Considering Causes:
Forces Driving the Conversion Trend

The Influence of Market Forces on Health Care Institutions

Why are these changes in the health care market occurring? Commentators have offered several explanations for the health care conversion phenomenon.[1] Among the most frequently mentioned reasons are the managed care revolution and the increasingly competitive nature of the health care industry. These market forces have made consolidation a rallying cry among health care institutions, which in turn has heightened the need for capital. As health policy experts have explained:

> Competitive forces in the marketplace have forced hospitals and health plans to be more efficient, and many have sought efficiencies through consolidation via mergers and acquisitions.
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> In today's competitive environment, increasing market share is often a necessary strategy. Hospitals need increased market share to build networks that will guarantee patient flow and to increase their bargaining power with managed care plans and physician groups. Health plans seek to build large enough networks to serve regional and national employers and to give them increased leverage in their negotiations with providers. Network building is expensive and often is accomplished through merger and acquisition, regardless of organizational form.[2]

In this context, the legal constraints on nonprofits may be a disadvantage. Nonprofits cannot raise money through the sale of stock. Nor can they offer their executives stock options plans, profit sharing or the other types of incentive compensation that are routine in the business world. These constraints may hamper nonprofits' efforts to compete with for-profits for managerial talent.

The surge in conversions and consolidations beginning in the mid-1990s generated momentum and reinforced the notion that big is best and that only large, integrated delivery systems would thrive. Some argue that: "Access to capital is particularly important in a managed care environment, in which substantial investments may be necessary for information systems, network development, utilization management, and expanding market share. . . . For-profit firms can acquire competitors by issuing stock,

thereby expanding their market shares without reducing their reserves or accumulating substantial debt."[3]

Yet even in this competitive environment many nonprofit institutions continue to thrive. Nonprofit hospitals, responding to competition from large for-profit hospital chains, are linking together to form their own networks. These arrangements allow the hospitals to experience the benefits of consolidated management and services without relinquishing their nonprofit status. And some believe that nonprofit institutions are in a better position to respond to market dynamics. For example, Kaiser Permanente, America's largest nonprofit HMO, once considered converting to for-profit status but ultimately rejected the idea.[4] According to the chief executive officer of Kaiser Foundation Health Plan, "Kaiser Permanente has adequate capital and sufficient discipline to compete effectively without converting. However, the primary reason the organization chose to remain nonprofit is that we believe the marketplace and public policy needs that will emerge in health care over the next several years will best be met by nonprofit organizations."[5]

Market forces can create an atmosphere of greed, which may also motivate some nonprofits to convert to for-profit status. In some conversions, nonprofit insiders, both top management and members of the board of directors, reap substantial financial gains as a result of the transactions. For example, some managers and directors obtain valuable stock options and high salaries as employees of the new for-profit company, while others receive "golden parachute" severance packages when they leave the employ of the converting nonprofit.[6]

Government Policies Create Incentives for Conversions

Changing laws and policies also have played a role in the conversion trend, particularly when government has modified tax preferences and eliminated subsidies for nonprofit institutions. Consider the HMO industry. Federal loans and grants to nonprofit corporations under the HMO Act of 1973 were an important source of capital for development. The end of federal funding in 1983 sparked the first round of conversions in the health care industry.[7] The HMO industry's subsequent shift to for-profit domination was fast and emphatic. In 1981, 82% of the nation's HMOs were nonprofit institutions; by 1998, the number of nonprofits had dropped to 26%.[8]

The nation's Blue Cross and Blue Shield (BCBS) plans, which for decades were nonprofit organizations, are experiencing a similar trend. Like nonprofit HMOs, the BCBS plans lost one of the primary advantages of nonprofit status – full exemption from federal taxes – with the enactment of the 1986 Tax Reform Act. The 1986 law subjected the plans to taxation, but created a special deduction for them not available to for-profit insurers.[9] This change was largely due to the lobbying efforts of for-profit companies, who argued that the BCBS plans did not provide public benefits that justified tax exemption. Even the Internal Revenue Service advised Congress "'that the significant differences between nonprofit and for-profit insurers that may have justified the initial tax exemptions have been eroded by competitive developments.'"[10]

The loss of the primary benefit of nonprofit status, combined with the competitiveness of the insurance market, made conversion to for-profit status an increasingly attractive option. Historically the national BCBS Association, which controls the valuable blue "cross" and "shield" trademarks, required all Blues plans to be nonprofit organizations in order to use those trademarks. In June 1994, however, the national BCBS association changed the rules to allow its member plans to become for-profit companies, citing changing marketplace dynamics and the plans' need to access equity capital as reasons for the new policy.[11] Blues plans across the country responded eagerly to the siren song of the stock market.

State government policies have sometimes added to the incentive to convert. Georgia's legislature, for instance, virtually propelled its state's BCBS plan towards conversion. In that case, legislation enacted in 1995 authorized the health insurer to convert "into a for-profit company without any obligation to use its assets for public benefit. Rather than requiring a transfer of assets to charitable purposes, the Georgia insurance commissioner approved [the distribution] of stock to Blue Cross Blue Shield policy holders."[12] Ultimately, several nonprofit community groups sued the BCBS plan for converting charitable assets to private use; the lawsuit was settled when the plan agreed to transfer approximately $80 million to a new charitable foundation.

Is Government at the Fulcrum of the Conversion Trend?

Government influences the nonprofit sector in myriad ways, three of which shed light on the causes of conversions: funding, other incentives, and regulatory oversight. Government spending is the most visible measure of state power and may have the most immediate impact on nonprofits. But in addition to the power of the purse, government pursues an array of programs and policies that affect nonprofit organizations. Exemption from income and property taxation is the most familiar, and possibly the most important, government benefit conferred on nonprofits. The state may provide other benefits including: relief from regulations as far ranging as worker safety and parental leave; free and reduced-cost supplies and equipment; tax-free borrowing authority; and eligibility to receive tax-deductible contributions. Government also determines which organizations receive nonprofit status and oversees the activities of charitable entities. In its regulatory role over conversions, government is responsible for safeguarding the accumulated value of the charitable assets held by the hundreds of thousands of nonprofit entities located in virtually every community in America.

Although the benefits of being nonprofit can be substantial, charitable preferences come with powerful constraints. For example, nonprofit entities are prohibited from distributing earnings or assets to individuals and cannot, therefore, issue stock or raise equity capital. The law imposes limits on legislative lobbying for most nonprofit groups. Direct involvement in electoral politics is also off-limits for many nonprofits. At times, substantive restrictions are imposed on day-to-day operations, as in the case of local nonprofit organizations funded by federal government initiatives such as the Legal Services Corporation or the National Endowment for the Arts.

The law also charges charitable nonprofits with a duty to promote public welfare or to serve "religious, charitable, scientific, testing for public safety, literary, or educational purposes[.]"[13] State and local governments have begun focusing more on the activities of nonprofits, rather than on their organizational form or broadly-stated purpose, to determine whether they are entitled to tax exemptions. Pennsylvania, for example, has specific criteria that a nonprofit must meet to be considered a tax-exempt, "purely public charity."[14] One of the statutory requirements is that the organization "must donate or render gratuitously a substantial portion of its services."[15]

Nonprofit hospitals in particular face increased scrutiny of whether the community benefits that they provide justify their tax-exempt status. Many states have enacted community benefit laws for nonprofit hospitals.[16] These laws typically require nonprofit hospitals to assess community health needs and formulate plans to meet them. In addition, the hospitals must report on the community benefits they provide. Some laws go a step further and require nonprofit hospitals to meet a minimum level of spending on community benefits to qualify for tax exemptions.[17]

While the vast majority of organizations evidently find that the benefits of nonprofit status exceed the burdens, the increasing number of conversions suggests that the tide may be turning. If it is, government policy may bear a significant share of the responsibility.

The Power of Government as Funder

From modest beginnings in the nineteenth century, government investment in the nonprofit sector "expanded massively in the 1960s and 1970s when the federal government entered the scene in response to continued poverty and distress, limited growth in private charitable support, and a changed political climate."[18] This rise in government spending fueled rapid growth in the nonprofit sector, particularly in the human services subsector. By 1982, three-fifths of all nonprofit human service agencies in the nation had come into creation since 1960.[19]

While Medicare and Medicaid funds were not touched by cutbacks in the 1980s, most other pools of federal government money for nonprofits dried up during the Reagan years. And, while government funding began growing again in the late 1980s, it has not returned to its former heights. When nonprofits that were accustomed to receiving government money faced losing it, they had to seek funding elsewhere. Although private giving (including donations from individuals, foundations, corporations, and bequests) is a desirable source of financing, it has proven to be neither a stable nor a sufficient source for many nonprofits. The most obvious problem is that the total quantity of private grants and donations is not sufficient to fund the activities of the entire nonprofit sector. Even when the U.S. economy is booming, charitable donation rates do not keep pace with rising incomes.[20]

And digging a little deeper reveals a more complicated picture. In fact,

> . . . the *composition*, as opposed to the scale, of giving does not seem to match the profile of government spending sufficiently to suggest that one could be a substitute for the other *even if the amounts were equivalent*. Generally speaking, giving is greatest where wealth is greatest, rather than where need is greatest. [And] much of private giving flows not to those in greatest need but to functions with a significant "amenity" value to the givers (e.g., education, culture).[21]

Therefore, particularly in the health and human services area, private giving cannot be expected to replace government funding.

How Government Spends Money Matters Too

Nonprofit service providers that contract directly with the government are concerned about both the amount of funding that they receive, and the manner in which funds are disbursed. Health policy experts, for example, have pointed to the influence of different forms of Medicare reimbursements on organizational behavior among hospitals.[22] Before the 1980s, hospitals received Medicare payments on a retrospective cost or charge basis. But beginning in 1983, the federal government implemented the Medicare Prospective Payment System, which set fixed payments for inpatient care, with price varying according to diagnosis-related groups. Under this new payment system, hospitals had to lower their costs to meet the fixed payments. The tremendous cost-cutting pressure that resulted was one factor fueling the drive for market-share acquisitions and consolidation among hospitals.[23]

Federal and state adoption of performance contracts in the human services arena has also added new financial stress for many nonprofits. "Unlike more traditional cost-reimbursement contracts, which protect providers of services by covering their costs regardless of outcomes, performance contracts shift the risk to providers, which only get paid for successfully completed assignments."[24] While performance-based contracts serve worthwhile policy goals, they may also put nonprofit organizations at a competitive disadvantage because they typically are smaller and less well-capitalized than their for-profit competitors. Performance contracts may also have qualitative effects on service delivery as nonprofits, or competing for-profits, seek to contain costs by screening out more difficult clients and declining to provide more labor-intensive services.

Opening the bidding for block grants and social services program contracts to for-profit businesses has also had dramatic effects. Lockheed Martin, for instance, has moved aggressively to win government contracts to provide a comprehensive package of welfare-to-work services. Lockheed Martin's contract in Dade County, Florida, is typical. The corporate giant has a "master contract" to both deliver services and manage the county's entire system of service delivery. Essentially, Lockheed Martin acts as a general contractor and has hired "agencies to supply various welfare-to-work services – including transportation, child care, mental health services, and treatment for drug and alcohol abuse, . . . job readiness, skill training, and job placement services."[25] Many of these subcontractors are community-based nonprofits that have experience with and access to the "clientele" receiving the services. Rather than financing their services through direct government funding, these nonprofits now depend on their contractual relationship with Lockheed Martin for their continued operation.

Welfare-to-work services are not the only social programs that are ripe for competition between nonprofit and for-profit entities as a result of altered government policy. The 1996 welfare reform law also put federal funding for foster-care programs – amounting to $3 billion annually – up for grabs.[26] Indeed, for-profit social services companies like Maximus inform prospective investors that government-funded social service programs constitute a multi-billion-dollar market."[27]

Government Oversight of Conversions Is Inconsistent and Often Inadequate

Government also has the power and duty to protect charitable assets and promote the public's beneficial interests. Critical failures in government oversight of early conversion transactions allowed public dollars to fall into private hands. When Pacificare (a California HMO) converted in 1984, regulators accepted a valuation of $360,000. But less than a year later, the market value of the new for-profit company was $45 million.[28] Similar undervaluations occurred in transactions across the country. For example, Greater Delaware Valley Health Care was valued at $100,000 in 1984, but two years later and after it converted, the new for-profit was worth $20 million.[29] The value of Group Health Plan of Greater St. Louis increased tenfold within a year after it converted.[30] By failing to require converting nonprofits to preserve the full value of their assets, regulators allowed millions of public dollars to be pocketed by the new for-profit companies' executives and investors.

After these early regulatory failures, community coalitions and consumer advocates began demanding more careful and thorough scrutiny of conversion transactions to protect charitable dollars and services. As a result, later conversions did not suffer from the egregious undervaluation of assets that characterized the early transactions.

Government failure to adequately regulate conversions and preserve charitable assets can create a powerful financial incentive for conversions. Nonprofit executives and board members can make millions of dollars on a single transaction. When the California HMO HealthNet converted in 1992, thirty-three executives purchased 20 percent of the company for a mere $1.5 million. By April 1996, their shares were worth roughly $315 million.[31] One former top executive of HealthNet paid only $300,000 for stock that within a few years was worth $31 million, a gain of 10,000 percent.[32]

Insufficient Regulatory Resources and Authority

Several factors contribute to the government's limited ability to protect charitable assets effectively. Attorneys General, the state officials charged with overseeing nonprofit organizations, often lack adequate staff, funding, and training to oversee complex conversions. The time required to effectively review even a single conversion transaction can run into hundreds of hours. Similarly, the cost of an expert, independent valuation of a health plan or student loan secondary market easily can extend to six figures. Even in cases where a converting charity may be required to pay the costs of oversight, Attorneys General are faced with an uncomfortable choice. They can require a converting nonprofit to spend tens of thousands of dollars on lawyers and accountants – money that would otherwise fund charitable programs – or approve the deal without adequate information.

While state regulators generally lack adequate funding, for-profit investors spend freely to consummate a conversion. The high potential payoff has for-profit buyers employing the nation's leading investment bankers, accountants, and lawyers to broker the deals. In some cases, the nonprofits themselves spend millions to complete a transaction. For example, when Massachusetts' new student loan conversion foundation sought to sell its wholly-owned, for-profit secondary market, the board approved a $2 million fee for a finance firm to close the deal.

State laws that regulate health care conversions have improved oversight by making the requirements for regulatory approval more stringent.[33] These statutes typically tighten

the rules of review by requiring public disclosure of transaction data, verification of the value of the converting nonprofit's charitable assets, and assessment of the impact of any proposed conversion on community benefits. These laws have helped to increase the availability of public information and reduce charitable losses.

Unfortunately, these laws are too often narrowly drawn for particular nonprofit sectors. Thus, conversions of nonprofit hospitals to for-profit status may elicit enhanced oversight, while transactions involving nonprofit health insurers or student loan secondary markets do not. In Ohio and Nebraska, for example, conversion legislation rewrote the rules for regulatory oversight of nonprofit hospitals.[34] But because these laws applied only to health care institutions, the nonprofit student loan secondary market conversions in both states proceeded with far less rigorous scrutiny.

Some legislative reforms even fail to cover diverse transactions within a particular regulated sector. For instance, California enacted a hospital conversion law in 1996 in response to the rising number of transactions.[35] This law created a thorough review process for nonprofit to for-profit conversions, including: (1) providing mechanisms to ensure that the full value of the converting hospital's assets is preserved, (2) requiring the commissioning of a health impact statement to assess the proposed transaction's effects on the availability and accessibility of health care in the community involved; and (3) mandating at least one public hearing on the proposed transaction. But the statute did not apply to consolidations among *nonprofit* hospitals, even though such transactions may present issues of purpose, governance, community benefits, and antitrust impacts just like nonprofit to for-profit conversions.[36]

Government Influence: What Does the Future Hold?

Some believe that there is reason to be optimistic that the relationship between the federal government and the nonprofit sector may be entering a new, more collaborative era. Other signs suggest a less rosy future for nonprofits. The economic prosperity of the closing years of the twentieth century has propagated an unquestioning faith in the market and a new fervor for business practices as the means to solve any and all societal problems. This market milieu may encourage some nonprofit entrepreneurs to move from working for a social service organization to owning the organization and operating it as a profit-making government contracting business.

The for-profit model itself has tarnished the image of nonprofits. "Because they do not meet a 'market test,' nonprofits are always vulnerable to charges that they are inefficient in their use of resources and ineffective in their approaches to problems."[37] For-profit businesses can measure and tout their success in terms of earnings and profitability. Nonprofits, on the other hand, often seek to accomplish broadly stated missions, the success of which cannot readily be quantified and assessed.

General concerns about the effectiveness of nonprofits have been exacerbated by public sentiment against "big government" and "tax and spend" liberalism. When nonprofits, such as those that provide human services, receive a large portion of their funding from government subsidies, they may be viewed as part of the problem rather than as a solution to social problems. And widely publicized scandals at trusted nonprofits, such as criminal charges of fraud and money laundering brought against former top officials at the United Way of America, further damaged the public perception of nonprofits. As two nonprofit scholars studying Canadian charities engaged in commercial ventures have observed: "The language of the market place has put management at the centre of our organizations, corporate business at the centre of society and defined government and nonprofit organizations as nonproductive or burdensome."[38] Their observation is equally applicable to the influence of market ideology in this country.

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[1][1] See, for example, the discussion of reasons conversions occur in Gary Claxton, Judith Feder, David Schactman, and Stuart Altman, "Public Policy Issues in Nonprofit Conversions: An Overview," *Health Affairs* (March/April 1997), pp. 13-15; Bradford H. Gray, "Conversion of HMOs And Hospitals: What's At Stake?" *Health Affairs* (March/April 1997), pp. 32-33; and Bell, et al., *The Public Interest in Conversions*, pp. 7-8.

[2] Claxton, et al., "Public Policy Issues," pp. 13-14.

[3] Claxton, et al., "Public Policy Issues," p. 13.

[4] David Lawrence, "Why We Want To Remain a Nonprofit Health Care Organization," *Health Affairs* (March/April 1997), p. 118.

[5] Ibid.

[6] Michael Hiltzik, "HMO Acquisition Shows There's Still Big Money in Medicine," *Los Angeles Times* (April 5, 1995), p. D1; Greg Miller, "Health Net Execs Make a Healthy Investment," *Los Angeles Times* (January 17, 1995), Business Section, p. 3; and Anne Lowry Bailey, "Charities Win, Lose in Health Shuffle," *Chronicle of Philanthropy* (June 14, 1994), p. 11.

[7] John H. Goddeeris and Burton A. Weisbrod, "Conversion from nonprofit to for-profit legal status: Why does it happen and should anyone care?" in Weisbrod, ed., *To Profit or Not To Profit*, p. 137.

[8] "For-Profit HMOs: Are the Glory Days Gone?," *Health Line* (The National Journal Group, Inc.) (April 12, 1999) and Claxton, et al., "Public Policy Issues," p. 12.

[9] 26 U.S.C.A. § 833 (West Supp. 1999).

[10] Robert Cunningham, III and Robert M. Cunningham, Jr., *The Blues: A History of the Blue Cross and Blue Shield System* (DeKalb: Northern Illinois University Press, 1997), pp. 214-15 (quoting U.S. General Accounting Office, Report to the Chairman, Subcommittee on Health, Committee on Ways and Means House of Representatives, *Health Insurance*: *Comparing Blue Cross and Blue Shield Plans with Commercial Insurers* (July 1986), pp. 2-3)).

[11] Claxton, et al., "Public Policy Issues," p. 12.

[12] Bell, et al., *The Public Interest in Conversions*, p. 37.

[13] 26 U.S.C.A. §501(c)(3) (West Supp. 1999).

[14] Institutions of Purely Public Charity Act, 10 Pa. Cons. Stat. § 371, et seq. (1997).

[15] 10 Pa. Cons. Stat. § 375(d)(1) (1997).

[16] *Redefining the Community Benefit Standard: State Law Approaches to Ensuring the Social Accountability of Nonprofit Health Care Organizations,* Coalition for Nonprofit Health Care (Washington D.C.: July 1999), p. i.

[17] Ibid.

[18] Salamon, *Holding the Center*, p. 14.

[19] Ibid., p. 15.

[20] Eileen Daspin, "Philanthropy: How to Give More; During the 1990s stock-market boom, proportionately fewer households gave to charity," *Wall Street Journal* (October 2, 1998), p. W1.

[21] Salamon, *Holding the Center*, p. 24 (emphasis in original).

[22] See, for example, Frank A. Sloan, "Commercialism in nonprofit hospitals," in Weisbrod, ed., *To Profit or Not to Profit*, pp. 151-168.

[23] Ibid.

[24] Ryan, "The New Landscape for Nonprofits," p. 130.

[25] Ibid., p. 132.

[26] Moore, "A Corporate Challenge for Charities," p. 34.

[27] Ryan, "The New Landscape for Nonprofits," p. 129.

[28] Bell, "Saving Their Assets," p. 63; see also Bailey, "Charities Win, Lose in Health Shuffle," p. 12 (chart: "What Charities Got From Conversions of 19 Health Organizations to For-Profit Status").

[29] John George, "Who's to Profit From Sale of Delco HMO?" *Philadelphia Business Journal* (April 1, 1991), Sec. 1, p. 1.

[30] Patricia Miller, "$9 Million for Shareholders: GHP Stock Sold at 43 Times Original Price," *St. Louis Business Journal* (June 8, 1987), Sec. 1, p. 1A.

[31] Robert Kuttner, "Welcome to Hospitals R Us," *Sacramento Bee* (September 29, 1996), p. F1.

[32] Michael A. Hiltzik and David R. Olmos, "Are Executives At HMOs Paid Too Much Money?" *Los Angeles Times* (August 30, 1995), p. A13.

[33] For a comprehensive examination of health care conversion legislation across the country, see *Protecting Health Preserving Assets: A Comprehensive Study of Laws Governing Conversions, Mergers and Acquisitions Among Health Care Entities* (Community Catalyst 1998 Update) (first published in *Clearinghouse Review* (March/April 1998)).

[34] Nonprofit Hospital Sale Act, Neb. Rev. Stat. §§ 71-20, 102 *et seq.* and 1997 Ohio Laws Am. Sub. House Bill No. 242.

[35] Stats. 1996, c. 1105, AB 3101 (Isenberg) codified at Cal. Corp. Code § 5914 et seq. (West Supp. 1999).

[36] A bill passed by the California legislature in September 1999 would extend regulatory oversight to consolidations of nonprofit health care institutions; the bill is awaiting action by the Governor. AB 254 (Cedillo).

[37] Salamon, *Holding the Center*, p. 37.

[38] Zimmerman and Dart, *Charities Doing Commercial Ventures*, p. viii.