

Original Investigation

Policy Commercializing Nonprofits
in Health: The History of a Paradox From
the 19th Century to the ACA

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Policy Points:

- Health policy in the United States has, for more than a century, simultaneously and paradoxically incentivized the growth as well as the commercialization of nonprofit organizations in the health sector.
- This policy paradox persists during the implementation of the Affordable Care Act of 2010.

Context: For more than a century, policy in the United States has incentivized both expansion in the number and size of tax-exempt nonprofit organizations in the health sector and their commercialization. The implementation of the Affordable Care Act of 2010 (ACA) began yet another chapter in the history of this policy paradox.

Methods: This article explores the origin and persistence of the paradox using what many scholars call “interpretive social science.” This methodology prioritizes history and contingency over formal theory and methods in order to present coherent and plausible narratives of events and explanations for them. These narratives are grounded in documents generated by participants in particular events, as well as conversations with them, observing them in action, and analysis of pertinent secondary sources. The methodology achieves validity and reliability by gathering information from multiple sources and making disciplined judgments about its coherence and correspondence with reality.

Findings: A paradox with deep historical roots persists as a result of consensus about its value for both population health and the revenue of individuals and organizations in the health sector. Participants in this consensus include leaders of governance who have disagreed about many other issues. The paradox persists

because of assumptions about the burden of disease and how to address it, as well as about the effects of biomedical science that is translated into professional education, practice, and the organization of services for the prevention, diagnosis, treatment, and management of illness.

Conclusions: The policy paradox that has incentivized the growth and commercialization of nonprofits in the health sector since the late 19th century remains influential in health policy, especially for the allocation of resources. However, aspects of the implementation of the ACA may constrain some of the effects of the paradox.

Keywords: health financing, health policy, health providers, health services.

FOR MORE THAN A CENTURY, HEALTH POLICY IN THE UNITED States has incentivized both expansion in the number and size of tax-exempt nonprofit organizations in the health sector and their commercialization. As a result of this history, many people who govern, manage, and provide professional services for tax-exempt organizations that care for patients, educate health professionals, represent their interests, and conduct health research have combined, comfortably, doing good with doing well. They have done good by helping relieve considerable pain and suffering and by developing and applying ever more effective interventions to diagnose, prevent, and often cure disease. They have done well by generating substantial revenue for provider systems, research universities, and other types of tax-exempt organizations; often surplus revenue that would be considered profits by commercial firms and the agencies that tax them. This revenue has also enabled many individuals employed by tax-exempt organizations to be compensated as highly as their counterparts in for-profit entities.

The implementation of the Affordable Care Act of 2010 (ACA) has initiated a new chapter in the history of this policy paradox (or, as an anonymous reviewer wrote, an “ironic” result of the politics of policy-making for health). In order to increase access to care, the ACA allocates new public funds to subsidize coverage for millions of patients and, as a result, is enhancing the revenue of insurance plans, clinicians, and provider organizations. In response to the ACA, for example, the number of nonprofit health plans and hospitals converting to for-profit status has increased for the first time in a decade, and competition among provider organizations for market share has intensified. The ACA, however, also encourages tax-exempt organizations to contribute to the public good.

The provisions of the Act intended to slow the increase of health care costs could constrain the rate of growth in the revenue of provider organizations, whatever their profit status, and of clinicians. A new provision of the Internal Revenue Code, incorporated in the ACA, augments the accountability of tax-exempt provider organizations for unreimbursed benefits they provide to residents of the communities they serve.

This article explores the long history of policymakers for health incentivizing, both deliberately and as a result of achieving other purposes, the growth and the commercialization of nonprofit organizations. I focus on how the governance of the health sector has created and maintained this paradox. By governance I mean who does what, to, for, and with whom to achieve what goals. The first several sections summarize the considerable evidence about the origin of this paradox and its history from the late 19th to the early 21st century. Next, I describe how the paradox is affecting the implementation of the ACA. Then I propose an explanation of why the paradox has been sustained for so long by the federal government, the states, providers of health services, institutions that educate health professionals and conduct research, and the industries that construct health facilities and supply providers. The concluding section describes recent policies and proposals that could inhibit the further commercialization of nonprofit organizations in the health sector; or that could be too weak and too late to change significantly a policy paradox that has persisted for more than a century.

A variety of sources inform what follows. Primary sources for the history of the paradox are mainly published and unpublished documents and conversations that have been the basis of my publications as well as of my career as a public official, adviser to policymakers, manager of a provider system, chief executive of an endowed foundation, and member of governing boards of nonprofit organizations. I have agreed to keep confidential some of these unpublished documents and conversations, but most of them are matters of public record. In articles and books, I have explored the politics of policymaking for health by federal and state agencies responsible for taxation, regulating employee benefits, and subsidizing access to care; the political and policy history of health plans and academic health centers; and the governance of the health sector. In my career as a public official, executive, adviser, and board member, I have acquired and analyzed evidence and made judgments about each of these issues.

My frequent reliance on personal experience in the politics of policymaking is also a potential cause of bias. For example, several scholars who strongly defend both nonprofit organizations and markets have asked me why I criticize commercialization. I reply that although I applaud business success, I consider greed to be reprehensible when it reduces funds that tax-exempt organizations could use to benefit the public. Accordingly, at times in this article, my values may distort my interpretation of evidence.

I rely on and cite secondary sources in the rich, scholarly literatures that address the politics of policymaking for health and the organization and management of nonprofit organizations. Recent publications in each of these literatures have documented some of the effects of the commercialization of nonprofits. My intent is to supplement, and sometimes to challenge, the conclusions of some of these publications by demonstrating the historical roots of this commercialization and the central role of the federal government and the states in that history.

The Paradox From the Late 19th Century to the Second World War

In the late 19th century, hospitals incorporated as charities began to compete, intensely, for shares of the growing market for health care and to finance their operations from public subsidies for construction, for the care of indigent patients, and for payments by or on behalf of patients as well as from gifts. These voluntary hospitals, previously financed by charitable gifts alone, had admitted patients recommended by trustees as belonging to the “deserving poor;” that is, employed, abstemious adults and their children, preferably those with illnesses that were not contagious. Physicians had donated their services. Many of these hospitals had been established to serve particular ethnic and religious groups and to provide practice opportunities for physicians who were denied hospital privileges elsewhere because they were members of these groups. Now, as Rosemary Stevens wrote, hospitals sought “government subsidy (or purchase of service) with little or no government supervision.”¹ Moreover, increasingly confident about the effectiveness of treatment based on advances in biomedical research, physicians changed, in Charles Rosenberg’s words, from depending on “donation to charging for these services.”² David Rosner described how, beginning in the late 19th

century, in New York City, managerial and medical values eclipsed voluntary hospitals' initial mission of serving the poor. By 1915, he concluded, each of these hospitals had been transformed from a "paternalist charity" into a "highly complex bureaucracy in which medical services were bought and sold."^{3,4}

As a result of this transformation, voluntary hospitals in New York City and elsewhere in the country developed principles of governance and styles of management that enabled them to take maximum advantage of the increasing resources allocated to the health sector since the early 20th century. Resources to protect and promote personal and public health grew substantially during the first half of the century as government on all levels responded first to the consequences of tenement housing and factory labor, especially for recent immigrants and their children; then to the consequences of the Great Depression for the millions who were unemployed and their families; and next to the effects of the Second World War on soldiers, ex-soldiers, their families, and civilian workers. Stevens, agreeing with Rosner, entitled a chapter on hospitals in the early 20th century "Charities and Businesses." Reflecting on hospitals' subsequent history, she concluded that "the key question now [1989] as in the past is . . . the availability and channeling of hospital income."^{1(p364)} By then, many hospitals owned by government, especially teaching hospitals, were prioritizing the same question.

Between 1915, when Rosner's book concludes, and the end of the Second World War, public policymakers collaborated with leaders of the hospital industry, universities, and the medical profession to institutionalize the paradox by which government and employers subsidized both the expansion of the nonprofit sector and, gradually, its commercialization. During these 3 decades, policy increased public subsidies for educating physicians, for constructing health care facilities, for financing services to patients, and for conducting research in the medical and, increasingly, the social and policy sciences. Formulating and implementing this policy required collaboration among public officials, leaders of public and nonprofit academic institutions that educated health professionals, executives and trustees in the hospital industry (and the growing long-term care adjunct to it), and physicians, particularly the growing number of specialists who combined research with caring for patients.⁵

Constantly increasing revenue incentivized each of these collaborators to want more: more and higher fees for health services; more grants and

contracts for research; more new and expanded facilities; more employers at rising salaries; and, for public officials, more revenue from taxation to subsidize these aspirations. The institutionalization of the paradox would, as I will describe, eventually (and over-simply) acquire the label “commercialization.”

Another innovation in policy that contributed to establishing the paradox was the amendment of state laws of charity, beginning in the 1890s, to permit philanthropists to endow general-purpose foundations. As a result of this innovation, state law no longer required charitable organizations—later renamed nonprofits—to specify the services they would provide when they applied for incorporation.⁶

Some of these new foundations promoted, subsidized, and helped persuade public officials to join in financing the expansion of voluntary hospitals and medical schools. In 1910, for example, the Carnegie Foundation for the Advancement of Teaching, allied with leaders of the American Medical Association, sponsored and published a report by Abraham Flexner exposing the inadequacy of medical schools under proprietary (that is, for-profit), public, and charitable auspices. Over the next decade, the General Education Board (GEB), a Rockefeller endowment, financed the reorganization and refinancing of medical education and patient care associated with it, initially in private universities and soon, despite ideological misgivings among the GEB’s trustees, in public institutions as well. As a result of the GEB’s funding, full-time salaried faculty proliferated in the basic and clinical science departments of nonprofit and public medical schools, and proprietary schools eventually became extinct. Deans and department chairs determined the compensation of full-time faculty members on the basis of the fees they generated from patients or third-party payers and the monetary value of their research grants.^{5(pp38-41),7}

General-purpose foundations, acting as surrogates for government, also incentivized innovations in the organization and financing of health care. In the 1920s, for example, the Milbank Memorial Fund sponsored projects in 3 communities in New York State that integrated government and nonprofit services for health care and public health.⁸ Between 1927 and 1933, 5 foundations sponsored the national Committee on the Costs of Medical Care (CCMC), which commissioned extensive, and pioneering, research on the organization, cost, quality, and staffing of health services and made recommendations about reorganizing and paying for them that the American Medical Association and its state

affiliates condemned.^{5(pp45-51)} This opposition and, a year later, the success of organized medicine in preventing the inclusion of health insurance in the legislation creating Social Security, inhibited federal policymaking to subsidize health care financing for a generation.

Subsidies for other aspects of health affairs continued to grow during the 1930s, however. The Social Security Act included substantial subsidies for state and local public health work. Foundations, especially the Commonwealth and Julius Rosenwald Funds and the Duke Endowment, collaborated with state governments in the South to subsidize access to care by constructing and expanding segregated community hospitals.⁹ As a result of federal legislation in 1938, the new National Cancer Institute (NCI) adapted policy for organizing and financing research that had been pioneered by the Rockefeller Institute since the turn of the century and had been augmented by the Rockefeller Foundation since the 1920s. Although several states and cities had established public health laboratories since the 1890s, and some of them had collaborated on research studies with foundations and nonprofit health organizations, the NCI was the first federal agency to subsidize investigator-initiated medical research at private and public universities.¹⁰

Evidence of the erosion of hospitals' predominantly charitable missions continued to accumulate during the 1930s. Rosner described the growth of "medical services bought and sold" by hospitals in the decades before 1915; Stevens continued the story of their commercialization. The principal policy initiative contributing to commercialization was the creation of what Rosner, Stevens, and I called "hybrid private-public corporations" to replace hospital revenue lost as a result of the Depression.¹¹ Hospital board members and managers allied with leaders of state and county medical societies to establish and market the services of these new, technically "nonprofit," organizations. Officials of state government expedited changes in laws regulating charities in order to establish these hybrids and permit them to market prepaid insurance to corporations, public agencies, and labor unions that represented or aspired to represent their employees. These new local organizations, initially called Hospital Service Corporations and then Blue Cross plans, collaborated nationally under policy coordinated by the American Hospital Association (AHA). They soon remedied the decline in hospitals' revenue by pooling funds from subscribers in

order to reimburse hospitals for what they could justify as their costs. Beginning in 1939, Blue Shield plans used a similar strategy to reimburse physicians' fees.

The Paradox From the Second World War to Medicare and Medicaid

During the war, new public subsidies for the health sector added to the revenue of nonprofit hospitals and medical schools. The federal Committee on Medical Research (CMR) of the Organization for Scientific Research and Development (OSRD) funded direct and indirect costs of considerable war-related research at nonprofit and public universities and teaching hospitals affiliated with them. In 1946, the CMR/OSRD program became the model, and supplied the initial funding, for the Extramural Program of the National Institutes of Health (NIH). According to a widespread (but as yet undocumented) legend, the new NIH program paid higher overhead rates to nonprofit than to public universities and teaching hospitals (allegedly because the nonprofits claimed that they relied on private philanthropy for infrastructure that states subsidized at public institutions).¹⁰

Federal financing for health care increased during the war in the temporary absence of strenuous opposition from organized medicine as a result of patriotism. Soon after mobilization for war, federal policy subsidized payments by 30 states to nonprofit and public hospitals and to physicians providing perinatal care to the wives of servicemen. In 1943, Congress formalized and enlarged this subsidy in the Emergency Maternity and Infant Care (EMIC) program. By the time the authorization for the EMIC expired in mid-1947, the federal government had financed 1,203,500 births.¹² Beginning in 1942, moreover, new federal policy enhanced the revenues of both nonprofit and public providers of health care by exempting from taxation as personal income health insurance and other "fringe benefits" provided by employers to employees and their families. (I will return to this policy, assessing its postwar impact.)

By 1943, staffs of the United States Public Health Service (PHS) and the AHA were drafting specifications for federal legislation that would subsidize the planning, construction, and expansion of both nonprofit and public hospitals. This collaborative effort responded to widespread anxiety about the adequacy of hospital care for workers who were

producing goods for the war effort and analysis by PHS staff that predicted a postwar shortage of hospitals, especially in rural areas. The joint AHA/PHS work led, in 1946, to the Hill-Burton Act, a massive federal-state program to subsidize planning, building, equipping, and renovating acute general hospitals; extended in 1954 to skilled-nursing and rehabilitation facilities.^{5(pp115-131),13}

The authors of Hill-Burton recommended that hospitals and medical practices be organized in pyramids in geographic regions, with teaching hospitals at the apex of each of them and primary care at the base. Senator J. Lister Hill, like most members of Congress, embraced a widely endorsed international theory about how medical progress occurred that justified this arrangement. According to this theory, which I call “hierarchical regionalism,” research in the medical sciences conducted in the laboratories of medical schools and teaching hospitals generated innovations in prevention, diagnosis, and treatment that could improve health. Faculty of the schools tested the effectiveness of these innovations on patients in these hospitals. Then faculty members and the students and house staff they trained disseminated effective interventions to community hospitals and the physicians who practiced in them.^{5(pp149-168)} Implementing hierarchical regionalism required establishing formal and informal coordinating organizations of nonprofit and public hospitals and physicians, and it required states, assisted by federal grants, to accord quasi-governmental authority to these organizations.

The federal government also began to subsidize the education of medical students during the war. The initial purpose of this subsidy was to produce more physicians by reducing the time required to earn a medical degree from 4 to 3 years. As evidence of a likely postwar shortage of physicians accumulated, the federal government made policy to subsidize veterans who sought medical education, especially general practitioners eager to become specialists. To make health care for veterans more effective and efficient, as well as to train house staff and encourage the conduct of research in veterans’ hospitals, toward the end of the war the federal Veterans Administration (VA) began to subsidize alliances between its hospitals and nearby medical schools, both public and nonprofit (conventionally called private). This arrangement enabled these schools to increase the number and pay of faculty members who cared for private patients as well as for veterans, who taught students and house staff in nonprofit, state-owned, and veteran’s hospitals, as well as

to retain a substantial portion of the indirect costs paid by NIH and the VA (now the Department of Veterans Affairs) for research that included patients who were veterans.¹⁴

This alliance of public and nonprofit medical schools, their principal teaching hospitals, and the VA would, after the war, contribute patterns of organization as well as revenue to the creation of the organizations at the apex of regional hierarchies that came to be called academic health centers. In particular, the alliance incentivized the convergence of the aspirations of public and nonprofit medical schools to benefit from the policy paradox that this article is describing.

After the war, the growing demand for educational opportunity in general as well as for entry into the health professions stimulated increased public spending for higher education. States began to fund planning, construction, and academic salaries at new and enlarged campuses for public institutions and, in some states, for private colleges and universities as well. In the late 1940s, for example, New York and Florida began to subsidize both public and nonprofit schools for the direct costs of educating students who aspired to become health professionals.¹⁵ Federal subsidies for educating health professionals gradually grew as opposition to them from organized medicine diminished in response to increasing demand for health care. The elaboration of federal policy subsidizing the education of health professionals peaked in 1964 and 1965. The Health Professions Education Assistance Act of 1964 funded colleges and universities to build new and expanded facilities and provided loans to students. A year later, the new Medicare program became (and has remained) the largest funder of graduate medical education.

During the first 2 decades after the war, state and federal spending for higher education also stimulated a substantial increase in the number and compensation of full-time faculty members of schools educating health professionals. By the end of the 1960s, most faculty members assumed that their numbers and rewards would grow without interruption.

The most persuasive evidence sustaining this assumption was “life on the reimbursement rate,” a phrase a colleague taught me when in 1970 I joined the faculty of an academic health center. Generous reimbursement was the most important contribution to the paradox of health policy during and after the war. The cause of the seemingly limitless growth in reimbursement was the increasing demand for health care that was simultaneously becoming more expensive as a result of advancing

technology. The growing number of people with coverage from third parties made this demand more effective.

The substantial expansion of the revenue of hospitals and physicians as a result of reimbursement policy began as federal policy to control wages for workers producing war materials. A significant component of this policy was exemption from taxation of health insurance provided by employers to their employees as “fringe benefits.” This subsidy began in 1942, as I noted earlier, and was made permanent in 1954 when Congress revised the Internal Revenue Code. Its initial purpose was to reward civilians employed by companies producing for the war effort while restraining disputes about their pay that, if resolved in favor of labor, could lead to higher prices for consumers. Federal policymakers also worried that raising civilians’ wages significantly above the much lower pay of soldiers, sailors, and airmen would enrage them and their families.¹⁶

Moreover, the Internal Revenue Service (IRS) and the Treasury, making health policy through tax policy for the first time, increased potential new revenue for providers of health care. They did this through 2 policies that exemplify the paradox described in this article. The first of these policy innovations exempted fringe benefits from taxation as employees’ income. The second permitted taxpayers to deduct from their gross income, up to a specified limit, spending on health services for themselves and members of their immediate families.¹⁷

Subsidies under this policy, labeled “tax expenditures” in the 1960s (by Stanley Surrey, a law professor and policymaker who elaborated legal theory justifying them), became and have remained a substantial component of health care finance, endorsed by employers, union leaders, and workers. In the Budget Act of 1974, Congress required the Treasury to publish an annual Tax Expenditure Budget that estimated the amount of revenue lost as a result of exemptions, deductions, exclusions, and other aspects of tax law.¹⁸ That same year, a new federal law, intended mainly as policy for employee retirement, gave employers an incentive to self-insure for employees’ health benefits in order to avoid state regulation of insurance coverage.¹⁹

Tax expenditure policy made a substantial percentage of health care spending the outcome of negotiations (mainly confidential) involving employers, union leaders, and providers of health services. As a result of these negotiations, associations representing hospitals and physicians avoided public accountability for their routine assertions that rising

costs justified their receiving higher prices. Tax policy alone initially financed these negotiated prices. In the 1950s and, more substantially in the 1960s, direct federal and state appropriations financed negotiated prices (still called costs by almost every participant in negotiating them). Under tax expenditure policy, the simultaneous growth and commercialization of nonprofit organizations providing care has been limited only by the occasional success of employers (public and private) and unions in exerting countervailing power in negotiations.

When the federal government began to increase its financing of health services for people who were neither in uniform nor their dependents nor veterans, it joined employers and unions in negotiating prices with organizations representing hospitals and physicians. This change in federal financing policy began in 1950 when Congress amended the Social Security Act to create a new program, Old-Age Assistance, for patients who qualified as “medically indigent.” This legislation, which Congress expanded in 1956 and 1960, transferred funds to states to make “vendor payments” to health care providers on behalf of these patients.²⁰

Like the Blue plans and commercial insurers that were reimbursing providers mainly with subsidies created by tax expenditure policy, the federal government, acting through the states, strengthened the paradox through policy that reimbursed providers (“vendors”) for the costs that hospital managers and physicians claimed to have incurred. Physicians and hospitals now received higher federal subsidies for what had long been their preference: to bill for procedures, length of hospital stays, and ordering and interpreting diagnostic tests (rather than, for instance, seeking payment for conversations about preventing, treating, and managing illness, what would later be called “cognitive” interventions). In 1953, the authors of an AHA publication, *Principles for the Payment of Hospital Care*, prescribed standards for “retrospective cost-based funding” and asserted that “hospitals should be reimbursed in full.” Blue plans, many commercial insurers, the federal government, and many states endorsed the *Principles*; that is, they agreed that payment policy would prioritize the self-interest of hospitals and physicians. As a result of their agreement, collective purchasers, a political scientist concluded, “had little market leverage to control either the price or the utilization of health care services.”²¹ Another result was that as the nonprofit Blue plans switched from a community to an experience rating of patients in order to meet competition from commercial

insurers over the price of premiums, they became “more ‘private’ . . . and less ‘public.’”¹¹

Medicare and Medicaid, enacted in 1965, incorporated the prevailing reimbursement policy, thus reinforcing the paradox of incentivizing both the expansion of nonprofit organizations and the commercialization of their pricing behavior. From then until the early 1980s, these programs reimbursed providers—nonprofit, for-profit, public agencies, and professional corporations—for whatever costs they could persuasively claim to have incurred.

Providers, already adept at such persuasion, became even more sophisticated at it now that public financing paid approximately half (and, by some estimates, considerably more) of the costs of care.²² Executives responsible for finance in provider organizations engaged audit and consulting firms to devise methods of accounting for costs that supported their claims (including, eg, the blurring of bad debt with charity care and overestimating aggregate acuity among patients). (In 1984, for example, the chief financial officer of the principal teaching hospital of the academic center at which I worked asked an interim chief executive, “Doctor, do you want the bottom line to be black or red?”) Federal and state officials usually were reluctant to challenge these accounting practices. Blue plans, many of which augmented their revenues by serving as “fiscal intermediaries” for Medicare, usually reimbursed charges as submitted by hospitals (as several senior executives of Blue plans told me in confidence). There was, however, considerable variation in what charges intermediaries (called “contractors” since 2004) approved, especially for particular technologies.²³ Thus, as a result of policy and its implementation, growth in expenditures for Medicare and Medicaid, like spending by public and private employers for health care, annually exceeded the rate of inflation in the general economy.

At the end of the 1960s, moreover, federal policymakers for taxation made new health policy that reinforced the paradox. In 1969, the IRS ruled that, in order to qualify for federal tax exemption, hospitals need not provide free or below-cost care to patients who were unable to pay. Hospitals could now qualify for exemption by providing other benefits to the communities they served. A study of the first 2 decades of this policy found that it had incentivized hospitals to maximize revenue because the IRS “almost invariably accepted the hospital industry’s view of its history and profits.” IRS and Treasury

policymakers with whom the study's authors spoke insisted that they were "deciding an issue of technical tax law" while rejecting evidence that they were "accepting as decisive the hospital industry's view of health policy."²⁴

The Paradox From Cost Containment to the Passage of the ACA

By the early 1970s, a growing number of state and federal policymakers and members of their staff, researchers, journalists, and even physicians had begun to suspect—and some to conclude—that in making and implementing policy for reimbursing health care providers, "cost-based" was frequently a euphemism for "cost-plus" reimbursement. In this section I describe how federal and state policymakers attempted, beginning in the 1970s, to restrain the paradox (or irony) that policy to incentivize the growth of nonprofit organizations by increasing their revenues also incentivized their commercialization. The burden of history was too heavy for this policy to succeed. The paradox persisted; its effects, like costs, only modestly contained.

Efforts to contain costs began in the states. New York set an example in 1964 when it began to regulate hospital construction and expansion by requiring regulatory approval expressed in "certificates of need" (CON). A decade later, a new federal law for health planning incentivized states to create CON programs; 47 had done so by the end of the 1970s.²⁵

During the 1970s, states also began to regulate the rates at which nonprofit and commercial insurers, as well as Medicaid, reimbursed hospitals. Federal legislation in 1972 permitted states that "wanted to experiment with new hospital payment systems" to seek waivers to regulate Medicare reimbursement from what was then the Department of Health, Education and Welfare. Six states received such waivers. They implemented payment methodologies that tested and refined concepts of prospective, in contrast to cost-based, reimbursement; these regulators, in effect, set prices for episodes of care rather than assessing what they cost in particular hospitals. New Jersey implemented reimbursement policy that applied a prospective methodology, diagnosis-related groups (DRGs), that researchers at Yale University had devised in the mid-1970s. DRGs measured and monetized the resources that hospitals typically allocated to episodes of care for particular diagnoses.²⁶

In 1983, the Reagan administration, eager to reduce or restrain the rate at which spending for Medicare was rising, made DRGs national policy, adjusting payments to hospitals on the basis of acuity and regional variation in average costs. Some states used DRGs to reimburse hospitals for Medicaid patients; many Blue plans and commercial insurers devised payment methods that resembled DRGs. Although prospective reimbursement temporarily slowed the rate at which payment for hospital care increased, most provider organizations maintained, and some increased, their margins under it.

They did so in several ways. Creative consultants devised cost-accounting techniques that permitted hospitals to upgrade many patients to more highly reimbursed DRGs. These techniques earned the name “DRG creep” from state regulators, who shared anecdotes with colleagues nationally about catching hospital staff overinterpreting evidence in patients’ records.

Hospitals and physicians also used tax expenditure policy to compensate for the cost constraints of prospective reimbursement by “cost-shifting” (a pejorative translation of “cross-subsidy” in economic analysis) to employers and workers. They increased their revenue by charging higher prices for the care of patients and dependents in employee groups whose insurance premiums were excluded from their taxable income. A political scientist recently described managed care, which began as employers’ defense against cost-shifting, as “largely a response to an unintended consequence” of Medicare payment reform. Managed care, he continued, despite its stated purpose of containing the growth of costs, was fostering the “increased commercialization of health care.”²⁷

Two reviewers of this article recommended that I emphasize more strongly the combined effects of tax expenditure policy and increased public spending for health care. One of them, commenting on the previous paragraph, expanded my argument. As a result of both tax expenditure and financing policy, “Government not only allows but encourages nonprofits to act as profit maximizers.” The other went further: Unlike nonprofit hospitals a century ago, “greed [now] permeated the attitudes of [their] administrators and staff.” This reviewer added that another factor contributing to the failure of policy to contain costs was the court decisions permitting lawyers, and by analogy hospitals and physicians, to implement “conventional marketing and advertising” strategies.

Executives of nonprofit hospitals began, in the 1970s, to summarize their commitment to preserving the paradox of policy in a new platitude, “no margin, no mission.” (In 1986, recognizing that this platitude had become part of the culture of health care, I organized a public meeting, titled “The Missions and the Money,” at the academic health center at which I worked and advertised the event with a poster depicting our 19-story hospital tower with a dollar sign as a top-to-bottom external ornament. To my knowledge, nobody objected to either the poster or to the use of the platitude to frame a public meeting about the purposes and financing of our institution.)

Most of the states that were making policy for new payment systems discontinued doing so in the 1980s. They abandoned their policy initiatives mainly because prospective payments for hospital care under Medicare and Medicaid and managed care for private and public employees sharply reduced what they could regulate. However, states also abandoned rate regulation in response to effective lobbying by associations of nonprofit and the increasing number of investor-owned hospitals. By the 1990s, only 2 states, Maryland and West Virginia, continued to regulate hospital reimbursement.

During the 1980s, federal legislation also “accelerated the commercialization of academic science,” especially of biomedical research but also other areas of science and engineering. The Bayh-Dole Act of 1980 permitted universities, teaching hospitals, and independent nonprofit research organizations to “patent and profit from discoveries they [and their employees] made through federally funded research.” The political history of Bayh-Dole exemplifies the effectiveness of nonprofit and public organizations, especially but not exclusively in the health sector, in achieving commercial goals. In a recent book, *Creating the Market University*, the author documents that “as late as 1978 it appeared that the Department of Health, Education and Welfare was about to tighten restrictions on discoveries funded by the NIH.”²⁸ Many interest groups lobbied against restricting the conversion of public subsidies into private profits, however, especially organizations of researchers and the institutions that employed them, and manufacturers of drugs and medical devices. As a result of this lobbying, the number of patents awarded to universities rose from 380 in 1980 to 3,088 in 2009, causing an increase in the GDP that the Congressional Research Service estimated as being between \$47 billion and \$187 billion.²⁹

Academic medical/health centers' increasing revenues from commercial activities have, to some extent, compensated for the intermittent reductions in funding for the National Institutes of Health since the 1970s. By 2013, commercialization had become such a normal aspect of the culture of academic medicine that the chief executive of a prestigious private university medical center did not separate research revenue from commerce from revenue from the NIH when he summarized his institution's finances to the board of a (highly profitable) nonprofit research institute.

During the 1970s, the governance of public academic health and medical centers began to resemble that of their nonprofit peers. In 1970, only 1 public academic teaching hospital (serving the University of Oklahoma) was still financed, as were most nonteaching public hospitals around the country, by a state appropriation for each line item in its budget, with all revenue deposited in the state's general income accounts. In several states (eg, New York), teaching hospitals operated by public universities were funded partly by appropriations for line items but more by revolving funds administered in state capitals in which they deposited all revenue from reimbursement for the care of patients. In most states, however, revolving funds financed the entire budgets of public teaching hospitals, although some received small subsidies by appropriation. By the mid-1980s, leaders of state university hospitals in 2 states (Florida and Maryland) had achieved total separation from state government, to the envy of their peers who tried, with varying success, to gain similar independence in order to behave as nonprofits.³⁰

Beginning in the 1970s, moreover, state subsidies for the salaries of academic clinicians declined as their institutions' revenue from patient care grew. Leaders of the executive and legislative branches of state government, managing revenue shortfalls that resulted from recessions along with political pressure to increase funding for K-12 education and infrastructure, reduced appropriations for faculty salaries at public medical schools. In 1979/1980, for example, when the public university at which I worked was about to open its new teaching hospital, state appropriations funded about 70% of the salaries of faculty in the clinical disciplines. I devised a proposal for the state to front-fund the salaries of clinicians over 4 years as we went from 0 to 540 beds. Under this proposal, new clinicians would join the faculty shortly before the opening of beds to serve patients for whom they would be responsible. My colleagues and I predicted that 5 years later, state funding for

the salaries of clinicians would have fallen from 70% to approximately 20% as a result of revenue from both reimbursement for care and research conducted in the new hospital. Our prediction turned out to be overly cautious.

Between the late 1980s and the early 2000s, leaders of many nonprofit health plans and hospitals sought permission from public policymakers to improve their organizations' earnings (as well as their own compensation) by converting them to for-profit status. By 2000, legislative and executive branch officials in 13 states had approved the conversion of Blue Cross / Blue Shield and other nonprofit health plans. By then, they had also approved converting the profit status of 330 hospitals, 7% of the United States' nonprofit hospitals.³¹⁻³⁴

Legislators and state insurance commissioners frequently required converting plans and hospitals to compensate the public for the exemption from taxation they had enjoyed. The most frequent form of such compensation was the creation of endowed foundations. A few states, New York, for example, required converting nonprofits to deposit most of these compensatory assets in their general funds. The largest number of conversions, and hence the chartering of new foundations, was in California. The conversion of its Blue Cross plan (renamed WellPoint and later Anthem), for instance, yielded 2 foundations, the California Endowment (with an original corpus of just over \$4 billion) and the California Healthcare Foundation (just short of a billion dollars).³⁵

The number of conversions diminished sharply between 2000 and the passage of the ACA a decade later. This decline was mainly a result of senior state policymakers' dismay at the lavish payouts enjoyed by executives of converting organizations. Accordingly, in 2002, policymakers in Kansas, Maryland, Missouri, North Carolina, and Washington State thwarted the conversion of Blue plans.^{36,37} Only 216 additional hospitals converted before 2010.³⁸ As had happened 2 decades earlier in the transition from cost-based to prospective reimbursement, policymakers demonstrated that the paradox was vulnerable to widespread outrage that could overcome both large campaign contributions from executives of nonprofits in the health sector and 1 in 7 voters or members of their families working in the health sector.

Nevertheless, few policymakers challenged the paradox aggressively, even those who were cynical about the politics of the paradox and regretted its cost to taxpayers and their employers. The IRS, for example, began in 1999 to hold nonprofit organizations accountable for the

salaries of what it defined as “highly-compensated employees.” In 1999 it issued regulations requiring the governing boards of nonprofit service providers, research organizations, and foundations to document how they set executive pay. This requirement had the perhaps unintended effect of endorsing the policy of many governing boards of nonprofit research organizations, health plans, and hospital systems of benchmarking salaries against those paid by both their for-profit and nonprofit competitors. Most nonprofit boards in the health sector engaged consulting firms that arrayed data on salaries and benefits paid by competitors, whatever their profit status, in ways that assured their compensation committees that their organizations were law-abiding and virtuous as well, because they did not pay the highest salaries and benefits among peer organizations in their geographic region. (Full disclosure: I participated in what I have just described as a member of nonprofit boards, and even of compensation committees.)

In 2013, New York became the only state to issue regulations capping the salaries of executives of nonprofit service providers that received substantial revenue from state appropriations or federal subsidies that passed through state government. Consistent with the history of the paradox, however, by 2014 many of them were seeking exemptions from the cap for their most highly compensated executives, using procedures specified by the regulators in response to intensive lobbying by trade associations representing nonprofit providers. (Note my full disclosure at the end of the previous paragraph.)

The Paradox Since the Enactment of the ACA

Although numerous supporters of the ACA hope that it will reduce the rate at which the cost of health care increases, the Act, by expanding coverage—and hence access to care—is also incentivizing many health care executives to enhance the benefits they and their organizations receive as result of the policy paradox that is the subject of this article. In 2010, 4 months after the ACA became law, Consumers Union reported that nonprofit Blue Cross and Blue Shield plans—then operating in 37 states—had “set aside billions of dollars in surplus funds—essentially retained profits—even as they raised premiums by as high as twenty percent annually.” Executives of many of these plans were soon using

these surplus funds to increase their share of customers in their markets; for example, by increasing their budgets for television advertising.³⁹

Executives and board members of numerous hospitals and business firms associated with them began to calculate how to increase their share of the patients who would gain access to health care as a result of subsidies in the ACA. The *Economist*, for instance, reported the positive financial results that had occurred and would likely increase after “Cerebus, a private equity firm, bought a struggling chain of Catholic hospitals [in Boston] in 2010.”⁴⁰ An article in the *New York Times* described “a surge of supersizing hospitals” among “for profit systems as well as non-profit hospitals.”⁴¹ Regulators in New York, despite that state’s long history of official antagonism to for-profit health care chains, have, since the enactment of the ACA, approved proposals by investor-owned firms to purchase and convert the profit status of 5 skilled-nursing homes in New York City that had been under religious auspices.⁴²

The ACA also reactivated interest, dormant for a decade, in converting the profit status of Blue plans. Legislation in Michigan in March 2013, for instance, authorized that state’s Blue plan to become a mutual insurance company (ie, a for-profit company owned by its subscribers).⁴³ Several months later, the insurance regulator in Montana approved the purchase and conversion of that state’s Blue plan by a mutual company that owns Blues in 4 other states.⁴⁴ Legislators and insurance lobbyists in Pennsylvania told reporters that as a result of the ACA, the state may no longer need its 4 Blue plans as tax-exempt insurers of last resort, implying that safety-net payers may have become obsolete, even if universal coverage has not been achieved.⁴⁵ In contrast, several Blue plans, in Maryland and Massachusetts, for example, have reaffirmed their commitment to nonprofit status.⁴⁶

Evidence continues to accumulate of resistance to commercialization in the health sector, despite the incentives for it in the ACA. In mid-December 2013, for example, an article in the *New York Times* on changes in requirements for reporting community benefits under the new section 501(r) of the ACA (amending the Internal Revenue Code), described a lawsuit by the city of Pittsburgh against the nonprofit University of Pittsburgh Medical Center. The article quoted the city’s lead attorney saying that the medical center is “fail[ing] most, if not all, of Pennsylvania’s criteria for a tax-exempt charity” while accumulating “excess operating revenue of nearly \$1 billion and reserves of more than \$3 billion.”⁴⁷ In February 2014, the *New York Times* reported that

WellPoint (recently Anthem), which has become the country's largest for-profit owner of converted Blue plans, "could end up benefiting most from the new federal health care law."⁴⁸ A recent story in the *Economist* concluded that the "fuss over Obamacare's teething troubles is obscuring a bigger story for investors: American health care is gradually being both nationalized and privatized."⁴⁹ Stories in the media continue to array evidence that the ACA is yet another chapter in more than a century of the history of a policy paradox that is a unique feature of health affairs in the United States.

Nevertheless, efforts continue to mitigate the effects of a paradox that has significantly influenced the health sector for more than a century. Early in 2014, for example, the federal Department of Health and Human Services granted Maryland a waiver of federal law that will enable its Health Services Cost Review Commission to place every hospital in the state on a global budget, financed by public, nonprofit, and commercial payers.^{50,51} If Maryland succeeds in using its 30-plus years of experience of all-payer rate setting as the basis for achieving this goal, its new policy could have national significance as a result of containing cost increases, improving quality, contributing to the health of populations, and, not least, mitigating to some extent the commercialization that results from the paradox.

Explaining the Persistence of the Paradox

I sought explanations for the persistence of the paradox in the literatures of health policy and nonprofit studies. The citations in this article are evidence that scholars in a variety of disciplines have studied health policy and the organizations that influence and implement it. Most of these scholars concur that important events in the health sector have been profoundly influenced by 2 related factors. The first is the power of interest groups, especially those representing physicians, the prescription drug and medical device industries, hospital associations, universities and academic health centers, and third-party payers. The second factor has been considerable public support for ideology that subordinates collective responsibility (itself an ideology, of course) to individualism and liberty, both personal and corporate.

Most researchers who study health policy, however, have different views about the goals and interpretive methodology of scholarship than do many of their colleagues who study nonprofit organizations. Since the 1960s, most scholars of health policy and services, like most of their colleagues in the disciplines of the social and policy sciences, have given priority to objectivity and relativism. They have abandoned what methodologists call “historicism,” a belief prevalent among scholars internationally since the 19th century that their research should seek to explain why purposes that seem self-evidently desirable were, were not, or were incompletely achieved. A notable example of historicism was the literature purporting to explain why the United States consistently failed to enact national health insurance.^{52,53}

An influential number of persons who study nonprofit organizations have, however, remained historicists. They continue to claim, as the founders of their field in the 1960s did, that nonprofit organizations constitute a “third,” or “independent,” sector of American society whose self-evident purpose is to promote important values.⁵⁴ The editor of a recent handbook of scholarship in the field emphasized, for example, the “distinctive character of nonprofits in civil society” and claimed that the sector has “a mission.”⁵⁵

As a result of the persistence of historicism, many scholars of nonprofit organizations have regarded their commercialization as unavoidable. These scholars adduce historical and contemporary evidence as the basis for inferring that the paradox that is the subject of this article does not exist. An economist argued in 1997 that increasing fiscal pressure “would lead non-profit organizations into more creative commercial activity.”⁵⁶ Five years later, eminent scholars described the “widespread commercialization . . . of social and economic life” as the “dominant force shaping the non-profit sector.”⁵⁷ A scholar concluded in 2005 that “nonprofits need to make profits . . . or their enterprises [will] falter.”⁵⁸ A year later, an article in a new edition of a leading book on research in the field described commercialization as “inevitable.”⁵⁹ In 2009, an article in a prominent journal of public administration concluded that nonprofits’ increasing reliance on investments and earned income, as well as contributions, has had the salutary effect of reducing their “revenue volatility.”⁶⁰ A study published 2 years later found that “nonprofits target profits and seek their accumulation over time.”⁶¹

My explanation of the paradox augments findings on power and ideology by scholars of health policy and the assumption by their colleagues in nonprofit studies, that commercialization helps these organizations achieve their purpose in American society. This explanation begins with the fact that policy to create, expand, and sustain the paradox was controversial only between the mid-1990s and early 2000s, when a substantial number of health plans and hospitals converted their profit status. The history of the policy paradox, that is, is different from the history of policy to use tax revenue and governmental regulatory authority to expand access to care and improve its quality and efficiency. Such policy has been controversial from the first decade of the 20th century through this week.

The rarity of controversy leads me to hypothesize that there has been consensus on the value, or perhaps the nonexistence, of the paradox among leaders of governance in the health sector who have disagreed on many other issues. Two subordinate hypotheses explain the consensus. The first is that its basis is shared assumptions about health and health care. The second is that these assumptions have helped diverse and even competing groups in the health sector—interests that I listed at the beginning of this section—ignore evidence of both the commercialization of nonprofit organizations and its actual and potential effects.

The assumptions to which I allude have been central factors in the politics of policymaking for health for more than a century. One of them is that subsidizing biomedical research and its translation into professional education and practice has produced—and will continue to yield—ever more effective ways to prevent, diagnose, treat, and manage illness.⁶² Most of this research has been conducted and applied (“research translation” is a recent synonym for “application”) by persons associated with nonprofit or public academic centers and hospitals affiliated with them. Endowed foundations funded most of this research during the first 4 decades of the 20th century, and agencies of the federal government have been the dominant sponsors since then. Because most policymakers and voters assume that biomedical research is necessary in order to improve and maintain health, they have made or supported policy to incentivize more and more successful research. This policy included endorsing the commercial interests of biomedical scientists and their institutional employers, what some call the “corporatization” of universities and independent research organizations. Policy that endorsed the commercial interests of scientists and universities also enhanced the

profits of organizations in the chain of supply for drugs and medical devices. Moreover, it increased the amount of money from research funding and its commercialization which has been spent and, as economists have documented, multiplied in value in local economies.⁶³

The persistence of the paradox can also be attributed to assumptions about the burden of disease and ways to address it, as well as to changes in these assumptions. By 1920, the number of deaths from chronic disease annually exceeded the number of deaths from infections and injuries. In the mid-1930s, several million Americans told interviewers for a National Health Survey organized by the federal government that they worried most about managing the disabling consequences of chronic disease, including such issues as adequate access to health and social services, income, and housing.^{5 (pp34-36)}

Leaders in the governance of the health sector did not, for decades, prioritize what citizens had told the surveyors. For them, the important priorities for policy to address chronic disease were subsidizing their diagnosis, providing care during and after acute episodes of these conditions, and conducting research in order to increase knowledge about their causation and treatment. As a result of these priorities, policy increased the number, size, and sophisticated equipment of health care facilities, the proliferation of health care professions and professionals, opportunities to conduct biomedical research, and the subsidization of Americans' access to health services, mainly through tax expenditures and public subsidies directed at people who were poor, old, or too disabled to hold a job.⁶⁴

As the amount of national spending for health rose, so did evidence that the care of patients with chronic diseases could be improved—and the rate of increase in its cost slowed—by policy that accorded more resources to integrating and managing primary, specialty, and long-term care that was coordinated effectively with social services and housing. This evidence gradually stimulated new policy to finance health care: in the mid-1950s, the creation and spread of major medical coverage by commercial and nonprofit insurers; a decade later, an unprecedented increase in the breadth of coverage for care through Medicare and Medicaid; and, many incremental changes later, by payment policy under the ACA.

In recent decades, increasing numbers of participants in the governance of the health sector—but still only a minority of people with power—have become committed to a new potential consensus. As a

result of this emerging consensus, which the ACA seems to be strengthening, policy could more quickly and thoroughly encourage the integration of different levels and types of care. Policy could also finance access to health care by methods other than fees for individual services and payments for episodes of care. Participants in the emerging consensus argue that policy to implement it would benefit patients, and reduce the rate at which costs increase, by reducing reliance on hospitals and health systems and unwarranted variation in the interventions that physicians order.

An anonymous reviewer properly took issue with my optimism that a consensus may be emerging for integrating care in the interests of patients. The reviewer doubts whether “most doctors and hospitals any longer place the needs of patients first . . . [that they] are no longer interested in the public good [as a result of] commercialization, self-absorption, and greed.” I hope this reviewer is wrong.

Addressing the Effects of the Paradox

Although the ACA has mainly, to date, sustained the policy paradox that incentivizes the simultaneous growth and commercialization of nonprofits, the struggle to enact and implement it also makes it possible to speculate that it could also reduce the force of the paradox by constraining commercialization. Since 2009, for example, the IRS has required nonprofit hospitals (but not skilled-nursing facilities) to report annually the community benefits they provide. By that year, 16 states had mandated hospitals to report on community benefits.⁶⁵ Maryland’s Hospital Rate-Setting Commission requires what seem to be the most extensive reports.

Similarly, since 2010, legislation in 14 states has attempted to distinguish commercial from charitable activities by permitting for-profit corporations to “pursue a social or environmental mission” through new tax-exempt “benefit corporations” and organizations called “L3Cs.” A journalist described the purposes of these hybrid entities as “making money, attracting private investors, and addressing societal concerns.”⁶⁶ More than half of the remaining states are considering policy to create such hybrids. But the more than a thousand benefit corporations established to date have provoked criticism. For instance, a critic recently noted that many of these corporations are emulating “hospitals,

universities . . . and others that have long built strong revenue-generating programs” while lobbying for minimal regulation by states and the federal government.^{67,68} The policy paradox persists.

Many nonprofits, moreover, are increasing commercialization by establishing for-profit subsidiaries. A national news service reported in 2014, for example, on nonprofit community health centers and hospital systems that have established for-profit insurance plans to compete for patients covered by Medicaid managed care and the ACA. A consortium of community health centers in Maryland, in partnership with Johns Hopkins Medicine, organized a for-profit plan that earned nearly \$12 million in 2013. The chief executive of the consortium explained to a reporter that “we are trying to move up the food chain to get better in line for revenue.”⁶⁹ Again, the paradox persists.

An association of nonprofit organizations in health care has proposed that Congress and the IRS strengthen regulations for accountability. In April 2014, the president of the Alliance for Advancing Nonprofit Health Care recommended new federal policy requiring nonprofits “to demonstrate that the costs of the special benefits/subsidies they provide equal or exceed the monetary value of their federal tax exemption.”⁷⁰ Less than a year earlier, however, hospital associations and their allies had persuaded the IRS to weaken proposed regulations to implement the new section, 501(r), on reporting community benefits that the ACA added to the Internal Revenue Code. The final regulations implementing the new section do not require nonprofit hospitals and systems to justify the expertise or the data they use to assess and prioritize their communities’ health needs. But the IRS does require hospitals to coordinate with state and local departments of health. David Kindig, who is alert to the commercialization of nonprofits, told me in May 2014 that this requirement has contributed to improved population health in some communities.⁷¹

In sum, the policy paradox that has incentivized both the growth and the commercialization of nonprofit organizations for more than a century remains a prominent characteristic of American health policy. Some aspects of the ACA, reinforced by extensive media coverage of the generous salaries earned by executives of nonprofits in the health sector and physicians who practice in them, may be persuading some participants in the governance of health affairs to support restraints on the commercialization of nonprofits. The politics of governing the health

sector will decide the future of this policy paradox, just as they have been responsible for its past.

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