Executive Summary

Background

This is a report on the history of nonprofit acute-care hospitals converting to for-profit status in California from 1993 to 1998. Three years ago, Consumers Union, nonprofit publisher of *Consumer Reports* magazine, began the Community Health Assets Project, a partnership with Community Catalyst of Boston. The project seeks to protect nonprofit charitable assets and to ensure that any potential adverse health impacts that may result from these transactions are mitigated. This was the expansion of work started by Consumers Union in the mid 1980's to preserve the assets of converting nonprofit California HMO's.

These transactions raise concern because millions of charitable dollars that belong to the public are at stake. Particularly in transactions of nonprofit hospitals the very health care of communities will also be affected. These charitable assets have been built and operated with the generosity of communities that have given these hospitals tax exemptions and the ability to float tax-free bonds, accept charitable contributions, and even employ volunteer labor. Nonprofit hospital trustees do not own these assets. They are simply entrusted with the temporary management of these assets for the benefit of the public.

Both nationally and in California, between 1993 and 1996, there was a threefold increase in the number of nonprofit hospitals converting to for-profit status. In this report we attempt to assess the effectiveness of California's current regulatory framework, trends emerging in new transactions (such as the increasing number of nonprofit stand-alone hospitals merging with larger nonprofit hospital systems), and, in particular, the impact these transactions can have on hospital charity-care.

When a nonprofit hospital converts or is sold to a for-profit, the law requires that the sale proceeds (which should equal the full fair market value of the assets of the nonprofit less debt retired) must be returned to the community. This is accomplished by the nonprofit's transfer of all of its assets to another charitable organization, usually a foundation. These sale proceeds must be used in a manner consistent with both the nonprofit's original mission and the historical uses of its assets. So far, nearly $13 billion has been pumped into about 100 new charitable "conversion" foundations nationwide. Between 1993 and 1998 in California, ten hospital transactions have resulted in the creation of eight foundations and two charitable funds with assets worth over $400 million.

In response to the wave of nonprofit/for-profit mergers in 1996 California enacted AB 3101 (Isenberg), the state's first hospital conversion law. The law became effective on January 1, 1997. Among the law's new requirements were: 1) the converting nonprofit or Attorney General engage the services of a valuation expert or otherwise engage in a bidding process to establish the value of the assets to be transferred; 2) the nonprofit file or the Attorney General commission a Health Impact Statement assessing the affect the proposed transaction was likely to have on the availablity and accessibility of health care in the community involved; and 3) the Attorney General hold at least one public meeting before approving or disapproving the transaction.

Methodology

The fundamental purpose of this report is to provide a methodology to assess the impact nonprofit to for-profit hospital conversions have on the communities they serve, and the impact legislation can have on this process. In addition, this report begins the process of data gathering to provide guidance to policy makers to meet the challenge of re-structuring in the hospital sector. Accordingly, in this report we analyze 10 conversion transactions involving the transfer of nonprofit acute-care hospitals, which we believe include all the hospital conversions known to have occurred in California between 1993 and 1998.

The hospitals included in this study are: Sacred Heart, Hanford; Centinela Hospital, Inglewood; Good Samaritan, San Jose; United Western Medical Center, Santa Ana; United Western Medical Center, Anaheim; Pacific Hospital of Long Beach; Riverside Community Hospital, Riverside, Queen of Angels, Los Angeles; Watsonville Community Hospital, Watsonville; and Sharp Healthcare, Murrieta, Murrieta. Other recent transactions addressed, but for which there is not as complete information available, include Alexian Brothers, San Jose and Summit Hospital in Oakland. In this report we attempt to assess whether these transactions have been a net gain or a net loss to the communities involved. We also attempt to assess the impact of California's new hospital conversion law by looking at a number of transactions before and after the enactment of AB 3101. We have identified a number of deficiencies in AB 3101, but again, it is too early to tell whether all our suggested changes to the law would change the outcomes in these transactions.

Through the lens of AB 3101, the use of case studies, and data available from California's Office of Statewide Health Planning and Development ("OSHPD"), we looked at a number of variables. These variables included charity-care, bad debt, sale price, public process, deal terms, sale proceeds, foundation structures, and community benefits before and after each conversion. We also looked at the degree to which the Attorney General has exercised his new regulatory role and been willing and able to minimize the adverse health impact of these transactions by the imposition of contractual obligations. This data and our case studies form the factual basis for the findings and recommendations that follow in this report.

Key Findings

Public Process

Public process is the single most important facet of conversion transactions. Without public participation only the corporate interest of the for-profit business and the sometime conflicted interest of the nonprofit board are represented. Public participation forces the Attorney General to consider the public interest in addition to corporate interests. This improves the opportunity for better outcomes for the community, though it does not guarantee it. Public process is the framework within which information is released, and public participation is encouraged or discouraged.

As demonstrated in particular by the Riverside Community Hospital ("Riverside"), Queen of Angels/Hollywood Presbyterian Medical Center ("Queen"), and Watsonville Community Hospital ("Watsonville") case studies in this report, without meaningful public process there is little opportunity for the public to insist that the deal terms meet community needs.

In Riverside, the Health Impact Statement submitted by the hospital did not address the level of charity-care it provided or was provided by other hospitals within its service area. The Attorney General did not commission an independent Health Impact Statement, nor did he extend the review period to address this issue, even though he had the authority to do so. The result was that the Attorney General approved the deal without requiring that the for-profit suitor commit to stringent charity-care guarantees. The Attorney General did commission an independent valuation of the hospital, but did not make this valuation report public until after the public hearing on the matter, and he did not have a second hearing to discuss the issues raised by the new report.

In the Queen conversion it was clear that the Attorney General had learned from his prior mistakes, he commissioned an independent Health Impact Statement and valuation report, he extended the review period, and he had a timely second hearing to discuss the issues raised by these new reports. The result was a vastly improved deal than that originally submitted by the parties. In the Watsonville deal, however, a conversion reviewed by the Attorney General only a few months later, the public process lessons apparently learned by the Attorney General during the Queen transaction were quickly forgotten.

In Watsonville, the Attorney General held two public meetings, but they were rushed and the Attorney General refused to extend the 60-day review period. The public process followed by the Attorney General before and after these two hearings was unsatisfactory. The Attorney General failed to provide timely notice of major developments to the public. Critical and dense documents were received only days before the public hearing, and notification of additional filings was delayed by the Attorney General, despite the community's documented interest in keeping abreast of the review process. The result was a lack of public confidence in the review process mandated by law, and a deal whose terms did not meet all of the community's needs.

Probably the most important change brought about by AB 3101 is the requirement that the Attorney General hold at least one public meeting before approving or disapproving a conversion transaction. A meaningful public process presumes more, however, than the simple act of scheduling the public meeting and releasing critical documents at some point during the review process. A meaningful and fair process hinges on timely notice to the community of the pending transaction, the release of documents and the scheduling of public meetings at a time when public participation can be maximized to impact the terms of the proposed transaction.

Although, AB 3101 is a vast improvement over prior law, we found that not only is the Attorney General not required by law to make certain information public, but that when it is released, it is done sporadically, and in a fashion not likely to maximize public input. For example, there is no legal requirement that the Attorney General notify the public when he: 1) receives a Section 5914(a) Notice of Pending Transaction Letter from the applicant; 2) determines the applicant's application is complete; 3) requests additional documents from the applicant; 4) receives new documents and/or reports; 5) decides the review period commences, ends, or should be extended; 6) makes documents available for inspection and duplication; and 7) retains consultants or experts or when he decides their reports will be made

public. These shortcomings have been expressed at virtually every public meeting held under AB 3101. It is within the Attorney General's discretion to remedy them, and the Legislature's purview to correct them.

Health Impact

Another of the new tools available to the Attorney General under AB 3101 is his ability to consult with experts and obtain an independent assessment of the probable health impacts of the proposed transaction. When first used, there was little appreciation for the importance of this tool by regulators, nor the impact it would have on deal terms communities would be able to negotiate as a result of it in order to safeguard their health care.

In the Riverside transaction, for example, the for-profit suitor, Columbia/HCA Healthcare Corporation ("Columbia") only agreed to maintain the charity-care "policies" adopted and implemented by the hospital as of the date of the agreement. Columbia did not commit to provide a specified level of charity-care for any particular length of time or to keep the emergency room open for at least a set number of years. This is due to the fact that the Health Impact Statement submitted by Riverside nowhere specifically discussed the level of charity-care provided by Riverside Community Hospital, other hospitals in its service area, and how the proposed transaction would affect those levels.

Some members of the public requested that the Attorney General retain the Department of Health Services or a private consultant for the purpose of properly evaluating the health impact of this transaction. The Attorney General refused to do so and on April 22, 1997 approved the proposed deal. In announcing his decision, the Attorney General said, "The agreement . . . improves indigent medical care in Riverside County." Unfortunately, the Attorney General's prediction did not come to pass: charity-care declined at Riverside by 31% the year after it converted. In fact, this was a trend we saw in other transactions with either weak or no charity-care, service, and patient-volume guarantees at all.

Charity-care declines at hospitals that convert in the absence of tight charity-care, service, and patient-volume guarantees by the new for-profit owner.

"Charity-care" or "indigent care" is defined by OSHPD as the amount of care given to patients who are *unable* to pay for all or part of their bill or are not sponsored by any form of third-party coverage. In other words, it is care provided by a hospital for which there is absolutely no expectation of payment. Based on the available data, once hospitals convert to a for-profit business, the amount of charity-care they provide generally declines in the absence of tight charity-care, service, and patient-volume commitments.

At some hospitals the decline is quite substantial. For instance, Good Samaritan in San Jose, a hospital that converted before AB 3101, had an 88% decrease in charity-care between its last year as a nonprofit and its first year as a for-profit. Other hospitals that converted prior to AB 3101 followed similar patterns, with United Western Medical Center of Anaheim incurring an 84% decline and United Western Medical Center of Santa Ana sustaining a 94% decline. At Riverside Community Hospital, a hospital that converted after AB 3101, charity-care declined by 31%.

The only exception to this pattern was Pacific Hospital of Long Beach, where charity-care increased by 71%. This transaction, however, was different than all the other transactions that took place prior to the effective date of AB 3101 because, while containing no charity-care obligations, the sales documents did contain very strong service and patient-volume guarantees.

At two hospitals that converted after AB 3101, data was insufficient due to these hospitals' failure to report required data to OSHPD. At four hospitals that converted after AB 3101, data was insufficient due to the recency of the conversion. In all conversions that took place after Riverside, stronger charity- care, service, and patient-volume guarantees were by and large negotiated by the parties, or required by the Attorney General.

For example, quantifiable and perpetual charity-care guarantees were included in the Queen, Watsonville, and Sharp Healthcare Murrieta transactions. Service and/or patient-volume guarantees were required by the Attorney General in the Queen and Sharp Healthcare, Murrieta conversions. It remains to be seen, however, when additional data is available, whether these tighter guarantees will be sufficient to forestall the general decline in charity-care we have observed after hospitals convert.

Declines in charity-care appear to coincide with an increase in bad debt.

At three of the five hospitals, for which there was sufficient data, the decline in charity-care coincided with a substantial increase in bad debts. "Bad debt" is defined by OSHPD as the amount of charges that a hospital is not able to collect from patients who are *able* to pay for all or part of their bills, but are *unwilling* to pay. At Good Samaritan Hospital in San Jose, charity-care decreased by 88% while bad debts increased by 61% the first year after conversion. At United Western Medical Center, Santa Ana, bad debts increased by 58% the first year after conversion and charity-care decreased 94%. At Riverside Community Hospital, bad debt increased by 16% and charity care declined by 31%. The only exceptions to this pattern were at United Western Medical Center of Anaheim and Pacific Hospital of Long Beach. At United Western Medical Center of Anaheim, bad debts decreased 38% in the first year after conversion compared with an 84% decline in charity-care, but bad debt still rose 2% by the second year of conversion compared with a 99% decline in charity-care. Pacific Hospital of Long Beach, a very special case as discussed above, bad debts increased by over 1000% and charity-care increased by 71%.

Given this data, it seems likely that nonprofit hospitals that converted began to charge some patients whom they previously considered indigent. While charity-care and bad debt can both be considered "uncompensated costs" for the hospital, the experience for patients is likely to be different. A patient who now goes to a for-profit hospital that before converting may have considered him indigent and who is not covered by Medicare, MediCal, or other third-party coverage, may now have to decide whether to seek treatment at all, defer treatment, or go to another hospital. If they go to a for-profit hospital they will also likely have to face the harassment of a collection agency or suffer the consequences of a bad credit rating, all because the hospital they have always gone to now considers them a bad debt risk instead of a charity case.

Because charity-care and bad debt appear to be related, it is not unusual for for-profit companies to claim that their level of "uncompensated costs" remains the same after a conversion. In doing so, however, for-profit companies mislead unless they concede that what has really happened is that their level of charity-care has gone down, their level of bad debt has gone up, and that as for-profits they draw the line at different points than nonprofit hospitals of who can pay and cannot pay. The importance of this distinction cannot be overstated, particularly when 7 million Californians lack health insurance, 50,000 a month lose coverage, overloaded hospitals refuse to treat patients who can not pay, and more nonprofit hospitals convert. The likely result is that more of the poor will be caught in the middle, and are likely not to get the care that they need.

Community Benefits

In assessing the total impact of these transactions we also looked at "community benefits." Since 1995, under Senate Bill 697 ("SB 697") nonprofit hospitals have been required by law to report to OSHPD their level of community benefits. Community benefits means a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status. These benefits include health care services rendered to vulnerable populations and charity-care.

In no case, did the sale proceeds (usually set-aside in a foundation), sufficiently pay for the community benefits, including charity-care, provided by the hospital before it converted. This is a hole that needs to be filled. This gap therefore highlights the need for strong charity-care, service, and patient-volume guarantees on the part of the new for-profit owner to mitigate the adverse health impact of these transactions. This gap also highlights the need to require that for-profit hospitals also provide community benefit information. Without this information it is impossible to assess whether these transactions are a net gain or net loss for the communities involved. For-profit hospitals are currently exempted from the reporting requirements of SB 697. Attempts by Consumers Union and others to have for-profit hospitals voluntarily supply this information proved futile.

Foundation Structure

In some hospital conversions, allowing the converting entities' trustees to remain on the new foundation's board of directors has led to questions about whether they were the best persons for the job or, in some cases, even had conflicts of interest. In the United Western Medical Centers/OrNda/Tenet deal, some philanthropy experts asked whether anyone involved in managing a financially troubled hospital should determine how a foundation spends its money. In the United Western Medical Centers deal, the interim nine-member foundation board included six members from the former nonprofit hospital board. Similar concerns were raised by the community in the Good Samaritan deal, where the hospital suffered a $43 million dollar loss in the year before it converted, and the board granted itself and other managers $650,000 in bonuses. In the Queen of Angel's transaction, certain board members exercised their ability to terminate other board members who were more critical of the terms of the for-profit conversion. They then succeeded in getting seats on the new foundation board, and even attempted to increase their salaries for their role in brokering the deal. They were stopped by the Attorney General.

New Trends

Under the category of new trends, hospital mergers in the late 1990s are beginning to look nothing like the mergers of even a few years ago. Nationally, in 1997, for instance, 75% of the hospital buyers were non-profit organizations, compared to 67% in 1996 and only 36% in 1994. The new national trend is toward consolidation of nonprofit systems. This trend has been mirrored in California, where since 1993, there have been a total of 11 conversions to for-profit, but 32 nonprofit/nonprofit consolidations during the same period, with 23 of them occurring in 1996. Yet, there is little if any regulatory oversight of these transactions. The potential impact of this type of transaction on the availability and accessibility of health care in the community can be as significant as the impact of hospital conversions from nonprofit to for-profit status.

Top Recommendations

Public Process

A meaningful and fair process hinges on timely notice to the community of the pending transaction, the release of documents and the scheduling of public hearings at a time when public participation can be maximized to impact the terms of the proposed transaction. Accordingly, in this report, we make specific recommendations to the Attorney General, the Legislature, and Governor to promulgate regulations and/or legislation to achieve this goal.

Health Impact

Any health impact statement must specifically include the following information: examine the short-, medium-, and long-term impact of a proposed conversion; identify any unprofitable services that are needed by the community but are likely to be cut by the new for-profit owner; and analyze whether the charitable proceeds – in addition to contractual commitments made by the for-profit corporation – are sufficient to mitigate any gaps identified.

Charity-care

To mitigate any likely decline in charity-care, the new for-profit owner must be required to provide at least the same level of charity-care as defined by OSHPD that the nonprofit hospital has historically provided, calculated as a percentage of gross revenues or gross expenses, adjusted annually for inflation, and in perpetuity.

Sales Price & Sale Proceeds

To maximize the charitable proceeds that result from these transactions and minimize the adverse impact on community benefits after a conversion, the for-profit suitor must be required by the Attorney General to pay full fair market value for the public charitable assets it wishes to acquire, not just a value within a "reasonable range." The price should be paid in cash and secured assets that would be expected in an arm's length transaction.

Community Benefits

All hospitals, both nonprofit and for-profit, must be required to submit community benefit information and relevant financial data to OSHPD in a timely fashion. Enforcement, penalties, and oversight must be enhanced so that the public and policy makers can properly scrutinize transactions.

In addition, the Legislature and Governor must strengthen SB 697 (the community benefit law) so that all hospitals properly assess their community needs and report the community benefits they provide. Currently, reports filed with OSHPD vary greatly in content and format. These reports must be comprehensive and consistent in the information they provide and use consistent methodologies for the economic value of community benefits.

Foundation Structure

With respect to the structure of any new conversion foundations, we believe: 1) that ideally the foundation should be a new and independent body with all new directors and staff. Any possible conflicts of interest or even the appearance of a conflict of interest should be avoided; 2) the new board of directors should also serve without compensation or receive only reasonable levels of compensation; and 3) the board should reflect the views and interests of the community, represent the diversity of our state and skill mix from the field which the fund is intended to support, and be independent of the new and old entities. Additional reforms to minimize conflicts of interest and enhance accountability appear in the Recommendations section of this report.

New Trends

Nonprofit/nonprofit mergers are currently exempted from regulatory oversight, although such mergers are on the rise. The potential health impact of these transactions can be as significant as conversions to for-profit status for the communities involved. Accordingly, we support passage of Assembly Bill 254 (Cedillo), which would require at least the same regulatory oversight of nonprofit/nonprofit mergers as conversions now receive.

Conclusion

We set out in this report to provide a methodology to assess the impact of nonprofit to for-profit hospital conversions on the communities they serve. We also set out to assess the impact legislation can have on this process. In addition we have set in motion a process for gathering data so that policy makers and the public are better able to craft solutions that maintain needed hospital services as the health care sector re-structures itself. Although quite early, we have also identified some important issues. We now know that: 1) a meaningful public process is essential in order for the public to impact transaction terms and protect their health care; 2) once hospitals convert to for-profit status the amount of charity-care declines in the absence of tight charity-care, service, and patient volume guarantees; 3) in a number of more recent conversions, in response to public pressure, stronger charity-care and other commitments have been negotiated by the parties, or imposed by the Attorney General; 4) the sale proceeds from these transactions are never enough to replace the community benefits, including charity-care, provided by a hospital before it converted; and 5) new independent boards to govern resulting foundations are the best way to protect a community's health.

What we do not know yet is whether tighter charity, service, and patient volume guarantees will be sufficient to completely negate the decline in charity-care we have observed after hospitals convert. And we do not know whether these transactions have been a net gain or loss to the communities involved. We do not know these things because the data for this analysis is not available, is not required to be reported to any state agency, or has been withheld by the parties who posses it. Until this data is available, communities cannot preserve their health care, and policy makers cannot make informed decisions about this very important sector of our economy. The need for this information is especially heightened at this time when we see that nonprofit/nonprofit mergers are on the rise, and we note that even less public information is available about these consolidations. It is our hope that this report has taken us a little further down the road to understanding this phenomenon, and more importantly alerted us all as to what needs to be remedied to obtain the information to make solid health policy.