

Conversion of HMOs and Hospitals: What's at Stake?

Bradford H. Gray, Ph.D.
Director, Division of Health and Science Policy
The New York Academy of Medicine

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For-profit conversions have been occurring among nonprofit hospitals and HMOs for many years without attracting much attention beyond the participants in particular transactions.¹ Then the words, *billions*, *HMOs*, and *conversions* appeared together in California,² and Columbia/HCA began a highly publicized campaign of nonprofit hospital acquisitions. Conferences on the topic suddenly became a small industry. Observers use apocalyptic language, such as “the dissolving nonprofit sector”³ and “potentially the largest re-deployment of charitable assets in history.”⁴ The parties to whom the topic is of great interest now include the entrepreneurs who hope to obtain nonprofits' assets, nonprofit boards that are trying to fulfill their responsibilities, the lawyers and consultants who advise both parties, existing nonprofits that hope to receive proceeds from conversions, policy makers, regulators, and researchers.

The state regulatory processes through which conversions of nonprofit HMOs and hospitals have generally moved include the courts and state attorneys general and departments of insurance or corporations. Interestingly, agencies with responsibilities for health care are not necessarily involved, and hospital and HMO conversions have generally not been treated as a health policy matter.

This paper provides a framework for assessing the desirability of conversions of nonprofit hospitals and HMOs from a health policy standpoint. I begin with a discussion of some specific implications of the basic ownership forms of health care organizations. I then discuss some of the reasons that conversions have been occurring and lay out

arguments regarding the advantages and disadvantages of these transactions from a policy perspective. I continue by exploring in greater detail the concerns and evidence regarding a major possible disadvantage -- loss of the trustworthiness and social benefits of nonprofits in health care. I conclude by suggesting a public policy perspective from which conversions in health care might be viewed.

Basic Ownership Forms in Health Care

Legal and economic comparisons of nonprofit and for-profit organizations have emphasized the absence of equity owners in the nonprofit form and the prohibition in nonprofits of the distribution of profits to owners or other private persons (what Hansmann has called the nondistribution constraint).⁵ Also important is the related difference in internal accountability structures. Managers of for-profit organizations are ultimately accountable to owners, who generally seek to maximize the value of their investments, while nonprofit managers are accountable to boards of trustees whose members lack an ownership stake and who may be chosen in a variety of ways and have a variety of values, motivations, and goals, including community service. Agency problems may exist on either the nonprofit or for-profit side, with managers pursuing their own interests as they define them, rather than focusing primarily on the interests of stockholders or the values of trustees. But the for-profit health care companies use several devices to align the incentives of owners and managers. Senior executives commonly own substantial amounts of corporate stock, and companies often use large economic incentives to motivate executives toward corporate goals.⁶

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

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

Although many sorts of organizations may seek growth, equity capital provides special growth incentives. For organizations with growing earnings, equity capital can be much cheaper than debt. The higher the stock price in relationship to earnings, the cheaper the organization's access to equity capital.⁷ High price/earnings ratios result from investors'

expectations of future earnings; such expectations can be fed by a history of earnings increases, a pattern that is achieved more readily via acquisitions and mergers than via improved performance of a fixed set of hospitals or health plans.

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

A final point of contrast concerns nonprofits' exemption from a variety of federal, state, and local taxes that for-profits must pay. Estimates in the mid-1980s put the value of nonprofit hospitals' tax exemptions at about 5% of revenues,⁸ although these estimates were rough or were based on questionable extrapolations from a small number of financially healthy institutions during a brief period when hospitals had particularly healthy bottom lines as a result of the early implementation of Medicare's prospective payment system.⁹ As an ownership-related matter, the tax exemption issue has complexities. For example, at certain points in their histories, many for-profit health care firms have enjoyed significant tax breaks designed to stimulate investment. Also, nonprofits are not exempt from all taxes. They pay payroll taxes and, in some states, taxes levied by the state on hospital admissions or payments to government in lieu of taxes; in some locales nonprofit hospitals actually pay more taxes on average than do for-

profits because of their larger size and payrolls.¹⁰

Reasons for Conversions of Hospitals and HMOs

In broad terms, conversions take two forms which reflect different circumstances and dynamics. One form involves the acquisition of an organization or its assets by insiders from its management, board, or medical staff.¹¹ This is often a leveraged buy-out, where the purchasers borrow the money to purchase the organization's assets. The second form is the purchase of a nonprofit's assets (perhaps including its name) by an external organization. (There are, of course, mixed cases in which an insider is involved with an external purchasing organization.) It appears, though systematic data do not exist, that purchases by insiders have been common among HMOs and rare among hospitals, where the sale and conversion of nonprofits seems generally to involve an external investor-owned company.

Related, though not identical, to the insider/outsider purchaser distinction is the question of whether the sale/conversion is primarily driven by positive organizational goals or by an absence of alternatives. That is, for trustees and those who influence them, the decision about conversion may be driven by strategic considerations regarding access to capital, building market share, forming strategic alliances and so forth -- matters that can bespeak a healthy organization that is trying to position itself to do well in the rapidly changing health care system. At the other extreme are organizations that are in trouble, unable to compete and lacking the capital and the vision to respond to health system

change. Their trustees might be searching for a White Knight to rescue the organization and relieve them of the problems that they face in trying to run it.

This suggests that conversions might occur in two very different situations -- in organizations that believe their future is very bright and in organizations that are very troubled. Although systematic empirical data is lacking, I believe that some HMO conversions have been undertaken out of strength and strategy and that hospital conversions have tended to occur out of fear, a choice from a list of unpleasant alternatives.

Public Policy Issues Raised by Nonprofit Conversions

Should conversions of nonprofit health care organizations be encouraged or discouraged by public policy? Arguments can be offered on both sides of the question.

Why Might Conversions be Encouraged? At least six reasons can be advanced for public policy encouraging conversions of nonprofit health care organizations. (I've not included the war horse about greater efficiency on the list because (a) its meaning is often murky in health care¹² and (b) the preponderance of evidence does not suggest that for-profits necessarily have lower costs or are less expensive either to purchasers or from a societal point of view.¹³)

1. To facilitate health coverage of the uninsured. The replacement of nonprofit health care organizations with for-profits, it might be argued, would hasten the end of the belief that the medical needs of the uninsured can be met adequately without governmental

action to assure universal insurance coverage. The presence of a large “voluntary” sector was used as an argument against national health insurance in the 1930s,¹⁴ and it may account for the confidence sometimes expressed by conservative politicians today that America’s 40 million uninsured get Medicaid care when needed. That confidence might decline if nonprofit institutions were replaced by for-profits.

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

3. To put charitable assets to more productive uses. An enormous amount of capital is tied up in hospitals and HMOs that generate almost all of their revenues from the sale of services. If that capital were extracted, perhaps it could be used for services for which sources of payment are less readily available, such as care of the uninsured, prevention programs, or services deemed experimental by payers.¹⁵

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

5. To facilitate consolidation and capacity reductions. Surplus hospital capacity is a serious public policy problem. Insofar as nonprofits' boards view their responsibility as preserving their institutions, they may find it difficult to cease operations. Selling the assets may be a useful alternative for preserving value.¹⁶ The sale of several hospitals in the same market to the same purchaser may hasten the closure of some facilities, since the market share of the acquiring organization would be enhanced. Depending upon one's perception of larger consequences (e.g., the impact on safety-net hospitals), this may be a good idea.

6. To end the "fiction" that nonprofits are more socially beneficial than their for-profit counterparts. Advocates of for-profit control commonly assert that nonprofits enjoy a halo effect and tax exemptions that are not justified by their performance (typically on narrowly defined criteria).¹⁷ This is both a conceptual question [How *might* we expect nonprofits to differ from for-profits?] and an empirical one. We will return to this issue.

Why might conversions be discouraged? At least three reasons can be cited for a public policy of discouraging conversions of nonprofit organizations.

1. The difficulty of preserving the nonprofits' value in the nonprofit sector and of preventing private inurement. Establishing the value of a nonprofit organization can be difficult. Windfalls by purchasers have been quite common, with a substantial net loss to the nonprofit sector. There are several reasons for this. Competitive bidding, and its benefit for establishing an organization's worth, is often missing in these situations.

Moreover, the individuals who know the organization best (e.g., the CEO) may be on both sides of the transaction. Particularly in the HMO situation, purchasers have frequently been insiders. But even when an outside purchaser is involved, financial payments or promises of future employment may be made to the nonprofit's managers.¹⁸ Thus, in several common situations, those who are responsible for the nonprofit (as managers or trustees) may have an interest in minimizing the price paid for the nonprofit's assets.

In addition, because nonprofits have likely not been seeking to maximize profits from their operations, their revenue-generating potential may be difficult for a seller (or regulators) to assess. Purchasers -- particularly those who have experience in buying nonprofits and operating them for profit -- may have a substantial informational advantage over sellers in this situation. It is difficult to prevent purchasers from acquiring the organization at a bargain price, particularly since the financial details of such transactions are often not made public where they might inform future sellers of nonprofits. Improved processes -- public disclosure and technical expertise regarding pricing -- would ameliorate this problem. In a growing number of states public officials have required that details of hospital deals be made public; in some instances the acquiring organization has then shifted its attention on to other targets.

2. Uncertainties about protecting the public interest. Neither the trustees of the converting organization nor the purchasers of their assets are responsible for considering the community impact of a conversion. So far as I can determine, often no one is. And even if legislation was to assign review responsibility to a state agency with substantive

responsibility (e.g., a department of health), no generally recognized conceptual tools exist for guiding reviewers regarding what information or potential consequences they should consider.

3. Potential loss of social benefits of nonprofit health care. If substantial social or community benefits inhere in nonprofit organizations in health care, conversions could have significant disadvantages. The potential social benefits of nonprofit health care organizations are discussed in the next section.

What Are the Social Benefits of Nonprofits?

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

Regulatory. One reason for preserving a predominantly nonprofit health care system is the regulatory tool provided by the tax exemption. When faced with a public policy goal or challenge, government commonly faces a choice between using tax revenues or forcing (or encouraging) others to take action. Depending on the issue that is involved, these others might be individual citizens, lower levels of government, businesses, or nonprofit organizations. As with tax policy generally, nonprofits' exemptions provide policy makers

with a lever to which a variety of conditions can be attached. In recent years, all levels of government have become interested in attaching performance-related conditions -- most commonly, charity care requirements -- to tax exemptions for nonprofit health care organizations.¹⁹ The wisdom of this approach is debatable both regarding the desirability of governmental control of nonprofit organizations²⁰ and on efficiency grounds, but the tax exemption is nevertheless a tool that can be used to accomplish governmental purposes. The disappearance of institutions that are subject to this tool, or to moral suasion regarding community responsibilities, would be a disadvantage of replacing nonprofits with for-profits.

Trustworthiness. Healthcare is characterized by serious informational asymmetries because of the vulnerabilities of patients and the use of third-party payment.²¹ Parties that are at informational disadvantages must trust that their vulnerabilities will not be exploited. Henry Hansmann hypothesized that nonprofit organizations, because of the constraint on the use of surpluses, may be seen by purchasers as less likely than for-profit organizations to behave in an untrustworthy manner in the presence of an informational advantage.²² He also suggested that in the health care context patients' vulnerabilities are protected by their agency relationship with physicians and that the nonprofit form therefore is not needed to increase the trustworthiness of hospitals.²³

There is, however, an extensive body of literature showing that physicians' patient care decisions are influenced by a variety of non-medical factors, including economic incentives.²⁴ Moreover, many other parties in health care have economic interests that

lead them to seek to influence physicians' patient care decisions. HMOs or hospitals may seek to influence physicians' patient care decisions with methods that range from persuasion to finding ways to put money in their pockets. Some past attempts have violated the fraud provisions that apply to Medicare (e.g., the Paracelsus Health Corporation's scheme of a decade ago to split profits with doctors on their Medicare patients admitted to the hospital under the DRG payment system).²⁵

Not subject to the nondistribution constraint, for-profit health care organizations can enter into profit-sharing arrangements with doctors that may influence their patient care decisions. Columbia/HCA's strategy of forming local partnerships with physicians who admit to their hospitals is an interesting example.²⁶ According to Kuttner, Florida's Agency for Health Care Administration found evidence that physicians are influenced by this arrangement. Medicare patients for whom hospitals receive fixed, diagnosis-related reimbursement who were admitted to Victoria Hospital in Miami, a Columbia/HCA hospital, stayed an average 8.48 days, while the same doctors' Medicare patients who were admitted to other area hospitals had an average length of stay of 13.5 days, suggesting that doctors either were steering their sickest patients to hospitals other than Victoria or were treating patients differently in the hospital in which they had a financial interest. The report, which was never released, talked of the "possibility of cream skimming" and the "possible adverse effects on a market of physician ownership in a hospital."²⁷

HMOs have become the object of much distrust in recent years because of instances in

which they seem to be simultaneously depriving patients of needed care, creating conflicts of interest for affiliated physicians, and profiteering at the expense of all other parties in the system. Critics of HMOs' practices often link their concerns to HMO owners' financial stake in limiting services for patients, suggesting that there may be a connection between the growing distrust of managed care and the prominent presence of for-profit HMOs. Perhaps this explains public perceptions of regarding HMO ownership. In a national survey by Louis Harris and Associates in 1995, more than half of respondents expressed a strong preference regarding the ownership form of HMOs; of these, more than 80 percent preferred a not-for-profit organization over a plan owned by a for-profit company.²⁸ In one of the few studies that has examined ownership and incentives in HMOs, Pauly, Hillman, and Kerstein found that the incentive devices used for primary care physicians by for-profit plans significantly impact physicians' patient care decisions, while this is not true of the incentives used by nonprofit plans.²⁹

Whether there are systematic ownership-related differences in trustworthiness of HMOs is uncertain, but there is evidence that for-profits and nonprofits are at the opposite ends of some pertinent distributions. Thus, a HCFA review of disenrollments from Medicare risk contracts in 1993 found that the five HMOs with the highest rates were all for-profit HMOs of the IPA model and the five HMOs with the lowest rates were all nonprofits of either the group or staff model.³⁰ A similar pattern has been reported in the appeal process for Medicare beneficiaries enrolled in HMOs, where the highest appeal rates were from for-profit plans, and the lowest rates were all nonprofits.³¹ The rate of

complaints per thousand enrollees ranged from 4.58 in Humana's Florida plans down to .18 in nonprofit Group Health Cooperative of Puget Sound. A third example comes from the 20,000 responses to *Consumer Reports* survey of readers' experiences with, and assessment of, 37 HMOs: An average 12.2% of respondents from for-profit plans reported that they did not get care that they felt they needed because the plan discouraged it, compared with an average 7.8% of respondents from the 18 nonprofit plans about which data were obtained. The distribution of responses hardly overlapped.³²

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

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

Why might we expect ownership-related differences in the provision of public or collective goods? Economic theory predicts that market-driven organizations will not respond to wants or needs that are not accompanied by money demand,³³ and nonprofit

organizations are governed by, and accountable to, parties whose concern is not profit-making. Moreover, there are public expectations, somewhat inchoate but reflected in tax exemption policies, that nonprofits will operate to serve the public interest. Even so, the adequacy of the community benefits provided by nonprofit health care organizations has been the subject of much controversy and attacks on nonprofits' tax advantages.

These attacks have been fed a number of factors: dubious performance by some nonprofits, skepticism from some legal analysts, governmental appetites for new revenue sources, the search by advocates for the uninsured for ways to enhance the ability of the poor to obtain medical care, and lobbying activities by the investor-owned health care industry.³⁴ A sense has grown that nonprofits' tax exemptions in health care should be tied to the organization's community benefit activities. Discussion of this issue, however, is plagued by conceptual confusion regarding the meaning of community benefit.

The narrow view of community benefit focuses on charity care for the poor. This has some policy appeal because it seems (misleadingly, unfortunately)³⁵ to refer to something quite concrete and measurable and because it addresses an important problem (the uninsured) that lawmakers have not addressed more directly. Moreover, most nonprofit hospitals and HMOs are tax exempt as *charitable* organizations, although the Internal Revenue Services defines this term not in terms of free care but in terms of community benefit.

For-profit advocates generally frame the community benefit issue in terms of charity care, perhaps because it suggests a narrow picture of the role of nonprofits³⁶ and because

the extent of charity care, generally measured as uncompensated care (deductions from revenues for bad debt and charity), varies widely among nonprofit hospitals (as it does among for-profits) depending on a variety of factors, including hospital location. Many hospitals are located where the need for provision of charity care is small. If charity care were adopted as the sole measure of community benefit for tax-exemption purposes, some nonprofits would fail the test.

National uncompensated care numbers based on hospital self-reports in surveys by the American Hospital Association show only slightly higher levels of uncompensated care in nonprofit than in for-profit hospitals, a pattern that has been quite persistent for many years.³⁷ Uncompensated care data for 1994 showed nonprofits at 4.5 percent with revenues and for-profits at 4.0 percent.³⁸

This picture of comparative behavior is widely cited, but it may be misleading because of weaknesses in the measure used (unaudited self-reports by hospitals and with some nonresponse problems) and because it ignores state level differences. Nonprofits are found in large numbers in all states, including many that have low levels of the uninsured and, therefore, proportionately low levels of need for hospitalization among the uninsured. For-profits are concentrated in states that had growing populations and friendly regulatory environments; many of these states have relatively and high levels of uninsured people.³⁹ In such states, nonprofits tend to provide much higher levels of uncompensated care than do for-profits; this is true for Texas, Tennessee, Florida, and Virginia.⁴⁰ An inference that can be drawn from this pattern is that nonprofits may be

more responsive to unmet needs for medical care than are for-profits. However, when the need for indigent care is relatively low, because of low numbers of uninsured or the availability of governmentally-subsidized public hospitals,⁴¹ differences between for-profit and nonprofit hospitals are small.

Several other pieces of information are consistent with this idea. Research has shown that nonprofit hospitals admit many more uninsured and Medicaid patients than do for-profits.⁴² For-profit hospitals are also more likely than nonprofits to put pressure on physicians not to admit uninsured and Medicaid patients,⁴³ and physicians report conflict over the treatment of indigents more often in for-profit than in nonprofit hospitals.⁴⁴

Community benefit can be viewed in much broader terms than indigent care. In work published elsewhere, Mark Schlesinger, Elizabeth Bradley, and I developed a more comprehensive set of measures derived from tax law, economic theories of nonprofits, and the work of scholars and hospital associations regarding community benefit.⁴⁵ We identified some 30 different dimensions including activities that create positive externalities (e.g., contracting with essential community providers; reporting bad clinical practices to appropriate authorities), minimizing negative externalities (e.g., shifting the burdens of cost containment to providers or patients' families), creation of public goods (e.g., involvement in research and educational activities), minimizing the exploitation of informational asymmetries, and various forms of community involvement.

The research base with which to assess the overall community benefits of different types of health care organizations has serious inadequacies, particularly regarding HMOs,

and a full summary of available information is beyond the scope of this paper. But a wide variety of indicators suggest that nonprofits have substantial advantages from a broadly defined community benefit standpoint. For example, local governance is much more typical among nonprofit than for-profit hospitals; nonprofit hospitals are more likely to be located in urban areas with large numbers of poor and uninsured; nonprofit hospitals and HMOs are much more involved in research and education than are for-profits; nonprofit hospitals offer a greater array of services including some that typically lose money; nonprofit HMOs have been much more likely to participate in the Medicare and Medicaid programs; and nonprofits are much less likely than for-profits to undergo recurrent changes of ownership and control.⁴⁶

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

Most of the data on uncompensated care and other community benefit activities in nonprofit hospitals comes from an era in which nonprofits were under little governmental pressure to provide and document their "community benefit" activities. In recent years,

nonprofit hospitals have come under much additional pressure to serve the poor and uninsured to justify their tax exemptions. Some hospitals have begun including such service in their budgets and making public reports of their community impacts. How the new public pressures have affected the community benefit activities of nonprofit hospitals is not known. Research on psychiatric hospitals, however, has shown that public pressure on nonprofits is associated with greater differences with for-profits in care for indigent patients.⁴⁷

An Appropriate Public Policy Stance

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

1. Whether one views community benefit in narrow or broad terms. If only "charity care" counts, many hospitals and most HMOs provide very little. However, the number and magnitude of differences between for-profit and nonprofit health care organization grows as the number of comparative dimensions is increased.
2. Whether one believes that health care essentially involves private goods or that the community benefit aspects of health care (however that may be defined) are important. Or, in a different formulation, if one is highly confident that pursuit of economic incentives in health care will produce an appropriate set of outcomes for

patients and communities, one would have little concern about the possible negative effects of conversions because there is considerable evidence that the behavior of for-profits tracks the economic incentives more closely than does the behavior of nonprofits.

3. Whether one believes that performance measurement and reporting by purchasers has reached a point of completeness and sophistication as to obviate the problems of trustworthiness that arise from the informational asymmetries that exist between provider and patient and between provider and payer; and whether one furthermore believes that purchasers will serve as reliable protectors of patients' best interests.
4. Whether one believes that tax exemptions can and should be used to advance public policy goals, because the performance of nonprofits on community benefit measures may improve as a result of public scrutiny and pressure.
5. Whether one believes that local control by voluntary trustees plays a valuable role in meeting community needs. One's attitude about the importance of stability of control of health care organizations will also be important.
6. How high a burden of proof should justify a public policy stance supporting conversions. Should it be viewed as benign as long as no one can show it would be harmful from a community standpoint, or should conversions be discouraged until there is clear evidence that it is a beneficial change.

Conclusion

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

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

Conversions of nonprofits may be an alternative that will help preserve essential services in some instances, so a general policy of opposition to conversions seems undesirable. However, a sound process would protect the public interest by (a) preserving the value of converting in the nonprofit sector (e.g., in new or existing foundations), (b) preventing private benefit (as occurs when assets are purchased for less than fair market value) and (c) surfacing and minimizing the harmful effects of conflicts of interest, and (d) assessing in a comprehensive way the community benefit dimensions that may be affected by a conversion.

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

1. The earliest hospital conversion of which I am aware occurred prior to 1970: E. Hoy and B.H. Gray. "The Growth of the Major Investor-Owned Hospital Companies," in Institute of Medicine, *For-Profit Enterprise In Health Care*, ed. B.H. Gray (Washington: National Academy Press, 1986), Table 5. The earliest HMO conversion to which I have seen reference occurred in 1978. See K.C. Dunn, et al., "The dynamics of leveraged buy-outs, conversions, and corporate reorganizations of not-for-profit health care institutions", *Topics in Health Care Financing*, (Spring 1986), 19-34.
2. D.M. Fox and P. Isenberg, "Anticipating the Magic Moment: The Public Interest in Health Plan Conversions in California," *Health Affairs* (Spring 1 1996):202-209.
3. Fox, et al., "Anticipating the Magic Moment: The Public Interest in Health Plan Conversions in California."
4. C. McDermott, "The Changing Health Care Scene and Health Philanthropy: The New >Conversion Foundations," Talk at Council on Foundations Annual Conference, April 23, 1996.
5. H. Hansmann, "The Role of Nonprofit Organizations." *Yale Law Journal*, v.89 (1980): 835-901.
6. In interviews at Humana in 1987, I was told that as much as 50% of the compensation of the CEO of Humana hospitals was in incentives tied to explicit economic goals set by the corporation. Columbia/HCA establishes local joint ventures that own hospitals or other facilities, with local doctors and executives as investors. Kuttner was told by a Columbia/HCA executive that hospital CEOs fall short of the corporate goal of a 20% gross return on revenues are "regularly called to corporate headquarters in Nashville to explain and are ordered to redouble their efforts." See R. Kuttner, "Columbia/HCA and the Resurgence of the For-Profit Hospital Business: Part 1," *New England Journal of Medicine* (1 August 1996): 362-367.
7. At least six HMO companies have had price/earnings ratios in excess of 30 in recent years; HMO companies are generally far below that now. See *Sherlock Company P.U.L.S.E. Report*, September 1995, cited in: Kaiser Family Foundation, "Marcus Welby Goes to Wall Street," Chart Pack (December 13, 1995).
8. J. Copeland and G. Rudney, "Federal Tax Subsidies for Not-for-Profit Hospitals," *Tax Notes* 46(March 26, 1990): 1565.

N. Kane, in an HCA funded study, concluded that the cost of tax exemption among Virginia hospitals was about 8.4% of revenues (see Kuttner "Columbia/HCA and the Resurgence of the For-profit Hospital Business", 365), an amount that exceeded the difference between nonprofits and for-profits in the amount of free care they are providing (3.7% of revenues vs 1.7% of revenues) and education (1.1% vs nothing). An issue raised by such analyses is whether the community benefit activities of nonprofit health care organizations are more beneficial to communities than are taxes paid by health care companies into the general funds of the local, state, and federal governments.

9. Nonprofit hospitals' total margins fell from 7.6% of revenues in the first year of the prospective payment system (roughly 1984, although the prospective payment system was phased in a rolling fashion) to less than four percent within three years. See Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress June 1995*. (Washington:, 1995),56.

10. See, for example: Parker, et al., "Analysis of Central Florida Hospital Community Benefits: Community Hospitals Compared to Investor-Owned Hospitals," report prepared for Florida Hospital and Orlando Regional Healthcare System, (July 1995).

11. A legal issue that may arise in these circumstances concerns what share of nonprofit's assets can be sold before triggering the need for approval as a nonprofit conversion. Hypothetically, a nonprofit could put all of its assets into a for-profit subsidiary and then sell the subsidiary.

12. Although certain services are highly standardized and can be compared, it is difficult to compare organizations such as hospitals that provide differing mixes of services to diverse patient populations. Depending upon the way that efficiency is defined, chronically under-funded public hospitals may be the most efficient in that they serve the most patients for the least money. As a practical matter, most studies have compared hospital expenses or charges on either a per day or per stay basis, using a case-mix adjustment to compensate for some hospitals' (e.g., major teaching hospitals) having a much sicker population of patients than do others. But these comparisons are seldom discussed in terms of efficiency, since it is not clear that a hospital day or a hospital stay is a standard or meaningful measure.

13. See, for example, the evidence reviewed in: B.H. Gray, *The Profit Motive and Patient Care*, (Cambridge: Harvard University Press, 1991), Chapter 5.

14. R. Stevens, *In Sickness and in Wealth: The American Hospital in the Twentieth Century*, (NY: Basic, 1989).

15. The conversion of nonprofits should not be imagined as a solution for the problem of

the uninsured. In "Let's End the Nonprofit Charade," (*New England Journal of Medicine* 334(April 18, 1996): 1057, Malik Hasan, CEO of Health Systems International, a for-profit managed care company, avers that \$92 billion would be raised by the conversion of nonprofit health plans. Although a significant amount of money, it is a one-time source of funding that would be sufficient to provide coverage for the uninsured for about one year.

16. Other alternatives for under-used hospitals include changing the use of a facility, making a hospital primarily an outpatient or long-term care facility.

17. Hasan, "Let's End the Nonprofit Charade."

18. A current example is in Columbia/HCA's troubled acquisition of Blue Cross & Blue Shield of Ohio, where the Chairman of the latter organization is to receive \$3 million under a non-compete agreement and \$7 million for managing the transaction and its chief counsel and an outside counsel are each to receive \$3.5 million. This has been described as a "thinly disguised kickback for selling out at a lowball price." See H. W. Jenkins, Jr., "To the Rationalizers Go the Spoils," *Wall Street Journal*, 30 July 1996, A15. Jenkins's view, incidentally, is that A17 million dollars hardly seems worth getting out of bed for" and that "in an economy that dumps millions on a Snoop Doggy Dogg, it would be hard to begrudge Mr. Burry [the Blue Cross chairman] and colleagues a nice reward for honest labors."

19. For a recent summary of such actions, see: K. Barnett, *Community Benefit Law and California Hospitals: Opportunities and Challenges of SB 697*. (Berkeley, CA: Western Consortium for Public Health, 1995). See also: *Colloquium Report on Legal Issues Related to Tax Exemption and Community Benefit*, (Washington: National Health Lawyers Association, 1996).

20. M. V. Pauly, "Health Systems Ownership: Can Regulation Preserve Community Benefits?" and B. H. Gray, "Tax Exemptions as Health Policy", in *Frontiers of Health Services Management* 12:3 (1996): 3-34 and 37-42.

21. K.J. Arrow, "Uncertainty and the welfare economics of medical care", *American Economic Review* 53(1963): 941-73.

22. Hansmann, "The Role of Nonprofit Organizations." Hansmann focuses on contract failure problems involving patients, but there have also been problems between payers and providers. The rise and proliferation of for-profit health care organizations over the past three decades has been accompanied by an apparent efflorescence of fraud in health care and recurrent extensions and strengthening of federal fraud-and-abuse legislation. See Gray, *The Profit Motive and Patient Care*, Chapter 6.

23. Ibid.

24. Among the places where the evidence on practice variations and economic influences on medical decision making is summarized is in Gray, *The Profit Motive and Patient Care*, Chapters 8 and 10.

25. Gray, *The Profit Motive and Patient Care*, 136-137.

26. Kuttner, "Columbia/HCA...", 362. *Wall Street Journal* reporter Robert Tomsho described Columbia/HCA's physician partnership strategy in 1994. "Columbia has been building and buying outpatient-service facilities and wooing referring physicians with lavish entertainment and lucrative offers to become Columbia investors ... Columbia has been making investment offers just as many physicians have been forced to divest themselves of direct ownership of outpatient facilities such as diagnostic clinics amid new state and federal regulations designed to prevent their overuse . . . Columbia has responded by bundling such facilities with its hospitals into regional investment packages and offering local doctors the opportunity to acquire up to a 40% stake in the entire network. Federal guidelines generally permit such arrangements so long as physician-investors don't own more than 40% of an entity or generate more than 40% of its revenues. Nevertheless, Columbia acknowledges that some of its joint-venture agreements with physicians may not meet the stricter rules that federal regulators have threatened to impose in some of these circumstances. "There's a great big gray area," says Stephen Braun, Columbia's general counsel." See R. Tomsho. "Giant Hospital Chain Uses Tough Tactics to Push Fast Growth." *Wall Street Journal*, 12 July 1994, P1.

27. Kuttner, "Columbia/HCA...", 365.

28. J.M. Sever, "Navigating the Changing Healthcare System: The Towers Perrin Survey of What Americans Know and Need to Know," (Louis Harris and Associates, 1995).

29. M. V. Pauly, et al., "Managing Physician Incentives in Managed Care: The Role of For-Profit Ownership," *Medical Care* 28 (Nov. 1990):1013-1024.

30. Prospective Payment Assessment Commission: Staff Report, *Enrollment and Disenrollment Experience in the Medicare Risk Program*, (19 December 1994).

31. G. Anders, "Humana Gets Some of the Poorest Scores in Study of HMO Medicare Complaints," *Wall Street Journal*, 31 January 1995, B5.

32. Calculated from plan-specific data reported in "How Good Is Your Health Plan,"

Consumer Reports, (August 1996), 40.

33. B.A. Weisbrod, *The Nonprofit Economy*, (Cambridge: Harvard University Press, 1988), 18-19.

34. As part of its campaign to improve its ability to acquire nonprofit hospitals, Columbia/HCA has been particularly aggressive in arguing that nonprofits do not deserve their tax exemptions, claiming in some instances that nonprofits provide "negative community benefits," although the benefits to which they refer are defined in the narrowest of terms. The famous *Washington Post* quote from CEO Richard Scott is "nontaxpaying hospitals shouldn't be in business." See Kuttner, "Columbia/HCA...", 448.

35. Complexities include whether "charity" patients should have to be designated in advance or whether charity also includes patients who prove unable to pay their bills. In addition, because the costs of services such as a hospital stay can vary enormously from patient to patient, it makes more sense to measure the extent of charity care in dollar terms rather than in terms of numbers of patients. But requiring the documentation of the costs of the services provided to any particular patients -- as opposed to the hospital's *charges* for such services -- could be quite onerous, perhaps requiring the establishment of a new cost accounting system. But, measuring uncompensated care in terms of *charges* would make the amount of charity care an organization provides a function, in part, of the size of the gap between the hospital's costs and its charges. See L. S. Lewin, et al., "Setting the Record Straight: The Provision of Uncompensated Care by Not-for-Profit Hospitals," *New England Journal of Medicine* (5 May 1988): 1212-1215.

36. For an example of the politics of this, a 1993 report by the consulting firm, Healthcare Management Decisions, Inc., for Columbia HCA contended that several Southwest Florida hospitals provided less community benefit than the value of their tax exemptions. The only community benefit that was counted, however, was the hospitals' "charity care" deduction from revenue; even other tangible measures (losses on Medicaid payments, unreimbursed educational costs) were ignored. An independent study of the same topic by a consulting firm hired by the Association of Voluntary Hospitals of Florida using a broader (though still relatively narrow) measure of community benefit, concluded that voluntary hospitals (defined to include both publics and nonprofits) provided much larger amounts community benefits than did for-profits, and substantially more than the value of their tax exemptions.

37. J. Ashby, *The Trend and Distribution of Hospital Uncompensated Care Costs, 1980-1989*, (Washington: Prospective Payment Assessment Commission, 1991). Ashby also shows that the oft-noted higher levels of uncompensated care provided by public hospitals shrink substantially when direct governmental subsidies are counted.

38. Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress*, (Washington, 1996), 84.

39. For example, Connecticut (with about 11% uninsured) and Massachusetts (with about 13% uninsured) have had no for-profit hospitals until the past year, while Florida (about 23% uninsured) and Texas (about 26% uninsured) have large numbers of for-profit hospitals.

40. The 1986 Institute of Medicine report on *For-Profit Enterprise in Health Care* makes this point and summarizes the relevant literature to that date. For subsequent evidence on the point, see L.S. Lewin, et al., "Setting the Record Straight: The Provision of Uncompensated Care by Not-for-Profit Hospitals," *New England Journal of Medicine* (5 May 1988): 1212-1215. See also, B.H. Gray, 1991, and B. Arrington and C.C. Haddock, "Who Really Profits from Not-for-Profits?" *Health Services Research* 25 (June 1990): 290-304. A more recent series of reports on Florida, Virginia, Georgia, and Tennessee for 1993 or 1994 show that for-profit hospitals provide much less than their proportionate share of charity or indigent care (using several different definitions); these reports, which were done by the Voluntary Hospitals of America and by the Atlanta law firm, Parker, Hudson, Ranier, and Dobbs, are based on excellent sources of data. Unfortunately, for our purposes, these reports do not distinguish between governmental and private nonprofit hospitals, with Parker et al. referring to all either as not-for-profits or voluntaries and with VHA using the conceptually more interesting term, Community Owned Hospitals.

41. Ashby's report, cited earlier, notes that the government subsidies received by government hospitals account for virtually all of the oft-reported difference between public and private hospitals in the amount of uncompensated care they receive. Ashby, p. 13. The presence of large numbers of public hospitals may explain why nonprofit and for-profit hospitals provide similarly low amounts of uncompensated care. Brotman reports that no ownership differences in "indigent care" expenses in Georgia, attributing it to a regulatory requirement that all hospitals devote at least 3 percent of revenues to indigent care; however, Brotman does not actually provide any data. See B.A. Brotman, "Hospital Indigent Care Expenditures," *Journal of Health Care Financing* 21(1995): 76-79.

42. D. Rowland, "Hospital Care for the Uninsured: An Analysis of the Role of Proprietary Hospitals," paper prepared for Annual Meeting of the American Public Health Association, 1984; R. Frank, D. S. Salkever, and F. Mullan, "Hospital Ownership and the Care of Uninsured and Medicaid Patients: Findings From the National Hospital Discharge Survey 1979-1984," *Health Policy* 14 (1990): 1-11.

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43. M. Schlesinger, et al, "The Privatization of Health Care and Physicians' Perceptions of Access to Hospital Services," *The Milbank Quarterly* 65(1987), 25-58.
44. L.R. Burns, R.M. Anderson, and S.M. Shortell, "The Effect of Hospital Control Strategies on Physician Satisfaction and Physician-Hospital Conflict," *Health Services Research* 25, (August 1990): 527-558.
45. M. Schlesinger, et al., "Charity and Community: The Role of Nonprofit Ownership in a Managed Health Care System," *Journal of Health Politics, Policy, and Law* 21(Winter 1996): 697-751.
46. Much of this evidence is reviewed in: Institute of Medicine, *For-Profit Enterprise in Health Care*, ed. B.H. Gray (Washington, D.C.: National Academy Press, 1986) and B.H. Gray, *The Profit Motive and Patient Care* (Cambridge: Harvard, 1991). See also: J. Alexander, et al., "Acquisition Strategies of Multihospital Systems," *Health Affairs* 4 (Winter 1995): 49-46; E.C. Norton and D.O. Staiger, "How Hospital Ownership Affects Access to Care for the Uninsured," *Rand Journal of Economics* 25 (Spring 1994): 171-185; A.J. LeBlanc and R.E. Hurley, "Adoption of HIV-Related Services Among Urban US Hospitals: 1988 and 1991," *Medical Care* 33 (1995): 881-891; Prospective Payment Assessment Commission: Staff Report, "Comparison of HMOs Across Paper Types," (January 1995); H.S. Luft and M.R. Greenlick, "The Contribution of Group- and Staff-Model HMOs to American Medicine," *The Milbank Quarterly* 74(1996): 445-468; J. Veloski et al., "Medical Student Education in Managed Care Settings: Beyond HMOs," *JAMA* 276 (4 September 1996): 667-71.
47. M. Schlesinger, "Mismeasuring the Consequences of Ownership: External Influences and the Comparative Performance of Public, For-Profit, and Nonprofit Organizations," working paper 204 from the Program on Non-Profit Organizations, Yale University, (1995).