest (say, 20 percent) in the new venture. The for-profit contributes cash to the venture (equal to 80 percent of value of the hospital assets) and receives ownership interest (80 percent) in the venture.[3] Proceeds of the transfer of a nonprofit's assets generally are placed in a nonprofit foundation. In this case, the foundation becomes the holder of the nonprofit's 20 percent interest in the venture.

There are several interesting aspects to such a transaction. The for-profit company gains effective control of the hospital's assets (that is, it owns 80 percent of the assets and has a contract to manage the hospital) without having to pay their entire value. The trustees of the former nonprofit hospital maintain substantial influence over the hospital's operation through their 50 percent representation on the venture's board. By accepting an ownership interest in the venture as part of the consideration for transferring its hospital assets, the nonprofit has in essence gone at risk for 20 percent of the amount of its hospital assets. The total amount that the foundation ultimately receives for the nonprofit hospital assets will depend on the venture's future success.

Other types of reorganization. Other types of transactions may be conversions as well. For example, several Blue Cross/Blue Shield plans have either implemented or proposed reorganization plans that call for the nonprofit health plan to transfer a substantial portion of its assets to a for-profit subsidiary. The subsidiary would offer stock to the public, resulting in partial public ownership of the

plan's assets. Most of the insurance operations would be carried out through the for-profit subsidiary, which would have the same management as the nonprofit parent.

Whether this type of transaction should be considered a conversion—that is, whether the core enterprise of the nonprofit organization has been transformed—has been a matter of dispute. In California a proposed reorganization with a similar structure was initially accepted by regulators as a restructuring of the nonprofit health plan, but after concerns were raised by consumer representatives and others, regulators ultimately treated it as a conversion. Similar disputes have occurred or are occurring in several other states, including Missouri and Maryland.

■ **Scope of conversion activity.** Conversion activity has proceeded at different paces and in different ways across nonprofit health care organizations. The distribution of hospital beds by ownership has remained markedly stable.[4] In 1994, as in 1984, about 70 percent of all beds were nonprofit, 20 percent were public, and 10 percent were for-profit.[5] Nevertheless, there has been significant change in a number of states. In New Hampshire, Utah, Idaho, and New Mexico the for-profit share of beds in 1994 was about 10 percent higher than in the previous decade. Perhaps more significant, after more than a decade in which approximately nine hospital conversions occurred per year, thirty-four occurred in 1994 and fifty-nine occurred in 1995.[6]

Conversion activity also has increased among Blue Cross/Blue Shield plans. Historically, the Blue Cross and Blue Shield Association (BCBSA) required that licensees of its trademarks be nonprofit. That requirement was eliminated in June 1994, to permit plans to better adapt to the changing marketplace and to obtain access to equity capital.[7] Since the change, three of the sixty-three plans (Georgia, California, and Virginia) have converted to for-profit ownership. Other plans, including those in Colorado, Maryland, Massachusetts, New York, and Ohio, are considering conversions.

The health maintenance organization (HMO) industry presents a different picture. That industry began as almost exclusively nonprofit—fueled in part by the availability of federal grants for nonprofit organizations and BCBSA policies. However, over the past ten to fifteen years the HMO market has become predominantly for-profit. In 1981, 82 percent of HMOs (accounting for 88 percent of overall membership) were nonprofit.[8] By 1995 the proportion of nonprofit plans fell to 29 percent (accounting for 41 percent of members).[9]

Furthermore, among the more loosely integrated HMOs that are growing most rapidly, for-profit organizations are most prevalent.

"Conversions can provide nonprofit organizations access to capital, which... is particularly important in a managed care environment."

For-profit plans now account for 76 percent of enrollees in open-ended plans, compared with only 57 percent in pure HMOs.[10] Among preferred provider organizations (PPOs), which also are growing rapidly, 80 percent of plans are for-profit.[11]

■ **Reasons conversions occur.** In many cases, conversion is simply the outcome of a consolidation strategy, rather than a specific organizational goal. In other cases, nonprofit organizations may see disadvantages to their ownership status and explicitly pursue a conversion strategy. Here we describe how market and institutional factors are contributing to the surge of conversions.

Access to capital. Conversions can provide nonprofit organizations with access to capital, which they can use to restructure operations and put themselves in a better competitive position. Health plans have followed this strategy for several years, beginning with conversions of several nonprofit HMOs in the mid- and late 1980s and followed by several Blues plan conversions in recent years. Access to capital is particularly important in a managed care environment, in which substantial investments may be necessary for information systems, network development, utilization management, and expanding market share.

Equity can be a cheaper method of raising capital than debt, particularly for firms with good growth potential whose stock may be valued at a high multiple of its current earnings. For-profit firms can acquire competitors by issuing stock, thereby expanding their market shares without reducing their reserves or accumulating substantial debt. Managed care plans have followed this strategy successfully in the past several years. For example, it is estimated that United Healthcare issued more than sixteen million shares of stock to finance acquisitions in 1994 alone.[12]

Efficiency. Competitive forces in the marketplace have forced hospitals and health plans to be more efficient, and many have sought efficiencies through consolidation via mergers and acquisitions. In the hospital industry a large overcapacity of inpatient beds has reinforced this trend. For-profit consolidation activity is likely to focus on nonprofit institutions because the vast majority of hospitals are nonprofit.[13] Many advocates of for-profits also contend that the resulting conversions enhance efficiency through the greater managerial skill and market responsiveness of for-profit operations.

Market share and growth strategies. In today's competitive environ-

ment, increasing market share is often a necessary strategy. Hospitals need increased market share to build networks that will guarantee patient flow and to increase their bargaining power with managed care plans and physician groups. Health plans seek to build large enough networks to serve regional and national employers and to give them increased leverage in their negotiations with providers. Network building is expensive and often is accomplished through merger and acquisition, regardless of organizational form. These consolidations often occur between nonprofits and for-profits and result in conversions. For-profits, because of their access to equity capital, have an inherent advantage in this realm.

For investor-owned hospital chains, the dynamic of the stock market creates additional pressure. The stock of some companies is now selling at a price that is a high multiple of earnings, which reflects investors' expectations that these firms will maintain their recent high rates of growth. Given hospital overcapacity, acquisitions are a primary means for these firms to increase revenues at rates necessary to meet their investors' growth expectations.[14]

Survival and continuance of mission. For weaker nonprofit organizations threatened with closure, the sale of their health care assets to or a joint venture with a for-profit firm might be seen as the best alternative to sustain any institutional presence and to preserve what may be an important source of community employment. Even if closure is not an immediate threat, some organizations may perceive selling their nonprofit assets as an opportunity to generate funds to continue missions, such as medical education or charity care, that are threatened by competitive pressures that limit operating revenues.

Reduced regulatory constraints. Another factor in an organization's decision about conversions relates to the greater flexibility that for-profit organizations have in compensating executives, staff, and partners. A hallmark of nonprofit organizations is that they exist for public rather than private benefit, and federal and state tax rules prohibit the earnings of nonprofit organizations from inuring to the benefit of insiders or other individuals. However, this greatly limits the ability of nonprofit organizations to use flexible compensation arrangements, such as profit sharing, that some see as important tools for competing in the market. For example, permitting staff physicians to share in hospital revenues from outpatient departments or other services is considered a way for hospitals to recruit and maintain physicians and attract patients and referrals, but Internal Revenue Service (IRS) rules limit nonprofit hospitals' ability to enter into such arrangements. For-profit hospitals have greater flexibility in this regard, which may provide them with a market

advantage.

Potential benefit for directors and managers. Finally, as highlighted by consumer groups, regulators, and others, the opportunity for substantial personal financial gain by insiders of nonprofit organizations may influence some conversion decisions.[15] In several notorious cases from the 1980s, key insiders of nonprofit HMOs were able to purchase their plans for prices apparently far below market value.[16] In these cases, the insiders essentially were both sellers and buyers and had a personal interest in paying less than full value. Advocates have suggested that the same potential conflicts of interest may exist in some of the joint venture arrangements between nonprofit hospitals and investor-owned hospital chains today.[17]

Does Profit Status Make Any Difference?

Not-for-profit institutions have played dominant roles in the hospital and health plan markets for decades. As such, they have received substantial subsidies from federal, state, and local governments, premised, at least in part, on the theory that these organizations provide special benefits to the communities they serve. Whether the amount of benefits they provide is sufficient to justify their tax-exempt status has been a matter of some controversy and raises important questions for tax policy.[18] If nonprofits provide more community benefits than their for-profit counterparts do, then conversions could result in the loss of such benefits to communities. If, on the other hand, nonprofits provide fewer benefits than for-profits do, or if the benefits provided are less valuable than the tax exemptions conferred, then the tax preference is subject to question, and conversions may result in a net benefit to communities.

■ **What are community benefits?** Debate about nonprofit versus for-profit community benefit is longstanding. Research has not resolved this controversy, in part because of considerable variation in the way community benefits have been defined and measured. As a result, comparing findings across studies becomes complex. For example, comparison of charity care in nonprofit and for-profit hospitals has been studied both nationally and within individual states. Using aggregate national data, several prominent organizations found relatively small differences between nonprofits and for-profits in the provision of charitable care.[19] But Lawrence Lewin and colleagues contend that aggregate data may be deceiving.[20] They point out that most for-profits have been concentrated in thirteen states. These states tend to have leaner Medicaid eligibility rules and fewer public hospitals than do states that are chiefly populated by nonprofits. The demand for charity care in those thirteen states is likely to be relatively higher, so the amount of charity care for-profit hos-

pitals provide relative to total revenue may be high compared with national averages but low in relation to demand and what other nonprofits provide in that state. In comparing nonprofits and for-profits within the same state, Lewin and colleagues find larger differences in the provision of charity care than is the case in national studies.[21]

Recognizing that differences and controversies exist, we list here items that might be included in measuring community benefits. The list moves from relatively concrete and more easily measured benefits to benefits that are more abstract and difficult if not impossible to measure. Tax payments are listed last because of a lack of consensus as to the appropriateness of their inclusion. The list focuses primarily on hospitals because they have received the most attention in the literature, although a recent paper by Bradford Gray and Mark Schlesinger also looks at HMOs through some indirect measures (for example, loss ratios and annual disenrollment by Medicare beneficiaries).[22]

Charity care. For hospitals, providing care to persons who are unable to pay is almost universally considered a community benefit. For health plans, the analogue of charity care might be accepting applicants without regard to health status (where it is not required), subsidizing the premiums of persons with preexisting medical conditions through community rating, or providing direct premium subsidies to persons who cannot afford insurance. Health plans that own hospitals or clinics can provide direct charity care.

Bad debt. In data sets that measure hospital uncompensated care, bad debt is often combined with charity care. Many analysts use this measure because studies have shown that most bad debt likely results from patients who are unable to pay.[23] The level of bad debt so far exceeds that of pure charity care that the question of whether to include it as a community benefit is not trivial. If bad debt is not counted, actual charity care is underestimated, but if all of it is included, the amount of charity care is overstated. Some question the inclusion of bad debt, citing reasons such as poor management of receivables or free care given to staff and trustees. Both charity and bad debt are more accurately measured on a cost rather than a charge basis, and data based on charges should be adjusted using a cost/charge ratio.

Losses from serving public program enrollees. To the extent that Medicare and Medicaid set provider reimbursement rates below provider cost, the losses sustained by hospitals serving these patients may be considered as similar to charity care (for the extent of the losses).[24]

Losses from subsidizing necessary community services. Services such as burn units, twenty-four-hour trauma centers, or programs for

special-needs populations such as hemophiliacs are medically important but often unprofitable because of high costs or low volume.[25] The benefit to the community would be access to vital health care services that otherwise might be unavailable.

Net cost of research and education. Providing or participating in medical education or research programs may be considered a community benefit since health care organizations may not be fully reimbursed for the total cost of these activities.

Lower prices. Some analysts contend that lower prices charged by nonprofits constitute a community benefit. They argue that nonprofits do not fully exploit their market power to maximize revenues, and as a result, the benefit of lower prices inures to consumers.

Community needs assessments, education, and service programs. Health care organizations can assess the health care needs of their communities and develop specific initiatives (such as health screenings or programs for high-risk groups) to address those needs. Including these activities as community benefits has been criticized because health care organizations often use these types of services as a means of advertising and sometimes charge for these services.[26]

Community control and accountability. Control of health care organizations by local volunteer boards may be considered a community benefit on the theory that organizations controlled by community volunteers will be more receptive and responsive to local health care needs. Nonprofit organizations also provide a vehicle through which citizens can express their civic and charitable ideals.

Nonprofit orientation and trustworthiness. The lack of profit motive of not-for-profit organizations itself is sometimes considered a community benefit. The theory for this proposition rests on the idea that health care is a complex good and that consumers do not understand their health care choices as well as do those providing care.[27] In such situations, suppliers can take advantage of consumers' lack of information by withholding services or by reducing quality. Firms with a profit incentive are considered more likely to take advantage of these informational asymmetries because they can profit from doing so. Not-for-profit firms, because they are constrained from using any net earnings for personal benefit, are considered not to have an incentive to exploit their information advantages.

One potential objection to this theory is that physicians play a mediating role that protects consumers from exploitation in these situations.[28] However, the various economic ties between hospitals and physicians and the influence of third-party payment practices such as managed care bring into question the impartiality of physicians as mediators.[29]

Taxes. There is no consensus regarding whether taxes paid by

"Nonprofit hospitals provide more community benefits than for-profits....[But] there is wide variation among nonprofit hospitals."

for-profit organizations should be counted as community benefits. Advocates of for-profits contend that all taxes should be counted. Others point out that few if any taxes contribute directly to the health care needs of the local community, particularly federal and state income taxes, which are both uncertain in amount and outside of community control. Some argue that property and other local taxes that remain under community control should be counted, while others recommend complete exclusion of taxes or the inclusion of only those taxes that are earmarked for health services.

■ **Evidence on community benefits.** Examination of twenty studies of comparative community benefit (virtually all of those found in the literature) and numerous studies on price and cost differentials yields the following major conclusions.[30]

(1) Nonprofit hospitals provide significantly more community benefits than for-profit hospitals provide. The differences are more evident when comparisons are made across hospitals within states.

(2) There is wide variation among nonprofit hospitals in their provision of benefits, with a large proportion of benefits being provided by a few nonprofit hospitals. Public hospitals (rather than nonprofit community hospitals) and major teaching hospitals provide a disproportionately large share of community benefits, and a significant number of nonprofit community hospitals provide few community benefits.

(3) When employing a reasonably broad definition of community benefits (charity care, bad debt, losses from public programs, and net cost of teaching and research), we find that nonprofit hospitals, as a whole, contribute significantly more in benefits than the cost of their tax exemption.

(4) Prices charged by nonprofit hospitals are generally lower than those charged by their for-profit counterparts for similar services.

(5) If taxes paid by for-profit hospitals are counted as community benefits, then, overall, the benefits provided by for-profit hospitals would exceed those of nonprofits. However, the relation between taxes paid and community benefits is uncertain and tenuous, and although no consensus exists, it seems appropriate to count only those taxes that are specifically earmarked for health services.

In sum, the evidence indicates that there is a substantial difference between nonprofit and for-profit hospitals in terms of the community benefits they provide. However, the burden of providing

those benefits is uneven, with many nonprofit community hospitals receiving tax exemptions in excess of the benefits they dispense.

■ **Policy Implications.** *Hospitals.* These findings raise questions regarding current tax treatment of nonprofit hospitals and policies toward conversions. Some have recommended eliminating the tax exemption and giving all health organizations, whether nonprofit or for-profit, tax deductions for legitimate expenditures on community benefits. From an economist's perspective, this approach would be advantageous in terms of horizontal equity and would more efficiently target tax expenditures. However, this policy proposal assumes a tighter connection between tax breaks and community benefits than actually exists. The fact that nonprofits generally provide community benefits worth more than their tax exemptions suggests that the nonprofit ownership form has value. Further, as discussed above, not all community benefits are clearly definable; linking tax breaks to expenditures would ignore benefits such as accountability or trustworthiness, which are difficult to define. The availability of a tax deduction is unlikely to induce for-profits to provide new community services. Hence, the overall result of a linked approach is likely to be a reduction in community benefits or increased reliance on publicly owned hospitals, which are not generally viewed as the preferred providers of community services.

A strong argument can be made for a focused and effective third sector (the private nonprofit hospital) that receives its tax exemption based on a clearer standard of benefit provision than exists under current law.[31] Community benefit standards have been recommended by two of the most prominent nonprofit organizations, the Catholic Hospital Association and the Voluntary Hospital Association. Some states have already taken steps to define community benefits for the purpose of state and local tax exemptions. Texas and Utah, for example, have adopted relatively narrow definitions focusing on charity care. Other states, such as New York, have taken a broader approach.[32] Benefit standards could also be added to federal tax policy.

Adding standards to tax preferences would improve value for the dollar in tax policy. However, it would not ensure that valued activities or organizations would survive in the face of market pressures. Although the goal of policy development should not be to prohibit conversions, it should be to ensure that conversion is an option rather than a necessity for nonprofits that are competing in the marketplace. That assurance may require policymakers and regulators to facilitate access to alternatives to equity capital, reexamine regulatory constraints on nonprofit operations, and more effectively prevent inappropriate and illegal insider financial gains from con-

version transactions.

Preserving community benefits also requires attention once conversions occur. Oversight is needed to address both the redirection of a nonprofit's charitable assets and the service obligations of new for-profit organizations. These topics are covered below.

Nonhospital organizations. The underwriting and coverage practices followed by nonprofit insurers today are similar to those of their for-profit competitors, and the willingness to accept all applicants at community rates has virtually disappeared from the marketplace.[33] Preferred tax status for Blue Cross and Blue Shield plans, which, at their origins, provided this community service, has already been eliminated. It seems unlikely that conversions will make any further difference in insurance behavior.

A distinction must be made, however, between insurance companies and plans that integrate the financing and delivery of care—that is, nonprofit HMOs. Although many nonprofit health plans operate in a fashion similar to their for-profit counterparts, some have the capacity to provide significant community benefits through their own hospitals and clinics, through community needs assessment, and through their support of teaching and research. Although the literature provides no evidence of quality differences between for-profits and nonprofits, nonprofits also may offer intangible community benefits. Thus, while it may be desirable to apply benefit standards to these organizations in return for their tax-exempt status, eliminating that status could jeopardize community benefits.

How Can Conversions Be Regulated To Protect Charitable Assets?

Conversions not only affect health care organizations; they also affect communities' access to and use of charitable assets. Yet most states have neither enacted specific legislation nor instituted any specific process to oversee health industry conversions. Under current law, state policies have been highly variable. As conversion activity has increased, so has the call for greater oversight of and public participation in the process. Here we review key areas in which oversight is required.[34]

State laws generally establish the legal framework under which corporations, including charitable organizations, are established. These laws establish the procedural requirements for changes in corporate structure. In addition, the transfer of assets of a nonprofit organization is governed by state charitable trust law because the assets are considered to be held in charitable trust for the public. When a charitable organization is dissolved, however the transaction is structured, its assets must be transferred to a nonprofit or-

ganization that will carry out the original purpose of the charitable trust as nearly as possible. In many cases, a new foundation is formed for this purpose.

Changes in nonprofit status have federal tax law implications as well. Section 501(c)(3) of the Internal Revenue Code grants federal tax exemption to organizations formed and operated exclusively for charitable purposes, provided that no part of the organization's net earnings inure to the benefit of any private shareholder or individual. Penalties are imposed for violation of these rules.

While virtually all nonprofit hospitals are organized as charities under section 501(c)(3) of the Internal Revenue Code, many nonprofit HMOs and Blue Cross and Blue Shield plans are not. Laws applicable to charitable trusts may not apply to these organizations unless they have dedicated their assets for charitable purposes through their corporate articles, bylaws, or some other means.[35]

For example, some Blue Cross and Blue Shield plans are organized as "mutual benefit" organizations, which generally are operated for the benefit of their members rather than for charitable purposes. When a mutual benefit organization converts from nonprofit to for-profit status, the members of the organization, rather than the community, may be entitled to the proceeds of the transaction. A controversy may arise, however, if the mutual benefit organization was originally incorporated as a charity, or if the mutual benefit organization's corporate documents state that the organization is operated for the benefit of the public.[36] An example is the case of Blue Cross and Blue Shield of Virginia (operating as Trigon Blue Cross and Blue Shield).

The application of legal principles regarding conversions has varied considerably among the states. In some states public officials—notably attorneys general and insurance commissioners—have aggressively pursued their interpretations of charitable trust and other laws to oversee conversions and promote public involvement. In other states, however, officials have been more reactive, and the policy vacuum and limited resources have resulted in relatively little oversight.

Consumer and other advocacy organizations have taken a lead in calling attention to the importance of oversight when conversions occur. They have frequently served as a resource for public officials and the press in explaining what is at stake and what options exist for addressing policy concerns. In a number of instances, they have initiated or intervened in legal proceedings related to conversions.

■ **Valuation of charitable assets.** If states are not diligent, conversions can clearly result in the loss of nonprofit charitable assets that rightfully belong to a community. No issue is more critical to

this than the valuation of the assets of the converting nonprofit organization. Valuation is at the heart of two key policy issues raised by conversions: the potential for insiders to realize inappropriate financial gain (inurement), and the level of funding that will be available for future charitable activities.[37] To prevent the former and promote the latter, public policy must address a number of issues regarding the valuation process.

(1) Do the not-for-profit trustees have an obligation to solicit competing bids to determine the value of the not-for-profit assets that are to be transferred? Without competing bids, it may be difficult to ascertain the value of intangible assets of the converting organization, such as good will.

(2) Do the not-for-profit trustees have an obligation to accept the highest bid for the assets that are converted? By accepting the highest bid for the conversion, the trustees would be maximizing the amount available for future charitable purposes. There may be circumstances, however, in which a lower bidder agrees to operate in certain ways or to provide certain benefits that the trustees believe would benefit the community. Or a potential purchaser may agree to give the not-for-profit trustees (usually the trustees of the foundation accepting the consideration) a voice in the operations of the converted enterprise. Placing a value on these agreements may be difficult unless there are a number of competing purchasers.

(3) Do the not-for-profit trustees or management personnel have any obligation to disclose potential conflicts of interest to the officials with authority to oversee a conversion?

(4) Should the not-for-profit organization or the for-profit purchaser have an obligation to fund an independent valuation of the converting assets? State officials with oversight of conversions often do not have the resources to independently value the assets that are being converted. Such a procedure may be particularly important where the management of the not-for-profit organization will be heavily involved with the for-profit enterprise, as has been the case in a number of health plan conversions.

(5) Is it appropriate for not-for-profit trustees to accept consideration that is contingent on the future success of the for-profit enterprise? This question arises when the charitable foundation is funded through stock in the for-profit enterprise or when it accepts a partnership percentage in a joint venture. On the one hand, past conversions have been criticized when the value of the converted entity later skyrocketed and the not-for-profit organization did not realize any of the gains.[38] On the other hand, accepting stock or a promise of future earnings may place the charitable foundation at significant risk, particularly if the foundation's assets are concen-

trated in the one enterprise.[39]

(6) Should an independent representative to the conversion process be appointed to look out for the interests of the new charitable foundation? This type of proposal recognizes that there may be conflicts of interest within the converting not-for-profit organization, or that the not-for-profit trustees may be unable to adequately ascertain the value of the assets being transferred.

Failure to publicly address these questions could be detrimental to communities in which conversions occur.

■ **Continued provision of health services in the community.** Critics of hospital conversions have raised concerns that for-profit hospitals might provide fewer community benefits than their preconversion nonprofit predecessors provided. Some states have enacted legislation and/or used their regulatory powers to negotiate with successor for-profit entities for specific levels of charity care and health services after a conversion.

In the case of many hospital conversions or, for that matter, hospital consolidations, there are often efficiencies to be gained by closure or curtailment of certain services. What some consider as cost-saving efficiency, however, others may regard as reduction in necessary community services. Hence, states and municipalities have negotiated with successor hospital entities for continuation of such services as twenty-four-hour emergency care, burn and trauma units, neonatal intensive care units, and other services that may be costly, low volume, or unprofitable.

States also have negotiated with successor entities for provision of a minimum level of charity care or other community benefits. A few states, such as California and Nebraska, have enacted legislation that specifically includes the consideration of future benefits to be provided to the community after a conversion. A process that specifically sets forth such authority can be valuable to effective public policy. In a proposed Massachusetts conversion, for example, the attorney general initially received accolades for negotiating a three-year postconversion agreement to maintain the level of charity care. Later, however, he was criticized for conducting a secretive process and for failing to obtain more than a three-year commitment.[40]

Regulation of successor for-profit entities can have unintended negative consequences. Regulations that are too stringent can be used to protect the status quo and keep out competition that might bring about lower prices and, hence, increased access to care. In legislating and implementing a regulatory process, states must find the appropriate balance for their communities.

■ **Public participation in the conversion process.** Despite the potential impact of conversions on a community's health care serv-

ices or charitable assets, there is no process in most cases for the community to express its views, raise objections, or intervene in conversion decisions. In theory, the trustees and management of nonprofit organizations have a fiduciary duty to ensure both that the assets of the organization are used for the purposes stated in the organization's articles of incorporation and that the conversion is in the best interests of the organization.[41] In practice, however, exercise of this duty is fraught with conflicts of interest and is not self-enforced. Unlike investor-owned companies, nonprofit organizations generally do not have stockholders who must approve decisions about changes in ownership or who can intervene if the management or directors are not operating in the firm's best interests.[42]

As conversion activity has increased, so has the call for greater oversight of and public participation in the conversion process. In some cases, consumer groups, community organizations, and other advocacy groups have been successful in focusing public attention on proposed conversions.[43] However, the lack of a formal public role has left such interventions to chance and excluded other voices from the conversion process. Although states' attorneys general are usually given the role of representing the public in these transactions, limits on their resources and time may prevent them from recognizing the potential impact of a conversion on a community.

Potential ways for the public to participate in conversions include public hearings, formal input into a regulatory process, legal standing to challenge transactions, and input into the disposition of charitable assets. In deciding how to facilitate public input, states must balance the need to prevent private abuses and the loss of charitable assets with the need to provide an efficient—rather than a cumbersome or obstructive—regulatory process.

■ **Governance of new foundations.** When a charitable organization is dissolved, issues arise regarding the creation, initial governance, independence, and mission of new charitable foundations that are being established to carry out the original charitable purpose. In 1996 Grantmakers In Health identified approximately sixty such foundations formed since January 1990 and successfully surveyed forty of them in seventeen states and the District of Columbia. Collectively, these foundations represented more than $5 billion in assets (with three foundations holding more than $1 billion each). They are likely to pay out about $250 million annually in charitable spending. Key issues include the application of tax rules to prevent conflict of interest, the independence and expertise of foundation boards, and the nature of foundation missions—all of which will determine whether charitable purposes are in fact continued. Nancy Kane delves into these issues in her paper in this volume.[44]

In making policy for new conversion foundations, it is important to avoid overregulation once the initial governance and mission have been established. Here again, a vibrant third sector (the private nonprofit foundation) can provide services that might otherwise be provided only by the government.

■ **Policy implications.** To ensure that state regulators appropriately and systematically address the policy issues conversions raise, consumers and other organizations, along with regulators and legislators in some states, are calling on states to enact legislation that clarifies regulatory authority and responsibility in the conversion process. A few states have passed such legislation affecting hospitals and/or health plans. These legislative initiatives have addressed a wide array of procedural and substantive issues, including the basis for and locus of regulatory authority; the kinds of transactions subject to that authority; the formulation of a regulatory process for preconversion submission and review; the requirement for independent and accurate valuation of assets; the proper role of citizens and community groups; the initial governance and mission of charitable foundations; and the evaluation of the impact of the transaction on the health care system. Although changing the rules under which transactions occur cannot guarantee that all parties or all issues will get the attention they deserve, a more explicit process increases the likelihood of good public policy.

Conclusion

Conversions of health organizations from nonprofit to for-profit status are interwoven into the changes occurring in the U.S. health care industry. Some conversions have economic advantages in consolidating excess capacity and promoting efficiency. They may also pose the risk that communities will lose valuable charitable assets or important health services. The goal of public policy should not be to prevent conversions; such rigid policy could impede desirable change. Rather, the goal should be to preserve valued functions and resources in the context of a competitive marketplace.

A review of the literature on what difference ownership form makes leads us to conclude that the nonprofit organizational form enhances the potential for community benefits for hospitals and (albeit with less evidence) for some HMOs. To ensure that these benefits are realized, tax policy that supports nonprofit organizations should be sustained but modified to require minimum standards for community benefits. Action also could be considered to reduce pressure on nonprofit organizations to convert for reasons other than economic efficiency—for example, ready access to capital, regulatory flexibility, or insider financial gains.

A review of the conversion experience also reveals that effect oversight can make the difference between a beneficial or a det mental conversion. Effective oversight does not require highly sp cific rules or stringent regulations. Rather, it requires the esta lishment of a process that enables states to explicitly address a negotiate the multiple issues that conversions raise. Consiste with the action of a few states, other states could benefit fro enactment of legislation that provides such a process and th avoids the problems that have occurred from lack of oversight.

The magnitude of charitable assets at risk and the potential f conversions to affect, either positively or negatively, important co munity health services argue for greater attention. Until now, ma conversions have occurred with little public oversight or comm nity involvement. Given the stakes involved, policymakers shou take greater initiative.

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NOTES

1. There sometimes are disputes over whether an organization's assets are dedi cated to not-for-profit purposes or whether a change in an organization structure constitutes a "conversion" to for-profit status. Differences regardin the effect of "reorganizations" of several Blue Cross and Blue Shield plans ar recent examples.
2. T. Silk, "Conversions of the Tax-Exempt Nonprofit Organizations: Federa Tax Law and State Charitable Law Issues" (Presentation at the American Ba Association Section of Taxation Mid-Winter meeting, New Orleans, Januar 1996).
3. Ventures could be established with different ownership shares, such as fifty fifty.
4. Changes have nevertheless occurred. Lewin Group analysis of American Hos pital Association (AHA) data between 1980 and 1993 shows 488 hospitals changing status. The most prevalent change (215) was public hospitals con verting to nonprofit status.
5. Ibid.
6. Irving Levin Associates, New Canaan, Connecticut.
7. C.A. Ascari, "Direct Testimony and Exhibits on Behalf of Blue Cross and Blue Shield of Virginia (d/b/a Trigon Blue Cross and Blue Shield), in Application of Blue Cross and Blue Shield of Virginia (d/b/a Trigon Blue Cross and Blue Shield) for Conversion from a Mutual Insurance Company to a Stock Corpo ration," State Corporation Commission, Commonwealth of Virginia, 14 June 1996.
8. InterStudy, "HMO Summary" (Excelsior, Minn.: InterStudy, June 1985).
9. InterStudy, *The InterStudy Competitive Edge, Part II: Industry Report* (Excelsior, Minn.: InterStudy, April 1996).
10. Ibid.
11. S. Findlay, "When Nonprofits Decide to Make a Buck," *Business and Health* (March 1996): 38–46.