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 I: NOT-FOR-PROFITS - VIABLE OR OBSOLETE?

Background information for the discussion at the

CAPITOL FORUM
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Masonic Temple Library
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ISSUE: We have a uniquely American institution — a group of nonprofit organizations which came into existence to serve a mission that was not being served by any other sector. We have funded these nonprofits via federal, state and local resources and through corporate giving and philanthropy. Reductions in funding support from both governmental and philanthropic sources seem to be suggesting that this "institution" is no longer necessary. **As the move towards acquisitions, mergers and conversions to for-profit status continues, will the original mission of the nonprofits be lost in this competitive health care arena? What impact will the business and financial realities of the 21st century have on the role of state government as policy maker, funder and regulator in our health care system, which is rapidly become a commercial enterprise?**

FOR-PROFIT AND NONPROFIT HEALTH CARE: NEGOTIATING THE TRANSITION

Throughout the country, a trend which began in California, Florida and Texas, is affecting many other states: the shifting of not-for-profit hospitals, health care providers and nonprofit health plans (such as health maintenance organizations and Blue Cross & Blue Shield plans) to for-profit status through mergers, partnerships, acquisitions and conversions.[1] It has been observed by both conservatives and liberals alike that the nonprofit sector in health care is dissolving across the country; its most rapid dissolution is taking place in California (Fox and Isenberg, 1996). This trend is driven by growing competition in the health care marketplace coupled with reductions in public support for nonprofit providers of health care. The primary players in this dynamic environment are the not-for-profit hospitals, Blue Cross and Blue Shield plans and nonprofit managed care health plans (under which insurance and service delivery are integrated). Although it is estimated that billions of dollars of charitable assets are at stake, up until this point there has been little input or oversight from federal or state governments (Alpha Center, 1996).[2]

A 1991 analysis of leveraged buy-outs, conversions and corporate reorganizations of nonprofit health care institutions to for-profit status enumerated several ways in which such transactions may take place: as a buyout by a business corporation; by amendment to the not-for-profit organizationís articles of incorporation; as a "spin-off" in a corporate re-structuring, or by merger with a for-profit entity, with only the for-profit entity remaining intact after the merger (Shields et al, 1991). Some more recent conversions of hospitals have taken yet another form — partnerships forming either a limited partnership or a limited liability company between the not-for-profit organization and the for-profit corporation (Challot et al., 1996).

Where do the imperatives of political responsiveness and public accountability, as well as the dictates of medical professional standards and personal principles, lead us when looking at the question of for-profit takeovers and mergers of nonprofit providers? Under the new Federalism, the Federal government continues to reduce its role as funder and regulator and shift more power and authority to state governmental levels. How will state governments — in the roles as regulators, policy makers and funders — respond to the changes in the free-market health care delivery and financing systems?

[1] For purposes of this brief, the term "nonprofit" will be used to refer generically to both not-for-profit and non-profit entities. In cases when each term is specifically used, it is done so to refer to the tax status of the organization being discussed.

[2] The December 11, 1996 Capitol Forum will analyze the issue of conversions against the background of government's role as regulator. Special attention will be given to the impact such conversions may have on the provision of charity care to uninsured and underinsured citizens.

ISSUE BRIEF No. 17

Capitol Forums on Health & Medical Care

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The broad public policy question that may be asked is what does the public gain by having health care delivered by nonprofits. Historically, nonprofit organizations are driven by their mission; in most cases, to meet a need of society or its members. In contrast, the fundamental purpose and operating principle (both economic and legal) for for-profit business is the maximization of profit for the organization's owners, its shareholders. One important aspect of the nonprofit organization is that any surplus income that is generated is turned back to the organization, usually to improve or expand the services they provide. While for-profit conversions can offer the potential to increase access to capital and allow non-profit providers to be on "a level playing field" with for-profit competitors, will the missions, standards and values of the traditional nonprofit providers remain true? Historically, health care has been thought of as a charitable activity provided (except for physicians) by nonprofit providers (Friedman, 1996). Critics of for-profit health care argue that it is not strong in the areas of providing indigent care or of maintaining a commitment to teaching and research; advocates of for-profit health care assert that proprietary systems create a higher level of efficiency and accountability. In reality, there is little conclusive study to substantiate the validity of either claim (Challot et al, 1996; Friedman, 1996). The primary reason for the absence of rigorous study lies in the "newness" of the market. Further, there is great diversity among the types of nonprofits operating in the health care arena, as well as significant differences among the procedures through which for-profit mergers, acquisitions and conversions are taking place. How can government adequately regulate an industry in such a state of flux as the health care industry?

THE END OF NONPROFITS AS WE KNOW THEM?

How does this commercialization of health care, which appears to be an irreversible trend, affect the traditional role of nonprofit health care providers in their communities? The shift to a for-profit enterprise is a shift to a value ethic that is profit-driven, as the basic workings of charity and commerce are quite different. Will the demand and accountability to investors have a negative impact on the needs of the community served? The answers to these questions are not clear-cut, especially in the context of the health care industry, whose history includes shifts in the power structure between for-profit and nonprofit health care providers. In reality, the health care industry is one of the only industries in this country in which there is competition between large nonprofit and for-profit systems (Nudelman and Andrews, 1996). There are advocates and opponents on each side of the issue. Critics of for-profit health care organizations emphasize that their primary legal, fiduciary and ethical duty is to return a profit to the stockholders. Concern regarding this imperative arises out of the possibility that this duty puts patients and community health and welfare in second place. Nonprofit health care providers, whose mission is rooted in strong community service values, have incentives to provide health care not only to individuals entering their hospital or clinic, but also to monitor and preserve the public health of their communities.

While for-profit companies define their "products" by what the consumers are willing and able to pay for it, the nonprofit sector evolved in this country in response to societal needs that were not being met, or were not adequately met, by the for-profit sector (Miller 1996). The quandary that arises out of the health care nonprofit/for-profit struggle is rooted in the problem that it appears that American society does not view health care as a public good; consequently, it has not organized an incentive system and financial structures in order to deliver health care to all individuals. The private, voluntary sector of nonprofit health care providers have traditionally filled in the gaps left by the for-profit and public sectors — to provide care to the poor and vulnerable. It is anticipated that the nonprofit sector will bear much of the burden for developing new strategies to deal with health and social problems in communities after Federal downsizing of public programs and the implementation of block grants have occurred. (Weil, 1996).

HISTORY

In his 1982 work studying the history of medical practice in America, Paul Starr observed some 15 years ago:

> Profit-making enterprises are not interested in treating those who cannot pay. The voluntary hospital may not treat the poor as same as the rich, but they do treat them and often treat them well. A system in which the corporate enterprises play a larger part is likely to be more segmented and more stratified. With cutbacks in public financing coming at the same time, the two-class system in medical care is likely to become only more conspicuous.

And the cutbacks in public financing have continued. With the advent of managed care in the health care industry, nonprofit health care providers and health plans are confronted by questions of survival in an increasingly competitive health marketplace. The intersection of business ethics with medical ethics and social responsibility continue to clash as competitive market forces drive the health care delivery system.

Although there is great diversity among providers in the nonprofit sector, there are various factors that are

peculiar to all nonprofits: they are incorporated under state laws; most are governed by voluntary, self-perpetuating boards and do not have "owners"; nonprofits are chartered under state laws for several statutory purposes — charitable, religious, scientific, educational - and their assets and revenues must be used for those purposes; and they are prohibited from distributing surplus revenues (or assets, if the corporation is dissolved) to those who control the organization (Gray, 1991). The other primary distinctive element is that broad categories of nonprofit organizations, including hospitals, benefit from their tax exemptions and related public subsidies.

THE INTERNAL REVENUE SERVICE AS HEALTH POLICY MAKER?

Throughout the 20th century, the tax-exempt status enjoyed by nonprofits has been challenged; however, the 1990s may bring to bear the most difficult series of such challenges. A brief overview of amendments to Federal laws, regulations and Internal Revenue Service (IRS) rulings illustrates how the IRS, as compared to Federal and state regulatory agencies, has a primary role in shaping the identity of nonprofits.[3]

It was in 1913 that the income tax statutes exempted organizations that were operated for charitable purposes from taxation; donations to these organizations were made tax-deductible in 1917 (Ibid). Over the decades, amendments have been made to the tax exemption regulatory language, which most directly affected hospitals and the provision of charity care. Although a 1956 IRS revenue ruling (56-185) held a hospital to be charitable only "if operated to the extent of its financial ability for those not able to pay for services rendered and not exclusively for those able and expected to pay," the Treasury Department amended its Federal regulations in 1959 to define "charitable" as being "for the benefit of an indefinite number of people rather than for the relief of the poor (emphasis added) (Fox and Schaffer, 1991). Since the Federal requirement to provide charity care was ostensibly removed, the states have taken the lead in setting mandates regarding its provision.[4] A later 1968 revenue ruling by the IRS (69-545) again redefined the criteria for hospital tax exemptions as: providing a community benefit through the promotion of health, through participating in governmental programs such as Medicare, and by maintaining an emergency room open to the community (Gray 1991). Since 1985, there have been Federal, state and local governmental challenges to hospitals' tax exemption status throughout the country. These challenges have increased in number during the 1990s, as the documented numbers of uninsured Americans have increased.

SUPPORT FOR THE NONPROFIT SECTOR

Historically, over the past 60 years, a relationship has been sealed in which government raises the money to finance income transfers and basic welfare and charities deliver direct services (Wolpert, 1996). Between 1950 and 1980 a massive increase took place in the size and scope of Americaís nonprofit sector. By the late 1970s, the private nonprofit sector had become the principle vehicle for the delivery of government-financed health and human services, and government had become the principal source of nonprofit health and human services agency financing. As a result of massive reductions in Federal support for the nonprofit health care organizations during the 1980s and with the development of a competitive health care industry via deregulation and the emergence of managed care organizations, many believe the survival of nonprofits as we know them is threatened. In the current climate of mergers and conversions, nonprofit organizations are seeking investment capital in order to maintain and expand their services in a competitive marketplace.

THE SAFETY NET

The health care safety net concept refers to health care providers that are legally obligated to provide care to persons who cannot afford it. In actuality, the health care safety net is a loosely knit network of doctors, hospitals and clinics, both public and private, that provides services to the poor and the uninsured. These providers typically include public and teaching hospitals, federally funded community health centers and city and county health departments (Lipson, 1996). Also included in the definition of safety net providers are private, not-for-profit hospitals that provide uncompensated care to the community, and nonprofit organizations (such as Visiting Nurses Associations, Planned Parenthood, and religious organizations of every denomination and faith) and clinics who provide health care services at no charge or at discounted rates. Independent physicians who offer these services to vulnerable populations are also viewed as safety net providers (Ibid). These safety net providers are considered specialists at what they do, and most public hospitals, community health centers and nonprofit organization programs provide a wide range of medical and social services necessitated by the needs of their populations, including case management, patient education programs and home

[3] In 1985, John Simon, founding director of the Yale University Program on Nonprofit Organizations, estimated that between 1945 and 1985, there were at least eight congressional investigations and hearings on the tax treatment of nonprofits and six major statutes were passed (some 500 pages in the IRS Code and Regulations). The number of state and local conflicts over property tax exemptions were "beyond count" (Gray 1991).

[4] Reference is made to the 1995 Capitol Forums Issue Brief on Uncompensated Care.

visits (Rovner, 1996) [See Appendix, "Safety-Net Providers."]

Although many of the programs and services of safety net providers sustained the massive reduction of Federal support during the mid-1980s, many of them did not survive. Those most vulnerable were the small community-based programs funded primarily by Federal funds and a stream of mixed funding sources from foundations, religious organizations, the United Way and corporate and private donations.[5] These programs cover a wide range of public health and social problems, such as shelters for women who are victims of domestic violence, home health care for the vulnerable elderly and substance abuse outreach programs. At the present time, the nonprofit safety-net health care providers are facing major challenges for their future survival with funding cutbacks in Federal, state and local support, the diversion of Medicaid revenues to managed care organizations, the conversion of Medicaid from an entitlement program to a block grant and the pressures of a competitive marketplace (Davis, 1996).

HOW DEEP ARE THE FEDERAL CUTBACKS TO NONPROFITS?

It is estimated that between 1997 and 2004, Federal budgetary changes will reduce spending on health, education, social services and housing and community development by $773 billion (Salamon, 1996). This set of programs — 38 percent of the current Federal budget — will absorb 55 percent of the budget cuts required to meet the goals of a balanced budget. Health care spending will be reduced by 25 percent over the next seven years; it is anticipated that the changes will cost nonprofit organizations over $263 billion in Federal funds. Private giving can not be expected to meet these reductions, as it would have to increase at 16 to 20 times its growth rate in recent years (Ibid). At the same time, the Federal move to establish block grants will have an impact on how health and social services programs on state and local levels will provide services to individuals and communities. As states and municipalities seek new revenue sources for their own survival, they are scrutinizing tax exemptions allowed for nonprofits in their communities and demanding greater effectiveness and accountability.

Equally as threatening to the future of the nonprofit sector in health care is the moral-political crisis affecting the public's perception of the nonprofit sector. Many critics view it as an extension of government in its role of provider of services to vulnerable populations. Much of the funding that nonprofits use to provide services comes directly from government grants and contracts. As characterized in a recent Twentieth Century Fund report on "What Charity Can and Cannot Do," a massive shift from government support into a greatly enhanced role for charities ignores this historical relationship: it is a "sizable leap" into the unknown, advocated by those who are questioning the merits of social programs and their beneficiaries (Ibid). The report states that charitable, nonprofit organizations lack the resources to sustain the nation's poorest residents even at minimal safety-net levels. It estimates that by the year 2002, charitable nonprofits in the United States would have to more than double their private contributions to make up for cutbacks being proposed by advocates of a sharply reduced government role providing assistance to those in need. In reality, the report cautions, decreases (not increases) can be expected in charitable contributions and volunteerism during the next five years.

In a move to strengthen its members' ability to survive in an ever-more competitive marketplace, the National Association of Community Health Centers is encouraging safety net providers to form networks of their own in order to attract bids for contracts as providers of care. In similar moves, Planned Parenthood affiliates are exploring mergers across the country in order to cope with competition for private funding, a changing patient base as a result of managed care and rising operational costs. For example, in the Charlotte, North Carolina area, two affiliates are merging to create a larger organization to provide more efficient service delivery and increased fundraising power.

Catholic charities have long been players in the health care and social services arena. In speaking at an Alpha Center meeting this year, venture capitalist Paul Queally predicted that Catholic charities would be out of the health care marketplace in the next century, primarily because of lack of capital to compete in the new competitive health care market (Hiebert-White, 1996). In response, William Cox of the Catholic Health Association asserted that the challenge to his members is to compete successfully but in a way that does not undermine their values and identity as Catholic, religious organizations.

A recent survey conducted by the Home News and Tribune found that New Jersey-based corporations are committed to maintaining their current level of philanthropic commitment to nonprofit organizations in the

[5] Foundations play a significant role in nonprofit support to fill in where government cannot or will not. Foundations also traditionally meet the needs of small groups, institutions and organizations which are under-represented in the health care arena and those which may provide "politically sensitive" services, such as family planning.

state, even in light of downsizing and restructurings. Responses from corporate sponsors indicated that the two leading factors in determining which nonprofits receive funding are the change to improve the quality of life in local communities and to associate the firm with a project that spreads good will. Nonprofit fund-raisers in New Jersey point out that the greatest challenge to them this past year has been mergers. For example, where they might have had five or six banks in their region that gave corporate gifts in 1994, there may be only two banks in 1996.

STILL, THE FOR-PROFIT/NONPROFIT DEBATE CONTINUES

At this point in time, against the backdrop of reduced funding support, nonprofits continue to play a major role in the provision of health care, as do their growing for-profit competitors. Who can provide the best level of access and quality health care — a for-profit or nonprofit provider? This question is by no means easily answered and the environment in which both exist is rapidly changing. In 1994, 21 for-profit and nonprofit managed care health plans across the country participated in the National Committee for Quality Assurance's (NCQA) Report Card Pilot Project. This study indicated that there is no correlation between profit status of a health plan and the level of preventive care services; some nonprofits scored below the mean, while some for-profits scored above it.

The Alpha Center, at the request of the Commonwealth Fund, is involved in analyzing the various public policy issues and concerns related to the for-profit conversion of public hospitals, not-for-profit hospitals and health plans (Blue Cross and Blue Shield plans; managed care health plans) since 1980. In their 1996 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" (Id.). As to the question as to 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.

IT'S THE ACCOUNTABILITY ISSUE

The question of accountability is primary in a discussion of nonprofit as compared to for-profit health care organizations. Advocates of nonprofit health care delivery assert that their organizations are accountable to the patient and the public — not the shareholder. Their net income does not go to shareholders but is (in theory) retained for the benefit of members and the public. For-profit advocates argue that historically, nonprofits have not lived up to their community benefit claims; they argue that nonprofit health providers should enjoy tax subsidies only if their contributions to society equal or exceed the value of the subsidy (Heibert-White,-White 1996). This clash of views will require that both nonprofit and for-profit health care organizations evaluate, study and assess their contributions to their community in a rigorous, empirical manner.

Community benefit from nonprofit providers cuts across many dimensions: the provision of charitable services and of essential (yet in most cases, unprofitable) services; and in maintaining a research and advocacy role in the public health of the community. Dimensions of accountability in the health care sector include political accountability (especially regarding the retention of tax-exemption status); commercial accountability; community accountability in maintaining appropriate services and overseeing community health status, and clinical/patient accountability in terms of access and quality outcomes (Gamm, 1996).

The effects of conversions on community benefit are complex and raise multiple public policy issues. For example, when a for-profit health care provider such as Columbia/HCA dominates a community market, what entity subsidizes trauma units and indigent care if the for-profit provider does not make a commitment to do so? This type of question is embedded in the accountability issue — when necessary, is the for-profit hospital or health care provider willing to provide the "safety net" function traditionally filled by nonprofit health care providers? With close to 45 million uninsured individuals in this country — an estimated 1 million in New Jersey — will for-profits make a commitment to provide health care to these citizens?

What is the role of public policy makers regarding such issues? As responsibility falls to the state governmental level to respond to these market trends in the rapidly changing health care arena, policy makers are challenged to require accountability from nonprofit and for-profit organizations alike.

CURRENT STATUS: MERGERS, ACQUISITIONS AND CONVERSIONS

A brief overview follows of current trends in the national health care arena regarding the shifting of nonprofits to for-profit status. It is offered to put the role of nonprofits within a context of the competitive health care

market. As the trend continues in mergers, acquisitions, and conversions, it is estimated that billions of dollars of charitable assets are at risk unless state regulators and policy makers work with the organizations involved in the conversion transaction (Bell 1996). Many states are looking to the National Association of Insurance Commissioners (NAIC) which continues to develop guidelines regarding the reorganizations or conversions of not-for-profit health plans in areas such as operational structure, valuation of assets, the regulatory authority of the states and how to decide on the distribution of assets. In the absence of Federal guidelines, states are working to oversee such transactions.

Hospitals

At this time in health care, every aspect of health care — including managed care organizations, nursing homes, pharmaceutical manufacturers and home care — except hospitals, is dominated by proprietary, for-profit enterprises. Bradford Gray, in a commentary entitled "Why Nonprofits? Hospitals and the Future of American Health Care," asserted that the future of the nonprofit hospital, more than any other nonprofit, is affected by the changes in the business and governmental sectors (Gray 1991). He notes that governmental tax subsidies "may well be larger for hospitals than for any other type of nonprofit organization because of the amount of revenue they generate and the aggregate value of their capital assets" (Ibid). Further, government not only plays regulatory roles, but it is also the largest purchaser of hospital services through its Medicare and Medicaid programs.

Historically, between 1980 and 1990, almost one-third of all general hospital conversions involved a conversion to for-profit status (Challot et al., 1996). In the early 1980s, there emerged a growing presence of for-profit health care and investor-owned hospital companies, such as Humana, Inc. and the Hospital Corporation of America (which only came into existence in 1968). These companies initially purchased existing, independent for-profit hospitals and by the early 1980s, after they had been successful in purchasing most smaller, for-profit hospitals, their acquisition activities turned towards not-for-profit hospitals (Gray, 1991).

By the mid-1980s, acquisitions and mergers of not-for-profit community hospitals and public hospitals by for-profit "megasystems" began to accelerate. As of summer 1996, Columbia/HCA, the largest for-profit chain in the country, owned 340 hospitals, 135 outpatient-surgery offices, and 200 home health agencies in 38 states, controlling almost 50 percent of the for-profit hospital beds and 7 percent of all hospital beds in the country (Kuttner, 1996). In 1994, Columbia/HCA Healthcare announced plans of acquiring as many as 500 more hospitals before the end of the decade (Bell, 1996). During 1995, Columbia purchased or became involved in joint ventures with 41 nonprofit hospitals. Across the country, the number of nonprofit hospitals merging with or being acquired by for-profit businesses increased from 18 in 1993 to 176 in 1994. The Chronicle of Philanthropy found in a 1995 survey at least 65 conversions of nonprofit health care institutions pending throughout the country.

These mergers and acquisitions have significant impact on the policy and legal questions regarding the protection of charitable assets; the value of a nonprofit hospital, in many cases, can exceed $100 million (Bell, 1996). While research indicates that it is common practice that for-profit corporations initiate hospital conversions, there are many cases were communities in fiscal trouble have proactively sought hospital conversions as a means to survive in the community (Bell 1996; Challot et al., 1996). What happens to the public resources that have contributed to building these nonprofits? And whose role is it to decide? Currently, there appears that there is not a consistent public oversight procedure in place regarding hospital conversions.

Last year, speaking before the National Association of Attorneys General, the Volunteer Trustees Foundation for Research and Education urged state attorney generals to assert authority over conversions of nonprofit hospital assets to for-profit use. The Foundation encourages the use of existing laws that require directors of nonprofit charitable corporations to obtain prior court approval for any fundamental change in corporate purposes and recommends a set of actions to protect public interest and avoid changes being made for self-interest of for-profit purchasers, which include the holding of public hearings on nonprofit asset conversions; the protection of the community from the loss of essential health care services, such as emergency room care; and the proactive involvement of the state attorney general in any transactions under which the use of charitable assets is being changed (Miller, 1995).

In recent news, a Michigan trial court judge ruled in early September 1996 that a proposed 50-50 joint venture between Michigan Capital Medical center — a not-for-profit hospital system — and Columbia/HCA Healthcare violated the Michigan laws governing public charities. The proposed merger would have made Michigan Capital the first for-profit hospital in the state. In the case, which was initiated by the state attorney general's office, the judge asserted that Michigan law does not permit assets of a not-for-profit hospital legally formed for charitable purposes to be transferred to a for-profit joint venture. Michigan Capital announced that it will appeal the state court ruling which blocked its proposed 50-50 joint ven-

ture with Columbia/HCA.

Blue Cross and Blue Shield Plan Conversions

Blue Cross plans were organized in the 1930s as not-for-profit, community-based entities that accepted all members of the community, regardless of health status. Emerging from the Depression and the American Hospital Association's move for legislation to create a special class of nonprofit corporations and hospital insurance, the first Hospital Service Plan enabling act was adopted by the New York state legislature in 1934. By 1938, 1.4 million people had enrolled in 38 Blue Cross plans across the country (one of which was Blue Cross and Blue Shield of New Jersey). Two major characteristics that have distinguished Blue Cross from most commercial insurance companies are: payment of service benefits to hospitals rather than of cash benefits to the individual insured and community rating.

In June 1994, the National Association of Blue Cross and Blue Shield plans voted to amend its rules to allow plans to convert to for-profit status, after 60 years of requiring that plans be not-for-profit. The changes were spurred by the evolving health care marketplace, growing increasingly more competitive by the market penetration of managed care, and the individual plan needs to raise capital. By early 1991, three Blue Cross plans had filed for bankruptcy (Miller 1995). At present, only 12 of the 63 Blues plans across the country are designated as "insurers of last resort" for those individuals who cannot obtain insurance on the market. It is estimated that nationally, the asset value of the Blues' plans is approximately $60 billion.

Blue Cross of California was the first state Blue Cross plan to convert after the national association amended its rules in June 1994 to allow for conversion of plans to for-profit status. Currently, Blue Cross and Blue Shield in at least 17 other states, including Colorado, Maine, New York, Missouri, Maryland, Georgia and Virginia, are in the midst of considering such conversions (Ibid). As case examples, conversion transactions in California and Georgia are illustrative of two contrasting outcomes. In California, where consumer advocacy and state oversight was strong, two grant-making foundations focused on improving health care and public health in the state, were created with a total endowment of $3.3 billion, as a result of the conversion of nonprofit Blue Cross of California to a for-profit entity. The state of Georgia enacted legislation in 1995 to simplify the conversion of its Blue Cross and Blue Shield plan to for-profit status. Such legislation may result in the state's losing access to any charitable assets.

In other states, such as New Jersey, Maine and Colorado, Blue Cross plans are involved in advocating for change of state laws, as was accomplished in Georgia, to facilitate conversions. Such negotiations are currently in process. In the state of Maine, most recently the proposed conversion of Blue Cross of Maine was not passed by the Legislature because of questions about the ownership of the company's assets. Empire Blue Cross in New York is planning the creation of for-profit managed care units in 1997-98; the state's regulatory entities are working on how to address the plan's reorganization, in which the plan would establish a for-profit subsidiary instead of converting their entire operation. In January 1995, Maryland Insurance Commissioner Dwight Bartlett rejected a similar proposal from Blue Cross and Blue Shield of Maryland. In his decision, the Commissioner wrote that the proposal to set up a for-profit subsidiary created an inherent conflict of interest between policyholders and stockholders and with the pressure to satisfy investors: "...the interests of the subscribers of Blue Cross and Blue Shield of Maryland would be secondary to the for-profit enterprise."

Another emerging trend (most recently seen in Ohio, Georgia and North Dakota) is the conversion of Blue Cross plans to mutual insurance companies and merging with larger, for-profit firms. In New Jersey last year, under P.L. 1995, Chapter 196, procedures were established for a health service corporation to convert to a mutual insurance company. Blue Cross and Blue Shield of New Jersey's plans include converting to a mutual insurance company and merging with Anthem, Inc., a for-profit mutual insurance company. The merger, scheduled to be finalized by the end of 1996, must be approved by insurance commissioners in New Jersey and Indiana (Anthem's home state). One significant issue for New Jersey regards 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. In some cases, such as in Virginia, the Virginia Blues initially converted to a nonprofit mutual insurance company and is now proposing to convert to full for-profit status. In the intermediate step of mutual insurance company conversion, the plan was not required to transfer charitable assets.

Health Maintenance Organizations and For-Profit Conversions

The evolution of health maintenance organizations (HMOs) is illustrative of an industry-wide shift from nonprofit to for-profit status. The majority of HMOs began as not-for profits; the Federal HMO Act of 1973 provided grants only to nonprofit HMOs. The government invested in the HMOs to support health care that was lower in costs and increased access to health care and preventive care. In early 1982, federal support of not-for-profit HMOs was significantly reduced as the Reagan administration encour-

aged the HMOs to convert to for-profit status (Challot et al., 1996 et al). By the mid-1980s, most state legislatures passed laws allowing for HMOs to be for-profit businesses and to allow for conversions of nonprofit HMOs (Bell 1996). In the state of California, with its mature market penetration of managed care organizations, the percentage of for-profit HMOs increased from 16 percent to 65 percent of the HMO market during the period between 1980 and 1994. Currently, all but two of the state's largest HMOs are for-profit.

While the issue of community benefit is not as significant regarding conversion of nonprofit managed health plans as it is with the conversion of not-for-profit hospitals and other health care providers, the issues of access and quality remain strong (Challot et al., 1996). In the current environment, the for-profit sector in managed health plans is under scrutiny to ensure that quality and access are not compromised for the sake of profit. Conversions to for-profit status will raise the same issues regarding the monitoring of services delivered to specific populations. Public oversight responsibilities to monitor not-for-profit health plan conversions vary greatly between states. In most states, authority rests with the Department of Insurance; in New Jersey, both the Departments of Health and Insurance are involved in such transactions.

State Oversight of Conversions

Under almost all state laws, the assets of nonprofit organizations must be "permanently dedicated to charitable purposes" (Bell 1996). Most nonprofit health care organizations were created and evolved through tax-exempt status and publicly supported funds, including tax-free bonds. Volunteer time and charitable contributions also form a large part of the assets over time. Under, section 501(c)(3)(of the Internal Revenue Code) not-for-profit organizations — which are entities organized for religious, charitable, educational or scientific purposes — are required to show that no part of net earnings go to the benefit of private individuals (Chollet et al., 1996). Further, the governing board must represent the community being served by the organization (Ibid). Although there are no Federal laws that require not-for-profit hospitals or other not-for-profit health organizations to support indigent or charity care in order to retain their tax-exempt status, some states have obligated not-for-profit hospitals to provide such care in order to retain their not-for-profit status.

Under most state laws, when a nonprofit makes the decision to convert to for-profit status, merge, or to be acquired by a for-profit company, it is required to transfer the value of its assets to another nonprofit organization or charitable foundation pursuing "similar charitable goals" of the converting nonprofit (Bell 1996). Oversight authority for these activities at the state government level varies across states: usually the insurance commissioner oversees nonprofit HMO and insurance company conversions and the attorney general monitors hospital and nursing home activities (Ibid). In California — now a precedent-setting state in terms of acquisitions and conversions — the Department of Corporations oversees the conversions of health plans. In 1995, legislation was enacted in California regarding the review of conversions to ensure that nonprofit HMO assets are reserved for charitable purposes (Ibid). Across the country, however, given the complexity and "newness" of these transactions, many regulatory agencies are struggling with the staff resources and expertise to take a lead in monitoring such conversions. Their efforts are framed by existing state laws, articles of incorporation of the nonprofit entities, and the current political environment in the 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 et al., 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 et al., 1996).

Consumer Groups

Regarding the conversions of hospitals and health plans, policy makers and regulators in the state of California expressed a need to focus on the issues raised by conversions and acquisitions, based on their experiences with the conversion of Blue Cross and HealthNet (a for-profit HMO conversion) (Challot et al., 1996). Specifically, state policy makers emphasized the importance of public hearings and consumer involvement throughout the transaction process. Consumers groups such as the Consumers Union are instrumental in monitoring the converting of nonprofit health care companies in California. Their advocacy activities in working with state regulators in California influenced the valuation of HealthNet (a for-profit HMO) and increased the transfer of its charitable assets to endow a new foundation — the Wellness Foundation — in the state. Consumers Union is working jointly with Families USA to monitor these conversions as they are taking place across the country.

CONCLUSION

As the commercialization of health care continues, the issue of public benefit is paramount in the realm of public policy making regarding mergers, acquisitions and conversions among for-profit and nonprofit health care organizations. Without the support of state and local government working in tandem with them, nonprofit health care entities will have great difficulty surviving in a profit-driven economy. Is there a place for both nonprofit and for-profit entities in the new health care arena? The jury is still out. Public policy makers and governmental leaders are confronted by the challenges of creating an environment in which decisions about health care are made from the perspective of protecting the public good and keeping the public interest as the central focus. The overall goal is to create a health care system that affords accessible, quality health care in an cost-effective manner, whether it be for-profit, nonprofit or a balanced combination of both. The challenge to public policy makers and legislators is not to have the issue obscured by either side, but to keep the public interest as the central focus in making decisions.

QUESTIONS FOR DISCUSSION

Health policy analysts predict that state and local governments, rather than picking up the slack, will effect spending cuts in safety net and other programs, as those benefiting from these programs have little political clout. This prediction is based on the experience of the cuts during the 1980s and the current propensity of many states to cut revenues and spending. What is New Jersey's commitment to preserve its safety net providers and ensure access to health care for its vulnerable populations?

In the mid-1980s throughout the country, community-based shelters for women and children who were victims of domestic violence developed a revenue-raising strategy to keep their programs in operation. A surcharge was placed on marriage license fees at the state level to provide funding for domestic abuse. In the state of California alone in one year's time, $1.2 million was raised through the surcharge. In the current climate when surcharges are not favorably viewed as an alternative owing to their perception as "another form of taxes," how can nonprofits work with state and local government for creative revenue-raising strategies to support their community programs?

In a recent trend, managed care organizations are interested in working with community health centers, as they have established relationships in their communities and high clinical standards imposed by Federal requirements. However, a National Association of Community Health Centers study of some 200 national managed care contracts found that reimbursement was extremely low — in some cases 50 percent lower than Medicaid reimbursement for health center services. What role do public policy makers have in monitoring the managed care contracts with providers such as the community health centers?

In an August issue of the New England Journal of Medicine, a physician writing from Germany in response to an earlier article about the positive aspects of the rapidly changing for-profit health care sector, notes that the problem with a fully privatized for-profit medical system is that it will ultimately "create a pyramid of medical care modeled after the pyramid of income distribution." Under this pyramid, those at the top will enjoy access to quality health care, while those at the bottom will continue to struggle. He asserts that this is the reason no "civilized" nation has chosen to open medicine to full-scale competition. While acknowledging that nonprofit and public sector health care need rigorous reform, he makes a plea that the system not be altogether abandoned to market forces. How do public policy makers continue to focus on the values inherent in nonprofit health care and an increasingly profit-driven market focused on the "bottom line"?

The most recent issue of Competitive Healthcare Market Report, a publication dedicated to tracking mergers, acquisitions and conversions in the health care industry, included eight, single-spaced pages reporting on such business transactions around the country. As the commercialization of health care continues to expand, how does government "keep up" with industry changes that affect the public?

APPENDIX

SAFETY-NET PROVIDERS[6]

The following are some key elements in the health care safety net. While a formal definition of the safety net providers encompasses only those who are legally required to provide health care for free or at reduced rates, on a practical level, the net is much broader. (Robert Wood Johnson Foundation Advances, 1996).

Public Hospitals

Competition puts public hospitals at risk. Of the nation's 6,500 community hospitals, about 1,400 are "public" — they are owned and operated by states, cities and counties. Funding sources include Medicare, Medicaid, insurance companies and patients themselves, as well as direct subsidies from state and local tax monies. These hospitals provide services to the community that are typically under-funded by insurance, such as trauma care, burn centers, neonatal intensive care units and emergency psychiatric care.[7]

Private Hospitals

These are private hospitals, both nonprofit and for-profit. In a competitive market, even nonprofit private hospitals are likely to decrease their levels of charity care. Using California hospitals as an example, when hospitals discounted their charges to managed care organizations in order to be competitive when they were sustaining Medicaid and Medicare cutbacks, the private hospitals reduced their provision of uncompensated care by 36 percent.

Community Health Centers/Migrant Health Centers

Located primarily in inner-city and rural areas with shortages of health care providers, there are approximately 600 community and migrant health centers throughout the country, offering some 2,500 delivery sites. Approximately 9 million individuals are served each year via comprehensive, case-managed primary and preventive care. The centers are involved in working with managed care organizations and exploring capitation as ways to remain competitive in the current health care environment.

Public Health Agencies

Supported by federal, state, county and local sources, public health agencies act as both providers and planners of community health. Services range from child immunizations, home health care and the monitoring and prevention of the spread of communicable diseases. The advent of managed care is having a significant affect on the public health activities of these agencies.

Family Planning Clinics

There are over 4,000 clinics in this federally funded program and an estimated 4 million women and teenagers receive primary care, cancer screening and disease prevention services.

Health Care for the Homeless

A federal program that funds 129 projects that offer primary care health services to approximately 420,000 individuals. Almost half the projects are administered by community health centers; the other are operated by nonprofit coalitions, nonprofit urban hospitals and local public health departments.

Ryan White AIDS Program

The Ryan White CARE Act provides health care and social services to an estimated 80,000 patients with AIDS or who are HIV-positive. The program is federally funded and last year served approximately 80,000 patients.

Rural Health Clinics

There are approximately 2,500 federally designated Rural Health Clinics which are mostly privately owned and operated. These clinics provide access to health care for almost 4 million patients each year. Approximately 70 percent of their clients are either Medicaid or Medicare beneficiaries.

Privatization

An emerging trend among financially strapped counties, states and municipalities is to contract with private nonprofit or for-profit organizations to provide public health services. Such contractual relationships have been expanding since the mid-1980s, especially in the area of social service programs, such as child day care and maternal and child health programs.

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[6] Definitions and terms are derived from many sources; two primary sources are: a Supplement to *Advances*, 1996, a publication of the Robert Wood Johnson Foundation; and *States of Health*, December 1995, from Families USA Foundation.

[7] In New Jersey, under state law all hospitals are required to provide indigent care. Reference is made to the Capital Forums Issue Brief on Uncompensated Care (1995).

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