The Charity Law & Practice Review

FROM CHARITY TO COMMERCE: NONPROFIT HEALTHCARE CONVERSIONS

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Introduction

The United States is witnessing the largest redeployment of charitable assets in the Anglo-American world since Henry VIII closed the monasteries in 1536-1540 as formerly nonprofit healthcare providers are switching to for-profit status. Conversions refer to a growing array of transactions that have in common the transformation of the core enterprise from a charitable undertaking to a for-profit venture. Billions of pounds in charitable assets have been redeployed from eleemosynary to profit-seeking purposes, leading to a fundamental change in the structure of the American healthcare system.

This paper does not address the truly significant policy issues: whether for-profit healthcare should be allowed or encouraged; whether provision by for-profit providers is better or worse than nonprofits or what criteria should be used; or what is the impact of these conversions on the communities they serve. It discusses less significant issues: those of process - how can we shape and control this tidal wave of change, so that the public will be served and charitable assets preserved to the maximum extent possible. The focus is upon the valuation of these charitable assets, the appropriate process of conversion, how to protect the public; who should represent the public interest; and what if any should be the legal response. The author will present a very brief overview of the American system of charities, examine the landscape of the healthcare sector affected by conversions, detail conversion procedures, call attention to some of the trouble spots and offer a suggested legal response.

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Some Comparisons and Contrasts between US and English Regulation of Charities

A. Section 501(c)(3) Organisations: "Traditional Nonprofits"

There is a vast array of organisations in the United States that share the designation "nonprofit". Section 501 of the Internal Revenue Code provides 25 different organisational categories which exempt an organisation from federal income taxation.[1] These categories of tax exempt organisations include corporations, title holding companies, civic leagues, local associations of employees, business leagues, social clubs, organisations operated for religious, charitable, educational and similar purposes.

Over half of the 1.2 million charities registered with the Internal Revenue Service are in section 501(c)(3) which consists of traditional charities.[2] The tax code states that these traditional charities must be organized and operated exclusively for religious, charitable, scientific, literary or educational purposes. No part of their net earnings can inure to the benefit of any private shareholder or individual, and no substantial part of the activities can be carrying on propaganda or otherwise attempting to influence legislation. These traditional charities may not participate or intervene in political campaigns. This category is the most valuable to organisations, because contributions to such charities are deductible by the donor from their personal or corporate income.

The Internal Revenue Code is the longest statute in the world, and is accompanied by even longer regulations. Yet, there is no definition of "charitable" in the Code. The Regulations interpreting the Code state that the term is used in its generally

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1 IRC ss. 501(c)(1)-501(c)(25); 501(d), 501(e), 501(f), 501(k).

2 Section 501(c)(3) of the Internal Revenue Code exempts "[c]orporations, and any community chest, fund or foundation, organised and operated exclusively for religious, charitable, scientific, testing for public safety, literary or educational purposes, or to foster national or international amateur sports competition ... or for the prevention of cruelty to children or animals, no part of the 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 on behalf of any candidate for public office."

accepted legal sense.[3] Charity is an evolving concept that expands to meet changing societal needs. Its meaning has been based on case law and law of charitable trusts.

B. Use of Corporate Form rather than Trust

The corporate form was used widely for American charities from the beginning of the nineteenth century and even before. After the Revolutionary War, there came a rise of political and cultural nationalism in the new American republic, the belief that the law should reflect the present rather than be restricted by the dead hand of the past, and a reaction against all things British. This led to the repeal of all British statutes in Virginia and six other states, including New York. Lawyers then argued that the repeal of the Statute of Charitable Uses meant charitable trusts could not be sustained. The legal rationale was the mistaken belief that equity's powers derived solely from the Statute of Uses and did not exist at common law.[4]

This view was upheld in a 1819 Supreme Court case, *Trustees of Philadelphia Baptist Assn v Hart's Executors*.[5] In fact, the Calendars of the Proceedings on Chancery had been published in England and conclusively showed that charitable trusts had been upheld prior to the Statute of Charitable Uses. These early Chancery reports were not yet available in the United States and were first published there in 1827. The Supreme Court corrected its historical error in 1844,[6] but several states still refused to enforce charitable trusts. Others enforced them quite restrictively. This was due to more than historical ignorance. Anti-clericalism was at work. There was also the belief that charities, religious or otherwise, trampled individual rights by depriving future heirs of property to which they were entitled. The charitable corporation became and remained an increasingly important form for philanthropic activities.

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3 The regulations - borrowing principles from charitable trust law - expansively construe it in its "generally accepted legal sense" by providing that charity includes such divergent activities as: relief of the poor and distressed; promotion of social welfare; advancement of religion, education and science; promotion of health; erection of public buildings; and lessening of burdens of government. "Charitable" has been construed to mean far more than benevolence or philanthropy. Treas. Reg. s.1.501(c)(3)-1(d)(2).

4 See generally, James J Fishman, 'The Development of Nonprofit Corporation Law and an Agenda for Reform', 34 Emory L. J. 617, 631-637 (1985).

5 17 US (1 Wheat) 1 (1819).

6 *Vidal v Girard's Executor*, 43 US (2 How) 127 (1844).

C. The Regulation of Charities

The regulation of charities is more complex in the United States than in the United Kingdom as there are both state and federal registration and reporting requirements. At the state level charity incorporates and usually must register with the attorney general or another state official, and may have to register again if it intends to solicit funds from the public. Typically, there are annual filing requirements with one or more state agencies.

At the federal level charities must apply for recognition of tax exempt status.[7] The Internal Revenue Service will send the charity a letter recognising its exemption from federal taxation. Thereafter, it will monitor the organisation for ongoing compliance with statutory requirements. It may fine the organisation for certain types of violations or revoke tax exempt status. After receiving federal exemption, the charity will seek exemption from various state and local taxes.

Oversight of charities primarily is the responsibility of the state attorney general in the jurisdiction of incorporation. The Internal Revenue Service primarily is responsible for seeing that the tax laws are followed. The state attorney general has the authority to initiate legal proceedings. Prosecutions can be initiated on the federal level if there is a criminal violation of the tax laws. There is no real equivalent to a Charities Commission.

Dissolution of Non-profits

Nonprofit organisations may outlive their purposes, utility to society, or their members or financial difficulties threaten survival. To obtain exemption under section 501(c)(3), the organisation's articles of association must state that upon dissolution, the assets by reason of a provision in the organisation's articles or by operation of law are distributed for one or more exempt purposes, to a governmental body for a public purpose or would be distributed by a court to another organisation to be used in such manner as in the judgment of the court will best accomplish the general purposes for which the dissolved organisation was

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7 Exemption from federal taxation is a statutory privilege. The Internal Revenue Code provides that an organisation is exempt unless for some reason exemption is denied. Exemption therefore is a privilege granted by law and not the IRS. Thus, properly organised and operated organisations are exempt unless the Internal Revenue Service proves otherwise. Receiving recognition of exemption is almost automatic if the application form is completed properly. Charities with gross receipts under £2,942 are exempt. There are annual filing requirements if gross receipts exceed £14,700.

formed.[8] Normally such a provision is not a problem, for many nonprofits that dissolve do so in an atmosphere of difficulty caused by financial problems. There are few assets to transfer to public use. Thus, the law is clear that when an organisation is exempt under s.501(c)(3) of the Code, it must contribute its remaining assets to another 501(c)(3) organisation.[9]

Typically, little is contributed to other organisations as lack of assets are the primary cause for most organisations' demise.[10] In the context of hospital and HMO conversions in contrast, the assets at stake are enormous and their valuation and disposition are crucial elements in the transaction. Consider how the following example of the conversion of a California nonprofit health maintenance organisation differed from the norm.

Health Maintenance Organisations (HMOs) offer comprehensive primary health care through physicians who are employees or partners or through arrangements with groups of physicians on a cost efficient basis to subscriber members on a prepaid fee contract. The Family Health Programme (FHP) was founded in 1961 as a nonprofit HMO by Dr Robert Gumbiner and offered prepaid medical and dental care through a network of 22 company-operated clinics in Southern California, Utah, and Guam as well as through contractual arrangements with physicians in Arizona and New Mexico. FHP received the benefits of tax exemption. Federal loans and grants then available to nonprofit HMOs enabled expansion.

In February 1985 when it first applied for conversion to a for-profit, the board of directors valued its assets at approximately £8 million as of 30th June, 1984. Gumbiner and seventeen other investors, including other board members, founded HMO Health Group, Inc. (HGI) as the for-profit purchaser of FHP's assets. Gumbiner owned 50.5% of HGI. The California Department of Corporations rejected the £8 million figure and proposed £27.7 million as the fair market value.

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8 Treas. Reg. 1-501(c)(3)-1(b)(4).

9 The Charities Act 1993 s.74(2) is roughly the same.

10 A study by William G Bowen, Thomas I Nygren, Sarah E Turner, and Elizabeth A Duffy, *The Charitable Non-Profits* (1994), illustrates some differences between non-profit and for-profit dissolutions. First, nonprofits are more likely to resist closure and simply hold on in the face of economic setbacks than for-profits, which may see economic and tax benefits in combinations or liquidations. Second, nonprofits with substantial assets are less likely to close than other nonprofits. Id at 99. There may be greater pressures to keep nonprofits in existence than for profit-seeking entities. Thus, many nonprofits survive too long, drawing down their resources to finance annual deficits, or they stay alive on the basis of faded but still useful reputations. Boards may be embarrassed to close or to seek a merger with a stronger organisation.

The Department and FHP then negotiated a £23 million price which included £4.24 million in cash, and the rest paid over ten years.

Another for-profit HMO, Maxicare Health Plans, made a competing offer to buy FHP for £30 million and sued to prevent HMO Health Group's conversion of FHP. Maxicare was joined by the California Attorney General who urged that FHP be required to accept the highest offer. At the time both the president of Maxicare and FHP's own documents indicated that FHP's fair market value might have been substantially higher. The court permitted the conversion to HGI, holding that the law did not require sale to the highest bidder.[11] A foundation was established to receive the money used to purchase the HMO.

Eight months after the conversion, HGI floated a public offering of stock with a market value of £88 million. Approximately £15 million went to the for-profit HMO and just under £6.25 million went to the FHP Foundation, established as part of the conversion. The former managers, including Dr Gumbiner, continued to hold a 75.9% stake in the for-profit company worth £67 million.[12] These assets belong to the public not to a nonprofit's managers. Gumbiner & Associates used the nonprofit form to receive private inurement.

Why are Conversions Important?

Conversions are neither new, nor are they confined to the healthcare field despite the media attention and state regulatory focus on hospitals and HMOs. The category of charitable organisation susceptible to conversion is much broader. It includes virtually any exempt organisation that provides products or services for which there is a significant market - nonprofit book publishers, nonprofit television stations, as well as tax-exempt biotechnology research institutes.[13]

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11 *Maxicare Health Plans v Gumbiner*, No C-565072 (Los Angeles Superior Court, 1986).

12 HGI has since been taken over by a larger firm, further enriching its shareholders.

13 Reverend Pat Robertson and his family purchased a controlling interest in the programming subsidiary of the Christian Television Network for £108,000 in 1989. It went public in 1992 and its shares were worth £53 million. Reverend Robertson and his family retained majority control. In June 1997 Rupert Murdoch agreed to purchase International Family Entertainment, Inc., still controlled by the Robertson family, for £1.1 billion. Geraldine Fabrikant, 'Murdoch Set to Buy Family Cable Concern', *New York Times*, 12th June 1997 at D1.

Healthcare conversions have occurred with:

. HMOs

. Exempt hospitals acquired by proprietary enterprises

. Spinoffs of Blue Cross/Blue Shield insurance plan assets into taxable subsidiaries.

Note that there also have been conversions of for-profits to non-profit status.[14]

The Landscape

Conversions occurred among hospitals and HMOs for many years without attracting much attention.[15]

A. Hospitals

Three ownership types of hospitals have long coexisted: public, charitable, and for-profit. Public hospitals are owned and operated by a governmental unit. Charitable hospitals, frequently termed "voluntary hospitals", originally were organized by religious societies, heavily funded by donations, and staffed by doctors who worked without compensation and nurses who worked for room and board as part of their commitment to a religious order devoted to caring for the

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14 These include medical practice groups acquired by integrated delivery systems, freestanding medical groups or clinics, and hospitals that formed for-profit subsidiaries to engage in certain ventures that wish to change the tax status of such subsidiaries. Conversion of for-profits to nonprofits allow the new nonprofits to: (a) receive and accumulate income from exempt activities tax free; (b) receive charitable contribution on a tax-deductible basis (I.R.C. s.501(c)(3) only); (c) gain access to the tax-exempt bond market; (d) avoid "phantom income" from services provided to related organization; (e) reduce federal payroll taxes; (f) avoid paying state property taxes; (g) achieve the prestige and philanthropic support associated with nonprofit, charitable status ("the halo effect"); (h) provide tax-sheltered annuities, avoid paying certain federal excise taxes, participate in shared service organisations (hospitals), receive preferred postal rates and certain sales tax exemptions, avoid Robinson-Patman Act federal price discrimination law, and receive other miscellaneous benefits. Richard Mancino, *Taxation of Hospitals and Health Care Organisations* Ch 21 (1995) & (1997 Supp.).

15 See Bradford Gray, 'Conversions of Nonprofit Health Plans & Hospitals: An Overview of the Issues and the Evidence, in Conversion Transactions: Changing Between Nonprofit and For-Profit Form' (National Center on Philanthropy and the Law 1996) [hereinafter, Gray].

poor.[16] Nor are for-profit hospitals, owned by shareholders, new. At the turn of the twentieth century approximately half of all hospitals were proprietary, typically small organisations owned by physicians as an adjunct to their medical practices. For-profit hospitals declined to about 15% of all community hospitals by 1965, the dawn of Medicare and Medicaid, federal programmes of reimbursement for the elderly and others.[17]

Medicare and Medicaid

Unlike virtually every other industrialised nation, the United States still lacks a programme that makes healthcare comprehensively available to its citizens. It does have Medicare, introduced in 1966, which covers hospital care for the over-65s and some others such as long term disabled.[18] A second voluntary Medicare programme covers certain outpatient costs. Though limited in scope, it is enormously expensive.

Medicaid is a cooperative federal and state programme that finances health care for the poor - well, the worthy poor - lower income individuals who are aged, blind, disabled, or families of dependent children or those of any income who have catastrophic illnesses. Nationwide about 52% of persons with income levels below the federal poverty limit are covered by Medicaid. The government contributes 50-83% of the cost of Medicaid; the states the rest.[19] Both programmes are enormously expensive, and by and large, the third party payor - the government - foots the cost.

For-profit hospitals were jump-started by Medicare. The programmes also encouraged mergers. The most dramatic trends occurred between the mid 1960s and early 1980s with the growth of hospital management companies - HCA, American Medical International and others that owned multiple hospitals. These companies were created post-Medicare, but their growth stopped by the early 1980s because of changes in Medicare reimbursement.[20] There were few hospital

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16 Mark A Hall and John D Colombo, 'The Charitable Status of Non-profit Hospitals: Toward a Donative Theory of Tax Exemption', 66 Wash. L. Rev. 307, 317 (1991).

17 Gray, supra note 15, at 13-14.

18 42 U.S.C.A. Ss.1395-1395ccc. See Barry R Furrow, Thomas L Greaney, Sandra H. Johnson, Timothy Stoltzfus Jost & Robert L Schwartz *Health Law*, Ch 13 (1995) for an excellent summary of these programmes.

19 Id. s.14.01.

20 Gray, supra note 15 at 14-16.

conversions in the first golden age of investor-owned hospitals.[21] From the mid 1960s to the mid nineties the overall for-profit-nonprofit-public composition of the hospital industry changed remarkably little, perhaps one percent of the total.[22]

The Emergence of Goliath

Columbia Hospital Systems was formed in 1987. Within a decade it grew to a corporation with £123 billion in revenues which owned approximately 350 hospitals, 500 health care offices and scores of other medical businesses in 38 states.[23] Columbia not only expanded by acquiring for-profit hospitals. In 1995 Columbia acquired 33 tax exempt hospitals. In 1996 17 of its 28 acquisitions or joint ventures involved tax exempt hospitals with an additional 14 pending.[24]

B. HMO Ownership Trends

Though prepaid medical services have existed since the eighteenth century, in the second half of the twentieth century their use widened because HMOs were seen as devices to hold down the ever-increasing cost of health care. Through the Health Care Maintenance Act of 1973,[25] the federal government served as a venture capitalist for nonprofit HMOs, providing loans and financial guarantees. Because of the availability of federal assistance, nonprofit HMOs dominated. In

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21 Between 1980-1993 there was a total of 647 conversions: 197 were conversions to for-profit (some were government hospitals); 119 of these were nonprofit to for-profit; 79 conversions were for-profit to nonprofit (Deborah J Chollet, Jo Ann Lamphere, and Jack Needleman, 'Conversion of Hospitals and Health Plans to for-profit Status: A Preliminary Investigation of Community Issues' Washington: Alpha Center, May 1996 *cited in* Gray, supra note 15, at 18).

22 Gray, supra note 15, at 19.

23 Martin Gottlieb & Kurt Eichenwald, 'Health Care's Giant', *New York Times*, 11th May, 1997, s.3, at 1.

24 Bruce Japsen, 'Another Record Year for Dealmaking: Activity Among Medium-Size Companies - Fuels Continued Drive Toward Consolidation', *Modern Healthcare*, 23rd December, 1996 at 37. The 1995 year end review of mergers and acquisitions by Modern Healthcare indicated 48 nonprofit hospitals had converted or planned to convert to for-profit status in 1995, in 1996 only 8% or 63 of the hospitals that merged converted to for-profit status. Demise of the Not-for-Profit Has Been Greatly Exaggerated, *Modern Healthcare*, 23rd December 1996, at 35.

25 42 U.S.C.A. Ss.300e-300e-14.

1983 the federal loan programmes ceased, and HMOs with growing capital needs began to convert to for-profit status.[26]

Differences Between Hospitals and HMOs

Investor ownership of hospitals emerged late in a mature field. The ownership picture in HMOs was heavily influenced by fact that the field has been growing rapidly over two decades. Only one percent of nonprofit hospitals have converted to profit-seeking status, whereas one third of HMOs have.

Why have so few hospitals converted to for-profit status compared to HMOs? The hospital as an institution has a more longstanding and significant place in most communities. Sales to for-profit chains have been contentious, because ownership by national investor-owned firms threaten a valuable community institution and replacement of local control with new standards, distantly determined. The charitable hospital has been an elite institution. Historically, hospital boards constituted important philanthropic activities of the most influential and powerful members of the local power structure.[27]

Most of these conversions are negotiated in private. The HMO conversions did not generate same the concerns because HMO boards were more likely to be composed of insiders. They also were entrepreneurial and less representative of the broader community than hospitals. Conversions began at the time of increasing demand, so HMOs did not have to fight valued community institutions for market share.[28] The Internal Revenue Service's concern over HMOs led to restrictive requirements for tax exemption[29] and when capital resources dried up, the for-profit form became attractive.

Despite the controversial reactions by the communities in which they are located, there are enormous temptations for local hospitals to convert. Too many hospital beds for too few patients engendered competition between hospitals. For-profit chains using economies of scale and instituting administrative efficiencies were able to provide services for less than nonprofit counterparts. Increasing capital requirements for new equipment to attract patient-business place many nonprofit

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26 At least two-thirds of all HMOs are profit-seeking compared to 20% in 1981. Anne Lowrey Bailey, 'Charities Win, Lose in Health Shuffle', *Chron. of Philanthropy*, 14th June 1994 at 1, 11.

27 Gray, supra note 15, at 27-34.

28 Id. at page 31.

29 *Sound Health v Commissioner*, 71 T.C. 158 (1978).

hospitals at a competitive disadvantage. Investment bankers spoke to trustees about the "monetizing of the community hospital asset". The economic argument runs as follows: the law of comparative advantage postulates that resources, dollars, people, and business have a best use. Society or community is better off when that best use is realised.[30] By converting former nonprofit hospitals to a for-profit, the theory is that capital in bricks and mortar have been released for a better social use. Community hospital boards faced with a parlous financial situation and induced by what seem to be huge sums sell their hospitals too quickly, at too low a value with little community input.

C. Blue Cross Conversions

Blue Cross is an insurance plan for the less affluent. Hospitals established "Blues Plans" as not-for-profits in 1930s to ensure that patients would have the means to pay for care. For years Blues enjoyed regulatory and tax exemptions because of their social mission. Generally Blue Cross took greater risks than other insurers. It used to be said that Blues' claims departments' mission was to figure out how not to reject the claim but how to pay it.

There are nearly sixty independent Blue Cross plans serving nearly 70 million in widely differing markets.[31] There were nearly 100 such plans a few years ago but competitive pressures caused by the growth of managed care plans and drastically increased capital needs have led to waves of mergers and attempted conversions to for-profit status.[32] This is a time of tumult and change as Blues are merging, affiliating in consortia, creating for-profit subsidiaries, and converting to for-profit status.[33] Critics say these conversions are siphoning billions into investors' and executives' pockets. Several plans have converted to for-profit status or announced conversion plans.[34]

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30 Craig Havighurst, 'Solid Foundations,' 29 Health Systems Review 33 (1996).

31 Louise Kertesz, 'Not Your Father's Blue Cross', *Mod. Healthcare*, 14th October 1996 at 14.

32 Liz Runge, 'The Blues are Learning Some New Tunes', 97 Best's Rev.-Life- Health Insur. ed 60 (Mar. 1997) available in LEXIS, News Library, BRLIFE file.

33 Kertesz, supra note 31, at 14.

34 Four are completed. Others are in the process. Three other Blues plans - Wisconsin, Indiana and Missouri - have owned publicly traded managed care subsidiaries for several years.

Other Blues are merging which may be a prelude to for-profit conversion.[35] The reasons for conversion correlate to those of hospitals and HMOs: a need for more capital and new competition. In the case of Blues Plans the competition has come from HMOs which through expansion have siphoned off customers from Blue Cross. In New York State, Empire Blue Cross lost five million subsidiaries in a few years to HMOs.

Regulators have objected to Blue Cross conversions. The Blues Plans were established as nonprofits because of their public mission, and the feeling has been that they essentially are owned by the public and the public should receive money for their conversions, not private individuals. Nor should Blues' assets be used as seed money for for-profit ventures.

Causes of Conversion to For-profit Status

Conversions of nonprofit healthcare providers allow the new for-profits to: avoid increased Internal Revenue Service regulation and scrutiny; take advantage of current operating losses; compete better and seek profits aggressively; provide equity incentives to service providers, such as physicians; engage in unlimited lobbying and political activity; take advantage of private and public equity capital markets; and allow weaker hospitals to consolidate and replace antiquated equipment and heavy debt load.[36]

The fundamental reason for healthcare providers' move to for-profit status is for easier access to capital. Historically, nonprofit healthcare organisations raised capital through the use of tax exempt financing, which enabled nonprofit healthcare borrowers to pay a lower cost of interest than if the regular capital markets were used. In the early 1980s, there were significant savings over entering the taxable bond market. A second benefit from tax exempt financing was arbitrage investment profits. The proceeds from tax exempt financing were invested in taxable securities earning a greater rate of interest, with the profits going to the exempt organisation. Congress caught up with this, and required that if a nonprofit borrowed with tax exempt bonds it could not reinvest the funds to receive a taxable rate of interest. Still, there were loopholes existing.

This meant there was an incentive to borrow in advance of your need. Institutions would invest in for-profit vehicles and then use the dollars when they needed to.

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35 Most Blue Cross Plans have formed wholly owned for-profit subsidiaries offering a spectrum of products.

36 Mancino, supra note 14, at Ch 21.

Much of the overcapitalization and the overbuilding in the hospital sector resulted from the use of this technique. The money was there and could be used for certain periods of time for anything, but eventually hospitals had to build something. Thus, there was a great incentive to borrow.

The 1986 Tax Reform Act changed and limited the use of tax exempt financing. Pre-1986, 25% of tax exempt bonds could be used for unrelated business operations. These might include physicians' offices, management contracts with private companies and cooperative ventures. Now there is a 5% limit on unrelated business operations. There is also a £88 million limitation on borrowing. Any section 501(c)(3) organisation that borrows for other than hospital purposes cannot borrow more.[37]

These tax law changes made tax exempt financing less valuable to the nonprofit and limited a hospital's flexibility. Additionally, the spread between tax exempt financing and for-profit financing which was 70-80% in 1980s moved to 85-90%, narrowing the significance of interest savings. The tax exempt marketplace became over-saturated with tax exempt paper of financially weak hospitals, making the regular capital markets more comparable in terms of cost of borrowing. All in all, the desirability of nonprofit status diminished for hospitals.[38]

What is a Conversion in the Internal Revenue Code and State Charitable Corporation Law?

A. The Conversion in Place

A conversion in place refers to a process by which the board recommends an amendment to the corporation's articles of incorporation which deletes its nonprofit aspects and add for-profit powers.[39] The newly converted for-profit corporation is empowered to issue stock, permitted to conduct all lawful business and allowed

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37 The £88 million borrowing limit is a restriction on mergers of nonprofit hospitals. One cannot underestimate the economic importance of shifts in the tax laws.

38 For non-profit HMOs tax exempt debt was unavailable after 1983 for new product development, geographic expansion or acquisitions. Mancino, supra note 14, at 8.

39 Typically, the board will recommend an amendment, and the members, if there are any, must approve.

to pay dividends.[40] In a conversion in place the legal entity remains in place, the "xyz charitable corporation" merely becomes the "xyz business corporation". Existing contractual relationships remain. The conversion in place is permitted only in a few states. Typically, it is favoured by HMOs, preferred provider organisations and other managed care organisations not dependent on fixed assets like real property.

B. Asset Sales

Another conversion approach is a sale of assets. A nonprofit corporation, exempt under section 501(c)(3) of the Internal Revenue Code, sells its operating assets to a for-profit corporation for fair market value. Unlike a conversion in place, an asset sale requires the for-profit to obtain appropriate state licences. After the sale, the for-profit corporation owns the charitable corporation's assets formerly owned by the nonprofit, which may receive stock, notes, or other property in addition to cash as consideration. This is a typical transaction structure for acquisition of a nonprofit hospital by a for-profit acquirer.[41] Federal and state laws require that the proceeds of sale continue to be held in charitable trust and used for charitable purposes.[42] Foundations are usually the post-conversion holder of these charitable assets.

C. Merger

Another technique involves a merger of nonprofit corporations into a for-profit. Here, the charity forms a new for-profit corporation to which it contributes its assets in exchange for cash, notes, and stock. Then, there is a merger of the nonprofit corporation into the for-profit corporation. This is permitted in a few states. Here again, state and federal laws join in requiring the exchange proceeds to remain in charitable trust and to be used for charitable purposes. A foundation or nonprofit corporation is created to receive the cash or stock from the surviving

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40 The fundamental distinction between a charitable nonprofit and a business corporation is the non-distribution constraint, i.e. the non-profit cannot distribute its earnings to members or shareholders.

41 It is common that the for-profit will purchase selected assets, usually the most profitable.

42 Either in its charter or under applicable state law a charitable nonprofit must expressly dedicate its assets to an exempt purpose in the event of dissolution. This means that the assets may not be distributed to the organisation's members. Thus, the charter of a charitable nonprofit invariably provides that upon dissolution the assets will be distributed to another s.501(c)(3) organisation in furtherance of an exempt purpose. See Treas. Reg. 1.501(c)(3)-1(b)(4).

corporation. After the conversion, there are ordinarily two organisations: the for-profit corporation and a private foundation.

D. Drop-down Conversions

This approach involves the transfer of some or all of the operating assets and liabilities of a hospital or HMO to a wholly or partially owned subsidiary in exchange for stock and/or notes. This approach is used when an organisation, such as an HMO, desires to convert some or all of its assets into a for-profit.[43] After the transaction is completed, the for-profit subsidiary may go into the equity markets in an initial public offering.

In a drop-down, the original owner of the assets usually retains a substantial percentage of the equity in the newly formed corporation. This type of conversion when used by an HMO is usually a preliminary step to some other form of transaction: takeover by another health plan. The argument used by some Blue Cross plans has been that they don't need to transfer any assets to charity as the nonprofit remains in existence. The converting organisation may be exempt under section 501(c)(4) or some other non-charitable provision of the Internal Revenue Code. After the conversion, there may be three organisations. In addition to the for-profit corporation and the foundation, a section 501(c)(4) organisation may be created to receive and hold the stock for later sale and to remit the proceeds to the foundation.

Major Legal Implications of this Sector-Shift

The shift to for-profit status has highlighted the inadequacy of state conversion procedures. Several jurisdictions have responded by strengthening and slowing the conversion process. California, for example, addressed the inadequacy of its conversion procedures by enacting legislation that requires the conversion price to be at fair market value, the assets resulting from the conversion to be held by an independent foundation, and the converting organisation to have in place policies prohibiting conflicts of interest.[44] Other jurisdictions are trying to deal with this sector shift by improved monitoring in an area which has been largely self-regulated. Nebraska has passed legislation regulating the sale of hospitals to

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43 In 1993 Blue Cross of California transferred a substantial percentage of its operating assets to Wellpoint Healthcare, a wholly owned for-profit subsidiary, see infra.

44 Cal. Health & Safety Code ss.1399.70 - 1399.75 (1995).

ensure disclosure of conflicts of interest, assurance of fair value and the use to which charitable assets will be put.[45]

Another product of the conversion wave has been the reawakening of the role of the Attorney General in the regulation of charities. In Massachusetts the attorney general's office used its historic powers of oversight to shape the conversion process. California increased the role of the attorney general to control and monitor conversions. There have been efforts in other states by attorneys general to become involved in the conversion process. Publicity has been a great catalyst. However, most attorneys general have little experience and are overmatched by for-profit converters' experts and counsel.

Another result of this healthcare sector shift has been the revitalization of the cy-près doctrine. The theory of cy-prés is that when a charitable purpose becomes impossible, inexpedient, impracticable of fulfilment or already accomplished, equity will permit the trustee to substitute another charitable object which approaches the original purpose as closely as possible.[46] In modifying the trust's purpose, the court must follow the donor's original purpose as closely as possible or *cy-près comme possible* - Norman French for "as near as possible". The power of modification has been strictly construed.

Cy-près comes into play at two points in the conversion process. Can assets which were given for nonprofit purposes be used in a conversion or even in a joint venture with a for-profit? Most observers feel that if a nonprofit hospital, an HMO, or Blue Cross proposes to sell its assets or enters into a whole hospital joint venture, the charity must seek advance court approval in a cy-près type action. On 5th September, 1996, a Michigan trial court judge ruled that a joint venture between a Michigan nonprofit acute care hospital facility and Columbia/HCA violated the state's charitable purpose laws.[47] The court concluded that state law prohibited the transfer of charitable assets to a for-profit joint venture.[48] Cy-près

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45 Neb. Rev. Stat. Section 71-20,102 - 71-20,113 (1996). Arizona, Georgia, Ohio and Washington have passed legislation which brings greater scrutiny and state oversight. Charlote Snow, '3 More States on List, Ga, Ohio, Wash. Adopt Laws on Sales of Not-for-Profits', *Modern Healthcare*, 5th May 1997 at 6.

46 Bogert & Bogert, *The Law of Trusts & Trustees*, s.431 at 95 (2d rev. ed. 1991).

47 *Kelley v Mich.* Affiliated Healthcare, No. 96-83848 C2 (Ingham County Cir. Ct. Jan. 3, 1997) available LEXIS, Taxana Library, 96 TNT - 187-18.

48 This was not directly a cy-près issue, for the court did not rule directly on the cy-près point.

comes into play at a second point after the conversion: Do the proceeds from the conversion have to be put to the same charitable use as before?

Another issue that has arisen is whether the Internal Revenue Service should be involved in these conversions, examining the fiduciary responsibilities of nonprofit directors, which is traditionally a function of the states and state corporate law. The IRS historically has had a rear-view mirror approach to regulation of such sales.[49] Internal Revenue oversight at the conversion stage raises federalism questions.

Trouble Spots - Problems and Conversion Issues

1. Conflicts of Interest

A fundamental problem is that directors of the nonprofit entity may be involved with the for-profit company. They may be promised stock or already be substantial shareholders of the for-profit. The acquiring corporation may promise bonuses and salaries if the director joins the for-profit organisation or "golden parachutes".[50] In its nonprofit guise, the fiduciary responsibility of the director is to obtain the highest value for the nonprofit, and to assure that provision of healthcare remains for community. That individual's interest as a for-profit shareholder or as a future employee may be the opposite. This has been a particular problem in hospital and Blue Cross conversions where executives of the nonprofit are promised substantial bonuses and long term compensation agreements. In Ohio, the management of Blue Cross of Ohio accepted an offer to be sold to Columbia/HCA. Four executives were to receive a £11.18 million "goodbye fee" as part of the transaction, and seven former directors were to receive £2.18 million.[51] Generally, these conversions are "friendly" transactions as viewed by management. The governing body and key staff of the converting nonprofit usually work closely with the for-profit entity. The response of several jurisdictions has been to introduce legislation prohibiting bonuses as part of the

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49 This has not been so with joint ventures between a nonprofit and a for-profit where the former is attempting to preserve its exempt status. *Plumstead Theatre Society, Inc v Commissioner*, 74 T.C. 1324 (1980); Gen. Coun. Memorandum 39862 (1991).

50 That is, substantial termination payments.

51 The national Blue Cross Association revoked the charter of Ohio Blue Cross for this attempt and Ohio Dept of Insurance rejected the transaction on 12th March 1997.

transaction.[52] Most other jurisdictions have declined to do anything. Such largesse to former directors and officers of nonprofits may be a violation of private inurement and private benefit proscriptions of the Internal Revenue Code and Regulations.[53]

There should be enhanced scrutiny of conflicts of interest with respect to the placement of proceeds, whether into a new nonprofit entity or with a joint venture undertaken by the nonprofit entity and a for-profit purchaser. All transactions should be approved and negotiated by an independent committee of disinterested outside directors. This may not be possible in HMO situations, where boards of nonprofit HMOs have consisted largely of insiders. The test then would be the intrinsic fairness of the transaction to the nonprofit with the burden on the board of directors. All of these transactions should be subject to review by the attorney general and by a court.

2. Valuation Issues

At the heart of the conversion controversy are difficult issues of valuation. How can one attain a fair market value for the converting organisation? Nonprofit entities present difficulties in valuation that are not present with the valuation of a for-profit firm. Nonprofit valuation is more complex and uncertain than the valuation of a comparably-sized for-profit.[54]

One factor is that there is no readily ascertainable market value. Another is that nonprofit firms are not regularly scrutinized by gaggles of securities analysts and investment advisors who follow for-profit counterparts. Valuation then rests upon the appraiser's craft, inherently a subjective process. Valuation of nonprofit hospitals is generally calculated as a multiple of the hospital's earnings before the expenses of interest, depreciation, taxes, and amortization, known by the acronym "EBIDTA". Appraisers generally have placed the value of a nonprofit hospital at five to seven times EBIDTA, though valuations outside of this range are not

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52 Colorado has prohibited converting corporations from going public within three years of a conversion. Usually the former nonprofit managers would own substantial sums of stock which would become enormously valuable on a public offering.

53 IRC s.501(c)(3). Treas. Reg. 1.501(c)(3)-1(c)(2). They may also be violations of the newly enacted IRC s.4958, intermediate sanctions legislation.

54 Harvey J Goldschmid, 'Nonprofit Conversion Transactions: Existing Fiduciary Duties and Necessary Reforms', in National Center on Philanthropy & the Law, *Conversion Transactions: Changing Between Non-profit & For-profit* Form 2 (1996) [hereinafter, Goldschmid].

uncommon.[55] Valuation is severely tested in the healthcare area by attempts to find market value where there has not been a market, and when the conversion is followed by an incredible increase in the value of a publicly-traded healthcare company in comparison to its nonprofit value.[56]

The subjectivity and difficulty in valuation may be demonstrated by the sale of St Vincent's Hospital, Worcester, Massachusetts, part of Fallon Healthcare System, to OrNda, a large investor-owned hospital chain. The sale was for very little: basically the hospital, burdened with debt, handed the keys over the promise that the for-profit would run the hospital and pay off long term debt of £40 million. However, OrNda (which purchased the Fallon Clinic as well) paid over £35 million to the 200 doctors and executives who ran Fallon Healthcare System of which the hospital was but a part. The hospital had property and equipment valued at £42.35 million and working capital of £10 million. The community got £2.3 million, and this was after the Massachusetts Attorney General intervened and issued a glowing press release on the conversion. The Attorney General's appraiser, Arthur Anderson Consulting, had concluded the hospital had a negative net value because of its heavy debt, and felt OrNda overpaid for the hospital and clinic. Anderson compared St Vincent's to other hospitals and treated it as worst off of any in a comparable group. If it had treated the hospital as merely equal to the weakest in the sample, it would have been worth £12 million. If the sample had been broadened, and Anderson had based its calculations on the weakest hospital from a larger sample, it would have been worth £23.5 million. An independent real estate valuation firm hired by the *Boston Globe*, a newspaper, came up with a value of £22.35 million.[57]

The problem of determining valuation is that a hospital may have a different value as a nonprofit, a for-profit, or a for-profit taken over by a chain, or as a hospital that will be the first in an area to convert, and relative to the competition in the area as well as other market specific factors.

Increased intervention by state regulators and legislation may also assure conversions at a fair market value.[58] Some have recommended that legislation

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55 Robert A Boisture & Albert G Lauber, 'Comment Letter to IRS on Whole Hospital Joint Ventures', 16 Exempt Org. Tax Rev. 650, 652 (1997).

56 Goldschmid, supra note 54, at 2-3.

57 Gerard O'Neil, Mitchell Zuckoff & Delores Kong, 'Profit Motives Doom Worcester Hospital', *Boston Globe*, 17th November, 1996 at A1 [hereinafter, Profit Motives].

58 See Neb. Rev. Stat. 71-20,108(5).

require a market test.[59] In other words, any hospital, HMO, or Blue Cross that is up for sale or conversion would be required to offer itself to other bidders beyond the initial offeror once the nonprofit board has reached a decision to sell or convert. The requirement of a market test would entail public disclosure of the proposed transaction; the provision of relevant information (subject to appropriate confidentiality safeguards) to responsible persons; an adequate time period for competing offers to be made; and prohibitions on lock-ups and other devices which would taint the test should be required.[60]

Should there be an absolute duty to maximise financial return? Under Delaware business corporate jurisprudence, once it appears that a corporation will be sold the duty of the board of directors is to maximise the company's value at a sale for the stockholders' benefit.[61] In the nonprofit context the board's responsibilities should be to maximise the return to the public. This does not necessarily mean that the board must accept the highest price. Whether or not to recommend acceptance of a particular bidder is within the business judgment of the board. It may be that the highest bid may not be the best for the organisation as a deliverer of healthcare. Or the highest bidders, its financial situation may be precarious. For instance, in the Family Health Plan conversion described earlier, another bidder, Maxicare Health Plans, made a competing offer at a substantially higher price and sued to prevent HMO Health Group's conversion of FHP.[62] The court held that the law did not require sale to the highest bidder. One year after the conversion Maxicare went into bankruptcy.

3. Lack of Disclosure

At the beginning of negotiations between the for-profit acquirer and the nonprofit a confidentiality agreement is signed. Some conversion transactions have been completed in secret without community knowledge. Should the community have

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59 Goldschmid, supra note 54, at 13-15.

60 A lock-up is a generic name for a variety of techniques used in a tender offer to assure a particular bidder will be successful and to thwart competitive bidding. Sometimes stock is issued to the favoured bidder making the acquisition more expensive for other offerors. Other devices included an agreement to reimburse the favoured bidder's fees and the sale of prized assets of the target to the favoured bidder. See Ronald J Gilson & Bernard S Black, *The Law and Finance of Corporate Acquisitions*, 1020-1023 (2d ed. 1995). Lock-ups are not illegal per se under Delaware law, the most important jurisdiction for corporate law. *Revlon v McAndrews and Forbes Holding*, 506 A.2d 173, 183 (1986).

61 *Revlon v McAndrews & Forbes Holdings, Inc*, 506 A.2d 173, 182 (Del 1986).

62 *Maxicare Health Plans v Gumbiner*, No. C-565072 (Los Angeles Superior Ct. 1986).

the right to know the terms of the venture? The trustees of a hospital in Ohio owned by a religious order did not even know the price the hospital was sold for. They were fired by the religious order that owned the hospital before its sale to Columbia/HCA.

Should there be community input into the terms of the transaction?[63] There is nothing similar to the disclosure required in listing requirements under the Companies Acts, the authorisation requirements under the Financial Services Act or the disclosure and registration requirements under American securities regulation.[64]

In Massachusetts, the attorney general agreed with the parties in the Fallon Healthcare-OrNda conversion that the underlying financial documents which justify prices paid are trade secrets that are nobody else's business.[65] One suggestion is that state regulators require the parties to a conversion to disclose to the regulator all the terms of the transaction and any conflicts, an approach which legislation dealing with conversions has adopted.[66] A criticism is that state regulators may not obtain the necessary information in timely fashion, and in any

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63 The difficulty of finding out details about these transactions is illustrated by this testimony by Linda B Miller, President of the Volunteer Trustees Foundation, in a statement before the Committee on Health and Human Resources of the Nebraska State Legislature (1 February 1996):

> "Confidentiality agreements are signed early in the negotiation - and the community **never** knows what the deal looks like. It never knows what the hospital considered by way of other offers, how the asset was valued, what the for-profit buyer actually paid out and what it got in return, what portion of the proceeds were redeployed to a charitable foundation or under what terms. Everything is secret. (Three years after Nashville Memorial in TN was sold, the incorporators of the hospital are still in court trying to find out what the hospital was sold for!)"

64 Generally, the Securities and Exchange Commission regulates public corporations, which means corporations with at least 500 shareholders and approximately £3 million in assets. There are an estimated 14,000 such corporations in the United States.

65 Profit Motives, supra note 57. In California, according to a researcher with whom the author spoke, the Blue Cross of California Document file concerning that conversion which was most contentious has been almost completely deleted by the Commissioner of Corporations' Office, making scholarly inquiry difficult if not impossible.

66 See Nebraska Rev. Stat. S.71-20,108(4); Cal. Health & Safety Code s.1399.71(e)(2)(D).

case lack the capacity to analyse it.[67] Another proposal, an SEC-type governmental body (or Charities Commission on the English model), was first mentioned over 35 years ago.[68] However, the American political ethos has moved away from establishing new governmental agencies. Still yet another suggestion has been a mandatory disclosure system with collaboration among state charity regulators.[69] There has not been such collaboration yet. At best it would be many years away, long after the conversion wave will have run its course.

4. Financing

Originally, sales of nonprofit hospitals to investor-owned chains were paid in cash. Today, most are asset sales and the use of stock is the dominant financing model. Often the transaction is structured as a "joint venture" in which only a portion of asset value is paid at the time of conversion, and the charitable organisation becomes a partner of the for-profit. The for-profit actually runs the hospital. Profits are shared.

HMOs have used a variety of sophisticated financing techniques, involving various kinds of securities. In some cases the terms of sale require as little as 50% of asset value to be paid on the closing date. The balance is paid with shares or stock in the new for-profit venture, which may place the charity at risk for the economic benefit of the for-profit purchasers. Recent indications are that Columbia/HCA and other chains are facing growing resistance. One wonders what will happen if

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67 Goldschmid, supra note 54.

68 See, Kenneth Karst, 'The Efficiency of the Charitable Dollar: An Unfulfilled State Responsibility', 73 Harv. L. Rev. 433, 476-483 (1960).

69 Goldschmid, supra note, 54 at 11-12.

the acquirers, like Columbia/HCA for instance, come upon hard times.[70] There are significant financial implications for these new foundations and organisations that have received large amounts of stock as part of the consideration in the transaction.

5. How much Assets should be set Aside, i.e. Remain in the Public Domain?

What is the theoretical rationale for requiring assets to be set aside when there is a conversion? Jurisdictions differ over the theory of the benefits of tax exemption. Should the amount of assets devoted to public use be based on a tax benefit theory, i.e. set aside limited to value of tax benefits received by organisation plus interest, or should the traditional charitable trust theory be applied, which would require the value of all the assets of the exempt organisation to be set aside? The differences in amount, depending on the method of valuation, could be enormous.

When Blue Crosses have converted they have typically used the drop-down approach.[71] Thus, the insurance company becomes a for-profit subsidiary of the nonprofit parent. This technique was used in California when Blue Cross of California, the state's largest health insurer, created a for-profit subsidiary, Wellpoint Health Networks, and transferred to it a 423,000-member HMO, its 1.5 million-member preferred provider network, and the company's pharmacy, dental, mental health, senior, and workers' compensation programmes. Blue Cross retained 82% of Wellpoint and sold the remainder for $517 million. At first Blue Cross argued that since it did not itself convert to for-profit status and only created a for-profit subsidiary, it owed nothing to the public. Though from a formal legal perspective, Blue Cross's argument was correct, it did not pass the "smell test". This led to a public outcry. Eventually, the Wellpoint subsidiary was sold to another HMO and two private foundations were created, the California Healthcare

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70 The California attorney general objected to a joint venture between Columbia and Sharp Healthcare and threatened to hold nonprofit directors personally liable for undervaluing the chain by £100-200 million. The deal later unwound because of objection. Milt Freudenheim, 'California Challenges Deal on Nonprofit Hospital', *New York Times*, 9th November 1996 at 35; Anita Sharp & Rhonda L. Rundle, 'Columbia/HCA's California Expansion Falters as Sharp Healthcare Pact Fails', *Wall Street Journal*, 24th February 1997 at B8. An effort in Ohio to acquire Blue Cross was thwarted. For a description of some of the controversy facing Columbia, see Martin Gottlieb and Kurt Eichenwald, 'Health Care's Giant - When Hospitals Play Hardball', *New York Times*, 11th May 1997 at s.3, 1. The Federal Bureau of Investigation and several government agencies were examining some of the recent acquisitions and business practices of Columbia/HCA. Kurt Eichenwald, 'FBI Reported Examining Hospital Operation in Ohio', *New York Times*, 1st April 1997 at D2.

71 See supra page 33.

Foundation, with £1.18 billion in stock, and a second one, the California Endowment, with £730 million in cash. Some state courts have agreed that Blue Crosses owe nothing to the public, because they had lost their charitable exemption.[72] A back-up argument in some jurisdictions has been that Blue Cross should return public monies that were received because of the tax exemption, i.e. the set aside of monies to the public is limited to the tax benefit received by the organisation plus interest.

6. Who Should Regulate these Conversions? - The Role of the Attorney General

Historically, the role of the attorney general in most states has been the responsibility of supervision and oversight of charitable trusts and corporations. He may maintain such actions as appropriate to protect public interest.[73] Most jurisdictions, but not all, require attorneys general to receive advance notice of organic changes such as conversions. The Volunteer Trustees Foundation for Research and Education which has studied health care conversions has recommended that the attorney general should be primarily responsible for: 1) safeguarding value of charitable assets; 2) safeguarding community from loss of essential health services; and 3) assuring the proceeds of the transaction are used for appropriate charitable purposes.[74] The problem is that attorneys general have neither the resources nor expertise to closely monitor these conversions. For all practical purposes, charities are self-regulated. Only thirteen states have charities

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72 A Georgia court said that Blue Cross was not charitable because the company had been taxed since 1960. In Missouri, a court gave summary judgment to Blue Cross stating it owed nothing to the state. 'Blue Cross Missouri Gains in Legal Fight with State Officials', *Wall Street Journal*, 10th September 1996 at B2. Blue Crosses lost their federal tax exemptions in 1986. IRC s.501(m).

73 Revised Model Nonprofit Corp. Act ss.1.7, 3.04, 8.10, 14.03-14.04; Cal. Corp. Code ss. 5142, 5250, 6511, 9230; N.Y. Not-for-Profit Corp. L. s.112.

74 'Selling Off the Nation's Not-for-Profit Hospitals: The Legal Basis for Oversight', 1995 Charitable Trusts and Solicitations Seminar.

sections within attorneys general offices.[75] Additionally, there is limited standing for others to sue. Nonprofits have no shareholders. Few charities have members. Generally, the public has no standing.

What needs to occur is increasing the leverage of state attorneys general. One way to do that is to use the common law concept of relators to challenge the terms of proposed transactions. A relator is a party who may or may not have a direct interest in a transaction, but is permitted to institute a proceeding in the name of the state when that right to sue resides solely in the attorney general. Thus, to expand the resources of the attorney general, an action would be brought by a private party, e.g. a public interest law firm on behalf of the public interest or the state. The attorney general would exercise ultimate control of the litigation. There would be a need for legislation to ensure that expenses are recovered, including attorney's fees.[76]

7. The Internal Revenue Service's Role

The Internal Revenue Service has the authority to prevent private inurement so as to ensure an adequacy of purchase price. It has indicated its concern with conflicts of interest in the healthcare area.[77] It does not, however, have the authority to require advance approval except for joint ventures between for-profit and nonprofit

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75 Peter Swords & Harriet Bograd, *Nonprofit Accountability* (1996). These states are home to 55% of US charities and have 65% of national charitable revenues. Except for New Hampshire and New Jersey, all have more than two full-time attorneys. "Integrated" state attorney general offices generally provide: registration and reporting systems for charities and for professional fundraisers; an enforcement programme that includes inquiries, investigations, negotiations, and litigation to protect charitable assets and prevent fundraising abuse; educational programs to promote more responsible board governance and/or to prevent fundraising fraud; and oversight of charitable trusts or bequests. Some but not all of these offices also oversee certain structural changes such as mergers, dissolutions, or major transfers of assets. Many of these offices have self-sustaining budgets, supported by fairly modest registration and reporting fees. The second most common pattern is for one state agency to handle charitable registration and reporting, while the attorneys in the attorney general's office handle enforcement. The agency responsible for overseeing charitable solicitations may be the secretary of state, the consumer protection agency, or an agency that deals with registration and licensing. In ten states, there is no general system of registration and reporting for charities. Of these, Texas still has an actively staffed charities office within the state attorney general's office, and Iowa has an active program of prosecution of solicitation fraud.

76 In the United States, failing a specific statute to the contrary, the general rule is that each side pays for its own legal fees.

77 See 'IRS Continuing Professional Education Technical Instruction Programme', *Integrated Delivery Systems and Health Care Update*, 384, 396 (1996).

organisations. Even if it desired to take a more active role, it is faced with decreasing resources.[78] The Exempt Organisations Division supervises 1.2 million nonprofits with only 400 agents and a budget of £36 million.[79] This works out to one agent for every 3,000 nonprofit organisations.[80] In contrast, the Charities Commission listed 154,500 main charities and 26,967 subsidiary charities on its Register in 1995. Of the 180,000, 140,000 have annual incomes of less than £10,000.

8. The New Foundations

It has been noted that when a nonprofit converts, the purchase money must remain in the charitable stream. There have been several approaches to handling the consideration generated by these transactions. One has been to create a new private foundation; another to create or affiliate with a public charity; and a third, to distribute assets to other tax exempt charities. The first approach has been most common. Several enormous foundations have been formed by the conversion of nonprofit healthcare institutions.

Approximately sixty foundations in all have been formed since 1990 through conversions, though it is difficult to obtain good figures. These foundations represent the "pay back" (in the words of one foundation executive) on a community's years of investment in a health care facility.[81] Some of the new foundations are immense, as the two foundations created from the conversion of California Blue Cross demonstrate. The California Wellness Foundation, formed in 1992 from the conversion of Health Net (an HMO) has assets of £705 million. The Rose Foundation in Denver, formed in the aftermath of the sale of Rose Hospital, has assets of £88 million. In Dickson, Tennessee, hardly in anyone's geographical memory, the foundation created from a local hospital conversion has assets of £47 million. Foundations are required to spend 5% of their endowment

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78 For 1997 Congress cut the agency's budget by 10.5% or nearly £456 million from the 1996 fiscal year's level of funding. Christopher Georges, 'House Approves Deep Cutbacks in IRS Funds', *Wall Street Journal*, 18th July 1996 at A14.

79 IRS Exempt Organization officials devote about 30% of their resources to the largest nonprofits, principally hospitals and universities. The Service's primary function is to collect taxes and to manage applications for tax exempt status and the annual report, Form 990 reporting system as well as auditing, investigation and enforcement.

80 In contrast, The Securities and Exchange Commission supervises approximately 14,000 corporations with a substantially larger budget. Swords-Bograd Report, supra note 75.

81 Craig Havighurst, 'Solid Foundations', 29 Health Systems Rev. 33-37 (1996).

annually on direct support or grants.[82] Thus, a foundation with £30 million in assets sounds enormous, but its annual charitable spending may be less than £1.6 million. These new healthcare foundations, despite their seemingly enormous size, are not going to solve the problems of providing adequate health care to the poor, or curing cancer, or making up for government cutbacks.

Several problems have arisen. The formation of the foundation comes well after the deal has been finalised, almost as an afterthought. The community or public is not involved at an earlier point. After the formation, there has been little focus on what foundations are actually doing.[83] Derek Bok, the former President of Harvard, has recently written: "Of all institutions in America, philanthropic foundations are surely among the least accountable." States don't really monitor much after the foundation has been formed. They seem to assume that the Internal Revenue Service is doing so. However, as discussed above, that is unlikely given the scope of the IRS's brief and its lack of person-power in the exempt organisation area.

Many of the new foundations have no experience in philanthropic activity. A very real problem for philanthropy is to spend such large sums of money effectively.[84] Many of the new foundations are run by the former trustees of the HMO or the hospital which created the situation and they hardly have the independence one would wish - which may be more important than experience in philanthropy. Basically, foundations only have to answer to their trustees. Most of the boards are not cross-sections of the community.[85] The philanthropic records of some of these new foundations give pause:

- The public benefit programme run by Blue Cross of California exclusively funnelled subsidies for covering uninsured children to its affiliated HMO.[86]

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82 IRC s.4942. The 5% figure includes administrative expenses.

83 Harris Meyer, 'From Giving Care to Giving Grants', 37 Foundation News & Commentary 40 (1996) [hereinafter Harris].

84 A foundation consultant and former foundation trustee told the author that it took ten years for a foundation to figure out how to efficiently achieve its mission.

85 Massachusetts has been in the forefront of regulating both conversions and creation of foundations. The attorney general has taken a supervisory role in the establishment of the foundations and has backed community groups who have demanded a role in board formation and goals development.

86 Rhonda L Rundle, 'Philanthropy: Big Charities Born as Health Plans Go For-Profit', *Wall Street Journal*, 4th April, 1995 at B1.

- When Colorado Trust was first established as the result of the sale of Denver's Presbyterian/St Luke's Medical Center in 1985, the trust's board, made up of doctors and officials from the hospital, heavily steered funding to the hospital.

- St Luke's Charitable Health Trust in Phoenix, formed with the sale of a hospital, started out by funding charity care to that hospital after it was converted.[87]

9. Cy-près Issues Relating to the New Foundations

Do the new foundations have continuing responsibilities for healthcare? Or can they broaden their mission to anything? Under traditional cy-près analysis, if there was a hospital conversion, the assets would have to be used for the delivery of primary healthcare as provided by a hospital, e.g. healthcare for the poor.[88]

New York has a more liberal approach to cy-près as applied to a nonprofit corporation compared to the cy-près requirements of charitable trust law, allowing for distribution to organisations engaged in substantially similar activities and leaving it to the board of directors to determine to whom the distribution should be made. This means that assets given over on dissolution to an organisation need only be contributed to an entity that has "substantially similar activities".[89] This loose phrasing can cause much mischief, as both the "substantially similar" and the corporate standards are quite vague.[90]

The question arises: are these new foundations supposed to take over the charitable services of existing money-losing hospitals and HMOs, e.g. providing for the

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87 Harris, supra note 83.

88 In California the cases support the proposition that a corporation organised exclusively for charitable purposes holds its assets in trust for the purposes enumerated in its articles even if the assets were not expressly earmarked for charitable trust purposes when the corporation acquired them. When a bequest, devise, or donation is made to a charitable corporation in California the organisation is expected to apply it to the charitable purposes in its articles of association. Therefore, in the usual hospital conversion, even though the operating assets of a charitable hospital have been sold to a for-profit corporation, a strict constructionist view of cy-près would require the corporation to use the cash it received to carry out its original purpose. Thomas Silk, 13 Exempt Org. Tax Rev. 745, 746 (1996).

89 *Matter of Multiple Sclerosis Service Organisation*, 68 N.Y.2d 32 (1986).

90 The new California statute regulating conversions states that the entity created in course of a conversion be a s.501(c)(3) organisation but doesn't really address the cy-près issue.

uninsured and assuming the charity care that the old nonprofit hospital or HMO may have provided? Clearly, the for-profits provide less charity care than nonprofit hospitals.[91] Often the for-profit hospital will claim that it no longer has responsibilities for charity care: that is the responsibility of the foundation created in the aftermath of the conversion.

In California there is a dispute between the attorney general and the Good Samaritan Charitable Trust in San Jose over use of £33 million received from the sale of Good Samaritan Health System specifically for physician and hospital care for the needy. The former hospital leaders now in charge of the foundation want to be able to operate and fund a wider variety of programmes than primary health care, including meals-on-wheels and a health library.[92] The California Attorney General's position is that primary healthcare was the purpose of the original trust for which the money was raised, and that use must continue. In the FHP conversion discussed at the commencement of this essay, the foundation endowed three chairs in medical schools in California, Utah and Guam. Board members of foundations who believe the answer is "yes" to the question above posed have funnelled support to their former hospitals but not to other health providers. However, legally, morally, and socially these foundations should be independent. In fact, the trustees of these new foundations are almost all members of the former hospital boards.

Another issue is whether these new foundations should make grants completely outside of the healthcare area. Some trustees of these newly created foundations want to move away from the illness side, i.e. direct medical care. In Los Gatos, California 20% of Valley Foundation's £1.2 million in grants went to the arts. The Jackson Foundation (born of the sale of Regional Medical Center in Dickson, Tenn.) is considering financing a sports-training complex, an arts center, and a foreign language programme. It provided two airplanes and made pilot training a free elective at the local high school.[93]

The Rose Medical Center in Denver, formed in 1940s as a place where Jewish doctors could practise, sold to Columbia/HCA chain and created a £100 million foundation. It has sponsored a Jewish community festival with music by the Borscht Brothers band and will sponsor an Ann Frank contest in schools. The

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91 One reason is that many states condition the property tax exemption for nonprofit hospitals on giving a substantial amount of charity care. See *Utah County v Intermountain Health Care, Inc*, 709 P.2d 265 (Utah 1985).

92 Greg Jaffe & Monica Langley, 'Generous to a Fault? Fledgling Charities Get Billions from the Sale of Nonprofit Hospitals', *Wall Street Journal*, 6th November 1996 at A1.

93 Id.

Wellness Foundation in California gave money for Little League baseball in South Los Angeles, and for a world music festival.

These also are complicated issues about which it is difficult to come to concrete answers beyond suggesting: 1) a majority of the trustees should not be affiliated with the former nonprofit or the for-profit successor; and 2) in determining the foundation's mission there should be some public input and representation on the board. For example, for the first five years of the foundation's existence, there should be a representative of the attorney general on the board. Public representatives on the boards of private institutions are not unknown. New York City appoints a representative to the board of the Metropolitan Museum of Art because the City contributes a percentage of the Met's budget. Perhaps a relator who brought an action on behalf of the public would be an appropriate appointment.

No matter what the cy-près standard used, though the looser New York approach for charitable corporations seems best suited,[94] the foundation's mission should be restricted to health care as it is defined by experts in the field. Thus, borscht, Russian beet soup, would be okay, but not the Borscht Brothers band! It should be required that a foundation over a certain size - £30 million - be required to have professional management and its trustees receive training in foundation stewardship and public responsibility.[95] The office responsible for oversight of the conversion should be given a monitoring role for the first five years of the foundation's existence. This would mean that the foundation would be expected to file a copy of its annual report required to the Internal Revenue Service with the Attorney General.

10. Politics and the Conversion Process

One of the most disturbing, yet unsurprising aspects of the spate of conversions is how the wheels of the political process have been greased by the large flow of funds to decision makers. In the course of the conversion of Virginia's Trigon Blue Cross/Blue Shield to for-profit status in January 1996, the Virginia House majority leader resigned as Trigon's counsel, after it was uncovered that he received £106,000 in legal fees in 1994 during the period negotiations were going

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94 See supra page 37.

95 The £30 million figure is derived from the cut-off size by the Association of Smaller Foundations, an association of smaller private foundations. Such a requirement most likely would be negotiated by the attorney general.

on over the price of the conversion.[96] In Georgia, Blue Shield of Georgia was approved for conversion to for-profit status by the insurance commissioner amidst criticism that special interests behind the conversion financed his campaign. No transfer of assets to a charitable foundation was required in that conversion. The largest contributor to a candidate running for the Georgia Secretary of State, who lost, received most of his support from entities he helped in the controversial conversion process to a for-profit.[97]

Investor-owned hospitals have long been more politically active than nonprofit hospitals.[98] When Columbia/HCA enters markets in pursuit of an acquisition, it retains the best legal talent, identifies allies among local civic, political and medical elite and spreads around lots of money. In 1995 Columbia/HCA had 33 lobbyists in Tallahassee, Florida alone![99]

Blue Crosses after years of lobbying in state capitals because their rates were set by Insurance Commissioners or some other agency are particularly sophisticated when it comes time to get support for conversions.[100] The interests seeking to convert nonprofit entities to for-profit status are bounded only by the laws governing political contributions, whereas nonprofit organisations, particularly those seeking to stop these conversions, are strictly limited in the lobbying and legislative actions they can pursue, and are largely unsophisticated. While investor-owned chains, Columbia/HCA in particular, have generated a backload of unfavourable publicity, after the news is cold the long term political influence remains.

The Legal Response to Conversions

Traditional fiduciary legal doctrines - the duty of care, the business judgment rule, the duty of obedience and the duty of loyalty generally developed in corporate and

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96 Milt Freudenheim, 'Blue Cross Groups Seek Profit and States Ask Share of Riches', *New York Times*, 25th March 1996 at A1. Spencer S Hsu and Peter Baker, 'Va. Delegate Quits as Insurer's Attorney', *Washington Post*, 19th January 1996 at B3.

97 Peter Mantius, 'Secretary of State Contest is Costliest Ever', *Atlanta Constitution*, 8th October 1996 at 2C. As noted previously, Georgia Blue Cross owed nothing to the public.

98 Gray, supra note 15, at page 22.

99 Robert Kuttner, 'Columbia/HCA + Resurgence of For-profit Hospital Business', *New Eng. J Medicine*, 1st August 1996 at 448.

100 Gray, supra note, 15 at 22.

nonprofit law - can protect the public's interest in these transactions with the addition of some statutory assistance. There is an analogy to be drawn to the jurisprudence of management buyouts, tender offers and other changes in control. These kinds of transactions, called "organic changes", i.e. a fundamental shift in operation, control or structure, have received increased scrutiny by the courts, particularly in Delaware, the most important jurisdiction for corporate law.

A. The Duty of Care

Directors and officers are required to discharge the duties of their respective positions in good faith, and with that degree of diligence, care and skill which ordinary prudent persons would exercise under similar circumstances in like positions.[101] Broadly stated, a director can neglect his or her duty of care in two ways: 1) failing to properly monitor or supervise the corporate entity - the duty of attention; or 2) so long as the director is disinterested, independent and acting in good faith, by failing to make an informed decision about an important transaction or fundamental change in the way the corporate entity operates - the duty of informed decision-making. For our purposes the latter is most important.

In the context of a nonprofit corporation, practical elements of informed decision-making would include the following:

- the opportunity to hear a detailed presentation by management, accompanied by written materials if appropriate, explaining the rationale for the proposed decision and why management is making the particular recommendation;

- the opportunity to hear the advice and recommendation of recognized outside experts, including legal counsel, on the subject;

- the opportunity to debate and deliberate on the proposal at board level and, if possible, to allow a period of several days or weeks for reflection and further consideration before requiring a vote;

- where appropriate, the gathering of information from comparable institutions about how they had dealt with similar situations; and

- the opportunity to request any additional information deemed relevant by a director from management or outside experts, including legal counsel, and time for the directors to consider such additional information.

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101 American Law Institute, *Principles of Corporate Governance* s.4.01 (1994).

If the board exercises a duty of care in reaching a decision, and the directors are free of a conflict of interest the outcome, even if disastrous to the organisation, will be protected by the business judgment rule or (in the nonprofit context) the best judgment rule.

B. The Business Judgment Rule as a Safe Harbor for Directors

The Business Judgment Rule raises a presumption that "in making a business decision, the directors of a corporation acted on an informed basis, in good faith and in the honest belief that the action taken was in the best interest of the company."[102] However, the board must exercise the duty of care. The Business Judgment Rule does not protect decisions by board members who have breached their duty of care by failing to obtain sufficient information to make informed judicial scrutiny.[103]

Delaware cases have given special scrutiny to transactions in which control of the company will change hands.[104] The reason that courts have required enhanced scrutiny has been the fear that managements will regard most favourably those offers that favour themselves rather than the shareholders or the corporation. This is human nature and a subject as much for psychology as law. The healthcare conversions demonstrate that nonprofit managers are no different than their corporate counterparts, and self-interest is a major motivating factor.

C. The Duty of Loyalty

A director owes a duty of loyalty to the corporation on whose board he or she serves.[105] This duty requires a director to act in a manner that does not harm the corporation. It further requires directors themselves to avoid using their position to obtain improperly a benefit for herself or an advantage which might more properly belong to the corporation. That a transaction involves interested

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102 *Aronson v Lewis*, 473 A.2d 805, 812 (Del. 1984).

103 *Smith v Van Gorkom*, 488 A.2d 858 (Del. 1985). In that case the directors breached the duty of care by not considering and informing themselves adequately about a sale or the chief executive officer's role in promoting the transaction. The board did not independently attempt to value the company, and the decision was made too quickly to reach an informed judgment.

104 See, *Revlon, Inc v MacAndrews & Forbes Holdings, Inc.*, 506 A.2d 173 (Del. 1985); *Paramount Communications v Time, Inc.*, 571 A.2d 1140 (Del. 1989); *Paramount Communications, Inc. v QVC Network*, 637 A.2d 34 (Del. 1994).

105 *Principles of Corporate Governance*, Part V, Duty of Fair Dealing.

parties is less significant than whether it was fair to the corporation at the time the decision was made, and whether the decision was reached in an impartial board environment. Thus, the fact that a nonprofit's officers or managers will participate in the for-profit entity is not in and of itself a reason to prohibit the transaction. However, if there is a conflict of interest the burden is on the directors or senior executives to prove the fairness of the transaction.[106]

Corporate law has developed procedures to insulate the interested directors from approval of the transaction. Typically when a change of control occurs, the board will establish a special committee of disinterested directors to evaluate the transaction. This committee will retain its own counsel, investment bankers, and other advisers. This process-oriented approach assures a deliberative decision that will benefit the corporation's shareholders.

The chances that a nonprofit board will be taken advantage of and the charity fail to receive maximum value in these transactions is greater than with a business corporation. This results from the dynamics of nonprofit boards. Most boards of charitable organisations are of a nonadversarial nature. Probing questions are viewed as simply bad manners. Secondly, there is a tradition of inattentive or token directors, individuals who are selected for their prestige, name recognition, or affluence and have little time to devote to the organisation. Virtually all charitable boards consist of volunteers, who may not have the vested interest of business corporate directors. More important in the conversion context is that nonprofit boards have little acquisition experience and, unlike many for-profit directors, have been selected for reasons wholly unrelated to their ability to obtain fair value.[107] They are just not in same division as the acquirers.

Nonprofit boards are unaccustomed to and may be wary of spending scarce resources on investment bankers, accountants, major law firms, i.e. the intermediaries that are the glue of for-profit changes in control. Unlike their business counterparts nonprofit boards and their organisations exist in the shade. They are not subject to the same scrutiny as for-profit corporations of similar size. There are no shareholders or stock. There is nothing analogous to the requirement of shareholder approval of changes in control or sale of assets, as virtually all charities are non-membership. The access to capital markets requires less disclosure than for-profits. Valuation and the newer techniques of determining asset worth are unfamiliar to boards. In the case of HMOs, it may be impossible to find disinterested directors.

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106 Cf. *Principles of Corporate Governance* s.5.15.

107 Goldschmid, supra note 54, at page 1.

There is a philosophical question in the conversion context: whom do the boards represent - patients, the doctors, a part of the public and which sector, or the community as a whole? It is unclear whether board members know. This is a particularly important issue with HMOs where boards have not been community oriented.

Dealing with the Conversions: The Standard of Enhanced Scrutiny

When faced with a conversion there should be a requirement of enhanced board scrutiny and fiduciary responsibility analogous to the heightened scrutiny that Delaware courts have imposed upon directors of business corporations in the change of control context. There is a need to create through judicial interpretation appropriate or special standards of conduct in the conversion context and appropriately rigorous standards of review by the courts.[108] Directors must engage expert independent outside counsel, seek to consider all alternatives, attempt to obtain competing offers whenever possible, through a market test, and consider community needs. The Delaware standard of care is gross negligence.[109] Directors must exercise their duty of inquiry and proceed through a deliberate decision-making process.

All conflicts of interest must be disclosed. Directors should refuse themselves from voting or participating in decisions where they have a conflict. Where this may be impossible, as in the case of an HMO, conflicts should be measured by a standard of intrinsic fairness and the burden of proof should be upon the interested directors to show fairness. When decisions face the board where some directors are interested, an independent committee of disinterested directors should be formed. The following proposals may not, and should not, prevent conversions but will slow them down and ensure that they are evaluated with the care and scrutiny the public interest deserves.

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108 A Standard of Conduct states how an actor should conduct a given activity or play a given role. A standard of review states the test a court should apply when it reviews an actor's conduct to determine whether to impose liability or grant injuncture relief. William L Cary & Melvin A Eisenberg, *Corporations* 602 (7th ed. unabridged 1995).

109 *Smith v Van Gorkom*, 488 A.2d 858 (Del. 1985), but see *Rabkin v Philip A. Hunt Chemical Corp.*, 13 Del. J. Corp. L. 1210, 1987 W.L. 28436 (Del. Ch. 1987). The gross negligence standard is not without criticism. In *Williamson v Brett*, 152 Eng. Rep. 737 (1843), Baron Rolfe once defined gross negligence as the same thing as ordinary negligence "with the addition of a vituperative epithet".

Recommendations for Protecting the Public when Non-Profit Assets are Transferred to For-Profit Entities[110]

The Conversion Transaction

- Advanced court approval in a cy-près proceeding to convert, sell or enter into whole hospital or HMO joint ventures with for-profit entities.
- Detailed public disclosure of the terms of the transaction.
- Community Benefit Impact Statement.
- Public Hearing on the impact of the transaction on the delivery of healthcare in the community.
- Specification in the transaction agreement on the continuation of existing healthcare particularly charity care.
- Provisions for monitoring, independent auditing of healthcare delivery and an enforcement mechanism.
- Reimbursement of all valuation, attorney, and investment banking fees incurred by Attorney General or relators.

Attorney General Intercession

- Automatic party to all proceedings.
- Granted specific authority to seek advanced court approval of transactions.
- Given statutory authority for appointment of relators in such transactions.
- Responsible for independent fairness review.

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110 These recommendations are derived in part from: proposed guidelines prepared by the Volunteer Trustees Foundation for Legal Research, California Corporations Code s.5913, Review Protocol of Sale of Charitable Assets to For-Profit Entities-Review Protocol published by the California Office of the Attorney General, and proposals by Robert Boisture, Esq and Professor Harvey Goldschmid.

Board of Directors

- Enhanced duty of care standard applied.
- Require transaction to be approved by independent committee of outside directors
- All conflicts of interest must be disclosed and are measured by the standard of intrinsic fairness
- Board is responsible to maximise value and to have an independent valuation and fairness opinion.
- Board should provide for fair market test wherever possible.
- Written report discussing grounds for selection of particular offer.

Proceeds of Transaction

- Assets must be held by a s.501(c)(3) charity.
- Proceeds must not be used for private benefit. Conflicts of interest prohibited.
- Any new charitable entity must not be controlled by the for-profit either by board representation or through grantmaking.
- Attorney General shall monitor charitable entity for five years after creation or conversion transaction.
- Assets must be utilized for health care.
- Some public representation on the entity's board.
- Foundations over £50 million in assets must have professional management and the boards should receive training in trusteeship.

Valuation

- Duty to seek fair market value.

- Detailed description of valuation components and approaches to reaching price.
- Competing valuation report by Attorney General or relator.
- Market test where possible.

Legislative Action Required

- Explicit authority given to Attorney General to participate in all proceedings during the conversion process.
- Converting party must fund use of outside experts hired by Attorney General.
- Attorneys' fees paid by converting party in relator actions.
- Market test required before approval of offer.
- Public disclosure of all material terms of the agreement.
- Mandated independent fairness opinion.
- Board of nonprofit required to consider short and long term impact from the transaction on the delivery of healthcare to the community.