State Oversight of Hospital Conversions: Preserving Trust or Protecting Health?

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Abstract

This paper explores the recent trend of hospital conversions from not-for-profit to for-profit corporate organizational form. Hospital conversions implicate the public interest in charitable assets and affect health policy goals. The paper concludes that current and developing oversight regimes do not adequately protect these interests.

The paper finds that state attorneys general are frequently the only government actors with authority to review conversions. In some states, there is no effective regulation of conversions, and/or converted assets are not accurately valued. Without adequate oversight and thorough valuations, assets meant for charitable purposes are transferred to for-profit buyers or executives of the not-for-profit sellers. Even when attorneys general are able to oversee conversion, the doctrines upon which their authority is based -- trust law and corporations law -- hinder the advancement of health policy goals. These doctrinal limitations do not constrain all attorneys general from conducting substantive health policy reviews when they oversee conversions. While conversion statutes and proposed legislation resolve some of the obstacles to oversight, they do not address the conflict between health policy goals and trust and corporations law.

The data are drawn primarily from interviews with assistant attorneys general in thirty-two states.

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I. Introduction

While most American hospitals are primarily organized as not-for-profit, tax-exempt corporations, the for-profit form is increasingly common. Between 1970 and 1995, 330 (about 7 percent) out of approximately 5,000 not-for-profit hospitals have converted to for-profit corporate form.[1] The recent history of conversions raises

cause distortions in the for-profit hospital market by making conversions more profitable than they would be absent the inappropriate transfers. These transfers may harm the very health outcomes attorneys general seek to protect; for example, the transfers may discourage public donations to health care or, if the not-for-profit form is better for health, encourage conversions that would otherwise not happen.

The paper, however, identifies four reasons that support the attorneys general's use of trust and corporations law to conduct substantive, health-care reviews of conversions. These reasons rest on the attorneys general's ability to protect public investment goals, the special nature of health care, and the public perception of a crisis in the health care industry.

Finally, Part VII examines conversion statutes and proposed legislation. The statutes and bills reviewed would resolve some of the obstacles to effective oversight raised above. They explicitly authorize the attorney general to oversee conversions, and mandate valuations; some even require the participation of health policy administrators. They do not, however, resolve the tension between public charities interests and health policy. Most bills require that proceeds be used for purposes similar to those of the converting entity and to further the health care needs of the community, not recognizing the potential conflict between past purposes and current needs.

The paper concludes, in Part VIII, that the public, through elected officials, must decide which interest should prevail when the tenets of trust and corporations law conflict with community health policy needs. If public policy dictates that health care needs should trump the conservation of not-for-profit hospital purposes, the attorney general is not the right party to determine how proceeds should be employed to most effectively further public health. This job should be delegated to public servants with substantive health care and policy training.

A. A Note About Sources and MeeTc- pubieac- p3.8attn feieor piev pw to pubac- pserctac- pnn p0007 9 t

codes, case law, attorney general's policies, conversion documents and decrees, and correspondence between attorneys general and parties. In total, the paper addresses the laws and policies of thirty-two states,[3] twenty of which had seen conversions at the time of the interviews. Representatives in the remaining twelve states reported no history of conversions. The interviewees likely underestimated the number of conversions because some whole-hospital conversions and many joint ventures that approximate conversions escape regulatory detection.

That the primary data are interviews, not published sources, represents a choice. Oversight of hospital conversions is a new activity for attorneys general, who must act without direction from legislatures; in fact, at the time of the interviews only two states had passed conversion legislation. Under these conditions, what lawyers think about the law matters, even if those thoughts are preliminary. In relying on the statements of lawyers who are responsible for overseeing conversions, I hoped to develop a picture of the law in action.

This paper, and the data upon which it relies, are subject to two caveats. First, because state legislatures and attorney generals' offices are only beginning to develop oversight policies for conversions, the paper's empirical findings are preliminary. Second, although the interviewees were candid and well-informed, many said that since they had yet to oversee conversions their comments reflected opinions regarding probable oversight policies, not statements of law or official policy. The striking similarity of responses across states, however, suggests the results can be used to identify emerging laws and policies, anticipate likely trends, and draw conclusions about these approaches.

B. Why study1 Tf-3 -1.77 e0 Ii(B.)18r9t

hospitals were organized as for-profit corporations,[4] and now for-profits are on the rise. These trends raise questions regarding why not-for-profit and for-profit corporate forms become more or less attractive to hospitals over time. If for-profits represent windfall dividends, generated by tax exemptions and financial subsidies, the public has an interest in keeping the gains from private parties.

Second, hospital conversions involve a particularly important and controversial good, health care. According to the California legislature, "Charitable nonprofit health facilities have a substantial and beneficial effect on the provision of health care …providing…uncompensated care to uninsured low-income families and under-compensated care to the poor, elderly, and disabled."[5] The regulation of health facilities also reflects social values and causes social change. Executive Vice President of the Catholic Health Association William Cox believes that health is best advanced in a predominantly not-for-profit delivery system, and whether we provide care through not-for-profit or profit-making institutions is a reflection of values.[6] If the not-for-profit structure is indeed the preferred structure, then society should stop conversions. If society fails to protect the values embodied in delivery of care through charitable institutions, it fails more generally.

Third, there is a lot of money at stake. In 1996 alone, "$1.6 billion of community hospital assets were sold to or joint ventured with for-profit companies."[7] Such large transfers will directly affect health care markets and indirectly affect other markets, like labor markets. Columbia/HCA employs 285,000 people, making it the ninth largest employer in the country.[8] Conversions also represent potential sources of federal and state taxation revenues. Aggregate annual tax subsidies to hospitals, from state and federal corporate income tax exemptions, state property tax exemptions, deductibility for donations, access to tax-exempt bonds, and various other special exemptions have been

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[4] BRADFORD H. GRAY, CONVERSIONS OF HMOS AND HOSPITALS: WHAT'S AT STAKE 9 (Program on Non-Profit Organizations Working Paper No. 238, Yale Univ., 1997).

[5] CALIFORNIA LEGISLATIVE ASSEMBLY, Assembly Bill 3101, §1(c) (1996).

[6] William J. Cox, Exec. Vice President, Catholic Health Assoc. of the United States, Remarks at Changes in the Not-For-Profit Status of Health Care Organizations Conference 3 (Oct. 30, 1996) (transcript on file with author).

[7] DAVID SHACTMAN & ANDREA FISHMAN, STATE REGULATION OF HEALTH INDUSTRY CONVERSION FROM NOT-FOR-PROFIT TO FOR-PROFIT STATUS 1 (Council on the Economic Impact of Health System Change Working Paper, 1996).

[8] Columbia/HCA, *Fact Sheet*, (1996) (on file with author).

estimated to be as high as $8.5 billion.[9] However, for-profit health care corporations also enjoy tax exemptions.[10] If for-profits are better or equivalent providers of care, then the not-for-profit tax subsidies are a waste of resources.

Fourth, conversion oversight raises questions about the appropriate activities of attorneys general since this oversight reflects "the first concerted involvement of state attorneys general in the corporate (non-anti-trust) affairs of nonprofit healthcare corporations."[11] Giving government lawyers who are experts in litigation new responsibilities with health policy effects raises several questions. For example, What is the appropriate role of government lawyers? If government lawyers play a larger substantive policy role, how will the division of government powers change?

Fifth, although researchers are beginning to explore the issue, the paucity of information regarding the not-for-profit organizational form and hospital behavior means policy-makers must develop appropriate regulation without knowing which form is better for hospitals. Bloche, argues that until there are strong grounds for preferring that the government, rather than the market, determine the appropriate public purposes of health care organizations and which form of corporation should achieve these purposes, there should be "benign neglect of the for-profit/non-profit question in American medicine."[12] Sloan et al. has found that "there is not a dime's worth of difference" between patient outcomes and cost for Medicare patients at for-profit and not-for-profit hospitals.[13] According to Bloche, not-for-profit hospitals provide more community benefit than for-profit hospitals may just be an accident of history or hospital culture.[14]

On the contrary, there are reasons to favor the not-for-profit form. Those for-profit hospitals which seem to provide indigent care at comparable rates to not-for-profit hospitals, may do so only temporarily. Once the community and media attention surrounding conversions dissipates, for-profits may reduce levels of indigent care. In

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[9] Michael A. Morrisey et al., *Do Nonprofit Hospitals Pay Their Way?*,15 Health Affairs 132 (1996) *citing* J. Copeland and G. Rudney, *Federal Tax Subsidies for Not-for-Profit Hospitals*, Tax Notes 1559-1576 (Mar. 26, 1990).

[10] Gray, *supra* note 4 at 7.

[11] Michael W. Peregrine, *Digest Analysis: State Attorneys General Increase Enforcement of Charitable Trust and Fiduciary Duty Laws*, 24 Health L. Dig. 3 (1996).

[12] M. Gregg Bloche, Professor of Law, Georgetown University, Remarks at Changes in the Not-For-Profit Status of Health Care Organizations Conference (Oct. 30, 1996) (at 2-3 of handout entitled, Should the State Prefer the Non-profit Form?, on file with author).

[13] FRANK A. SLOAN ET AL., HOSPITAL OWNERSHIP AND COST AND QUALITY OF CARE: IS THERE A DIME'S WORTH OF DIFFERENCE

addition, "[f]or-profit hospitals are observed to be quick to enter and exit a market as conditions change, which is consistent with dynamic efficiency in resource allocation."[15] Where policy-makers wish to maintain hospitals, they should not neglect the question of organizational form.

Finally, since not-for-profit health organizations account for a large portion of the total nonprofit sector, 46.9 percent in 1986,[16] studies of health care markets may inform the study of not-for-profit corporations generally.

II. Background

A. Definitions: What is a Charitable, Not-for-profit Corporation? What is a Conversion?

The great majority of hospitals are charitable, not-for-profit corporations, as distinguished from for-profit corporations.[17] There are various sources from which to determine whether an organization is a charitable, not-for-profit including state filings, compliance with the IRS code and regulations, common law, statutory definitions, and internal documents.

When a hospital organizes, it must file a certificate of incorporation with a state department, which indicates its profit status, identifies its mission, and may limit the scope of authority to deviate from that mission. For example, the Roger Williams Medical Center in Rhode Island incorporated "for the purpose of establishing . . . a hospital and of rendering medical and surgical aid to those in need thereof, and especially for the purpose of assisting such poor and unfortunate persons as are in need of medical and surgical treatment and are unable to pay therefore."

State and federal tax statuses also suggest form. The IRS exempts from income taxes,

> [c]orporations… organized and operated exclusively for religious, charitable, scientific, … or educational purposes … no part of net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation ..., and which does not participate in, or intervene in ... any political campaign ….[20]

Not-for-profits' articles often incorporate this language. The IRS also requires that hospitals be operated 'primarily' for exempt purposes and forbids distribution of earnings to private shareholders or individuals. In a 1969 revenue ruling, however, the IRS removed the exemption requirement of free or below cost care to indigent patients. On the other hand, some state courts have imposed poverty-relief requirements; for example, Utah and Pennsylvania[21] require hospitals to provide charity care to maintain hospital property tax exemptions.

Some state statutes and regulations limit the behavior of not-for-profit hospitals. In New York only individuals or other charitable organizations may comprise the corporate membership of a hospital.[22] The Massachusetts Attorney General has encouraged hospitals to meet community benefit requirements and file reports voluntarily, threatening legislation to the same effect should the hospitals not comply.[23]

Hospital reporting structures and accountability also signal organizational form. While for-profit managers are accountable to corporate owners, not-for-profit managers are accountable to non-owner boards of trustees. Corporate form may affect other dimensions of accountability. Gamm has identified four distinct types of not-for-profit hospital accountability: 1) political, such as that required to obtain and maintain tax-exempt statutes; 2) commercial, such as that involved in the relationship between the hospital and commercial payers; 3) community, the hospital's role in addressing local,

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out programs at the expense of profit).

[20] I.R.C. §501(c)(3) (CCH 1995).

[21] Utah County v. Intermountain Health Care, Inc., 709 P.2d 265 (Utah 1985); *see* UTAH CODE ANN. §59-2-1101 (analysis of charitable purposes; Allentown Hospital-Lehigh Valley Hospital Center v. Board of Assessment Appeals, 611 A.2d 793 (Pa. Cmwlth. 1992).

[22] N.Y. NOT-FOR-PROFIT CORP. LAW §2801-a(e) (McKinney 1996).

[23] SCOTT HARSHBARGER, COMMW. OF MASS ATT'Y. GEN., COMMUNITY BENEFIT GUIDELINES FOR NONPROFIT ACUTE CARE HOSPITALS, (June 1994).

social needs; and, 4) clinical, the accountability to patients regarding access and medical outcomes.[24]

The term 'conversion' has been applied to transactions ranging from simple asset sales to complex joint ventures. The uncertainty regarding what constitutes a change in corporate form presents oversight problems for state attorneys general. For the purposes of this paper, the term conversion is defined as any mechanism by which a hospital changes its essential orientation from not-for-profit to for-profit or vice versa.

There are many hospital conversion mechanisms.[25] In some states, by simply re-incorporating -- amending articles of incorporation and filing with the state -- a not-for-profit hospital may independently switch form. Other methods of converting include: acquisitions,[26] mergers,[27] corporate restructurings,[28] consolidation,[29] joint ventures with for-profit corporations,[30] and lease agreements.

integrity, avoidance of regulations, and self-interest of management and directors.

For-profit status may answer the increased need for capital caused by recent changes in the health care market. First, some not-for-profit hospitals may desire equity financing when other capital sources are unavailable or too expensive. Although not-for-profit hospitals have access to capital sources unavailable to for-profits such as tax-exempt donations and tax-exempt debt, administrative restrictions and issuing limits make debt capital too expensive or unavailable for some projects or some hospitals.[32] Under some circumstances the market spread between equity and debt makes equity financing more desirable for hospitals. Bond insurance and state issuing agency fees may also contribute to a higher cost of debt. Other financing options, such as securitization, leveraging of assets, and pooling schemes, provide more options to not-for-profits, but can be risky. In addition, equity financing may also limit agency costs associated with high levels of debt.[33] After considering several options, including affiliations and mergers with other not-for-profit hospitals, the Portsmouth (NH) Hospital trustees concluded, "the only organization which had the financial resources necessary to solve Portsmouth Hospital's facility problem was HCA," a for-profit hospital corporation.[34] If cumbersome regulatory restrictions bar not-for-profit hospitals from raising adequate capital and not-for-profits should be preferred to for-profits for other reasons, policy makers should change those restrictions rather than encourage hospitals to adopt otherwise undesirable ownership forms.

Second, according to investment bankers, access to equity is perceived to be a valuable currency in hospital merger markets and generates more consolidation options than other forms of capital.[35] Consolidation may be desirable if hospitals can gain economies of scale unavailable to free-standing hospitals.[36] In fact, hospitals affiliated

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[31] *See generally* CULTER & HORWITZ, *supra* note 1.

[32] Hospitals face absolute limits on bond issues. In addition, "arbitrage rebate requirements and limits on a hospital's ability to replenish working capital used to make capital acquisitions with bond proceeds, create a significant 'opportunity' costs as well as a financial cost." DOUGLAS M. MANCINO, TAXATION OF HOSPITALS AND HEALTH CARE ORGANIZATIONS 6 (forthcoming) (draft on file with author).

[33] Michael C. Jensen & William H. Meckling, *Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure,*3 J. Fin. Econ. 305 (1976) (Although this article deals with for-profit firms, equivalent agency

with systems demonstrate higher returns on equity than do free-standing hospitals, regardless of ownership form.[37]

Third, conversions may even bring increased access to debt. When a not-for-profit hospital has a poor debt-rating its debt costs may be higher than those of a potential for-profit partner. In fact, for-profit system hospitals use more debt than do not-for-profits systems, financing about 80 percent of total assets with debt.[38] While not-for-profit system hospitals borrowed almost as much long-term debt as for-profit systems, they demonstrate significantly lower levels of short-term debt financing – between 44 and 54 percent.[39] If not-for-profits face obstacles to raising short-term debt, "[t]hese data suggest that the constraint faced by nonprofit organizations is in access to debt markets rather than on equity."[40]

In addition to capital needs, some hospital executives believe they must sell the hospital to a for-profit corporation as a defensive strategy. The chief executive of one not-for-profit hospital that merged with a national for-profit corporation rather than a local not-for-profit, said the for-profit was the only potential merger partner that promised to maintain the hospital; the other non-profits would have disbanded the hospital.[41]

Not-for-profit sellers also argue that for-profit entities are more efficient and, therefore, more adept competitors. The directors of one failing not-for-profit believed, for example, that their hospital's survival depended on management experience held by a for-profit buyer.[42] In another sale, "[o]f considerable importance to the Hospital was [the for-profit buyer's] financial strength and its ability to purchase supplies, services, and equipment at better rates . . . ."[43] Shareholders and for-profit managers may also have greater incentives than trustees and not-for-profit managers to root out incompetence.

Owned, 18 Topics Health Care Fin. 63 (1992) (demonstrating that non-system hospitals have lower costs per case mix adjusted discharges. However, cost differences could be explained by location, severity differences or inappropriate case mix adjustment).

[37] Return on Equity = [Operating Income + Non-Operating Income] * [Net Revenues/Total Assets] * [1/Equity or Fund Balance/Total Assets].

[38] Cleverly, *supra 36*, at 72.

[39] *Id.*

[40] Frank & Salkever, *supra* note 16, at 133.

[41] Roger Peloquin, President and Treasurer MetroWest Health Inc., Remarks at Changes in the Not-For-Profit Status of Health Care Organizations Conference (Oct. 30, 1996).

[42] Letter from Patricia Jenkins, Atty. Hogue, Hill, Jones, Nash & Lynch, to Sherry Cornett Lindquist, N.C. Assistant Attorney General. (Apr. 19, 1996) (Re: Proposed Sale of Assets of Cape Fear Memorial Hospital, Inc. to Columbia Cape Fear Healthcare System, LTD.).

[43] N.C. Dep't of J., Conditional Approval Proposed Sale of Cape Fear Memorial Hospital, Inc., at Introduction 7.

In fact, case studies have shown some efficiencies associated with conversions such as cost-cutting, increased access to capital, and debt-burden relief.[44] For-profits are also adept at increasing reimbursement from the public sector.[45] Critics of the efficiency explanation argue that "a for-profit faces greater pressure to be efficient, but efficient only relative to the simple objective posed for the [for-profit] entity, to maximize the owners wealth."[46] For-profit hospitals are not necessarily better at promoting social interests.

Not-for-profit hospitals may convert to avoid cumbersome regulatory requirements and community responsibilities. The Colorado General Assembly recognized "the need for equal regulatory treatment and competitive equality for health care insurers" given changes in the health care market.[47] Some researchers have found not-for-profit hospitals, "provide significantly more charity care than their…for-profit counterparts, particularly if one uses within state comparisons and a reasonably inclusive definition of community benefits."[48] However, other studies indicate that although charity care provision is different at for-profit and not-for-profit hospitals, the different locations of not-for-profit and for-profit hospitals account for the difference.[49]

Finally, not-for-profit managers, directors, and staff may convert their hospitals for personal financial gain.[50] In addition to receiving compensation for their roles in conversions they often receive prestigious and well-paid jobs at the converted entity or related foundation. In Kansas, for example, the proceeds of one not-for-profit hospital sale were used to pay the seller's directors for covenants not to compete.[51]

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[44] Cutler & Horwitz, *supra* note 1.
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III. Oversight of Conversions

A. Primacy of the Attorney General

State attorneys general are usually the only officials with authority to conduct comprehensive, advance reviews of conversions. Other government departments may oversee some aspects of conversions, but their authority is generally limited.

Some health departments and health planning agencies operate Certificate of Need

of uncompensated care.[58] The federal government may recall the loans if a hospital does not adhere to the required charitable mission. Similarly, federal research grants often include restrictions.

State antitrust units analyze conversions to determine whether they jeopardize competition. Antitrust reviews do not, however, address other questions raised by conversions such as whether a transaction violates a not-for-profit's charitable mission or creates private inurement. Many conversions do not involve any change in market concentration and, when they do, the anti-trust review is not concerned with the preservation of assets or substantive health care policy.

Finally, courts may also oversee hospital conversions. (See Section IB, cou-et

Twenty-four out of thirty-two interviewees indicated that the state attorney general has or would rely on state charitable trust law[59] and the *cy pres* doctrine to oversee conversions; Three interviewees did not know; Two interviewees did not mention trust law as a potential source of authority; The question did not apply in three states.[60]

Under common law dating back to the sixteenth century, charitable gifts must be applied for charitable uses indefinitely.[61] States adopted this rule as both state common law and statute. The Connecticut Statute of Charitable Trusts, for example, states "any charitable trust or use created in writing…shall forever remain to the uses and purposes to which it has been granted according to the true intent and meaning of the grantor and to no other use."[62]

Sometimes the purposes for which trusts were established "become obsolete or impossible or impracticable of execution due to changes in social, economic, political or other conditions," and courts may use their equitable power to direct the administration of trusts to new purposes.[63] Using this power, known as c*y pres* from the French "cy pres comme possible" -- as close as possible,[64] courts exercise broad discretion to direct charitable funds to another charitable purpose that is as close to the settlor's (one who creates a trust) intent as possible. Applying *cy pres* requires a "prerequisite finding that the settlor had a broad or general intent to aid charity as a whole….[H]e must have intended that there should be some discretion in applying his gift to the public good."[65]

power in the terms of the trust.[67]

After a private trust is established, the rights of the settlor are usually extinguished, and the law relies upon the trust's beneficiaries to ensure its proper administration. Therefore, trust beneficiaries have standing to sue when a trust is being improperly administered, such as when a trustee changes the trust's purpose. Charitable trusts and organizations, on the contrary, promote the interests of indefinite public beneficiaries rather than particular individuals. Accordingly, groups of potential beneficiaries do not have standing to sue.[68] When charitable donations are misused, therefore, there is no identifiable plaintiff – as in the case of private trusts the settlor has already parted with her interest, and there are no beneficiaries with standing.

Since at least 1601, the attorney general has ensured the proper use of charitable trust funds by standing in for an unspecified beneficiary and representing the public through litigation. Traditionally, the attorney general's standing was grounded in *parens patrie* authority. As counsel to the King he guarded the public interest as "sovereign and guardian of persons under legal disability, such as juveniles or the insane…"[69] Today many states grant the attorney general statutory authority.[70] To the extent not-for-profit

charitable purposes as well as those given in the form of charitable trusts. Today, many states deem gifts given to charitable corporations to create statutory trusts. For example, "the Connecticut Supreme Court has consistently held that a gift given to a charitable corporation for a specific charitable purpose creates a 'statutory trust' recognized by law which imposes upon the corporation an obligation to hold the funds and apply them for the purpose for which they were given."[71] While trust law does not always reach charitable corporations in the same manner and to the same extent as it does formal charitable trusts,[72] "[o]rdinarily the rules that are applicable to charitable corporations…. It is probably more misleading to say that a charitable corporation is not a trustee than to say that it is…."[73] Where charities law is broadly construed, it extends to charitable corporations as well as their assets.[74]

C. Application of Trust Concepts to Hospital Assets in a Conversion

In a typical conversion, the not-for-profit hospital sells its assets to a for-profit entity, exits the hospital business, and uses the transaction proceeds to establish a not-for-profit, grant-making foundation. This section provides a hypothetical illustration, used by some states, of how charitable trust law may be applied to four types of assets in a conversion: restricted donations and assets, general charitable donations and assets, non-donated tangible and intangible assets, and government benefits.[75] Regardless of the approach taken by a state, sharp determinations of which assets and funds should be

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*Regulation 3*7 New Hampshire Bar Journal 8, 9 (1996).

[71] Pl.'s Mem. In Supp. of Mot. for J. on Stipulation, State of Conn. et al. V. Cancer fund of America, Inc. et al., CV-89-0361764-S at 10 (Conn. Sup. March 25, 1991) citing Dwyer v. Leonard, 100 Conn. 513, 519 (1924), Accord Eccles v. RI Hosp. Trust Co., 90 Conn. 592, 598 (1916). Blocker v. State, 718 S.W.2d 409, 415 (Tex. Ct. App. 1986) (gifts to a charitable corporation, just as gifts to a charitable trust, can be used only for the intended purpose).

[72] *E.g.* Stern v. Lucy Webb Hayes Training School for Deaconesses and Missionaries, 381 F.Supp. 1003 (D.D.C. 1974) (charitable directors not subject to fiduciary standards of charitable trustees.); In North Dakota, although directors are not the equivalent of trustees, the holding of the principle case may be limited to procedure and may not affect the North Dakota attorney general's jurisdiction. Telephone Interview with David Huey, North Dakota Assistant Attorney General (Jan. 14, 1997) *citing* In Re Myra Foundation 112 N.W.2d 552 (N.D. 1961).

[73] WILLIAM F. FRATCHER, SCOTT ON TRUSTS §348.1 (4th

deemed charitable are difficult to make; if money is fungible, the categories and justifications for different treatment dissolve under scrutiny.

Some donors make donations to hospitals for specific, articulated reasons, such as subsidizing indigent care or construction of a community health center. When a hospital converts and directs the proceeds to a foundation, it changes the use of the donated funds. In that case, if the donor reserved an express reversionary interest, the asset, or money equal to its value, should automatically be returned to the donor. Otherwise, as discussed above, the hospital must seek judicial permission to change the purpose of the restricted funds. First, the hospital must prove that the donor had a general charitable intent. If the court finds the gift was made for a very narrow purpose, the funds must be returned to the donor.[76] Some assets are impressed with a specific charitable purpose that is general enough to escape reversion yet specific enough to preclude a charitable organization from independently reforming their use. Second, the hospital must demonstrate that accomplishing the donor's purpose has become impossible, impracticable, or inexpedient.[77] A purpose that has become merely inconvenient or undesirable may not be abandoned. While permissible and impermissible reasons vary by jurisdiction, courts have loosened the definition of impossibility and impracticality.[78] If the hospital is dissolved or sold, for example, it would argue that it is no longer possible to provide care at its facilities. As noted above, unless she reserved powers, the donor cannot permit a deviation from the terms of the gift.[79] Third, the hospital must show that the proposed use of funds falls within the general intention of the donor.[80]

In states that have adopted the Uniform Management of Institutional Funds Act ("UMIFA")[81] hospitals may alter charitable purposes under statute. An institutional fund is "a fund held by an institution for its exclusive use, benefit or purposes, but does not include" a fund held by a non-institutional trustee or a fund in which a non-institutional

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Assistant Attorney General (Jan. 6, 1997).

[76] BOGERT & BOGERT, *supra* note 61, at § 436.

[77] *Id.* at §438-39.

[78] FRATCHER, *supra* note 73, at § 399.4.

[79] *Id*. at §367.2. However, "[i]t would seem that in minor matters the consent of the settlor may be effective to remove restrictions on the trustees in the administration of a charitable trust." *Id.*

[80] *Id*. at §399.2.

[81] UNIF. MANAGEMENT OF INSTITUTIONAL FUNDS ACT (1972 & Supp. 1996) (adopted in 38 states and the District of Columbia).

beneficiary has an interest.[82] UMIFA specifies two methods of release from fund restrictions. First, unlike trust law, UMIFA authorizes donors to release restrictions by giving written permission. Second, courts may release restrictions using a test similar to the *cy pres* obsolescence test.[83] Under the uniform act, a release from restrictions "may not allow a fund to be used for purposes other than…charitable, or other eleemosynary purposes of the institution affected."[84] In some states, institutions may use released funds in any manner permitted under the institution's articles of incorporation.[85]

While judicial power to release restrictions may seem broad, in two seminal cases

subject to the same analysis as restricted funds -- the intent of the donors would be inferred by the hospital's solicitation appeal.[91]

Not-for-profit hospitals also own other unrestricted tangible and intangible assets the treatment of which, as a practical matter, depends upon their source. Tangible assets include equipment and real estate purchased with operating income, not donations. In many states, trust law would not affect the sale of these assets because they were not purchased with donations. However, trust law would apply where the not-for-profit's assets are deemed to be held in charitable trust, and the assets or sale proceeds could be used only to further the purposes of the charitable corporation.

Intangible assets include volunteer time, good will, and preferable supplier contract terms. To the extent that any asset transferred to a for-profit was built with money, work, and goodwill attributable to the hospital's not-for-profit, charitable status, charities law may be implicated. Volunteers, for example, might be less willing to donate their time to for-profit hospitals so that investors may enjoy a higher rate of return than to not-for-profit hospitals for treatment of more patients; Transferring funds from the not-for-profit to the for-profit could be considered an impermissible conversion of volunteer efforts.

State and federal governments also give not-for-profit hospitals direct economic benefits such as appropriations, tax-exemptions from income and property taxes, and access to exempt debt markets. In addition, not-for-profit hospitals receive the indirect benefit of tax-deductibility for tax payers who make donations. In some states, the attorney general would analyze the legislative intent regarding these benefits as she would analyze donative intent and restrict assets accordingly.[92] If legislatures give tax breaks and funding to not-for-profit hospitals to subsidize care for the needy, the use of non-restricted assets or sale proceeds would be limited.

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profit directors to dissolve a not-for-profit corporation and distribute the assets at their discretion, with no application of charities law. "Assets received and held by the corporation, subject to limitations permitting their use only for charitable, religious, eleemonsynary, benevolent, educational, or similar purposes, but not held upon a condition requiring return, transfer, or conveyance by reason of the dissolution shall be transferred or conveyed to one or more domestic or foreign corporations, societies, or organizations engaged in activities similar to those of the dissolving corporation, pursuant to a plan of distribution…." COLO. REV. STAT. § 7-26-103 (1996). Legislation to replace this language, introduced in the Colorado legislature in early 1997, is even more permissive. Telephone Interview with Elizabeth Carver, Partner -- Yu, Stromberg, and Cleveland (Feb. 25, 1997).

[91] According to Conn. Assistant Attorney General Janet Spaulding-Ruddell, Connecticut, a state with strong charities law, would use this approach. Spaulding-Ruddell, *supra* note 75.

D. Corporations Law

Twenty-two out of thirty-two interviewees said that the attorney general has or would rely on corporations law in overseeing hospital conversions; three interviewees said they did not know; four interviewees did not mention corporations law as a potential source of authority; and, the question did not apply in three states.

charitable purposes of the organization, for choosing another buyer."[96]

action permitted by law, hospital charters and bylaws frequently include restrictions.[102] According to the Kelley court, the not-for-profit hospital violated its corporate charter for the same reasons it violated state statute.[103]

3. Other Statutory Provisions

Many state Nonprofit Corporations Codes specify procedures for mergers, acquisitions, joint ventures, dissolutions, and other transactions involving all or substantially all the corporation's assets. The codes often limit the use of charitable assets. In North Dakota, for example, charitable assets cannot inure to the benefit of any person.[104] In Pennsylvania, no charitable asset may be diverted from a charitable purpose.[105] On the contrary, Virginia merger laws permit a merger between a nonstock and stock corporation, thus allowing not-for-profit assets to inure to the benefit of for-profit shareholders.[106]

Procedures regarding the disposition of charitable assets also vary considerably. In Arizona, "any person who intends to purchase, lease or otherwise acquire all or substantially all of the assets of a tax exempt corporation" must give public notice and hold a hearing regarding the transaction, the sole purpose of which is to receive public comment.[107] Louisiana does not have a relevant corporations statute.[108]

State statutes also address the voluntary dissolution of not-for-profit corporations; without statutory authority, charities may dissolve without court approval.[109] The state dissolution provisions that track for-profit corporate dissolution statutes allow corporate directors to dissolve the corporation by vote,[110] develop a distribution plan, and distribute

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[102] Unless corporate articles expressly limit the powers of the corporation, many state statutes interpret default power to be the power to engage in any lawful business. Some states, such as Massachusetts, require charters to name specific powers.

[103] Opinion and Order, Kelley v. Michigan, *supra* note 100, at 7.

[104] Huey, *supra* note 72, *citing* ND Century Code ch. 10-24 *et seq.*

[105] Telephone Interview with Mark Pacella, Attorney in the Charitable Trust and Organizations Division of Office of the Pennsylvania Attorney General (Jan. 9, 1997) *citing* NFP code Title 15, 55-47(b).

[106] VA. CODE ANN. §13.1-898.1 (Michie 1996). Such a reading, however, may conflict with other statutes and state case law. Telephone Interview with Catherine Hammond, Virginia Assistant Attorney General (Jan. 9, 1997); VA. CODE ANN. §13.1-814 (Michie 1996) (prohibiting nonstock corporations from distributing dividends to members, directors, or officers); Hanshaw v. Day, 202 Va. 818, 823-24, 120 S.E.2d 460, 464 (1961) (holding assets of non-stock corporations must be distributed to ensure continued use for public and civic purposes upon dissolution).

[107] ARIZ. REV. STAT. ANN. §10-2402, §10-2402(B) (Michie 1996).

[108] Telephone Interview with Barbara Lake, La. Assistant Attorney General (Jan. 9, 1997).

[109] 14 C.J.S. *Charities* § 68 (1991).

[110] 19 C.J.S. *Corporations* § 813 (1991).

the assets according to that plan after notifying the state corporations commission, secretary of state, or some other government entity charged with overseeing corporations.[111] Most states require dissolving corporations to satisfy their liabilities and execute special obligations conditioned on dissolution such as returning assets.

Some statutes incorporate trust law into the dissolution provisions by announcing reverter rules or requiring *cy pres* proceedings.[112] In Arizona,

> [a]ssets received and held by the corporation subject to limitations permitting their use only for charitable, religious, eleemosynary, benevolent…or similar purposes, but not held upon a condition requiring return…shall be transferred or conveyed to one or more domestic or foreign corporations, societies or organizations engaged in activities having purposes substantially similar to those of the dissolving corporation….[113]

Directors may distribute remaining assets at their discretion provided they comply with corporate articles and bylaws[114]and they transfer charitable to another not-for-profit or for-profit that is "engaged in activities substantially similar to those of the dissolving corporation."[115] The charity's purpose is preserved, the corporate form is not.

Some state codes are more permissive. In Colorado, after liabilities are discharged, conditional assets are returned, charitable assets are disposed of appropriately, and the charter provisions are met, "[a]ny remaining assets may be distributed to…[any person or entity], whether for profit or nonprofit, as may be specified in a plan of distribution."[116] Whether residual assets exist depends on the interpretation of state charities law. If all the assets held by a charitable corporation are deemed charitable trust assets, they must be transferred to another entity "engaged in activities similar to those of the dissolving corporation."[117] Finally, some states, such as Wisconsin, are silent regarding the use of a dissolving not-for-profit's charitable assets.[118] In practice, dissolving Wisconsin not-for-profits have transferred their assets to similar charitable corporations.

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[111] *Id.* at § 815.
[112] 14 C.J.S. *Charities* § 68 (1991).
[113] ARIZ. REV. STAT. ANN. §10-2422(3) (Michie 1996).
[114] *Id.* at §10-2422(4).
[115] *Id.* at §10-2422(5).
[116] C.R.S. 7-26-103(e) (1996). Also *see* W. VA. CODE §31-1-155 (1996).
[117] C.R.S. 7-26-103(c) (1996).
[118] Telephone Interview with Jerry Hancock, Director of Consumer Protection at the office of the Wisconsin Attorney General (Jan. 10, 1997).

E. Role of the Attorney General in Enforcing Corporations Law

Attorneys general's enforcement roles vary considerably. In some states, the attorney general is a necessary party to all judicial proceedings related to oversight of charities.[119] In Virginia, for example, the courts have equitable power over charitable corporations, and the attorney general may bring suit against violations of permissible activities.[120]

Attorneys general have based their oversight authority on notice requirements. In North Carolina, charitable corporations must notify the attorney general twenty days before selling or otherwise disposing of all, or substantially all, its assets.[121] While the statute does not include explicit review authority, Attorney General Michael Easley has interpreted this notice requirement "to include specific information requested by the Attorney General regarding the pertinent terms of the transaction" such as decision-making procedures, assurance that conflicts of interest were avoided, and information regarding the future availability in the area upon which he will instigate litigation if appropriate.[122] Similarly, in Massachusetts, "[a] public charity shall provide written notice to the attorney general not less than thirty days before" disposing of all or substantially all its assets, if the transaction will lead to a material change in the nature of the activities conducted by the charity.[123] Attorney General Scott Harshbarger has interpreted this notice requirement "to give the Office of the Attorney General the opportunity to review these matters in an orderly fashion to determine prior to a transaction whether, in the office's view, court approval for such a change is required…."[124]

Even if the attorney general does not have statutory or regulatory power to oversee conversions, in most states she has general *parens patrie* legal authority to act in the

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[119] The attorney general is arguably a party to dissolutions of charitable corporations in Massachusetts. MASS. GEN. L. ch.12, §8G (1996).

[120] VA. CODE ANN. §17-123 (Michie 1996) (jurisdiction of circuit court).

[121] N.C. GEN. STAT. §55A-12-02(g) (1996).

[122] Joint Statement of Cape Fear Memorial Healthcare Corporation 2, Cape Fear Memorial Hospital, Inc., and Columbia Cape Fear Healthcare System, LTD. Partnership to The State of North Carolina Department of Justice Office of the Attorney General, (Apr. 1, 1996).

[123] MASS. GEN. L. ch. 180, §8A (1996).

[124] MASSACHUSETTS OFFICE OF THE ATTORNEY GENERAL, FOR-PROFIT CONVERSIONS AND A

for charitable interests may be wasted or transferred to shareholders.

1. Obstacles to Oversight

In seven of the thirty-two states surveyed, state attorneys general have not overseen conversions, may not have legal authority to oversee them, or have yet to consider the issue.[128] In two states, West Virginia and Louisiana, practical and legal reasons prevented the attorneys general from intervening in hospital conversions. Because the West Virginia attorney general does not have *parens patrie* authority, he must find a client to bring a legal action, yet neither the West Virginia Secretary of State nor the Department of Health and Human Services will agree to be a client in an action against a for-profit buyer.[129] Therefore, despite a statutory regime that seems to encourage oversight, the attorney general has not reviewed any conversions.[130]

Louisiana's unique civil law system, which does not incorporate the common law of charitable trusts, precludes conversion oversight. Only a decade ago, trust law was introduced in -1. 0 0 visiana's d nn -i-- f(odu(n4(odhe)4.5(-- lincs 3)le)4.aw was)]TJT*0.(e)4.8(d)1(in -1. 0

general may have foregone intervention because they believed the conversions posed no threat to charitable and public interests.

2. Notice Mechanisms

Even attorneys general who are authorized and eager to oversee conversions cannot do so without notice. Formal mechanisms that require hospitals to notify attorneys general of conversion plans are one measure of the likelihood that attorneys general will learn of a conversion. Because only two states, California and Nebraska, have statutes that require notification of conversions, attorneys general in other states must rely on notice provisions in the corporate code or under trust law.[136]

According to nine of thirty-one interviewees, converting hospitals are required to notify the attorney general of a conversion according to corporations law, trust and charities law, or state conversion statutes.[137] Eight interviewees said that the attorney general would receive notice either under the corporations law or trust and charities law depending on the form of transaction and type of documents filed with state courts under trust law.[138] Fourteen interviewees stated that neither the buyer nor seller would be required to notify the attorney general of a conversion.[139]

Attorneys general may learn about conversions without formal notice. Other government agencies or attorneys general's antitrust departments may be notified and can alert the appropriate deputy attorney general. In some states, the small number of hospitals and people involved in hospital business would make a conversion unlikely to escape the attorney general's attention.[140] Finally, for-profit buyers may voluntarily alert the attorney general to establish good faith with her and other state regulators.[141]

Where parties do not notify the attorney general about conversions, the attorney

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[136] CAL. CORP. CODE § 5910 *et seq*. (Deering 1996); NEB. REV. STAT. § 71020, 102 *et seq*. (1996).

[137] California, Nebraska, New Hampshire, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, and Tennessee. See appendix C for detailed chart. The question is inapplicable in New York where conversions are not permitted. N.Y. NOT-FOR-PROFIT CORP. LAW §2801-a(e) *supra* note 22.

[138] Arizona, Connecticut, Florida, Idaho, Massachusetts, Michigan, Missouri, and Minnesota.

[139] Alabama, Colorado, Hawaii, Illinois, Iowa, Kansas, Louisiana, Maine, Maryland, New Jersey, North Dakota,

general must allocate resources to track conversions or risk missing them. The costs of tracking and overseeing transactions can be lowered by allowing relator actions. Although attorneys general may seek retroactive return of assets,[142] unwinding some forms of joint ventures can be more expensive and difficult than stopping it at the outset.

3. The Problem of Joint Ventures

Conversions structured as joint ventures often do not trigger government oversight. A recent Internal Revenue Service private letter ruling encouraged joint-ventures, announcing that not-for-profits may enter joint-operating agreements with for-profits and retain their ability to appoint their own directors and the tax-exempt status of their bonds. However, "to achieve tax-exempt status for the new joint venture, participants must demonstrate to the IRS that[,] by combining, they will still fulfill their original tax-exempt purpose of serving patients, and are not joining solely for the benefit of the hospitals, which would be considered taxable unrelated business income." [143]

The difficulty of determining when a corporation's essential orientation changes from not-for-profit to for-profit poses problems for oversight. Deciding when to apply a corporations statute raises similar definitional problems. What counts as 'all or substantially all' of a corporation's assets? Does moving corporate assets into a jointly-owned subsidiary comprise an asset transfer? Further, although dissolution statutes dictate the use of charitable assets, they do not apply to some transaction forms. That a constituent corporation ceases to exist in its previous form as a result of a merger or joint

the hospital conversion context may be particularly high.

There has been at least one case in which a court prohibited a joint venture where a conversion would have been permitted. As discussed above, in Kelley v. Michigan Affiliated Healthcare System, Inc., the court found that the joint venture violated state law because under the arrangement the not-for-profit would exceed its statutory powers as a not-for-profit corporation.[146] During the proceedings, however, the Judge stated that a sale of all the not-for-profit assets, as opposed to a joint venture, would be permissible.[147]

4. Practical Obstacles

Uncooperative parties make conversion oversight difficult and expensive. Although attorneys general may enlist courts to compel cooperation, formal proceedings require resources that may strain attorneys general's offices. Although the Michigan attorney general's office has broad investigatory power over transactions to determine whether charitable trust is properly administered,[148] Michigan Attorney General Frank Kelly was unable to obtain information regarding the terms of a Columbia/HCA offer to buy a Michigan hospital without a court order.[149]

B. Problem II - Valuation

Even when attorneys general overcome the obstacles identified above, valuation

industries, or the price/earnings ratio of publicly traded health-care corporations. Cost-based approaches value the reproduction or replacement cost of assets.

Because there is no market for trading not-for-profit hospital stock, determining an accurate price with market methods is particularly difficult. For example, the valuation methods that rely on price/earnings ratios may have led to systematic under-valuations. While for-profit hospital chains have price/earnings ratios from fifteen to twenty-five, not-for-profit hospital ratios are around six – arguably an unreasonably low estimate, given limited evidence of efficiency differences.[150] Methods that estimate only the book value of the assets and discounted cash flow will underestimate the worth of a not-for-profit hospital, because it is encumbered by community benefit requirements and a charitable mission from which a for-profit buyer will be released.[151]

Gray notes several factors that have made not-for-profit hospital valuations difficult. First, "[c]ompetitive bidding seems to rarely typify these situations, so a potentially useful way of establishing the organization's value is missing."[152] Second, the "individuals who know the organization best (e.g., the chief administrator or the CEO) may be on both sides of the transaction."[153] Trustees, as well, have been rewarded for their involvement in conversions. Third, "because a nonprofit has likely not been seeking to maximize profits, its revenue-generating potential may be difficult for a seller (or regulators) to assess."[154]

Some advocates have argued that large increases in the value of a corporation after a conversion are evidence of systematic under-valuation.[155] A Consumer's Union report lists twelve HMOs whose value increased substantially after conversion.[156] For example, $360,000 cash proceeds for the 1984 Pacificare Health sale were given to charity; in 1985, the corporation was valued at $45,300,505, a 12,483% increase; twelve years later it was valued at $2,193,000,000 -- a 609,067% increase. The paper does not

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[149] *Sixty Minutes: Conversions* (CBS television broadcast, Oct. 1996).

[150] Gerard F. Anderson, *The Role of Investment Bankers in Nonprofit Conversions,*16 Health Affairs 144, 145 (1997).

[151]

indicate whether the not-for-profit received other payments such as retirement of debt. Furthermore, some of the increase in value may be attributed to the market value of the for-profit corporate form.[157] While determining whether the increases are attributable to the improper transfer of charitable assets is difficult, the magnitude of the increases over

There are substantive issues of health policy related to the appropriate mechanism of care delivery that are jeopardized by the agnostic role of attorneys general. First, some not-for-profit hospitals play an important and desirable redistributive role that is lost in conversions. Second, conversions often represent a shift in the locus of health care decision-making. Third, recent government policy, medical research, and health policy scholarship suggest that there has been over-investment in hospitals. Health policy experts, therefore, would seek to transfer conversion proceeds to non-hospital uses; yet, a strict reading of the law forbids such transfers. In practice, as discussed in section VI, doctrinal limits do not constrain all attorneys general from considering health policy needs.

A. Health Policy Concerns Implicated in Conversions

1. Redistributive Loss

Although most patients receive hospital care through private or public insurance, market distortions and political constraints obstruct the provision of socially optimal levels of care and other services.[163] The government is unable "to meet the demand for public goods – like care for medically indigent, medical education, community outreach programs, and so on – in populations with heterogeneous preferences for such public services (at the existing tax prices of those services)."[164] Even if the heterogeneous populace authorized the government to meet the demand for care, not-for-profit hospitals may have cost and efficiency advantages over the government. The government is constrained by cumbersome civil service rules, and faces higher costs of monitoring patient needs than local hospitals.

Not-for-profit hospitals pay for these services in two ways. First, not-for-profit hospitals use their profits differently than do for-profit hospitals. Some not-for-profit hospitals, mainly teaching hospitals, cross-subsidize by pricing services so that excess

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Hospital Conversion in the Carolinas, 79, (May 1998).

[163] FRIEDMAN, BERNARD S. ET AL., *Tax Exemption and Community Benefits of Not For Profit Hospitals, in* ADVANCES IN HEALTH ECONOMICS AND HEALTH SERVICES RESEARCH V1, 130 (Richard M. Scheffler & Louis F. Rossiter eds., 1990).

[164] Frank & Salkever, *supra* 16 note, at 134 (summarizing Burton Wesibrod, *Toward a Theory of the Voluntary Non-Profit Sector in a Three-Sector Economy, in* ALTRUISM, MORALITY AND ECONOMIC THEORY (Edmund Phelps ed.,

payments by private insurers or the government subsidize care for medical indigents and other services. Second, they solicit donations from private parties. Although estimating these hidden redistributions is hard, they may be as high as $15 billion.[165]

For-profit buyers are unlikely to provide uncompensated services or to cross-subsidize at the same level as not-for-profit sellers for two reasons. First, donors are unlikely to make equivalent donations to for-profit and not-for-profit hospitals because most donations to for-profit hospitals are not tax-deductible. Likewise, volunteers are unlikely to provide the same level of service to a corporation dedicated to maximizing shareholder returns that they provide to a charitable corporation.[166] Second, the for-profit's duty to maximize returns makes it unlikely that for-profit buyers will continue subsidizing and cross-subsiding services, except to the extent the subsidies build community good-will and, therefore, increase business. Taxes paid by for-profit hospitals are not restricted to health care uses and, therefore, cannot be counted on to make up the loss.

These potential losses, however, may not be large. Increased competition has caused not-for-profit hospitals to take "on the appearance of business enterprises by serving mostly paying patients, decreasing their reliance on donations or volunteer labor, and striving to generate as much surplus revenue as possible through commercial transactions."[167] In addition, because for-profit hospitals locate in areas with comparatively high levels of insured patients,[168] the need for cross-subsidies in those areas may be low. The high level of insured patients does not, however, affect the need for other services financed with hidden cross-subsidies such as medical education and research. Still, "[i]t appears that the rate of revenue growth for [new commercial] …

charitable giving and third party payment for inpatient and out patient care."[169]

Regardless of the magnitude of the effect of conversions on redistribution of funds for care, under current doctrine an attorney general is not permitted to consider it.

2. Local Control of Health Policy Decisions

Hospital conversions usually involve an individual not-for-profit hospital selling its assets to a national for-profit chain, with out-of-state corporate headquarters. Not-for-profit hospital directors generally live in the hospital service area. They interact with local residents and have direct interests in their community's health care needs. Local taxing entities such as property tax-assessors can threaten to revoke benefits when hospitals do not provide adequate community benefit. When a not-for-profit hospital is sold to a for-profit corporation, these local sources of control are reduced.

For-profit hospitals may be less likely to undertake programs that improve health yet adversely affect hospital earnings because the decision-makers will have fewer ties to the community. A not-for-profit Idaho hospital that sponsored a program to reduce bicycle injuries in children was so successful that it reduced emergency room visits for head injuries in bicycle accidents by 40 percent; although the program also caused a massive reduction in emergency room revenues, the hospital continued the program.[170] It is likely easier for an executive sitting thousands of miles away from the community to decide to discontinue such a program than for a local citizen to make the same decision.

The for-profit buyer is also likely to close a hospital that may be medically important but financially unsuccessful because "[f]or-profit hospitals are observed to be quick to enter and exit a market as conditions change…."[171] While the community may be able to ensure the maintenance of a hospital using contractual mechanisms, contracting is expensive and imperfect. The appropriate contract terms delimiting permissible behavior of the for-profit will be difficult to specify in advance. Contractual mechanisms

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[169] Richard Frank & David Salkever, *Market Forces, Diversification of Activity, and the Mission of Non-Profit Hospitals* in NONP

Other factors besides traditional medical care affect physical health. One study on elderly people, for example, demonstrates that behavioral, social (having a marital partner, contacts with friends, and membership in religious organizations or volunteer

Like trust law, corporate law allows attorneys general to conduct procedural reviews, not substantive health policy reviews.[183] There are two methods by which attorneys general may attempt to stop a transaction between a not-for-profit and a for-profit hospital, thus preserving the not-for-profit assets for hospital use:[184] 1) If the hospital exceeds its statutory powers, the attorney general may institute a *quo warranto* action to stop the sale; 2) If the sale violates provisions in the hospital's founding documents, the attorney general may enjoin the sale. Neither method permits the attorney general to redirect funds to better health uses; they only provide the blunt tool of stopping the transaction, thus maintaining the status quo.

VI. State Experience - Substantive Health Policy Review

Doctrinal limitations have not constrained all attorneys general from considering

applications of the law would require the funds be used only for hospital care or other

Other attorneys general leverage their oversight powers under charities, corporations, or general *parens patrie* authority to protect the uninsured. Five out of twenty-seven interviewees stated that the attorney general would encourage or require the for-profit buyer to provide charity care.[200] Some would require, as a condition of approving the transaction, that the buyer to provide a specified level of charity care or maintain charity care at the existing level.

In 1985, "[a]s part of a sale agreement to Hospital Corporation of America, Wesley Medical Center…required HCA to maintain traditional levels of charity care and other essential services…."[201] In the oversight of North Carolina's only conversion to date, the Attorney General reviewed several features of the transaction, including "Whether the services currently offered by the Hospital will remain available to the community."[202] Attorney General Michael Easley found that community health care services would be protected in

conditioned upon the buyer's adherence to a promise to "maintain the existing community services and indigent care currently performed by the Hospital in its service area."[203] However, the Joint Statement of the Parties makes no such promise. It "Subject.wef4(to the)4.628ne to ae continuenaiaility, a we theecise

appropriate business judgment by Columbia in its local and national operations,

patients.

Attorneys general have also interpreted their authority to oversee conversions to consider other health policy issues. In testimony before the Massachusetts Joint Committee on Health Care, Attorney General Scott Harshbarger outlined the issues he considered central "to ensure access and quality of care for all citizens" in a conversion.[206] These included: whether there were safeguards to prohibit "cream skimming" of healthier patients leaving sicker patients for nonprofit facilities; whether there should be ways to ensure the for-profit will serve the uninsured and the disadvantaged;[207] and protections against for-profit market exit, both the exit of the entire hospital or exits from the treatment of certain diseases or high risk populations.[208]

Considerations of the health effects of conversions have not been permitted in all states. According to the Kelley court in Michigan, the benefit to the community and questions related to the health care industry are not relevant to conversion inquiries.[209]

C. Attorneys General as Health Regulators

By considering substantive health care issues and allowing conversion proceeds to be used for purposes other than hospital care, attorneys general may protect the health of communities affected by conversions even though they may be violating charitable trust and corporations law. However, this section concludes that legislators and health policy experts, not attorneys general, should decide whether trust and corporations laws or

1. Negative Consequences

Allowing attorneys general to redirect the use of charitable funds may have several negative consequences. First, not-for-profit hospital donors may want to restrict their donations despite understanding that health care priorities change. Regardless of the substantive desirability of the changed purpose, when an attorney general reads a donor's intent broadly, and allows diversion of restricted assets into new health care uses, she violates the precepts of charities law. If donors believe their restrictions will be ignored,

2. Mitigating Factors

In addition to the potential for positive health outcomes, this section identifies four reasons that support attorneys general's substantive review of conversions. Depending on the results of these reviews, attorneys general would permit the transfer of

agency problems particular to financing and delivery organization of health in the United

comparable decline in disposable income and, therefore, a decline in standard of living.[215] A re-deployment of hospital sale proceeds to cost-saving projects may protect the standard of living as no other re-deployment in other industries would.

Furthermore, continuing to fund hospitals with proceeds may be dangerous to the health status of residents. Empty beds and lower frequencies of high intensity interventions in hospitals lead to poorer medical outcomes.[216]

A fourth mitigating factor might be that allowing the transfer of funds to supporting non-hospital health policy goals better reflects the donor's intent than do traditional common law requirements. Whether an attorney general accurately choose the

legislators modeled the legislation on either the California or Nebraska statute.[220]

the state's common law power.[230]

The Nebraska Nonprofit Hospital Sale Act[231] only applies to hospitals and delegates oversight to the attorney general and the Department of Health. The statute applies to transactions that 1) involve a change of ownership or control of greater than or equal to twenty percent of the not-for-profit assets or, 2) results in the for-profit buyer holding at least a fifty percent interest in the not-for-profit hospital.[232] The attorney general must approve the acquisition unless he finds it violates the public interest. Factors to be considered, among others, include: the legality of the transaction; whether the hospital board of directors exercised due diligence and fair process in its decision-making; the disclosure of conflicts related to board members, managers, and experts of both parties; the fairness of the price; the fairness of any management contract under the acquisition; and, the existence of a right-of-first-refusal to repurchase the hospital if it is sold, acquired by, or merged by another entity.[233] The Department of Health must consider how the transaction will affect the affordability of care and the parties' commitments to providing health care to the needy.[234] Sunshine provisions include mandated notice in local newspapers and public hearings.[235] The Department of Health and the attorney general may also oversee the post-transaction activities of the buyer.[236]

These statutes address the oversight obstacles outlined in Part IV-A above: 1) no oversight authority, 2) no notice mechanism, and 3) joint ventures that escape detection. First, the statutes create an explicit role for the attorney general, and sometimes the Department of Health, to review hospital conversions. While the legislation grants considerable discretion to attorneys general and will not counter firm resistance to reviewing conversions thoroughly, they require some oversight attention. Second, notice and sunshine provisions may prevent parties from avoiding public and government scrutiny. Third, the broad scope of the legislation makes structuring joint ventures to elude oversight more difficult. A Colorado bill (that subsequently failed), for example, applied to any series of transactions in any three year period involving greater than fifty

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[230] LEG(T*0.001 Tc0 6.96 124.68 120.9440 6.96 124q c)4..68 12,

percent of the not-for-profit's assets or revenues.[237] Fourth, many bills require the parties to pay oversight costs, thus reducing the burden on state resources. Oversight still imposes a significant work burden on understaffed offices. In Maine, for example, the public protection division handles all antitrust, consumer protection, civil rights, and charities cases – including conversions.[238]

The statutes and bills do not untangle the difficult valuation issues, such as identifying the best valuation method. The Nebraska statute, for example, requires the attorney general to determine "[w]hether the seller will receive reasonably fair value for its assets."[239] California provides more detail by defining fair market value as:

> the most likely price that the assets being sold would bring in a competitive and open market under all conditions requisite to a fair sale, the buyer and the seller, each acting prudently, knowledgeably, and in their own best interest, and a reasonable time being allowed for exposure in the open market.[240]

Increased reliance on expert consultation, which is more likely if the parties pay, could help attorneys general define vague terms like "fair value" and result in more accurate valuations.

All the legislation reviewed in this study included review of the conversion's health effects. The California attorney general may evaluate whether "[t]he agreement or transaction may create a significant effect on the availability or accessibility of health care services to the affected community."[241] Other legislation requires foundations created

Hospital goals are likely limited to hospital-related activities, goals that are significantly narrower than the broad goal of promoting health. One Maryland bill mandates that foundations created from conversion proceeds be dedicated to serving the state's unmet health care needs, particularly the needs of the medically uninsured and under-served.[246] It is unlikely that Maryland not-for-profit hospitals were organized to focus exclusively on the needs of the medically uninsured or under-served; many hospitals are organized to conduct research, provide medical education, treat particular illnesses, or provide services to the general population in areas where the are high levels of insured residents.

VIII. Conclusion

The current flood of hospital conversions puts the conflict between charitable trust and corporations law, and health policy goals, into stark relief. At least in theory, trust and corporations doctrines, which seek to preserve charitable purposes and assets, may be obstructing the re-deployment of billions of health care dollars into the most effective public-health uses. In practice, to the extent that such re-deployment is occurring, it undermines a centuries-old tradition of protecting charitable interest by only allowing changes in charitable purpose under extreme conditions.

There are serious decisions to be made. One cannot assume that people who founded not-for-profit hospitals and crafted their mission statements, and whose

funds for purposes that differ from those of the converting hospital will violate charitable trust law, and may violate corporations law. Attorneys general should not decide whether health policy goals or the preservation of charitable purposes should prevail without the direction of elected representatives.

As hospitals convert from not-for-profit to for-profit corporate form, society has a unique opportunity to choose how best to use billions of health-care dollars. Substantial public health benefits may be attainable through re-directing assets from hospitals into targeted public-health initiatives, medical research, or other social services. Conversely, the importance of honoring and preserving charitable intention may outweigh these benefits. Legislatures, advised by medical professionals, health-policy experts, and the public, should be the final arbiters.

Appendix A

1. State/Date

2. Contact (name and title).

3. Have any hospitals converted from not-for-profit to for-profit corporate form in your state?

4. Is there, or would there be, any government oversight of conversions? If so, which government offices would be involved?

5. Form and substance of authority for oversight? (legislation, common law, formal or informal review protocol etc.) Specific citations?
   a) Does the AG have the power to initiate litigation?
   b) Does the state have a Uniform Management of Institutional Funds Act?

6. Is there a mechanism that requires notice be given to the attorney general in the event of a conversion?
   a) Which activities trigger review? (i.e. What constitutes a conversion? joint venture, asset purchase, change in ownership - % threshold).

7. Is there a state definition of community benefit? (e.g. care for medically indigent, no expectation of payment, service at below cost rates, all bad debt).

8. How does or would your state protect care for the uninsured in the event of a conversion?

9. Are there any requirements on hospitals, for-profit, not-for-profit, government, or all, regarding the provision of charity care? (e.g. is there a % or $ amount that must be spent on the uninsured?)

10. Does your state require foundations formed with conversion proceeds to use charity funds for health care purposes? E.g.:
    a) State does not limit use to charitable purpose.
    b) State limits use to charitable purpose, but no substantive restriction.
    c) State limits use to health care purpose (research or service).

Appendix B

Alabama	
Arizona	
California	Documents only
Colorado	
Connecticut	
Florida	
Hawaii	
Idaho	
Illinois	
Iowa	
Kansas	
Louisiana	
Maine	
Maryland	
Massachusetts	Documents only
Michigan	
Minnesota	
Missouri	
Nebraska	Documents only
New Hampshire	
New Jersey	
New York	
North Carolina	
North Dakota	
Oregon	
Pennsylvania	
Rhode Island	
South Carolina	
Tennessee	
Virginia	
Wisconsin	
West Virginia	

Appendix C

State	Conversions[i]	Government Oversight[ii]	Notice to Attorney General[iii]
Alabama	Yes	AG	No
Arizona	No	AG[iv]	Maybe (antitrust law). 10 day public notice/ hearing tax-exempt asset sale. AG not notified under statute.[v]
California	Yes	AG	Yes, 20 days before transaction to AG.
Colorado	Yes[vi]	AG[vii]	No
Connecticut	No	AG[viii]	Maybe. Court application required for charitable-asset conversion. Certificate of Need required.
Florida	Yes	AG[ix]	Maybe. Court application required for charitable-asset conversion.
Hawaii	No	AG (tax)[x]	No
Idaho	No	Doesn't know	Maybe. Court application required for charitable-asset conversion.
Illinois	Yes	AG	No
Iowa	Yes	None	No
Kansas	Yes	AG[xi]	No
Louisiana	Yes	No	No
Maine	No	AG	No
Maryland	No	Maybe AG[xii]	No
Massachusetts	Yes	AG[xiii]	Sometimes, transaction may trigger notice provision of corporations code.
Michigan	Yes	AG	Sometimes, if transaction involves dissolution or other disposition of assets.
Missouri	No	AG	Sometimes, transaction may trigger notice provision of corporations code.
Minnesota	No	AG[xiv]	Sometimes, transaction may trigger notice provision of corporations code.
Nebraska	Yes	AG	Yes
New Jersey	Yes	AG[xv]	No
New Hampshire	Yes	AG	No[xvi]
New York	No	N/A	N/A

Appendix D

State	Corp. Code	Charitable Trust/Cy Pres	Statute	Joint Venture	Limits on initiating litigation
Alabama	X				
Arizona	X[xx]	X	Proposed 1997	Joint ventures may not trigger oversight.	
California			X		
Colorado	X[xxi]	X	Proposed 1997	Joint ventures may not trigger oversight.	
Connecticut		X	Proposed 1997	Unclear.	
Florida	X	X			
Hawaii	DK	DK			
Idaho	DK	DK			
Illinois	X[xxii]	X			
Iowa	DK	DK[xxiii]			
Kansas	X	X	Proposed 1997		
Louisiana			Proposed 1997		AG unlikely to sue under civil law system.
Maine	X	X		Unclear[xxiv]	
Maryland	X	X	Proposed 1997		
Massachusetts	X	X	Proposed 1997		
Michigan	X	X			
Missouri	X	X			
Minnesota	X	X		Transfer to wholly owned sub. likely deemed asset transfer.	
Nebraska			X		
New Jersey	X	X	Proposed 1997		

N

West Virginia	X[xxxiii]	X[xxxiv]			No parens patrie authority.

Appendix E

State[xxxv]	Protection of Care for the Uninsured[xxxvi]	General Requirements on Hospitals for Care for the Uninsured[xxxvii]	Restrictions on Foundation Funds[xxxviii]
Alabama	No protocol. Secondary concern.	No	Charitable, but no restriction to health care.
Arizona	DK (haven't dealt with issue yet).	DK	Cy Pres (for money donated for health purposes)
Colorado	At discretion of AG.	Not generally[xxxix]	Cy Pres
Connecticut	Protected by Cy Pres. CON may involve agreement re: uninsured.	AG, does not require. Maybe under CON.	Cy Pres
Florida	Unclear[xl]	No	Probably to charity with a rational relation to health care.
Hawaii	DK	DK	DK
Idaho[xli]	DK	DK	No current restriction, in process of developing policy.
Illinois	Secondary consideration.	DK	Probably health care, but concern that money flow to buyer. Almost certainly restricted to a 501(c)(3).[xlii]
Iowa	DK	No	DK
Kansas	Open question. Maybe preservation of funds under Cy Pres.	No	Previously no requirements. In future, probably limited to specific health care uses.
Louisiana	No power to protect.	State public hospital system.	None[xliii]
Maine	No procedure, but AG interested.	No, except state requirement related to Hill-Burton.[xliv]	DK. Probably to hospital uses.
Maryland	DK	DK	DK, but thinks some health care use, like research, would

Appendix F

State	Statute/ Bill	Primary Oversight	Authority	Covered Activities[lv]	Notice

Appendix F2

State	Public Notice/ Hearing	Factors to be considered	Substantive Health Care Considerations	Post Transaction Authority	Other
Federal	Public notice and hearing required.	DHHS secretary conducts independent fairness review, must conclude no assets inure to private benefit. 12 factors considered (most relate to fairness, conflicts, and use of proceeds).	Sec. may not approve transaction unless proceeds used for promotion of health, safeguards to assure continued access to affordable hospital services. For-profit must commit to provide comparable charity care.	uptr	

Kansas	Notice in local newspaper; public hearing.	Sec. to consider same factors considered by Nebraska Dep. of Health. AG to consider same factors outlined in Nebraska legislation.	Same factors as Nebraska legislation.	Dep. of Health and

[i] Respondents were asked, “Have any hospitals converted from not-for-profit to for-profit corporate form in your state?”

[ii] Respondents were asked, “Is there, or would there be, any government oversight of conversions? If so, which government offices would be involved?” Because most respondents could only answer with certainty whether the attorney general’s office would be involved, other departments are listed in footnotes.

[iii] Respondents were asked, “Is there a mechanism that requires notice be given to the attorney general in the event of a conversion?” and, “Which activities trigger review?” Responses to these questions were not necessarily based upon careful reading of statute and case law. The responses, therefore, should be understood as the respondent’s understanding whether some mechanism for notifying the attorney general’s office of a conversion, in some cases indirectly, exists.

[iv] The attorney general’s power has not been exercised. The Corporations Commission and the Department of Insurance would also oversee hospital conversions.

[v] Amendments to the not-for-profit law were to be introduced in 1997. A preliminary draft of the senate bill includes provi.5(cl)4.2(u)9.1le67 (pon)9.7(s)7.3(e)1.(s)7. 0 0 2(u)9e ntvoa8a(re)nt

[xxvii] Oregon common law *cy pres* doctrine might be preempted by the states extensive not-for-profit corporations law.

[xxviii] In addition to the application of the *cy pres* doctrine to changes the use of restricted funds, the Orphans Courts must approve transfers of charitable assets.

[xxixxxix] TENN. CODE ANN. §§48-51-701(b) (1996) authorizes the attorney general to commence a proceeding, take appropriate action such as seeking injunctive relief, and intervene in proceedings brought by third parties whenever notice is required to be given to the attorney general regarding disposition of charitable assets. TENN. CODE ANN. §§48-51-701(c)(5) gives the Attorney General broad power "to bring whatever action or proceeding he subsequently comes to believe is required by the public interest." General Burson has interpreted the valid public interests as guarding against self-interest and self-dealing, ensuring proper disposition of nonprofit assets, and ensuring a fair and realistic market price for assets. Mem. of the Att'y Gen., Burson v. Nashville Memorial Hospital, Inc. 4, (Tenn. Ch. Mar. 17, 1994).

[xxx] Tennessee *cy pres* doctrine follows the case law trend that limits the use of the *cy pres* trust analyses to formal trusts.

[xxxi] The Virginia corporations code (which permits mergers of stock and nonstock corporations) and other

[lv] The terms "transfer" and "acquisition" below are used generically to cover the terms "sale, transfer, lease, exchange, option, conveyance, restructure, conversion, gift, merger, or other disposition." The statutes and bills listed in this appendix generally list all these terms.

[lvi] H.R. 443, 105th Cong., 1st Sess. (1997).

[lvii] S. 1288, 43rd Leg., 1st Sess. (1997). As of March 2, 1997, the Senate had adopted the Bill and, it was under consideration in the Arizona House of Rep.

[lviii] CAL. CORP. CODE