Nonprofit to For-Profit Hospital Conversions: Policy Implications and Alternatives

By Beth A. Tapper

The changing health-care market has resulted in shifts in the ownership status of hospitals in the United States. Many nonprofit hospitals are being sold to the for-profit sector and foregoing their philanthropic roots for greater access to capital. Consequently, communities are often left without adequate and accessible care for the indigent and charity care has diminished in many circumstances. Concerns over these changes have heightened public policy concerns over the quality of care and loss of community benefit. This article will discuss policy alternatives to these problems and offer viable solutions to many of the challenging outcomes of hospital conversions.

Changes in hospital ownership have provoked concern in the health policy arena, as many nonprofit hospitals have responded to market pressures by giving up their tax-exempt status and selling their assets to for-profit corporations. Consequently, as the pace of these changes has accelerated in recent years, conversion among hospitals from nonprofit to for-profit status has become a focus of national debate. These conversions represent the largest potential redistribution of charitable assets in the nation's history (Shactman and Fishman, 1996). Critical questions for policy makers have emerged: what effect will such changes have on the public benefit, and how can charity care continue to be delivered? Concerns about the viability of the nonprofit hospital and its philanthropic history in the health-care sector have prompted policy makers to evaluate the implications of conversion for the hospital industry, patients, and communities.

A fundamental concern is whether conversion of ownership from nonprofit to for-profit makes a difference in delivery of health care. It is unclear whether conversions will result in a loss of community benefit, but conversions may pose the risk for a drop in charity care, placing both uninsured and

underinsured individuals at a greater disadvantage. While some research comparing nonprofit and for-profit hospitals shows that for-profit hospitals inflate prices, raise expenditures, and neglect social obligations, policies can be enacted to protect patients and continue charitable care (Woolhandler and Himmelstein, 1999). Such policies should reflect current health policy goals that preserve valued functions and resources in the context of a competitive health-care marketplace. This article will discuss policy alternatives to this problem and offer viable solutions to many of the challenging outcomes that it creates. Further, this study will discuss and evaluate three policy alternatives: organized regulation and accountability, public participation in governance, and protection of charitable assets through the development of new foundations.

BACKGROUND

The majority of hospital conversions have occurred over the past two decades. Beginning first in the early 1980s and then resurging again in the mid-1990s, there have been increases in acquisitions by for-profit companies (Collins, Gray, and Hadley, 2001). Nonprofit hospitals often view selling to a for-profit company as the best alternative to ensure survival in an increasingly competitive marketplace. Hospitals are selling their assets to gain a number of perceived advantages, including access to capital markets, relief of debt burden, increased efficiency, and greater purchasing power. A hospital may also be motivated to convert in order to avoid closure, to continue the hospital's mission, to preserve or expand market share, or to reduce regulatory constraints (Cutler, 2000). Financial rewards inherent in for-profit ownership may provide incentives for hospitals to contain costs and respond effectively to patients' needs. Conversely, the opportunity to earn profits may lead hospitals to cut corners, take advantage of patients, and adopt a profit-maximizing strategy. How will communities fare with for-profit hospitals? Who will ensure continued access to care for the uninsured and other vulnerable patient populations? Will nonprofit organizations receive a fair price for their hospitals? Is there a process to ensure that the charitable assets will continue to serve the public interest? These questions need to be addressed by policy makers when evaluating the implications of conversions.

COMMUNITY BENEFITS AND THE VALUE OF NONPROFIT HOSPITALS

The retention and safeguarding of nonprofit hospitals is important for many reasons. Three rationales support special status for nonprofits: charity care, community benefits, and consumer protection (Marsteller, Bovbjerg, and

Nichols, 1998). In exchange for favorable tax exemptions, nonprofit hospitals are required by law to satisfy certain social obligations, including the delivery of charity care and other services to the indigent. There are also numerous community benefits to having a nonprofit hospital serve a community, provide charitable care, and steer charitable giving. Conversely, profit-driven concerns for efficiency are motivations among for-profit hospitals. For-profit providers answer to shareholders and focus on the bottom line. It is also asserted that for-profits provide less care for the uninsured, fewer unprofitable services, less medical teaching and research, and less accountability to the community (Claxton et al., 1997). Nonprofit ownership may therefore enhance the potential for community benefit, while for-profit ownership may preclude quality patient care and equal access.

Defining and valuing community benefits is important, because nonprofit hospital conversions may reduce these benefits. First, measurements of community benefits include a hospital's provision of charity or uncompensated care (Claxton et al., 1997). Nonprofit hospitals view the provision of uncompensated care to those who are unable to pay as a major part of their mission. Second, nonprofit hospitals spend a considerable amount of time and money on medical research and education. This investment provides community benefit. Third, non-reimbursable or unprofitable services, such as 24-hour emergency room trauma care and burn centers, are often provided at a loss to the hospital. Fourth, community representation on the board is a community benefit because hospitals may be more receptive and responsive to local health care needs, and this may be an indicator of the hospital's interest in serving the needs of the community (Young and Desai, 1999). Lastly, community benefits may include broader views, such as minimizing the burdens of cost to families and contracting with essential community providers (Gray, 1997).

Opponents of conversions have pointed to evidence that, compared to nonprofit hospitals, for-profits provide fewer services benefiting the broader community (Gray, 1997; Claxton, et al., 1997). Hospital conversions usually involve the sale of a nonprofit institution's assets to a national for-profit chain that is often headquartered elsewhere. Nonprofit hospital directors generally live in the hospital service area, interact with local residents, and have direct interests in the community's health-care needs. When a nonprofit hospital is sold to a for-profit corporation, these local sources of influence and control are reduced. For-profit hospitals may be less likely to undertake unprofitable programs that improve health, because decision makers have fewer ties to the community (Horwitz, 2002). Conversions of nonprofits to national for-profit chains may therefore cause hospitals to lose their local identities and neglect

community benefit.

Conversions may establish a divide between the hospital's mission and the needs of the community it serves; unprofitable community services and charitable care are lost, and communities are left with fewer of the valued benefits. Consequently, the pressure to make a profit can render the for-profit hospital unreceptive to the needs of the host community. Proponents of conversion argue that any community losses from conversion are offset by financially strengthened institutions, an increase in community tax revenues, and the redirection of nonprofit assets to other charitable purposes. Conversion advocates argue that with the inclusion of increased tax revenues, for-profit hospitals provide greater benefit than their nonprofit predecessors (Marschke, 1997). Proponents also maintain that in some oversaturated markets where failing hospitals might be of questionable value to communities, for-profit owners of multiple hospitals in the same markets claim to benefit the community and reduce redundancy by shutting down institutions that nonprofit boards were unwilling to close (Gray, 1997).

RESEARCH ON CONVERSIONS: ARE THEY REDUCING QUALITY AND SACRIFICING CHARITY CARE?

A vast amount of research examining the conversion process and its implications reveals conflicting arguments between opponents and proponents of conversions. Some national data suggest only minor differences between nonprofits and for-profits in the provision of charitable care, while others suggest that differences are more readily apparent when making comparisons within specific states. Some research has shown that conversions can lead to lower quality health-care delivery coupled with greater costs to both consumers and insurance companies.

A large study by Sara Collins, Bradford Gray, and Jack Hadley (2001) examines conversions and their long-term impact on community benefit activities and financial performance. In Illinois, for example, Michael Reese Hospital was purchased by Humana in 1991 as part of deal to purchase the hospital-owned HMO. Collins and associates (2001) assert that community benefit appeared to decline post-conversion. At the time, it was a 600-bed prominent teaching hospital on Chicago's near south side. Collins and colleagues (2001) find that after conversion, it shrunk to 150 beds, with little teaching or research. Moreover, the hospital underwent three ownership changes and several changes in administration under each of its owners. The teaching and research activities went into a decline after Humana purchased

the hospital in 1991. Neither Humana, nor it successor, Columbia/HCA, had substantial experience running a teaching hospital and their management de-emphasized that aspect of Michael Reese's activities (Collins et al., 2001). As part of its teaching and service mission, the hospital had also operated several specialty outpatient care clinics that served the local community. The new management consolidated and closed some of the clinics.

A review of 20 available studies of community benefits finds that non-profits provide significantly more community benefits than do for-profits, particularly when comparisons are made among hospitals within a given state (Claxton et al., 1997). It also finds a wide variation among nonprofit hospitals, with public and large teaching hospitals providing a disproportionately larger share of community benefits (Claxton et al., 1997).

Other literature reveals that problems with conversions can often lead to negative and unforeseen outcomes. A study by Gary Young and Kamal Desai (1999) examines the impact on communities of conversions of nonprofit hospitals to for-profit status. They conclude that after conversions, hospitals shift the composition of their governing boards, including fewer community representatives and more hospital senior management (Young and Desai, 1999). Some research shows that hospital conversion from nonprofit to for-profit status is more costly per patient, and is associated with a decrease in the ratio of staff to patients (Mark, 1999). A study by Steffie Woolhandler and David Himmelstein (1999) in the *New England Journal of Medicine* concludes that for-profit hospitals are more expensive than nonprofit facilities. For-profit hospitals cost Medicare an additional $732 per enrollee, or an extra $5.2 billion annually. They also assert that prior research confirms that for-profit hospitals are 3 to 11 percent more expensive than nonprofit counterparts. So too, for-profits spend more on overhead and administration costs while hiring fewer nurses, providing less charity care, and allowing patients fewer days of inpatient care (Woolhandler and Himmelstein, 1999). However, these findings do not indicate that the for-profits are less efficient. Benefits may accrue from the for-profit emphasis on a streamlined workforce and shorter inpatient stays.

Another study by Gabriel Picone, Shin-Yi Chou, and Frank Sloan (2002) examines mortality rates among nonprofit hospitals and those that converted to for-profit status. They find that among hospitals that converted from non-profit to for-profit status, there was a statistically significant increase in mortality rate at 1 year following conversion. These effects persisted for first 2 years following conversion, but disappeared after 3 or more years. There was a similar pattern for mortality at 30 days and at 6 months after hospital admission, but effects were not statistically significant at conventional levels (Picone,

Chou, and Sloan, 2002). As a result of many of these studies, a growing body of research shows that patients in for-profit hospitals receive a different level of care than those in nonprofit settings. This underscores the need for greater oversight and regulation. These findings, however, could be explained by the adjustments, such as acclimating to new management and staff, that take place in the conversion process. Further, long-term studies are needed to ascertain whether or not these differences will be important in the long run.

CURRENT POLICY PROBLEMS AND CONSEQUENCES

Although the benefits of efficiency and competition may lead to a more streamlined health-care system, the ramifications of allowing hospital conversion without adequate policies for regulation are cause for great concern. Whether nonprofit and public hospitals should be allowed to convert to for-profit status continues to be an issue of contention. If so, what are the parameters of, and restrictions on such conversions? Since the primary motivation of the for-profit is concerned more with the profit margin, policy needs to be altered and more strictly enforced. Policy should outline regulatory standards that force for-profit hospitals to adhere to similar procedures of accountability and practice of nonprofits. Standards and hospital practice should include recognition of social obligations to vulnerable populations and community involvement. Goals should consider including measures of community benefit, including uncompensated care, provision of unprofitable services, price discounts, and community representation on governing boards.

Regulation and oversight has also been a problem in hospital conversions. To date, there is no comprehensive federal oversight of hospital conversions. State laws generally do not specify a supervision process, and many state legislatures have not fully considered the public policy issues related to the conversion activity. In addition, many states lack the resources necessary to sufficiently deal with the complexity of the conversion transactions. A study by Jill Horwitz (2002) explores the current trends of hospital conversions from nonprofit to for-profit status and how the well the public interest is protected. Many times, converted assets, meant for charitable purposes, are not accurately valued and are transferred to for-profit buyers or executives of the nonprofit sellers (Horwitz, 2002). One failure of the current system is that assets have been sold for less than their fair market value (Shactman and Fishman, 1996).

While the state's attorney general is typically charged with overseeing these transactions, he or she may suffer from a lack of knowledge on the subject, and may not always receive sufficient notice of conversions (Horwitz,

2002). In Illinois, for example, the attorney general is not given notice of a conversion; it is only after the conversion occurs that any possible oversight may be conducted (Horwitz, 2002). Many nonprofit hospital sales have been conducted in private, often with only a small cadre of the board and management privy to the transaction terms. The community is often unaware of the pending sale, its price, structure, or terms, and is often denied opportunity to provide input. Such exclusion contradicts hospitals' stated commitment to public benefit, and leaves communities vulnerable.

Given the inconsistencies in provisions and regulations, it is relevant to ask whether and how proposed conversions affect health-care delivery. Since health care is not only important to individual welfare, but also serves to improve the public good, a key component of the analysis of a proposed conversion is the extent to which the resulting for-profit entity will alter or abandon the predecessor's charitable nonprofit mission. If the health-care industry currently seeks to lessen the disparity in access to health care amongst racial and socioeconomic groups and to decrease incidence of disease, then the industry should ascertain how hospital conversions are either helping or hindering these objectives. Will race, class, and access to care continue to stretch and challenge the legitimacy of private, for-profit ownership? Are for-profit objectives congruent with those of nonprofit hospitals? In light of these concerns, greater public oversight is needed to scrutinize the valuation of conversion targets, to develop strategies that stabilize access to care, and to maintain community benefit. In order to develop standards for the disposition of community assets, it is important to gain a better understanding of the impact of conversion on the financial stability of hospitals, on the range of services that they provide, and on access to care in the community.

THREE POLICY ALTERNATIVES

Regulation

Effective regulation of hospital conversions is needed to protect the public interest in two important areas: heath and money (Horwitz, 2002). Proposed alternatives to the current systems of inadequate oversight include the creation of stronger regulations, as well as state and federal guidelines that provide a framework for conversions. To ensure that community benefits are fulfilled, regulation should require minimum standards of care. Conversions affect not only health-care organizations, but also 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. States differ greatly in the level of stringency that their charitable trust laws apply to hospital conversions. Some states have enacted legislation or used regulatory powers to negotiate with for-profit successors to ensure continuation of specific levels of charity care and health services after conversion. In some states, public officials (mainly attorneys general and insurance commissioners) have aggressively pursued individual interpretations of charitable trust and other laws to oversee conversions and promote public involvement. In other states, however, officials have been more reactive.

Therefore, to address these inconsistencies, states should establish a formal oversight process that is backed by federal policies, and that process should be enacted legislatively. Federal guidelines for states should include five specific measures. First, new federal guidelines should require detailed descriptions of how charitable assets and purpose are being preserved by for-profit successors. Without public consideration of the amount of money set aside and for designated purposes, conversions threaten to eliminate significant community resources and services. Second, federal guidelines should permit ownership conversions to occur only if the social benefits of for-profit ownership exceed the social costs (Robinson, 2000). Conversion, then, should not be based solely on the needs of the hospital owners. Owners must consider the implications of the event for patients and the needs of the community. Third, federal guidelines should require states to monitor local market conditions through community-benefits assessments (Marsteller et al., 1998). This will allow states to assess what is gained and lost from conversion. Fourth, federal mandates should require states to designate an official, such as an attorney general, who will be notified of a possible conversion. If conversion occurs, attorneys general must demonstrate formal oversight and ensure that public benefit will not be compromised in the process. Finally, the government should regulate the conversion rate of hospitals so that there is a proper balance of for-profit and nonprofit hospitals. Competition and balance between nonprofit and for-profit hospitals may result in lower costs and improved market performance.

The health policy issues that arise in conversions might be best addressed by a team of state experts. Such teams might include health officials, policy makers, and hospital administrators. This approach has not been widely adopted to date, but some state regulators are looking increasingly to others in government for assistance (Shriber, 1997). Policies should establish an efficient and accountable process through which possible conversions can be evaluated and actual conversions managed. Since many for-profit hospitals are owned by

larger national entities that may own several hospitals in numerous states, it is only reasonable to create national guidelines on how hospitals can manage newly acquired assets. By overseeing the appropriate disposition of nonprofit assets in individual conversions, tighter control will be gained over how money is spent and resources are allocated.

To ensure that state regulators appropriately and systematically address the policy issues raised by conversions, 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 (Claxton et al., 1997). A few states have passed such legislation. These legislative initiatives address 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 review; the requirement for independent and accurate valuation of assets; the definition of 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 (Gray, 1997). Regulations that are too stringent, however, can be used to protect the status quo. Such regulations may also stifle the competition that could result in 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

A second policy alternative is to incorporate public participation in the conversion process. This alternative recognizes that community health policy issues should be decided by those who are most affected. Despite the potential impact of conversions on a community's health-care services and charitable assets, there is typically no process for the community to express views, raise objections, and intervene in conversion decisions (Claxton et al., 1997). Potential ways for the public to participate in conversions might include public hearings, formal input into a regulatory process, creation of legal standing to challenge transactions, and input into the disposition of charitable assets (Claxton et al., 1997). This job should be delegated to public servants with substantive health-care and policy training (Horwitz, 2002). It would also be advantageous if policies required some community representation on governing boards. 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, unobtrusive regulatory process. Although these hospitals may be private and ownership is typically not local, they can adopt individualized identities and ties with communities. With public participation, there is greater likelihood that community needs will not be overlooked. This will encourage continuity of service in the conversion and may foster trust in the community, instead of skepticism.

New Charitable Foundations

Finally, policy alternatives that ensure access to charity care can be achieved by creating foundations that fund the charitable care formerly provided by the nonprofit. A good way to ensure this is to encourage the creation of new, joint-venture foundations. When a charitable organization is dissolved, issues arise regarding the creation, initial governance, independence, and mission of the new charitable foundations that are being established to carry out the hospital's original charitable purpose. Here, a joint venture between the nonprofit hospital and the for-profit successor would result in a partnership to manage the assets transferred by the nonprofit in conversion. This joint venture would exist as a nonprofit foundation. The nonprofit hospital would contribute its charitable assets in exchange for cash and ownership interest in the new venture. The for-profit entity would contribute capital to the joint venture, receiving an ownership interest of 80 percent (Claxton et al., 1997). Consequently, the foundation would become the holder of the nonprofit hospital's 20 percent interest in the new venture. In 1996, for example, there were 60 such foundations with over $5 billion in assets (Claxton et al., 1997). Such foundations would ensure that the public good is still maintained in some capacity.

When forming joint ventures, states should require that all proceeds from a conversion transaction between a nonprofit hospital and a for-profit entity be placed in a foundation independent of the parties involved in the transaction. This transaction and the transfer of proceeds to an independent foundation should be overseen by agencies that govern nonprofits. This would ensure that the foundation is responsibly using proceeds of the sale and maintaining a strong level of community benefit. In doing so, overseers can prohibit officers and shareholders involved in the transaction from serving on the foundation. Regulators would also require the foundation to dispose of proceeds arising during conversion from the sale of a community benefit asset. Disposal of the assets should be completed in a manner consistent with the community benefit purposes of the asset.

EVALUATION OF POLICY ALTERNATIVES

Regulation

As previously noted, conversions are most often regulated by attorneys general, but there are many barriers to effective oversight. Depending on the organization of a state attorney general's office, one of several divisions may oversee conversions. These divisions include: charities, consumer protection, corporations, health care, taxation, and trade regulation (Horwitz, 2002). In an extensive review of state conversions, Horwitz (2002) concludes that although many states are using attorneys general to monitor conversions, the process is filled with inconsistencies and problems. By obtaining data from 32 states and their attorneys general, Horwitz (2002) finds that current and developing oversight methods do not adequately protect the interests of the public. Horwitz also finds that the great majority had primary authority to oversee hospital conversions (Horwitz, 2002). However, in 7 of the 32 states studied, state attorneys general did not oversee conversions. Horwitz notes that in West Virginia and Louisiana, for example, attorneys general are barred from reviewing conversions because the states will not agree to be a party in an action against a for-profit buyer (Horwitz, 2002). Therefore, despite a statutory method that appears to encourage oversight, the attorneys general have not reviewed any conversions. The striking similarity of responses across states in Horwitz's research, however, suggests that the results can be used to identify emerging laws and policies, anticipate trends, and draw conclusions about these approaches (Horwitz, 2002).

Another research study by David Shactman and Andrea Fishman (1996) examines how many states have passed legislation specific to conversion. The findings reveal that most states have not initiated legislative or regulatory action specific to hospital conversions. Among the states that have, the regulation varies considerably (Shactman and Fishman, 1996). Moreover, they find that some states have negotiated with successor entities for provision of minimum levels of charity care and other community benefits. A few states, such as California and Nebraska, have enacted legislation that specifically mandates consideration of future benefits to be provided to the community after a conversion (Shactman and Fishman, 1996). These, however, are the only two states with statutes that require notification of conversion. Legislation passed in many other states sets standards for conversions. The clear propensity for discontinuity in the conversion process is demonstrated by the reported variations in oversight by attorneys general (Horwitz, 2002) and the policy differences

across states (Shactman and Fishman, 1996).

Charitable Foundations

As a result of conversion trends, assets of new charitable foundations have been on the rise (Williams and Brelvi, 2000). Foundations around the country fund a variety of health activities in their communities, health and wellness programs, women's health services, and substance abuse treatment programs (Williams and Breivi, 2000). In Chicago, for example, many conversions have resulted in the creation of charitable trusts. The Michael Reese Health Trust is the largest foundation in the Chicago area dedicated exclusively to funding health care, particularly health care that meets the needs of vulnerable and underserved Chicagoans. The trust is now valued at over $100 million (Collins et al., 2001). Conversions involving joint ventures, though, sometimes are not considered in existing regulatory procedures. For example, conversions that are structured as joint ventures often do not generate government oversight (Horwitz, 2002). In the Michael Reese case, for example, Humana negotiated a 4-year, front-loaded, $54 million subsidy to be paid as part of the sale by the Michael Reese Health Trust (Collins et al., 2001). If proper oversight was in place, the trust would not have used any of its money to fund the hospital. Despite the establishment of newly formed ventures, room for improvement can still be achieved through regulation.

MOVING TOWARDS A BETTER POLICY ALTERNATIVE

Ownership status alone is not likely to determine a hospital's commitment to the community or to safe, quality care. Without clear lines of accountability to the community and clear standards for community services and quality care, it cannot be assumed that merely maintaining a hospital's nonprofit status will ensure preservation of the traditional mission. Among the three policy alternatives presented, no one alternative is more important than the others. Rather, it is most important that policies enable more comprehensive regulation, ensuring the fairness of conversion across all states. The past few years, however, have shown a marked increase in regulation and in standardizing procedures. Most states attorneys general are now involved in some supervision of conversions, even if that oversight is frequently inconsistent. The development of new foundations also serves as a viable alternative to banning conversions. These foundations can then fund the charitable care formerly provided by the nonprofit hospital. Foundations may also provide added benefit to communi-

ties. Due to overwhelming structural problems and red tape, such foundations may be managed more efficiently and better able to target vulnerable populations that the nonprofit hospital.

CONCLUSION

Nonprofit hospitals may enhance the potential for community benefits and protect the assurance of equal and accessible care. Because conversions represent sources of federal and state tax revenues and capital can be made on these transactions, it is difficult to enact legislation that will curb the sale of these hospitals. It is evident, though, that if nonprofit hospitals continue to be converted without adequate public oversight into private, competitive, for-profit entities, vulnerable populations will see additional declines in adequate, accessible health services. With an influx of hospitals converting to the for-profit sector, these issues need to be addressed through policy changes at the state and federal levels. Policy to address this problem should incorporate stimuli from the public hospital sector, government regulatory agencies, and the community at large. Such stimuli should be based on stronger guidelines for provision of charity care. Efforts should also address the needs of vulnerable populations while ensuring comprehensive state and local monitoring of performance. Further, federal and state policies should require strong public oversight of conversions and mandate direct community control in determining a hospital's community benefits. These practices should be implemented across all states. Consequently, no one policy alternative will be sufficient. The problem requires a collection of approaches and solutions. New policies must be adopted and enforced. If this occurs, conversions may someday be viewed more favorably by those who so outwardly criticize them now. ■

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