THE CAPITOL FORUMS
On Health & Medical Care

WILL THE BUSINESS AND FINANCIAL REALITIES OF THE 21ST CENTURY ELIMINATE THE ROLE OF STATE GOVERNMENT IN HEALTH CARE DECISION MAKING?

PART II
CONVERSIONS – PROCESS, PROTECTION, PROFIT

The League Of Women Voters of New Jersey

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ISSUE: The health care marketplace continues to change at an unprecedented pace. Competition is the definitive driving force behind the changes. It still waits to be seen what combination of nonprofit and for-profit providers and insurers will survive the changes and rise to the challenge of meeting the country's health care needs in this new landscape.

Traditionally, not-for-profit community hospitals and nonprofit health plans (such as Blue Cross and Blue Shield plans) have formed a significant part of the American health care system's infrastructure.[1] As the trend towards the converting of these health care entities to for-profit status continues, how will the health care system be affected in terms of access, quality and costs? What role will government have in this new environment of conversions, mergers and consolidations? How will New Jersey protect the public interest?

INTRODUCTION

In a scene from Milan Kundera's contemporary novel, *The Unbearable Lightness of Being,* the protagonist — a young Prague physician — is discussing with his friends the political and socio-economic changes that have occurred in eastern Europe during the 20th century. As the group ponders how the various leaders differ — whether communists, socialists or capitalists — they unanimously reach the same conclusion: they are all scoundrels, no matter what "label" they are wearing. And in many cases, they are the same people; they are just wearing different hats.

In today's current health care environment, critics from all sides are quick to point to the "scoundrels." But the solutions are more complicated than that. And it behooves all players to take the time to ascertain how the new landscape of the health care industry will be laid out, while retaining quality health care that is cost-efficient and equitably accessible. This issue brief is the second part of a discussion on nonprofit health care and the national trend of the shifting of not-for-profit hospitals, health care providers and nonprofit health plans (such as health maintenance organizations (HMOs) and Blue Cross & Blue Shield plans) to for-profit status through mergers, partnerships, acquisitions and conversions.

FOR-PROFIT VS. NONPROFIT HEALTH CARE - IS THERE THAT MUCH OF A DIFFERENCE?

As discussed in the October 23, 1996 Issue Brief, nonprofits are re-structuring and consolidating in several different ways: as a buyout by a business corporation; by amendment to the not-for-profit organization's articles of incorporation; as a "spin-off" in a corporate re-structuring and by merger with a for-profit entity, with only the for-profit entity remaining intact after the merger (Shields et al, 1991). Some recent conversions of hospitals have taken the form of partnerships, either a limited partnership or a limited liability company between the not-for-profit entity and the for-profit corporation (Challot 1996). The recent trend of joint ventures or 50-50 partnerships is of concern because of the question as to whether or not the investment is an appropriate use of charitable assets and/or a good risk for the community. Each variation in the merger and acquisition activity creates another set of pub-

[1]For purposes of this brief, the term "nonprofit" will be used as a generic reference to both not-for-profit and non-profit entities.

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lic policy issues regarding oversight and monitoring of these transactions, which involve significant amounts of charitable assets.

The practice of conversions forces the issue of the very nature of the health care system, which has long been the only enterprise that has large numbers of nonprofit and for-profit entities operating within its parameters. Several public policy questions are raised by the conversion activities: do nonprofit providers offer more charity care and community benefits than for-profits; should there be requirements to do so for both nonprofits and for-profits; what would be the nature of a market dominated by for-profit providers; are communities "better off" after conversions; and should the conversion process be regulated and if so, to what extent (Shactman & Altman, 1996). Each of these questions is comprised of complex contingency questions; and there are no easy answers. At present, there is little standardization regarding oversight of conversion activities, and the responsibility for rising to the challenge of these issues falls to the state level of governance.

Supporters of for-profit conversion contend that it will create a more efficient and market-oriented system, resulting in more affordable health care (Shactman & Altman, 1996). They commend the formation of charitable foundations, targeted for health care needs specific to states and regions. Critics of the conversions have great concerns that for-profits will not provide necessary health care services to their communities, will reduce charity care and will not support graduate medical education. Further concerns are that in the absence of strict monitoring and oversight, conversions will result in the loss of charitable assets. Federal and state laws require that charitable assets must be used for the same "charitable" mission or purpose as the nonprofit entity. The assets may go either to an existing 501(c)3 organization, or to a newly created foundation.

Two 1996 studies in progress (being conducted by the Alpha Center and the Council on the Economic Impact of Health System Change) are looking at the effects of conversions on nonprofit hospitals and health plans, and the regulatory environment in which they are taking place. Both research groups point out the importance of ongoing, empirical research on the impact on communities when a nonprofit hospital is converted to a for-profit hospital and a charitable foundation. It is also noted that while research regarding the measurement of charity care and community benefit is riddled with methodological differences, some preliminary findings indicate that nonprofits do provide significantly more charity care than their for-profit counterparts. The authors cautioned that national aggregate data regarding the for-profits' commitment to charity care was statistically unreliable because most for-profit hospitals are located in areas that have low needs for the provision of charity care. For-profit hospitals were found to be more aggressive in seeking operating efficiencies, especially in the area of staffing levels (Shactman & Altman, 1996).

In the 1996 Alpha Center working paper, the researchers noted that "despite growing levels of conversion activity and public concern in many states, available information about conversions by not-for-profit hospitals and health plans to for-profit is extremely limited" (Challot et al., 1996). As to the question of whether or not and how well vulnerable populations continue to be served after conversion, available information precludes a fair assessment. Across the states, financial arrangements that are made to support indigent care differ, as do the terms regarding how the new for-profit entity will provide such care.

FOR-PROFIT CONVERSIONS - WHY NOW?

While the mergers and takeovers in the late 1980s and early 1990s primarily involved large for-profit hospital chains acquiring for-profit hospitals, the mid-1990s have seen the acceleration of takeovers of nonprofit hospitals by the for-profit chains. In 1995, 59 nonprofit hospitals were sold or joint-ventured to for-profit organizations (Ibid). By the end of 1996, it is expected that more than 100 hospitals once controlled by state and local government, religious organizations or community boards will have been purchased by for-profit investors (*The Wall Street Journal,* October 18, 1996).

The trend of for-profit hospital chains looking to nonprofits has been triggered by many inter-related factors: consolidation has already occurred amongst the country's for-profit hospitals (which number over 700); the approximately 4,500 nonprofit hospitals have billions of dollars of assets, are valued in the community and often have teaching hospital affiliations already established (Ibid). These nonprofits are experiencing reduced funding from governmental sources, aggressive competition from managed care entities, and are in need of access to capital in order to survive and compete in a deregulated marketplace. They contend that increased capital will allow them to compete on a level playing field; it would be used to develop new products and services, such as information systems. Both nonprofit providers and health plans assert that health care "giants" like Humana, Aetna, Tenet Healthcare and Columbia/HCA have the ability to raise capital and gain greater market share, which they do not have under their current nonprofit status (Ibid).

OVERSIGHT AND MONITORING - WHO'S IN CHARGE?

The conversion process is extremely complex and rife with technical details, such as asset valuation, transaction analysis, structure, issues of private inurement and conflict of interest (Miller, 1996). In most states, oversight authority of conversions from nonprofit to for-profit status (whether providers or insurers) rests with the attorney general, who technically is the only party in the state legally empowered to represent the public interest (Ibid). Since 1995, when more than $1.6 billion of community hospital assets were sold, attorneys general throughout the country have been confronted with the challenges of identifying their roles in the process and applying appropriate legal tools in the oversight process. The conversions of the nonprofit entities is a "new phenomenon" on many levels: the sheer number of conversions, their scope and the resulting new structures (Ibid).

The attorney general's responsibilities in assets sales are driven by legal authorization under common law. Specifically, the doctrine of *cy pres* (regarding the re-formation of a charitable trust or foundation); the doctrine of *parens patria* (that the attorney general, as the officer of the sovereign, represents the people and the public interest); and the writ of *quo warranto* (which relates to nonprofit corporations and the attorney general's right to take action on proposed changes given to an original charter granted by the state to the nonprofit) (Cambridge Partners *Brief,* 1996)

How broad or how narrow the role of the attorney general is to be has varied from state to state. In a recent talk in Washington, DC, California Deputy Attorney General Jim Schwartz discussed the attorney general's role in conversion transactions (Council on the Economic Impact of Health System Change, October 1996, meeting). He emphasized that the role is one of enforcement and protection of the public good and interest; it is not a role of regulator. The transaction is reviewed within the parameters of trust law. Oversight by state attorneys general may require that the parties submit proposed transactions for advance review and approval, and the attorney general has the authority to impose requirements as conditions for approval.

As a result of the great number of conversion transactions (Deputy Attorney General Schwartz estimated five transactions involving thirteen hospitals in the last year, as well as the conversion of California Blue Cross), legislation was passed setting forth requirements for conversions in California. The California law requires that public meetings be held and that procedures of the attorney general's office are a matter of public record. Financial details of the conversion transaction are also public information, because the assets being valued and transferred are public assets.

ACCOUNTABILITY AND COMMUNITY BENEFIT

Hospital and health plan conversions raise a number of issues for communities regarding community benefit. Answering the questions of how community benefit is defined and the ways in which it is measured once a definition is agreed upon is a complex process. The answers are critical, however, in order to evaluate accurately the performance of nonprofit and for-profit health care providers. Community benefit involves looking at several activities, including the provision of charity care in the community; the level of access to care; support in research, education and training; the provision of unprofitable but essential health care services, such as emergency room and trauma units, and the entity's participation in maintaining and ensuring the public health of the community. (See table in Appendix 1.)

According to a recent Alpha Center research analysis of conversion activity throughout the country, "available information does not allow a careful assessment of how well vulnerable populations continue to be served when public or nonprofit hospitals convert to for-profit ownership or management" (Challot, 1996). Further, fragmented and unreliable data make it difficult to track whether or not communities experience any change in essential (but unprofitable) services. In some cases, however, when there was active community involvement in establishing the terms of the conversion and the ongoing management of the for-profit hospital, the community's interest in maintaining these services appeared to be protected (Ibid).

CONVERSIONS IN OTHER STATES - LESSONS LEARNED

Across the country in 1996, states actively promulgated legislation regulating managed care entities and providing patient protection. Analysts are predicting that 1997 will see the emergence of legislation to tighten state oversight of conversions (*Modern Healthcare,* October 14, 1996; *The Wall Street Journal,* October 18, 1996). In the absence of any standardized Federal guidance regarding conversion issues, significant public policy issues such as regulation and oversight are falling to the states to undertake. At present, only the states of Nebraska and California have laws specifically focused on conversions. Nebraska's law requires full public disclosure, an independent valuation process supported by a buyer and a monitoring process assuring future compliance. It also gives broad powers to the attorney general and state regulators to act in the public interest (Miller, 1996).

In Ohio, two Republican state legislators (Representative Van Wyven and Senator Drake) and the Ohio Attorney General Betty Montgomery recently introduced legislation requiring that nonprofit health care entities need state attorney general's approval to transfer assets to for-profit companies. The Ohio bill would require a provider or health plan that wishes to transfer 20 percent or more of its assets to notify the attorney general's office; it would also require public hearings to allow the community to determine how the transfer's proceeds would be used for the provision of charitable health care. Ohio has seen a significant increase in conversion activity since the beginning of 1995. Attorney General Montgomery, who reviewed five of the transactions, asserted that the charitable assets involved were accumulated over decades but had been converted to for-profit assets "in just days —without any public input" (*Modern Healthcare,* October 21, 1996). It is anticipated that the new law will allow for greater scrutiny of the conversion process, by both the Attorney General's office and the public.

ONGOING OVERSIGHT

Some states are also considering mandating the creation of monitoring mechanisms once the sale has been effected, in order to ensure that the for-profit entity does not discontinue providing essential health services, such as neonatal care or trauma units. Historically, for-profit chains have not invested in providing services such as indigent care, medical education and research, or burn units and other high technology services (Challot, 1996; Friedman, 1995; Miller, 1996). Ongoing oversight of hospital and foundation activities is also critical to monitor such trends as the cost shifting of certain services, e.g., cases in which it was found that charity care services in the community were being paid for by the foundation formed by the transfer of charitable assets, rather than being contributed to by the converted for-profit hospital (Miller, Council on the Economic Impact of Health System Change, October 6, 1996 meeting).

THE ISSUE OF VALUATION

The trend of converting health plans and managed care organizations began in the state of California in the 1980s. During the early transactions, when there was little if any oversight, billions of dollars of charitable assets were lost to the public. A recent analysis in the *Chronicle of Philanthropy* evaluated five nonprofit HMO conversions in the mid-1980s and found that as much as $212 million that might have gone to health care charities or other community uses was lost to under-valuation.

The issue of valuation of assets is one of great debate, with much disagreement as to the most appropriate and reliable way to do so. Approaches for the valuation of assets range from the amount the plan could be sold for on the open market; to valuing the physical plant and other tangible assets; or to establishing the total of taxes not paid (which varies from state to state).

The 1996 Alpha Center survey of such transactions in the states of California, Florida, Texas and Georgia found that even when it was required by regulators that assets be transferred to a new charitable foundation, the assets have been undervalued; specifically, the valuation of health plan assets at the time of conversion "is likely to be substantially less than the value Wall Street places on the successor for-profit organization" (Challot, 1996). The fair market value of the assets are extremely difficult to evaluate, appraise and transfer at the time of conversion. In many cases, state regulators valued only tangible property; yet such things as name recognition, good will and provider contracts are not included in the valuation. In California, during the 1980s, the value of not-for-profit HMOs offered and retained as a charitable contribution at conversion was less than one fourth of the value of the plan when measured in terms of its publicly traded stock soon after conversion (Hamburger et al. 1992; Challot 1996).

GUIDELINES FOR REGULATION

Shactman and Altman (1996) describe two levels of regulatory measures that may be considered in states regarding conversions:

- Level 1: Regulate conversions to safeguard and conserve the full value of the nonprofit assets and insure that all proceeds from the conversion are used for appropriate charitable purposes.

- Level 2: Regulate conversions to ensure that the community continues to have access to needed amounts of health care services and that the community is satisfied with the degree of local control over its health care delivery system.

The authors caution that "too much regulation" could be counter-productive and may increase prices. Yet, their findings indicated that when states did not have specific conversion laws, the full value of charitable assets was not protected. In the absence of legislation, there is no clear structured administrative process for conversions.

The Volunteer Trustees Foundation for Research and Education has set forth guidelines for state regulators' oversight of the sale and joint venture transactions in which the assets of nonprofit hospitals or health maintenance organizations are transferred to for-profit enterprises. These guidelines set forth that the primary objectives of the state regulator's oversight should be: (1) safeguar

ing the value of the charitable assets; (2) safeguarding the community from loss of essential health care services and (3) ensuring that the proceeds of the transaction are used for appropriate charitable purposes (Boisture et al, 1995). The Foundation sets out various procedures in order to accomplish the three primary objectives, including conducting an independent review of the fairness of the transaction, assessing the degree of risk to charitable assets; requiring the disclosure of conflicts of interest; determining appropriate safeguards for the continuation of essential health services; implementing public hearings and soliciting public comments; determining that sale proceeds are not used for the private benefit of the for-profit purchaser and providing governance and oversight of the nonprofit entity that receives the sale proceeds (*Guidelines,* 1995).

BLUE CROSS AND BLUE SHIELD PLANS - A TRADITION IN TRANSITION

The evolution of the "Blues" is a significant national and local discussion point regarding the complex issues raised by conversion. The Blue Cross and Blue Shield Plans were originally organized in the 1930s as not-for-profit, community-based entities that accepted all members of the community, regardless of health status. For several decades, community rating prevailed among the Blues, which operated under their nonprofit social mission. Changes in the evolving health care marketplace in the 1980s, including increased competition from managed care entities, led to the national association's June 1994 decision to allow plans to convert to for-profit status. The plans pushing for for-profit conversion argue that to survive in a marketplace with for-profit competitors, they need access to capital in order to expand, increase market share and continue to provide affordable coverage (*Modern Healthcare,* October 14, 1996).

Currently, there are 62 independent Blues plans operating in the competitive health care marketplace. Across the country, the plans, which serve 66.3 million people in mixed markets, are merging, affiliating in consortia, creating for-profit subsidiaries and converting to for-profit status. Industry analysts contend that plans engaged in activities such as creating for-profit subsidiaries, affiliations and mergers may be taking initial steps towards conversions. Although consolidating brings some efficiencies, if there are a number of entities pursuing the same market, it may be that some find it necessary to convert to for-profit status so as to have access to capital in order to invest in more competitive new products and services and to offer competitive discounts based on volume (*Modern Healthcare,* October 14, 1996).

There are currently several mergers pending across the country, such as the Illinois Blues with the Texas Blues; the Colorado Blues with the Nevada Blues; and the Connecticut Blues with Anthem, Inc., based in Indiana and one of the country's major health care management companies. Health industry analysts predict that the future of competitive health care will have only 10 to 20 major integrated health care management companies serving the majority of the U.S. health care market.

According to the national Blue Cross and Blue Shield Association president Pat Hays, although five Blues plans have converted to for-profit status or announced conversion plans, it is expected that most others will not. He pointed out that the majority of the Blues plans are committed to their nonprofit heritage and are involved with innovative strategies "to preserve that heritage" (*Modern Healthcare,* October 14, 1996). Consumer advocates contend that the Blues are distancing themselves from their original social mission.

Among the 62 plans, only two have completed conversion to for-profit status and issued stock - Blue Cross of California and Blue Cross and Blue Shield of Georgia. Plans in Colorado, New York, Virginia and New Jersey have started the conversion process. Three other plans own publicly traded subsidiaries: in Wisconsin (1991); Indiana (1992) and Missouri (1994). Empire Blue Cross and Blue Shield of New York points to two significant 1996 state laws affecting its decision to convert to a for-profit entity: the first mandated that every managed care plan enroll chronically ill patients and the second ended Empire's discounts for hospital fees (*The New York Times,* September 1996).

Blue Cross and Blue Shield of Ohio's decision to transfer most of its business to Columbia/HCA Healthcare Corporation is raising many issues. The $300 million deal would provide an almost $15 million "windfall" to Blues executives (*Modern Healthcare,* October 14, 1996). The national Blue Cross and Blue Shield Association reports that it will revoke the Ohio Blues license if it goes through with its proposed sell-off to Columbia. In the beginning of November, US District Court Judge Wells enjoined Ohio Blue Cross from using the Blues names and trademarks pending a final decision in the lawsuit between the plan and the national Association.

TWO CONVERSIONS AND TWO OUTCOMES: CALIFORNIA AND GEORGIA

Because each case is unique, states are settling conversion transactions in a variety of ways. In California, after lengthy negotiation and public pressure, two charitable foundations dedicated to health care were created. In very distinct contrast, the Georgia insurance commissioner ruled that the Blue Cross was not a charity and therefore, owed none of its assets to the public.

Blue Cross of California's conversions took three years and involved an active battle with state regulators and legislators. It was only after pressure from legislators that Blue Cross established two charitable foundations worth $3 billion; it had initially maintained that creating the WellPoint Health Networks for-profit subsidiary was a restructuring and not a conversion, and therefore, the public was not owed anything by the company. California law requires converting companies to donate their fair value to charity. WellPoint is currently engaged in acquisition and growth in out-of-state health insurance companies.

By contrast, Georgia Blues went through a process over the course of one year. In 1995, the Legislature passed a law allowing the plan to convert to for-profit and the state insurance department authorized the re-structuring. In February, Cerulean Co., the holding company for the Blues, secured an initial private investment of $49.9 million and issued stock. The Georgia plan was not required to establish a charitable foundation because the state Supreme Court in 1960 ruled that the company was taxable. The plan's assets are not public and paid taxes in 1995. Consumer advocates believe that Georgia is an example of what an insurance commissioner should not do in reviewing a conversion plan and stress the importance of a lengthy and thorough review for such transactions (Id.).

NEW JERSEY BLUE CROSS AND BLUE SHIELD - A CASE IN PROGRESS

Negotiations continue regarding the conversion of Blue Cross and Blue Shield of New Jersey to a mutual insurance company and its proposed merger with Anthem, Inc., a for-profit mutual insurance company based in Indiana. The merger, scheduled to be finalized at the beginning of 1997, would create Anthem East, with its corporate headquarters in Newark overseeing operations for Anthem on the East Coast.

Other aspects of the proposed merger plans involved regional mergers, under which New Jersey Blues will purchase Delaware Blues and Anthem would later buy the combination (*Modern Healthcare,* 1996). $103 million would be earmarked for a charitable foundation by conversion in the state of Delaware. A significant issue for New Jersey involves the question of whether or not the plan is required to establish a charitable foundation under the terms of its conversion to a mutual insurance company. P.L. 1995, c. 1996, the bill which provided for a health services corporation to convert to a domestic mutual insurance company, does not have specific requirements for the establishment of a charitable foundation as "all assets and liabilities of the health service corporation would become the assets and liabilities of the new domestic insurer" at the time of conversion (Kane, 1996). As with most other states, New Jersey currently has no specific law regarding conversions; all transactions are reviewed under the doctrines of common law by the Attorney General. A.2368 introduced in September 1996, addresses the issue of conversion and the government's role in the process.

At the same time, a merger plan in Connecticut — scheduled to be finalized in early 1997 — comprises the formation of a multi-regional health care company, including New Jersey and Delaware Blues. Operating companies will be present in all three states and administratively coordinated through the new holding company, Anthem East. When these pending mergers with Blue Cross & Blue Shield of New Jersey and Connecticut are finalized, Anthem will rank among the top 5 health care management companies in the country. Its consolidated revenues will exceed $11.5 billion, and combined assets will equal more than $7.5 billion (*Blue Cross & Blue Shield Report,* October 1996).

The ongoing conversion process in Virginia with Trigon Blue Cross Blue Shield is illustrative of some potential issues when a Blues plan has already converted to a mutual insurance company and parallels similar issues confronting the state of New Jersey. The two primary questions raised by Trigon's conversion were: what portion (if any) of Trigon's value should go to taxpayers to make up for 50 years of nonprofit status and what amou of its stock should go to policyholders. Because Trigo became a mutual company in 1991 and mutual companies, by definition, belong to their policyholders, Trigon executives initially argued that all of its stock should go to policyholders, none to charity or to the state. Two Virginia laws made an interesting counterpoint: the state law governing mutual nonprofits declares that if the business liquidates, the policyholders are entitled to its shares; however, because Trigon had been a nonprofit company in the state for some 56 years before it became a mutual company, another law states that nonprofits wishing to change their status should liquidate and use their assets to form a charitable foundation with a similar mission - health care for Virginia's citizens and support of medical education in the state. Strong consumer activism in Virginia from its Citizens Consumer Council and Virginia Common Cause is helping to focus the issue of the fair valuation of Trigon's assets.

GREATER SCRUTINY OF CONVERSIONS BEGINS

Although earlier transactions were accomplished outside of the view of public scrutiny, through the activities of state attorneys general, volunteer boards, consumer advocacy groups (national and local) and increased media attention, the transactions are being held to more intensi

analysis and oversight. According to monitoring by the Volunteer Trustees Foundation for Research and Education, many of the buy-outs and joint ventures creating for-profit hospitals are part of a highly confidential negotiation process. Confidentiality agreements are signed early on by the parties involved; consequently, the community is left out of the process by which "community-owned" hospitals and health plans are being converted. The investor-owned companies argue that disclosure of terms of the sale may "hurt" their competitive positions in negotiations. However, advocates for the nonprofits assert that in the absence of disclosure, there are no mechanisms to ensure that the interests of the community are being served, or that the long-term assets and attributes of the nonprofit are being protected (Ibid).

It is anticipated that greater public scrutiny will open the acquisitions to a competitive bidding process and allow for fairer valuation of the hospital itself and its charitable assets. A recent Wall Street Journal article on the subject of conversions notes that in two recent transactions — one done quietly and the other with competitive bidding — the "quiet" sale hospital sold for $30 million; the competitive bidding transaction resulted in a $50 million sale. Both hospitals were of similar size and had a local near-monopoly (Id.).

The Internal Revenue Service has reported that it is increasing its scrutiny of such transactions based on the change in tax status. It is currently developing guidelines and planning an intensive audit program on health care transactions to ensure that no institution or individual unduly benefits from the transaction and transfer of charitable assets.

On the Congressional level, the Government Accounting Office (GAO) is involved in what is expected to be a year-long study on the trend in nonprofit hospital conversions and the potential loss of charity care and other essential health services. The study will also look at the mission and control of charitable foundations that result from nonprofit conversions to for-profit and the use of the funds designated for charitable purposes (*Modern Healthcare,* 10/28/96).

CONCLUSION

The health care system in New Jersey, as throughout all of the states, continues to be rapidly evolving. In this dynamic environment, every individual change affects and has an impact on every other part of the system: some traditional structures are being irrevocably changed, while new entities are coming onto the scene with the promise of bettering the entire health care system. Much remains unknown, but lessons can be learned from the experiences of other states. In this time of change, the state leaders and policy makers have various issues to balance for New Jersey: the future of its non-profit hospital system; the protection of its vulnerable populations; the integrity of its communities and their public health and its regulator role in health care.

QUESTIONS FOR DISCUSSION

Administrative Law vs. Contracts Law: In a de-regulated health care arena, where many aspects of corporate transactions and activities fall under the purview of contracts law, what happens to the regulatory and monitoring role of state government and administrative rulemaking? What are the limits of regulation?

A 1996 study by the California Office of Statewide Planning and Development focused on hospital mergers in the state and their effect on competition and health care delivery. The researchers assessed the hospitals' finances, payer mix and services before and after the mergers. While study findings were inconclusive, they did show that mergers appear to increase efficiency, but they may also compromise competition. For example, in Northern and Southern California, three integrated health care systems are becoming dominant in two markets. Are three players enough to insure competition and preserve quality? Regarding charity care, the study found that levels of charity care were already so low that no drastic reduction in care was evident.

The impact of managed care entities on New Jersey's hospitals (some 85 acute care facilities in the state) has led to outright mergers and partnerships which are critical to economic survival. Through these consolidations, hospitals can take advantage of the efficiency of specialization and can offer managed care companies a full range of medical services, from walk-in clinics to nursing home care. In New Jersey, these transactions are nonprofit with nonprofit. Is the degree of oversight currently in place for mergers between nonprofit hospitals sufficient? Should there be a more aggressive governmental role in the process?

Non-profit hospital systems throughout the country are strategizing to remain viable competitors in the health care arena. In Texas and New Mexico, VHA Southwest Community Corporation was formed, a new company dedicated to preserving a not-for-profit hospital presence in Texas and New Mexico; its goal is also to take over not-for-profit hospitals in the region who are considering converting to for-profit status. In New Jersey, where currently all hospitals are not-for-profit, will recent mergers and consolidations to form large not-for-profit hospital systems throughout the state work to strengthen the position of the not-for-profit hospitals and block the entry of for-profit players?

Representative Stark (D-Calif.) is calling for investigation of changes in physician referral patterns after nonprofit hospitals are taken over by for-profit hospital chains and physician investors. His concern is based on reports that physician groups are referring the healthiest and best insured patients to the for-profit hospitals with which they have financial ties, while referring uninsured and expensive patients to public or other hospitals in the community (Modern Healthcare, October 28, 1996). Such referral would violate federal physician self-referral laws. As changes in the economic relationships between physicians, hospitals and provider groups continue, how will New Jersey monitor the market environment for such trends that have significant impact on "the public welfare"?

When "mega" for-profit hospital chains purchase nonprofit community hospitals, localities are confronted with the "absentee landlord" syndrome and fears that the new owners will have little knowledge or concern about the community in which their hospital is located. Should incentives be given to owners in order to ensure they "do the right thing" for their communities? What level of responsibility to the community is appropriate? A recent California Medical Association study found that for-profit HMOs in California use more of their revenues on administration than nonprofits: in fiscal year 1994-95, nonprofit Blue Cross of California spent 93.4 percent of its revenues on patient care; in comparison, for-profit Aetna health plans of California spent 77.4 percent on patient care. What are the implications for access to health care based on these figures?

As the changing market and health care environment, as well as reductions in the traditional revenue streams of Medicaid and Medicare, are driving the ways in which medical residents are trains, states are confronted with deciding on how to address the problem. Throughout the country, they are evaluating options that include seeking new mechanisms for graduate medical education to replace lost revenues at teaching hospitals, developing incentives to induce managed care companies to contribute to medical education, and taking a "wait and see" position for guidance from the Federal government. (This past year Senator Moynihan (D-NY) introduced S. 1870, the Medical Education Trust Fund Act of 1996. The purpose of the trust fund is defined "to assist medical schools in maintaining and developing quality educational programs in an increasingly competitive health care system" (Kane, 1996)). What ways is New Jersey exploring to address this pressing problem?

The debate regarding nonprofit vs. for-profit health care providers is just beginning. Accurate comparisons along the dimensions of quality, access, efficiency and community benefit cannot be made without solid research. Once again, the lack of reliable data, as well as fragmentation of data sources, thwarts the goal of validly measuring the performance and outcomes of either system. What is New Jersey's commitment to proactively standardize health data for evaluation and analysis purposes?

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APPENDIX 1

Selected Conversions of Not-For-Profit Health Organizations: Charitable Beneficiaries and Amount of Assets Transferred

Health Organization	Name of Foundation Created or Charitable beneficiaries	Year of Conversion	Asset Value Transferred	Current Value For-Profit Asset (Date of Valuation)
Hospitals and other medical facilities				
Anciote Psychiatric Center (Tarpon Springs, FL)	Anciote Manor Hospital	1984	$6.9 million	29.6 million (1985)
Northwest Area Community Hospital	Mid-Iowa Health Foundation	1984	$8 million	$14.5 million (12/31/93)
Ridgeway Hospital (DesPlaines, IL)	Blowitz-Ridgeway Foundation	1984	$10.5 million	$16.8 million (9/30/92)
Eastmoreland Hospital (Portland, OR)	Northwest Osteopathic Foundation	1984	$6.3 million	
Davenport Osteopathic (IA)	Quad City Osteopathic Foundation	1984	$4.5 million	
Portsmouth Hospital (NH)	Foundation for Sea Coast Health	1984	$45 million	
Eisenhower Osteopathic Hospital (Colorado Springs, CO)	Colorado Springs Osteopathic Foundation	1984	$13.8 million	
St. Joseph Hospital (Omaha, NE)	Health Future Foundation	1984	$70 million	
Presbyterian/St. Luke's Healthcare Corporation (Denver, CO)	Colorado Trust	1985	$123 million	$259.8 million (12/31/93)
North Miami General (Miami, FL)	Modern Health Care Services	1985	$.25 million	
Presbyterian Hospital (Oklahoma City, OK)	Presbyterian Health Foundation	1985	$110 million	
Wesley Medical Center (Wichita, KS)	Kansas Health Foundation	1985	$200 million	$332.8 million (12/31/93)
Greater Bridgeport Foundation (Trumbull, CT)	University of Connecticut Foundation	1986		
Tucson Osteopathic (Tucson, AZ)	Tucson Osteopathic Medical Foundation	1986	$9 million	
Georgia Osteopathic Hospital (Tucker, GE)	Georgia Osteopathic Institute	1986	$5 million	
Irvine Medical Center (Irvine, CA)	Irvine Health Foundation	1986	$15 million	$22.25 million (12/31/93)
St. Marks Hospital (Salt Lake City, UT)	Episcopal Church Trust Fund	1987	NA	
Flow Regional Medical Center (Denton, TX)	Flow Health Care Foundation	1989	$1.2 million	
Montefiore Hospital (Pittsburgh, PA)	Jewish Health Care Foundation of Pittsburgh	1989	$75 million	$88.8 million (1993)
Michael Reese Medical Center (Chicago, IL)	The Michael Reese Foundation	1991	$2 million	
Cedars Medical Center (Miami, FL)	Health Foundation of South Florida	1993	$50 million	
Hilton Head Hospital (Hilton Head, SC)	Hilton Head Foundation	1994	$12 million	
Helen Ellis Memorial Hospital (Tarpon Springs, FL)	Tarpon Springs Hospital Foundation	1994	NA	
Nashville Memorial Hospital (Nashville, TN)	Nashville Memorial Foundation	1994	$108 million	$100-$108 million (1994)
St. Francis Hospital (Memphis, TN)	Primary Corp./Assisi Foundation of Memphis	1994	$130 million	
University of Louisville Hospital (Louisville, KY)	Columbia/HCA Healthcare Foundation	1994		
Southwest Texas Methodist Hospital (STMH) (San Antonio, TX)	Methodist Healthcare Ministries of South Texas	1994	$27 million, plus about $47.7 million in retired hospital debt. STMH retains 50% ownership & remains not-for-profit.	
Winter Park Memorial Hospital	Winter Park Health Foundation	1994	$29 million, plus future earnings from WPMH/Columbia/HCA for-profit partnership	$47 million (1995)
Tulane University Medical Center (New Orleans, LA)	Tulane University	1994	$130 million; plus 20% of future distributions from Columbia HCA/Tulane's health care system, $20 million/year to the University's medical education and research, and up to $75 million in loans and guarantees for 11 new centers of excellence.	
Heartland Medical Center	Dakota Medical Foundation	1995	50% ownership of Dakota Heartland Health Care System plus 50% of system's annual earnings	

Rapides Regional Medical Center (Alexandria, LA)	Rapides Foundation	1995	$66 million, plus 50% ownership and half of distributions from new Central Louisiana Healthcare Corporation	
St. Joseph's Hospital and St. Joseph Center Mental Health (Omaha, NE)	Creighton University	1995	Reorganization of 1984 sale to AMI (now Tenet Healthcare Corporation). Creighton received $100 million for 1984 sale and in reorganization received 26% ownership of new limited liability company holding both hospitals.	
Memorial Hospital (Jacksonville, FL)	Genesis Health Foundation	1995	$5 million	
Rose Medical Center (Denver, CO)	Rose Foundation	1995	NA	
LaGrange Memorial Hospital (Chicago, IL)	Community Memorial Foundation (LaGrange, IL)	1995	$50 million	
Chicago Osteopathic Hospital (Chicago, IL)	Not Named	1995	NA	
JFK Medical Center (Atlantis, FL)	JFK Medical Center Foundation	1995	$275 million	
Bishop Clarkson Memorial	Clarkson Foundation	1995	NA	
Olympia Fields Osteopathic (IL)	Not Named	1995	NA	
	Academy of Medicine of Columbus and Franklin County Foundation (Dublin, OH)			
	Drs. Bruce and Lee Foundation (Florence, SC)			
	Dr. John T. MacDonald Foundation, Inc, (Coral Gales, FL)			
	The Memorial Foundation (Goodlettsville, TN)			
	Mercy Hospital Foundation (Charlotte, NC)			
	Donald W. Reynolds Foundation (Tulsa, OK)			
	Springs Foundation (Lancaster, SC)			
	St. Luke's Charitable Trust (Phoenix, AZ)			
	St. Luke's Foundation (Bellingham, WA)			
	Tri-State Health Foundation (Cincinnati, OH)			
	Paso del Norte Health Foundation (El Paso, TX)			
	Good Samaritan Health System (San Jose, CA)			
	Daughters of Charity National Health Systems (St. Louis, MO))			
Health Care Financing Organizations:				
Family Health Plan(Sacramento, CA)	*Sierra Health Foundation*	1984	*$38.3 million*	$1.7 billion (6/30/95)
	Foundation Health	1984	$78 million	$1.9 billion (6/30/95)
Greater Delaware Valley Health Care/Del Val HMO (Concordville, PA)	3 not-for-profit hospitals	1984		
Pacific Health Systems (Cypress, CA)	PacifiCare Charitable Dedication Irrevocable Trust	1984	$360,000, plus $1 million non-interest-bearing promissory note	$2.2 million (6/30/95)
FHP, Inc. (Long Beach, CA)	FHP Foundation	1985		$69.6 million (1994)
Group Health Association (Washington, D.C.)	Consumer Health Foundation			$5-$10 million (4/15/94)
Group Health Plan of Greater St. Louis (St. Louis, MO)	Group Health Foundation, sold to Coventry Corporation	1985		$4 million (10/31/92)
Inland Health Care (Loma Linda, CA)	Various charities in San Bernardino and Riverside Counties, CA.	1985		
HEALS (Herrick Alta Bates Study) Pueblo, CO)	East Bay Community Foundation, Easter Seals, General Foundation for Medicine, *Planned Parenthood*	1987		
Health Net (Woodland Hills, CA)	California Wellness Foundation	1992	$300 million	
	Allina Foundation (Minneapolis, MN)			
	Blue Cross of CA (Woodland Hills, CA)			
	Blue Cross/Blue Shield of Colorado (Denver, CO)			
	Blue Cross/Blue Shield Community Foundation of Maryland (Owings Mills, MD)			

See References for Source