NONPROFIT TO FOR-PROFIT CONVERSIONS BY Hospitals, Health Insurers,

SYNOPSIS

Conversion of hospitals, health insurers, and health plans from nonprofit to for-profit ownership has become a focus of national debate. The author examines why nonprofit ownership has been dominant in the US health system and assesses the strength of the argument that nonprofits provide community benefits that would be threatened by for-profit conversion. The author concludes that many of the specific community benefits offered by nonprofits, such as care for the poor, could be maintained or replaced by adequate funding of public programs and that quality and fairness in treatment can be better assured through clear standards of care and adequate monitoring systems. As health care becomes increasingly commercialized, the most difficult parts of nonprofits' historic mission to preserve are the community orientation, leadership role, and innovation that nonprofit hospitals and health plans have provided out of their commitment to a community beyond those to whom they sell services.

CONVERSION OF HOSPITALS, health insurers, and health plans from nonprofit to for-profit ownership has become a focus of national debate over the past several years. The rapid growth of the for-profit hospital chain Columbia/HCA followed by allegations of widespread fraud and billing irregularities; the expansion of Tenet Healthcare into the second largest for-profit chain in the US; the conversion of some Blue Cross plans from nonprofit to for-profit operation; and the growth of for-profit managed care plans have helped draw scrutiny to the conversion issue at the national level.

Historically, nonprofit ownership has dominated US health care; this is in marked contrast to other sectors of the economy, including those providing other essential services such as food and shelter. It is useful as we consider the issues raised by conversions to review why this pattern of ownership emerged and what has sustained it.

THE EMERGENCE OF NONPROFITS

The earliest US hospitals—Pennsylvania Hospital in Philadelphia (established in 1752) and New York Hospital (chartered in 1771)—were private nonprofit institutions for the care of the poor, supported by donations. Prior to the introduction of anesthesia and antisepsis around 1870, medical care could be administered as well or better at home. Physicians made home visits to the financially well-off, who were nursed by family or hired help. Nonprofit hospitals treated only the poor, transients, and those more affluent people who lacked family support.

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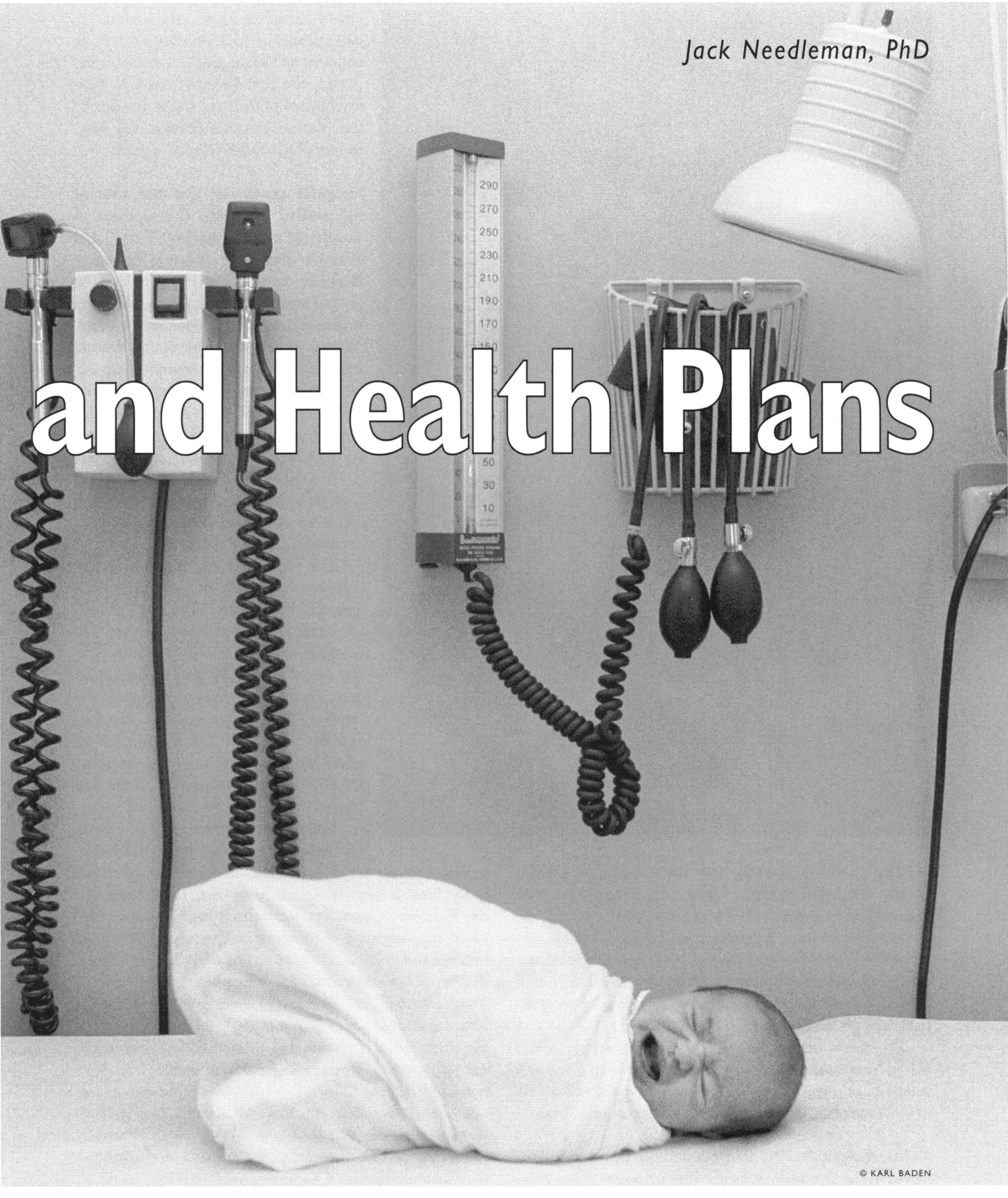
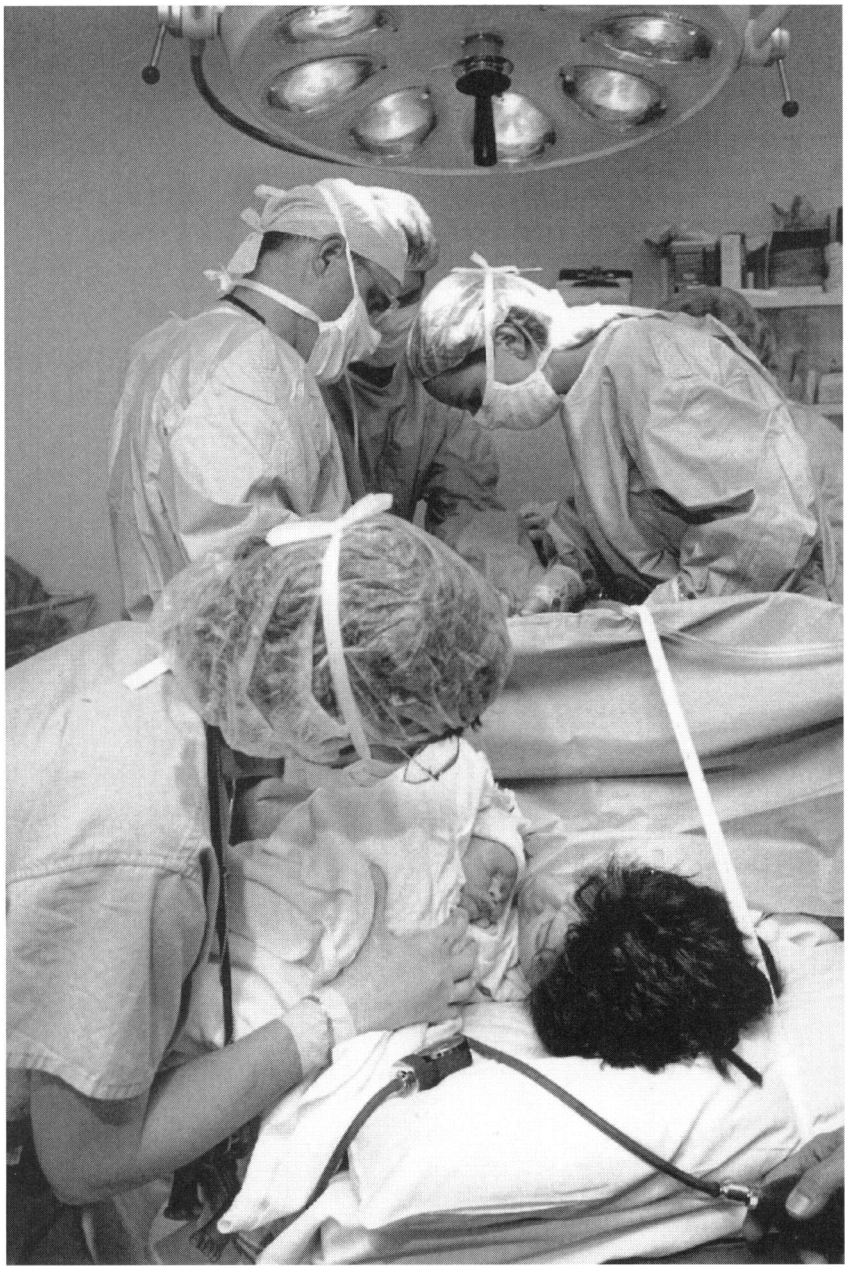
and Health Plans





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The charitable impulse and the absence of a sufficiently developed system of government services fueled the early development of nonprofit institutions.[1]

For philanthropic sponsors, donations to hospitals provided the rewards of participation in charitable activities, conferred community status and power, and legitimized individual wealth and position,[1] benefits equally germane to today's philanthropists.

Physicians helped establish these institutions, which served "as a means of developing medical education and as a source of prestige."[1] Hospital affiliation also provided access to other members of the medical staff, a source of referrals.

Public hospitals. The first public hospitals were established in the late 18th and early 19th centuries. They principally served the poor and were direct descendants of the poorhouses run by counties and municipalities. In the same period, the first Federal hospitals were established to treat merchant seamen by the Marine Hospital Service, the forerunner of the Public Health Service.

Hospital expansion and the role of for-profits. With the development of anesthesia, aseptic surgery, X-rays, and effective drug and antibiotic therapies, hospitals, now much safer and offering unique services, became places where the well-to-do, not just the poor, were treated. As the proportion of revenues derived from fees increased, nonprofit hospitals expanded, offering care to both the poor and non-poor (often in separate wings). New nonprofits were built, many sponsored by religious groups.

A number of new government hospitals, some of which restricted their services to the poor, were established between 1870 and 1930.

The first for-profit hospitals—typically owned by one or more physicians and offering medical and surgical services to paying patients—were also established in the late 19th century. The number of proprietary for-profit hospitals grew rapidly and soon outstripped the number of nonprofits. In 1873, a Federal census counted 178 hospitals, all of which were public or private nonprofits.[2] By 1910, for-profit hospitals accounted for just over half of the 4359 total.

Market-driven health care is not just a contemporary phenomenon. When for-profits became widely available, nonprofit hospitals no longer limited their mission to charity care. They moved into the business of providing mainstream care for those who could pay, adjusting their operations to appeal to paying patients and physicians. Nonprofits relaxed or removed rules that restricted physicians from billing hospitalized patients. They attracted and retained physicians by moving from closed staffs—in which access to the hospital was restricted to a select group of physicians—to open staffing, and by giving physicians more control of medical practice.[3] As Starr notes, "Physicians' interest in maintaining proprietary hospitals waned...as community hospitals opened their staffs to wider membership and doctors found they were able to have the public provide the capital for hospitals and maximize their incomes through their professional fees."[1]

In 1928, 36% of the 6852 hospitals in the US were for-profits.[2] From the Depression to the advent of Medicare and Medicaid in 1965, for-profit hospitals' market share declined by half or more in every region of the country[3] as the number of nonprofit hospitals increased and for-profits converted to nonprofit status or closed. For-profit hospitals were typically capitalized as small businesses, and many failed during the Depression. By contrast, nonprofit hospitals had community boards that could pursue fundraising. In addition, the Hill-Burton program introduced at the end of World War II provided substantial Federal support for new construction to public and nonprofit hospitals through grants and subsidized loans. This asymmetry in access to capital during the 1950s contributed further to a decline in the importance of for-profit hospitals and to their continued conversion to nonprofit status.

Private insurance expanded in the 1960s, and with the enactment of Medicare and Medicaid in 1965 a large portion of previously unpaid care was now funded. Generous third-party reimbursement encouraged purchases of hospitals by for-profit chains as well as repurchase of hospitals previously sold to nonprofit organizations. Reversing the declines of the 1950s, the percentage of for-profit hospitals remained stable at about 13.5% of all hospitals during the 1970s and 1980s, and their market share measured in bed capacity increased from 3.86% in 1970 to 7.66% by 1980.[4,5]

In the 1970s, corporate chain hospitals grew larger, moved to become full-service general hospitals, and successfully recruited physicians in competition with nonprofits through a combination of financial support for relocation, physician amenities, and a full range of supporting technologies.

By the early 1980s, substantial political and economic pressure mounted to control health care costs. The Medicare prospective payment system (using a fixed payment schedule based on Diagnosis Related Groups, or DRGs), an increase in price negotiation and "utilization review" by insurers, and the growth of health maintenance organizations (HMOs) and preferred provider organizations (PPOs) pressured hospitals. In this new environment, the for-profit chains faltered badly. Profits declined, and with them stock prices. This led to massive reorganization of the chains. Columbia/HCA emerged in the 1990s as the dominant chain, incorporating hospitals formerly associated with the Hospital Corporation of America (HCA), HealthTrust (an HCA spinoff), and Humana, among others. With the growth of Columbia/HCA, the pace of nonprofit to for-profit conversion accelerated. In 1995, 18% of hospitals were for-profits.

In response to the growth of for-profit chains, many nonprofit hospitals have sought to model themselves on the successful for-profits. These efforts have included the creation of for-profit subsidiaries, the growth of nonprofit chains, contracting management of nonprofit hospitals to for-profit management companies, contracting operation of selected services to for-profit companies (for example, emergency departments and drug and alcohol rehabilitation), and joint ventures with for-profit firms or physician groups. This trend has been characterized as the hybridization of the nonprofit and for-profit sectors.[6]

Lessons from history. Nonprofit hospitals' dominance in the hospital sector from the mid-17th century to the present is thus a function of several factors—their establishment as charitable institutions; decisions by existing nonprofit hospitals at the end of the 19th and beginning of the 20th century to treat paying patients and actively compete for patients and physicians through the services and amenities they provided and their treatment of medical staff; and preferential access to operating subsidies and capital during the Depression and post–World War II period. The growth of for-profit hospitals since the 1960s has been fueled by favorable capital reimbursement under Medicare rules and infusions of equity from the stock market. Clearly, access to capital has been a major factor in the relative growth of nonprofit and for-profit hospitals for a century.

The growth of nonprofit health insurers. At the start of the 20th century, few insurance companies offered health coverage, fearing adverse selection (disproportionate purchase of insurance by the sick) and moral hazard (the tendency of insured people to use more services). During the Depression, hospitals confronted the prospect that patients would increasingly be unable to pay for services. Realizing that even partial payment through insurance would improve their financial situations, hospitals sponsored the first Blue Cross plans, beginning in Texas in 1934. Plans were soon established in other states. In most states, these plans were organized under legislation that put them under a separate set of regulations from other insurers and allowed them to operate as nonprofit organizations. Prepaid medical plans for physician services, Blue Shield plans, were established on this model but as separate entities. The Blue Shield plans trace their origins to mining camps in the Northwest after World War I.

Because of their dominant role in the insurance market in many communities and their close ties to hospitals and other providers, the "Blues" developed distinctive approaches and methods. For example, they "community rated" their premiums—establishing common rates for high and low risk individuals and groups. They offered open enrollment periods, in which any individual could obtain coverage at the community rate. The combination of community rating and open enrollment made the largest Blues the insurers of last resort in their markets.

Distinctive approaches also applied to the Blues relationships with hospitals. Instead of paying hospitals'

charges, many plans paid a portion of costs. Among some of the plans, this evolved into an annual review of hospital budgets that was a precursor to rate setting by states. Review of hospital capital budgets likewise set the stage for the review of capital expenditures required for Medicare and Medicaid payment under Section 1122 of the Social Security Act and state certificate of need legislation. Thus private negotiation became the framework and model for public regulation.

Dominant market position and a community leadership role fostered by nonprofit status and community ties also allowed the Blues to lead in other innovations in the market. For example, the Western Pennsylvania Blue Cross plan developed a low-cost limited benefit insurance policy for low-income children. Funded by charitable contributions, this policy was available to eligible families at no charge. Other Blues plans also adopted this approach to expanding coverage for children.

During the 1950s and 1960s, the market for health insurance grew and commercial insurers such as Prudential and Aetna expanded into markets they had previously left to the Blues. Focusing on group coverage and identifying low risk groups for whom the community rates offered by the Blues were high, these insurers ate away at the Blues' market share. The Blues responded by abandoning community rating for their group policies. Often, however, the preferential rates they got from hospitals allowed the Blues to continue to surcharge their group customers to generate subsidies for their small group and individual products. In rate-setting states, a Blues differential was often established in regulation to support access to insurance through the open enrollment and community rating the Blues provided.

During the 1980s and 1990s, as insurers and managed care plans began negotiating rates directly with hospitals and as states abandoned rate setting, the price advantage held by the Blues disappeared in many markets. The Blues' market share declined, and the financial position of many plans became perilous. Forced to compete more aggressively, plans sponsored HMOs, upgraded management and information systems, and expanded marketing, all of which required additional capital.

Focusing on survival, the Blues continued to move away from their community missions. Several sought to convert to for-profit status. In 1994, the Blue Cross and Blue Shield Association eliminated its requirement that the companies holding its licenses be organized as nonprofit corporations. The Association advanced three reasons for this change: First, the Blues had evolved from "social service" models to "mutual company" models with their primary commitment to their subscribers, not their communities. Second, the Association recognized that for some Blues plans to survive they needed greater access to capital markets, and this could be achieved through for-profit conversion. Third, research by the Association showed "that the vast majority of consumers either did not know the difference between for-profit and nonprofit insurers, or did not care," and "the vast majority of business decision makers who bought health insurance had decidedly negative impressions of the nonprofit form."[7] This paved the way for several large conversions, many highly contested.[8,9]

The emergence of nonprofit health plans. Nonprofit HMOs—integrated systems of financing and service delivery, often built around salaried medical staffs—were the dominant managed care model in the 1970s. Harvard Community Health Plan, Tufts Health Plan, Kaiser Permanente, the Group Health Cooperative of Puget Sound, the Health Insurance Plan of New York, and others were all organized under nonprofit ownership. There were at least two reasons for this. First, to avoid problems associated with legal restrictions on the corporate practice of medicine, these plans were organized under the nonprofit corporation statutes that created the Blues, or under legislation modeled on these statutes. In some states, laws prohibited for-profit plans. Second, because of the opposition of organized medicine to the creation of these plans, they were often initially sponsored by community groups or labor unions that had service rather than profit-making orientations.

The alternative model to these closed panel plans were physician-sponsored foundations, organized much like Blue Shield plans but collecting premiums and accepting the risk for hospital and physician care and other services. These foundations became the model for independent practice associations (IPAs).[10]

In the 1970s, the Federal government established programs to promote the development of HMOs. Support was directed primarily at nonprofit plans, although for-profit plans were offered loan guarantees as an incentive to operate in medically underserved areas. While some groups—the American Public Health Association, the AFL-CIO, and the American Nurses Association—argued that nonprofit organizations were more likely to provide quality care and would better reflect community needs, it is not clear to what extent these concerns influenced Federal policy.[11]

In 1981, President Reagan ended Federal grants, loans, and loan guarantees to HMOs. As HMOs looked to expand in a market more hospitable to managed care, they increasingly looked to Wall Street for capital funds. Using equity capital, for-profit HMOs expanded nationally into markets not traditionally served by nonprofits. The early 1980s also saw a series of nonprofit to for-profit conversions—among them US Health Care, MaxiCare, FHP, and PacifiCare. These were joined by for-profit startups or by new managed care programs offered by traditional

health insurers. Most nonprofit HMOs remained focused on their local markets, although Kaiser Permanente expanded nationally using internal funds.

WHY CONVERSION?

Public interest in the issue of conversions has been fueled by perceptions that the phenomenon is growing and that for-profits are moving into places where they have historically not existed; by concern about the impact of conversions on access to care and other community benefits; and by questions about returning to communities their investment in these organizations.

The number of conversions is difficult to ascertain. In a 1997 report, my colleagues and I estimated that at least 174 nonprofit to for-profit hospital conversions occurred between 1980 and 1993.[12] In an extension and refinement of that analysis, I now estimate that between 1980 and 1995, 270 nonprofit hospitals converted to for-profit operation. The higher number reflects 63 conversions in 1994–1995 and more accurate counts of conversions for 1980–1993.

Hospital conversions are largely acquisitions of nonprofit hospitals by for-profit entities. This can occur through sale, lease, creation of a joint venture in which the for-profit entity is the managing partner, or merger. Direct conversion of a hospital from nonprofit to for-profit ownership as a freestanding corporation has been rare.

By contrast, conversions of Blue Cross/Blue Shield plans have generally resulted from a change in corporate form. Subsequent to the conversion, there may be merger with or acquisition by another entity. There are no accurate counts of these conversions; in some states there are disputes over whether restructurings are actually conversions.[7,8,13] More Blue Cross/Blue Shield conversions are likely.

Following the rash of HMO conversions in the early 1980s,[10] some historically nonprofit HMOs such as Group Health in Washington, DC, were acquired by for-profit companies. Many of the converted HMOs have since merged with one another or with historically for-profit insurers.

The reasons for conversion differ for hospitals, health insurers, and managed care organizations but have common roots in financial and market pressures.

"Specific community benefits" are usually seen as being at risk in nonprofit to for-profit conversions.

Hospital conversions. Hospital conversions require both a buyer and a seller. Each must find value in the transaction or it will not proceed. Selling appears to be motivated by three factors, singly or in combination: financial distress, in cases in which the management and board do not feel they can be successful in turning the institution around; need to finance capital improvements, when the hospital's debt capacity is not sufficient to allow it to raise additional funds; fear that the hospital does not have the market power to survive except in alliance with a larger partner.[14,15] Other motivations may also come into play, including a perception that the nonprofit form is no longer appropriate. For example, Coye describes a conversion motivated in part by the board and administration's feeling that the nonprofit structure made it difficult to undertake bold actions necessary for future survival.[15]

From the purchaser's perspective, there are several possible reasons for acquiring a hospital. One possibility is to attempt a financial turnaround, believing that better management or greater investment can improve the financial status of the hospital. Since most studies that have looked for differences in the efficiency of nonprofit and for-profit hospitals have concluded that for-profits are not more efficient,[16,17] turnaround can only be expected if the hospital has significant operating inefficiencies relative to other hospitals or if it can improve its financial status by raising prices or changing services. The evidence on the ability of for-profit chains to achieve increased efficiency in converted hospitals is mixed.[18]

A second reason for acquisition is to expand a network. Networks offer the potential to increase efficiency through economies of scale, to close low-volume units and shift patients to other providers, and to increase negotiating power vis à vis managed care plans and insurers.

Converted hospitals generally need to fit the strategic plans of the acquirer and must be seen as having the potential to meet its financial expectations. Converting hospitals are more likely to be suburban than urban or rural and to have a broad payer base, to be sole community providers, or to be located in communities in which the acquirer seeks to build or expand its network.

It is significant that in many of the cases in which for-profit and nonprofit chains compete for hospitals, the for-profit chain wins the bidding war. This seems to occur for two reasons. First, a for-profit chain typically retires the nonprofit's debt and transfers assets to a nonprofit successor foundation, which leaves the community with additional locally controlled nonprofit funds. Nonprofits typically assume the debt of the acquired facility and will pay it down through patient service revenues, with no transfer of funds to the community. The second reason is that the large chains have been able to generate substantial funds from capital markets by making purchases. The purchase prices of nonprofit hospitals have been around eight times

their annual earnings. The large chains' stock prices have typically been 20 to 21 times the chains' annual earnings, reflecting expectations of future growth.[19]

Conversions of health insurers and managed care organizations. Conversions of insurers such as Blue Cross plans or of managed care organizations appear driven by two considerations—access to capital and entrepreneurship. The CEO of California Blue Cross, who led the company through conversion to for-profit status, described the reasons for the change as a response to "significant challenges: uncertainty over future government policy and regulation, limited access to capital markets, and increasing competition in a rapidly growing marketplace."[20] The goal was to "ensure the long-term health of the business" and to "position the organization for future growth."

Among the key uses for the influx of capital are development of new products, upgrading information systems and other infrastructure, and expansion. Expansion and growth are motivated by two pressures—the need to bulk up to obtain economies of scale and pressures from investors for substantial growth in earnings. Thus, for-profit status, entered into to obtain capital for what is perceived to be needed investment and growth, also becomes a source of pressure to maintain growth.

CONCERNS ABOUT CONVERSION

As conversions by hospitals and health plans have become more visible, public discussion has focused on the appropriateness of conversions and the gains and losses to communities that result. The concerns raised by critics fall into three broad categories:

- Community benefits
- Quality of care and fair dealing with patients and consumers
- Appropriate valuation and retention of assets within the community.

Community benefits. One of the principal issues raised in conversions is whether the community benefits and services that have been provided by a nonprofit will continue to be provided by the successor for-profit.

There are no generally accepted definitions of the community benefits provided by nonprofit hospitals, health insurers, or managed care organizations.[11,13,21-26] In what follows, I summarize the principal benefits claimed for nonprofit health care organizations and assess the extent to which they are threatened by nonprofit to for-profit conversion.

Hospitals. The Catholic Hospital Association has been one of the leading organizations attempting to define the community benefits provided by hospitals. The CHA has strongly pressed institutions to distinguish true community benefits from basic services, that is, those services and activities that are expected of a high quality health care organization regardless of its ownership or tax status. The CHA also distinguishes between *general community benefits*—programs that reflect a commitment to the community and either pay for themselves, involve minimal cost, or are provided by volunteers or through donated time—and *specific community benefits*, programs that respond to particular health programs in the community but, because they result in financial loss to the organization, would be discontinued if the decision were made on a purely financial basis.[24]

It is these "specific community benefits" that are usually seen as being at risk in nonprofit to for-profit conversions. They may include:

Charity care and care for those who cannot pay. The community benefit most frequently cited in the literature is charity care (or a proxy, uncompensated care, which includes both charity care and bad debt since hospitals are inconsistent in differentiating between the two). The evidence is mixed on whether nonprofits provide more uncompensated care than for-profits. In some states, there are wide differences, while in others, such as California, the differences are small.[27] Some of the differences are due to location and thus the demand for uncompensated care.[28]

Studies of changes in uncompensated care among converting hospitals are just beginning to be reported. Young and his colleagues, looking at converting hospitals in California, found that the level of uncompensated care in these hospitals prior to conversion matched that of comparable for-profits and that it did not decline following conversion.[29] Mark and colleagues, based on a limited sample, likewise concluded that the level of uncompensated care did not decline after conversion.[14] In a preliminary analysis of hospitals in Florida, where nonprofit and for-profit levels of uncompensated care differ more than in California, I found that prior to conversion the converting nonprofits on average provided a level of uncompensated care lower than that of other nonprofits and comparable to that of for-profit hospitals, and that the level did not change post-conversion.

If, as the limited data suggest, nonprofits involved in conversions provide low levels of uncompensated care prior to conversion, uncompensated care or charity care may not be at risk in a conversion. Further study is required to assess whether hospitals that start with high levels of charity care provide lower levels after conversion.

In states such as Massachusetts and New York, which have created and maintain free care pools, any threats to uncompensated care may be mitigated by the operation of these pools. (In these states, hospitals receive payments

from the pool to cover the costs of uncompensated care in excess of a fixed levy, and contribute to the pool the difference between the levy and their costs for uncompensated care if their costs are lower than the levy.) Programs such as these were originally constructed to limit market pressures on nonprofit hospital systems. To the extent they are adequately financed, they should have the same effect on for-profit hospitals.

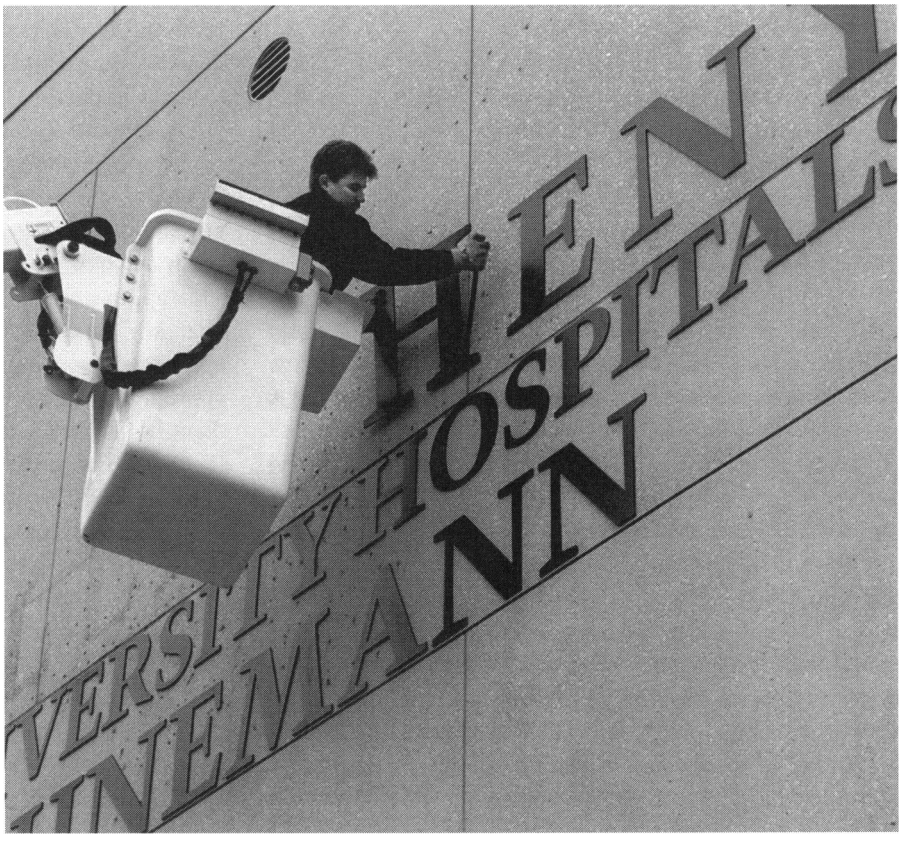
Medicaid services. In some states, Medicaid payments to hospitals are below cost. Where this is the case, hospitals may make a commitment to serving Medicaid patients as part of their mission or seek to reduce their volume of service to this population. The spread of Medicaid managed care programs has allowed some hospitals to avoid Medicaid patients by choosing not to contract with these plans, although this strategy becomes more difficult when major managed care organizations contract with Medicaid. Further study of this issue is needed.

Unprofitable services. Hospitals provide a wide range of services that are considered unprofitable but are valued by the community. These include emergency departments, trauma services, and specialized services for which full reimbursement is generally not provided by insurers or which are likely to be used by uninsured patients. In its 1986 report on *For-Profit Enterprise in Health Care,* the Institute of Medicine found that for-profit hospitals were less likely to offer such services than nonprofit hospitals.[30] In an analysis of the American Hospital Association's (AHA) Annual Survey data for 1980–1995, I also found that for-profit hospitals are less likely to offer emergency departments or trauma services and that, as with uncompensated care, converting nonprofits on average started with a level comparable to that of for-profits and that the level did not change following conversion. There are no data on whether hospitals have restricted access to these unprofitable services while continuing to offer them. Access to emergency departments, for example, can be restricted by reductions in hours, cutbacks in translation services, or more aggressive financial review of patients' ability to pay, all of which can discourage use of the service.

Lower prices. Studies of hospital pricing in the 1980s generally found that for-profit hospitals priced their services higher than nonprofits, which appeared to price at break even level or at a fixed margin over costs.[31–33] Thus, lower prices are a benefit offered by nonprofit hospitals. While this issue has not been extensively studied, there are indications that price differences between for-profit and nonprofit hospitals have narrowed in the 1990s. It is unclear to what extent this is due to market pressures squeezing prices down or to more aggressive pricing by nonprofit hospitals.

Medical education. Prior to the rash of conversions of nonprofit and public hospitals, virtually no for-profit hospitals had medical school affiliations or substantial commitments to medical education. However, according to AHA Annual Survey data, 9% of the nonprofit hospitals that have converted to for-profit operation have been teaching hospitals, and all have maintained their teaching mission.

Community ownership and continuity. Community-based ownership and continuity of ownership are valued by many advocates of nonprofit health care and represent benefits typically provided by non-profit hospitals. In contrast, for-profit chains have formed and reformed over the past 15 years and have demonstrated a willingness to sell hospitals that no longer fit their corporate plans. Sometimes institutions are sold to other for-profits; in other cases they are sold to nonprofit or public owners or returned to community control. Interestingly, 10% of the



nonprofit hospitals that converted from nonprofit ownership to for-profit ownership between 1980 and 1995 have reconverted, according to AHA data.

It is not clear how these shifts in ownership affect converting hospitals. Resale may reduce access to capital, support for development of information systems and other infrastructure, and enhanced market power through participation in a network. Furthermore, a hospital's historic ties to its community may be severed by repeated changes in ownership and hospital management.

Preserving specific community benefits. Communities and boards need to carefully consider whether the potential gains from conversion outweigh the potential losses. If a hospital is providing substantial benefits to the community and these are threatened by conversion, the hospital's administration and board, advocacy groups, and regulatory bodies can take one of four approaches to preserving these benefits.

The first approach is to require the new management to commit contractually to maintain certain services or a certain level of service. This was done in the Good Samaritan Health System conversion in California and has been made an integral part of the California Attorney General's review of hospital conversions. As Boards and executives of converting institutions have become more sensitive to these issues, negotiation over continuity of services has become more common. There are several potential weaknesses to this approach, including lack of specificity in contracts; the difficulty in monitoring compliance with the terms of contracts; and inflexible provisions that do not allow a "nonprofit-like" response to future unanticipated changes in needs.

A second approach to preserving the continuity of community benefits is to make these benefits the responsibility of successor foundations established with the proceeds from conversions. This would maintain the nonprofit mission as the responsibility of nonprofit entities. This approach allows for flexibility over time to adjust to changing demands for care. Issues in implementing this approach are whether the successor boards have the appropriate knowledge and capacity and whether sufficient funds are available to meet demands.

A third approach is to create public programs to provide the specific community benefits that would be lost as the result of a conversion. Free care pools are an illustration of such a program. The obvious drawback to this approach is that a source of ongoing funding must be identified for these activities and that they require action on the part of public officials.

The final approach to assuring continuity of community benefit is to prevent the conversion. The most important weakness of this approach is that it fails to acknowledge the conditions and circumstances that led the nonprofit hospital to consider conversion in the first place.

This approach should be used only if the three approaches outlined above are judged infeasible and alternative strategies for assuring the continuity and capacity of the nonprofit to maintain these services (such as merger with a financially stronger nonprofit or an influx of community funds) can be developed.

Health insurers and managed care organizations. The community benefits provided by nonprofit health insurers and managed care plans are different from those provided by hospitals.

Larry Brown has described Blue Cross and Blue Shield plans as resting on three core values: voluntarism, community, and a cooperative ethos.[34] These were also the core values of early nonprofit HMOs. Flowing from these values were a series of commitments and operational decisions that defined the community benefits these organizations offered at their inception. The first was a commitment to assuring affordability and availability of insurance through community rating and subsidy of small groups and individuals by larger groups and the sick by the healthy. This benefit has been virtually eliminated by market pressures. Where states have sought to preserve this benefit in the face of market forces, they have done so by creating high risk pools with capped premiums or requiring community rating by all insurers in the small group and individual market. Some nonprofit HMOs have continued community rating, but it is unlikely this would survive conversion.

A second benefit was a commitment to protecting critical community resources. The intimate relationship between Blues plans and hospitals and other service providers led the plans in some cases to set reimbursement levels above market level or to work with providers in other ways to assure the continued viability of institutions that were judged critical resources. As the plans have adopted a definition of their role as serving their customers, this function, too, has essentially ended.

A third community benefit was innovation in products to meet community needs. Although there is substantial innovation in today's health insurance markets, it is customer- and market-driven and will be measured by its success in increasing profits or market share. Innovation, particularly innovation in coverage, has shifted to government initiative, as reflected in Medicaid expansion, the development of the Federal-state children's health insurance program, and state health reform initiatives.

A fourth community benefit has been the role played by health plan executives in community service and leadership. Nonprofit ownership provides the freedom to invest funds in service and research rather than returning earnings to stockholders. The standing to take a leadership role comes from nonprofit sponsorship and grounding in and identity with the community. This standing has been attenuated by efforts to "go national," while the funds to support these activities have been eroded by market competition. Nonetheless, this benefit is perhaps the one that has best survived the overhaul of the health insurance system in the United States. Whether the plans' needs for greater access to capital will outweigh this benefit will need to be analyzed on a case-by-case basis.

In general, one may reasonably conclude that the ability of nonprofit insurers such as Blue Cross and Blue Shield to continue to offer community benefits has been fundamentally eroded by market pressures. Nonprofit HMOs continue to play significant roles in education, research, and leadership,[35] and a more limited role in expanding access through community rating. Whether these roles are sustainable in the changed market is an open question.

Quality and fair dealing with patients and customers. One of the arguments frequently put forward for preferring nonprofits to for-profits is that nonprofit providers are less likely to skimp on care and will provide higher quality care. The counter argument is that physicians are, by and large, independent of the institutions in which they work and have separate ethical obligations to their patients. The limited available evidence on quality differences between nonprofit and for-profit hospitals is mixed. No studies provide convincing evidence of higher or lower quality at for-profit hospitals.

A key issue in the quality debate is whether joint hospital-physician ownership or other economic entanglements influence care. Columbia/HCA has had a practice of creating physician-hospital partnerships. An unreleased Florida study quoted by Robert Kuttner found that the length of stay of Medicare patients admitted by physicians to a Columbia/HCA hospital was five days shorter than that of patients admitted by the same physicians to other hospitals[36] The report suggests the possibility that financial incentives encouraged physicians to direct lower risk or lower cost patients to these hospitals or to discharge patients earlier.

The evidence suggests that nonprofit managed care plans offer higher quality care and achieve higher levels of patient satisfaction than for-profit plans,[37,38] but the reasons for these differences are not clear. The differences in satisfaction with care across plans may reflect differences in health care quality across regions, the age of the plans, or length of enrollment in the plan. Further study is required to assess whether conversion would lead to changes in practice that would change satisfaction or quality.

Appropriate valuation and retention of assets within the community. There is a perception in the health policy community that in many of the early conversions, full value was not received for assets. There have been calls for greater public participation and appropriate regulatory oversight in both the initial transaction and execution of the agreement

to assure that the nonprofit's assets are appropriately valued and that they are retained within the community.

In some early hospital conversions, valuations appeared low. In other cases, joint ventures were created in which the for-profit chain became the managing partner. This effectively ceded control over the nonprofit assets to the for-profit manager, while providing no assured return of assets to the community. These problems were exacerbated by inadequate oversight of conversions by state officials and by requirements that negotiations be kept confidential and that competing bids not be sought. In some cases, it was alleged, hospital board members and executives put themselves in conflicts of interest by accepting bonuses, jobs with the new entity, and stock options and, as a result, failed to meet their fiduciary obligations.

Blues plan conversions, which have been conversion of ownership rather than acquisition by outside parties, have introduced additional complications. Issues of fiduciary responsibility and conflict of interest are rife in cases in which the same management will lead the new for-profit. State law has been unclear on questions such as whether these plans are charitable organizations and whether they should be valued on the basis of their tangible assets or as ongoing businesses with substantial assets in good will and trademarks. The scope of regulatory authority on the part of state Attorneys General and insurance commissioners is also unclear in many states.

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In the face of these issues, consumer advocates have become extremely vocal. The Consumers Union and Families USA actively pushed for legislation to govern the conversion of Blue Cross of California. As a result of the process established in that legislation, the Blue Cross conversion resulted in the creation of two foundations with combined assets of $3.3 billion.[8,20,39] Consumer advocates have also been active in encouraging greater oversight of nonprofit hospital conversions.[26,40,41]

Several recommendations that have emerged in these calls for greater oversight have influenced practice in many states. These include: expanding the statutory authority for review of conversions by the state Attorneys General and insurance departments; establishing as a principle that fair market value be obtained for assets; making provisions for net assets from the transaction to be placed in one or several foundations independent of the new stock corporation and the former nonprofit's officers, directors, and staff; developing mechanisms for public input; developing mechanisms for assessing the community benefits being provided by the converting entity and establishing procedures for tracking whether they continue to be provided; and developing mechanisms for ongoing monitoring of the terms and conditions of the conversion. To the extent these principles guide state oversight and are effectively implemented, the issues of appropriate valuation and retention of assets appear manageable.

COMMERCIALIZATION OF HEALTH CARE

Underlying the critique of nonprofit to for-profit conversion has been a concern about what critics characterize as the commercialization of health care, the transition of health care providers from community resources to market-driven economic agents. There is great fear that in a health system dominated by for-profit institutions, nonprofit norms would be replaced by standards that are less protective of patients and that physicians would be under great pressure to skimp on patient care.

The market response to these concerns has been to encourage the collection and dissemination of more data: on quality of care, patient satisfaction, and enrollment and disenrollment rates. Because definitive data are not yet available, these issues will continue to be raised in future conversions. To the extent that we continue to establish explicit standards of care drawing on evidence-based medicine and monitor providers and health plans against these standards, type of ownership may become irrelevant as a signal of quality.

Another major concern is the long-term relationship of health providers to their communities. Although, as we have seen, nonprofit providers have been responding to market signals for over a century, the relationship of providers to their communities appears different now from in the past. The declared mission of nonprofit HMOs such as HealthPartners in Minnesota to "improve the health of our members and our community" appears almost anachronistic. Today, most providers define their missions in terms of their customers and not the community at large.

Many of the specific community benefits offered by nonprofit providers, such as care for the poor and uninsured or a commitment to teaching, could be maintained or replaced by adequate funding of public programs (instead of relying on private, half-hidden, and inefficient

systems of cross-subsidization and cost shifting). Quality and fair treatment can be better assured through clear standards of care and adequate systems to monitor care against standards. The most difficult part of the historic nonprofit mission to replace or preserve is the community leadership and innovation these organizations have provided out of their commitment to a community beyond those to whom they sell services. The debate on conversion should focus more attention on how vital this set of benefits are, how extensively they have been and are still being provided, and how much they are threatened by the changes occurring in the health care system.

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