

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

**By  
Jill R. Horwitz**

**The Hauser Center for Nonprofit Organizations  
The Kennedy School of Government  
Harvard University**

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Jill Horwitz is post-doctoral fellow at the National Bureau of Economic Research. She received her Bachelor of Arts (Northwestern '88), Master of Public Policy (Harvard '94), Juris Doctor (Harvard '97), Ph.D. (Harvard '02). The author would like to thank Benjamin Black, Troyen Brennan, Perry Craft, David Cutler, Einer Elhauge, Richard Frank, Andrew Hyams, Anita Krug, Michael Leotta, Joseph Newhouse, Edward Parson, Janet Spaulding-Ruddell, and Alan Weil for comments on earlier drafts. The views expressed in this paper are those of the author. Comments should be sent via e-mail to [jill\\_horwitz@post.harvard.edu](mailto:jill_horwitz@post.harvard.edu).

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### **Abstract**

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

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

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

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## I. Introduction

While most American hospitals are primarily organized as not-for-profit, tax-exempt corporations, the for-profit form is increasingly common. Between 1970 and 1995, 330 (about 7 percent) out of approximately 5,000 not-for-profit hospitals have converted to for-profit corporate form.<sup>1</sup> The recent history of conversions raises important questions such as why hospitals convert, and which corporate form is best and for whom. This paper addresses a separate, though related, set of questions by focusing on the oversight of conversions. Understanding oversight is important because regardless of whether the not-for-profit or for-profit form is best, effective regulation of hospital conversions is needed to protect the public's interest in two important goods that hospitals control: health and money.

This paper argues that the current oversight regime does not adequately protect public and charitable interests in either good. Without adequate oversight, assets meant for charitable purposes have been diverted to the for-profit pockets of buyers or executives of the former not-for-profits. Such transfers are a form of theft from the donors and intended beneficiaries of corporate charities. Further, inadequate attention to conversions may also prevent resource transfers from acute hospital care to more effective public health interventions.

After this introduction, Part II of the paper provides background on the corporate organization of hospitals and conversions. Part III reports that attorneys general are often the only officials with authority to conduct comprehensive reviews of conversions before they occur. Their legal jurisdiction to oversee conversions is grounded in two doctrinal areas, trust and corporations law.

As part IV discusses, in some states there is no effective regulation of

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<sup>1</sup> Cutler, David M. & Jill R. Horwitz, *Converting Hospitals from Not-for-profit Status: Why and What Effects?*, (National Bureau of Econ. Research Working Paper Series No. 6672, August 1998).

conversions. Sometimes no entity has regulatory authority; sometimes the attorney general suffers from a lack of resources or interest, and sometimes she does not receive sufficient notice of conversions to regulate effectively. In these states, hospitals can be, and have been, converted without a reliable public accounting. In most states, however, attorneys general hold and exercise legal authority to oversee conversions. Even in these states, attorneys general have difficulty identifying and valuing the assets of not-for-profit hospitals.

Where it does have bite, the current oversight regime precludes the consideration of health policy issues, and often hinders the advancement of health policy goals. Part V demonstrates that although conversions may cause the potential loss of the redistributive capacities of not-for-profit hospitals and local control over health care decisions, relevant statutes prohibit attorneys general from considering these issues. Furthermore, because charitable trust and corporations doctrines focus on conservation of purposes and assets, conversion proceeds must be used for the same or similar purposes as the converting not-for-profit hospital. Yet government health care policy, medical research, and health policy scholarship suggest that there has been over-investment in hospitals. Thus, a goal of health policy – shifting resources from hospital care to more effective ways of improving health – is systematically thwarted by current conversion law.

Part VI finds that in practice these doctrinal limitations do not constrain all attorneys general. Some attorneys general, for example, have permitted conversion proceeds to create foundations that make grants to non-hospital grantees. To protect the perceived health needs of their communities, other attorneys general leverage their authority to encourage, or even require, for-profit buyers to adopt the charitable activities of sellers. By permitting transfers of proceeds to non-hospital uses, attorneys general may protect the health of communities affected by conversions.

When attorneys general act as health regulators by making substantive health policy decisions driven by contemporary needs, however, they violate the intent of trust and corporations law. Under charitable trust law, charitable funds must be used according to the wishes of the donor, even if shortsighted. Under state corporations laws, when a charity dissolves, its purposes are conserved. By permitting the diversion of charitable assets, attorneys general could undermine donor and public confidence, or

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

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

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

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

#### A. *A Note About Sources and Methods*

The data are drawn from interviews with assistant attorneys general, legislators, regulators, and advocates.<sup>2</sup> Various primary sources were also consulted, including: state

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<sup>2</sup> The interviews were conducted from January to March 1997. See Appendix A for survey instrument and the remaining appendices for interview summaries.

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

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

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

*B. Why study conversions and their oversight?*

First, these transactions raise questions regarding the appropriateness of not-for-profit compared to for-profit corporate organizational status for hospitals. During the early 1900s, approximately half of hospitals were small for-profit organizations, owned by physicians as an adjunct to their practices. Yet by 1965 only approximately 15% of

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<sup>3</sup> See Appendix B. Of the remaining states, deputy attorneys general in four states refused interviews. I did not study the other fourteen states because their attorneys general did not participate in a National Association of Attorneys General conference on conversions in 1996 and, therefore, were likely less interested in and knowledgeable about conversions.

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

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

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

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

<sup>5</sup> CALIFORNIA LEGISLATIVE ASSEMBLY, Assembly Bill 3101, §1(c) (1996).

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

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

<sup>8</sup> Columbia/HCA, *Fact Sheet*, (1996) (on file with author).

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

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

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

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

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

<sup>10</sup> Gray, *supra* note 4 at 7.

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

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

<sup>13</sup> FRANK A. SLOAN ET AL., *HOSPITAL OWNERSHIP AND COST AND QUALITY OF CARE: IS THERE A DIME’S WORTH OF DIFFERENCE?*, (National Bureau of Econ. Research Working Paper Series No. 6706, August 1998).

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

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

## II. Background

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

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

When a hospital organizes, it must file a certificate of incorporation with a state department, which indicates its profit status, identifies its mission, and may limit the scope of authority to deviate from that mission. For example, the Roger Williams Medical Center in Rhode Island incorporated “for the purpose of establishing . . . a hospital and of rendering medical and surgical aid to those in need thereof, and especially for the purpose of assisting such poor and unfortunate persons as are in need of medical and surgical treatment and are unable to pay therefore.”<sup>18</sup> Charitable purposes may not be a perfect indicator of organizational status since for-profit corporations may pursue such goals and specify them in their charters.<sup>19</sup>

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<sup>14</sup> Bloche, *supra* note 12.

<sup>15</sup> JAYENDU PATEL ET AL., CHANGING FORTUNES, HOSPITAL BEHAVIORS, AND OWNERSHIP FORMS (John F. Kennedy School of Gov. - Harvard U., Fac. Res. Working Papers Series No. R94017, 1994).

<sup>16</sup> Richard G. Frank & David S. Salkever, *Nonprofit Organizations in the Health Sector*, 8 J. Econ. Persp. 129, 147 (1994).

<sup>17</sup> This paper does not distinguish between investor and operator owned for-profit hospitals.

<sup>18</sup> Consumers-Union & The Center for Community Health Action, West Virginia: The Conversion of Non-Profit Health Care Organizations into For-Profit Corporations (1996) (conversion guide on file with author).

<sup>19</sup> Frank H. Easterbrook & Daniel R. Fischel, *Contractual Freedom In Corporate Law: Articles & Comments; The Corporate Contract*, 89 Colum. L. Rev. 1416, 1446 (1989) (arguing that managers of for-profit corporations may carry

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

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

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

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

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

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out programs at the expense of profit).

<sup>20</sup> I.R.C. §501(c)(3) (CCH 1995).

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

<sup>22</sup> N.Y. NOT-FOR-PROFIT CORP. LAW §2801-a(e) (McKinney 1996).

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

social needs; and, 4) clinical, the accountability to patients regarding access and medical outcomes.<sup>24</sup>

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

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

#### B. *Why Are Hospitals Converting?*

There are several reasons why not-for-profit hospitals convert to for-profit organizational form.<sup>31</sup> These reasons are related to financial concerns such as need for capital or attempts to increase profits through increased efficiency, defense of corporate

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<sup>24</sup> Larry D. Gamm, *Dimensions of Accountability for Not-for-Profit Hospitals and Health Systems*, 21 *Health Care Mgmt. Rev.* 74, 78 (1996).

<sup>25</sup> Insurance companies have used an additional conversion technique involving first converting to a mutual company (one in which there is no stock and the policy-holders own all the assets, and then converting to a for-profit company. Using this technique, not-for-profit health plans can change forms without conserving their not-for-profit assets because in most states mutual companies owe their assets to members who can be transformed into shareholders. This technique has recently been challenged. *Blue Shield of Missouri v. Angoff*, No. CV196-619CC (Cir. Ct. 1996). While hospitals have not organized as mutual benefit corporations in the past, as the functions of hospitals and insurers blur through entities such as Physician - Hospital Organizations (organizations that link hospitals, physician groups, and other entities in an integrated care system) they may eventually incorporate as mutual benefit corporations. Interview with Susan T. Sherry, Director of the Center for Community Health Action -- Families USA Foundation (Jan. 21, 1997).

<sup>26</sup> Usually the not-for-profit sells its assets to a for-profit entity. The assets can be sold either to outside entities or to individuals associated with the hospital such as managers, trustees, or physicians, generally through leveraged-buyouts. The buyer only assumes the liabilities included in the sale contract.

<sup>27</sup> In a merger the not-for-profit hospital disappears into the for-profit hospital, whose corporate existence continues. The for-profit hospital owns all the assets and liabilities of the not-for-profit hospital.

<sup>28</sup> Assets are transferred to a for-profit subsidiary of the not-for-profit corporation. The not-for-profit may do this independently.

<sup>29</sup> A not-for-profit hospital and a for-profit hospital may transfer assets and liabilities into a new, for-profit corporation. The two hospitals will contract to consolidate at which point the hospitals cease existence.

<sup>30</sup> The term ‘joint ventures’ applies to various structures. Under the most common structure, the not-for-profit hospital transfers assets to a new partnership or limited liability corporation in which it holds a minority investment interest. The for-profit may transfer cash to the new company, and will operate and control the new company. Joint ventures can also be structured so that the for-profit and not-for-profit hospitals jointly own a parent company that holds the hospital assets or a jointly owned operating company.

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

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

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

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<sup>31</sup> See generally CULTER & HORWITZ, *supra* note 1.

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

<sup>33</sup> Michael C. Jensen & William H. Meckling, *Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure*, 3 J. Fin. Econ. 305 (1976) (Although this article deals with for-profit firms, equivalent agency issues may arise between charitable purposes and management conduct in not-for-profit corporations).

<sup>34</sup> Portsmouth Hospital v. Att’y. Gen. N.H., No. E-426-84, Master’s Report at 5 (Super. Ct. N.H. Jan. 7, 1985).

<sup>35</sup> Steve Hollis, Vice President - Cain Brothers, Remarks at Changes in the Not-For-Profit Status of Health Care Organizations Conference (Oct. 30, 1996).

<sup>36</sup> *But cf.* William O. Cleverly, *Financial and Operating Performance of Systems: Voluntary Versus Investor-*

with systems demonstrate higher returns on equity than do free-standing hospitals, regardless of ownership form.<sup>37</sup>

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

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

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

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

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

<sup>38</sup> Cleverly, *supra* 36, at 72.

<sup>39</sup> *Id.*

<sup>40</sup> Frank & Salkever, *supra* note 16, at 133.

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

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

<sup>43</sup> N.C. Dep’t of J., Conditional Approval Proposed Sale of Cape Fear Memorial Hospital, Inc., at Introduction 7.

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

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

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

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<sup>44</sup> Cutler & Horwitz, *supra* note 1.

<sup>45</sup> *Id.*

<sup>46</sup> Uwe E. Reinhardt, Remarks at Changes in the Not-For-Profit Status of Health Care Organizations Conference (Oct. 30, 1996) (Handout at 3, on file with author).

<sup>47</sup> COLO. REV. STAT. § 10-16-324(1) (1996) (An Act Concerning Nonprofit Hospital, Medical-Surgical, and Health Service Corporations). Legislation regarding insurance company conversions has served as a template for hospital conversions, and, therefore, may be instructive in the hospital context.

<sup>48</sup> David A. Schactman & Stuart H. Altman, The Conversion of Hospitals from Not-for-Profit to For-Profit Status ii (Sept. 26, 1996) (unpublished manuscript, on file with author). Schactman & Altman also note that “[p]ublic hospitals...provide the lion’s share of community benefits, and the provision of benefits by private NFPs, while exceeding those of FPs, are highly variable and often concentrated in a few hospitals.” *Id.*

<sup>49</sup> Edward C. Norton & Douglas O. Staiger, *How Hospital Ownership Affects Access to Care for the Uninsured* 25 RAND J. Econ. 171 (1994) (finding that when for-profit and not-for-profit hospitals are located in the same area, they serve an equivalent number of uninsured patients, but that for-profit hospitals locate in better-insured areas); Billie Ann Brotman, *Hospital Indigent Care Expenditures*, 21 J. Health Care Fin. 76 (1995) (finding not-for-profit hospitals do not fund more charity care than for-profits in a study of 144 Georgia general hospitals).

<sup>50</sup> Daniel M. Fox & Phillip Isenberg, *Anticipating The Magic Moment: The Public Interest in Health Plan Conversions In California*, 15 Health Affairs 202 (1996).

<sup>51</sup> Telephone Interview with Kevin Case, Kan. Assistant Attorney General. (Jan. 6, 1997).

### III. Oversight of Conversions

#### A. *Primacy of the Attorney General*

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

Some health departments and health planning agencies operate Certificate of Need (CON) programs which typically require hospitals to apply for a CON before changing the number of in-patient beds. Conversions do not always involve a CON review since, as of 1995, 39 states had active programs.<sup>52</sup> Further, although some regulations trigger a CON review whenever a hospital's ownership structure changes,<sup>53</sup> often such reviews apply only when transactions involve either expenditures over a threshold amount or the establishment of new services. In addition, other states limit CON review to a particular types of facilities, most commonly nursing homes.<sup>54</sup>

A conversion transaction that distributes cash is a tax realization event that implicates the Internal Revenue Service (IRS).<sup>55</sup> The IRS may also investigate conversions to determine their consistency with exemption and private inurement rules. The IRS has limited regulatory efficacy because tax reviews are slow, confidential, affect few conversions, impose only monetary sanctions, and occur *ex post*.<sup>56</sup> Though the IRS may issue letter rulings in advance of a transaction, they are not binding. The IRS' role in conversion oversight is growing; the exempt organizations division recently revealed plans to concentrate on whole hospital joint ventures.<sup>57</sup>

Federal grant and purchasing program restrictions also affect hospital conversions. For example, hospitals built with Hill-Burton Act loans must provide significant amounts

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<sup>52</sup> BARRY R. FURROW ET AL., HEALTH LAW 32 (1995).

<sup>53</sup> Many state statutes or regulations are silent regarding whether a change of ownership requires a CON review. In Iowa, for example, although the statute is silent the health department believes that case law precludes CON review in the event of a change of ownership. Telephone Interview with Rose Vasquez, Iowa Assistant Attorney General (Jan. 28, 1997).

<sup>54</sup> FURROW ET AL., *supra* note 52, at 33.

<sup>55</sup> MANCINO, *supra* note 32, at 23.

<sup>56</sup> In October 1996 the IRS was auditing 44 conversions that occurred in or before 1994. Each audit takes approximately 2 ½ years to complete. Marcus Owens, Dir. of Exempt Organizations Division, Internal Revenue Service, Remarks at Changes in the Not-For-Profit Status of Health Care Organizations Conference (Oct. 31, 1996).

<sup>57</sup> *Livingston: Whole Hospital Joint Venture Guidance May be Released by Year's End*, HIGHLIGHTS AND DOCUMENTS 1056 (Nov. 1, 1996).

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

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

Finally, courts may also oversee hospital conversions. (See Section III,B below for complete discussion). However, courts participate only if the converting entity voluntarily files a cy pres motion or a third party challenges the transaction. Often the attorney general is the only party permitted to file a lawsuit against the charity.

Depending on the organization of a state attorney general's office, one of several divisions may oversee conversions. These divisions include: charities, consumer protection, corporations, health care, taxation, and trade regulation. The office organization and the particular division that happens to handle conversions determines the theory by which conversions are overseen.

Attorneys general typically rely upon two doctrines to oversee conversions of hospitals from not-for-profit to for-profit form, trust law and corporations law. Trust law is primarily based on received English common law. Some state statutes designate not-for-profit directors as trustees and not-for-profit assets as charitable assets for purposes of trust law. In contrast, state corporations law is grounded in state statute and case law. To highly varying degrees, it allows attorneys general to oversee the activities of not-for-profit corporate directors and managers and to ensure the proper use of not-for-profit assets. Though the legal structures of these authorities may seem similar from state to state, their application varies widely. Therefore, the following two sections are generalizations of state law.

## *B. Charitable Trust Law*

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<sup>58</sup> 42 U.S.C.A. §291 (1945).

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

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

Sometimes the purposes for which trusts were established “become obsolete or impossible or impracticable of execution due to changes in social, economic, political or other conditions,” and courts may use their equitable power to direct the administration of trusts to new purposes.<sup>63</sup> Using this power, known as *cy pres* from the French “*cy pres comme possible*” -- as close as possible,<sup>64</sup> courts exercise broad discretion to direct charitable funds to another charitable purpose that is as close to the settlor’s (one who creates a trust) intent as possible. Applying *cy pres* requires a “prerequisite finding that the settlor had a broad or general intent to aid charity as a whole....[H]e must have intended that there should be some discretion in applying his gift to the public good.”<sup>65</sup> Courts may not, therefore, use their powers to turn a narrow settlor intent into a broad one.<sup>66</sup> Charitable trustees do not have *cy pres* powers and may not change the use of charitable funds, regardless of new use’s desirability, unless the settlor included such

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<sup>59</sup> “A charitable trust is a fiduciary relationship with respect to property arising as a result of a manifestation of an intention to create it, and subjecting the person by whom the property is held to equitable duties to deal with the property for a charitable purpose.” RESTATEMENT (SECOND) OF TRUSTS § 348 (1959).

<sup>60</sup> See Appendix D. California and Nebraska have hospital conversions statutes. New York bans for-profit hospitals. N.Y. Not-For-Profit Corp. Law §2801-a(e) *supra* note 22.

<sup>61</sup> G.G. BOGERT & G.T. BOGERT, THE LAW OF TRUSTS & TRUSTEES §373 (2d rev. ed. 1991) (*citing* The Statute of Charitable Uses 43 Eliz. C.4 (1601)). The Statute of Charitable Uses created an exception to the rule against perpetuities which prevents indefinite property transfers by requiring ownership to vest within at least one generation. “To be precise, 39 Eliz. I, c.5 (1597) permitted charitable trusts to have perpetual life. The subsequent Statute of Charitable Uses, 43 Eliz. I. c. 4 (1601)” established enforcement mechanisms. Evelyn Brody, *Charitable Endowments and the Democratization of Dynasty* 39 Ariz. L. Rev. (forthcoming 1997) (manuscript on file with author).

<sup>62</sup> Conn. Gen. Stat. §45a-514.

<sup>63</sup> GEORGE T. BOGERT, TRUSTS § 147, 520 and §147, 525 (1987).

<sup>64</sup> BOGERT & BOGERT, *supra* note 61, at §431.

<sup>65</sup> BOGERT, *supra* note 63, at §147, 523.

<sup>66</sup> BOGERT & BOGERT, *supra* note 61, at §431.

power in the terms of the trust.<sup>67</sup>

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

Since at least 1601, the attorney general has ensured the proper use of charitable trust funds by standing in for an unspecified beneficiary and representing the public through litigation. Traditionally, the attorney general's standing was grounded in *parens patrie* authority. As counsel to the King he guarded the public interest as “sovereign and guardian of persons under legal disability, such as juveniles or the insane...”<sup>69</sup> Today many states grant the attorney general statutory authority.<sup>70</sup> To the extent not-for-profit hospitals benefit from charitable trusts, the attorney general has exclusive authority to ensure the assets are continually used only for specified, charitable purposes.

The power to oversee charitable trusts has been extended to other assets owned by charitable corporations and even to the corporations themselves. Under English common law, the King's power reached the disposition of donations given to a charity for

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<sup>67</sup> BOGERT, *supra* note 63.

<sup>68</sup> See generally Mary Grace Blasko et al., *Standing to Sue in the Charitable Sector*, 28 U.S.F.L. Rev. 37, 40-47 & 52-82 (1993). However, some courts have loosened the standing requirements in at least one of two ways, allowing some private parties to sue charities. First, borrowing from for-profit corporate law, some courts have granted standing to voting members of not-for-profit charitable corporations to sue in actions akin to shareholder's derivative suits. This expansion is of limited applicability in the hospital conversion context because many not-for-profit hospitals are organized without any outside voting members or such that the only corporate members are related corporations. Second, courts have borrowed from private trust law to loosen standing requirements. In some cases minority trustees have been permitted to sue. In addition, private parties deemed to have 'special interests' may sue for breach of trust. A sufficient 'special interest' depends on an analysis of four factors: 1) the extraordinary nature of the breach; 2) whether the directors have committed fraud or misconduct; 3) the availability and effectiveness of the attorney general in the matter; 4) the class of beneficiaries and their relationship to the charity. This second kind of expansion may also be of limited use in the conversion context because, according to Blasko et al., members of large and changing classes, such as the general public and potential patients, have generally not been granted standing.

<sup>69</sup> HENRY CAMPBELL BLACK, *BLACK'S LAW DICTIONARY* 1114 (1990).

<sup>70</sup> Although state attorneys general held common law power to oversee the use of charitable trusts for centuries, it was in 1943 that New Hampshire was the first state to codify the common law powers of the attorney general. In doing so, New Hampshire established a Register of Public Trusts. Terry M. Knowles, *A Brief History of Charitable*

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

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

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

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*Regulation 37* New Hampshire Bar Journal 8, 9 (1996).

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

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

<sup>73</sup> WILLIAM F. FRATCHER, *SCOTT ON TRUSTS* §348.1 (4<sup>th</sup> ed. 1987); 15 Am Jur 2d *Charities* §81 (“a gift or bequest to a corporation or unincorporated association engaged solely in charitable work will usually be construed as held in trust for that purpose.”).

<sup>74</sup> *Blasko et al.*, *supra* note 68, at 39 n. 10 *citing* *MacCurdy-Salisbury Educ. Fund v. Killian*, 309 A.2d 11, 14 (Conn. Super. Ct. 1973) (doctrines of deviation and *cy pres* are equally applicable to charitable trusts and charitable corporations).

<sup>75</sup> Identifying, valuing, and determining the appropriate treatment of assets involved in a conversion are difficult and controversial activities. This section provides only a cursory overview of how an attorney general might apply trust law to broad categories of assets in a conversion. I am grateful to Ms. Janet Spaulding-Ruddell for explaining how trust law might apply to various categories of assets. Telephone Interview with Janet Spaulding-Ruddell, Conn.

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

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

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

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Assistant Attorney General (Jan. 6, 1997).

<sup>76</sup> BOGERT & BOGERT, *supra* note 61, at § 436.

<sup>77</sup> *Id.* at §438-39.

<sup>78</sup> FRATCHER, *supra* note 73, at § 399.4.

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

<sup>80</sup> *Id.* at §399.2.

<sup>81</sup> UNIF. MANAGEMENT OF INSTITUTIONAL FUNDS ACT (1972 & Supp. 1996) (adopted in 38 states and the District of Columbia).

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

While judicial power to release restrictions may seem broad, in two seminal cases courts construed hospital missions quite narrowly. In *Queen of Angels Hospital v. Younger*, a not-for-profit corporation leased a hospital to a for-profit with the hope of using the lease proceeds for indigent care.<sup>86</sup> The California Appeal Court found that the not-for-profit corporation’s articles of incorporation and operating history required it to operate a hospital.<sup>87</sup> In *Attorney General v. Hahnemann Hospital*, the Massachusetts Supreme Judicial Court ruled that the hospital, established under a trust for a homeopathic hospital, had to use sale proceeds for hospital purposes indefinitely and, therefore, could not use them to establish a grant-making foundation.<sup>88</sup> Allowing the hospital to use unrestricted funds to become a grant-making institution simply by amending its charter would undermine the public trust and “eviscerate the Attorney General's power and responsibility to ‘enforce the due application of [charitable] funds ... and prevent breaches of trust in the administration thereof.’”<sup>89</sup>

Not-for-profit hospitals also receive unrestricted donations. In many states, there are no restrictions regarding the use of unrestricted funds; in some states the hospital may even give the funds to the new for-profit institution.<sup>90</sup> In other states, their use would be

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<sup>82</sup> *Id.* at §1(2).

<sup>83</sup> *Id.* at §7.

<sup>84</sup> *Id.* at §7(2).

<sup>85</sup> *Yale University v. Blumenthal*, 621 A.2d 1304 (Conn. 1993).

<sup>86</sup> *Queen of Angels Hospital v. Younger*, 136 Cal.Rptr. 36 (Cal.App. 1977).

<sup>87</sup> The Court relied on several facts, including: 1) The name in the articles included the term “Hospital”; 2) One purpose of the corporation was to establish, own, and maintain a hospital; 3) A second purpose of the corporation was to provide acts of Christian charity particularly among the sick and ailing, and to house and care for them, suggesting a hospital facility; 4) A third purpose of the corporation, to educate nurses and medical students, also implied the existence of a hospital; 5) A fourth purpose provided that operating revenues were to be used to enlarge and improve the hospital, implying that the hospital was to be maintained. *Id.*

<sup>88</sup> *Attorney General v. Hahnemann Hospital*, 494 N.E.2d 1011 (Mass.1986).

<sup>89</sup> *Id.* at 1021.

<sup>90</sup> The Colorado Corporations and Associations, Non Profit Corporations Code can be read to permit not-for-

subject to the same analysis as restricted funds -- the intent of the donors would be inferred by the hospital's solicitation appeal.<sup>91</sup>

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

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

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

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

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

#### D. Corporations Law

Twenty-two out of thirty-two interviewees said that the attorney general has or would rely on corporations law in overseeing hospital conversions; three interviewees said they did not know; four interviewees did not mention corporations law as a potential source of authority; and, the question did not apply in three states.<sup>93</sup> The relevant corporate laws for conversion oversight are state corporations codes, and common law and statutory fiduciary duty laws.

##### 1. Fiduciary Duties

All corporate directors have the duties of care and loyalty. The duty of care requires directors to act with “care which men of ordinary prudence would exercise in similar circumstances...”<sup>94</sup> The duty focuses on responsible procedure and, therefore establishes a norm against second-guessing directors’ substantive decisions. According to the rule applied in duty of care cases, “the business judgment of the directors will not be challenged or overturned by courts or shareholders, and the directors will not be held liable for the consequences of their exercise of business judgment – even for judgments that appear to have been clear mistakes – unless certain exceptions apply.”<sup>95</sup> However, deference to business judgment does not apply if the directors did not make a business judgment, had a conflict of interest, or acted in bad faith.

In deciding to convert a hospital, directors must establish a careful deliberative process. Evidence of reasonable care might include consideration of alternative bids, deal structures, partners, and methods of preserving the not-for-profit such as other capital-raising options as well as using consultants to establish the accuracy of valuations. One interest group has stated that fiduciary duties include a requirement to maximize corporate value such that “directors carefully...consider all competing offers and...either accept the highest offer or be able to demonstrate a principled reason, rooted in the

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<sup>92</sup> *Id.*

<sup>93</sup> See Appendix D. California and Nebraska have hospital conversions statutes; New York does not permit for-profit hospitals. N.Y. NOT-FOR-PROFIT CORP. LAW §2801-a(e) (McKinney 1996).

<sup>94</sup> 19 C.J.S. *Corporations* §483 (1990).

<sup>95</sup> ROBERT C. CLARK, *CORPORATE LAW* 123 (1986).

charitable purposes of the organization, for choosing another buyer.”<sup>96</sup>

The duty of loyalty addresses actual and potential conflicts of interest between the decision-making director and the corporation. In reviewing conversions, attorneys general consider whether the directors followed a fair process in selecting a buyer and negotiating the deal, and whether decision-makers or their relatives have a financial interest in the deal’s outcome. Directors must know whether managers’ judgments have been tainted by buyers’ promises of money and future employment.<sup>97</sup> Employees, such as hospital managers or physicians who are involved in the negotiation of the conversion transaction, may violate the duty of loyalty by spending corporate resources securing future employment at the buyer’s hospital.<sup>98</sup> Promises of physician ownership in the new entity also raise conflicts of interest concerns.

## 2. Ultra Vires

Corporate activities that exceed legislatively authorized powers are known as ultra vires acts.<sup>99</sup> In *Kelley v. Michigan Affiliated Healthcare System*, a joint venture between a Michigan not-for-profit hospital system and Columbia/HCA in which the not-for-profit planned to move substantially all its assets to a jointly-owned subsidiary violated state law because under the arrangement the not-for-profit would exceed its statutory powers as a not-for-profit corporation.<sup>100</sup> The court granted summary judgment on a count for *quo warranto* for engaging in an ultra vires act – permitting assets held by a corporation for charitable purposes to be used, conveyed, or distributed for non-charitable purposes -- finding it to be the plaintiff’s most persuasive claim.<sup>101</sup>

Ultra vires acts include those that exceed the scope of authority permitted by corporate documents. Although most corporations draft their documents to authorize any

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<sup>96</sup> LINDA B. MILLER ET AL., Volunteer Trustees Foundation, *The Case for an Activist Approach by State Charity Regulators in Overseeing For-profit Conversions of Nonprofit Hospitals and HMOs*, Tab 2, 14 (1995).

<sup>97</sup> *Id.*

<sup>98</sup> *Cf. Rapistan Corp. v. Michaels*, 203 Mich.App. 301, 511 N.W.2d 918 (1994).

<sup>99</sup> 19 C.J.S. *Corporations* §573.

<sup>100</sup> Opinion and Order, *Kelley v. Michigan Affiliated Healthcare System, Inc.*, No. 96-83848-CZ (Cir Ct. Ingham County 1996) citing Mich. Comp. Laws. Ann. §600.3601 (West 1996); Mich. Stat. Ann. §27A.3601 (Callaghan 1996) (against unauthorized exercise of corporate rights).

<sup>101</sup> *Id. citing* Mich. Stat. Ann. §121.197(101)(5). The court found the *cy pres* claim moot. “What is critical, indeed dispositive in this situation is that the hospital will be operated as a for-profit entity. Not unimportantly, both the physical assets and day-to-day hospital operations will be managed by Columbia.” *Id.* at 3.

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

### 3. Other Statutory Provisions

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

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

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

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

<sup>103</sup> Opinion and Order, *Kelley v. Michigan*, *supra* note 100, at 7.

<sup>104</sup> Huey, *supra* note 72, *citing* ND Century Code ch. 10-24 *et seq.*

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

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

<sup>107</sup> ARIZ. REV. STAT. ANN. §10-2402, §10-2402(B) (Michie 1996).

<sup>108</sup> Telephone Interview with Barbara Lake, La. Assistant Attorney General (Jan. 9, 1997).

<sup>109</sup> 14 C.J.S. *Charities* § 68 (1991).

<sup>110</sup> 19 C.J.S. *Corporations* § 813 (1991).

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

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

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

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

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

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<sup>111</sup> *Id.* at § 815.

<sup>112</sup> 14 C.J.S. *Charities* § 68 (1991).

<sup>113</sup> ARIZ. REV. STAT. ANN. §10-2422(3) (Michie 1996).

<sup>114</sup> *Id.* at §10-2422(4).

<sup>115</sup> *Id.* at §10-2422(5).

<sup>116</sup> C.R.S. 7-26-103(e) (1996). Also see W. VA. CODE §31-1-155 (1996).

<sup>117</sup> C.R.S. 7-26-103(c) (1996).

<sup>118</sup> Telephone Interview with Jerry Hancock, Director of Consumer Protection at the office of the Wisconsin Attorney General (Jan. 10, 1997).

E. *Role of the Attorney General in Enforcing Corporations Law*

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

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

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

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

<sup>120</sup> VA. CODE ANN. §17-123 (Michie 1996) (jurisdiction of circuit court).

<sup>121</sup> N.C. GEN. STAT. §55A-12-02(g) (1996).

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

<sup>123</sup> MASS. GEN. L. ch. 180, §8A (1996).

<sup>124</sup> MASSACHUSETTS OFFICE OF THE ATTORNEY GENERAL, FOR-PROFIT CONVERSIONS AND ACQUISITIONS OF NONPROFITS: ATTORNEY GENERAL ISSUES AND PROCEDURES 1 (Oct. 30, 1995).

public interest. As a practical matter, the attorney general often can leverage her power to stop or delay a transaction if she does not believe the transaction is in the public interest.

In Massachusetts, Attorney General Scott Harshbarger has stated,

In most [conversion] cases, court approval is required. If the Office of the Attorney General is satisfied that the public interest will be served by the transaction, the Attorney General will assent to the request for court approval. If court approval is not sought by the charity, the Attorney General may ask the court to enjoin the transaction.<sup>125</sup>

Attorneys general may also compel parties to produce information using civil investigative demands.<sup>126</sup>

#### IV. The Inadequacy of Attorneys General’s Authority to Protect Conversion for Private Gain

While the public does not own charitable assets, it has a legal interest in ensuring that charitable assets do not inure to the benefit of private parties. This section identifies two sets of obstacles to effective protection of charitable and public interests. First, there are legal, self-imposed, and practical bars to oversight. Second, the difficulties of asset valuation also obstruct the adequate protection of charitable and public interests. Valuation is a complicated issue, only briefly explored in this paper.

##### A. *Problem I - Bars to Oversight*

In the great majority of the surveyed states, the attorney general has sole or primary authority to oversee hospital conversions.<sup>127</sup> Yet in many states there are practical and legal bars to effective oversight such as lack of authority, no formal notice mechanisms, transactions structured to avoid oversight, and practical limitations to the attorney general’s power. Without government oversight, assets that should be preserved

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<sup>125</sup> *Id.* at 3.

<sup>126</sup> Tennessee Attorney General Burson has used civil investigative demands. Charles W. Burson, Tennessee Attorney General, Remarks at Changes in the Not-For-Profit Status of Health Care Organizations Conference (Oct. 31, 1996). Tenn. Code Ann. §§8-6-401 *et seq.* “The exercise of such authority was warranted by the substantial concerns expressed directly to the State Attorney by concerned parties and by the allegations in State ex rel. Adventist Health System/Sunbelt Health Care Corporation v. Nashville Memorial Hospital, Inc., No. 93-3413-I (Davidson chancery February 28, 1994).” Mem. of the Att’y Gen., *Burson v. Nashville Memorial Hospital, Inc.*, (Tenn. Ch. Mar. 17, 1994).

<sup>127</sup> See Section III,A above. Few interviewees knew of other government entities, in addition to the attorney general, that held oversight authority. See Appendix C.

for charitable interests may be wasted or transferred to shareholders.

### 1. Obstacles to Oversight

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

Louisiana's unique civil law system, which does not incorporate the common law of charitable trusts, precludes conversion oversight. Only a decade ago, trust law was introduced in Louisiana for the limited purpose of reconciling IRS policies with Louisiana law.<sup>131</sup> According to a Louisiana assistant attorney general, even if Louisiana had a civil code that permitted oversight, its application would be diluted by the state's bias towards unfettered ownership rights.<sup>132</sup>

In other states, attorneys general have chosen not to monitor conversions. In Kansas, Attorney General Bob Stephan did not oversee the four conversions that occurred during his tenure.<sup>133</sup> Similarly, although a selling not-for-profit hospital notified the Colorado attorney general of an extensive joint venture between a not-for-profit and an out-of-state for-profit hospital chain, she declined involvement.<sup>134</sup> In Florida, the attorney general's office decided not to closely monitor conversions.<sup>135</sup> These attorneys

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<sup>128</sup> These states are: Colorado (not exercised), Florida (does not monitor), Hawaii (review probably limited to tax review), Idaho (does not know), Iowa (not yet considered), Kansas (previous AG did not monitor), and West Virginia (unclear). See Appendix C. The issue is inapplicable in New York where conversions are not permitted. N.Y. NOT-FOR-PROFIT CORP. LAW §2801-a(e) *supra* note 22.

<sup>129</sup> Telephone Interview with Debbie McHenry, West Virginia Managing Deputy Attorney General (Jan. 17, 1997).

<sup>130</sup> See Appendix C.

<sup>131</sup> Lake, *supra* note 108.

<sup>132</sup> *Id.*

<sup>133</sup> Case, *supra* note 51.

<sup>134</sup> Carver, *supra* note 90. See CUTLER & HORWITZ, *supra* note 1 for a detailed description of the transaction which involved a complicated history of conversion, a not-for-profit repurchase, and a joint venture.

<sup>135</sup> Interview with Jerry Currington, Special Counsel of the Florida Attorney General (Jan. 14, 1997).

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

## 2. Notice Mechanisms

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

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

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

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

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<sup>136</sup> CAL. CORP. CODE § 5910 *et seq.* (Deering 1996); NEB. REV. STAT. § 71020, 102 *et seq.* (1996).

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

<sup>138</sup> Arizona, Connecticut, Florida, Idaho, Massachusetts, Michigan, Missouri, and Minnesota.

<sup>139</sup> Alabama, Colorado, Hawaii, Illinois, Iowa, Kansas, Louisiana, Maine, Maryland, New Jersey, North Dakota, Virginia, Wisconsin, and West Virginia.

<sup>140</sup> Representatives of the Hawaii, New Hampshire, North Dakota, and Maine attorney generals' offices indicated that they would be likely to hear about a conversion because of the small size of their states or because the hospital community knows that the state attorney general is interested in conversions.

<sup>141</sup> Interview with Michael DeLucia, Director of Charitable Trusts of the New Hampshire Department of Justice (Jan. 13, 1997).

general must allocate resources to track conversions or risk missing them. The costs of tracking and overseeing transactions can be lowered by allowing relator actions.

Although attorneys general may seek retroactive return of assets,<sup>142</sup> unwinding some forms of joint ventures can be more expensive and difficult than stopping it at the outset.

### 3. The Problem of Joint Ventures

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

The difficulty of determining when a corporation’s essential orientation changes from not-for-profit to for-profit poses problems for oversight. Deciding when to apply a corporations statute raises similar definitional problems. What counts as ‘all or substantially all’ of a corporation’s assets? Does moving corporate assets into a jointly-owned subsidiary comprise an asset transfer? Further, although dissolution statutes dictate the use of charitable assets, they do not apply to some transaction forms. That a constituent corporation ceases to exist in its previous form as a result of a merger or joint venture does not mean it dissolves.<sup>144</sup> These ambiguities allow many joint ventures to avoid oversight.<sup>145</sup> While applying statutes to new situations always leads to inconsistent application and enforcement for some period of time, the costs of under-enforcement in

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<sup>142</sup> In addition, for transactions that occur after September 14, 1995, the IRS may impose penalty taxes on the persons who received excess benefit from a 501(c)(3) organization and on the persons who participated in the transactions approval or implementation. MANCINO, *supra* note 31, 38-47 (discussing I.R.C. §4958).

<sup>143</sup> Stanton, *IRS: Joint Ventures By Public Hospitals Won’t Affect Debt*, The Bond Buyer, Nov. 8, 1996, at 6.

<sup>144</sup> “In a dissolution, the corporate entity disappears, its creditors are paid, and the remaining assets are distributed to stockholders. In a merger, by contrast the constituent corporation disappears in the sense that it no longer survives as a separate distinct legal entity. Rather, it continues as part of the surviving corporation, losing only its separate identity, but not its life.” 5 Del. C. @ 781 (1985).

<sup>145</sup> Lawyers purposely structure deals to avoid oversight. In Maryland, for example, Blue Cross Blue Shield attempted to create an affiliated for-profit company to run its insurance business. Blue Cross labeled the complex transaction a ‘reorganization’ in its filing with the insurance commissioner. The insurance administration rejected the plan, characterizing the deal as a ‘conversion’ and requiring the blue Cross to follow conversion procedures. In Re: Blue Cross Blue Shield of MD, Reorganization Plan, Md. Ins. Admin., No. MIA-95-12/94 (1995).

the hospital conversion context may be particularly high.

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

#### 4. Practical Obstacles

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

#### B. *Problem II - Valuation*

Even when attorneys general overcome the obstacles identified above, valuation poses an additional barrier to effective oversight. Identifying the appropriate assets to value, choosing the right valuation method, and accurately applying the method are all controversial and difficult tasks, particularly for not-for-profit hospitals. Attorneys general seldom have legal guidance in these areas.

Various methods are used to value assets, some of which are briefly set out in this section. Some approaches estimate asset values on different measures of a hospital's income such as multiples of earnings before interest, taxes, depreciation, and amortization (EBITDA), operating revenues, or discounted cash flow. Other methods use market measures, such as the sale price of comparable transactions in health care or related

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<sup>146</sup> Kelley v. Michigan, *supra* note 100, at 5.

<sup>147</sup> Court Record at 5, Kelley v. Michigan Affiliated Healthcare System, Inc., No. 96-83848-CZ (Cir Ct. Ingham County 1996).

<sup>148</sup> MICH. COMP. LAWS § 14.258 (1996); MICH. COMP. LAWS ANN. §126.1200(8) (1996).

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

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

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

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

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<sup>149</sup> *Sixty Minutes: Conversions* (CBS television broadcast, Oct. 1996).

<sup>150</sup> Gerard F. Anderson, *The Role of Investment Bankers in Nonprofit Conversions*, 16 *Health Affairs* 144, 145 (1997).

<sup>151</sup> Linda B. Miller, *The Conversion Game: High Stakes, Few Rules*, 16 *Health Affairs* 112, 114 (1997).

<sup>152</sup> Gray, *supra* note 4, at 28.

<sup>153</sup> *Id.*

<sup>154</sup> *Id.* at 30.

<sup>155</sup> Fox & Isenberg, *supra* note 50, at 203.

<sup>156</sup> Judith Bell et al., *The Preservation and Protection of Charitable Health Care Assets* 15 (Oct. 24, 1996) (unpublished manuscript, on file with author) *reproducing chart from Anne Lowry Bailey, Charities Win, Lose in*

indicate whether the not-for-profit received other payments such as retirement of debt. Furthermore, some of the increase in value may be attributed to the market value of the for-profit corporate form.<sup>157</sup> While determining whether the increases are attributable to the improper transfer of charitable assets is difficult, the magnitude of the increases over such short periods raise reasonable suspicions. Indeed, according to one study, “It is clear from recent history...that states without specific [conversion] legislation have repeatedly failed to protect the full value of charitable assets.”<sup>158</sup> Jurisdiction grounded on corporate or trust law lacks the “structured and predictable administrative process” of statutes necessary to protect assets.<sup>159</sup>

Although accurately valuing a not-for-profit hospital is hard, deriving a fair monetary value is possible. As Gray notes, improved processes such as public disclosure of transaction details and the use of experts can balance the power between buyers and sellers.<sup>160</sup> Further, experts may also help the seller arrive at a fair selling price. North Carolina Attorney General Michael Easley, approved a conversion after being satisfied with the valuation conducted by Coopers & Lybrand, “considered to be one of the world’s largest leading professional services firms....”<sup>161</sup> Experts, however, may not fully understand intangible factors that contribute to a good choice of buyer.<sup>162</sup>

## V. Health Policy

The current and emerging oversight regimes often hinder the advancement of health policy goals. As discussed above, attorneys general’s legal jurisdiction to oversee conversions is based upon trust and corporations law, which focus on the conservation of charitable purposes and assets. They usually exercise their authority by requiring fair process (particularly valuation process) and assuring that proceeds are used for health purposes.

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*Health Shuffle*, CHRON. PHILANTHROPY, June 14, 1994, at 12.

<sup>157</sup> Cf. Easterbrook & Fischel, *supra* note 19, at 1430-34 (arguing that stock prices reflect corporate governance because professional investors analyze changes in governance terms, even the most obscure of these terms).

<sup>158</sup> Schactman & Altman, *supra* note 48 at iv; Steven R. Hollis, *Strategic and Economic Factors in the Hospital Conversion Process*, 16 *Health Affairs* 131, 141 (1997) (stating that author has witnessed a surprising number of under-valuations).

<sup>159</sup> *Id.* at v.

<sup>160</sup> Gray, *supra* note 4, at 29.

<sup>161</sup> N.C. Dep’t of J., Conditional Approval Proposed Sale of Cape Fear Memorial Hospital, Inc., at 5.

<sup>162</sup> Duke University Center for Health Policy, Law and Management, *A Guide for Communities Considering*

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

A. *Health Policy Concerns Implicated in Conversions*

1. Redistributive Loss

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

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

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

<sup>163</sup> FRIEDMAN, BERNARD S. ET AL., *Tax Exemption and Community Benefits of Not For Profit Hospitals*, in *ADVANCES IN HEALTH ECONOMICS AND HEALTH SERVICES RESEARCH* v1, 130 (Richard M. Scheffler & Louis F. Rossiter eds., 1990).

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

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

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

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

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1975)).

<sup>165</sup> “Hospitals delivered approximately \$15 billion in services for which they were not reimbursed in 1989, which amounted to over 6% of gross patient revenues; approximately two-thirds of uncompensated care is delivered to uninsured patients.” Jonathon Gruber, *The Effect of Competitive Pressure on Charity: Hospital Responses to Price Shopping in California*, 38 *J. of Health Econ.* 183 (1994).

<sup>166</sup> For example, in 1991, when Humana bought Michael Reese Hospital in Chicago, philanthropists not only severed their association with the hospital but refused to affiliate with the resulting foundation. Arsenio Oloroso Jr., *Reese Donors Flee as Buyout Nears; Kept in Dark, They Won't Fund New Foundation*, CHICAGO CRAINS BUSINESS, Jan. 21, 1991, at 3.

<sup>167</sup> Mark A. Hall & John D. Columbo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 *Wash. L. Rev.* 307, 319 (1991).

<sup>168</sup> Norton & Staiger, *supra* note 49.

charitable giving and third party payment for inpatient and out patient care.”<sup>169</sup>

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

## 2. Local Control of Health Policy Decisions

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

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

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

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<sup>169</sup> Richard Frank & David Salkever, *Market Forces, Diversification of Activity, and the Mission of Non-Profit Hospitals* in NONPROFIT HOSPITALS, 2 (David Cutler ed., forthcoming 1998).

<sup>170</sup> TROYEN A. BRENNAN & DONALD M. BERWICK, NEW RULES: REGULATION, MARKETS, AND THE QUALITY OF AMERICAN HEALTH CARE 395 (1996). The program was started at St. Luke’s Regional Medical Center in Boise, Idaho, and involved the cooperation of other community hospitals and the local fire and police agencies. Julie Bailey, *Bicyclists’ Tip: Be ‘Head Smart’ Program Aimed at Preventing Head Injuries*, LEWISTON MORNING TRIBUNE, Mar. 8, 1991, at 1C.

<sup>171</sup> Patel et al., *supra* note 15.

such as the right to repurchase, may also be insufficient to protect community interests. The ability to repurchase may be too blunt a tool to correct small, yet undesirable for-profit behavior. In addition, once sold, the value of the hospital may increase and the remaining sale proceeds may not be sufficient for repurchase.

### 3. Hospital Spending

Existing hospitals were constructed in an era when in-patient care was considered an important national health priority.<sup>172</sup> The emphasis on in-patient hospital care has since declined. In the 1980s, government policy was directed toward controlling costs through price controls which had the predictable and welcome effect of reducing the number and duration of hospital admissions. In 1983, Congress introduced the prospective payment system (“PPS”), a new method for Medicare hospital payments.<sup>173</sup> Medicare previously paid hospitals on a cost-based system, thus creating an incentive for hospitals to keep patients longer than otherwise. PPS pays hospitals pre-determined prices set according to type of illness, encouraging shorter stays.<sup>174</sup> In fact, early reviews of PPS found reductions in the number and length of admissions.<sup>175</sup> Private industry has followed suit. Capitation, now a widespread payment mechanism, is meant to reduce the use of hospital resources.

The reduction of hospital visits and lengths-of-stay may not significantly affect health status. Research on cost-sharing has demonstrated that decreases in the use of medical services, including hospital services, “have little or no net adverse effect on health for the average person.”<sup>176</sup> This evidence suggests investments meant to improve health may be better spent in non-hospital, or even non-medical, settings.

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<sup>172</sup> The federal government’s first involvement in national health planning was through the Hill-Burton Act in 1946. Financial support under the program created almost one-half million in-patient beds. CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY 119-23, (1988) citing a report of a committee of the Institute of Medicine, National Academy of Sciences, Health Planning in the United States: Issues in Guideline Development 13-19 (1980).

<sup>173</sup> In addition, during the mid-1980s, the Health Care Financing Agency intended to cut Medicare hospital admissions by 10 to 15 percent through use of Peer Review Organization admission reviews. David B. Palmer, *Some Cons of PROs*, 103 Arch Ophthalmology 343 (1985).

<sup>174</sup> See Richard S. Schweiker, *Report to Congress: Hospital Prospective Payment for Medicare*. Washington, D.C.: Department of Health and Human Services. (1982) (rationale for Prospective Payment System and expected effects).

<sup>175</sup> See Robert F. Coulam & Gary L. Gaumer, *Medicare’s Prospective Payment System: A Critical Appraisal*, Annual Supplement Health Care Fin. Rev. 45 (1991) (for summary of early evaluations of PPS program). Cf. Joseph P. Newhouse & Daniel J. Byrne, *Did Medicare’s Prospective Payment System Cause Length of Stay to Fall?*, 7 J. Health Econ. 413 (1988) (Length of stay did not fall when all Medicare patients considered).

<sup>176</sup> JOSEPH P. NEWHOUSE, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 339 (1993).

Other factors besides traditional medical care affect physical health. One study on elderly people, for example, demonstrates that behavioral, social (having a marital partner, contacts with friends, and membership in religious organizations or volunteer groups), and psychological factors are linked to physical performance.<sup>177</sup> Advocates and scholars, therefore, have called for an increase in alternative interventions, in place of or combined with traditional medical care.

If these scholars and government payers are correct in seeking to decrease hospital stays and increase other less-costly interventions,<sup>178</sup> it is wasteful to preserve conversion proceeds for hospital uses. Rather than focusing on the preservation of not-for-profit hospital missions and funds, regulation of conversions could provide an opportunity to align government public health efforts. Spending conversion proceeds on “food, safe housing, environmental protection, college tuition, or even distributing cash” may lead to better health outcomes.<sup>179</sup> To better improve public health, conversion proceeds should be used for non-traditional health interventions, prevention initiatives, or other social services that improve health outcomes.

#### B. *Underlying Theory of Doctrinal Tools*

Corporations and charitable trust doctrines are concerned only with the preservation of charitable assets and purposes. Strictly applied, the doctrines restrict the rational redeployment of conversion proceeds because the funds are bound to past practices. As procedural doctrines, both can be interpreted to forbid attorneys general from conducting a substantive review of the appropriate use of hospital assets.<sup>180</sup>

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<sup>177</sup> Teresa E. Seeman et al., *Behavioral and Psychosocial Predictors of Physical Performance: MacArthur Studies of Successful Aging*, 50 A. J. Gerontology M177 (1995).

<sup>178</sup> Cf. Economist Uwe Reinhardt has argued that government payers may have cut down hospital stays for the wrong reason – because they believe hospital stays are expensive. It is not that hospitals are expensive places, but that the per diem pricing system for hospital care is so inaccurate that insurers focus on lowering length of hospital visits to lower overall payments. Reinhardt advocates the use of Ramsey Prices (minimizing aggregate departures from economic efficiency by pricing in inverse proportion to elasticity of demand). Uwe E. Reinhardt, *Perspective: Our Obsessive Quest to Gut the Hospital*, 15 Health Affairs 145 (1996).

<sup>179</sup> Einer Elhauge, *Allocating Health Care Morally*, 82 Cal. L. Rev. 1449, 1460-61 (1994).

<sup>180</sup> Shactman and Altman make a narrower claim about the regulation of conversions. They have identified “two levels of regulatory measures that could be considered in regard to hospital conversions.” They identify level one measures as those that “regulate conversions to safeguard and conserve the full value of not-for-profit assets and insure that all proceeds from the conversion are used for appropriate charitable purposes.” Level two measures “[r]egulate conversions to insure that the community continues to have access to needed amounts of health care services and that

A conservative interpretation of charitable trust law grants the court little discretion to consider contemporary health requirements. In fact, the judicial doctrine of *cy pres* should be distinguished from the English *prerogative cy pres* doctrine under which “the Crown, as *parens patrie*, was permitted in certain cases to apply the property for any charitable purpose it might select. The king in the exercise of this prerogative power was under no duty, save perhaps a moral duty, to consider what would have been the wishes of the testator.”<sup>181</sup>

At each step of the *cy pres* process (finding 1. broad charitable intent, 2. obsolescence of old purpose, 3. similarity of new purpose), the equitable powers of the court are constrained by the settlor’s intent – an intent formed in a previous era of medicine. Courts have refused to apply the *cy pres* doctrine when purposes were practicable even if they were undesirable.<sup>182</sup>

To comply with the obsolescence provision and release a not-for-profit hospital from its obligation to operate the hospital, the court must decide that the not-for-profit hospital in question could not continue in its corporate form. Even though it is difficult to imagine that operating a not-for-profit hospital is impossible, a court could decide that market changes make the not-for-profit intent impracticable. The court’s discretion to permit new uses is also constrained by past intent. Courts must consider, among other questions, whether the funds should be transferred to another hospital that provides similar services, whether allowing the proceeds to establish a health care foundation should be permitted and, if so, the permissible scope of grants from the foundation (e.g. hospital care, health care generally, research, or other services that improve health status such as job training and education).

Most state corporations laws similarly constrain the issues that can be considered in overseeing conversions. As discussed in Section III above, corporations laws relevant to conversions focus on fiduciary duties, the *ultra vires* doctrine, and limitations on use and distribution of charitable assets.

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the community is satisfied with the degree of local control over its health delivery system.” Schactman & Altman, *supra* note 48 at iv.

<sup>181</sup> FRATCHER, *supra* note 73, at §399.1.

<sup>182</sup> *Id.*, at §399.4 (citing e.g. *Conn. Bank and Trust v. Hartford Hosp.*, 29 Conn. Sup. 158, 276 A2d 792 (1971) (fund for free bed in named hospital; held fund cannot be used for other purposes of hospital, although there was no present demand for beds).

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

## VI. State Experience - Substantive Health Policy Review

Doctrinal limitations have not constrained all attorneys general from considering the health effects of conversions. Interviewees were asked “How does or would your state protect care for the uninsured in the event of a conversion?” and, “Does your state require foundations formed with conversion proceeds to use charity funds for health care purposes?”<sup>185</sup> To clarify the question, some interviewees were given four alternatives to choose among: a) State does not limit use to charitable purpose; b) State limits use to charitable purpose, but no substantive restriction; c) State limits use to health care purpose (research or patient services); d) State limits use to hospital care (patient services). Many attorneys general consider care for the uninsured. Many also intend some limits on the use of conversion proceeds.

### A. Foundations

Whether and to what extent attorneys general impose restrictions on the permissible purposes of foundations started with conversion proceeds indicate how constrained the attorneys general are by charitable trust and corporations law. Strict

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<sup>183</sup> “The corporate code in almost every state is an “enabling” statute. An enabling statute allows managers and investors to write their own tickets, to establish systems of governance without substantive scrutiny from a regulator and without effective restraint on the permissible methods of corporate governance.” Easterbrook & Fischel, *supra* note 19, at 1417.

<sup>184</sup> Suits may be filed after a transaction has been completed if the attorney general did not know about the transaction.

<sup>185</sup> See Appendix E for results.

applications of the law would require the funds be used only for hospital care or other activities legally performed by the selling hospital. The results of interviews suggest that the great majority of interviewees intend to limit the use of proceeds either to advance the seller's purposes or to health care services more generally. Recent surveys, however, suggest that attorneys general have permitted conversion proceeds to be used for broader purposes than those of a typical not-for-profit hospital.<sup>186</sup>

Two of twenty-seven interviewees<sup>187</sup> did not know what, if any, requirements would be imposed on foundations.<sup>188</sup> Three out of twenty-seven interviewees stated that there were no state restrictions on the use of foundation funds.<sup>189</sup> The remaining twenty-two interviewees identified current restrictions on foundations or expected there to be restrictions in the future.<sup>190</sup> Seven out of twenty-seven interviewees stated that the *cy pres* doctrine would determine the permissible scope of the foundation mission and grants.<sup>191</sup>

States that restrict the use of conversion proceeds require them to be used for some kind of health care purposes. Although requirements depend on specific circumstances, when asked to speculate on permissible uses many interviewees said the foundations would probably not be restricted to giving out grants for hospital care (which is at least the primary purpose of the converting entity) but could fund projects that are rationally related to health care such as medical research.

A listing of conversion foundations and typical grants awarded suggests that many foundations are wellness foundations that fund much broader activities than those of typical not-for-profit hospital.<sup>192</sup> Conversion foundations have funded, among other projects, projects for children's social services, violence prevention, strengthening

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<sup>186</sup> *Conversion Foundations: A Listing*, 16 Health Affairs 238 (1997).

<sup>187</sup> There were no responses from Massachusetts and West Virginia. New York does not permit for-profit hospitals. N.Y. NOT-FOR-PROFIT CORP. LAW §2801-a(e) (McKinney 1996). Conversions in California and Nebraska are governed by statute and are discussed in Section VII below.

<sup>188</sup> Hawaii and Iowa. See Appendix E for details.

<sup>189</sup> Alabama, Louisiana, and Kansas. There have been conversions in these three states, and the attorneys general have not overseen them. However, a Kansas assistant attorney general anticipated there would be restrictions imposed on foundations in the future. Interview with Kevin Case, Assistant Attorney General of the Kansas Attorney General (Jan. 6, 1997).

<sup>190</sup> Arizona, Colorado, Connecticut, Florida, Idaho, Illinois, Maine, Maryland, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, North Carolina, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Virginia, and Wisconsin.

<sup>191</sup> Arizona, Colorado, Connecticut, Florida, Minnesota, New Hampshire, and Virginia.

<sup>192</sup> *Conversion Foundations: A Listing*, 16 Health Affairs 238 (1997).

families, aging in California, scholarships for health-related careers, building community spirit and stronger neighborhoods, Jewish continuity, and public education regarding osteopathic medicine. While these goals are laudable and may more effectively improve health than more hospital care, they are likely broader than those of the selling hospitals.

Interviewees raised concerns that if the proceeds were restricted to hospital uses, they would benefit the for-profit buyer. In many small states or regions of larger states the only remaining hospital may be the for-profit buyer. Therefore, the goals of using proceeds for purposes consistent with the not-for-profit corporation's purposes and ensuring the separation of the foundation and the resultant for-profit hospital may conflict.<sup>193</sup> The Massachusetts attorney general considers whether "the sale proceeds [will] be used for appropriate charitable purposes consistent with the nonprofit's original purposes, and will the funds be controlled as charitable funds independently of the resulting for-profit?"<sup>194</sup>

#### *B. Care for the Uninsured*

Attorneys general in the great majority of states have or would consider the effects of conversions on uninsured patients.<sup>195</sup> Eight of twenty-seven interviewees stated that they have not yet developed procedures to protect care for the uninsured;<sup>196</sup> two of these interviewees stated that the attorney general planned to do so.<sup>197</sup> Four of twenty-seven interviewees said care for the uninsured was of secondary or no concern, either because the state has a comprehensive program for uninsured patients or because the attorney general has no authority in this domain.<sup>198</sup> Six of twenty-seven interviewees believed, however, that they could protect care for the uninsured within the confines of existing law through existing charitable trust or corporations law.<sup>199</sup>

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<sup>193</sup> This issue arose in the proposed transaction between Michigan Affiliated Health Care System, Inc. and Columbia/HCA. There are only three hospitals in the region. Two not-for-profit hospitals are merging. If the third is sold to a for-profit buyer like Columbia/HCA, there will only be two possible hospitals to receive the foundation money. Telephone Interview with David Silver, Michigan Assistant Attorney General (Jan. 21, 1997).

<sup>194</sup> Office of the Attorney General Massachusetts, *supra* note 124, at 4.

<sup>195</sup> See Appendix E for survey results.

<sup>196</sup> Arizona, Hawaii, Idaho, Iowa, Maine, Maryland, North Dakota, Oregon.

<sup>197</sup> Arizona and Maine.

<sup>198</sup> Alabama, Illinois, Louisiana, and Tennessee, which has a comprehensive Medicaid system known as TENNCare. The quality and stability of TENNCare, however, has been questioned. BRENNAN & DONALD M. BERWICK, *supra* note 170, at 269-70.

<sup>199</sup> Connecticut, Kansas, Minnesota, Pennsylvania, South Carolina, and Virginia.

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

In 1985, “[a]s part of a sale agreement to Hospital Corporation of America, Wesley Medical Center...required HCA to maintain traditional levels of charity care and other essential services....”<sup>201</sup> In the oversight of North Carolina’s only conversion to date, the Attorney General reviewed several features of the transaction, including “Whether the services currently offered by the Hospital will remain available to the community.”<sup>202</sup> Attorney General Michael Easley found that community health care services would be protected in the transaction because the approval of the transaction is conditioned upon the buyer’s adherence to a promise to “maintain the existing community services and indigent care currently performed by the Hospital in its service area.”<sup>203</sup> However, the Joint Statement of the Parties makes no such promise. It states, “Subject to the need to assure continued financial stability, as well as the exercise of appropriate business judgment by Columbia in its local and national operations, Columbia Cape Fear does not now plan to terminate existing community services presently performed by the Hospital in its service area.”<sup>204</sup> The only promise was that “the buyer must maintain emergency medical services at the level provided by the not-for-profit hospital at the time of the sale.”<sup>205</sup> Non-emergency services remained uncommitted. However, imposing requirements that for-profit buyers maintain or increase levels of charity care is not the best use of attorneys general’s leveraging power if for-profit hospitals are systematically locating in areas where there are few uninsured

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<sup>200</sup> See Appendix E for details.

<sup>201</sup> David Dunlap, *A Delicate Balancing Act*, MODERN HEALTHCARE, (March 13, 1995), at 34. On the contrary, one Wesley Medical Center director said that the charity agreement was “understood” and included in the sale contract. See CUTLER & HORWITZ, *supra* note 1, at 15.

<sup>202</sup> Conditional Approval of Proposed Sale of Cape Fear Memorial Hospital, Inc., N.C. Att’y Gen. Approval Introduction 3 (May 1996).

<sup>203</sup> *Id.* at Findings 9.

<sup>204</sup> Joint Statement of Cape Fear Memorial Healthcare Corporation, Cape Fear Memorial Hospital, Inc., and Columbia Cape Fear Healthcare System, LTD. Partnership to The State of North Carolina Department of Justice Office of the Atty. Gen., April 1, 1996, at 19.

patients.

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

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

### C. *Attorneys General as Health Regulators*

By considering substantive health care issues and allowing conversion proceeds to be used for purposes other than hospital care, attorneys general may protect the health of communities affected by conversions even though they may be violating charitable trust and corporations law. However, this section concludes that legislators and health policy experts, not attorneys general, should decide whether trust and corporations laws or health policy goals should guide conversion oversight. If legislatures leave the question open, attorneys general should only consider the substantive issues of health policy in overseeing conversions to the extent they are protecting public investments.

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<sup>205</sup> Conditional Approval, *supra* note 202, at Conditional Approval 12.

<sup>206</sup> *For-Profit Health Care, 1995: Hearings Before the Joint Comm. On Health Care*, Mass. Leg. Sess. (1995) (Prepared testimony of Scott Harshbarger, Massachusetts Attorney General, on file with author).

<sup>207</sup> *Id.* Buyers of not-for-profit hospitals may voluntarily agree to continue specified levels of charity care to maintain good public relations or woo sellers. In a joint venture with hospitals owned by the Sisters of Charity Saint Augustine, Columbia/HCA agreed to maintain the Catholicity of the hospitals, including charity care. Telephone Interview with Susanna Crey, Vice President for Corporate Development of the Sisters of Charity St. Augustine Health Systems (Mar. 25, 1997).

<sup>208</sup> *For-Profit Health Care*, *supra* note 206.

<sup>209</sup> Opinion and Order, *Kelley v. Michigan*, *supra* note 100, at 7.

## 1. Negative Consequences

Allowing attorneys general to redirect the use of charitable funds may have several negative consequences. First, not-for-profit hospital donors may want to restrict their donations despite understanding that health care priorities change. Regardless of the substantive desirability of the changed purpose, when an attorney general reads a donor's intent broadly, and allows diversion of restricted assets into new health care uses, she violates the precepts of charities law. If donors believe their restrictions will be ignored, they may forgo giving to charities altogether. While a default rule that allows transfers to more effective charitable activities might, in fact, encourage donations people differ over what constitutes the most effective activity. In the conversion context, a donor might oppose for-profit medicine and, reasonably, want her donations to be transferred to another not-for-profit hospital where it can help strengthen the hospital and prevent a takeover by another for-profit hospital. If attorneys general are free to transform the use charitable hospitals' assets, they may be more likely to transform other types of charitable assets.

Second, conditioning approval of conversion transactions on the buyer adopting the same charity care policies as not-for-profit hospitals may also have negative consequences. To the extent the for-profit corporate form is a preferable form for hospitals, the public is deprived of that form if the for-profit behaves like a not-for-profit. For-profit hospitals that behave like not-for-profit hospitals may be unattractive investments as compared to other corporations. If potential investors are dissuaded from investing, the for-profits may face reduced access to capital and choose to exit the business. Some communities will be left without any hospital if for-profits exit.

Third, the attorney general is not the right party to determine community health needs. Lawyers specialize in litigation, preparing documents, and interpreting and applying law; they neither have training to make policy choices nor a mandate from the public to do so.<sup>210</sup> Several interviewees noted that even if state statutes authorize attorney general oversight of conversions, the statutes do not provide guidance regarding the appropriate oversight of health policy considerations.

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<sup>210</sup> Telephone Interview with Perry A. Craft, Tennessee Deputy Attorney General (Mar. 10, 1997).

## 2. Mitigating Factors

In addition to the potential for positive health outcomes, this section identifies four reasons that support attorneys general's substantive review of conversions. Depending on the results of these reviews, attorneys general would permit the transfer of conversion proceeds to organizations that pursue different purposes than those pursued by the converting entity or condition approval of a conversion upon the buyers' agreement to continue services offered by the seller. The justifications for this extended authority rest on the ability of the attorney general to represent public investment goals, the special nature of health care, the perception of a health care crisis, and the accurate interpretation of donors' intents. Regardless of these justifications, however, attorneys general would be best justified in pursuing health policy goals under the explicit direction of legislatures.

First, to the extent transfers are meant to protect public investments, attorneys general may be justified in permitting conversion proceeds to be put to new uses. Tax exemptions and other publicly granted benefits are given to not-for-profit hospitals by legislatures motivated to protect the public health. These public benefits are often not as tightly linked to specific uses as are private grants and donations. To the extent the legislature's intent is broader than a private donor's intent, the attorney general may have more authority to change the use of assets from hospitals to other uses. Furthermore, as a member of the state government, the attorney general may have a better claim to represent the government's intent and modify the interest than to represent the private donor's intent and interest.

Second, the specter of the slippery slope by which the attorney general becomes more likely to order the reformation of charitable assets according to perceived changes in various public policy fields can be dismissed if health care or the health care industry can be distinguished from other goods and industries.<sup>211</sup> Many people believe health care is special; because of the moral and social implications of its provision it should be treated differently from other social goods.<sup>212</sup> Health care is also special product because of

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<sup>211</sup> *But see* Elhauge, *supra* note 179. (Elhauge refutes the traditional positive justifications for characterizing health care as special – i.e. its inherent nature, its use in treating undeserved and unpredictable misfortunes, paternalism, and externalities.)

<sup>212</sup> *See, e.g.*, NORMAN DANIELS, *JUST HEALTH CARE* (1985).

agency problems particular to financing and delivery organization of health in the United States. Furthermore, externalities<sup>213</sup> and moral hazard problems may differentiate the health sector from others. These problems inhibit the market from correcting for excess capacity and other inefficiencies. Increased conversions may be a sign of correction, but the law inappropriately conserves resources in the hospital industry and conversions to for-profit organizations raise other problems for health care. Therefore, there may be more of a justification for the attorney general to intervene in the use of proceeds from health care corporation sales than in the use of proceeds from other sales.

It is also arguable that there should be a substantive health policy review of hospitals but no other types of corporation. Not only are hospitals special because they provide health care, a special commodity, but because they play a special institutional role in communities. Hospitals provide psychic comfort to community members as do police stations, fire departments, and schools. Because of that semi-public role, attorneys general may have a greater claim in encouraging or requiring for-profit buyers to behave like not-for-profit sellers who are less likely to enter and exit business according to market changes. In addition, a small number of hospitals are different from other corporations because they perform medical science, and without them research would be slowed, deterred, or precluded.

A third, less-ambitious claim is that health care is not usually a special commodity but it is now in a state of crisis unlike other goods and industries. Drastic steps, including allowing the attorney general to redirect the proceeds of charitable assets, are required. Unlike at other times in the history of health care in the United States,

*it is a time of crisis. The main problems bear the same names [as at other times when people claimed health the U.S. health system was in a state of crisis] – cost and access – but the level of acuity has risen dramatically. Unless there is radical change within the next ten years, there is a good chance that our health care system will collapse of its own weight.*<sup>214</sup>

The growth in the percentage of wages spent on health care indicates a

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<sup>213</sup> These include both health externalities (more widespread and effective health services lower the spread of disease) and psychic externalities (people feel better when they know health care is available to all who need it).

<sup>214</sup> VICTOR R. FUCHS, *THE FUTURE OF HEALTH POLICY* 11 (1993).

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

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

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

Finally, as a practical matter, citizens may tolerate intervention even if there is not a crisis or hospitals and health care are no different than other corporations and goods, because people perceive that health care is a unique good and industry. Citizens, therefore, may passively allow a re-deployment of hospital conversion funds but not allow the re-deployment of other funds.

## VII. Conversion Legislation

By spring 1997 two states, California and Nebraska, had enacted conversion statutes.<sup>217</sup> Of the remaining thirty states studied, interviewees in twelve states knew of existing conversion bills, or thought conversion bills would be introduced during the 1997 legislative session.<sup>218</sup> By the end of 1997, eleven states (seven of the studied states) and the District of Columbia passed conversion legislation.<sup>219</sup> With few exceptions,

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<sup>215</sup> *Id.* at 150.

<sup>216</sup> H.S. Luft et al., *The Volume-Outcome Relationship: Practice-makes-perfect or Selective-referral Patterns?*, 22 Health Services Res. 157 (1987) (volume and referrals explain outcomes); A.B. Flood et al., *Does Practice Make Perfect? Part II: The Relation Between Volume and Outcomes and Other Hospital Characteristics*, 22 Med. Care 115 (1984) (high volume associated with better outcomes for surgical and medical patients); A.B. Flood et al., *Does Practice Make Perfect? Part I: The Relation Between Hospital Volume and Outcomes for Selected Diagnostic Categories*, 22 Med. Care 98 (1984) (high volume associated with better outcomes for surgical patients); H.S. Luft et al., *Should Operations be Regionalized? The Empirical Relation Between Surgical Volume and Mortality*, 301 New Eng. J. Med 1364 (1979) (volume, referrals, or selection related to outcomes).

<sup>217</sup> See Appendices F-1 and F-2.

<sup>218</sup> See Appendix D for list of states.

<sup>219</sup> Arizona, Connecticut, D.C., Georgia, Louisiana, New Hampshire, Ohio, Oregon, Rhode Island, South Dakota, Virginia, and Washington. VOLUNTEER TRUSTEES FOUNDATION FOR RESEARCH AND EDUCATION, *THE SALE AND CONVERSION OF NOT-FOR-PROFIT HOSPITALS: A STATE-BY-STATE ANALYSIS OF NEW LEGISLATION* (1998).

legislators modeled the legislation on either the California or Nebraska statute.<sup>220</sup>

In addition, Congress-member Stark introduced federal conversion legislation, the Federal Medicare Nonprofit Hospital Protection Act of 1997. This bill requires not-for-profit hospitals to obtain the approval of the Secretary of Health and Human Services before transferring control or a material amount of assets to a for-profit hospital.<sup>221</sup>

Conversion statutes and bills only partially remove obstacles to effective oversight. Most importantly, they create an explicit role for attorneys general. Some mandate valuations and require the advice of health policy specialists. They do not, however, resolve the tension between charitable interests and health policy.<sup>222</sup> Most bills require conversion proceeds to be applied for purposes similar to those of the converting entities and to further the health care needs of the community; they do not recognize the potential conflict of those charges.

California's statute applies to health facilities organized as public benefit corporations.<sup>223</sup> Though the attorney general has sole oversight authority, he may seek advice from state agencies, experts, and consultants.<sup>224</sup> Converting hospitals must notify the attorney general at least twenty days<sup>225</sup> before the consummation of any agreement involving the transfer of a material amount of assets, or control over assets, to a for-profit corporation.<sup>226</sup> Although the factors reviewed are discretionary, the legislation recommends that the attorney general consider the fairness of the terms including the price, evidence of private inurement, and the sufficiency of information provided for the review.<sup>227</sup> He may also evaluate the transactions effect on "the availability or accessibility of health care services to the affected community."<sup>228</sup> A sunshine provision requires the attorney general to hold at least one public meeting.<sup>229</sup> By declaring that charitable, not-for-profit health facilities hold their assets in trust, the statute reinforces

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<sup>220</sup> See Appendices F-1 and F-2.

<sup>221</sup> H.R. 443, 105<sup>th</sup> Cong., 1<sup>st</sup> Sess. (1997).

<sup>222</sup> In some states any legislation that limits the *cy pres* powers of the court could be found unconstitutional as a violation of the state separation of powers doctrine. Cf. *The Bridgeport Public Library and Reading Room v. The Burroughs Home et als.*, 82 A. 582 (Conn. 1912).

<sup>223</sup> CAL. CORP. CODE § 5910 et seq. (1996); CAL. STAT. 1105 (1996); CAL. ADV. LEGIS. SERV. 1105 (Deering).

<sup>224</sup> *Id.* at § 5919.

<sup>225</sup> *Id.* at § 5913.

<sup>226</sup> *Id.* at § 5914.

<sup>227</sup> *Id.* at § 5917.

<sup>228</sup> *Id.*

<sup>229</sup> *Id.* at § 5916.

the state's common law power.<sup>230</sup>

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

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

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<sup>230</sup> LEG. COUNSEL'S DIGEST, AB 3103, (Feb. 23, 1996).

<sup>231</sup> NEB. REV. STAT. §§71-20, 102 et seq. (1996).

<sup>232</sup> *Id.* at §71-20, 103.

<sup>233</sup> *Id.* at §71-20, 108(1) - (9).

<sup>234</sup> *Id.* at §71-20, 109.

<sup>235</sup> *Id.* at §71-20, 106.

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

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

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

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

All the legislation reviewed in this study included review of the conversion's health effects. The California attorney general may evaluate whether “[t]he agreement or transaction may create a significant effect on the availability or accessibility of health care services to the affected community.”<sup>241</sup> Other legislation requires foundations created with sale proceeds to make grants related to indigent care. Had the Colorado bill passed, new foundations would have to serve the health needs of the Colorado population that have no, or inadequate, health insurance.<sup>242</sup> The Nebraska Department of Health must consider “[w]hether sufficient safeguards are included to assure the affected community continued access to affordable care[;] [w]hether the purchaser and parties...have made a commitment to provide benefits to the disadvantaged, the uninsured, and the

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<sup>236</sup> *Id.* at §71-20, 110 - 111.

<sup>237</sup> H.R. 97-1256, 61<sup>st</sup> Gen. Assem., (1997) (defeated in committee March 1997). If this bill were enacted it would still be possible for parties to structure transactions to avoid oversight since this bill would not have affected joint ventures involving less than 50% of not-for-profit hospitals' assets.

<sup>238</sup> Telephone Interview with Christina Hall, Maine Assistant Attorney General (Jan. 17, 1997).

<sup>239</sup> NEB. REV. STAT. §71-20, 108 (1996).

<sup>240</sup> CAL. CORP. CODE § 5917 (Deering 1996).

<sup>241</sup> CAL. CORP. CODE § 5917 (Deering 1996).

underinsured and to provide benefits to the affected community to promote improved health care.”<sup>243</sup> The legislation does not address redistributive loss, local control, and hospital spending. Incorporating health policy reviews into conversion oversight may protect health because the attorney general may not have the expertise to make good decisions. Only the bills patterned on the Nebraska legislation have a formal role for health policy officials.

Furthermore, heightened oversight of health effects may discourage conversions that otherwise should be encouraged. Gray has offered six reasons why it might be appropriate to encourage conversions.<sup>244</sup> First, increased conversions may lead to increased care for the uninsured if policy makers can no longer rely on charitable hospitals to provide care. Second, for-profits will pay taxes, creating a new revenue source. Gray acknowledges that repealing hospital tax-exemptions would have the same effect but says “there is some doubt that nonprofits’ books would show profits” to be taxed. Third, charitable assets tied to not-for-profit hospitals can be put to better uses. Fourth, conversion may open channels to needed capital. Fifth, to the extent there is excess hospital capacity, for-profit institutions may be better able to exit than not-for-profits. Sixth, allowing conversions may “end the fiction that nonprofits are more socially beneficial than their for-profit counterparts.”

Perhaps most significantly, the legislation does not address the potential incompatibility between law and health policy. If an attorney general requires a foundation to do anything other than activities substantially similar to those of the selling not-for-profit hospital, she will be undermining charitable trust law and corporations statutes. Many bills require or allow attorneys general to favor health policy needs over trust and corporations principles. The Nebraska attorney general may choose whether a foundation’s mission is consistent with the seller’s purposes *or* supports and promotes health care in affected communities.<sup>245</sup> Depending on the breadth of the seller’s purpose, these two goals may be incompatible.

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<sup>242</sup> H.R. 97-1256, 61<sup>st</sup> Colo. Gen. Assem., (1997) (defeated in committee March 1997).

<sup>243</sup> NEB. REV. STAT. §71-20, 109 (1996).

<sup>244</sup> Gray, *supra* note 4, at 26 - 28.

<sup>245</sup> NEB. REV. STAT. §71-20, 108 (1996). However, the potential of the Department of Health to secure care for the uninsured under its separate review is limited because the statute “does not apply higher standards to hospitals covered by the Nonprofit Hospital Sale Act than those applicable to hospitals not covered by the act.” *Id.* at §71-20,

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

## VIII. Conclusion

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

There are serious decisions to be made. One cannot assume that people who founded not-for-profit hospitals and crafted their mission statements, and whose donations endowed them, would gladly see the hospitals convert and their assets transferred to other health uses, even desirable ones. It is as plausible that the donors would vigorously oppose the conversions and the accompanying rise of for-profit medicine. The difficulty of retrospectively understanding the motivation of donors and founders accounts for the conservative *cy pres* doctrine.

In some cases, attorneys general may pursue health policy goals without conflict. Where missions are broad or transferred assets derive from tax-exemptions or other public benefits, funds may be re-deployed without conflict with charitable trust or corporations law. Most conversion assets do not meet these conditions. Using charitable

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110 (1996).

<sup>246</sup> H.R. 287, 411<sup>th</sup> Md. Leg., Reg. Sess., (1997).

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

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

## Appendix A

1. State/Date
2. Contact (name and title).
3. Have any hospitals converted from not-for-profit to for-profit corporate form in your state?
4. Is there, or would there be, any government oversight of conversions? If so, which government offices would be involved?
5. Form and substance of authority for oversight? (legislation, common law, formal or informal review protocol etc.) Specific citations?
  - a) Does the AG have the power to initiate litigation?
  - b) Does the state have a Uniform Management of Institutional Funds Act?
6. Is there a mechanism that requires notice be given to the attorney general in the event of a conversion?
  - a) Which activities trigger review? (i.e. What constitutes a conversion? joint venture, asset purchase, change in ownership - % threshold).
7. Is there a state definition of community benefit? (e.g. care for medically indigent, no expectation of payment, service at below cost rates, all bad debt).
8. How does or would your state protect care for the uninsured in the event of a conversion?
9. Are there any requirements on hospitals, for-profit, not-for-profit, government, or all, regarding the provision of charity care? (e.g. is there a % or \$ amount that must be spent on the uninsured?)
10. Does your state require foundations formed with conversion proceeds to use charity funds for health care purposes? E.g.:
  - a) State does not limit use to charitable purpose.
  - b) State limits use to charitable purpose, but no substantive restriction.
  - c) State limits use to health care purpose (research or service).
  - d) State limits use to hospital care (patient services).
11. Have there been any re-conversions in your state?
12. Who owns tax-exempt value in your state?
13. Are there any other questions I should have asked about the oversight of conversions in your state? Other.

## Appendix B

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

## Appendix C

State	Conversions <sup>i</sup>	Government Oversight <sup>ii</sup>	Notice to Attorney General <sup>iii</sup>
Alabama	Yes	AG	No
Arizona	No	AG <sup>iv</sup>	Maybe (antitrust law). 10 day public notice/ hearing tax-exempt asset sale. AG not notified under statute. <sup>v</sup>
California	Yes	AG	Yes, 20 days before transaction to AG.
Colorado	Yes <sup>vi</sup>	AG <sup>vii</sup>	No
Connecticut	No	AG <sup>viii</sup>	Maybe. Court application required for charitable-asset conversion. Certificate of Need required.
Florida	Yes	AG <sup>ix</sup>	Maybe. Court application required for charitable-asset conversion.
Hawaii	No	AG (tax) <sup>x</sup>	No
Idaho	No	Doesn't know	Maybe. Court application required for charitable-asset conversion.
Illinois	Yes	AG	No
Iowa	Yes	None	No
Kansas	Yes	AG <sup>xi</sup>	No
Louisiana	Yes	No	No
Maine	No	AG	No
Maryland	No	Maybe AG <sup>xii</sup>	No
Massachusetts	Yes	AG <sup>xiii</sup>	Sometimes, transaction may trigger notice provision of corporations code.
Michigan	Yes	AG	Sometimes, if transaction involves dissolution or other disposition of assets.
Missouri	No	AG	Sometimes, transaction may trigger notice provision of corporations code.
Minnesota	No	AG <sup>xiv</sup>	Sometimes, transaction may trigger notice provision of corporations code.
Nebraska	Yes	AG	Yes
New Jersey	Yes	AG <sup>xv</sup>	No
New Hampshire	Yes	AG	No <sup>xvi</sup>
New York	No	N/A	N/A
North Carolina	Yes	AG	Yes, under trust law.
North Dakota	No	AG	No (proposed amendment to corporations statute transfer of assets requires notice).
Oregon	No	AG	Yes, corporations code requires review if transaction involves sale.
Pennsylvania	Yes	AG	Yes, nonprofit and charities laws require court approval for sale & certain uses of assets; AG notified of actions.
Rhode Island	1 <sup>st</sup> begins 1/97	AG <sup>xvii</sup>	Yes, under trust law.
South Carolina	Yes	AG <sup>xviii</sup>	Yes, under Nonprofit Corporations Code.
Tennessee	Yes	AG	Yes, under Nonprofit Corporations Code. <sup>xix</sup>
Virginia	Yes	AG	No
Wisconsin	No	AG	No
West Virginia	Yes	Unclear if AG authority.	No

## Appendix D

State	Corp. Code	Charitable Trust/Cy Pres	Statute	Joint Venture	Limits on initiating litigation
Alabama	X				
Arizona	X <sup>xx</sup>	X	Proposed 1997	Joint ventures may not trigger oversight.	
California			X		
Colorado	X <sup>xxi</sup>	X	Proposed 1997	Joint ventures may not trigger oversight.	
Connecticut		X	Proposed 1997	Unclear.	
Florida	X	X			
Hawaii	DK	DK			
Idaho	DK	DK			
Illinois	X <sup>xxii</sup>	X			
Iowa	DK	DK <sup>xxiii</sup>			
Kansas	X	X	Proposed 1997		
Louisiana			Proposed 1997		AG unlikely to sue under civil law system.
Maine	X	X		Unclear <sup>xxiv</sup>	
Maryland	X	X	Proposed 1997		
Massachusetts	X	X	Proposed 1997		
Michigan	X	X			
Missouri	X	X			
Minnesota	X	X		Transfer to wholly owned sub. likely deemed asset transfer.	
Nebraska			X		
New Jersey	X	X	Proposed 1997		
New Hampshire		X	Proposed 1997		
New York	N/A <sup>xxv</sup>				
North Carolina	X (weak)	X			
North Dakota	X	X <sup>xxvi</sup>			
Oregon	X	X <sup>xxvii</sup>	Proposed 1997		
Pennsylvania	X	X <sup>xxviii</sup>		Probably oversight if transaction involved charitable assets.	
Rhode Island		X	Proposed 1997		
South Carolina	X	X			
Tennessee	X <sup>xxix</sup>	X (limited) <sup>xxx</sup>			
Virginia	X <sup>xxxi</sup>	X (limited)			
Wisconsin	X	X <sup>xxxii</sup>	Possible 1997		No parens patrie authority.

West Virginia	X <sup>xxxiii</sup>	X <sup>xxxiv</sup>		No parens patriae authority.
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## Appendix E

State <sup>xxxv</sup>	Protection of Care for the Uninsured <sup>xxxvi</sup>	General Requirements on Hospitals for Care for the Uninsured <sup>xxxvii</sup>	Restrictions on Foundation Funds <sup>xxxviii</sup>
Alabama	No protocol. Secondary concern.	No	Charitable, but no restriction to health care.
Arizona	DK (haven't dealt with issue yet).	DK	Cy Pres (for money donated for health purposes)
Colorado	At discretion of AG.	Not generally <sup>xxxix</sup>	Cy Pres
Connecticut	Protected by Cy Pres. CON may involve agreement re: uninsured.	AG, does not require. Maybe under CON.	Cy Pres
Florida	Unclear <sup>xi</sup>	No	Probably to charity with a rational relation to health care.
Hawaii	DK	DK	DK
Idaho <sup>xii</sup>	DK	DK	No current restriction, in process of developing policy.
Illinois	Secondary consideration.	DK	Probably health care, but concern that money flow to buyer. Almost certainly restricted to a 501(c)(3). <sup>xlii</sup>
Iowa	DK	No	DK
Kansas	Open question. Maybe preservation of funds under Cy Pres.	No	Previously no requirements. In future, probably limited to specific health care uses.
Louisiana	No power to protect.	State public hospital system.	None <sup>xliii</sup>
Maine	No procedure, but AG interested.	No, except state requirement related to Hill-Burton. <sup>xliv</sup>	DK. Probably to hospital uses.
Maryland	DK	DK	DK, but thinks some health care use, like research, would probably be sufficient.
Michigan	In only conversion, issue addressed by contract between the hospital and county.	No	Limited to health care uses. DK regarding services v. research. Concern about money flowing to buyer because so few hospitals.
Missouri	Incorporated in foundation's documents.	DK, but thinks no.	DK, predicts limited to health care, probably service-oriented.
Minnesota	Protected to extent indigent care is required by charitable intent.	Unaware of requirements.	Cy Pres
New Jersey	Protected to extent seller provided service.	DK	AG would match seller and foundation's purposes.
New Hampshire	Protected by foundation, buyer required to continue indigent care. <sup>xlv</sup>	No	AG would match seller and foundation's purposes.
New York	N/A	N/A	N/A

North Carolina	In past, buyer intended to maintain existing community service, emergency, indigent care (conditioned upon continued financial stability and business judgment of buyer and buyer's parent). <sup>xlvi</sup>	No	Charitable purpose, health related activities in seller's region. Foundation must not deal exclusively with the Buyer or affiliates <sup>xlvi</sup>
North Dakota	DK	DK, but thinks no.	No policy. AG would consider.
Oregon	DK	DK, but thinks no. Licensing, tax-exemption issues. <sup>xlvi</sup>	No policy. However, in a failed HMO conversion, AG encouraged parties to limit foundation purposes to health.
Pennsylvania	Protected to extent seller's charitable purpose is to provide indigent care.	DK	Depends on form of transaction and court order. Strong tradition of fashioning narrow restrictions on foundations. <sup>xlvi</sup>
Rhode Island	Protected by foundation established with conversion proceeds.	DK	DK, depend on case.
South Carolina	AG would question buyer's commitment under nonprofit act.	DK	Probably restricted to local community, health purposes.
Tennessee	Already protected through TENNCare. <sup>i</sup>	No	Depends upon seller's representations to donors. <sup>li</sup> AG required increases in foundation directors, fair process for selection of CEO, 10-yr AG oversight of funding requests to and grants from foundation, processes for managing conflicts of interest. <sup>lii</sup>
Virginia	Depends on previous use of funds. Protected under trust or corporate law.	No, question for IRS.	Depends on cy pres analysis. AG would recommend proceeds be used in a manner similar to purposes of converting hospital. <sup>liii</sup>
Wisconsin	Indigent care requirements part of agreement to permit buyer to operate hospital. Duties under Hill-Burton, EMTALA <sup>liv</sup> . Concern that assets do not flow back to buyer.	No	Developing a policy.

## Appendix F

State	Statute/ Bill	Primary Oversight	Authority	Covered Activities <sup>lv</sup>	Notice
Federal	Medicare Nonprofit Hospital Protection Act of 1997 <sup>lvi</sup>	HHS Secretary	Disqualification from Medicare Payment.	Transfer of control or material amount of assets to for-profit entity.	
Arizona	An Act Amending §10-2402 <sup>lvii</sup>	Corp. Comm., Dep. of Health Services, AG	To require public notice and hearing.	Transfer of all or substantially all assets (if ≥ \$1 million) to another nonprofit health care entity or for-profit entity. Includes joint ventures.	90 days before anticipated closing.
California	Amendment to Corporations Code, 1996 <sup>lviii</sup>	AG	AG may consent, conditionally consent, or not consent to agreement on transaction.	Transfer of assets, or control over assets or governance, to a mutual benefit or for-profit entity or entity when a material amount of assets are involved in agreement. <sup>lix</sup>	20 days before transaction. <sup>lx</sup>
Colorado	Bill for an Act Concerning the Transfer of Assets <sup>lxi</sup>	AG (upon approval of Dep. of Health Care Policy and Financing)	AG must approve or disapprove transaction.	Transfer of assets or revenues to a for-profit. Transfer of control of operations to a for-profit. Series of transactions in any 3 year period involving > 50% of assets or revenues.	75 days before transaction.
Kansas	Nonprofit Hospital Sale Act <sup>lxii</sup>	Dep. of Health and Environ., AG oversight is discretionary.	Sec. of Health and Environ. approves or disapproves conversion.	“Acquisition” = transactions that involve change of ownership or control of ≥ 20% which results in for-profit holding ≥ 50% interest in ownership or control.	To Dep. of Health before transaction.
Maryland	Approval of Conversions <sup>lxiii</sup>	AG	AG must approve transaction.	Transactions involving transfer of a material amount of assets or change of control/responsibility to a for-profit.	90 days before transaction.
Nebraska	Nonprofit Hospital Sale Act <sup>lxiv</sup>	AG, Dep. of Health	Approve or disapprove conversion.	“Acquisition” = transactions that involve change of ownership or control of ≥ 20% or results in for-profit holding ≥ 50% interest in ownership or control. <sup>lxv</sup>	
New Hampshire	Proposed Standards for Acquisition Transaction 1997 <sup>lxvi</sup>	AG (Dir. of Charitable Trusts)	May bring proceeding to enjoin transaction.	Transfer of control of healthcare charitable trust or ≥ assets thereof.	120 days
Oregon	Bill for an Act Relating to Hospitals <sup>lxvii</sup>	AG	Must grant written consent prior to transaction.	Transactions involving transfer of a material amount of assets or change of control/responsibility for material amount of assets to a for-profit.	Before entering transaction.

## Appendix F2

State	Public Notice/ Hearing	Factors to be considered	Substantive Health Care Considerations	Post Transaction Authority	Other
Federal	Public notice and hearing required.	DHHS secretary conducts independent fairness review, must conclude no assets inure to private benefit. 12 factors considered (most relate to fairness, conflicts, and use of proceeds).	Sec. may not approve transaction unless proceeds used for promotion of health, safeguards to assure continued access to affordable hospital services. For-profit must commit to provide comparable charity care.		Applicant deemed to meet conditions if state law imposes at least as stringent requirements.
Arizona	Public notice and hearing required. Purpose of hearing is to receive comments.	Parties must set forth evidence of due diligence, management of conflicts, assurances regarding use of proceeds at public hearing.	Parties must set forth extent to which transaction will affect community benefit purposes, likelihood of creating adverse effect on access to or availability or cost of health care.		Provisions do not affect power of corp. commission to accept or deny new, restated, or amended articles.
California	AG must conduct at least one public meeting, one of which shall be in county in which facility is located. <sup>lxviii</sup>	AG shall consider any factors that she deems relevant, including, but not limited to: fairness of terms, private inurement, fair market value price, consistency of proceed use with charitable trust, evidence of breach of trust, sufficiency of information provided to evaluate effects on public, effect on availability and access of health care, and public interest. <sup>lxix</sup>	AG may evaluate whether transaction creates significant effect on the availability or accessibility of health care in community. <sup>lxx</sup>		Act declares that charitable, nonprofit health facilities, including nonprofit hospitals, hold all their assets in trust.
Colorado	Press release re: the filings; Public hearing required.	Parties must demonstrate: transaction in public interest, no likelihood of creating adverse health effects, no private benefit, evidence of due diligence in decision-making, proceeds at fair market value, use of proceeds for 501(c)(3), independence of grant recipients, foundation mission reflects seller's mission.	Foundation's charitable mission: 1) reflect seller's charitable mission; 2) shall be dedicated to serving health needs of CO population that have no, or inadequate, health insurance, medical education and research; 3) promote access to care.	New charitable organization must provide AG and Dep. of Health Care Policy and Financing with annual reports of activities for at least five years. Monitoring paid for by for-profit.	Act declares that charitable, nonprofit health facilities, including nonprofit hospitals, hold all their assets in trust. The public is the beneficiary of the trust.

Kansas	Notice in local newspaper; public hearing.	Sec. to consider same factors considered by Nebraska Dep. of Health. AG to consider same factors outlined in Nebraska legislation.	Same factors as Nebraska legislation.	Dep. of Health and Environ. may revoke license after hearing. AG may protect public interest.	
Maryland	Notice in local newspaper; public hearing.	AG to determine that terms are fair to: MD citizens, the public, enrollees and subscribers, policyholders, and the nonprofit corporation. Also, private inurement, adverse effect on health, due diligence in decision process, establishment of independent charitable trust.	AG ensures transaction doesn't create, or have likelihood of creating, adverse effect on availability, accessibility, and affordability of health care. Foundation dedicated to serving state's unmet health care needs, particularly medically uninsured and under-served.	Prohibition on grant-making to for-profit buyer; annual reports re: foundation activities to AG; May require corrective action if for-profit fails to fulfill commitments.	
Nebraska	Notice in local newspaper. <sup>lxxi</sup> Public hearing if transaction reviewed by AG. <sup>lxxii</sup>	AG must approve unless acquisition not in the public interest (value of charitable interest not safeguarded and used for appropriate charitable purposes). <sup>lxxiii</sup>	AG ensures proceed use matches seller's original purpose <i>or</i> proceeds use to support and promote health care in affected community. Dep. of Health must consider access to care, care for the under and uninsured. <sup>lxxiv</sup>	Dep. of Health may revoke license if purchaser does not comply sale terms. <sup>lxxv</sup> AG protects public interest, including compliance with commitments <sup>lxxvi</sup>	
New Hampshire	Discretion of Dir. of Charitable Trusts.	Standards include: due diligence, disclosure and management of conflicts, fair valuation, proceeds used for consistent charitable purposes, proceeds independent of acquirer, public process.	Use of proceeds devoted to charitable purposes consistent with seller's purpose and needs of community it serves. Acquirer must provide statement of how it will fulfill charitable objects of trust.		
Oregon	Public hearing.	Language based on CA statute.	AG may evaluate whether transaction creates significant effect on the availability or accessibility of health care in community.		

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<sup>i</sup> Respondents were asked, “Have any hospitals converted from not-for-profit to for-profit corporate form in your state?”

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

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

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

<sup>v</sup> Amendments to the not-for-profit law were to be introduced in 1997. A preliminary draft of the senate bill includes provisions for 120 day notice to the attorney general, a more structured public hearing, authority for the attorney general to recommend whether the corporation commission should reject or accept the filing of the new articles of incorporation.

<sup>vi</sup> There have been joint ventures with for-profit hospital corporations.

<sup>vii</sup> To date that authority has not been exercised.

<sup>viii</sup> The Office of Health Care Access would also oversee hospital conversions.

<sup>ix</sup> The Agency for Health Care Administration would also oversee hospital conversions. AG would not closely monitor.

<sup>x</sup> The Health Department and Department of Commerce and Consumer Affairs would also oversee hospital conversions.

<sup>xi</sup> No oversight of four conversions before current attorney general.

<sup>xii</sup> The attorney with whom I spoke said the Department of Health would probably be involved in oversight.

<sup>xiii</sup> In the event of a change in ownership of a health care facility, which may occur through a sale or joint venture, the entity must obtain a new license through the Department of Public Health. MASS. GEN. L. ch. 111 §51 (1996).

<sup>xiv</sup> The Department of Health would also oversee hospital conversions.

<sup>xv</sup> The Department of Health would probably be involved in oversight.

<sup>xvi</sup> Converting entities have notified the Attorney General voluntarily.

<sup>xvii</sup> The Department of Health would also oversee hospital conversions.

<sup>xviii</sup> The Department of Health and Environmental Control would also oversee hospital conversions.

<sup>xix</sup> TENN. CODE ANN. @ 48-62-102(g) (1996).

<sup>xx</sup> Arizona nonprofit law grants weak power to the state corporations commission. The decision to dissolve the not-for-profit is made by the board or members entitled to vote (ARIZ. REV. STAT. ANN. §10-2421A (1996)); a statement reflecting the decision must be delivered to the corporations commission. (ARIZ. REV. STAT. ANN. §10-2421C (1996)). Any person who acquires all, or substantially all, not-for-profit’s assets must give public notice and hold a hearing no less than 10 days before the transaction occurs the sole purpose of which “is to receive public comment regarding the proposed transaction.” ARIZ. REV. STAT. ANN. §10-2401B.

<sup>xxi</sup> When a nonprofit corporation dissolves its assets must be distributed according to a dissolution plan that addresses liabilities, restricted assets, and limitations imposed by the corporation’s articles and bylaws. At the directors’ discretion, any remaining assets may be distributed another organization regardless of its organizational form (either for- or non-profit). C.R.S. 7-26-103 (1996).

<sup>xxii</sup> Illinois corporate law the attorney general to ensure that directors meet their fiduciary duties.

<sup>xxiii</sup> The office of the Iowa attorney general does not have antitrust and charities divisions. It is unlikely, therefore, that the office would oversee conversions.

<sup>xxiv</sup> Corporations code applies to dissolution of assets or forfeiture of charter.

<sup>xxv</sup> Conversions forbidden by state statute.

<sup>xxvi</sup> Use of North Dakota trust law in conversion oversight would probably be limited to restricted assets, particularly those held in charitable trusts.

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<sup>xxvii</sup> Oregon common law *cy pres* doctrine might be preempted by the states extensive not-for-profit corporations law.

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

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

<sup>xxx</sup> Tennessee *cy pres* doctrine follows the case law trend that limits the use of the *cy pres* trust analyses to formal trusts.

<sup>xxxi</sup> The Virginia corporations code (which permits mergers of stock and nonstock corporations) and other statutes and case law (which prevent nonprofits from paying dividends and other limits on the use of nonprofit assets) conflict.

<sup>xxxii</sup> This power is probably limited to formal trusts, and does not extend to general charitable contributions to a hospital.

<sup>xxxiii</sup> The West Virginia Attorney General has not applied the corporate code to hospital conversions. There are relevant statutes: W. VA. CORP. ACT §31-1-6(n) and §31-1-144 (forbidding private inurement); *Id.* at § 31-1-155 (upon dissolution not-for-profit corporations “must ensure that assets held for charitable, benevolent, or similar purposes be transferred to nonprofit organizations engaged in similar activities,” among other provisions); *Id.* at §44-6A-6 (once impressed with a charitable trust, not-for-profit assets must not be used for private purposes). *But see Id.* at § 31-1-34 (not-for-profit corporations may merge with for-profit, stock corporations upon filing articles with the state).

<sup>xxxiv</sup> The *cy pres* doctrine exists in West Virginia, but the attorney general is not involved in its application. The statute only contemplates interested persons, and the attorney general is not an interested person in West Virginia.

<sup>xxxv</sup> Unable to obtain this information for Massachusetts and West Virginia.

<sup>xxxvi</sup> Respondents were asked, “How does or would your state protect care for the uninsured in the event of a conversion?”

<sup>xxxvii</sup> Respondents were asked, “Are there any requirements on hospitals (for-profit, not-for-profit, government, or all) regarding the provision of charity care?”

<sup>xxxviii</sup> Respondents were asked, “Does your state require foundations formed with conversion proceeds to use charity funds for health care purposes?” If the respondent did not understand the question or did not answer specifically, he was given four alternatives: 1) State does not limit use to charitable purpose; 2) State limits use to charitable purpose, but no substantive restriction; 3) State limits use to health care purpose (research or service); 4) State limits use to hospital care (service).

<sup>xxxix</sup> Denver Medical Center and University Hospital have specific legal requirements.

<sup>xl</sup> The Special Counsel to the Florida Attorney General reported that two methods could be used to protect indigent care: 1) proceeds are marked for indigent care, 2) the for-profit hospital is required to provide a certain level of indigent care. He could not tell me which of the methods had been used in Florida.

<sup>xli</sup> NB: The attorney with whom I spoke had recently been given responsibility for this area, and was only beginning to consider these issues.

<sup>xlii</sup> However, in an interview with another attorney at the Illinois Attorney General’s office, the attorney mentioned that in one conversion the proceeds went to the Jewish Federation because the selling entity was affiliated with the Jewish Federation. Furthermore, in the case of the Dyer HMO in which the AG found self-dealing the state put the funds into a state charity projects fund which was not limited to health care projects.

<sup>xliii</sup> There have been recent sales of Baptist and Catholic hospitals. Assistant Attorney General Barbara Lake presumes the proceeds went back to the not-for-profit religious organization that owned the hospital.

<sup>xliv</sup> Enacted in 1945, the Hill-Burton Act provided federal funds for hospital construction and expansion. The statute includes indigent care requirements. 42 U.S.C.A. §291.

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<sup>xlv</sup> In HCA's asset purchase of Portsmouth Hospital, HCA "contractually agreed to provide free care to indigent persons within the Seacoast area who are admitted to the facility." Master's Report, at 9. In another transaction the buyer was required, for a period of five years, to provide the same level of indigent care provided by the seller prior to the sale.

<sup>xlvi</sup> The North Carolina conditioned approval of Columbia/HCA's acquisition of Cape Fear Memorial Hospital upon several terms including: "Buyer shall maintain Emergency Medical Services at the level currently provided by the Hospital. Buyer shall maintain indigent and charity care services at the level currently provide by the Hospital." N.C. Dep't of J., Conditional Approval Proposed Sale of Cape Fear Memorial Hospital, Inc., at 12. However, the conditions of approval were amended to be consistent with the following statement: "Subject to the need to assure continued financial stability and giving due consideration to the appropriate level of services required by the community, as well as the exercise of appropriate business judgment by Columbia/HCA Healthcare Corporation, Columbia Cape Fear intends to continue existing community services presently performed by the Hospital in its service area." Letter from Robert L. Wilson, Jr., Maupin Taylor Ellis & Adams, P.A. to Sherry Cornett Lindquist, Ass. Att'y Gen., N.C. Dep't of Justice (May 1, 1996) (on file with author).

<sup>xlvii</sup> "The Foundation shall not deal exclusively with Buyer or its affiliates and shall provide community - based services to those counties traditionally served by the Hospital." N.C. Dep't of J., Conditional Approval Proposed Sale of Cape Fear Memorial Hospital, Inc., at 11. "The efforts of the Foundation will address three (3) needs. The first need is research correlated with the recently performed health care needs assessment undertaken by [the selling hospital, another hospital and another entity]...to develop a complete profile of services needs versus services available in our area. Of particular interest will be the identification of non-hospital services which may be offered by community-based providers, for which financial support sources do not currently exist. The second focus of the activity of the Foundation will be educational, broadly classified as preventive health promotion...the third focus of the foundation will be to support charitable enterprises proposed by community-based providers of health care services who have identified ways in which the health care needs of people in its geographic area may be provided in nonprofit endeavors." N.C. Dep't of J., Conditional Approval Proposed Sale of Cape Fear Memorial Hospital, Inc., at 14.

<sup>xlviii</sup> In one county, the tax assessor is holding hearings to determine whether the hospital provides adequate community benefit to justify the property tax exemption.

<sup>xlix</sup> However, in some cases it might not be appropriate to require the formation of a separate foundation. In one case in which thirteen bed rehabilitation hospital was sold, the administrative costs of starting a new foundation would have been excessive.

<sup>1</sup> TennCare, the state insurance program, covers all uninsured patients. The attorney general did not address this issue in oversight of the Nashville Memorial Hospital sale to HealthTrust, Inc. because of the TennCare program.

<sup>ii</sup> The breadth of permissible foundation activities depends upon restrictions on the hospital's charitable assets according to the hospital's controlling documents and representations made to the public. Nashville Memorial Hospital's controlling documents, for example, permitted it to embrace any lawful purpose. Furthermore, the hospital had not made any representations to the public or donors regarding limiting assets to specific activities. Therefore, the mission of the foundation established with the proceeds of the conversion is broad; it is to promote and advance the health and quality of life throughout the community. In addition, the spectrum of potential grantees is wide, allowing grants to civic and welfare organizations for the betterment of quality of life. Proposed State of Tenn. Amend. And Restated Charter of Nashville Mem. Health Systems, Inc. (1994) (on file with author).

<sup>iii</sup> Consent Decree, *Burson v. Nashville Mem. Hosp.*, (Tenn. Ch.)(No.94-744-T)(Mar. 17, 1994).

<sup>iiii</sup> In a proceeding regarding the application of Blue Cross and Blue Shield of Virginia (Trigon) to convert from not-for-profit to for-profit, the attorney general "questioned whether Trigon could lawfully convert... without accounting to the public for the value attributable to its long history as a tax-exempt, public benefit corporation." Pre-Hr'g Br. of Div. of Con. Counsel, Office of the Att'y Gen., Application of BC and BS of Va. for Conversion from a Mut. Insurance Co. to a Stock Corp., at 1 No. INS950103, (Aug. 30, 1996). In 1996 the state legislature passed a law that codified the conversion deal. The surplus from the period when Trigon was a not-for-profit corporation until the date when the state premium tax law changed, plus \$10 million, was to be paid to the state treasurer. VA. CODE ANN. §38.2-1005.1(B)(4).

<sup>liv</sup> The Emergency Medical Treatment and Labor Act applies to hospitals that participate in Medicare. Such hospitals must treat patients who arrive at emergency rooms with emergencies, and stabilize the medical conditions before transferring the patients to other facilities. 42 U.S.C.A §1395dd

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

<sup>lvi</sup> H.R. 443, 105<sup>th</sup> Cong., 1<sup>st</sup> Sess. (1997).

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

<sup>lviii</sup> CAL. CORP. CODE § 5910 *et seq.* (1996); CAL. STAT. 1105 (1996); CAL. ADV. LEGIS. SERV. 1105 (Deering 1996).

<sup>lix</sup> CAL. CORP. CODE § 5914(a)(1)-(2) (1996).

<sup>lx</sup> CAL. CORP. CODE § 5913 (1996).

<sup>lxi</sup> H.R. 97-1256, 61<sup>st</sup> Colo. Gen. Assem., (1997) (defeated in committee March 1997).

<sup>lxii</sup> S. 372, 1997 Kan. Sess. General Carla J. Stovall has endorsed this bill as well as S. 283, a conversion bill that vests more power in the AG and does not require oversight by the Sec. of Health and Environment.

<sup>lxiii</sup> H.R. 287, 411<sup>th</sup> Md. Leg., Reg. Sess., (1997). Another conversion bill, S. 531, 411<sup>th</sup> Leg., Reg. Sess., (1997) (companion to H.R. 753), received an unfavorable committee report.

<sup>lxiv</sup> NEB. REV. STAT. §§71-20, 102 *et seq.* (1996). The powers granted by the statute are meant to be held in addition to other common law and statutory powers. NEB. REV. STAT. §71-20, 114 (1996).

<sup>lxv</sup> If transaction falls outside definition of “acquisition”, the transaction may still require notice to and permission of attorney general, although it will not require notice to and permission of Department of Health.

<sup>lxvi</sup> Amendments to RSA chapter 7. (not yet introduced at time of writing, on file with author). Legislation will not supplant or restrict other legal authority.

<sup>lxvii</sup> H.R. 2328, 69<sup>th</sup> Leg., Reg. Sess. (1997) (filed at request of the Oregon Department of Justice).

<sup>lxviii</sup> CAL. CORP. CODE § 5916 (Deering 1996).

<sup>lxix</sup> CAL. CORP. CODE § 5917 (Deering 1996).

<sup>lxx</sup> CAL. CORP. CODE § 5917(H) (Deering 1996).

<sup>lxxi</sup> NEB. REV. STAT. §71-20, 105(1) (1996).

<sup>lxxii</sup> NEB. REV. STAT. §71-20, 106 (1996).

<sup>lxxiii</sup> The AG must consider the following factors: (1) Whether the acquisition is permitted under state nonprofit law; (2) Whether the hospital exercised due diligence in its decisionmaking (selling, selecting purchaser, negotiating terms); (3) Procedures used in making decision, including use of experts; (4) disclosure of conflicts related to board members, managers, and experts of both parties; (5) Fairness of value. The attorney general may hire an expert to help evaluate fairness and compel the seller to pay for the expert; (6) Whether charitable funds are placed at unreasonable risk, if the acquisition is financed in part by the seller; (7) Fairness of any management contract under the acquisition; (8) Whether proceeds used for appropriate charitable health care purposes consistent with the seller’s original purpose or for support of health care in the affected community, and whether the proceeds controlled as charitable funds independently of the purchaser or parties to the acquisition; (9) Existence of a right of first refusal to repurchase the hospital if it is sold, acquired by or merged by another entity. NEB. REV. STAT. §71-20, 108(1) - (9) (1996).

<sup>lxxiv</sup> The Department of Health is compelled to consider three questions regarding care for the community: (1) “Whether sufficient safeguards are included to assure the affected community continued access to affordable care; (2) Whether the purchaser and parties to the acquisition have made a commitment to provide benefits to the disadvantaged, the uninsured, and the underinsured and to provide benefits to the affected community to promote improved health care. Activities and funding provided by the seller or its successor nonprofit corporation or foundation to provide such health care may be considered in evaluating compliance with this commitment; (3) If health care providers will be offered the opportunity to invest or own an interest in the purchaser or a related entity to the purchaser, whether procedures or safeguards are in place to avoid conflict of interest in patient referral and the nature of such procedures and safeguards.” NEB. REV. STAT. §71-20, 109 (1996). However, the potential of the department to secure care for the uninsured is limited because the statute “does not apply higher standards to hospitals covered by the Nonprofit Hospital Sale Act than those applicable to hospitals not covered by the act.” *Id.*

<sup>lxxv</sup> NEB. REV. STAT. §71-20, 110 (1996).

<sup>lxxvi</sup> NEB. REV. STAT. §71-20, 111 (1996).