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Checkpoints on the Conversion Highway: Some Trouble Spots in the Conversion of Nonprofit Health Care Organizations to For-Profit Status

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Checkpoints on the Conversion Highway: Some Trouble Spots in the Conversion of Nonprofit Health Care Organizations to For-Profit Status

James J. Fishman*

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I. INTRODUCTION

For the past few years, the United States has witnessed the largest redeployment of charitable assets in the Anglo-American world since Henry VII closed the monasteries in 1536-1540 as formerly nonprofit health care 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 dollars in charitable assets have been redeployed from eleemosynary to profit-seeking purposes, leading to a fundamental change in the structure of the American health care system. The conversion of charitable health providers has created some of the nation's largest private foundations.¹

This essay does not address the truly important policy issues: whether for-profit healthcare should be allowed or encouraged;² how the quality of care compares to nonprofits or what criteria should be used to evaluate the quality of care;³ or what the impact of these conversions is on the communities they serve.⁴ 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 con-

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1. An estimated ninety foundations with total assets of \$9.3 billion have been created from health care conversions; the median asset size is \$57 million. See Harris Meyer, *A Lot is Not Enough: For Foundations Spun Off by Hospital Sales, Even Billions Go Only So Far*, 71 HOSP. & HEALTH NETWORKS 30, 30 (1997).

2. See generally David A. Hyman, *Hospital Conversions: Fact, Fantasy, and Regulatory Follies*, 23 J. CORP. L. 741 (1998); Malik M. Hasan, *Let's End the Nonprofit Charade*, 334 NEW ENG. J. MED. 1055 (1996).

3. See John Copeland, *Nonprofit Versus For-Profit Hospitals*, 18 Exempt Org. Tax Rev. 35 (1997) (comparing "(1) the charitable care provided by two categories versus taxes forgiven or paid; (2) hospital costs by type of hospital; and (3) hospital as a 'community institution'"); see also Gary J. Young et al., *Does the Sale of Nonprofit Hospitals Threaten Health Care for the Poor*, HEALTH AFF., Jan-Feb 1997, at 137 (examining "how the acquisition of nonprofit hospitals by investor-owned corporations affects acquired hospitals' provision of uncompensated care").

4. For a discussion of the public policy issues, see Gary Claxton et al., *Public Policy Issues in Nonprofit Conversions: An Overview*, HEALTH AFF. Mar.-Apr. 1997, at 9; Bradford H. Gray, *Conversion of HMOs and Hospitals: What's at Stake?*, HEALTH AFF. Jan.-Feb. 1997, at 29 (discussing the public policy issues).

version; how to protect the public; who should represent the public interest; and what, if any, should be the legal response.

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

There is a vast array of organizations in the United States that share the designation "nonprofit." Section 501 of the Internal Revenue Code provides twenty-seven different organizational categories which exempt an organization from federal income taxation.⁵ These categories of tax exempt organizations include corporations, title holding companies, civic leagues, local associations of employees, business leagues, social clubs, and organizations operated for religious, charitable, educational and similar purposes.

Over half of the 1.2 million charities registered with the Internal Revenue Service are covered by section 501(c)(3) which consists of traditional charities.⁶ The tax code states that these traditional charities must be organized and operated exclusively for religious, charitable, scientific, literary or educational purposes.⁷ No part of their net earnings can inure to the benefit of any private shareholder or individual, and no substantial part of their activities can include carrying on propaganda or otherwise attempting to influence legislation.⁸ These traditional charities may not participate or intervene in political campaigns.⁹ Recognition as a 501(c)(3) charity is very valuable to organizations, because contributions to such charities are deductible by the donor from their personal or corporate income.¹⁰

B. The Promotion of Health as a Tax Exempt Purpose

From the time of the Elizabethan Statute of Uses,¹¹ the promotion of health has been considered a charitable purpose, and in the United States, hospitals and other health care providers have always been tax exempt.¹² Non-profit hospitals seemed so much the symbol of charitable purpose that many states specifically granted them exemption from taxation.¹³ In the eighteenth century, the nonprofit hospital was often little more than an

5. See I.R.C. §§ 501(c)(1)-(27), 501(d), 501(e), 501(f), 501(k) (Supp. 1997).

6. Section 501(c)(3) of the Internal Revenue Code exempts:

Corporations, and any community chest, fund or foundation, organized 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.

7. See *id.*

8. See *id.*

9. See *id.*

10. See I.R.C. § 170 (1997).

11. 43 Eliz., ch. 4 (1601).

12. Trusts for the promotion of health are charitable and have been upheld as such even when the benefits were not exclusively limited to the poor. See IV.A WILLIAM R. FRATCHER, SCOTT ON TRUSTS § 372 (4th ed. 1989).

13. See Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a*

almshouse where the homeless came to die.¹⁴ During the nineteenth century, nonprofit hospitals were known as “voluntary” institutions—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 lifetime commitment to a religious order devoted to caring for the poor.¹⁵

Through medical advances, changes in the payment system which made the “voluntary” nature of the hospital a myth, and the emergence of for-profit competition, hospitals retained their tax exempt status. However, the Internal Revenue Service’s rationale for such status changed. Originally, the Treasury coupled exemption of health care providers with charitable care to the underprivileged even though such providers received substantial income from paying patients.¹⁶ If a hospital provided care to indigent patients to the extent of its financial ability, it would be considered an exempt entity.¹⁷

After mid-century, the voluntary nature of nonprofit hospitals eroded and came to resemble more closely their proprietary counterparts as third party payors, primarily Medicare and Medicaid, constituted the overwhelming source of revenues. In response to urgings of the hospital industry to eliminate the charity care requirement, in 1969 the Internal Revenue Service issued Revenue Ruling 69-545¹⁸ which adopted a “per se” rule of hospital exemption: an entity engaged in the promotion of health for the benefit of the community who pursued a charitable purpose was tax exempt, even though a portion of the community, such as indigents, was excluded from participation.¹⁹ Under this standard, some health maintenance organizations could be found eligible for section 501(c)(3) status.²⁰ Although the rationale for the continuation of nonprofit hospitals’ tax exempt status has been a subject of academic criticism and state court developments, the exemption remains.²¹

Donative Theory of Tax Exemption, 66 WASH. L. REV. 307, 318 n.33 (1991) (collecting authorities from many states).

14. See Douglas M. Mancino, *Income Tax Exemption of the Contemporary Nonprofit Hospital*, 32 ST. LOUIS U. L. J. 1015, 1021 (1988).

15. Hall & Colombo, *supra* note 13, at 318.

16. See M. Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 305 (1995).

17. Rev. Rul. 56-185, 1956-1 C.B. 202, 203.

18. Rev. Rul. 69-545, 1969-2 C.B. 117.

19. See *id.* at 118. One of the examples used in this Revenue Ruling was that a tax exempt hospital must maintain an emergency room open to all persons regardless of that person’s ability to pay. However, in a later ruling, the Service ruled that specialized hospitals (such as eye and cancer hospitals) qualified for section 501(c)(3) status despite the lack of an emergency room if other “significant factors” evidenced the hospitals’ commitment to community health care. See Rev. Rul. 83-157, 1983-2 C.B. 94. These significant factors included the existence of a broad based board of directors, an open medical staff policy, and treatment of Medicare and Medicaid patients. See *id.* at 95.

20. See *Sound Health Assoc. v. Comm’r*, 71 T.C. 158, 191 (1978) (stating that a health maintenance organization which provided health care services to members on a fee paid basis and to nonmembers on a fee-for-service basis, handled emergency cases without regard to membership status and provided free care and reduced rate care to a limited number of indigent patients qualified as a charitable organization serving the public interest as described in I.R.C. § 501(c)(3)).

21. For scholarly criticisms, see generally Bloche, *supra* note 16; Hall & Colombo, *supra* note 13; Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry*, 93 HARV. L. REV. 1416 (1980); John D. Colombo, *Health Care Reform and Federal Tax Exemption: Rethinking the Issues*, 29 WAKE FOREST L. REV. 215 (1994); Daniel M. Fox & Daniel C. Schaffer, *Tax Administration as Health Policy: Hospitals, the Internal*

II. WHEN NONPROFITS DISSOLVE

Nonprofit organizations may outlive their purposes or utility to society. Declining membership or financial difficulties may threaten survival. In order to obtain exemption under section 501(c)(3), the nonprofit's articles of association must state that upon dissolution, the organization's assets are to be distributed for one or more exempt purposes, to a governmental body for a public purpose.²² Such assets may also be distributed by a court to another organization to be used in a manner that in the judgment of the court will best accomplish the general purposes for which the dissolved organization was formed.²³ This "organizational test" is not met if the articles or applicable state law provide that the organization's assets upon dissolution would be distributed to its members or shareholders.²⁴

Under state corporate law the general rule is that public charities must transfer their assets on dissolution for charitable or similar uses,²⁵ while mutual benefit organizations may distribute their assets to members upon dissolution or in accordance with such other plan provided by the certificate of incorporation or bylaws.²⁶

Although the procedures differ depending upon the jurisdiction, the process of dissolution typically involves a resolution by the board of directors and a plan of dissolution, which must be approved by an appropriate vote of the membership (typically two-

Revenue Service, and the Courts, 16 J. HEALTH POL. POL'Y & L. 251 (1991). For developments concerning the denial of state and local tax exemptions, see generally *Utah County v. Intermountain Health Care*, 709 P.2d 265 (Utah 1985); Robert J. Hannen, *Nonprofit Hospitals: Should They Continue to Receive a Charitable Organization Tax Exemption Under Pennsylvania Law?*, 28 DUQ. L. REV. 727 (1990); see also Janne G. Gallagher, *When Local Governments Come Calling: The Movement to Tax Charities*, 18 Exempt Org. Tax Rev. 25 (1997).

22. See Treas. Reg. § 1.501(c)(3)-1(b)(4) (as amended in 1990).

23. See *id.*

24. However, even if the charter is not explicit, the test is met if state law requires that the organization's assets must be dedicated to a charitable purpose on dissolution. See Rev Proc. 82-2, 1982-1 C.B. 367 contains a list of states that provide for the distribution of a nonprofit's assets by operation of law in a manner that satisfies the organizational test requirement.

25. See REVISED MODEL NONPROFIT CORPORATION ACT § 14.06(6) (1988) (stating that "a public benefit or religious corporation [shall transfer] its assets: (i) to one or more persons described in section 501(c)(3) of the Internal Revenue Code, or (ii) if the dissolved corporation is not described in section 501(c)(3), to one or more public benefit or religious corporations"); CAL. CORP. CODE § 5410 (West 1997) (stating that no corporation shall make any distribution); N.Y. NOT-FOR-PROFIT CORP. L. § 1005(a)(3)(A) (McKinney 1997) ("Assets received and held by the corporation for a purpose specified as Type B...shall be distributed to one or more domestic or foreign corporations or other organizations engaged in activities substantially similar to those of the dissolved corporation...."). See generally *In re Los Angeles County Pioneer Society*, 257 P.2d 1 (Cal. 1953); *In re Multiple Sclerosis Service Organization*, 496 N.E.2d 861 (N.Y. 1986).

26. See REVISED MODEL NONPROFIT CORPORATION ACT § 14.06(7) (1988); CAL. CORP. CODE § 8717(b) (West 1990) (stating that "[i]f the articles or bylaws do not provide the manner of disposition, the assets shall be distributed among the members in accordance with their respective rights therein"); N.Y. NOT-FOR-PROFIT L. § 1005(a)(3)(B). Some jurisdictions, such as Illinois and Oregon, have based their dissolution provisions on section 46(c) of the original Model Nonprofit Act, which has been criticized for placing "no meaningful restrictions on distributions in dissolution beyond the ambiguous requirement that 'assets held by the corporation subject to limitations permitting their use only for charitable . . . or similar purposes' must be transferred to other organizations 'engaged in activities substantially similar to those of the dissolving corporation.'" Henry Hansmann, *Reforming Nonprofit Corporation Law*, 129 U. PA. L. REV. 497, 575-579 (1981); see also 805 Ill. Comp. Stat 105/112.16 (1997); Ore. Rev. Stat. § 61.530 (1997).

thirds of votes cast). In corporations without members, the board will adopt the dissolution plan by resolution. Dissolution requires notice to creditors and involves payment of liabilities and distribution of remaining assets. If the organization is a public charity the plan will specify the distributees. In those cases the attorney general is notified and the plan is submitted to a court for approval. This is often a perfunctory review, as the attorney general is overworked unless there is a particular public interest involved or the organization is notorious. If a regulatory agency has approved the formation of the organization, it will be notified and must approve the dissolution. Mutual benefit corporations are subject to less supervision by the attorney general than public benefit corporations. Upon the dissolution of a mutual benefit corporation, the assets remaining after creditors have been paid normally will be distributed to the members.²⁷

In determining whether to approve a plan of distribution proposed by a corporation's board, a court may consider: (1) the source of the funds to be distributed, whether received through public subscription or under the trust provision of a will or other instrument; (2) the purposes and powers of the corporation as enumerated in its certificate of incorporation; (3) the activities in fact carried out and services actually provided by the corporation; (4) the relationship of the activities and purposes of the proposed distributee(s) to those of the dissolving corporation; and (5) the bases for the distribution recommended by the board.²⁸ A certificate of dissolution is then filed with the secretary of state or appropriate state official.²⁹

The law is clear that when an organization is exempt under section 501(c)(3) of the Code, it must contribute its remaining assets to another 501(c)(3) organization. Normally, the requirement to distribute assets to another exempt organization is not a problem, because many nonprofits dissolve in an atmosphere of financial distress. Typically, when a nonprofit dissolves, little is contributed to other organizations as a lack of assets is the primary cause for most organizations' demise.³⁰ In contrast, the assets at stake in hospital and HMO conversions 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 organization differed from the norm.

27. See REV. MODEL NONPROFIT CORP. ACT Ch. 14; N.Y. NOT-FOR-PROFIT CORP. L. ARTS. 10-11; CAL. CORP. CODE Ch. 15-16.

28. *Multiple Sclerosis Service Organization*, 496 N.E.2d at 862. If the organization is a mutual benefit corporation, the plan of dissolution and distribution of assets must be submitted to a vote of the members.

29. After dissolution, the corporation carries on no activities except winding up of its affairs, preserving and protecting assets, minimizing liabilities, discharging existing liabilities, disposing of properties that will not be distributed in kind, and paying liabilities and distributing corporate assets in accordance with the specifications of the dissolution plan. If the organization has insufficient assets to cover its liabilities, the court may appoint a receiver to preserve the assets.

30. See generally WILLIAM G. BOWEN ET AL., *THE CHARITABLE NONPROFITS* (1994). Bowen examined the differences between nonprofit 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. See *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 organization. See *id.*

Health Maintenance Organizations (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.³¹ The Family Health Program (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 for-profit status, the board of directors valued its assets at approximately \$13.5 million as of June 30, 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 \$13.5 million figure and proposed \$47 million as the fair market value. The Department and FHP then negotiated a \$38.5 million price which included \$7.2 million in cash, and the rest paid over ten years.³²

Another for-profit HMO, Maxicare Health Plans, made a competing offer to buy FHP for \$50 million and sued to prevent HGI'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.³³ A foundation was established to receive the money used to purchase the HMO.

Eight months after the conversion, HGI floated an initial public offering of stock with a market value of \$150 million. Approximately \$25.3 million went to the for-profit HMO and just under \$10.6 million went to the FHP Foundation, established as part of the conversion.³⁴ "The former managers, including Dr. Gumbiner, continued to hold a 75.9% stake in the for-profit company worth \$114 million."³⁵ These assets belong to the

31. See CAL. HEALTH & SAFETY CODE § 437.03 (West 1990) (repealed 1995); MICH. COMP. LAW ANN. § 333.20106(2) (West 1997); N.Y. PUB. HEALTH LAW § 4401(1) (McKinney 1997) (defining HMOs).

32. See Michele Meldin & Jane Perkins, *HMO Conversions: How to Distribute the Charitable Assets*, 21 CLEARINGHOUSE REV. 467, 468 (1987); Robert Hanley, *Offering Puts FHP Corp's Value at Six Times Its Purchase Price*, L.A. TIMES, June 10, 1985 at Pt. 4, 1; Jube Shiver, Jr., *Judge Ok's FHP's Buy-out Plan, Thwarting Maxicare*, L.A. TIMES, Oct. 19, 1985 at Pt. 4, 1; *State Suit Seeks Gift to Charity by FHP Officers*, L.A. TIMES, Dec. 3, 1986 at Pt. 4, 1.

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

34. See JAMES J. FISHMAN & STEPHEN SCHWARZ, *NONPROFIT ORGANIZATIONS: CASES AND MATERIALS* 104 (1995).

35. *Id.* Nor is this the only example of executive largesse during a conversion. When HealthNet, now named Health Systems International, converted in 1992, thirty-three executives purchased twenty percent of the company for \$1.5 million. Those shares were worth \$315 in April 1996. The former CEO paid \$30,000 for shares later worth \$31 million. See Judith E. Bell, *Saving Their Assets; How to Stop Plunder at Blue Cross and Other Nonprofits*, AMERICAN PROSPECT, May-June 1996 at 60, available in LEXIS, Nexis Library, Mag File (discussing how executives have made millions converting nonprofits). HGI has since been taken over by a larger firm further enriching its shareholders. There have been other troubling examples: a hospital sale was negotiated and consummated in less than four weeks; a health system fired twelve trustees of a local hospital after they voiced opposition to a proposed sale to a for-profit system; and there are several incidents where

public, not to a nonprofit's managers. Gumbiner & associates used the nonprofit form to receive private inurement.

III. THE LANDSCAPE

Conversions are neither new, nor are they confined to the health care field, despite the media attention and state regulatory focus on hospitals and HMOs. The category of charitable organizations susceptible to conversion is much broader. It includes virtually any exempt organization that provides products or services for which there is a significant market—such as nonprofit book publishers, nonprofit television stations, as well as tax exempt biotechnology research institutes.³⁶ Health care conversions have occurred within HMOs, exempt hospitals acquired by proprietary enterprises, and spin-offs of Blue Cross/Blue Shield insurance plan assets into taxable subsidiaries.³⁷ Conversions occurred among hospitals and HMOs for many years without attracting much attention.³⁸

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, and heavily funded by donations. These voluntary hospitals were staffed by doctors who worked without compensation and nurses who worked for room and board.³⁹ For-profit hospitals, on the other hand, are owned by shareholders. At the turn of the twentieth century, approximately half of all hospitals were small, proprietary or-

insiders benefited from sales to proprietary firms. See Eric S. Tower, *Directors' Duty to Obtain a Fair Price in the Conversion of Nonprofit Hospitals*, 6 ANNALS HEALTH L. 157, 158 (1997).

36. Reverend Pat Robertson and his family purchased a controlling interest in the programming subsidiary of the Christian Television Network for \$183,000 in 1989. It went public in 1992 and its shares were worth \$90 million. Reverend Robertson and his family retained majority control. In June of 1997, Rupert Murdoch agreed to purchase International Family Entertainment, Inc., which was still controlled by the Robertson family, for \$1.9 billion. See Geraldine Fabrikant, *Murdoch Set to Buy Family Cable Concern*, N.Y. TIMES, June 12, 1997, at D1.

37. Note that there also have been conversions of for-profits to nonprofit status. See DOUGLAS M. MANCINO, TAXATION OF HOSPITALS AND HEALTH CARE ORGANIZATIONS 21-28 (1995 & Supp. 1997). 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 now wish to change the tax status of such subsidiaries. See *id.* 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, see I.R.C. § 501(c)(3) (1997); (c) gain access to the tax exempt bond market; (d) avoid “phantom income” from services provided to related organizations; (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; (i) avoid paying certain federal excise taxes, see John D. Colombo, *Health Care Reform and Federal Tax Exemption: Rethinking the Issues*, 29 WAKE FOREST L. REV. 215 (1994); (j) participate in shared service organizations (hospitals); (k) receive preferred postal rates and certain sales tax exemptions; (l) avoid Robinson-Patman Act federal price discrimination law; and (m) receive other miscellaneous benefits.

38. See Bradford H. Gray, *Conversion of Nonprofit Health Plans and Hospitals: An Overview of the Issues and the Evidence*, in CONVERSION TRANSACTIONS: CHANGING BETWEEN NONPROFIT AND FOR-PROFIT FORM 1 (National Center on Philanthropy and the Law 1996).

39. See Hall & Colombo, *supra* note 13, at 317-18.

ganizations owned by physicians as an adjunct to their medical practices. For-profit community hospitals declined to about fifteen percent of all community hospitals by 1965,⁴⁰ the dawn of Medicare and Medicaid, federal programs of reimbursement for elderly and others.⁴¹

B. Medicare and Medicaid

Unlike virtually every other industrialized nation, the United States still lacks a program that makes health care comprehensively available to all of its citizens. It does have Medicare, introduced in 1966, which covers hospital care for those over 65 and some others such as the long term disabled.⁴² A second voluntary Medicare program covers certain outpatient costs. Though limited in scope, these programs are enormously expensive.

Medicaid is a cooperative federal and state program that finances health care for certain poor people. Nationwide, about 52% of persons with income levels below the federal poverty limit are covered by Medicaid.⁴³ The government contributes 50 to 83% of the cost of Medicaid with the states covering the rest.⁴⁴ Both Medicare and Medicaid are enormously expensive, and, by and large, the government, as third party payor, foots the bill.

For-profit hospitals were jump-started by Medicare. The programs also encouraged mergers. The most dramatic trends occurred between the mid-1960s and early 1980s with the growth of hospital management companies, such as the Hospital Corporation of America and American Medical International. These companies were created post-Medicare, but their growth stopped by the early 1980s because of changes in Medicare reimbursement.⁴⁵ There were few hospital conversions in the first golden age of the investor-owned hospital.⁴⁶ From the mid-1960s to the mid-1990s, the overall for-profit-nonprofit public composition of the hospital industry changed remarkably little, perhaps one percent of the total.⁴⁷

The conversion of nonprofit health providers to for-profit status received its greatest impetus with the emergence and aggressiveness of Columbia/HCA. Columbia Hospital Systems was formed in 1987. Within a decade it grew to a corporation with \$20 billion in revenues which owned approximately 350 hospitals, 500 health care offices and scores of other medical businesses in 38 states.⁴⁸ Columbia not only expanded by acquiring for-

40. See Gray, *supra* note 38, at 21 (citing American Hospital Association Hospital Statistics (1995)).

41. See Gray, *supra* note 38, at 13-14.

42. 42 U.S.C. §§ 1395-1395ccc (1994). For an excellent summary of these programs, see Barry R. Furrow et al., *Health Law*, § 13 (1995).

43. See Furrow, *supra* note 42, § 14.01.

44. See *id.*

45. See Gray, *supra* note 38, at 14-16.

46. Between 1980-1993 there were a total of 647 conversions: 197 were conversions to for-profit (some were government hospitals); 119 of these were nonprofit to for-profit; and 79 conversions were for-profit to nonprofit. See Gray, *supra* note 38, at 18 (citing Deborah J. Chollet et al., *Conversion of Hospitals and Health Plans to For-Profit Status: A Preliminary Investigation of Community Issues*. Washington: Alpha Center, May 1996).

47. See Gray, *supra* note 38, at 19-20.

48. See Martin Gottlieb & Kurt Eichenwald, *Health Care's Giant*, NEW YORK TIMES, May 11, 1997, § 3, at 1.

profit hospitals, in 1995, they acquired thirty-three tax exempt hospitals as well. In 1996, seventeen of its twenty-eight acquisitions or joint ventures involved tax exempt hospitals with an additional fourteen pending.⁴⁹ Despite the recent humbling of Columbia⁵⁰ and the slow down of the conversion process, the underlying rationales of efficiency and cost containment remain.⁵¹

C. HMO Ownership Trends

Though prepaid medical services have existed since the 18th century, in the second half of the 20th 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 1973,⁵² 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 1983 the federal loan programs ceased, and HMOs with growing capital needs began to convert to for-profit status.⁵³

49. See Bruce Japsen, *Another Record Year for Dealmaking: Activity Among Medium-Size Companies—Fuels Continued Drive Toward Consolidation*, MODERN HEALTHCARE, Dec. 23, 1996 at 37. The 1995 year end review of mergers and acquisitions by Modern Healthcare indicated that 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. See *Demise of the Not-for-Profit Has Been Greatly Exaggerated*, MODERN HEALTHCARE, Dec. 23, 1996, at 33.

50. See Lucette Lagnado and Joann S. Lublin, *Columbia/HCA Sets \$71 Million Accord With IRS to Settle Compensation Dispute*, WALL ST. J., Dec. 4, 1997, at B8; Kurt Eichenwald and N.R. Kleinfeld, *How Scandal Put an End to the Flag-Waving*, N.Y. TIMES, Dec. 21, 1997, § 3, at 1; Kurt Eichenwald, *U.S. Confronts Billing Fraud at Columbia was 'Systematic'*, N.Y. TIMES, Oct. 7, 1997, at D1; Kurt Eichenwald, *3 Executives of Hospital Chain Charged With Medicare Fraud*, N.Y. TIMES, July 31, 1997, at A1; Lucette Lagnado, *Columbia Inquiry Yields First Indictment: Insurance Companies Start an Independent Probe Into Billing Practices*, WALL ST. J., July 31, 1997, at A3. Federal and state authorities have been reviewing billing practices at the home health care division as well as the coding of patients' diagnoses for Medicare reimbursement. These investigations, which involve much of the hospital chain, have prompted Medicare to stop signing off on annual claim audits to leave as many cases open as possible. Columbia settled a dispute with Alabama's Medicaid program for \$40 million. Because of projected settlements and fines, bond rating agencies have placed Columbia/HCA debt under review for a potential downgrade. See Keith A. Markey, *Columbia/HCA, Valueline Investment Survey*, Jan. 2, 1998, at 653. The negative publicity has taken a toll on admissions, as doctors, who had customarily referred a portion of their patients to Columbia, have begun to send business elsewhere.

51. See Anita Sharp, *Entrepreneurs Look to Profit on Nonprofit Hospitals*, WALL ST. J., Feb. 2, 1998, at B4 (discussing new groups of entrepreneurs who seek to purchase nonprofit hospitals); see generally, Lawrence E. Singer, *The Conversion Conundrum: The State and Federal Response to Hospitals' Changes in Charitable Status*, 23 AM. J.L. & MED. 221 (1997). Bradford Gray has offered six policy reasons for encouraging conversions: 1) to facilitate health coverage of the uninsured because the supersession of the nonprofit form would force the government to provide health care; 2) to move more organizations onto the tax rolls; 3) to move charitable assets to more productive uses; 4) to enhance access to needed capital; 5) to facilitate consolidation and reduction of capacity; and 6) to end the 'fiction' that nonprofits are more socially beneficial than their for-profit counterparts. Gray, however, concludes that the nonprofit form continues to hold significant advantages over the proprietary form in health care. See Bradford H. Gray, *Conversion of HMOs and Hospitals: What's at Stake?*, HEALTH AFFAIRS, Mar.-Apr., 1997, 29, 33-34.

52. 42 U.S.C. §§ 300e-300e-14a (1994).

53. See Claxton, *supra* note 4, at 12. In 1981, 82% of HMOs, accounting for 88% of overall membership, were nonprofit. By 1995, the proportion of nonprofit plans had decreased to 29%, accounting for 41% of overall membership. See *id.*

D. Differences Between Hospitals and HMOs

Investor ownership of hospitals emerged late in a mature field. The ownership picture of HMOs has been heavily influenced by the rapid growth in the field over the past two decades. Only one percent of nonprofit hospitals have converted to for-profit status, whereas one third of HMOs have converted to for-profit status. 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 by replacing local control with new distantly determined standards. Additionally, the charitable hospital has been an elite eleemosynary institution. Historically, hospital boards constituted important philanthropic activities of the most influential and powerful members of the local power structure.⁵⁴

Where possible, most conversions to for-profit status are negotiated in private. The HMO conversions did not generate the same concerns because HMO boards were more likely to be composed of insiders. HMO boards 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.⁵⁵ The Internal Revenue Service's concern over HMOs led to restrictive requirements for tax exemption,⁵⁶ 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 engenders competition between hospitals. For-profit chains using economies of scale and instituting administrative efficiencies are able to provide services for less than nonprofit counterparts.⁵⁷ Increasing capital requirements for new equipment necessary to attract patient business place many nonprofit hospitals at a competitive disadvantage. Investment bankers have spoken to trustees regarding the "monetizing [of] the community hospital asset."⁵⁸ The economic argument runs as follows: the law of comparative advantage postulates that resources, dollars, people, and business have a best use. Society or the community is better off when that best use is realized.⁵⁹ By converting former nonprofit hospitals to for-profit, the theory is that capital in bricks and mortar has been released for a better social use. Community hospital boards faced with a parlous financial situation and induced by what seems to be huge sums have sold their hospitals too quickly, at too low a value with little community input.

54. See Gray, *supra* note 38, at 29.

55. See *id.* at 31.

56. See *Sound Health v. Comm'r*, 71 T.C. 158 (1978) (granting an HMO tax exempt status when it served the public interest and was not engaged in providing a form of insurance); see also Gen. Couns. Mem. 39,829 (Aug. 25, 1990) (granting tax exempt status to HMO); but see Gen. Couns. Mem. 39,828 (Aug. 24, 1990) (failing to grant tax exempt status to HMO); Gen. Couns. Mem. 39,830 (Aug. 24, 1990) (same).

57. See Singer, *supra* note 51, at 230.

58. Daniel M. Cain, *Introduction to Bridging the Transition from Community Hospital to Charitable Foundation: An Emerging Force in Social Change*, STRATEGIES IN CAPITAL FIN., Spring 1996 at 1.

59. See generally Craig Havighurst, *Solid Foundations*, 29 Health Sys. Rev. 33 (1996) available in LEXIS, BusFin Library, ABI File.

E. Blue Cross Conversions

Blue Cross is an insurance plan for the less affluent. Hospitals established Blues plans as not-for-profits in the 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.⁶⁰ 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 seventy million people in widely differing markets.⁶¹ 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.⁶² 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.⁶³ Critics say these conversions are siphoning billions into investors' and executives' pockets. Several plans have converted to for-profit status or announced conversion plans.⁶⁴ Other Blues are merging, which may be a prelude to for-profit conversion.⁶⁵ The reasons for conversion correlate to those of hospitals and HMOs: a need for more capital and new competition.⁶⁶ 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 subscribers to HMOs in a few years.⁶⁷

Some regulators have objected to Blue Cross conversions. These critics contend that the Blues Plans were established as nonprofits because of their public mission, and that they are essentially owned by the public. Therefore, the public should receive money for their conversions rather than private individuals, and Blues' assets should not be used as seed money for for-profit ventures.

IV. CAUSES OF CONVERSION TO FOR-PROFIT STATUS

Conversions of nonprofit health care providers allow the new for-profits to: avoid increased Internal Revenue Service regulation and scrutiny; take advantage of current

60. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 298 (1982).

61. See 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.

62. See *id.*

63. See *id.*

64. Four are completed. Others are in the process. Blues in Colorado, Maryland, Massachusetts, and New York are in various stages of conversion. See Claxton, *supra* note 4, at 11-12. Three other Blues' plans—Wisconsin, Indiana, and Missouri—have owned publicly traded managed care subsidiaries for several years. See Louise Kertesz, *Not Your Father's Blue Cross*, *Modern Healthcare*, October 14, 1996, at 68.

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

66. Blues lost their federal tax exempt status in 1986 because the provision of commercial-type insurance as a substantial part of an organization's activities was no longer an exempt activity. See Tax Reform Act of 1986, Pub. L. 99-514, 100 Stat. 2390 (codified as amended in 26 U.S.C. §§ 501(m), 833 (1986)).

67. See Milt Freudenheim, *Empire Blue Cross Seeking to Become For-Profit Group*, N.Y. TIMES, Sept. 26, 1996, at A1; Milt Freudenheim, *Crisis Looms as Big Insurer Keeps Sliding*, N.Y. TIMES, Aug. 28, 1994, at § 1, 31.

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.

The fundamental reason for health care providers' moves to for-profit status is easier access to capital.⁶⁸ Historically, nonprofit health care organizations raised capital through the use of tax exempt financing, which enabled nonprofit health care 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—the profits of which went to the exempt organization. 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.⁶⁹ Still, there were loopholes.

One loophole was the incentive to borrow in advance of one's need. Institutions would invest in for-profit vehicles and then use the dollars when they needed them. 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, twenty-five percent 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 five-percent limit on unrelated business operations.⁷⁰ There was also a \$150 million limit imposed on any section 501(c)(3) organization that borrows money for other than hospital purposes.⁷¹

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 the 1980s) moved to 85-90% in the 1990s, narrowing the significance of interest savings. The tax exempt marketplace became over-saturated with tax exempt paper of financially weak hospitals, leading to a downgrading by bond rating agencies and making the regular capital markets more comparable in terms of the cost of borrowing. All in all, the desirability of nonprofit status diminished for hospitals, and their competitive position vis a vis for-profits deteriorated as the latter had easier access to capital.⁷²

68. See Mancino, *supra* note 37, at 21-7.

69. See I.R.C. § 148 (1986).

70. See I.R.C. § 145(a) (1997).

71. See *id.*; § 145(b)(2)(C). The \$150 million borrowing limit was a restriction on mergers of nonprofit hospitals. This was prospectively repealed for capital expenditures by the Taxpayer Relief Act of 1997, sec. 222, P.L. 105-34 (Aug. 5, 1997), effective the date of enactment. Specifically, new paragraph (5) of Internal Revenue Code section 145(b) ("\$150,000,000 Limitation on Bonds Other Than Hospital Bonds") reads:

(5) *Termination of Limitation.* This subsection shall not apply with respect to bonds issued after the date of the enactment of this paragraph as part of an issue 95 percent or more of the net proceeds of which are to be used to finance capital expenditures incurred after such date.

One cannot overestimate the economic importance of shifts in the tax laws.

72. See Singer, *supra* note 51, at 227-28 (concluding that "the exempt hospital, having reached its use

V. WHAT IS A CONVERSION IN THE INTERNAL REVENUE CODE AND STATE CHARITABLE CORPORATION LAW?⁷³

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, deleting its nonprofit aspects and adding for-profit powers.⁷⁴ The newly converted for-profit corporation is empowered to issue stock, permitted to conduct all lawful business, and allowed to pay dividends.⁷⁵ 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.⁷⁶ Typically, it is favored by HMOs, preferred provider organizations, and other managed care organizations not dependent on fixed assets like real property.

B. Asset Sales

Another conversion approach is a sale of assets, whereby 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 licenses. After the sale, the for-profit corporation owns the charitable corporation's assets, which in return may receive stock, notes, or other property in addition to cash as consideration. This transaction structure is typical for the acquisition of a nonprofit hospital by a for-profit acquirer.⁷⁷ Federal and state laws require that the proceeds from the sale continue to be held in charitable trust and used for charitable purposes.⁷⁸ Foundations are usually the post-conversion holders of these charitable assets.

C. Merger

Another technique for conversion involves a merger of a nonprofit corporation into a for-profit. The charity forms a new for-profit corporation to which it contributes its assets in exchange for cash, notes, and stock. Thereafter, the nonprofit corporation merges

restriction ceiling, may find itself pitted against an organization with a seemingly endless capital supply"). For nonprofit HMOs, tax exempt debt was unavailable after 1983 for new product development, geographic expansion, or acquisitions. See MANCINO, *supra* note 37, at 21.01-5.

73. See MANCINO, *supra* note 37, at 21-7 to 21-9 (developing this typology); see generally Thomas Silk, *Conversions of Tax-Exempt Nonprofit Organizations: Federal Tax Law and State Charitable Law Issues*, 13 EXEMPT ORG. TAX REV. 745 (1996).

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

75. The fundamental distinction between a charitable nonprofit and a business corporation is the nondistribution constraint. For example, the nonprofit cannot distribute its earnings to members or shareholders. See Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 838 (1980); REV. MODEL NONPROFIT CORP. ACT § 13.01 (1988); CAL. CORP. CODE § 5410 (West 1997).

76. Arizona, California, Pennsylvania, Utah and Virginia. MANCINO, *supra* note 37, at 21-7.

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

78. See *supra* notes 22 and 25 and accompanying text.

into the for-profit corporation.⁷⁹ Here again, state and federal laws require the exchange proceeds to remain in the charitable stream and to be used for charitable purposes. A foundation or nonprofit corporation is created to receive the cash or stock from the surviving corporation. After the conversion, there are ordinarily two organizations: the for-profit corporation and a private foundation.

D. Drop-down Conversions

Drop-down conversions involve 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 organization, such as an HMO, desires to convert some or all of its assets into a for-profit.⁸⁰ After the transaction is completed, the for-profit subsidiary may enter the equity markets through an initial public offering.

In a drop-down, the original owner of the assets usually retains a substantial percentage of equity in the newly formed corporation. This type of conversion, when used by an HMO, is usually a preliminary step to another form of transaction, such as a takeover by another health plan. Some Blue Cross plans have argued that they do not need to transfer any assets to charity, as the nonprofit remains in existence.⁸¹ After the conversion, three organizations may exist: in addition to the for-profit corporation and the foundation, a section 501(c)(4) organization may be created to receive and hold the stock for later sale and to remit the proceeds to the foundation.

VI. 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.⁸² California, for example, addressed the inadequacy of its conversion procedures by enacting legislation that requires the conversion price to be at fair market

79. This is permitted in a few states: Arizona, California, and Virginia. MANCINO, *supra* note 37, at 21-8.

80. 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* Part VII.E.

81. *See infra* notes 144-146.

82. *See* ARIZ. REV. STAT. § 10-2592 (1997); CAL CORP. CODE § 5914 (West 1997); GA. CODE ANN. § 14-3-1041 (Harrison 1994); LA. REV. STAT. ANN. § 2115.11 (West 1997); ME. REV. STAT. ANN. tit. 13-B, § 904 (West 1995); NEB. REV. STAT. § 71-20,108 (1996); N.H. REV. STAT. ANN. § 420-A:17 (1995); OHIO REV. CODE ANN. § 109.34 (Baldwin 1997); R.I. GEN. LAWS § 27-19-29 (1994); VA. CODE ANN. § 38.2-4204.1 (Michie 1994); WASH. REV. CODE ANN. § 24.03.195 (West 1996). For pending legislation see S. Res. 283, 77th Leg., 1997 Reg. Sess. (Kan. 1997) (the regular session adjourned on May 27, 1997 and the bill carried over to the 1998 regular session); H. Res. 287, 1997 Reg. Sess. (Md. 1997) (regular session adjourned on April 7, 1997 and the bill was not carried over); S. Res. 1722, 181st Leg., 1997 Reg. Sess. (Mass. 1997) (This bill was submitted to the Senate Committee on Ways and Means); S. Res. 149, 89th Leg., 1997 Reg. Sess. (Mich. 1997) (This bill was submitted to the Senate Committee on Health Policy and Senior Citizens); S. Res. 327, 89th Gen. Assembly, 1997 1st Reg. Sess. (Mo. 1997) (The regular session adjourned on May 16, 1997 and the bill was not carried over); S. Res. 1550, 207th Leg., 1996 1st Annual Sess. (N.J. 1997) (This bill was submitted to the Senate Committee on Human Services); S. Res. 1056, Sess. of 1997 (N.C. 1997) (The regular session adjourned, and the bill was not carried over); S. Res. 279, 46th Leg., 1st Sess. (Okla. 1997) (The 1997 regular session adjourned, and the bill was carried over to 1998 regular session); H. Res. 1923, 100th Gen. Assembly (Tenn. 1997) (The regular session adjourned, and the bill was carried over to 1998 regular session).

value, the assets resulting from the conversion to be held by an independent foundation, and the converting organization to have in place policies prohibiting conflicts of interest.⁸³ Other jurisdictions are trying to deal with this sector shift by improving monitoring in an area which has been largely self-regulated. Nebraska has passed legislation regulating the sale of hospitals to ensure disclosure of conflicts of interest, sale at fair value, and proper use of charitable assets.⁸⁴

Another product of the conversion wave has been the reawakening of the role of the state 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.⁸⁵ California increased the role of the attorney general to control and monitor conversions.⁸⁶ Attorneys general in other states have also attempted to become involved in the conversion process.⁸⁷ 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 pres doctrine. The theory of cy pres is that when a charitable purpose becomes impossible, inexpedient, impracticable of fulfillment or already accomplished, equity will permit the trustee to substitute another charitable object which approaches the original purpose as closely as possible.⁸⁸ In modifying the trust's purpose, the court must follow the donor's original purpose *cy pres comme possible*—Norman French for "as near as possible."⁸⁹ The power of modification has been strictly construed.⁹⁰

Cy pres comes into play at two points in the conversion process. The first is in determining whether assets which were given for nonprofit purposes can be used in a conversion or even in a joint venture with a for-profit. Generally, 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 pres type action.⁹¹ 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.⁹² The court concluded that state law prohibited the transfer of charitable assets to a for-profit joint venture.⁹³ The second point at which cy pres comes into play is after the conversion: must the proceeds from the conversion be put to the same charitable use as before?

83. CAL. HEALTH & SAFETY CODE §§ 1399.71(e)(1), 1399.72(c) (West 1998).

84. NEB. REV. STAT. §§ 71-20,103 to 71-20,113 (1996).

85. Richard C. Allen, *The Massachusetts Experience*, HEALTH AFF., Mar.-Apr. 1997, at 85; CAL. HEALTH & SAFETY CODE § 1399.75(e).

86. See CAL. HEALTH & SAFETY CODE § 1399.75 (e) (West 1998); CAL. CORP. CODE § 5914 (West 1998).

87. Colorado, Missouri, Nebraska, Georgia, Oklahoma and Rhode Island. See James F. Owens, *States Regulate Non-Profit Hospital Conversions*, NAT'L L.J., Sept. 8, 1997, at B10.

88. GEORGE G. BOGERT & GEORGE T. BOGERT, THE LAW OF TRUSTS & TRUSTEES ch. 22, § 431, at 95 (2d rev. ed. 1991).

89. *Id.*

90. See *id.*

91. See *Queen of Angels Hosp. v. Younger*, 66 Cal. App.3d 359 (1977) (involving the lease of a nonprofit hospital's facilities, the profits of which were to be used to open additional medical clinics); Allen, *supra* note 85, at 87.

92. *Kelley v. Michigan Affiliated Healthcare*, No. 96-83848CZ, 96 TNT 187-18 (Mich. Cir. Ct. for the County of Ingham Sept. 5, 1996).

93. This was not directly a cy pres issue, for the court did not rule directly on the cy pres point.

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.⁹⁴

VII. TROUBLE SPOTS—PROBLEMS AND CONVERSION ISSUES

A. Conflicts of Interest

A fundamental problem with conversions 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 venture. The acquiring corporation may offer bonuses, salaries, or “golden parachutes”⁹⁵ if the director joins the for-profit organization. There may be contingency compensation based upon the success of completing the transaction. In its nonprofit guise, the fiduciary obligation of the director is to obtain the highest value for the nonprofit and to assure that the community is provided with health care. That individual’s interests as a for-profit shareholder or a future employee may be in opposition. 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.⁹⁶ Four executives were to receive \$19 million in payouts as part of the transaction, and seven former directors were to receive \$3 million.⁹⁷ Gener-

94. 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. In Revenue Ruling 98-15, the IRS tightened the ability of for-profit hospitals to control joint venture arrangements with non profit hospitals. See Rev. Rul. 98-15, 1998-12 I.R.B. 6; Gen. Couns. Mem. 39,862 (1991); see also *Plumstead Theatre Soc’y, Inc. v. Comm’r*, 74 T.C. 1324 (1980) (holding that a nonprofit theatre company whose activities included the presentation of dramatic theatre productions, workshop for new American playwrights, and the establishment of a fund to assist new and established playwrights which entered into joint venture with investors who were to receive a percentage of profits from production was entitled to § 501(c)(3) status because commercial investors were limited partners without control). Additionally, Internal Revenue oversight at the conversion stage raises federalism questions which will be discussed later in this article.

95. That is, substantial termination payments.

96. The transaction was structured as follows: Blue Cross Blue Shield of Ohio (BCBSO) was to spin off a wholly-owned for-profit subsidiary, Blue Co., and transfer substantially all of BCBSO’s assets to it. A wholly owned subsidiary of Columbia/HCA would purchase all of Blue Co.’s stock for \$299.5 million. At the time BCBSO had \$233 million in reserves. If BCBSO failed to exercise its best efforts to transfer its rights to the Blue Cross Blue Shield trademark to Blue Co., the purchase price would be reduced by \$50 million. If BCBSO accepted another acquisition proposal from another suitor, it would be required to pay a stiff “good bye fee” of \$25 million, in addition to sending its subscribers to Columbia/HCA hospitals and paying Columbia/HCA’s highest hospital service rates for a period of five years. See Craig R. Mayton, *The View from Ohio*, HEALTH AFF., Mar.-Apr. 1997, at 94. One can only wonder about the quality of Blue Cross’s lawyering in signing such a one-sided agreement. Perhaps the answer is that the insider general counsel was scheduled to receive \$1.2 million for a 10-year agreement not to compete and \$2.3 million for two consulting agreements. See Diane Solov, *Blue Cross’ Top Executives to Get Millions in Buyout*, THE PLAIN DEALER, May 10, 1996, at 1A. Furthermore, Blue Cross’s outside counsel was scheduled to receive \$3.5 million for a five-year agreement not to compete. See *id.*

97. Bloomberg Bus. News, *Columbia/HCA to Pay Blue Cross Officials*, N.Y. TIMES, May 10, 1996, at D6. The national Blue Cross Association revoked the chartered Ohio Blue Cross for this attempt and the Ohio Dept. of Insurance rejected the transaction on March 12, 1997. See Mary Chris Jaklevic, *Ohio Blues Gives Up*:

ally, 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. This raises questions about the integrity of the organization’s decision-making process as well as the quality of information provided by the staff to the board. The charity may be operated during the period leading up to the transaction in a way that potentially devalues the organization’s business or assets in order to make the acquisition more attractive to a potential future employer.⁹⁸ The response of several jurisdictions has been to introduce legislation prohibiting bonuses as part of a transaction.⁹⁹ Most other jurisdictions have declined to do anything.

There should be enhanced scrutiny of conflicts of interest with respect to placement of proceeds, whether into a new nonprofit entity or with a joint venture undertaken by a nonprofit entity and a for-profit purchaser.¹⁰⁰ 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.

B. 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 organization? Nonprofit entities present greater valuation difficulties than for-profit firms. Nonprofit valuation is more complex and uncertain than the valuation of a comparably-sized for-profit.¹⁰¹

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 that follow for-profit counterparts. Valuation, then, rests upon the appraiser’s craft, inherently a subjective process. The subjectivity of the valuation process is overlaid by the very human and economically rational behavior that the appraiser may use their discretion to serve the interests of those who hire them.¹⁰²

Insurer Agrees to Call Off Columbia Deal, Remove CEO, MODERN HEALTHCARE, Mar. 24, 1997, at 2.

98. See Allen, *supra* note 85, at 86.

99. 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 as a form of bonus, which would become enormously valuable on a public offering. See COLO. REV. STAT. ANN. § 10-16-324 (West 1997).

100. See CAL. HEALTH & SAFETY CODE § 1399.71(e) (Supp. 1998) (prohibiting inurement and conflicts of interest in joint ventures and their transactions by a nonprofit).

101. See Harvey J. Goldschmid, *Nonprofit Conversion Transactions: Existing Fiduciary Duties and Necessary Reforms*, in CONVERSION TRANSACTIONS: CHANGING BETWEEN NONPROFIT & FOR-PROFIT FORM 1 (1996) (stating that “nonprofit conversions suffer when compared to for-profit acquisitions because of . . . the general difficulty of valuation in the nonprofit conversion context”); see also GAO, *Not-for-Profit Hospitals Conversion Issues Prompt Increased State Oversight*, 19 EXEMPT ORG. TAX REV. 261, 264-66 (1998) (describing valuation approaches).

102. See Lucian A. Bebchuk & Marcel Kahan, *Fairness Opinions: How Fair are They and What Can Be Done About It?*, 1989 DUKE L.J. 27, 37 (1989); Charles M. Elson, *Fairness Opinions: Are They Fair or Should We Care*, 53 OHIO ST. L.J. 951, 965 (1992); Tower, *supra* note 35, at 169; Elliott J. Weiss, *The Law of Take Out Mergers: Weinberger v. UOP, Inc. Ushers in Phase Six*, 4 CARDOZO L. REV. 245, 255 (1983). The

Traditionally in health care transactions three different methods of valuation are utilized: 1) replacement cost or asset valuation; 2) market comparison, which involves setting the sale price in relation to comparable assets; and 3) the most widely used method, discounted cash flow analysis, which establishes a price by projecting a health provider's earnings potential.¹⁰³ Valuation of nonprofit hospitals is generally calculated as a multiple of a 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 uncommon.¹⁰⁴ Valuation is severely tested in the health care area where there has not been a market, and in which the conversion is followed thereafter by a substantial increase in value of a publicly-traded health care company in comparison to its nonprofit value.¹⁰⁵

The subjectivity and difficulty of valuation may be demonstrated by the sale of St. Vincent's Hospital in Worcester, Massachusetts, part of Fallon Healthcare System, to OrNda, a large investor-owned hospital chain.¹⁰⁶ The sale was for \$4 million, though the plant was worth substantially more. The hospital, burdened with debt, handed the keys over with the promise that the for-profit would run the hospital and pay off long term debt of \$68 million. However, OrNda, which purchased the Fallon Clinic as well, paid over \$60 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 \$72 million and working capital of \$17 million. The community got \$4 million, 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. Vincents to other hospitals and treated it as worse off than 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 \$20 million. If the sample had been broadened, and Anderson had based its calculations on the weakest

subjectivity and willingness of investment bankers to issue fairness opinions that are favorable to the needs of the retainer is demonstrated in *Mills v. Macmillan*, 559 A.2d 1261, 1272-73, 1281-82 (Del. 1989). On May 30, 1988, investment bankers informed management that a restructuring price of \$64.15 was fair, and on June 7, 1988, investment bankers advised that the company had a maximum breakup value of \$80 per share. On August 25, 1988, in the context of a hostile tender offer after urgings by management, the same group of investment bankers issued a new opinion that \$80 was unfair and inadequate. See *Dynamics Corp. of Am. v. CTS Corp.*, 794 F.2d 250, 257-58 (7th Cir. 1986), *rev'd* 481 U.S. 69 (1987) (involving an investment bank which structured a poison pill defensive measure; when the tender offer commenced, the bank was hired to determine fairness and would receive a bonus if hostile suitor lost proxy fight, and the bank wrote that the opinion offer was unfair); *Hanson Trust v. ML SCM Acquisition*, 781 F.2d 264, 270-71 (2d Cir. 1986) (dealing with an investment bank which structured and arranged financing in a lock up option, then declared it was unfair).

103. See Tower, *supra* note 35, at 160.

104. See Robert A. Boisture & Albert G. Lauber, *Full Text Comment Letters: Caplin & Drysdale Comments on Whole Hospital Joint Ventures*, 16 EXEMPT ORG. TAX REV. 650, 652-53 (1997).

105. See Goldschmid, *supra* note 101, at 2-3.

106. See Gerard O'Neill et al., *Profit Motives Doom Worcester Hospital*, BOS. GLOBE, Nov. 17, 1996, at A1.

hospital from a larger sample, it would have been worth \$40 million. An independent real estate valuation firm hired by the Boston Globe came up with a value of \$38 million.¹⁰⁷

The problem of determining value is that a hospital may have a different value as a nonprofit, a for-profit, a for-profit taken over by a chain, or a hospital that will be the first in an area to convert. The hospital's value may also be relative to the competition in the area, as well as to other market specific factors. Hospital valuations encompass a variety of industry specific factors including scope of services, market share and ease of entry of competition, payor mix, Medicare gain/loss recapture¹⁰⁸ and patient mix.¹⁰⁹ The difficulties of valuation may ease dramatically as a result of the growing number of acquisitions. Future earnings capacity, as estimated by capitalized earnings approaches and discounted cash flow analyses, will make determination of fair market value similar to the determination of value through an initial public offering of a close corporation.

Other factors may assist conversion sales at fair market value. Increased state regulation and legislation may also assure conversions at a fair market value.¹¹⁰ Some have recommended that legislation require a market test.¹¹¹ 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 release 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.¹¹²

Is there an absolute duty to maximize financial return? Under Delaware law, once it appears a corporation will be sold, the duty of the board of directors is to maximize "the company's value at a sale for the stockholder's benefit."¹¹³ In the nonprofit context the

107. *See id.*

108. Under Medicare regulations, a Medicare provider is entitled to reimbursement for the indirect cost of using tangible assets through an allowance for depreciation. *See* 42 C.F.R. § 413.134 (1998). Upon disposal of the asset, the regulations provide for adjustment of the allowable cost determination. If a conversion or disposal results in a gain, such as the sale price exceeding the book value of the asset, the government may recoup depreciation expenses paid to the provider. The adjustment for a gain is limited to the actual amount of depreciation previously allowed as Medicare allowable costs. *See* 42 C.F.R. § 413.134(f). Conversely, if the sale price is less than the depreciated book value of the asset, the provider is entitled to reimbursement for Medicare's proportionate share of the loss. The amount of an adjustment allowed for a loss is limited to the undepreciated basis of the asset permitted under the program. *See id.*; *see also* St. Mark's Charities v. Shalala, 952 F. Supp. 1488, 1490 (D. Utah 1997) (discussing 42 C.F.R. § 413-134(f) (1998)).

109. *See* Tower, *supra* note 35, at 161-62.

110. *See* NEB. REV. STAT. § 71-20,108(5) (1996) (listing factors for evaluating whether "appropriate steps have been taken to safeguard the value of charitable assets").

111. *See* Goldschmid, *supra* note 101, at 13-14.

112. A lock-up is a generic name for a variety of techniques used in a tender offer to assure that a particular bidder will be successful and to thwart competitive bidding. Sometimes stock is issued to the favored bidder, making the acquisition more expensive for other offerors. Other devices include an agreement to reimburse the favored bidder's fees and the sale of prized assets of the target to the favored 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. *See* Revlon v. McAndrews & Forbes Holding, 506 A.2d 173, 183 (Del. 1986).

113. *Revlon*, 506 A.2d at 182.

board's responsibilities should be to maximize the return to the public, including benefits to the community. 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 will not be the best for the organization as a deliverer of healthcare. Or, its financial situation may be precarious. For instance, in the Family Health Plan conversion described earlier,¹¹⁴ Maxicare Health Plans made a competing offer at a substantially higher price and sued to prevent HMO Health Group's conversion of FHP.¹¹⁵ The court held that the law did not require a sale to the highest bidder.¹¹⁶

C. Lack of Disclosure

Whenever possible, the principals to conversions attempt to impose a veil of secrecy over the transaction. At the beginning of negotiations between the for-profit acquirer and the nonprofit, a confidentiality agreement is signed.¹¹⁷ Some conversion transactions have been completed in secret without community knowledge. Should the community have the right to know the terms of the venture?

Should there be community input into the terms of the transaction? There is nothing similar to the disclosure mandates of American securities regulation.¹¹⁸ The participants in the transaction argue that the terms are proprietary information and fear that disclosure could jeopardize the transaction. In Massachusetts, the attorney general agreed with the parties in the Fallon Healthcare-OrNda conversion that the underlying financial documents that justify prices paid are trade secrets that are nobody else's business.¹¹⁹ During the attempted sale of Blue Cross of Ohio, state regulators, though promising to keep the

114. See *supra* notes 30-35 and accompanying text.

115. See *Maxicare Health Plans v. Gumbiner*, No. C-565072 (Los Angeles Superior Ct. 1986). One year after the conversion Maxicare went into bankruptcy.

116. See *Id.*

117. The difficulty of finding out details about these transactions is illustrated by the testimony of Linda B. Miller, President of the Volunteer Trustees Foundation:

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 re-deployed 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!)

Goldschmid *supra* note 101, at 3 (quoting Miller's statement before the Committee on Health and Human Resources of the Nebraska State Legislature on February 1, 1996).

118. Generally, the Securities and Exchange Commission regulates public corporations, which means corporations with at least 500 shareholders and approximately \$10 million in assets. See Securities Exchange Act of 1934 § 12(g), 15 U.S.C. § 78l(g) (1997). Rule 12g-1 exempts from registration companies with assets of less than \$10 million. 17 C.F.R. § 240.12g-1 (1997). There are an estimated 14,000 such corporations in the United States.

119. See O'NEILL et al., *supra* note 106. In California, according to a researcher with whom the author spoke, the Blue Cross of California Document file concerning the most contentious conversion has been almost completely redacted by the Commissioner of Corporation's Office, making scholarly inquiry difficult if not impossible. Telephone interview with Teresa McMahon (September 1996).

public informed, privately attempted to keep the facts of the transaction secret during the review process and released no information including facts about the \$3.9 million paid to board members.¹²⁰ The Ohio Supreme Court found that insurance regulators abused their discretion in keeping this information secret.¹²¹ Recent conversion legislation by states requires that the plan for conversion be available to the public and often sets forth what information must be made available.¹²²

Another important issue is what information should be part of the public record. Though some states now require or have held public hearings,¹²³ the legislation does not specify what role the public is supposed to play or which public is to be involved. The state attorney general formally represents the public interest. Is the hearing mere window dressing, allowing anyone to vent their anger or views or is it to have a genuine role in the conversion process? Patricia A. Butler has pointed out that there are likely to be many publics with different agendas: insurance plan policyholders, persons served by different activities of the converting hospital, the medical staff, potential beneficiaries of a foundation, and the "community."¹²⁴ These diverse views are more likely to be heard through a public hearing. A second purpose of the public hearing confirms Justice Brandeis's observation that "[s]unlight is said to be the best of disinfectants, electric light the most efficient policeman."¹²⁵ The conflicts of interest that many of these transactions contain are brought to the surface and often cannot survive the outrage of the public, encouraging a stricter scrutiny by regulators.¹²⁶

The public hearing also allows policyholders, public policy experts, and advocacy groups to shape the final transaction, assuring that the public's interest will be protected. The public process has brought out public interest groups such as Consumers Union, which led the fight against the California Blue Cross conversion.¹²⁷ The public process does create problems in closing the transaction that are often muted or absent in typical business transactions where timing is more important than process. When the terms are made public, the emphasis on process comes to the fore, and the time frame of the trans-

120. See Mark Tatge & Diane Solov, *Insurance Watchdog Fought for Secrecy*, PLAIN DEALER, Dec. 21, 1997, at 1G.

121. See *Plain Dealer v. Ohio Dept. of Ins.*, 687 N.E.2d 661, 667 (Ohio 1997) (stating that documents relating to the proposed acquisition of Blue Cross are not exempt from disclosure under the "work papers" exception to the Public Records Act); see also Tatge, *supra* note 120, at 1G. Among the more sought-after documents regulators kept secret were the details of the payout to the Blue Cross trustees. However, Blue Cross insisted that the board voted on their retirement largess before they approved the sale to Columbia HCA, thereby creating no conflict of interest. In fact, the board meeting approving the retirement benefits came three months after a board meeting authorizing the Chairman to sell Blue Cross to either Columbia or another company. In the aftermath of the collapse of the deal, six of the former trustees agreed to return \$2.4 million after they were sued. A seventh donated his retirement benefit to charity. See *id.*

122. See COLO. REV. STAT. § 10-16-324(3) (1997); OHIO REV. CODE ANN. § 109.34(D) (Banks-Baldwin 1997).

123. See CAL. HEALTH & SAFETY CODE § 1399.74 (West 1997); CAL. CORP. CODE § 5916 (West 1997).

124. Patricia A. Butler, *State Policy Issues in Nonprofit Conversions*, HEALTH AFF., Mar.-Apr. 1997, at 69, 77.

125. LOUIS D. BRANDEIS, *OTHER PEOPLE'S MONEY AND HOW THE BANKERS USE IT* 92 (1914).

126. The merits of the conversion of the Ohio Blue Cross seemed lost in the millions the senior management was to receive from the transaction.

127. See Eleanor Hamburger, et al., *The Pot of Gold: Monitoring Health Care Conversions Can Yield Billions of Dollars for Healthcare*, 29 CLEARINGHOUSE REV. 473, 479-489 (1995).

action may be so lengthened and scrutinized that appropriate conversions as well as questionable ones may not come to fruition. Recent state efforts to oversee conversions require parties to a conversion to disclose to the regulator all terms of the transaction and all conflicts of interest.¹²⁸

California requires nonprofit organizations to notify the Commissioner of Corporations and the Attorney General in advance of a plan to convert,¹²⁹ who must then hold at least one public hearing in the hospital's county, and provide a sixty-day period with one forty-five day extension to review the transaction.¹³⁰ Nebraska requires at least thirty days notification of an impending acquisition.¹³¹ If the attorney general or state regulator does not have sufficient notice of the transaction, the terms between the parties will be completely negotiated and signed in a contract, making the transaction more difficult to unwind.¹³²

Apart from the issue of the public hearing is the question whether state officials should have an informal review process to explore whether the proposed transaction is a conversion and whether certain aspects are controversial or impermissible.¹³³ The problem of informal advance review is that it may make the public hearings a charade. However, informal or advance scrutiny is regularly used by federal agencies in the antitrust field in the form of "business review letters,"¹³⁴ in federal income tax through private letter rulings,¹³⁵ and in securities regulation through "no action" letters.¹³⁶

128. See NEB. REV. STAT. § 71-20,108(4) (1996); CAL. HEALTH & SAFETY CODE § 1399.71(e)(2)(D).

129. See CAL. HEALTH & SAFETY CODE § 1399.71(a); CAL. CORP. CODE § 5914 (West 1997). See also NEB. REV. ST. 71-20,104 (1996).

130. See CAL. CORP. CODE § 5915; see also NEB. REV. STAT. §§ 71-20,107, 20,106.

131. See NEB. REV. STAT. § 71-20,107; see also OHIO REV. CODE ANN. § 109.35 (Banks-Baldwin 1997).

132. See Butler, *supra* note 124, at 76.

133. See *id.*

134. The leading treatise on anti-trust law states that:

Although the Justice Department lacks the power to immunize transactions generally from the antitrust laws, it may "approve" a transaction by stating in a "business review letter" that on the basis of its present information it "has no present intention to challenge" the proposed action. Such a clearance cannot bind a court, a private plaintiff, or the Federal Trade Commission, although a court might choose to give it weight in the same way that it can consider enforcement guidelines. Nor would the Justice Department feel inhibited from seeking the usual remedies if the party requesting the clearance had submitted the inaccurate or incomplete information.

II Phillip Areeda & Herbert Hovenkamp, Antitrust Law § 331c, at 100-01 (rev. ed. 1995)

135. A private letter ruling is a written statement issued to the taxpayer upon request, usually in advance of a proposed transaction in which the staff of the IRS interprets the tax laws to the specific set of facts presented. The private letter ruling advises the taxpayer of the treatment she can expect from the situation in the fact pattern. Private letter rulings are directed only to the organization or individual requesting it and cannot be used or cited as precedent. See I.R.C. § 6110(j)(3) (1997).

136. Under SEC procedure, in certain circumstances an informal statement of the views of the Commission may be obtained. See 17 C.F.R. § 202.1(d) (1997). Typically, a "no action" letter reaffirms the informal advice provided by the staff to a company that is attempting to determine what properly may be omitted from its proxy materials. The letter does not bind the SEC to a particular course of action. See *Roosevelt v. E.I. DuPont de Nemours*, 958 F.2d 416, 427 n.19 (D.C. Cir. 1992) (noting that the letter does not amount to adjudication or rulemaking).

A criticism is that state regulators may not obtain the necessary information in a timely fashion and in any case, may lack the capacity to analyze it.¹³⁷ Another proposal, recommending the establishment of an SEC-type governmental body or a Charities Commission on the English model, was first mentioned over 35 years ago.¹³⁸ However, the American political ethos has moved away from establishing new governmental agencies. Yet another suggestion has been a mandatory disclosure system with collaboration among state charity regulators.¹³⁹ At best, any such collaboration would be many years away, long after the conversion wave will have run its course.

D. 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 the asset value is paid at the time of conversion, and the charitable organization becomes a partner of the for-profit. The for-profit actually runs the hospital and shares profits.

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 of stock in the new for-profit venture, which may place the charity at risk of economic losses. Recent indications are that conversions are facing growing resistance. Acquirers like Columbia/HCA, for instance, have come upon hard times.¹⁴⁰ Its stock has declined over fifty percent in 1997.¹⁴¹ There are significant financial implications for these new foundations and organizations that have received large amounts of stock as part of the consideration in the transaction. If the purchasing entity's stock collapses or there is a general market turn-down, the value of conversion-created foundations will substantially decline along with the amount these organizations will spend for the public good.

137. See Goldschmid, *supra* note 101, at 12.

138. See Kenneth Karst, *The Efficiency of the Charitable Dollar: An Unfulfilled State Responsibility*, 73 HARV. L. REV. 433, 476-83 (1960) (discussing a proposal for a government agency to supervise and administer the system).

139. See Goldschmid, *supra* note 101, at 11-12.

140. 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 due to the objection. See Milt Freudenheim, *California Challenges Deal on Nonprofit Hospital*, N.Y. TIMES, Nov. 9, 1996, at 35; see also Anita Sharp & Rhonda L. Rundle, *Columbia/HCA's California Expansion Falters as Sharp Healthcare Pact Fails*, WALL ST. J., Feb. 24, 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 & Kurt Eichenwald, *Health Care's Giant—When Hospitals Play Hardball*, N.Y. TIMES, May 11, 1997, § 3, at 1. The Federal Bureau of Investigation and several government agencies were examining some of the recent acquisitions and business practices of Columbia/HCA. See Kurt Eichenwald, *FBI Reported Examining Hospital Operation in Ohio*, N.Y. TIMES, April 1, 1997, at D2; Kurt Eichenwald, *Columbia/HCA is Said to Settle Tax Case for \$71 Million*, N.Y. TIMES, Dec. 3, 1997, at D4.

141. The Valueline Investment Survey estimated in January of 1998 that "investors should look elsewhere for now." Markey, *supra* note 50, at 653.

E. How Much of the Organization's Value Should Remain in the Public Domain?

What is a 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 and over whether any assets must remain in the charitable stream. Should the amount of assets devoted to public use be based on a tax benefit theory by which the set aside would be limited to the value of tax benefits received by the organization plus interest, or should the traditional charitable trust theory (which would require that the value of all assets of the exempt organization be set aside) be applied? The differences in amount depending on the method of valuation could be enormous.

When Blue Crosses have converted, typically they have used the drop-down approach.¹⁴² 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 programs. Blue Cross retained 82% of Wellpoint and sold the remainder for \$517 million. At first, Blue Cross argued that because it did not convert itself to for-profit status, but only created a for-profit subsidiary, it owed nothing to the public. Although Blue Cross's argument was correct from a legal standpoint, it did not pass the "smell test," which led to a public outcry. Eventually, the Wellpoint subsidiary was sold to another HMO, creating two private foundations—the California Healthcare Foundation, with \$2.2 billion in stock, and the California Endowment, with over \$1 million in cash.¹⁴³

This dispute has been played out in other jurisdictions with mixed results. In some jurisdictions, Blue Cross has attempted to shape state laws to make conversion easier and cheaper by eliminating the nonprofit Blue's responsibility to keep assets in the charitable stream.¹⁴⁴ In other states, legislation has attempted to preserve the charitable assets upon conversion.¹⁴⁵ Courts in Missouri and Georgia concluded that their state's Blues owed nothing to the public because they had lost their charitable exemption.¹⁴⁶ A back-up argument in some jurisdictions has been that Blue Cross should return public monies that were received because of the tax exemption. For example, the set aside of monies to the public is limited to the tax benefit received by the organization plus interest. In Virginia, the legislature used the assets from the Blue Cross conversion for education funds, relieving the state's taxpayers and providing a refund to subscribers.¹⁴⁷

142. See *supra* notes 60-66 and accompanying text.

143. See Fishman & Schwartz, *supra* note 34 at 105-106.

144. See N.J. REV. STAT. §§ 17:48E, :48E-45, :48E-17 (1997).

145. See COLO. REV. STAT. § 10-16-324 (1997); ME. REV. STAT. ANN. tit. 5, § 194-A (West 1997).

146. The Georgia court said that Blue Cross was not charitable because the company had been taxed since 1960. In Missouri, a court granted summary judgment to Blue Cross, stating it owed nothing to the state. See *Blue Cross Missouri Gains in Legal Fight with State Officials*, WALL ST. J., Sept. 10, 1996, at B2. Blue Crosses lost their federal tax exemptions in 1986. See I.R.C. § 501(m) (1986).

147. See Butler, *supra* note 124, at 72; see also David Ress, *Trigon Conversion Approved*, RICHMOND TIMES DISPATCH, Oct. 29, 1996, at C-1.

F. Who Should Regulate These Conversions—The Role of the Attorney General

Historically, the attorney general in most states has had the responsibility of supervision and oversight of charitable trusts and corporations. He may maintain such actions as appropriate to protect the public interest.¹⁴⁸ Most jurisdictions, but not all, require attorneys general to receive advance notice of organic changes such as conversions.¹⁴⁹ The Volunteer Trustees Foundation for Research and Education, which has studied health care conversions, has recommended that the attorney general be primarily responsible for: 1) safeguarding the value of charitable assets; 2) safeguarding the community from loss of essential health services; and 3) assuring that proceeds of the transaction are used for appropriate charitable purposes.¹⁵⁰

The problem is that attorneys general have neither the resources nor the expertise to closely monitor these conversions. Health care providers may be supervised by other state agencies who certify, regulate, and oversee health providers, but the conversion phenomenon is potentially broader than the health care sector. For all practical purposes, charities are self-regulated.¹⁵¹ Only thirteen states have charities sections within attorneys general offices.¹⁵² Additionally, there is limited standing for others to sue. Non-profits have no shareholders, and few charities have members. Generally, the public has no standing.

What is needed is an increase in the leverage of state attorneys general. Giving attorneys general explicit legislative authority over conversions neither adds to their budgets nor the size of their offices. One way to leverage inadequate staffing is to use the common law concept of the relator 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 who is permitted to institute a proceeding in the name of the state when that right to sue resides

148. See REV. MODEL NONPROFIT CORP. ACT §§ 1.70, 3.04, 8.10, 14.03-14.04 (1988); CAL. CORP. CODE §§ 5142, 5250, 6511, 9230 (West 1990); N.Y. NOT-FOR-PROFIT CORP. L. § 112 (McKinney 1997).

149. See CAL. CORP. CODE § 5913; OHIO REV. CODE ANN. § 109.34(B) (Anderson 1997).

150. See Robert A. Boisture & Douglas N. Varley, *State Attorneys General's Legal Authority to Police the Sale of Nonprofit Hospitals and HMOs, in Selling Off the Nation's Not-for-Profit Hospitals: The Legal Basis for Oversight* Tab 2, 16 (Sept. 19, 1995) (unpublished presentation) (on file with author).

151. See Robert Abrams, *Regulating Charity—The State's Role*, 35 REC. 481, 484 (1980); see also MARION FREMONT-SMITH, *FOUNDATIONS AND GOVERNMENT* 226-228 (1965).

152. See PETER SWORDS & HARRIET BOGRAD, *NONPROFIT ACCOUNTABILITY* (visited Apr. 2, 1998) <<http://www.bway.net/~hbograd/cyb-acc.html>>. These states are home to 55% of the United States' 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 program 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 attorney general's office handles 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 prosecuting solicitation fraud. See *id.*

solely in the attorney general.¹⁵³ Thus, to expand the resources of the attorney general, an action would be brought by a private party, such as a public interest law firm, on behalf of the public interest or the state. The attorney general still would exercise ultimate control over the litigation. In order to recover litigation expenses incurred by the private party, such as attorneys' fees, legislation needs to be enacted.

G. The Internal Revenue Service's Role

The Internal Revenue Service (IRS) may become interested if the transaction violates the private inurement or private benefit proscriptions of the Code. The conversion process may provide directors, officers or employees with private inurement through transactions that improperly benefit management, such as golden parachutes, or undervalue the nonprofit entity when it is sold to a for-profit successor whose owners include managers of the nonprofit.¹⁵⁴

Section 501(c)(3) organizations are prohibited from engaging in activities that result in "inurement" of the organization's net earnings to insiders, such as founders, directors, and officers.¹⁵⁵ Related to the private inurement proscription is the "private benefit" doctrine that prohibits a section 501(c)(3) organization from providing a substantial economic benefit to individuals, such as employees, who do not exercise any formal control over the organization.¹⁵⁶ Thus, the inurement limitation applies only to an organization's insiders whose special relationship to the organization affords them an opportunity to benefit economically from the organization's income or assets.¹⁵⁷ The private benefit doctrine is founded on the principle that a charity must serve public rather than private interests. The private benefit prohibition applies to anyone outside of the intended charitable class, whether or not they are insiders. As interpreted by the IRS, a private benefit must be more than incidental, in contrast to the absolute ban on private inurement.¹⁵⁸

Until recently, even if the private inurement or private benefit proscriptions occurred in a conversion context, the only remedy was to revoke the exemption of the hospital. Although this remedy would penalize holders of tax exempt paper and change the financial valuation of the hospital, it would result in very little damage if the hospital was converting to for-profit status. Revocation of exemption for an isolated instance of inurement even on a transaction as qualitatively and quantitatively significant as a conversion was vastly disproportionate to the offense. In 1996, Congress passed intermediate sanctions legislation to impose excise tax sanctions short of revocation when excessive

153. See James J. Fishman, *The Development of Nonprofit Corporation Law and An Agenda for Reform*, 34 EMORY L.J. 617, 671-674 (1985).

154. See Singer, *supra* note 51, at 246.

155. Treas. Reg. 1.501(a)-1 (1997) specifies that an organization is not operated exclusively for one or more exempt purposes if its net earnings inure in whole or in part to the benefit of private shareholders or individuals. The regulators define "private shareholder or individual" as any person "having a personal and private interest in the activities of the organization." Treas. Reg. § 1.501(a)-1(c) (as amended in 1982).

156. See Treas. Reg. § 1.501(c)(3)-1(d)(1).

157. But see *United Cancer Council v. Comm'r*, 109 T.C. 326 (1997), where the inurement limitation was extended beyond the organization's insiders.

158. For the distinction in the context of joint ventures between tax exempt hospitals and private physicians, see Gen. Couns. Mem. 39,862 (Dec. 2, 1991).

economic benefits were provided to insiders—such as officers, directors, or employees of converting nonprofits.¹⁵⁹

The sanction, which is intermediate in the sense of being lesser than revocation, imposes an excise tax if there is an excess benefit transaction¹⁶⁰ between the exempt organization and a disqualified person.¹⁶¹ The initial penalty is 25% of the “excess benefit” imposed on the disqualified person.¹⁶² Penalties may also be imposed on one or more of the organization’s managers.¹⁶³ It is likely that some of the more egregious payments, bonuses, options and rewards could be recaptured under the intermediate sanctions legislation.

Thus, the Internal Revenue Service has the authority to prevent private inurement so as to ensure an adequate purchase price. Even prior to the addition of section 4958, the IRS had indicated its concern with conflicts of interest in the health care area.¹⁶⁴ It does not, however, have the authority to require advance approval except for joint ventures between for-profit and nonprofit organizations. The Service has indicated it will pay closer attention to mergers between for-profit and nonprofit health care organizations in the 1998 fiscal year.¹⁶⁵ Even if it desires to take a more active role, the IRS is faced with decreasing resources.¹⁶⁶ The Exempt Organizations Division supervises 1.2 million nonprofits with only 400 agents and a budget of \$62 million.¹⁶⁷ This works out to six agents for every 3,000 nonprofit organizations.¹⁶⁸

159. See Taxpayer Bill of Rights 2, Pub. L. No. 104-168, 110 Stat. 1452, 1475-79 (1996) (adding section 4958 to the Internal Revenue Code).

160. An “excess benefit transaction” is any transaction in which an economic benefit is provided directly by the organization or indirectly by a controlled entity, such as a taxable subsidiary to a disqualified person if the value of the economic benefit exceeds the value of the consideration received by the organization for providing the benefit. See I.R.C. § 4958(c)(1) (1997).

161. A disqualified person is any person who, at any time during the five-year period preceding the excess benefit transaction was “in a position to exercise substantial influence over the affairs of the organization.” I.R.C. § 4958(f)(1)(A).

162. See I.R.C. § 4958(a)(1).

163. See I.R.C. § 4958(a)(2). Additional second tier penalties up to 200% of the excess benefit can be imposed on the disqualified person if the violation is not corrected within a specified period of time. See I.R.C. § 4958(b).

164. See Charles F. Kaiser & T.J. Sullivan, *Integrated Delivery Systems and Health Care Update*, in EXEMPT ORGANIZATIONS 384, 396 (Internal Revenue Service Continuing Professional Education Technical Instruction Program 1996).

165. See Fred Stokeld, *Health Care Mergers to Get More Attention from IRS, Says Owens*, 18 EXEMPT ORG. TAX REV. 195 (1997).

166. In 1997, Congress cut the agency’s budget 10.5%, or nearly \$774 million from the 1996 fiscal year’s level of funding. See Christopher Georges, *House Approves Deep Cutbacks in IRS Funds*, WALL ST. J., July 18, 1996, at A14.

167. IRS Exempt Organization officials devote about 30% of their resources to the largest nonprofits, principally hospitals and universities. The IRS’s primary functions are to: (1) collect taxes; (2) manage applications for tax exempt status and the annual report; (3) provide a Form 990 reporting system; (4) audit; (5) investigate; and (6) enforce. See SWORDS & BOGRAD, *supra* note 152. Less than one-half of one percent of exempt organizations are examined each year, and the number of examinations fell from 7,541 in 1989 to 5,472 in 1993. House Ways & Means Comm., *Ways and Means Oversight Subcommittee Report on Reforms to Improve the Tax Rules Governing Public Charities*, 94 TNT 89-7, § III (May 5, 1994).

168. In contrast, the Securities and Exchange Commission supervises approximately nine to fourteen thousand corporations with a substantially larger budget. See SWORDS & BOGRAD, *supra* note 152.

It may be that the greatest impact of the intermediate sanctions legislation will be to encourage the creation of a procedural paper trail as a bulwark against a violation of section 4958. The House Report and the proposed regulations state that the parties to a transaction are entitled to rely on a rebuttable presumption of reasonableness with respect to a compensation arrangement with a disqualified person if such arrangement was approved by a disinterested board, who obtained and relied upon appropriate data of comparable arrangements and adequately documented the basis for its determination.¹⁶⁹ Thus, the game for counsel of nonprofit employees who may benefit from conversion transactions will be to follow procedures to shift the burden of proof to the IRS.¹⁷⁰ All in all, oversight principally will remain on the state level.

H. The New Foundations

It has been noted that when a nonprofit converts, the purchase money must remain in the charitable stream.¹⁷¹ 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; a third, to distribute assets to other tax exempt charities; and fourth, to place the resulting assets in the state treasury. The first approach has been most common, as several enormous foundations have been formed by the conversion of nonprofit health care institutions.

Approximately ninety foundations in all have been formed since 1990 through conversions, though it is difficult to obtain accurate figures.¹⁷² 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.¹⁷³ Some of the new foundations are immense, such as the two foundations created from the conversion of California Blue Cross demonstrate. The California Wellness Foundation, formed in 1992 from the conversion of the HMO Health Net, has assets of \$1.2 billion.¹⁷⁴ The Rose Foundation, formed in the aftermath of the sale of Rose Hospital in Denver, has assets of \$185 million.¹⁷⁵ In Dickson, Tennessee, a very small city, the foundation created from a local hospital conversion has assets of \$80 million.¹⁷⁶ Foundations are required to spend five percent of their endowment annually on direct support or grants.¹⁷⁷ Although a foundation with \$50 million in assets sounds enormous, its annual charitable spending may be less than \$2.5 million. These

169. See H.R. Rep. No. 104-506, at 56-57 (1996). Prop. Treas. Reg. 53.4958-6.

170. In the for-profit arena of takeovers, the major impact of the seminal case of *Smith v. VanGorkom*, 488 A.2d 858 (Del. 1985), has been to create procedural steps which boards follow to meet the demands of the duty of care.

171. See *supra* notes 22-26 and accompanying text.

172. See Meyer, *supra* note 1; see also Domenica Marchetti, *Redefining Health Philanthropy*, CHRON. OF PHILANTHROPY, July 24, 1997, at 1, 12 (recognizing 79 foundations and stating that others are being formed).

173. Craig Havighurst, *Solid Foundations*, HEALTH SYS. REV., July-Aug. 1996, at 33-37.

174. See Harris Meyer, *From Giving Care to Giving Grants*, 37 FDN. NEWS & COMMENTARY No. 4, 40 (July/Aug. 1996).

175. See Domencia Marchetti, *Redefining Health Philanthropy*, CHRON. PHILANTHROPY, July 24, 1997, at 1.

176. See Tamar Lewin & Martin Gottlieb, *Health Care Dividend*, N.Y. TIMES, Apr. 27, 1997, § 1, at 1; Greg Jaffe & Monica Langley, *Generous to a Fault? Fledgling Charities Get Billions from the Sales of Non-profit Hospitals*, WALL ST. J., Nov. 6, 1996, at A1.

177. See IRC § 4942(e) (1997). The five percent figure includes administrative expenses.

new health care foundations, despite their seemingly enormous size, will not solve the problems of providing adequate health care to the poor, financing a cure for cancer, or making up for government cutbacks.¹⁷⁸

Several problems have arisen. The formation of the foundation comes well after the deal has been finalized—almost as an afterthought. The community or public is not involved at any earlier point. After the formation, there has been little focus on what foundations are actually doing.¹⁷⁹ Derek Bok, the former president of Harvard, has recently written, “Of all the institutions in America, philanthropic foundations are surely among the least accountable.”¹⁸⁰ States do not really monitor much after the foundation has been formed.¹⁸¹ They seem to assume the IRS is doing so. However, as discussed above, that is unlikely given the scope of the Service’s brief and its lack of resources in the exempt organization area.

Many of the new foundations have no experience in philanthropic activity. There has been no rush to turn the assets over to existing community foundations, which would reduce administrative costs and provide expertise.¹⁸² A very real problem for philanthropy is spending such large sums of money effectively. Many of the new foundations are run by the former trustees of the originating HMO or hospital. These individuals hardly have the independence one would wish, which may be more important than philanthropic experience. Basically, foundations only have to answer to their trustees. The majority of boards are not composed of a cross-section of the community.¹⁸³ The philanthropic records of some of these new foundations give pause:

- The public benefit program run by Blue Cross of California exclusively funneled subsidies for covering uninsured children to its affiliated HMO.¹⁸⁴

- 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.¹⁸⁵

- St. Luke’s Charitable Health Trust in Phoenix, formed from the sale of a hospital, started out by funding charity care to that hospital after it was converted.¹⁸⁶

178. See Michele Bitoun Blecher, *Show Us the Money*, HEALTH & HOSP. NETWORKS, June 20, 1997, at 52, available in LEXIS, Health Library, HOSP File (stating that “the needs of the uninsured represent a black hole that new foundations simply cannot fill”); see also Meyer, *supra* note 1, at 30.

179. See Harris Meyer, From Giving Care to Giving Grants, FOUNDATION NEWS & COMMENTARY, July-Aug. 1996, at 40.

180. Derek Bok, *Mute Inglorious Wizards*, N.Y. TIMES, Nov. 17, 1996, § 7, at 42.

181. One exception is California. See *infra* notes 189-194 and accompanying text.

182. See Nancy M. Kane, *Some Guidelines for Managing Charitable Assets from Conversions*, HEALTH AFF., Mar.-Apr. 1997, at 229. In the earliest HMO conversions in California the charitable proceeds were used to underwrite government programs, particularly Medical, California’s Medicaid program. *Id.*

183. Massachusetts has been in the forefront of regulating both the conversions and the 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.

184. See Rhonda L. Rundle, *Philanthropy: Big Charities Born as Health Plans Go For-Profit*, WALL ST. J., Apr. 4, 1995, at B1.

185. See Meyer, *supra* note 179.

186. See Meyer, *supra* note 179, at 43 (commenting on the performance of some foundations, which has exacerbated worries about the independence of new charities and potential favoritism in their grant making).

I. Cy Pres Issues Relating to the New Foundations

Do the new foundations have continuing responsibilities for health care or can they broaden their mission to anything?¹⁸⁷ Under traditional cy pres analysis, if there was a hospital conversion, the assets would have to be used for the delivery of primary health care as provided by a hospital. This may include health care for the poor.¹⁸⁸

New York has a more liberal approach to cy pres as applied to a nonprofit corporation than does charitable trust law. It allows for distribution to organizations engaged in substantially similar activities and leaves it to the board of directors to determine to whom the distribution should be made. This means that assets given upon dissolution to an organization need only be contributed to an entity that has "substantially similar activities."¹⁸⁹ This loose phrasing can cause much mischief as both the "substantially similar" and the corporate standards are quite vague.¹⁹⁰

The question arises—are these new foundations supposed to take over charitable services of existing money-losing hospitals and HMOs, by providing for the uninsured and assuming the charity care that the old nonprofit hospital or HMO may have provided? In the absence of an agreement, the for-profit successor will provide less charity care than the nonprofit hospital.¹⁹¹ The for-profit hospital will often claim that it no longer has responsibilities for charity care; rather that is the responsibility of the foundation created in the aftermath of the conversion.

187. About two-thirds of new foundations focus exclusively on public health and health care projects, while most of the remainder have broadened their focus to education, the arts, and other community projects. See Meyer, *supra* note 1, at 84.

188. In California, cases support the proposition that a corporation organized exclusively for charitable purposes holds its assets in trust for the purposes enumerated in its articles of incorporation even if the assets were not expressly earmarked for charitable purposes when the corporation acquired them. *Lynch v. Spilman*, 62 Cal.Rptr. 12, 20, 431 P.2d 636, 644 (1967). When a bequest, devise, or donation is made to a charitable corporation in California, the organization is expected to apply it to the charitable purposes set forth in its articles of association. See *Queen of Angels Hospital v. Younger*, 136 Cal.Rptr. 36, 41 (1977). 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 pres would require the corporation to use the proceeds to carry out the charity's original purpose. See generally Silk, *supra* note 73, at 746.13; see also *Atty. Gen. v. Hahnemann Hosp.*, 494 N.E.2d 1011, 1018-20 (Mass. 1996).

189. See generally *In re Multiple Sclerosis Service Organization*, 496 N.E.2d 861 (N.Y. 1986).

190. The new California statute regulating conversions states that the entity created in the course of a conversion be a section 501(c)(3) organization, but the statute does not really address the cy pres issue. CAL. HEALTH & SAFETY CODE § 1399.72(2).

191. One reason that nonprofits provide more unreimbursed care is that many states condition the property tax exemption for nonprofit hospitals on providing a substantial amount of charity care. See generally *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985) (affirming a County board of Equalization's denial of property tax exemption of two nonprofit hospitals because of failure to sufficiently demonstrate they met criteria for being a charity). In 1986, one year after the Hospital Corporation of America acquired Presbyterian Hospital in Oklahoma City, charity care at the hospital dropped to \$165,000 from \$1.9 million the previous year. However, as a for-profit hospital, Presbyterian now paid \$629,554 in property and franchise taxes, \$639,484 in local and state sales taxes, and \$397,152 in state income taxes. Additionally, the Presbyterian Health Foundation, which was created out of the conversion, made thirty-three grants for \$653,722 that year. This constitutes nearly 90% of the grants given to the University of Oklahoma Health Science Center where the hospital and foundation are located. Jay Greene, *Charity Care Falls After Okla. Hospital's Sale*, MODERN HEALTHCARE, Mar. 13, 1995, at 36, available at 1995 WL 2495215.

In California, a dispute arose between the attorney general and the Good Samaritan Charitable Trust in San Jose over the use of \$53 million. The money was received from the sale of Good Samaritan Health System, specifically for physician and hospital care for the needy. The former hospital leaders in charge of the resulting foundation wanted to fund a wider variety of programs than primary health care including meals-on-wheels and a health library.¹⁹² The California Attorney General's position was that primary health care was the purpose of the original trust for which the money was raised and that use must continue.¹⁹³ In the Family Health Program 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 that the new foundation should continue the charitable services have funneled support to their former hospitals but not to other health providers.¹⁹⁴ However, legally, morally, and socially, these foundations should be independent. In fact, the trustees of these new foundations are almost all members of 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, such as direct medical care. In Los Gatos, California, twenty percent of Valley Foundation's \$2 million in grants went to the arts. The Jackson Foundation, born from the sale of Regional Medical Center in Dickson, Tennessee, is considering financing a sports-training complex, an arts center, and a foreign language program. It provided two airplanes and made pilot training a free elective at the local high school.¹⁹⁵

The Rose Medical Center in Denver, formed in the 1940s as a place where Jewish doctors could practice, was sold to the Columbia/HCA chain, creating a \$170 million foundation. It has sponsored a Jewish community festival with music by the Borscht Brothers band and an Anne Frank contest in schools. The California Wellness Foundation gave money for Little League baseball in South Los Angeles, a world music festival, public education campaigns on handgun violence, and on how the Republicans "Contract with America" would cripple federal programs that help children.¹⁹⁶

These 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 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

192. See Greg Jaffe & Monica Langley, *Generous to a Fault? Fledgling Charities Get Billions from the Sale of Nonprofit Hospitals*, WALL ST. J., Nov. 6, 1996, at A1.

193. The Trust agreed to make 45% of its annual distributions for in-patient hospital care; 31% for out-patient care; 14.3% for school health centers that provide free care to poor children, and the remaining 9.7% on general health issues. Marchetti, *supra* note 172, at 15.

194. The Edgewater Foundation created from a hospital conversion reputedly spent \$900,000 in its first five years settling two of the hospital's malpractice suits and paying its water bills as well as unemployment insurance. See Kane, *supra* note 182, at 233. The Colorado Trust awarded 40% of its grants in its first six years to the for-profit hospital who purchased the former nonprofit hospital. See *id.* When the for-profit decided to reconvert to nonprofit status, the foundation gave the hospital \$60 million, half in grant and half in subordinated debt to support the reconversion. See *id.* at 233; see also, Bruce Japsen, *CEO Profits as Hospital Changes Status—Again*, MODERN HEALTHCARE, Oct. 9, 1995, at 50.

195. See Japsen, *supra* note 194, at 50.

196. See Marchetti, *supra* note 172, at 14.

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 and Carnegie Hall because the City contributes a percentage of the organizations' budget. Perhaps a relator who brought an action on behalf of the public would be an appropriate appointment.

Although the looser New York approach for charitable corporations seems best suited,¹⁹⁷ no matter what cy pres standard is used, the foundation's mission should be restricted to health care as it is defined by experts in the field. Thus, borscht, a Russian beet soup, would be allowable, but not the Borscht Brothers band! It should be required that foundations over a certain size—\$50 million—be required to have professional management and have its trustees receive training in foundation stewardship and public responsibility.¹⁹⁸ 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 990PF annual report to the IRS and the Attorney General.

J. Politics and the Conversion Process

One of the most disturbing, yet unsurprising aspects of the state of conversions is how the wheels of the political process have been greased by the large flow of funds to decisionmakers. 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 \$179,000 in legal fees in 1994 during the period negotiations were going on over the price of the conversion.¹⁹⁹ 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 for-profit status.²⁰⁰

Investor-owned hospitals have long been more politically active than nonprofit hospitals.²⁰¹ When Columbia/HCA enters markets in pursuit of an acquisition, it retains the best legal talent; identifies allies among the local civic, political, and medical elite; and spreads around lots of money. In 1995, Columbia/HCA had thirty-three lobbyists in Tallahassee, Florida alone!²⁰²

197. See *supra* notes 186-191 and accompanying text.

198. The \$50 million figure is derived from the cut-off size by the Association of Smaller Foundations. Such a requirement would most likely be negotiated by the attorney general.

199. See Milt Freudenheim, *Blue Cross Groups Seek Profit, and States Ask Share of Riches*, N.Y. TIMES, Mar. 25, 1996, at A1; Spencer S. Hsu & Peter Baker, Va. Delegate Quits as Insurer's Attorney, WASH. POST, Jan. 19, 1996, at B3.

200. See Peter Mantius, *Secretary of State Contest is Costliest Ever*, ATLANTA CONSTITUTION, Oct. 8, 1996, at 2C. As noted previously, Georgia Blue Cross owed nothing to the public. See *supra* note 146; see also Andy Miller, Questions for Bowers on Blue Cross Deal, ATLANTA CONSTITUTION, Dec. 26, 1997, at E3.

201. See Gray, *supra* note 38, at 22.

202. See Robert Kuttner, *Columbia/HCA + Resurgence of For-profit Hospital Business*, NEW ENG. J.

After years of lobbying in state capitals because their rates were set by insurance commissioners or some other agency, Blue Crosses have become particularly sophisticated at getting support for conversions.²⁰³ The interests seeking to convert nonprofit entities to for-profit status are bound only by the laws governing political contributions. However, nonprofit organizations, 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, such as Columbia/HCA, have generated a backload of unfavorable publicity, the long term political influence remains.

VIII. THE LEGAL RESPONSE TO CONVERSIONS

Traditional fiduciary legal doctrines, such as the duty of care, the business judgment rule, the duty of obedience, and the duty of loyalty, can protect the public's interest in these transactions with the addition of some statutory assistance. An analogy can be drawn to the jurisprudence of management buyouts, tender offers, and other changes in control. These kinds of "organic changes," that is, a fundamental shift in operation, control, or structure, have received increased scrutiny by the courts, particularly in Delaware—the most important corporate law jurisdiction.

A. *The Duty of Care*

Directors and officers are required to discharge the duties of their respective positions in good faith and with the degree of diligence, care, and skill which ordinary prudent persons would exercise under similar circumstances in like positions.²⁰⁴ Broadly stated, a director can neglect 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 decisionmaking. For purposes of this article, the latter is most important.

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

- 1) 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;
- 2) the opportunity to hear the advice and recommendation of recognized outside experts, including legal counsel, on the subject;
- 3) the opportunity to debate and deliberate on the proposal at the board level and, if possible, to allow a period of several days or weeks for reflection and further consideration before requiring a vote;
- 4) the gathering of information (where appropriate) from comparable institutions about how they had dealt with similar situations; and

MEDICINE, August 1, 1996, at 448.

203. See Gray, *supra* note 38, at 22.

204. See PRINCIPLES OF CORPORATE GOVERNANCE § 4.01 (1994).

5) 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.

If the board exercises a duty of care in reaching a decision, and the directors are free from any conflict of interest with their decisions, then the outcome, even if disastrous to the organization, 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.”²⁰⁵ 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 an informed decision.²⁰⁶

Delaware cases have given special scrutiny to transactions in which control of the company will change hands.²⁰⁷ The reason that courts have required enhanced scrutiny has been the fear that management will regard more favorably those offers that benefit themselves rather than the interests of shareholders or the corporation. This is human nature and a subject as much for psychology as for law. 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 serves.²⁰⁸ This duty requires a director to act in a manner that does not harm the corporation. It further requires a director to avoid using their position to improperly obtain a benefit for herself or an advantage which might more properly belong to the corporation. That a transaction involves interested 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. 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.²⁰⁹

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

206. 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. *Id.* at 874-75.

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

208. PRINCIPLES OF CORPORATE GOVERNANCE, PART V, DUTY OF FAIR DEALING (1992).

209. Cf. PRINCIPLES OF CORPORATE GOVERNANCE: ANALYSIS AND RECOMMENDATIONS § 5.02 (1992). § 5.02 Transactions with the Corporation (a) General Rule. A director or senior executive who enters into a transaction with the corporation (other than a transaction involving the payment of compensation) fulfills the

Corporate law has developed procedures to insulate the interested directors from approving the transaction. When a potential change of control occurs, the board typically will establish a special committee of disinterested directors to evaluate the transaction.²¹⁰ This committee will retain its own counsel, investment bankers, and other advisers. This process-oriented approach ensures a deliberative disinterested decision that will benefit the corporation's shareholders.

duty of fair dealing with respect to the transaction if:

(1) Disclosure concerning the conflict of interest and the transaction is made to the corporate decisionmaker who authorizes in advance or ratifies the transaction; and

(2) either:

(A) The transaction is fair to the corporation when entered into;

(B) The transaction is authorized in advance, following disclosure concerning the conflict of interest and the transaction, by disinterested supervisor, who could reasonably have concluded that the transaction was fair to the corporation at the time of such authorization;

(C) The transaction is ratified, following such disclosure, by disinterested directors who could have reasonably have concluded that the transaction was fair to the corporation at the time it was entered into, provided (i) a corporate decisionmaker who is not interested in the transaction acted for the corporation in the transaction and could reasonably have concluded that the transaction was fair to the corporation; (ii) the interested director or senior executive made disclosure to such decisionmaker pursuant to Subsection (a)(1) to the extent he or she then knew of the material facts; (iii) the interested director or senior executive did not act unreasonably in failing to seek advance authorization of the transaction by disinterested directors or a disinterested superior; and (iv) the failure to obtain advance authorization of the transaction by disinterested directors or a disinterested superior did not adversely affect the interests of the corporation in a significant way; or

(D) The transaction is authorized in advance or ratified, following such disclosure, by disinterested shareholders, and does not constitute a waste of corporate assets at the time of the shareholder action.

(b) Burden of Proof. A party who challenges a transaction between a director or senior executive and the corporation has the burden of proof, except that if such party establishes that none of Subsections (a)(2)(B), (a)(2)(C), or (a)(2)(D) is satisfied, the director or senior executive has the burden of proving that the transaction was fair to the corporation.

(c) Ratification of Disclosure of Nondisclosure. The disclosure requirements of § 5.02(a)(1) will be deemed to be satisfied if at any time (but no later than a reasonable time after suit is filed challenging the transaction) the transaction is ratified, following such disclosure, by the directors, the shareholders, or the corporate decisionmaker who initially approved the transaction or the decisionmaker's successor.

§ 5.02. Courts have recognized instances such as a change of control where boards of directors may not be able to exercise their business judgment properly. Because of the omnipresent possibility that a board may be acting in its own interests in a change of control situation in either opposing or supporting such a transaction, rather than the interests of the corporation and the shareholders, courts have found an enhanced fiduciary duty on the board. *See Unocal v. Mesa Petroleum*, 493 A.2d 946, 954 (Del. 1985); *Paramount Communications v. QVC Network, Inc.*, 637 A.2d 34, 43 (Del. 1993). If a board uses outside investment advisors and a majority of the directors are outside directors, a court is more likely to support management's action. *See Unocal*, 493 A.2d at 952-56.

210. In *Smith v. Van Gorkom*, 488 A.2d 858 (Del 1985), the court outlined in detail the fiduciary missteps of a badly informed board in considering a change of control. In the aftermath of that case, courts, practitioners, and scholars developed techniques to assist judicial approval of management actions. *See Bayless Manning, Reflections and Practical Tips on Life in the Boardroom After Van Gorkom*, 45 BUS. L. 1, 8-14 (1985) (describing steps that should be taken to gain protection of the business judgment rule). Two of the common procedures to establish a fair price are the solicitation of a fairness opinion from an investment bank and the appointment of a special committee of independent directors to negotiate on behalf of the corporation and the shareholders. *See Richard Booth, Management Buyouts, Shareholder Welfare and the Limits of Fiduciary Duty*, 60 N.Y.U. L.REV. 630, 657 (1985); *Scott V. Simpson, The Emerging Role of the Special Committee—Ensuring Business Judgment Rule Protection in the Context of Management Leveraged Buyouts and Other Corporate Transactions Involving Conflicts of Interest*, 43 BUS. L. 665 (1988).

The chances that a nonprofit board will be taken advantage of and that the charity will 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 organizations are of a nonadversarial nature, and probing questions are viewed as a manifestation of bad manners. Secondly, there is a tradition of inattentive or token directors—individuals who are selected for their prestige, name recognition, or affluence, who have little time to devote to the organization. Virtually all charitable boards consist of volunteers, who may not have the vested interest that business corporate directors have. 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.²¹¹ They simply are not in the same league as the acquirers.

Nonprofit boards are unaccustomed to and may be wary of spending scarce resources on investment bankers, accountants, major law firms, or other intermediaries that are the glue of for-profit changes in control. Unlike their business counterparts, nonprofit boards and their organizations 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. Nothing in nonprofit governance resembles the requirement of shareholder approval of changes in control or the sale of assets because most charities are non-membership organizations.²¹² Disclosure requirements for nonprofit organizations seeking access to capital markets are less stringent than requirements for for-profit organizations. Nonprofit boards are unfamiliar with valuation and the newer techniques of determining asset worth. In the case of HMOs, it may be impossible to find disinterested directors.

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.

IX. DEALING WITH THE CONVERSIONS: THE STANDARD OF ENHANCED SCRUTINY

Nonprofit organizations faced with a conversion should be subject to 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. Courts need to create appropriate or special standards of conduct in the conversion context and appropriately rigorous standards of judicial review.²¹³ 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 com-

211. See Goldschmid, *supra* note 101, at 1.

212. This does not mean that the organization, for example a museum or symphony, does not have members, but in a legal sense they are merely preferred customers. They do not possess the legal indicia of membership, such as the right to elect directors, sue on behalf of the corporation, or the right to residual value of the corporation upon dissolution.

213. "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 injunctive relief." WILLIAM L. CARY & MELVIN A. EISENBERG, *CORPORATIONS* 602 (7th ed. unabridged 1995).

munity needs. The Delaware standard of care is gross negligence.²¹⁴ Directors must exercise their duty of inquiry and proceed through a deliberate decisionmaking process.

Directors must disclose all conflicts of interest. They should recuse themselves from voting or participating in decisions in which they have a conflict. When this is impossible, as in the case of an HMO which may have no outside directors, 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 the board faces decisions and some directors are interested, the organization should form an independent committee of disinterested directors. The attached recommendations may not, and should not, prevent conversions, but will slow them down, requiring their evaluation with the care and scrutiny the public interest deserves.

214. See *Smith v. Van Gorkom*, 488 A.2d 858, 872-73 (Del. 1985). However, the gross negligence standard is not without criticism. See *Rabkin v. Philip A. Hunt Chemical Corp.*, 13 DEL. J. CORP. L. 1210, available in 1987 WL 28436 (Del. Ch. 1987). The gross negligence standard is not without criticism. In *Wilson v. Brett*, 152 Eng. Rep. 737, 739 (1843), Baron Rolfe defined gross negligence as the same thing as ordinary negligence "with the addition of a vituperative epithet."

APPENDIX A

I. RECOMMENDATIONS FOR PROTECTING THE PUBLIC WHEN NONPROFIT ASSETS ARE TRANSFERRED TO FOR-PROFIT ENTITIES²¹⁵*A. The Conversion Transaction*

- Advanced court approval in a cy pres 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
- A public Hearing on the impact of the transaction on the delivery of health care in the community
- Specification in the transaction agreement on the continuation of existing health care, particularly charity care
- Provisions for monitoring, independent auditing of health care delivery, and an enforcement mechanism
- Reimbursement of all valuation, attorney, and investment banking fees incurred by the attorney general or relators

B. 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

C. 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
- The board is responsible for maximizing value and to have an independent valuation and fairness opinion
- The board should provide for a fair market test whenever possible
- A written report discussing grounds for the selection of a particular offer

215. These recommendations are derived in part from: (1) proposed guidelines prepared by the Volunteer Trustees Foundation for Legal Research; (2) the California Corporations Code section 5913; (3) Review Protocol of Sale of Charitable Assets to For-Profit Entities-Review Protocol, published by the California Office of the Attorney General; and (4) proposals by Robert Boisture, Esq. and Professor Harvey Goldschmid.

D. Proceeds of Transaction

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

E. Valuation

- Duty to seek fair market value
- Detailed description of the valuation components and approaches to reaching price
- Competing valuation report by the attorney general or relator
- Market test when possible

F. Legislative Action Required

- Explicit authority given to the attorney general to participate in all proceedings during the conversion process
- Converting party must fund use of outside experts hired by the attorney general
- Attorney's 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 health care to the community