Nonprofit Health Care Entity Conversions: A Legislative Guide

December 1997

Department of Legislative Services
Office of Policy Analysis

Annapolis, Maryland

For further information concerning this document contact:

Department of Legislative Services
90 State Circle
Annapolis, Maryland 21401

Baltimore area 410-841-3710 • Washington area 301-858-3710
Other areas 1-800-492-7122, extension 3710
TDD 410-841-3814 • 301-858-3814
Maryland Relay Service: 1-800-735-2258

The Department of Legislative Services does not discriminate on the basis of race, color, national origin, sex, religion, or disability in the admission or access to its programs or activities. Sherri M. Little has been designated to coordinate compliance with the non-discrimination requirements contained in Section 35.107 of the Department of Justice regulations. Requests for assistance should be directed to Ms. Little at the telephone numbers shown above.

DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF POLICY ANALYSIS
MARYLAND GENERAL ASSEMBLY

Karl S. Aro
Executive Director

Warren G. Deschenaux
Director

December 19, 1997

Honorable Thomas V. Mike Miller, Jr.
President of the Senate

Honorable Casper R. Taylor, Jr.
Speaker of the House of Delegates

Members of the Senate
Members of the House of Delegates

This report on the conversion of nonprofit health care entities was prepared by the Department of Legislative Services. Given the increasing public concern and scrutiny paid to nonprofit conversion activities around the country, a question is raised whether or not Maryland's existing regulatory structure provides appropriate and adequate regulatory oversight. This report provides some guidance in understanding the public policy issues surrounding nonprofit conversions and in analyzing any related proposed legislation.

The report was prepared by Mr. Enrique Martinez-Vidal and Ms. Lina Walker under the supervision of Ms. Linda Stahr. The Department of Legislative Services appreciates the assistance and cooperation it received from all interested parties.

We trust this document will be useful to the General Assembly during the upcoming session.

Sincerely,

Karl Aro
Executive Director

Warren G. Deschenaux
Director, Office of Policy Analysis

KA:WGD/lc

Legislative Services Building · 90 State Circle · Annapolis, Maryland 21401-1991
(410) 841-3710 · FAX (410) 841-3722 · TDD (410) 841-3814
(301) 858-3710 · FAX (301) 858-3722 · TDD (301) 858-3814

Contents

Executive Summary		vii
I.	Introduction	1
II.	What Does It Mean to Be a Nonprofit?	3
III.	Traditional Funding Mechanisms and Recent Trends Nationwide	6
	A. Hospitals	6
	B. Health Maintenance Organizations	8
	C. Blue Cross and Blue Shield Plans	8
IV.	The Experience in Maryland	10
	A. Blue Cross and Blue Shield of Maryland's Restructuring Proposal	10
	B. Conversion of Consumer Dental Care Company from a Non-Stock, Nonprofit Health Service Plan to a For-Profit Stock Corporation	12
	C. Proposal for a Business Combination Agreement Between Blue Cross and Blue Shield of Maryland and Group Hospitalization and Medical Services, Inc.	13
V.	Existing Law and Procedure Governing Transactions of Nonprofit Health Care Entities	13
VI.	Issues to Be Considered in Any Conversion Legislation	14
	A. The Type of Nonprofit Health Care Entity to Regulate	15
	B. The Type of Conversions to Regulate	15
	C. The Type of Post-Conversion Entity to Regulate	16
	D. Who the Regulatory Authority Should Be	17
	E. What Should Be Included in the Regulatory Process	18
	F. Is the Conversion Subject to Approval or Review Only?	23
	G. Requirements For Regulatory Approval	24
	H. Expert Assistance	33
	I. Subsequent Monitoring and Compliance	33
VII.	Conclusion	34
APPENDIX		35

Executive Summary

- The issue of nonprofit health care entities merging, engaging in joint ventures or converting to for-profit health care entities has aroused considerable public attention and policy discussions in recent years. While nonprofit conversions are not a recent phenomenon, the majority of hospitals around the country are nonprofit, and only a handful of Blue Cross and Blue Shield plans have actually converted to for-profit status, recent conversion activities have received considerable public and regulatory scrutiny.

- To date, nationally, four Blue Cross and Blue Shield (Blues) plans have converted to for-profit status; however, some Blues plans are in the process of converting and it is anticipated that more Blues plans will convert in the future. In the late 1970s and early 1980s, the pace of conversion activity by health maintenance organizations (HMOs) was quite active. This pace has since slowed mainly because the majority of HMOs today are for-profit. Nationally, approximately one percent of all hospitals in the country convert each year, and much of the activity has been concentrated in California, Florida, Georgia, and Texas.

- The justification for many of the conversions of nonprofit health care organizations to for-profit status has been to gain access to capital, particularly in a managed care environment. Increasing market share, geographic expansion, product development, utilization management, network expansion, and purchasing information and outcomes systems are the impetus to raise capital.

- Conversions of nonprofit health care entities to for-profit corporations raise several issues, such as: (1) the loss of community control; (2) the potential decrease in the access and availability of health care services; (3) private benefit; (4) breach of fiduciary responsibility and conflict of interest; (5) the preservation of the financial value of the nonprofits; and (6) the disposition, protection, and appropriate use of nonprofit assets.

- The federal tax exemption for charitable and other organizations may be traced to the origins of the income tax. The rationale for exemption could be inferred from the definition of "charitable" activities in the income tax regulations: the relief of the poor; advancement of education or science; erection or maintenance of public buildings; and the lessening of the burdens of government. Tax exemption for charitable organizations is derived from the premise that these organizations provide public services that would otherwise have to be provided by the government. Nonprofits relieve the government from certain functions and, therefore, the government is willing to forego the tax revenues it would have received.

- Between 1980 and 1990, nationally, there were a total of 532 hospital conversions; and between 1990 and 1993, 183 hospitals converted their corporate status. Most of the conversions, however, were from public status to nonprofit status. The proportion of

conversions that were from nonprofit to for-profit represented 21 percent of all conversion activity by hospitals between 1980 and 1990, and 20 percent of all conversion activity between 1990 and 1993. In 1993, about 13.6 percent of the 5,200 hospitals in the United States were for-profit. In 1981, 82 percent of all HMOs in the country were nonprofit. By 1995, this distribution shifted to 29 percent nonprofit HMOs and 71 percent for-profit HMOs.

- Prior to June 1994, the Blue Cross and Blue Shield Association required that licensees of their trademark be nonprofit. In June 1994, the Association eliminated the standard that required its member plans to organize and operate as a nonprofit health insurer, in an effort to help the independent Blues "raise capital to develop new managed care products, invest in integrated delivery and financing systems and undertake market diversification." As a result of this change in policy, some Blues plans started converting to for-profit companies. To date, Blues plans in California, Georgia, Missouri, and Virginia have converted to for-profit firms, and those in Colorado, and New York are considering.

- Currently, 49 of the 50 acute care hospitals in Maryland are nonprofit hospitals and seven of the 14 non-acute care hospitals are nonprofit. Three of the 22 HMOs licensed in Maryland have nonprofit status; only one of the nonprofit HMOs is domiciled in Maryland. Blue Cross and Blue Shield of Maryland (BCBSM) is a nonprofit health service plan organized with five for-profit HMO subsidiaries. Four of the five dental plans licensed in Maryland are nonprofit; there is one nonprofit vision plan, and one nonprofit mental health plan.

- Recent nonprofit activities in Maryland include the 1994 Blue Cross and Blue Shield of Maryland restructuring proposal; the conversion of Consumer Dental Care Company from a non-stock, nonprofit health service plan to a for-profit stock corporation; and the 1997 business combination proposal between Blue Cross and Blue Shield of Maryland and Group Hospitalization and Medical Services, Inc.

- Under existing State law, the Insurance Commissioner has regulatory jurisdiction over the conversion activities of nonprofit health service plans and HMOs. If the transaction involves a nonprofit HMO, however, the law requires the Insurance Commissioner to consult with the Secretary of Health and Mental Hygiene (DHMH) over health-related services, operations, and functions that fall under the regulatory jurisdiction of DHMH. Hospital conversions do not fall under the purview of the Insurance Commissioner. Hospital mergers, consolidation, and acquisitions in Maryland are subject to oversight by the Health Resources Planning Commission.

- Policymakers should consider the following items for inclusion in any legislation to regulate nonprofit conversions: the type of entity and type of conversion to be regulated; the responsible regulatory agency and process for oversight; requirements for regulatory approval of a conversion; nonprofit asset valuation; requirements for the oversight of any charitable trusts and the use of their assets; and the necessity of retrospective compliance or monitoring.

- The structure of the regulatory process, including parameters for time frames, public disclosure, and public participation as well as the authority which is given to the regulator is a crucial piece of conversion legislation. By having an established process on which a nonprofit considering conversion can rely, the uncertainty and expense of potential litigation can be averted..

- If policymakers decide that regulatory approval should be required in order for a conversion to occur, there are at least four main areas on which a regulator should focus: the protection of the nonprofit entity's assets; the valuation of the nonprofit's assets; the consideration of the transaction's impact on community services and local control; and the appropriate disposition of the charitable assets in a charitable trust or some other successor organization.

- In order to safeguard a nonprofit's assets during a transaction, most states have enacted conversion legislation directing a regulator to review the terms of the transaction and the process in which the parties have participated. Common requirements include: due diligence on the part of the nonprofit; disclosure of any conflicts of interest; and a prohibition on any private benefit.

- One of the most important, yet most controversial, aspects of protecting a nonprofit's assets during a conversion is the valuation of those assets. In order to determine how much should be turned over to a successor organization (e.g., a charitable trust), an accurate assessment of a converting nonprofit's worth must be performed. If the nonprofit is undervalued, the difference will eventually inure to private individuals at the expense of the community.

- A regulator should be concerned with the community impact of a nonprofit conversion transaction including whether the community continues to have access to the health care services it requires and whether the community retains an appropriate level of local control over its health care delivery system.

- The Internal Revenue Code requires that a charity's assets be dedicated irrevocably to charitable purposes. Thus, in a sale or conversion of a nonprofit health entity, the proceeds must be transferred to another nonprofit entity. The receiving entity could be a local, state, or federal government, as well as another tax-exempt organization such as a trust or foundation.

- Regulators may not have the money, personnel, or expertise to adequately oversee these conversions. Some state conversion laws require either the converting nonprofit or the for-profit buyer to pay for the cost of any necessary experts. Activities for which experts may be needed include: valuation assessment; processing applications and analyzing the public interest issues; determining the impact on community health services; overseeing the foundation of the charitable trusts; and any independent auditing for compliance and enforcement purposes.

- Following a conversion, policymakers may want to ensure compliance and monitor the parties involved in the transaction. Legislation could include oversight requirements to scrutinize retrospective compliance with any terms of the transaction on the part of the for-profit entity. It also may be important to monitor the charitable trust in order to see that it is fulfilling its stated mission. A more general issue is whether community health services should be observed over time in order to note any changes following a transaction.

Nonprofit Health Care Entity Conversions: A Legislative Guide

I. Introduction

The issue of nonprofit health care entities merging, engaging in joint ventures or converting to for-profit health care entities has aroused considerable public attention and policy discussions in recent years. While nonprofit conversions are not a recent phenomenon, the majority of hospitals around the country are nonprofit, and only a handful of Blue Cross and Blue Shield plans have actually converted to for-profit status, recent conversion activities have received considerable public and regulatory scrutiny. This response may be, in part, fueled by reports of executives and board members profiting as a result of these transactions and also by the dollar magnitude of some of these transactions. Since nonprofit health care organizations generally have been viewed as serving the public interest and providing needed health care services without the motivation of profit, the reaction also reflects the concern that the changing status of these nonprofit entities may result in the quality and availability of health care services being compromised. The increased attention may also reflect the concern that the pace of conversion activity may increase in the absence of regulatory oversight. The issues that have been raised center around three questions: (1) Why are nonprofit health care entities converting or restructuring? (2) What are the consequences of these restructuring activities? and (3) What public policy issues should policymakers understand with regard to nonprofit conversions?

To date, nationally, four Blue Cross and Blue Shield (Blues) plans have converted to for-profit status, although some Blues plans are in the process of converting and it is anticipated that more Blues plans will convert in the future. In the late 1970s and early 1980s, the pace of conversion activity by health maintenance organizations (HMOs) was quite active. This pace has since slowed mainly because the majority of HMOs today are for-profit. Nationally, approximately one percent of all hospitals in the country convert each year, and much of the activity has been concentrated in California, Florida, Georgia, and Texas. These figures, however, do not accurately reflect the incidence of business activity between nonprofit and for-profit health care entities. In fact, hospitals, large medical groups and Blues plans have been increasingly active in forming partnerships with other hospitals or medical/health systems, through joint ventures, mergers, and long-term leases.[1] Although not considered outright conversions, these transactions nonetheless could result in the same public and policy concerns as for-profit conversions. In addition, these partnerships are not limited to for-profit entities.

[1] Some articles have defined these transactions as conversion activities.

Hospitals and medical groups also look towards public and other nonprofit health care organizations to engage in business arrangements.

This report defines a for-profit conversion as any transaction that transfers all or a substantial portion of the assets of a nonprofit organization to a for-profit purpose. The sale of the nonprofit's assets to a for-profit organization is considered a conversion, as is the acquisition or merger by a for-profit organization in which the resulting corporation is operated for-profit. Under this definition, a joint venture between a nonprofit and a for-profit corporation, or the transfer of some or all of the operating assets and liabilities of the nonprofit health care entity to a wholly or partially owned subsidiary in exchange for stocks, could potentially result in a conversion. For instance, a nonprofit entity may contribute some portion of its assets to the partnership in exchange for cash and an ownership interest in the joint venture. The for-profit could contribute cash and receive ownership in the transaction. The proceeds from the sale of the nonprofit's assets are transferred to a nonprofit foundation. In this transaction, the nonprofit company could effectively gain control of the assets of the nonprofit organization without having to pay its entire value.[2]

The justification for many of the conversions of nonprofit health care organizations to for-profit status has been to gain access to capital, particularly in a managed care environment. As the following sections illustrate, increasing market share, geographic expansion, product development, utilization management, network expansion, and the purchase of information and outcomes systems are the impetus to raise capital. Joint ventures and mergers, both among nonprofit health care entities and between nonprofit and for-profit corporations, could be a result of the changing trends in the market place. For instance, increased competitiveness in the health care market has lead to consolidations or mergers to increase efficiency, build networks and gain market share. Finally, some conversion activities in recent years have been due to the aggressive acquisition of nonprofit health care entities by for-profit chains, the most prominent of which is by the for-profit hospital chain, Columbia/HCA. In 1994, Columbia/HCA alone acquired 34 nonprofit hospitals and, in 1995, the company acquired 58 nonprofit hospitals.[3]

Conversions of nonprofit health care entities to for-profit corporations raise several issues, such as:

- loss of community control
- potential decrease in the access and availability of health care services

---

[2]Gary Claxton et. al., "Public Policy Issues In Nonprofit Conversions: An Overview," Health Affairs (March/April 1997), p. 11.

[3] The pace of their acquisitions may be slowing in light of the recent controversies surrounding the company.

- private benefit
- breach of fiduciary responsibility and conflict of interest
- preserving the financial value of the nonprofits
- disposition, protection, and appropriate use of nonprofit assets

As the report will indicate, a significant number of business arrangements have been between nonprofit health care organizations. While transactions between nonprofit health care entities do not usually raise concerns such as private inurement or breach of fiduciary responsibility, they nonetheless share some of the issues raised by for-profit conversions or partnerships, such as loss of community control, and the access and availability of services.

During the 1997 Maryland legislative session, Senate Bill 531/House Bill 753 and House Bill 287 were introduced to regulate the conversion and restructuring activities of nonprofit health care entities in Maryland. Although there have been relatively few instances of conversion activity in Maryland, the legislation anticipated possible occurrences in the future. These bills did not pass the General Assembly and instead were sent to interim study.

The following section briefly outlines what it means to be a nonprofit health care organization and provides an estimate of the value of its tax exemption. Section III describes traditional sources of capital for nonprofit hospitals, HMOs, and Blues plans around the country. It also details recent restructuring trends among these nonprofit health care entities. Section IV provides accounts of some recent nonprofit activity in Maryland, and Section V explains current State law and procedures regarding nonprofit conversions and other restructuring efforts. Section VI details the public policy issues surrounding conversions and poses certain questions that policymakers should consider when examining proposed legislation. Finally, Section VII concludes the report.

II. What Does it Mean to Be a Nonprofit?

The federal tax exemption for charitable and other organizations may be traced to the origins of the income tax. Most of the committee reports accompanying the 1913 Act and subsequent revenue acts are silent on the reasons for initiating and continuing the exemption. The rationale for exemption, however, could be inferred from the definition of "charitable" activities in the income tax regulations, which includes purposes such as the relief of the poor, advancement of education or science, erection or maintenance of public buildings, and the lessening of the burdens of government.[4] Thus, the concept of tax exemption for charitable organizations is derived from the premise that these organizations provide public services that would otherwise have to be provided by

[4] Bruce R. Hopkins, "Rational for Tax-Exempt Organizations," The Law of Tax-Exempt Organizations, 6th Edition (John Wiley and Sons, Inc.), p. 8-9.

the government. In doing so, they relieve the government from certain functions and, therefore, the government is willing to forego the tax revenues it would have received.

Nonprofit charitable organizations are exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC).[5] The provision of health care services is generally seen as a charitable function for which exemption may be granted; thus nonprofit hospitals and most nonprofit health care facilities in Maryland are exempt from federal income taxes under Section 501(c)(3).[6] There is another category of tax exempt organization under which some nonprofit health service plans operate. They are referred to as social welfare organizations and are exempt under IRC Section 501(c)(4).[7,8,9] Prior to 1986, most Blues plans were organized as 501(c)(4) organizations. Under the 1986 Federal Tax Reform Act, however, the Blues lost their 501(c)(4) federal tax exempt status. Subsection 501(m) of the Internal Revenue Code was established which states that organizations providing "commercial-type" insurance are not eligible for federal tax exemption, whatever their other practices, unless they subsidize the premiums for many low-income enrollees. It was ruled that the Blues did not satisfy the provision of that subsection[10]. Currently Blue Cross and Blue Shield of Maryland is subject to the federal alternative minimum tax (AMT) rate of 20%.[11]

In Maryland, any nonprofit corporation exempt under IRC Section 501 is exempt from state income tax under Section 10-104 of the Tax-General Article. Thus nonprofit hospitals, medical systems, and HMOs are exempt from state income taxes in Maryland

---

[5] This exemption does not apply to unrelated business activity from which the nonprofit organization generates income.

[6] Exemption may be granted under Section 501(c)(3) as long as the organization's class of beneficiaries is sufficiently large so that the community as a whole benefits. Exemption from federal income tax is determined under the "community benefit standard": Rev. Rul. 69-545,1969-2 C.B. 117 and Rev. Rul. 83-157, 1983-2 C.B. 94. Rochelle Korman and William F. Gaske, "Joint Ventures Between Tax-Exempt and Commercial Health Care Providers," The Exempt Organization Tax Review (May 1997), p. 774- 775.

[7] U.S. General Accounting Office (GAO), Tax Exempt Organizations: Information on Selected Types of Organizations (Washington, DC: U.S. GAO, February 1995), p. 10-11.

[8] The distinction between the two registrations are: (1) social welfare organizations are primarily engaged in advocacy, lobbying, and other legislative activity, while charitable organizations do so only as a subsidiary activity; and (2) charitable organizations are eligible to receive tax deductible gifts and contributions while social welfare organizations are ineligible.

[9] Lester M. Salamon, America's Nonprofit Sector: A Primer, (New York: The Foundation Center, 1992), p. 14-15.

[10] Mark Schlesinger, Gary Bradford, and Elizabeth Bradley, "Charity and Community," Journal of Health Politics, Policy and Law (Vol. 21, no. 4, Winter 1996), p. 704.

[11] Blue Cross and Blue Shield of Maryland, 1995 Annual Report, Blue Cross and Blue Shield of Maryland, p. 24.

(this is an exemption from the current corporate income tax rate of 7 percent).[12] As an insurance company, Blue Cross and Blue Shield of Maryland is exempt from State income tax under Section 10-104(5) of the Tax-General Article. All nonprofit hospitals are exempt from Maryland property taxes under Section 7-202 of the Tax-Property Article. Maryland courts have ruled that an HMO whose primary purpose is to provide care to its members for a fee and whose educational aspects are only incidental to its main function of providing health care services to its members is not exempt from property taxation as a charitable organization.[13] Consequently, nonprofit HMOs in Maryland are subject to real property taxes. Blue Cross and Blue Shield of Maryland would be subject to real property taxes if it owned property in Maryland. The company, however, only leases its main facility and does not own any real property in Maryland.[14]

Table 1 provides an estimate of the value of the tax exemption for nonprofit hospitals in Maryland. It is noted that the estimates for real property exemption are likely undervalued because the assessments are not based on the fair market value of the properties. It is also noted that the estimates for State income tax exemption are probably overstated because they do not account for any deductions from income that hospitals are likely to take. Nonprofit hospitals are also exempt from personal property taxes, the estimate of which was not available for this report.

Table 1: Estimated Value of Hospital Exemption From Real Property Tax and State Income Tax[15]

	All Nonprofit Hospitals in Maryland	
	Real Property Tax[b]	State Income Tax[c]
Value of Exemption[a]	$15.0 million	$20.0 million

a. Rounded to the nearest tenth of a million. b. Reflects assessment roll year 1997-98
c. Reflects fiscal year 1996.

[12] Again, this exemption does not apply to unrelated business income.

[13] Supervisor of Assmts. v. Group Health Ass'n, 308 Md. 151, 517 A.2d 1076 (1986).

[14] According to the Maryland Department of Assessments and Taxation.

[15] Property assessments provided by the Department of Assessments and Taxation. Hospital data obtained from Disclosure of Hospital Financial and Statistical Information, Health Services Cost Review Commission, Department of Health and Mental Hygiene, March 1997. Value of tax exemption compiled by the Department of Legislative Services.

In addition, nonprofit health service plans, such as Blue Cross and Blue Shield of Maryland and some dental plans, are exempt from the State's 2 percent insurance premium tax.[16] The value of the premium tax exemption for nonprofit health care entities is represented in **Table 2**.

Table 2: Estimated Value of Nonprofit Health Service Plans Exemption from 2% Insurance Premium Tax[17]

	Total Writings in Maryland[a]	Value of Insurance Premium Tax Exemption[a]
Nonprofit Health Service Plans in Maryland	$773.2 million	$15.5 million

a. Rounded to the nearest tenth of a million.

III. Traditional Funding Mechanisms and Recent Trends Nationwide

A. Hospitals

The tax-exempt status of hospitals during the 1920s, 1930s and 1940s provided hospitals access to capital through charitable contributions, bequests, and other forms of philanthropic support. After World War II, substantial funds were appropriated for the construction of public and nonprofit hospitals and other health care facilities through the Hospital Survey and Construction Act (the Hill-Burton Act). In addition, following the enactment of the Medicare and Medicaid programs in 1965, the tax-exempt status of hospitals further allowed them unrestricted access to tax-exempt debt markets. These events spurred the growth in the number and size of nonprofit and public hospitals around the country. The tax-exempt financing reforms in 1986, however, eliminated many of the advantages of raising capital through traditional financing arrangements.

Consequently, some hospitals converted their corporate structure to gain access to alternate funding arrangements, such as raising capital through equity markets. Between 1980 and 1990, there were a total of 532 hospital conversions; and between 1990 and 1993, 183 hospitals converted their corporate status (see **Table 3**). Most of the conversions, however, were from public status to nonprofit status. As **Table 3** indicates, the proportion of conversions that were from nonprofit to for-profit represented 21

[16] HMOs are also exempt from insurance premium taxes. This exemption, however, is based on their status as an HMO and is independent of their corporate status. Both nonprofit and for-profit HMOs are exempt from insurance premium taxes.

[17] Based on estimates in Maryland's Tax Structure (Annapolis, MD: Department of Fiscal Services, October 1996).

percent of all conversion activity by hospitals between 1980 and 1990, and 20 percent of all conversion activity between 1990 and 1993.[18] In 1993, about 13.6 percent (or 707) of the 5,200 hospitals in the United States were for-profit. Given that some for-profit organizations become nonprofit, the distribution of hospitals beds has been relatively stable between 1984 and 1994: 70 percent were nonprofit, 20 percent were public, and 10 percent were for-profit.[19]

Table 3: Number of Hospital Conversions, 1980-1990 And 1990-1993[20]

	Between 1980 and 1990		Between 1990 and 1993	
	Number	Percentage	Number	Percentage
nonprofit to for-profit	110	21%	37	20%
public to for-profit	73	14%	7	4%
for-profit to nonprofit	55	10%	42	23%
for-profit to public	6	1%	14	8%
nonprofit to public	65	12%	32	17%
public to nonprofit	223	42%	51	28%
Total	**532**	**100%**	**183**	**100%**

Perhaps more significantly, nonprofit hospitals have increasingly engaged in mergers, consolidations, and joint ventures with other hospitals. Hospital mergers rose from less than 20 transactions a year between 1990 and 1993 to 184 transactions in 1994 and 230 transactions in 1995.[21] A significant portion of these mergers and acquisitions has been initiated by nonprofit organizations and resulted in partnerships with other nonprofit hospitals. In 1996, there were 164 publicly-announced hospital mergers and acquisitions. 111 of the acquirers were nonprofit hospitals (68 percent) and 144 of the acquired hospitals (88 percent) were nonprofit.[22] In addition, joint ventures with other health providers and health systems have become increasingly popular in the past several years. Nonprofit hospitals have teamed with other hospitals, physician practices or medical systems, themselves either nonprofit or for-profit.

---

[18] Jack Needleman, Deborah J. Chollet, and JoAnn Lamphere, "Hospital Conversion Trends," Health Affairs (March/April 1997), p. 189.

[19] Gary Claxon, "Public Policy Issues," p. 12.

[20] Health Trends' calculation of data from Irving Levin Associates, Inc., Healthcare Trends Report (May 1997), p. 16.

[21] Nancy M. Kane, "Uses of Charitable Assets After Changes in Not For Profit Status," (working paper, Department of Health Policy and Management, Harvard School of Public Health, 1996), p. 2.

[22] Health Trends' calculation of data from Irving Levin Associates, Inc., Healthcare Trends Report (May 1997), p. 16.

B. Health Maintenance Organizations

Most of the early HMOs were organized as nonprofits. These HMOs acquired capital though subscriptions from enrollees and/or membership fees. Those HMOs with capital assets (such as hospitals) were also able to use traditional asset-based financing, such as conventional mortgage financing, to raise capital.[23] Additional capital was made available to HMOs through the Health Maintenance Organization Act of 1973, which authorized federal funds to establish and develop HMOs over a period of five years.[24]

As managed care evolved in the United States and HMOs began to develop new products or to expand geographically, traditional sources of capital were not adequate for such endeavors. To finance these projects, nonprofit HMOs turned to internally-generated funds or taxable debt-financing. Some of these nonprofit HMOs, however, found themselves at a competitive disadvantage to for-profit HMOs that had access to public and private sales of stock, as well as internally-generated funds and public and private debt. Consequently, beginning in the late 1970s nonprofit HMOs starting converting to for-profit in large part to gain access to capital through equity markets.

In 1981, 82 percent of all HMOs were nonprofit and only 18 percent were for-profit HMOs. In 1995, this distribution shifted to 29 percent nonprofit HMOs and 71 percent for-profit HMOs. In addition, 80 percent of all Provider Sponsored Organizations (PSOs) nationally are for-profit.

C. Blue Cross and Blue Shield Plans

Prior to June 1994, the Blue Cross and Blue Shield Association ("Association") required that licensees of their trademark be nonprofit. It should be noted, however, that some of the Blues were organized as nonprofit mutual companies, which implied that their subscribers and policyholders owned stock in the corporation. As nonprofit health service plans, the independent Blues were subject to the same restrictions as other nonprofits in their ability to raise capital. In the face of increasing competition in a managed care environment, the independent Blues argued that improved access to capital was necessary for them to remain viable in the market place. The Blues, however, for the most part, were still able to expand their networks by engaging in joint ventures, merging with other Blues plans, or creating for-profit publicly-traded subsidiaries. While some issue remains over whether the creation of for-profit subsidiaries transforms the core business of the company and effectively changes the profit motivation of the Blues, these restructurings were generally acceptable to the Association.

---

[23] Douglas M. Mancino, "Converting the Status of Exempt Hospitals and Health Care Organizations," Journal of Taxation of Exempt Organizations (July/August 1997), p. 16.

[24] In fact, during this period conversions from nonprofit to for-profit status was actively encouraged by the United States Department of Health and Human Services.

In June 1994, the Association eliminated the standard that required its member plans to organize and operate as a nonprofit health insurer, in an effort to help the independent Blues "raise capital to develop new managed care products, invest in integrated delivery and financing systems and undertake market diversification."[25] As a result of this change in policy, some Blues plans started converting to for-profit companies. To date, Blues plans in California, Georgia, Missouri, and Virginia have converted to for-profit firms, and those in Colorado, and New York are considering conversion.[26] Some notable conversions are described below.

Blue Cross of California (BCC) was the first state Blue Cross plan to convert to a for-profit company. BCC originally proposed a restructuring plan to create a new publicly traded for-profit subsidiary, WellPoint Health Networks, with 90 percent of the nonprofit's assets. The nonprofit BCC would continue to exist and hold 80 percent of the stock in WellPoint while the remaining 20 percent would be sold on the New York Stock Exchange. The restructuring proposal was initially approved by the California Department of Corporations. Concerns raised by consumer groups and additional oversight by the new Corporations Commissioner led instead to the conversion of BCC to a for-profit company. In conversion, $3.3 billion in cash and stock was transferred to two nonprofit charitable health foundations. BCC completed its conversion in May 1996.

Trigon Blue Cross Blue Shield of Virginia (Trigon) was the next Blues plan to submit a proposal to convert to a for-profit mutual insurer. The company (which was a nonprofit mutual insurer) proposed to sell 18 to 35 percent of its stock to outside investors to raise between $140 million and $320 million. Initially, the Attorney General agreed to support Trigon's conversion in exchange for $165 million in a charitable foundation to fund medical research and education. The Attorney General had settled on $165 million as that was the company's surplus in 1987 when the company lost its state tax-exempt status. Governor George Allen, however, quickly budgeted $95 million of that amount to fund higher education, and the legislature increased the original allocation to $175 million and turned the entire amount over to the state general fund.

Blue Cross and Blue Shield of Georgia (BCBSG) completed its conversion to a for-profit health insurer in May 1996. BCBSG sold preferred stock to private investors in a private offering and distributed five shares of common stock to each of its policyholders. The company did not make any contributions to a charitable foundation.

---

[25] Announcement by Blue Cross and Blue Shield Association, as reported in State Health Notes (July 1996), p. 1.

[26] Patricia Butler, Profit and the Public Interest: A State Policymaker's Guide to Non-Profit Hospital and Health Plan Conversion (National Academy for State Health Policy, Portland, ME, December 1996), p. 9.

IV. The Experience in Maryland

Currently, 49 of the 50 acute care hospitals in Maryland are nonprofit hospitals (98 percent) and seven of the 14 non-acute care hospitals (such as chronic, specialty and psychiatric hospitals) are nonprofit hospitals (50 percent).[27] Three of the 22 HMOs licensed in Maryland have nonprofit status (14 percent); only one of the nonprofit HMOs is domiciled in Maryland. Blue Cross and Blue Shield of Maryland (BCBSM) is a nonprofit health service plan organized with five for-profit HMO subsidiaries. Four of the five dental plans licensed in Maryland are nonprofit; there is one nonprofit vision plan, and one nonprofit mental health plan.

In recent years, the only conversion activity by a nonprofit health service plan occurred in 1996 when Consumer Dental Care Company converted from a non-stock, nonprofit health service plan to a for-profit stock corporation. Some observers have suggested that Maryland's unique all-payer rate-setting system for hospitals may be a deterrent to hospital acquisitions by out-of-state for-profit hospital chains[28]. Entry into Maryland's health market for any profit-motivated entity would be determined by the profitability of such an action. There is no clear evidence that Maryland's all-payer system deters from that possibility. That is to say, the current lack of activity does not preclude the potential for future conversion activity.

While hospitals in Maryland may not have changed corporate status, they have been increasingly engaged in merger activities. Prior to 1985, there were two hospitals systems in Maryland and between 1988 and 1993, there was very little merger activity in Maryland. However, in 1996 and 1997, the Health Resources and Planning Commission received five hospital merger requests.

Some of the more recent nonprofit activities in Maryland are described below:

A. Blue Cross and Blue Shield of Maryland's Restructuring Proposal

In 1994, Blue Cross and Blue Shield of Maryland (BCBSM) submitted a reorganization plan to the Insurance Commissioner. BCBSM's proposal included the creation of a new for-profit commercial health insurance company which would sell indemnity health insurance products under a separate logo. In addition, the proposal created a general insurance agency and a downstream holding company. The general insurance agency would market BCBSM products and could market products for other insurers. The holding company would be the direct owner of BCBSM's five for-profit

[27] Information provided by Health Services Cost Review Commission, Department of Health and Mental Hygiene.

[28] Conversation with policy specialist at Health Policy Tracking Service, National Conference for State Legislatures, Washington, DC.

HMO's, BCBSM's third-party administration company, the new for-profit commercial health insurance company, and the general insurance agency. BCBSM would transfer to this downstream holding company 1900 of its 2200 employees and most of its assets, including direct and indirect ownership interests in its five HMO's and its third party administration company. The holding company would eventually sell stock to the public. The proceeds would be used by BCBSM to expand its business.

In addition, BCBSM planned to reactivate and expand an existing charitable foundation. This foundation would receive excess surplus from BCBSM which could be used to provide health benefits to certain uninsured individuals or for other health related activities. The foundation would be under the direct control of BCBSM. The Board of Directors and the management team for BCBSM, the holding company, and the foundation would substantially overlap.

In January 1995 the Insurance Commissioner rejected BCBSM's original proposal on the grounds that the plan would essentially convert the company into a for-profit enterprise, create a conflict of interest for certain fiduciary members, and benefit shareholders at the expense of subscribers. Opponents of the proposed restructuring plan of BCBSM had the following concerns:

- First, proceeds from the sale of BCBSM stock could be used to benefit private investors. Critics of the transaction claimed that the Maryland public is entitled to a portion of the proceeds because the public contributed to BCBSM's wealth in the form of favorable tax treatment and state-authorized discounts.

- A second issue concerned the valuation of BCBSM's HMO business. The Insurance Commissioner had requested that Coopers and Lybrand value BCBSM's HMO business using the discounted cash flow method. Coopers and Lybrand's valuation was based on the current value of any future profits the HMOs would make if they continued to be part of the nonprofit Blue Cross company. Critics suggested a better way to value BCBSM's HMO business would be to determine what a buyer would pay for the business on the open market.

- There were concerns that the nonprofit business would not survive under BCBSM's proposed restructuring because BCBSM could funnel the more attractive and more profitable business from the nonprofit company to the for-profit company, leaving the nonprofit business with the highest-cost subscribers. This would eventually require the nonprofit business to increase its rates, thereby reducing the affordability of the coverage.

- Finally, under the proposal, BCBSM's executives would work for both profit seeking stockholders and nonprofit subscribers. In addition, some members of

the Board of Directors of the for-profit company also would sit as members of the Board of Directors for the nonprofit company. This arrangement presented conflicting interests for agents with fiduciary responsibilities.

While the Maryland Insurance Code provides a procedure for nonprofit conversion, BCBSM chose not to pursue its restructuring proposal. Conversion would subject the company to the insurance premium tax.

B. Conversion of Consumer Dental Care Company from a Non-Stock, Nonprofit Health Service Plan to a For-Profit Stock Corporation

During a financial examination of Consumer Dental Care Company (CDC) in 1996, the Maryland Insurance Administration (MIA) established that CDC was being operated in a manner that was inconsistent with its corporate charter and the laws of Maryland governing nonprofit health service plans. CDC was expanding its operations and was profitable, however, the growth and general success of CDC did not result in any significant growth in its financial resources. Instead, it resulted in substantial compensation to all three officers of CDC through exclusive consulting and management contracts with the businesses owned by the same three officers.

On April 22, 1996, the Insurance Commissioner issued an order to CDC to either convert to a for-profit health insurer under Article 48A § 356AA or operate as a bona fide nonprofit health service plan. The latter option would have required that "CDC be operated either directly by employees of CDC or through contracts negotiated at arms length with entities which are not affiliated with or controlled by any officer or director of CDC." The order required CDC to file a written plan with the Commissioner within 30 days, and disallowed the execution of new contracts or agreements, or the assignment of existing contracts.

On June 26, 1996, CDC submitted a proposal to establish a new dental plan that would purchase all the Maryland assets of CDC and assume all its liabilities. In his review, the Insurance Commissioner determined that "any transformation of a nonprofit to a for-profit entity, whether by direct conversion or by the transfer of assets and the dissolution of the nonprofit corporation, the fair value of the assets must be first established and then distributed in a way that ensures that the assets not be used for the direct or indirect benefit of the principals." CDC was required to retain an independent reviewer (from a list provided by the MIA) to assess the fairness and reasonableness of the acquisition price, which was set at $650,000.

The fair market value of CDC was assessed in the range of $566,000 to $583,000. CDC proposed transferring the proceeds of the assets to the University of Maryland Dental School to be used to fund low cost or free dental care for the indigent. On

November 20, 1996, CDC's proposal to convert to a for-profit stock corporation was approved.

C. Proposal for a Business Combination Agreement Between Blue Cross and Blue Shield of Maryland and Group Hospitalization and Medical Services, Inc.

In March 1997, Blue Cross and Blue Shield of Maryland (BCBSM) and Group Hospitalization and Medical Services, Inc (GHMSI: formerly known as Blue Cross and Blue Shield of the National Capital Area) signed a business combination agreement to form an upstream nonprofit holding company. The holding company will become the sole corporate member of both companies. Filings have been made with the Insurance Commissioners in the District of Columbia, Maryland, and Virginia. The arrangement would establish a Blues plan with the largest combined HMO enrollment in the region. In addition, the business agreement removes the territorial boundaries that prevented BCBSM and GHMSI from marketing outside their region. In the absence of the agreement, GHMSI would only be able to market in its products in Montgomery and Prince George's counties, the District of Columbia, and northern Virginia, and BCBSM would not be able to market its services in Montgomery and Prince George's counties.

The Blues anticipate that the business combination agreement would give them increased leverage with health care providers because of their ability to attract large groups. In addition, they anticipate the business arrangement to result in increased efficiency and economies of scale, thereby reducing costs and ultimately premiums. Concerns regarding the transaction have also been raised. Some consumer groups have expressed concerns that the combination agreement is a prelude to conversion. A group located in the District of Columbia, Fair Care Association, contends that the consolidation would violate GHMSI's public trust by allowing charitable assets and premium revenues to be spent outside the service area. Regulators are expected to act on the filings by the end of the year.

V. Existing Law and Procedure Governing Transactions of Nonprofit Health Care Entities

Under existing State law, the Insurance Commissioner has regulatory jurisdiction over the conversion and restructuring activities of nonprofit health service plans and HMOs. If the transaction involves nonprofit HMOs, however, the law requires the Insurance Commissioner to consult with the Secretary of Health and Mental Hygiene (DHMH) over health-related services, operations, and functions that fall under the regulatory jurisdiction of DHMH.

The authority of the Insurance Commissioner to regulate the activities of nonprofit health service plans and HMOs could be governed by Title 7 (Maryland Insurance Acquisitions Disclosure and Control Act) and Title 14 (Nonprofit Health Service Plans) of the Insurance Article; Title 19, Subtitle 7 (Health Maintenance Organizations) of the Health General Article; and Title 5, Subtitle 2 (Nonstock Corporations) of the Corporations and Associations Article. In addition, under Section 14-112 of the Insurance Article, the Commissioner has the authority to revoke the certificate of authority of a nonprofit health service plan if there is reason to believe that the corporation is being operated for profit. The process and conditions for conversion approval under these statutes are included in the Appendix.

Hospital conversions and restructurings do not fall under the purview of the Insurance Commissioner. Hospital mergers, consolidations, and acquisitions in Maryland are subject to oversight by the Health Resources Planning Commission (HRPC) under Sections 19-115(h)(2)(iii), 19-115(I)(2)(iv), and 19-115(j)(5)(ii) and (v) of the Health-General Article. A consolidation or merger between hospitals in Maryland does not require a certificate of need (CON). However, HRPC may review the transaction and issue its findings if so requested by the merging institutions. If HRPC finds the transaction is consistent with the State Health Plan (SHP), is efficient and effective, and is in the public interest then State law grants the merging hospitals antitrust immunity, and an exemption from a CON may be granted for proposed changes in hospital beds or services. In addition, major capital expenditures may be exempt from the CON process if they are part of a consolidation or merger. Acquisitions of a health care system or hospital in Maryland require only a notification to HRPC if there are no changes to hospital beds or services, and conversion of a health care facility or part of a facility to a nonhealth-related use is exempt from CON review if the above three criteria are met.

Current standards grant hospitals and health systems an expedited, more limited review if the action is pursuant to a consolidation or merger. Instead of 90 to 150 days for a standard CON review, the review time period is 45 days. In addition, interested parties are not permitted in the review process, there is no evidentiary hearing, there is no published schedule for receipt of applications, there is only one procedural step before a final decision, and there are only three criteria used to review the proposed action.[29] A Technical Advisory Committee has been established to review existing merger and consolidation rules and is expected to issue a report by the end of the year.

VI. Issues to Be Considered in Any Conversion Legislation

Policymakers should consider the following items for inclusion in any legislation to regulate nonprofit conversions: the type of entity and type of conversion to be

[29] Minutes of the November 18, 1997 meeting of the Health Planning and Strategy Committee, Maryland Health Resources Planning Commission.

regulated; the responsible regulatory agency and process for oversight; requirements for regulatory approval of a conversion; nonprofit asset valuation; requirements for the oversight of any charitable trusts and the use of their assets; and the necessity of retrospective compliance or monitoring. The following section attempts to outline these items by providing a brief description of the issue and some questions related to that issue that should be considered by policymakers when crafting or analyzing proposed legislation.

A. The Type of Nonprofit Health Care Entity to Regulate

As discussed above, a number of nonprofit health care entities across the country have converted or have considered converting. In Maryland, most of the HMOs are already for-profit; the nonprofit HMOs (Kaiser and George Washington University Health Plan)[30] have less than 10 percent of all HMO enrollment in the state. Although BCBSM has five for-profit HMO subsidiaries, the parent company remains a nonprofit health service plan. Almost all acute-care hospitals in Maryland are nonprofit. With the enactment of federal Medicare reform legislation, a possibility now exists for the creation of Provider-Sponsored Organizations (PSOs) which are managed care organizations for Medicare patients. These PSOs may be organized as for-profits or nonprofits.

Some states have enacted legislation that only regulates Blues plans, while others have only sought oversight of hospital conversions. Still others have tried to include all nonprofit health care entities in legislation. Ohio has enacted legislation that applies to all types of health care entities that have ever had a federal tax exemption (including Blues plans which lost their federal tax exemption in 1986).[31]

Question 1: Which nonprofit health care entities should be regulated? These entities could include medical HMOs, dental HMOs, Blues plans, hospitals, and PSOs.

Question 2: Should different entities have different obligations imposed on them? For example, tax-exempt health plans may have different public missions than nonprofit hospitals, therefore different standards of review may be appropriate.

B. The Type of Conversions to Regulate

Again, as discussed above, conversions can take many forms. A straight-forward conversion from a nonprofit entity into a for-profit might occur. An outright sale of a nonprofit to a for-profit is another type of conversion. Entities might merge or engage in long-term leasing. However, most of the recent conversions of nonprofit assets have

[30] Total Health Care is another nonprofit HMO but provides services almost exclusively to Medicaid enrollees.

[31] Section 109.34(a)(2)(b) of the Revised Code of Ohio (HB 242 [1997]).

been achieved as joint ventures. Some state policymakers and many consumer interest groups contend that joint ventures may be a method to circumvent the issue of charitable assets. Proponents of joint ventures have suggested that since the nonprofit entities involved were not sold, charitable contributions are unnecessary.[32] At best, most state laws are unclear about how to treat joint ventures.

Joint ventures have also led to the loss of local control over facilities that the community thought it had retained; for example, when, unknown to the community, the nonprofit board's seats in the joint venture are non-voting.[33] Under a joint venture, a for-profit entity also could issue a "capital call" to require the nonprofit partner to contribute to expansion or give up certain control rights which, in turn, leads to the dilution of the nonprofit's share in the joint venture. A third possible occurrence under a joint venture leaves the community with a significant investment in the resulting for-profit. Under this scenario, the community's charitable foundation must rely on assets that are invested in the joint venture which may or may not prove to be a sound investment. The main issue in all of the cases is whether the nonprofit entity is under the control and management of the for-profit.

The Honorable Phillip L. Isenberg, the California Assemblyman who sponsored that state's act governing conversions, has suggested that any legislation to be enacted should be broad enough to cover any possible permutation of ownership change. "This should include sales, joint ventures, management agreements or restructures. Whatever the inventive minds of lawyers might create should be anticipated by legislators."[34]

Question 3: Which type or types of conversion should be permitted or regulated? A narrow structural definition, which specifies a particular type of conversion activity (e.g., a "sale" or a "merger"), or a more broad functional definition (i.e., "a transfer of ownership") may be used. Also, if joint ventures are to be regulated, should a certain percentage of ownership change be specified to trigger that oversight (i.e., an ownership change of at least 20 percent).

C. The Type of Post-Conversion Entity to Regulate

An additional concern has arisen recently in light of the increasing number of restructurings that involve nonprofits buying or merging with other nonprofits. Under

---

[32] "Conversion of Not-for-Profit Hospitals to For-Profit Status Stirs Up Concerns," BNA's Health Care Policy Report (8/19/96), p. 1355.

[33] "Effects of Sales of Non-Profit Hospitals on Communities Being Examined by States," BNA's Health Care Policy Report (8/26/96), p.1390.

[34] Phillip L. Isenberg, Esq. and Richard J. Battson, "Sales and Other Transfers of Nonprofit Health Facilities: Assembly Bill 3101 - The Economic, Politics, and Social Values that Shaped the New Legislation," California Health Law News (Vol. XVII, No. 1, Spring 1997), p. 13.

this type of restructuring, issues about charitable assets and local control have been raised. Stephen Morris, a retired Phoenix hospital executive, commented on the acquisition of a nonprofit Phoenix hospital by a nonprofit California-based health care system: "..[I]f Samaritan had sold to Columbia or another for-profit, Phoenix would have had $350 million for a community foundation,...this way, it gets nothing, and local healthcare still ends up under the umbrella of an out-of-state company."[35] In July 1997, Louisiana enacted a law to regulate all nonprofit conversions, whether the potential buyer is a for-profit or a nonprofit entity.

Policymakers also must decide whether a nonprofit health plan that wants to become a mutual insurer should be considered a conversion subject to state regulatory oversight. Mutualization may be the first step a nonprofit takes toward becoming a for-profit. However, after mutualization occurs, the ability of the state to require the set-aside of charitable assets is more difficult because a mutual benefit company may not be considered a "charitable organization."[36]

Question 4: Which type of transaction, with regard to ownership status of the buying and selling entity, should be regulated? These transactions could include: (1) the merger, conversion, or transfer of assets of a nonprofit entity into a for-profit entity; (2) the merger, conversion, or transfer of assets of a nonprofit entity into a mutual benefit entity; and (3) the merger or transfer of assets of a nonprofit entity into another nonprofit entity.

D. Who the Regulatory Authority Should Be

Once the decision has been made to regulate nonprofit conversions, the next issue becomes which government agency is best equipped to oversee the process. The answer might depend on which nonprofit entities are to be regulated. For example, if only hospital regulation is sought, that authority may fall with the Department of Health and Mental Hygiene, which currently has regulatory oversight over hospital rates, quality of care, and number of beds.

In many states, state attorneys general have had oversight responsibility for monitoring the changes of mission and dissolution of charitable trusts.[37] In the case of a nonprofit health insurance company, the state insurance commissioner usually has some oversight jurisdiction as well, typically focusing on how the converted entity will meet policyholder obligations and remain financially solvent. Some attorneys general have used the common law charitable trust doctrine to assure that the assets of a

---

[35] "Communities Strike Back," Modern Health Care (April 28, 1997), p. 32.

[36] Patricia Butler, Profit and the Public Interest, p. 19.

[37] Ibid., p. 19.

converting charitable entity are used consistently with the charitable purposes specified in the charitable trust or with public purposes. However, without precise statutory guidance, it is unclear to what extent an attorney general's regulatory power extends to a nonprofit charitable organization. "Whether charitable trust principles will apply to a charitable corporation in a given case will depend upon the facts at hand and the applicable jurisdiction."[38] Another common law doctrine, known as the *cy pres* doctrine, requires the assets of a charitable trust to be transferred to an organization engaged in activities similar to those of the dissolving/converting entity.

Legislation governing conversions has varied depending on the state regulatory structure and the entities that are converting. Nebraska requires converting hospitals to apply to and get approval from the Department of Health and the Attorney General (AG). California requires the Department of Corporations (the state insurance regulatory) to oversee the conversion of nonprofit health plans, while nonprofit hospital conversions must be approved by the Attorney General. Other states have given the Attorney General primary responsibility while requiring consultation with other appropriate agencies. Current law in Maryland is discussed in the Appendix.

Question 5: Which state agency or agencies should be charged with the regulation of nonprofit conversions? Different health care entities could be overseen by different regulators or by a single regulator acting with the consultation or review of other agencies.

Question 6: Should private parties be given authority to enforce conversion statutes or charitable trust obligations if the mandated regulatory agency fails to do so? These parties could include policyholders, potential beneficiaries of the charitable trust, or members of the general community.[39]

E. What Should Be Included in the Regulatory Process?

The structure of the regulatory process and the authority which is given to the regulator is a crucial piece of conversion legislation. By having an established process on which a nonprofit considering conversion can rely, the uncertainty and expense of potential litigation can be averted. At least three states, Michigan, Missouri, and Ohio, have needed to utilize the courts in order to intervene in recent conversion cases.[40] A well-defined process also guarantees advance notice of the conversion, ensures that all required documents are submitted to the regulator, and establishes set time frames within

---

[38] Michael W. Peregrine, "Charitable Trust Laws and the Evolving Nature of the Nonprofit Hospital Corporation," Journal of Health and Hospital Law (Vol. 30, No. 1, March 1997), p. 12.

[39] Patricia Butler, Profit and the Public Interest, p. 20.

[40] Donald Shriber, "State Experience in Regulating A Changing Health Care System," Health Affairs (Vol. 16, Number 2, March/April 1997), pp. 61-64.

which the review and decision process must occur. "A regulatory process enables industry leaders and NFP [not-for-profit] board members to have clearer expectations of requirements to be met and time frames and costs to be anticipated in order to complete a prospective conversion."[41]

Time Frames

All states that have enacted conversion legislation have required that advance notice be given to the regulators so that they can inform the public of the conversion and take meaningful steps to ensure that the conversion follows all statutory requirements. An important reason for timely notice is that, if a regulator is going to intervene in a conversion, it is less disruptive to do so early in the process. Early intervention avoids wasted time and effort that may have been expended by the health care entities, permits sufficient time to perform the review, deters potential conflicts of interest, and strengthens the chances of a cooperative relationship between the regulator and the converting entity. A number of states have experienced problems in the absence of timely notification requirements as the regulator learns of the conversion after the fact.

A requirement that the regulator make an approval or denial decision within a set time period is also an important aspect of providing greater certainty within the conversion process. Rhode Island enacted legislation that requires a 180-day time frame for review by the regulatory agency.

Question 7: How many days before an intended conversion should a nonprofit entity give notice to the state regulator? California and Virginia require a 60-day notice; Nebraska requires 30 days, while Georgia requires 90 days.

Question 8a: Should there be a specified time frame within which a regulator must approve or reject the request to convert? Colorado requires a regulatory decision within 60 days after completion of a public hearing. California's Attorney General must consent to, give conditional consent to, or not consent to the transaction within 60 days of written notice from the converting entity; the time period may be extended for an additional 45 days.

Question 8b: Should a regulator's failure to meet that requirement mean an automatic approval?

Question 8c: Should the response from the regulator be in writing?

---

[41] David Shactman and Andrea Fishman, "State Regulation of Health Industry Conversions from Not-For-Profit to For Profit Status" (December 30, 1996), p. 8.

Public Disclosure

Another important aspect of nonprofit conversions is the issue of public disclosure of the pending transaction. Because these transactions involve public assets potentially in the hundreds of millions of dollars, the process of review should be at least partially, if not fully, done publicly. The American Hospital Association has stated that the need for open communication with the community is the best method to combat the fear of the unknown which can be the single largest obstruction to a successful transaction.[42] One of the main objectives of recently enacted conversion laws is to bring these proposed transactions to public attention; it is important that the public's needs and expectations of the buyer become known.

A dilemma in the past for the community has been that, many times, negotiations have been performed secretly and the public was uninformed until after the deal had been completed. Often this secrecy led to the undervaluation of the nonprofit's assets, conflicts of interests between the negotiators, and the inability of the regulator or the community to intervene in a timely manner. Parties to these transactions often argue for secrecy in order to not jeopardize the deal. However, according to Charles Burson, the Tennessee Attorney General, the privacy and confidentiality concerns have become outweighed by the public's need to have confidence in the way the deal was done and the integrity of the deal.[43]

Consumer representatives argue that access to the underlying documents in a transaction is the single most important element for promoting public involvement.[44] Consumers Union argues that public disclosure of a transaction agreement can help trigger a market response by possibly generating higher or more advantageous bids. These alternative bids can serve to reveal the true market value of a nonprofit entity.[45]

The National Association of Attorneys General has issued guidelines for written disclosure of the transactions and public involvement. Proposed legislation in most states includes provisions to require that the terms of a transaction are fully disclosed to the public. California requires the regulating entity to make public all records pertaining to the sale price, the value of assets, the amount going to the charitable trust, any payments

---

[42] "AHA Unveils Guidelines for Changes in Health System Ownership or Control," BNA's Health Care Policy Report (7/28/97), p. 1191.

[43] "Conversion of Not-For-Profit Hospitals," BNA's Health Care Policy Report (8/19/96), p. 1355.

[44] Donald Shriber, "Conversions of Nonprofit Hospitals and Health Plans: Regulating a Changing Health Care System" (draft paper presented at the "Changes in the Not-for-Profit Status of Health Care Organizations" Conference, Washington, DC, Oct. 30-31, 1996), p.53.

[45] Judith Bell, et al., "The Preservation and Protection of Charitable Health Care Assets" (draft paper presented at the "Changes in the Not-for-Profit Status of Health Care Organizations" Conference, Washington, DC, Oct. 30-31, 1996), p. 13.

to officers, and many other details. In California, Colorado, and Nebraska, the acquisition application and all related documents are considered public records. Other information that could be publicly disclosed would be any governing arrangements, both between a nonprofit and a for-profit in the case of a joint venture and also within any charitable trust created from nonprofit assets, and the prospective use of the sales proceeds.

Most states have public records laws pertaining to documents in the hands of public officials, but they generally allow much leeway for the regulator to decide what information is privileged. Without specific statutory authority to make transaction records public, usually an Attorney General's investigatory files or proprietary information are exempt from disclosure.[46] California permits the Attorney General to decide which items are privileged by law from disclosure; these would include trade secrets, patient information, employment records, business projections, tort suit litigation, and reserves.

Question 9: What aspects of the conversion deal should be publicly disclosed? These could include the details of the transaction, the proposed purchase price, governing arrangements, the value of the nonprofit assets, the amount going to a charitable trust, and conflicts of interest. Legislation could also stipulate that all records are public except certain items that have been indicated statutorily.

Question 10: How much discretion should be given to the regulator to determine what is privileged? Legislation could give the regulator that decision-making ability or it could specify certain proprietary information.

Public Participation

Closely related to the public disclosure aspect of a conversion is the issue of determining how the public should participate in the transaction process. Public participation in the regulatory oversight of conversion transactions is desirable for several reasons. Each transaction could affect many "publics," including potential beneficiaries of the charitable trust, a health plan's policyholders, a hospital's or health plan's employees, different constituencies of a nonprofit hospital's services, and the "general public" or surrounding community.[47] These diverse groups may have differing ideas about the proposed transaction, and participation through a public hearing process may be the most efficient method for alternative points of view to be heard. The lack of public hearings can create the appearance of a potential conflict of interest between the negotiating parties. Public scrutiny also can encourage regulators to regard these transactions carefully and fairly. Another potential benefit can be gained from local and national groups who have cultivated certain technical expertise with regard to asset

---

[46] Patricia Butler, Profit and the Public Interest, p. 21.

[47] Ibid., p. 21.

valuation or distribution that can be utilized by regulators. In addition, as noted above, public hearings may encourage bids for the nonprofit entity that are higher or more advantageous than the original sale price.

Without specific statutory conversion laws, attorneys general or insurance commissioners generally can rely on their broad authority to hold hearings on issues pertaining to these transactions. Nebraska's new conversion law requires the regulator to "hold a public hearing in which any person may file written comments and exhibits or appear and make a statement."[48] Colorado requires its Insurance Commissioner to hold a public hearing within 60 days of publishing notice of the hearing.
The following questions will assume that some sort of public hearing is desirable.

Question 11a: Should the public notice be posted a specific number of days in advance of the public hearing(s)? Under California law, at least 45 days before conducting public hearings, written notice of the hearing is required. In Colorado, within 30 days of filing a conversion application, the converting entity must publish notice once a week for three weeks and submit proof of publication to the Insurance Commissioner.

Question 11b: Should a public hearing be required a specific number of days in advance of the planned transaction date? Arizona requires a public hearing on the intended transaction no less than 10 days after the first publication of the notice and no less than 10 days before the intended transaction.[49]

Question 11c: Should the public notice include a summary description of the transaction?

Question 12: Should there be a requirement that public records be made available a specific number of days before a public hearing?

Question 13: What type of hearing is desired? Hearings can be formal (quasi-judicial) or informal (similar to a legislative hearing). Written comments could be required from interested parties. Written responses to public comments could be required of the regulator and/or, when appropriate, from any of the parties to the conversion.

Question 14a: Who has standing to be considered an interested party? The regulator could be given discretionary authority on this issue, or it could be specified statutorily. Generally, under charitable trust law, an Attorney General has the authority to determine which parties can intervene. Under the California hospital conversion law, a party must establish a direct interest in the proceedings in order to receive standing to intervene in court.[50]

---

[48] Nebraska: Section 5 of the Nonprofit Hospital Sale Act (Leg. Bill 1188 [1996]).

[49] Arizona: Section 10-2402(b) of the Arizona Revised Statutes (Ch. 73 [1997]).

[50] Donald Shriber, "Conversions of Nonprofit Hospitals," p. 56.

Question 14b: Do interested parties have a right to appeal the regulator's decision? Connecticut has given all interested parties, from community health centers to unions to hospital trustees, standing to intervene in transaction proceedings.[51]

Question 14c: Is the appeal to a court or an administrative agency?

Question 15: Should an informal review process be available before public review?[52] It may be in the best interest of all parties concerned with a conversion to first have informal discussions with the state regulator. The discussions' purpose would be to clarify whether a proposed transaction would be considered a conversion or to be certain as to what actions on the part of the parties to the conversion might be legally required or may be controversial. Precedent for such discussions occurs under antitrust enforcement.

Additional Regulatory Powers

Two other questions about additional regulatory powers should be considered.

Question 16: Should the regulator have subpoena power?

Question 17: Should the regulator have waiver authority? Many times a regulatory agency has the ability to waive certain requirements that are statutorily mandated. In the case of nonprofit conversions, this discretionary power could include the ability to provide an expedited process, or waive some aspects of the review under certain circumstances, for example if the transfer of assets does not involve a substantial amount of the nonprofit's assets.[53]

F. Is the Conversion Subject to Approval or Review Only?

State authority over conversions can follow two directions. First, and more prevalently, a regulating agency must give its consent to the conversion in order for it to proceed; California is an example of a state with a consent requirement. In addition, California, Nebraska, and Kansas are examples of states that have given authority to regulators to stop or amend the terms of a conversion if it would not be beneficial to the community.[54] Other states such as Georgia, Arizona, and Virginia require their attorneys

---

[51] Connecticut Public Act No. 97-188 (HB 5645 [1997]).

[52] Patricia Butler, Profit and the Public Interest, p. 20.

[53] "Restructurings of Nonprofit Health Care Organizations," Issue Paper, Federation of American Health Systems, p. 4.

[54] California: Section 5917 of the Corporations Code (A 3101 [1996]); Nebraska: Section 8 of the Nonprofit Hospital Sales Act (Leg. Bill 1188 [1996]); Kansas: K.S.A. 1996 Supp. 40-3304(d)(1)(c).

general to "review" these transactions but an affirmative action must be initiated to stop a conversion.[55]

Question 18: Should a conversion transaction require regulatory consent or conditional consent to proceed or should only review requirements be mandated thus necessitating an affirmative action on the part of a regulator in order to stop the transaction?

G. Requirements For Regulatory Approval

If policymakers decide that regulatory approval should be required in order for a conversion to occur, there are at least four main areas on which a regulator should focus. A regulator must be concerned with the protection of the nonprofit entity's assets; the valuation of the nonprofit; the consideration of the transaction's impact on community services and local control; and the appropriate disposition of the charitable assets in a charitable trust or some other successor organization.

Safeguarding Nonprofit Assets

In order to safeguard a nonprofit's assets during a transaction, most states have enacted conversion legislation directing a regulator to review the terms of the transaction and the process in which the parties have participated. Several provisions have been common among these requirements: due diligence on the part of the nonprofit entity; the disclosure of any conflicts of interest; and a prohibition on any private inurement.

A regulator may oversee the process by which a nonprofit entity exercised due diligence in deciding to convert with regard to negotiating the terms and conditions of the transaction. The fiduciary duty of a nonprofit board requires that all competing offers be considered; a regulator could require a written report explaining the grounds for the choice of purchaser. Tennessee requires the regulator to focus on the fiduciary duties and obligations of corporate governance including due diligence by the nonprofit and its board by being informed on all aspects of the transaction, and by assuring that fair market value is received. A regulator also may want to guarantee that the terms and conditions are fair and reasonable to all interested parties (see section above on Public Participation). One consumer advocacy group believes that a major focus of the regulatory review should include a determination whether a transaction exposes the nonprofit's assets to improper economic risk associated with any future operations of the for-profit buyer especially if a joint venture is involved.[56]

---

[55] Carolyn Jacobs, "Public to Private Hospital Conversions," Mid-Atlantic Health Law Topics (Vol. 12, No. 3, Fall 1997), p. 2.

[56] When Your Community Hospital Goes Up for Sale, Volunteer Trustees Foundation for Research and Education (1996), p. 17.

A regulator must be cognizant of any conflicts of interest that may exist between the selling entity and the buying entity in order to determine if the transaction is in the best interest of all parties involved. A major concern should arise if the members of the board of the nonprofit entity, who are making recommendations about the transaction, have any conflicts of interest in the form of direct or indirect economic interests in the transaction, including offers of compensation, or the promises or discussions about future employment with the resulting for-profit entity or charitable trust. All state conversion legislation enacted to date requires that potential conflicts of interest be disclosed. The Nebraska law requires the Attorney General to consider "whether conflict of interest was disclosed, including, but not limited to, conflicts of interest related to board members of, executives of, and experts retained by the seller, purchaser, or parties to the acquisition..."[57]

Related to concerns of conflicts of interest is the issue of private inurement. The Internal Revenue Code and the *cy pres* doctrine require that the proceeds from the sale of charitable assets remain in the "charitable stream." The assets are to continue to serve the public benefit and not go to owners, stockholders, or any directors, officers, or key staff of the converting entity. The California law requires that, to guarantee that the transaction decision is made in the public interest, it must be clear that no personal benefit is received by key nonprofit officials.[58] In the past, lucrative employment contracts for hospital management have resulted from some nonprofit hospital sales.

IRC Section 501(c)(3) also requires that "no part of the net earning (of the exempt organization) inures to the benefit of any shareholder or individual." A violation of the private inurement prohibition would lead to the loss of federal tax-exempt status.[59] Concerned that the revocation of tax exempt status might be inadequate to deal with such actions, Congress enacted an intermediate sanctions provision (IRC Section 4958) in the 1996 Taxpayer Bill of Rights. This section imposes a penalty excise tax on Section 501(c)(3) and Section 501(c)(4) insiders who engage in "excess benefit transactions". The list of "excess benefit transactions" includes: (1) non-fair market value transactions; (2) unreasonable compensation; and (3) revenue sharing arrangements that violate the private inurement prohibition. The excess penalty tax is imposed on the individuals who benefit from such transactions and the organization manager who knowingly engage in such transactions.[60]

---

[57] Nebraska: Section 7(4) of the Nonprofit Hospital Sale Act (Leg. Bill 1188 [1996]).

[58] Isenberg and Battson, "Sales and Other Transfers," p. 13.

[59] William M. Todd, "The Fiduciary Duties Applicable to the Board of Trustees of a Nonprofit Corporation" (presentation to the Ohio Attorney General's Symposium on Nonprofit Health Care Conversions in Columbus, Ohio, April 1997), p. 7.

[60] Ibid., p.8.

Legislation could also include some other requirements that a regulator would have to consider before approving the transaction: whether the conversion complies with all other statutory requirements for corporations, if applicable; and whether a first right of refusal exists to repurchase the assets by a successor nonprofit entity if the resulting for-profit entity is subsequently sold to another entity.[61]

Question 20: Which of these items should be required for a regulator to approve a conversion transaction?: (1) due diligence by the nonprofit in selecting a buyer and negotiating the terms and conditions of the conversion; (2) the terms and conditions are fair and reasonable to all interested parties; (3) conflict of interest disclosure or prohibition; (4) the prohibition of private inurement or benefits; (5) if applicable, all statutory corporate requirements; and (6) any other requirements for approval.

Valuation of a Nonprofit's Assets

One of the most important, yet most controversial, aspects of protecting a nonprofit's assets during a conversion is the valuation of those assets. In order to determine how much should be turned over to a successor organization (e.g., a charitable trust), an accurate assessment of a converting nonprofit's worth must be performed. If the nonprofit is undervalued, the difference will eventually inure to private individuals at the expense of the community. There is a history of conversions where, especially during the 1980s, nonprofit entities were sold for much less than their fair market value and knowledgeable insiders were able to profit tremendously. In some cases, the entity was simply grossly undervalued before being sold; in other cases, especially in joint ventures, the nonprofit transferred only its profitable business to the for-profit partner for less than its proportional value. It has been estimated that past health industry conversions have resulted in the loss of billions of dollars of charitable assets that should have been committed to public use.[62] One example of a narrowly-avoided undervaluation is the California Wellpoint conversion where its initial valuation of $150 million increased to over $3 billion by the time the transaction was approved.

No consensus exists on the appropriate valuation method. Many different ways to value a nonprofit's assets have been proposed. A financial consultant who has been involved in many health entity transactions has suggested that valuation "should be viewed as a negotiation in which a wide range of acceptable values can be determined, not as an absolute value determination...".[63] On the other hand, Consumers Union believes that "the valuation and oversight process [should] ensure that the highest

[61] Nebraska: Section 7(9) of the Nonprofit Hospital Sale Act; Rhode Island: Section 23-17.14-7(10) of the General Law entitled "Health and Safety" (H.6668 [1997]).

[62] Shactman and Fishman, "State Regulation," p. 7

[63] "Valuation of Nonprofit Plans Must Be Negotiated, Speaker Says," BNA's Managed Care Report (6/12/96), p. 577.

possible value is paid for the nonprofit hospital, a public charitable asset, not just a value within a 'reasonable' range."[64] Many different valuation techniques are possible including the use of: (1) the assessment of both tangible and intangible assets in terms of book and comparative value; (2) multiples of earnings over several years; (3) multi-year cash flow projections utilizing several alternative discount rates; (4) the requirement of bids; (5) an analysis of value, retrospectively, based on the outcome of an initial public offering; or (6) extrapolation from similar recent transactions (there has been some objection to this method as other transactions may be faulty or undervalued and thus should not serve as models).[65]

A number of consumer groups have opposed several methodologies for valuation including: (1) the use of the present value of the entity, which results in undervaluation; (2) the use of only tangible assets; (3) the use of cash flow, which ignores an entity's potential value; and (4) the use of a value of what the entity would be worth on the "open market" which may be difficult to determine if there is no competitive bidding.

Factors such as a "growth premium" if the entity is expected to expand rapidly, or a "controlling premium/minority discount," in the case of joint ventures, should be considered to adjust the purchase price of the entity.[66] Intangible items such as a trademark or corporate logos, name recognition, provider contracts, and subscriber lists should be included in any valuation calculation.

Another important question with regard to valuations is who is paying for them? Most commentaries on valuation agree that they should be done by outside experts who are independent of the parties to the transaction. The Ohio Attorney General has its own in-house accounting staff but, more typically, a regulator would select an independent consultant to determine the value of the nonprofit's operations and assets which can then be compared to the terms of the transaction. Experts in valuation use actuarial, accounting, investment banking, tax, insurance, and economic principles to arrive at a value.[67] Consumer advocates have called for the valuation report to be detailed, in writing, and made public.[68] Conflict of interest disclosures also should apply to any relationship between a valuation expert and either the buying or selling entity.

---

[64] Judith Bell, "Preservation and Protection," p. 22.

[65] Patricia Butler, Profit and the Public Interest, p. 23; "Valuation of Nonprofit Plans Must Be Negotiated," p. 577; Judith Bell, "Preservation and Protection," pp. 22-23; Donald Shriber, "Conversions of Nonprofit Hospitals," p. 35.

[66] "Valuation of Nonprofit Plans Must Be Negotiated," p. 577.

[67] Donald Shriber, "Conversions of Nonprofit Hospitals," p. 33.

[68] When Your Community Hospital Goes Up for Sale, p. 16.

Question 21a: Should approval of a transaction be based on the process of the valuation, the outcome of the valuation, or both? Although the California law requires that the value is based on "fair market" standards, the Attorney General's office asserts that it more closely follows the process approach. This approach requires the regulator to determine if the converting entity had followed certain steps that a prudent seller would take; if so, then by definition, a fair market price had been reached.[69] Other states use the outcome approach which compares an independent valuation report to the terms of the transaction.

Question 21b: Should certain standards be required for approval of the outcome of the valuation or should that determination be left to the regulator's discretion? Tennessee requires the transaction to be based on a fair and reasonable price with no improper post-transaction obligations. The Colorado Blue Cross legislation requires the Insurance Commissioner to "determine the fair market value of the corporation at the time of conversion, determined as if it had voting stock outstanding and one hundred percent of its stock were freely transferable and available for purchase without restrictions. Consideration shall be given to market value, investment or earnings value, net asset value, and a control premium, if any."[70]

Question 22a: How should the valuation be done? Legislation could require that the converting nonprofit present a valuation report to the regulator and the regulator would determine if the report had been performed by an independent consultant. On the other hand, the regulator could hire an independent consultant and use those results to compare to the terms of the transaction.

Question 22b: If the regulator hires an independent consultant , who pays for that service? (See section below on Expert Assistance).

Question 23: Should a written valuation report be included in the public disclosure and public hearing process?

Community Impact

The third main area on which a regulator should concentrate when considering the approval of a nonprofit conversion is the community impact of the transaction. There is a dual issue of whether the community continues to have access to the health care services it requires and whether the community retains an appropriate level of local control over its health care delivery system.[71] Proponents of conversions argue that for-

---

[69] Donald Shriber, "Conversions of Nonprofit Hospitals," p. 34.

[70] Colorado: Section 10-16-324(4)(e)(I)(b) of the Colorado Revised Statutes.

[71] Shactman and Fishman, "State Regulation," p. 8.

profit entities provide needed capital, allow the creation of charitable trusts, and, through cost-effective management and market-driven competition, can bring down the cost of health care services. Opponents reply that for-profit entities provide less community benefits and "cost-effectiveness" is really only achieved through decreased service and quality.

Hospitals have traditionally provided services that have been historically unprofitable. These services include trauma and burn units; perinatal intensive care units; and care for the chronically ill, AIDS patients, and the uninsured.[72] Conversion opponents also have expressed skepticism in the ability of for-profit hospitals to adequately provide community benefits such as teaching, research, and public health outreach. The question may be raised whether a successor organization, such as a charitable trust, can replace what the nonprofit entity had been providing on an ongoing basis? The sale of a nonprofit hospital to a for-profit entity can lead to the loss of community control and accountability which translates into the community losing its ability to have any voice in decisions about local health care. Other concerns have been raised about the diversion of profits going to out-of-state coffers.

Consumers Union has identified a number of questions that a regulator should consider with regard to the community impact of a proposed conversion.[73] These include:

- What sorts of community services has the nonprofit been providing?
- Which of these services will the new entity continue to provide and which will be lost?
- Is the for-profit committing to the provision of vital services only for a limited time period?
- What will happen when the time period ends?
- Does the community have other nonprofits or public institutions that can fill in any gaps in community services left uncovered by the proposed transaction?
- Will the resulting charitable organization be expected to pay for services formerly provided by the nonprofit?

Question 24: Should the legislation include specific questions concerning the community impact of a proposed transaction or should it be left to discretion of the regulator?

Question 25: Should public hearings be held to specifically address community impact concerns?

---

[72] "State Oversight of Hospital and Health Plan Conversions," State Initiatives in Health Care Reform (Number 21, February 1997), p. 2.

[73] Judith Bell, "Preservation and Protection," p. 11.

Question 26a: Should the regulator have the ability to impose conditions on the post-conversion for-profit entity or on the nonprofit (if it continues to exist) for the transaction to be approved? Under the Nebraska hospital conversion law, the buyer must continue to serve disadvantaged and uninsured individuals. The Massachusetts Attorney General has required in some conversion cases that the for-profit hospital continue to maintain an open emergency department.[74]

Question 26b: If conditions are imposed, are there inspection and enforcement mechanisms? (See section below on Subsequent Monitoring and Compliance).

Disposition of Assets and Charitable Trusts

The Internal Revenue Code requires that a charity's assets be dedicated irrevocably to charitable purposes. Thus, in a sale or conversion of a nonprofit health entity, the proceeds must be transferred to another nonprofit entity. The receiving entity could be a local, state, or federal government, as well as another tax-exempt organization such as a trust or foundation. Some states require the receiving nonprofit organization to be related as closely as possible to the purpose for which the acquired or converting health entity was originally established (the "*cy pres*" doctrine).

A number of issues arise with regard to the type of trust, the trust's structure, the use of the assets, the requirements governing its board, and its accountability. The first question is whether to create a new trust or use an existing foundation. In addition, it is possible to direct all of the assets into a large centralized foundation to serve the entire state or a specific region or, allow the assets to remain in the community where the pre-conversion nonprofit had existed. The underlying guiding principle would be to find the best vehicle to ensure that the funds are used for their desired purpose.

The structure of the charitable trust is important. Legislation could define the trust's mission, tax status, and board membership and selection process. The trust could have the same or different purpose as the pre-conversion nonprofit. Under common law, a successor entity must adopt a purpose as close as possible to the original mission of the converting entity; however, statutory language can override common law. A charitable trust could be given a broader or a narrower mission than the converting entity.

Types of charities into which a successor entity could be organized include a public foundation, a private 501(c)(3) foundation, and a social welfare organization, established under IRC Section 501(c)(4). Each of these types of charitable organizations have varying levels of restrictions with regard to lobbying, business ownership capacity, asset payout obligations, tax requirements, and conflict of interest and reporting rules. Most states have required the successor charitable trust to be formed as a 501(c)(3).

---

[74] Butler, Patricia, Profit and the Public Interest, p. 22.

However, because 501(c)(3) foundations are prohibited from holding more than twenty percent of any single business, California allows the temporary use of a 501(c)(4) organization which has unlimited stock ownership capacity. California imposes restrictions on the temporary 501(c)(4) foundation which are similar to those required for 501(c)(3) organizations.

It is important that the new foundation board, management, and staff be independent of and unaffiliated with the converting nonprofit and the successor for-profit so as to avoid conflict of interest issues. Under California law, executives and officers of the converting entity may not work for the resulting foundation. There have been conversions in the past where foundation board members were also members of the converted for-profit entity. Tennessee's proposed legislation prohibits any pre-commitment of foundation funds and prohibits any agreements requiring any portion of the charitable trust's assets to return to the for-profit entity. Legislation can prescribe the number of board members, how they are selected, any qualifications required for board membership, and either specific or generic (e.g., "comparable to similar organizations...", "ordinary and reasonable") language to guide compensation levels for board members and staff.

Accountability both before and after the foundation of the charitable trust is an issue policymakers should address. Conversion legislation in a number of states requires public debate and discussion over the proper use of the charitable assets. Consumers Union suggests that the plan for the use of the charitable assets be submitted to the regulator for approval, and that there is a public process. After the foundation has been established, the regulator may want to require annual reports or public hearings in order to maintain oversight of the ongoing mission of the trust. In order to promote access to the foundation by the community, legislators may want to include a requirement for an advisory committee to the board; the committee could be comprised of community members reflecting its demographic and geographic characteristics.

It should be noted that transactions between nonprofits do not raise issues relating to the disposition of assets. This is because in such transactions, the acquiring nonprofit picks up the liabilities and obligations of the acquired nonprofit, as well as the assets. No money needs to be paid to the community, or other nonprofit organization, as long as the acquirer is also a nonprofit tax-exempt organization. Although in these situations, the assets of the acquired nonprofit are still subject to the constraints of continuing its charitable purpose.

Question 27: What type of entity should be the recipient of the proceeds? That entity could be a local, state, or federal government, or a charitable foundation. In the conversion of Trigon Blue Cross Blue Shield of Virginia (a nonprofit mutual company), the value of the company's tax-exemption over a specified time period, $175 million, was transferred to the state's general fund. However, in the conversion of Blue Cross of

California, $3.3 billion was distributed to two newly-created nonprofit foundation. Alternatively, the assets could be transferred to an existing nonprofit organization, such as the transfer of approximately $600,000 from the conversion of Consumer Dental Care in Maryland to the University of Maryland Dental School. Chapter 180 of the Acts of 1997 (Senate Bill 478) created the nonprofit charitable Maryland Health Care Foundation.[75] This foundation or other local nonprofit foundations could also be the recipient of the proceeds.

Question 28a: If the assets are to go to a charitable foundation, should a new or existing foundation be the recipient of the converting entity's assets?

Question 28b: Would a centralized or localized foundation better serve the needs of the community?

Question 29: What should be the mission of the charitable trust? Legislation might want to define the acceptable parameters of a trust's activities. The use of the assets could be allowed to be flexible or dedicated to specific purposes.

Question 30: What type of structure should the foundation have? Again, the entity could be formed as a public foundation, a private 501(c)(3) foundation, or a 501(c)(4) social welfare organization.

Question 31: What types of requirements should be considered with regard to the control of the foundation? These issues would include board member conflict of interest prohibitions, prohibitions on grants benefitting the foundation board or the successor organization; and the disallowance of any pre-commitment of foundation funds.

Question 32: How tightly should the legislation control aspects of the board membership, selection process, qualifications, and compensation?

Question 33a: Should the proper use of the charitable assets be subject to public debate and should the plan only be allowed after regulatory approval?

Question 33b: What sort of accountability measures should be required after the formation of the foundation? These measures could include an advisory committee to the board, and any number of annual reports.

---

[75] Chapter 180 (1997) establishes a statewide, nonprofit foundation to solicit and receive moneys and in-kind contributions to support programs that expand the availability of health care services for uninsured Marylanders. The foundation is empowered to provide grants to: (1) promote public awareness; (2) expand access for the uninsured; and (3) subsidize health insurance coverage for the uninsured.

H. Expert Assistance

Many times, regulators do not have the money, personnel, or expertise to adequately oversee these conversions. A number of state conversion laws require either the converting nonprofit or the for-profit buyer to pay for the cost of any experts which the regulator deems necessary. The reasonable direct costs of evaluating a conversion application may also be assessed in some cases. Colorado allows the cost of hiring experts to be charged to the converting entity. In California, the regulator is given the broad authority to charge all reasonable agency review costs to the applicant. Massachusetts is considering charging the cost to the for-profit purchaser in order to preserve the nonprofit's assets.[76]

Question 34a: Should the regulator be able to charge for the cost of expert assistance?

Question 34b: If so, which entity should be responsible for those costs? Either the converting entity or the purchasing entity could be charged. One consideration is how to handle a transaction when a number of purchasers are vying for one particular nonprofit.

Question 35: For what type of activities could a regulator hire experts and be reimbursed? These activities could include: valuation assessment; processing applications and analyzing the public interest issues; determining the impact on community health services; overseeing the foundation of the charitable trusts; and any independent auditing for compliance and enforcement purposes.

I. Subsequent Monitoring and Compliance

Following a conversion, policymakers may want to ensure compliance and monitor the parties involved in the transaction. Legislation could include oversight requirements to scrutinize retrospective compliance with any terms of the transaction on the part of the for-profit entity as well as required compliance with any conditions set by the regulator during the approval process. It also may be important to monitor the charitable trust in order to see that it is fulfilling its stated mission. A more general issue is whether community health services should be observed over time in order to note any changes following a transaction.

Question 36: Should there be retrospective oversight to ensure compliance by the for-profit entity?

Question 37: Should the charitable trust be monitored over time? The conditions which might be considered could include the prohibition on private inurement and conflicts of interest; the independence of the trust; and the fulfillment of its mission.

---

[76] Ibid., p. 26.

Question 38: Should some level of monitoring of the impact on community health services be required?

Question 39: Should the regulator have enforcement mechanisms? These tools might include the ability to perform audits, levy fines, or revoke licenses.

VII. Conclusion

Relative to California, Florida, and other parts of the country, there have been relatively few nonprofit health care entities converting to for-profit in Maryland. There have been, however, an increasing number of mergers and business arrangements between hospitals and other health care entities. In addition, Blue Cross and Blue Shield of Maryland, a nonprofit health service plan, has submitted a proposal to engage in a business combination agreement with Group Hospitalization and Medical Services, Inc. in Washington, D.C. All these activities bring to bear issues regarding the role of nonprofit health care entities in Maryland and the protection of Maryland's charitable assets.

Maryland's regulatory structure has in place a process to review mergers, acquisitions, consolidations, and conversions by nonprofit HMOs and health service plans. The review of these transactions fall under the purview of the Insurance Commissioner. In addition, existing law does address, albeit generally, the disposition of assets of a non-stock corporation (which may be applied to a nonprofit health care entity) at dissolution. There is no language in current law, however, that provides a process to review the conversion activities of nonprofit hospitals. In addition, hospital mergers and acquisitions are generally relieved from the CON process.

Given the increasing public concern and scrutiny paid to nonprofit conversion activities around the country, the question of whether or not Maryland's existing regulatory structure provides the appropriate and adequate regulatory oversight is raised. This report provides some guidance in addressing this question and in analyzing legislation regarding nonprofit conversions.

APPENDIX

A. Merger, Consolidation, Acquisition of Health Service Plans and HMOs (including Nonprofits): Title 7 (Insurance Article) and § 19-711 (Health General Article)

Process for Approval

- Any entity that intends to merge, consolidate, acquire, or in any way enter into any agreement that would result in the control of a domestic health insurer, insurance holding company, domestic or foreign health maintenance organization authorized to do business in Maryland must file a statement of intent (Form A) with the Commissioner at least 60 days before the proposed effective date of the transaction. The notification must include:
    - the identity and background information of the "acquirer";
    - fully audited financial information of each "acquiring party";
    - the terms and conditions of the proposed offer;
    - the source and amount of funds used to make the offer;
    - any plans or proposals to liquidate, sell its assets, merge, or make any other major changes to the business or structure of the "acquired" entity;
    - information regarding voting securities, such as ownership, recent purchase, etc. and any agreements with broker-dealers; and
    - "other information necessary or appropriate in the public interest or for the protection of policyholders that the Commissioner requires by regulation."[77]
- In addition, a pre-acquisition notification must be filed at least 30 days before the proposed effective date of the transaction.

Conditions for Approval

A transaction may not be made unless the Commissioner approves the transaction or does not disapprove the transaction.

- The Commissioner has 60 days to approve the transaction.
- The Commissioner may disapprove the transaction if:

[77] Section 7-304(c)(14) of the Maryland Insurance Article.

- the resulting health care entity cannot meet the State licensure requirements;
  - it substantially lessens competition in insurance;
  - the financial condition of the acquiring entity might jeopardize the financial stability of the resulting health care entity; or
  - the interests of the policyholders would be prejudiced, impaired, or not properly protected.

Expert Assistance

The Commissioner may retain attorneys and other experts at the expense of the acquiring entity.

Confidentiality

All materials are confidential and may not be made public unless: (1) the insurer gives prior written consent; or (2) after giving the insurer/HMO an opportunity to be heard, the Commissioner determines it is in the interest of the policyholders or public to make public all or part of the materials.

Sanctions

The Commissioner may impose sanctions for failing to file the appropriate information.

B. Acquisitions and Investments by a Nonprofit Health Service Plan; and Conversions by a Nonprofit, Non-stock Corporation to a For-profit Health Insurer or to a Mutual Health Insurer: Title 14, Subtitle 1, Part V (Insurance Article); Conversion of a Nonprofit HMO to a For-profit HMO: § 19-711.1 (Health General Article)

Process for Approval

- A nonprofit health service plan must submit a statement of proposed action (Form A) for approval to the Commissioner at least 60 days prior to the effective date of the proposed action before the plan may engage in any of the following transactions:
  - the creation, acquisition, or investment to control any affiliate or subsidiary;
  - altering the structure, organization, purpose, or ownership of the plan or its affiliates or subsidiaries; and
  - any investment exceeding $500,000 or any investment in an affiliate or subsidiary

Conditions for Approval

- The nonprofit health service plan or HMO may not engage in the proposed action unless the Commissioner approves the action in writing.
- The Commissioner will approve the plan if:
  - it is equitable to enrollees and shareholders;
  - it is in compliance with the State's Corporations and Associations Article relating to the amendment or reinstatement of charter;
  - it provides that no part of the assets or surplus of the nonprofit health service plan or HMO will inure directly or indirectly to any of its officers or directors;
  - the plan is approved by at least two-thirds of the certificate holders; and
  - it ensures the resulting stock health insurer has sufficient surplus to meet the State's requirements for licensure and provides for the security of certificate holders and policyholders.

Hearing

- At the discretion of the Commissioner, a hearing concerning the proposed transaction may be scheduled.

C. Consolidation, Merger, and Transfer of Assets: §5-207 (Corporations and Associations Article); Dissolution or Forfeiture of Charter: §5-208 (Corporations and Associations Article)

- A non-stock corporation may only consolidate or merge with another non-stock corporation.
- At dissolution, the assets of the corporation must be distributed under a plan to one or more corporations/associations having a similar or analogous purpose, or associated with the corporation.