Public Policy Issues In Nonprofit Conversions: An Overview

Does ownership status of hospitals and health plans make a difference? A review of conversion activity raises questions for public debate.

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PROLOGUE: The conversion of nonprofit health plans to for-profit status, or the acquisition of nonprofit hospitals by for-profit chains hungry for market share, continues to attract nationwide attention. Although the numbers are still small, the potential for more conversions and the enormous amount of money at stake demand policy attention. The authors of this overview paper offer some guidance through the morass of public opinion, legal precedent (or lack thereof), detailed financial transactions, emotional reactions, and other aspects of the topic of health plan conversions.

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

**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.

**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. 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. 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. 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.

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. 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. But Lawrence Lewin and colleagues contend that aggregate data may be deceiving. 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-
hospitals 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.\textsuperscript{25} The benefit to the community would be access to vital health care services that otherwise might be unavailable.

\textit{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.

\textit{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.

\textit{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.\textsuperscript{26}

\textit{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.

\textit{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{29}

\textit{Taxes.} There is no consensus regarding whether taxes paid by
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.10

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. 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. 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-
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.\(^\text{15}\)

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.\(^\text{16}\) 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. 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. 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.  

(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 pre-conversion 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.

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. 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.

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. 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.
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 effective oversight can make the difference between a beneficial or a detrimental conversion. Effective oversight does not require highly specific rules or stringent regulations. Rather, it requires the establishment of a process that enables states to explicitly address and negotiate the multiple issues that conversions raise. Consistent with the action of a few states, other states could benefit from enactment of legislation that provides such a process and that avoids the problems that have occurred from lack of oversight.

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

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NOTES

1. There sometimes are disputes over whether an organization’s assets are dedicated to not-for-profit purposes or whether a change in an organization’s structure constitutes a “conversion” to for-profit status. Differences regarding the effect of “reorganizations” of several Blue Cross and Blue Shield plans are recent examples.


3. Ventures could be established with different ownership shares, such as fifty-fifty.

4. Changes have nevertheless occurred. Lewin Group analysis of American Hospital Association (AHA) data between 1980 and 1993 shows 488 hospitals changing status. The most prevalent change (215) was public hospitals converting to nonprofit status.

5. Ibid.


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 Corporation,” State Corporation Commission, Commonwealth of Virginia, 14 June 1996.

8. InterStudy, “HMO Summary” (Excelsior, Minn.: InterStudy, June 1985).


10. Ibid.

18. Note that Blue Cross and Blue Shield plans no longer have tax-exempt status.
19. These include the American Hospital Association, 1982 and 1983; and the Prospective Payment Assessment Commission, 1995 and 1996.
21. Ibid.
24. Some observers have pointed out that the amount of the loss a provider incurs for serving public patients is in part due to the provider’s relative efficiency. This means that in studies that attempt to measure the amount of community benefit provided by particular providers, inefficient providers would be perceived as providing greater community benefits than more efficient providers. Health Management Decisions, “Community Benefits and Tax-Exempt Status of Central Florida Hospitals” (St. Petersburg, Fla.: HMD, February 1995).
26. Ibid.
31. Beyond the standard requirements for tax exemption (that the organization be organized for an exempt purpose and operate for public rather than private benefit), current federal tax law requires that nonprofit hospitals operate an emergency department open to all regardless of ability to pay (unless such services would be duplicative); have an open medical staff; accept Medicare and Medicaid patients; and be governed by a board of directors with community representation. See Revenue Ruling 69-545, 1969-2 Cumulative Bulletin, 117.
33. There remain several states in which local Blue Cross and Blue Shield plans are required to accept applicants that their competitors are permitted to reject.
36. Ibid.
37. In the case of a converting nonprofit mutual benefit organization, valuation is important to assure that the members are fully compensated for their ownership interest.
42. A vote of the membership may be required in the case of nonprofit organizations that are organized as mutual benefit organizations. Note that the problem of conflict of interest may occur in the case of conversion of a mutual benefit organization: Management and trustees of the mutual may have a financial interest in the resulting for-profit firm, which leaves the members of the mutual potentially vulnerable to receiving too little for their ownership interests. To protect members of mutual health plans, and to ensure that the resulting company will be financially sound, “demutualizations” generally are subject to the review of state insurance commissioners.