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Hospital Conversions: Does Not-for-Profit Status Matter?

BY JANE HIEBERT-WHITE

In the past few years, the number of not-for-profit hospitals converting to for-profit status has escalated rapidly. In 1994 about 34 not-for-profit hospitals converted. In 1995 the number of conversions nearly doubled, to 59. This is up from an average of only nine conversions per year in the previous decade.¹

Although the percentage share of not-for-profit versus for-profit beds remained about the same between 1984 and 1994 (70 percent not-for-profit, 10 percent for-profit, 20 percent public), public attention to the conversion phenomenon has begun to grow.² Newspapers around the country are scrutinizing local hospital deals. Last September the television newsmagazine "60 Minutes" focused on Columbia/HCA, the largest of the for-profit hospital chains and a leader in the merger and conversion movement. In December, *USA Today* editorialized: "Hospital sales are just one emerging part of a massive sea-change in the health-care industry. . . . Yet in many communities, hospitals are the focal point of community health care. Assuring that their future is decided openly and with the community interest foremost in mind should be the states' first order of business."³

Along with increasing public concern about hospital conversions has come new state legislation and oversight. The federal government is also beginning to scrutinize the trend. At issue are billions of dollars of public assets, questions about whether ownership status really affects a community's healthcare and social good, and concern about the conversions' impact on the healthcare system.

According to Linda Miller, president of the Volunteer Trustees of Not-for-Profit Hospitals, "The resurgence of conversions of nonprofit hospitals to for-profit status represents the largest potential redeployment of charitable assets in the nation's history. . . . Before we make the leap of faith that capitalism, free enterprise, and the market will cure an imperfect system, we should



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more fully understand what we are getting in the trade."⁴

This column delves into some of the latest policy thinking and activity surrounding not-for-profit hospital conversions. It also looks at such questions as, Why do not-for-profit hospitals convert? What are some reasons for remaining not-for-profit?

STATE AND FEDERAL ACTIVITY

Traditionally, the state attorneys general have overseen conversions of not-for-profit organizations to ensure that their charitable assets are fairly valued (not woefully underestimated, as they have been in a number of cases) and their charitable mission is preserved. Most often, a charitable foundation has been formed with the proceeds of the conversion sale to further the mission of healthcare for the community. "The increasingly active role of state attorneys general in policing conversions is a significant, telltale marker of just how high-risk the conversion and sale of non-profit hospitals has become for communities," warns Miller. In the absence of guidance on conversions from any federal agency—whether the U.S. Department of the Treasury, the Internal Revenue Service, or the Health Care Financing Administration—the state attorneys general have had to sort out which conversions are appropriate and how best to approve and monitor conversions, she said.

In 1996 Nebraska and California passed legislation clarifying the state's oversight process for hospital and health plan conversions and ensuring more public accountability in the process. More than half the states are considering expanding legislation on conversions.

California's law, which took effect January 1, 1997, is viewed by many as a model for other states to help clarify what is a murky process at best. It confirms and clarifies the role of the state attorney general in overseeing conversions. The not-for-profit must notify the attorney general in advance of any plan to convert. Then the attorney

general must hold at least one public hearing in the hospital's county. According to Patricia A. Butler, a Colorado-based health policy analyst and lawyer, the attorney general has the power to determine "that the terms are fair and reasonable to the nonprofit, the sale price is fair market value and has not been manipulated by interested parties, the transaction will not result in private inurement, the sale proceeds will be used in a manner consistent with the organization's charitable purposes, the board has not breached its fiduciary duty of trust, and the transaction is in the public interest and does not adversely affect the availability or accessibility of health care in the community."⁵

At the federal level, Rep. Fortney H. ("Pete") Stark, D-CA, introduced a bill on January 8, 1997, titled the "Medicare Non-profit Hospital Protection Act of 1997" (H.R. 443). In announcing his bill, Stark said: "I have many concerns about the sale of non-profit hospitals to for-profit corporations: too often the terms of the sale are secret; there are often conflicts of interest among the parties; the mission of the non-profit foundation that results from the conversion may not be consistent with the original mission of the hospital—the funds in the resulting foundation are sometimes used for things like sports training facilities, flying lessons, or foreign language programs in schools; and the valuation price is often much less than it should be."

Stark's proposed legislation, modeled after the California and Nebraska laws, would deny Medicare payment to any hospital that did not demonstrate to the secretary of Health and Human Services that the conversion process was fair.

DOES PROFIT STATUS MATTER?

A major policy question that has emerged among state policymakers and the policy researchers who advise them is: Does profit status really matter in healthcare? The literature provides a mixed response.

A new study by Boston University researcher Gary Young and colleagues looked at hospitals in California between 1980 and 1992. They found, among the 17 acquisitions studied, no statistical differences in the amount of uncompensated care (charity care and bad debt) provided before and after acquisition. This led the researchers to conclude: "The acquisition of nonprofit hospitals by

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investor-owned corporations does not lead uniformly to less uncompensated care among the acquired hospitals."⁶ The researchers added, however, that new studies should examine a longer time period after conversions to see if the trend holds up. Some states require for-profit corporations to maintain, for a specified period, the same level of charity care that was provided by the acquired hospital.

Sociologist Brad Gray of the New York Academy of Medicine argues that discussion of who provides more benefit to the community is "plagued by conceptual confusion regarding the meaning of community benefit."⁷ For-profit advocates tend to focus on narrower definitions of community benefit—on uncompensated care alone, for example. The American Hospital Association and the Prospective Payment Assessment Commission have also failed to detect a difference in the aggregate amount of charity care or uncompensated care provided by not-for-profit versus for-profit hospitals.⁸

Not-for-profit advocates argue that a narrower definition of community benefits excludes many positive activities that not-for-profits carry out to a greater degree than for-profit hospitals. These activities and benefits include medical education; research; community needs assessment, education, and service programs; community control and accountability; and trustworthiness. For-profit defenders counter that their hospitals pay taxes—a societal benefit—but there is no consensus among researchers regarding whether taxes should be counted as a healthcare "community benefit," since they rarely contribute directly to the community's healthcare.

Top policy analysts Gary Claxton of the Lewin Group, Judith Feder of Georgetown University, and David Shactman and Stuart Altman of Brandeis University reviewed the literature on this question and concluded that "nonprofit hospitals provide significantly more community benefits than for-profit hospitals provide."⁹ They added, however, "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."

William J. Cox, Catholic Health Association (CHA) executive vice president, offered his reasons why organizational status *does* matter at an October 30, 1996, conference at Georgetown University (sponsored by the Henry J. Kaiser Family Foundation). Cox argued that, since healthcare is a public good, the not-for-profit structure is better suited to protecting this good than is the investor-owned model. "I am not saying that not-for-profit healthcare organizations should be shielded from economic competition," he cautioned. "Properly structured competition can be good for most not-for-profits. I am also not saying that all not-for-profit healthcare organizations act appropriately. Some do not. But the answer to this problem is greater accountability in their governance and operation, not the extreme measure of shifting the balance of our delivery system from not-for-profit to investor-owned."

Cox pointed to important distinctions between not-for-profit healthcare, investor-owned care, and government-sponsored care. "Unlike investor-owned organizations, [not-for-profits] are not designed for the purpose of providing a return on capital to shareholders, and unlike government, they are privately controlled. Properly understood, not-for-profit organizations . . . are designed to improve the human condition."

REASONS FOR CONVERTING

While policy analysts and hospital advocates debate the merits of not-for-profit versus for-profit healthcare delivery, a number of strategic and economic factors are actively pushing not-for-profit hospitals to consider sale to (or affiliation with) an investor-owned corporation. These include:

- The need for market leverage in an increasingly competitive healthcare marketplace
- Access to capital
- Economies of scale in such systems as purchasing, marketing, and information management

Molly Joel Coye, a former senior vice president of the San Diego-based Good Samaritan Health System, explained some of her system's thinking in its recent decision to sell to Columbia/HCA. In addition to the three explicit reasons listed above, she said, "there also was a 'shadow motivation,' unspoken but always present: The board and the administration were increasingly convinced that Good Samaritan's existing local, non-

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profit structure would continue to make it difficult for them to undertake bold actions necessary for future survival."¹⁰

New research into hospital conversion trends further confirms that hospitals seeking conversion are facing difficult market decisions. "Hospitals subject to conversion were generally smaller and appeared to have weaker market positions, judged on the basis of occupancy rates," reported Jack Needleman of Harvard University, Deborah J. Chollet of the Alpha Center, and JoAnn Lamphere of the Barents Group of KPMG Peat Marwick.¹¹ They added, however, that conversion did not substantially change these hospitals' circumstances. The researchers studied hospital conversions from 1980 to 1993 for a report to the Commonwealth Fund.

For-profit hospital representatives argue that investor-owned corporations' superior access to capital is a key ingredient in their success. David Manning, who is vice president of the Columbia Center for Medicaid and the Uninsured, which operates within Columbia/HCA, fears that the onslaught of new state legislation and attention to conversions by state attorneys general and consumer advocacy groups may actually hamper not-for-profit hospitals' ability to compete. "If these parties are successful in stifling the conversion process, nonprofit hospitals will be cut off from the very source of capital that is required to sustain them," he explains.¹²

Federation of American Health Systems President Tom Scully raises a similar concern: "Appropriate state oversight should focus on the performance of hospital boards, not on identifying preferred capital structures. Regulators should facilitate transactions that will improve the quality of care and not create roadblocks to the development of a market that will deliver better care for all Americans."¹³

Some analysts believe that the investment banking community's high valuation of investor-owned hospital systems is fueling the recent trend toward conversion. Most for-profit hospital chains have price/earnings multiples in the 15 to 25 range. Columbia/HCA's price/earnings multiple was 18, as of January 31, 1997, reports economist Gerard F. Anderson of Johns Hopkins University. Anderson notes that not-for-profit hospitals typically are valued at a far lower price/earnings multiple of 6. He concludes that

Continued on page 16

SPONSORSHIP

Continued from page 15

Lay and religious have in common the notion of healthcare as a mission of the Church.

name more clearly and develop more explicitly the commonality."

A TIME OF OPPORTUNITY

We are in a time of tension between mission and business, of new types of partnerships, shifts in traditional relationships, and challenges to organizations' Catholic identity, participants agreed. The challenge, they said, is in reconciling different views of reality—business, mission, and professional.

"This is an opportunity to influence others, to use our roots," remarked Br. Peter Campbell, CFX, JD, then CHA's vice president of sponsor services. "We can't allow the market-driven imperative to win out," he insisted, pointing to managed care as an example of an endeavor that "can be done in the spirit of the early sisters."

THEOLOGICAL FOUNDATIONS

Informed by the thinking of forum participants, Sr. Talone and Gallagher will develop a document on the theological foundations of sponsorship. Attendees at a concurrent session at the 82nd Catholic Health Assembly, June 8-11, will critique a draft; the final document will appear in late summer. The document will aid sponsors in continuing the dialogue about the institution of sponsorship itself and, through reflective questions, help sponsors in future decision making.

—Judy Cassidy

HEALTH POLICY

Continued from page 12

"acquisitions of nonprofit hospitals by for-profit chains are likely to continue until the two multiples are more in line."¹⁴

REASONS TO REMAIN NOT-FOR-PROFIT

With strategic and economic forces pushing more not-for-profit hospitals to consider alliances with for-profit hospital chains, why should they retain their not-for-profit status? Kaiser Permanente Chairperson and CEO David Lawrence cites not-for-profits' commitment to sustain research, education, and community benefit activities over the long term. "We do not believe that the profit margins in health care [for investor-owned corporations] will be sufficient to sustain investment in direct community benefit and still meet shareholders' expectations," Lawrence writes.¹⁵

Brad Gray outlines several additional benefits of not-for-profit providers, suggesting that their tax-exempt status provides a useful regulatory tool for policymakers. They can use this lever to establish charity care requirements and other benefits for society in a way that is not available with for-profit healthcare corporations.

Trustworthiness is another area where Gray believes not-for-profits have an edge. "There are theoretical reasons, and some evidence that is consistent with those reasons, to suggest that trustworthiness problems [such as conflict of interest, patient information and care decisions, and adverse selection] may grow in concert with the growth of investor control of health care organizations."¹⁶

As Catholic hospitals strive to compete in an increasingly for-profit healthcare arena, each would do well to reinforce why it wants to remain not-for-profit, continue to measure what level of community benefit it is providing, and seek means of strengthening market share and access to capital to survive into the twenty-first century.

As CHA's Cox reminds us, "Today's uninhibited, price-competitive health-care markets strongly encourage healthcare organizations—including not-for-profits—to pursue private interest at the expense of public service. This development may be doing more than any other factor to undermine the public trust in not-for-profit healthcare organizations." □

NOTES

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