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Chapter Author: David M. Cutler, Jill Horwitz

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## Converting Hospitals from Not-for-Profit to For-Profit Status Why and What Effects?

David M. Cutler and Jill R. Horwitz

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The vast majority of American hospitals are organized as charitable, not-for-profit corporations. The public does not own them. Instead, they are private corporations organized to pursue a community health care mission. Their corporate and tax statuses rest on a combination of statutory provisions and revenue service definitions. While many aspects of their organization and regulation distinguish them from for-profit corporations, the fundamental distinction is their purpose to further charitable hospital goals rather than to maximize owners' wealth.

Between 1970 and 1995, 330 (about 7 percent) out of approximately 5,000 not-for-profit hospitals have converted to for-profit corporate form, including a dramatic number in just the past few years. Despite these large changes, there has been almost no empirical research on the reasons for and the effects of conversions.<sup>1</sup> This paper offers a preliminary exploration of the causes and effects of conversions. Throughout the paper, we focus on two case studies: Wesley Medical Center in Wichita, Kansas, and the

David M. Cutler is professor of economics at Harvard University and a research associate of the National Bureau of Economic Research. Jill R. Horwitz is a graduate student in the health policy Ph.D. program at Harvard University.

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1. There has also been little work comparing conversions in the hospital industry to conversions in other medical care industries, such as insurance or physician services, or in other industries outside of the medical sector, such as public utilities. This is a worthy topic for future research.

Columbia/HealthOne system in Denver, Colorado.<sup>2</sup> These two conversions interested us for many reasons. Wesley Medical Center and Columbia/HealthOne are both large, stable hospitals. As of 1995, Wesley, which employed over 3,000 people, was the fifteenth largest for-profit hospital in the United States, and measured by revenues, it was Columbia/HCA's largest hospital. In addition, HealthOne recently entered into a joint venture limited liability company (LLC) with Columbia/HCA, providing a good example of an increasingly popular corporate form. Because both hospitals initially converted over a decade ago, they offered long histories for study. The very factors that attracted us, however, also make the experience of the hospitals somewhat less generalizable. As we discuss below, the typical converting hospital is small and financially weak. Therefore, the motivations for these conversions are more complicated and subtle than those of the ordinary conversion.

The data in this paper are drawn from several sources, including interviews, Medicare cost reports, legal documents, and newspaper articles. In the course of our research we visited both hospitals to interview people familiar with and employed by the sellers, the buyers, the resulting foundations, and the government. Because many details of hospital transactions are confidential, the numbers and deal structures reported below are all derived from public sources. Of course, public sources may not be completely accurate, and several people we interviewed expressed displeasure with public reporting of the transactions involved; still, the public record is often the only one available.

Our case studies suggest two principal factors driving hospital conversions. The first is financial considerations. While profits are certainly important, financial considerations are not limited to concerns about profitability. Having a large debt load and gaining access to cheaper sources of capital are also important in the conversion decision. Second, we find that the culture of the not-for-profit hospital influences the conversion decision. Both of our case study institutions had boards of directors consisting primarily of businessmen, many of whom believed they were ill-trained to run a major hospital. Businessmen may also be more tolerant of the for-profit ownership form than people with a more religious or not-for-profit orientation.

Our evidence on the effects of for-profit and not-for-profit ownership is subtle. Looking at financial measures of hospital performance, we find that for-profit hospitals, particularly those run by Columbia/HCA, were more financially successful than not-for-profit hospitals. In part, this success derives from the for-profits' skill at increasing public sector reim-

2. Columbia-HealthOne operates six general hospitals (Presbyterian/St. Luke's Medical Center, Swedish Medical Center, Aurora Presbyterian Medical Center, Rose Medical Center, Aurora Regional Medical Center, and North Suburban Medical Center). In addition, it operates over 60 medical clinics and employs over 10,000 people.

bursements; in part it is because for-profit hospitals cut costs where not-for-profit hospitals do not. But perhaps most important, not-for-profit hospitals appear to follow for-profit hospitals in the same behavior. A few years after for-profit hospitals exploit Medicare loopholes, not-for-profit hospitals do the same. This pattern has troubling implications as for-profit hospitals become an increasingly large player in the medical care environment.

We are not able to examine the quality of hospital care in any detail. Determining hospital quality requires accurate measures of patient outcomes and adjustments for the health of patients across institutions. Neither of these measures is available to us. Examining the implications of conversions for hospital quality is an important issue for future research.

We begin by defining terms, describing some mechanisms by which hospitals convert, and detailing the transactions of the two case hospitals. In section 2.2, we present trends in the number of conversions over time. In section 2.3, we report and analyze the reasons commonly offered for conversions. In section 2.4, we present two case studies of converted hospitals, examining why they converted and how the conversions affected the hospitals and their markets. Finally, in section 2.5, we offer concluding thoughts.

## 2.1 The Mechanics of Hospital Conversions

The term “conversion,” for the purposes of this paper, is any mechanism by which a hospital changes its essential orientation from not-for-profit to for-profit or vice versa.<sup>3</sup> State law dictates which of many possible mechanisms charitable, not-for-profit hospitals may use to convert to for-profit corporate form. To convert in some states, a not-for-profit hospital may simply file amended articles of incorporation and bylaws with the state secretary or corporations commission. Most conversions, however, involve more than one party. Asset sales, in which the buyer takes all of the seller’s assets and only the liabilities specifically contracted for in the sales document, are typical in conversion transactions because buyers are often not permitted to buy some not-for-profit liabilities such as tax-exempt debt. In this type of transaction, a for-profit pays money to a not-for-profit hospital and subsequently owns the hospital and its assets. The not-for-profit hospital generally uses the proceeds from the asset sale to buy back outstanding debt, with remaining amounts directed to other charitable purposes.

Acquisitions, mergers, corporate restructurings that transfer not-for-

3. The term “conversion” has also been used to describe privatizations, the process by which a public hospital becomes private or a private hospital becomes public. This paper studies only private hospitals.

profit assets to for-profit subsidiaries, consolidations, lease agreements, and various forms of joint ventures between for-profit and not-for-profit hospitals have all been used to convert hospitals. Some of these transactions, particularly joint ventures, involve ongoing relationships between not-for-profit and for-profit hospitals. A joint venture may involve as little integration as joint marketing of a new service or as much integration as a partnership that looks to the outside world like a single corporation. In some, control is shared between the two entities; in others, one hospital effectively controls the other by dominating the subordinate hospital's board or operating the majority of the subordinate's assets. Joint ventures and asset sales may also differ in their tax implications; for example, passive income to a not-for-profit corporation may be taxed as unrelated income, while for-profit gifts to a not-for-profit are tax deductible.

According to federal tax law, not-for-profit assets may not be used for profit-making purposes. Thus, when not-for-profit hospitals convert to for-profit status, the proceeds must be directed toward another not-for-profit activity; they cannot benefit private individuals or for-profit buyers. If the IRS finds that a transaction involved private inurement, it may force the unwinding of a deal and impose stiff penalties on the participating institutions and individuals. State corporations codes generally dictate the use of charitable assets when a not-for-profit corporation merges, dissolves, or transforms itself in some other way. Statutes typically require that assets be used for purposes similar to those of the selling entity. Foundations established with conversion proceeds must, therefore, pursue community goals similar to those specified by the converting hospital's charter (e.g., community-based health care).

How similar the old and new purposes must be varies according to state corporations and trust laws. Not-for-profit hospitals frequently solicit contributions for particular purposes and receive funds with explicit and implicit restrictions upon their use. When hospitals convert they often are no longer able to comply with these restrictions. Judicial authorization, through a *cy pres* proceeding, is required for a new foundation to use the restricted funds.<sup>4</sup> A judge must find that the settlor<sup>5</sup> had a broad charitable intent, that the previous use has "become obsolete or impossible or impracticable of execution due to changes in social, economic, political or other conditions,"<sup>6</sup> and that the new use is as near as possible to the intended use. Under some state laws, this test applies not only to formal restricted trusts but also to all charitable donations and, in very restrictive states, even to the charitable corporation itself. In states that have adopted the Uniform Management of Institutional Funds Act, donors may permit

4. *Cy pres* comes from the French "*cy pres comme possible*," meaning "as near as possible."

5. A person who creates a trust.

6. George T. Bogert, *Trusts* §147.520 (1987).

a change in the use of institutional funds or the court may order the change under an analysis similar to the *cy pres* analysis.

State attorneys general are frequently the only government actors who interpret and apply restrictions on conversions and the proceeds they generate; consequently, the rigor with which statutes are applied, or whether they are applied at all, varies dramatically by state (Horwitz 1998). The public has an interest in ensuring adequate oversight of conversions and their proceeds for many reasons. The public allows not-for-profit hospitals to have tax exemptions because it wishes the hospital to perform desirable public services. Thus, the public has an interest in ensuring that the benefits of those exemptions are not appropriated by a for-profit buyer. Conversions may also represent redistributive losses to the extent that for-profits do not provide services that not-for-profits formerly did (such as uncompensated medical care); the public sector may want to minimize the extent of these losses (Horwitz 1998).

To illustrate the nature of hospital conversions, we discuss the details of the conversions for our two case-study institutions.

### 2.1.1 Wesley Medical Center

The Wesley Medical Center sale was relatively straightforward. (Fig. 2.1 shows the conversion graphically.) In 1985, Wesley's assets were sold to the Hospital Corporation of America (HCA), at the time one of the largest for-profit hospital companies in the United States. Wesley had 786 beds,<sup>7</sup> making it Kansas's second-largest hospital (behind a Veterans Administration hospital) and the largest hospital to have converted from not-for-profit to for-profit corporate status at that time. HCA paid approximately \$265 million for the operating assets, including \$40 million earmarked to defease outstanding debt. After the debt defeasance, the net proceeds were roughly \$225 million. In 1993, HCA merged with Columbia Hospital Corporation, becoming Columbia/HCA, and Wesley changed its name to Columbia Wesley Medical Center. In 1997, as Columbia/HCA faced widespread negative publicity, Wesley dropped "Columbia" from its appellation.

In the Wesley case, the use of the \$225 million proceeds from the sale was somewhat complicated. Wesley was founded by and affiliated with the Methodist Church, and there was considerable controversy regarding the role of the church in the sale. Whether the church held formal decision-making authority regarding the sale was never resolved, although the members of the Methodist Kansas West Annual Conference, the governing body for Methodist churches in Kansas, voted to support it. In the final agreement, the church received about 12 percent (approximately \$32

7. All statistics on number of hospital beds in the paper refer to staffed beds. Hospitals may also have licensed beds that are not staffed.

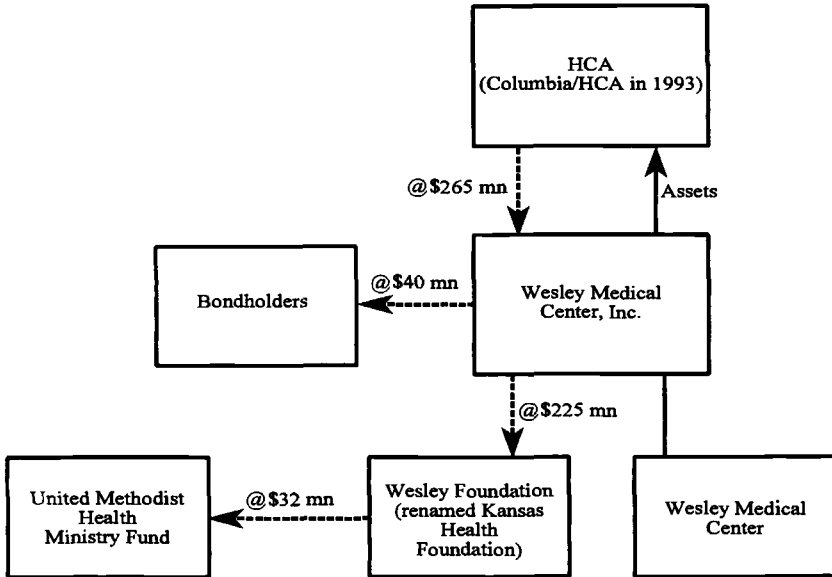


Fig. 2.1 The Wesley Hospital sale

million of the \$265 million deal) of the original sale over three years. Thus, two foundations were funded: the Kansas Health Foundation,<sup>8</sup> with the bulk of the money from the Wesley sale (about \$200 million); and the United Methodist Health Ministry Fund, with the payments to the Methodist Church. In 1996, the Kansas Health Foundation reported assets of \$377 million.

### 2.1.2 Columbia-HealthOne

Our second case study is the Columbia-HealthOne hospital system in Denver, Colorado. In 1995, the system was Colorado's third-largest private employer (10,000 people) and had estimated annual revenues of \$1.2 billion. HealthOne has a much more complicated history of transaction activity. (Figs. 2.2A, 2.2B, and 2.2C detail the ownership activities.) The forerunners to HealthOne were Presbyterian Hospital (sponsored by the Presbytery of Denver) and St. Luke's Hospital (sponsored by the Episcopal Diocese of Colorado), which merged in 1979 to form PSL Healthcare Corporation. In 1985, PSL Healthcare Corporation sold its assets to AMI—a for-profit hospital company—for \$173 million. At the time, Pres-

8. The Kansas Health Foundation is the descendant of the foundation previously associated with the medical center, the Wesley Foundation. Restrictions on funds held by that foundation before the conversion were released in state court under the *Kansas Uniform Management of Institutional Funds Act* (K.S.A. @58-3607 (1996)).

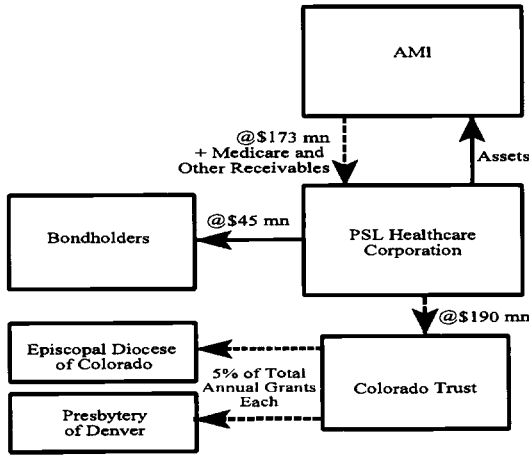


Fig. 2.2A The HealthOne mergers: AMI

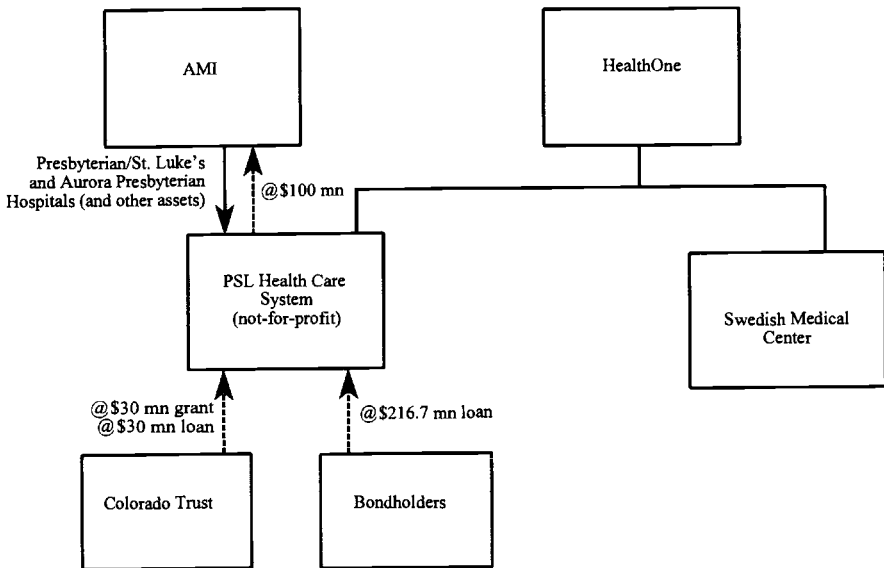


Fig. 2.2B The HealthOne mergers: Reconversion and establishment of HealthOne

byterian Hospital had 385 beds and St. Luke’s Hospital had 284 beds, so that the total institution had 669 beds. After paying off approximately \$45 million of outstanding debt and other obligations, PSL Healthcare Corporation was left with roughly \$123 million. Subsequent settlements of outstanding Medicare claims and other closing adjustments brought the net proceeds of the sale to nearly \$190 million.



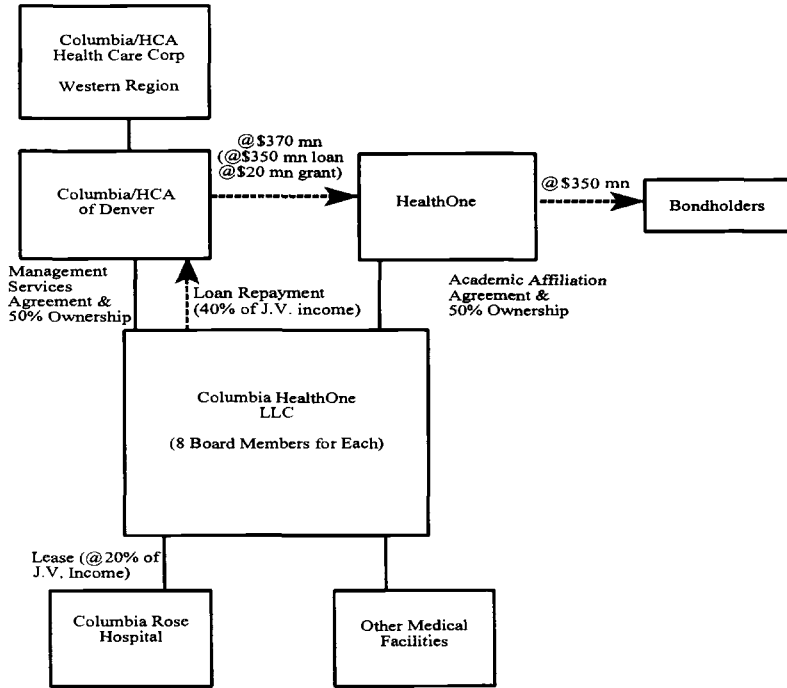


Fig. 2.2C The HealthOne mergers: The joint venture with Columbia/HCA

This sum was used to establish the Colorado Trust, the state’s second-largest private foundation. The Colorado Trust’s mission is “to promote the health and well-being of the people in Colorado through programs for affordable and accessible health care and the strengthening of families.” The seller imposed two restrictions on the Trust: (1) that it support medical research and education, and (2) that it distribute an amount equal to 10 percent of the preceding year’s grants to the Episcopal Diocese of Colorado and the Presbytery of Denver. In addition, the selling board was concerned about health care access for the poor. As a condition to the sale, AMI promised to maintain then-current levels of indigent care.

By 1991, AMI encountered financial trouble because of the high debt it incurred from a leveraged buyout. AMI suspended construction on a partially completed tower at the Presbyterian/St. Luke’s hospital complex. Disturbed by the hard luck that befell the hospital, doctors and other community members established a not-for-profit hospital corporation, PSL Healthcare Systems (PSL), to purchase the Colorado assets of AMI.<sup>9</sup>

9. These assets included Presbyterian hospital, St. Luke’s Hospital, and Aurora Presbyterian Hospital, among other assets.

Because the new not-for-profit would undertake medical research and education, the Colorado Trust decided that aiding PSL in purchasing AMI's Colorado assets would fulfill its obligation to support medical research and education. Therefore, the Colorado Trust granted \$30 million and lent \$30 million to PSL for the purchase. With these sources and an additional \$216.7 million borrowed from other sources, PSL purchased AMI's Colorado assets and made other investments.<sup>10</sup> The hospital again became a not-for-profit institution. In 1993, PSL merged with Swedish Hospital, another not-for-profit hospital in Denver. Shortly thereafter, the name of the combined institution was changed to HealthOne. The asset value of HealthOne was about \$550 million in 1995,<sup>11</sup> although HealthOne had outstanding debt of about \$350 million, for a net value of \$200 million.

Facing such a large debt burden, HealthOne once again chose corporate organizational change as the answer to its problems. In searching for a merger partner, HealthOne identified Columbia/HCA as the only candidate willing to act quickly. Columbia/HCA already owned two hospitals in the Denver area (North Suburban Hospital and Aurora Regional Hospital), as well as a number of medical clinics, surgery centers, and other medical services. These assets were worth about \$180 million. In addition, Columbia was in the process of purchasing a third hospital, Rose Hospital (long affiliated with the Jewish community), which had assets of about \$220 million and debt of about \$70 million, for a net value of \$150 million.

Rather than an outright sale, Columbia and HealthOne formed a joint venture. The joint venture is a for-profit holding company, named Columbia-HealthOne LLC.<sup>12</sup> The assets of the joint venture include Columbia's two existing hospitals and its outpatient facilities, and the hospitals in HealthOne. To equalize the ownership of the joint venture, Columbia/HCA loaned HealthOne approximately \$350 million to defease its outstanding debt. The loan was assumed by the LLC, however, so HealthOne's share of the repayment is small. In addition, Columbia/HCA contributed \$10–\$20 million to the HealthOne Foundation. After the contributions, Columbia/HCA and HealthOne had roughly the same net asset values (about \$180 million each), so the two are equal partners in the joint venture. Columbia, through an exclusive management contract with the joint venture, controls the day-to-day operations at the facilities.

10. About \$100 million was paid to AMI for the Colorado assets. Most of the remainder was used to complete construction on the patient tower.

11. By this point, HealthOne included the above mentioned hospitals and several outpatient facilities.

12. A limited liability company is a hybrid of a partnership and a business corporation. Like a partnership, profits and losses flow to the members of the company through distributions. Unlike most partnerships, however, members of limited liability companies benefit from some of the protections against personal liability afforded to employees of business corporations. Bankruptcy, death, dissolution, expulsion, resignation, or withdrawal of any member of the LLC usually leads to automatic dissolution of the company.

In addition to its assets, the joint venture leases Columbia Rose Hospital for a 99-year term. Since Columbia owns Rose Hospital, the lease payments of approximately \$19 million per year are made to Columbia, but the leasing arrangement preserved the equal ownership of the joint venture ownership.

The claims on the joint venture are therefore at least threefold: (1) some of the money generated goes to Columbia/HCA to repay the loan it extended to HealthOne; (2) some of the money is paid to Columbia/HCA for the Rose lease; and (3) the remaining profits of the joint venture are split equally between Columbia/HCA and HealthOne for the equity role in the joint venture. In 1996, the interest payments to Columbia/HCA were reported to be about \$60 million; the lease payments to Columbia/HCA for Rose Hospital were reported to be \$19 million; and profits were reported to be \$19 million. HealthOne's 50 percent interest in the LLC includes representation on the board equal to that of Columbia, thus ensuring HealthOne's veto power over Columbia decisions.

HealthOne now concentrates on graduate medical education. It pays the faculty and residents and administers medical education at HealthOne-Columbia facilities.

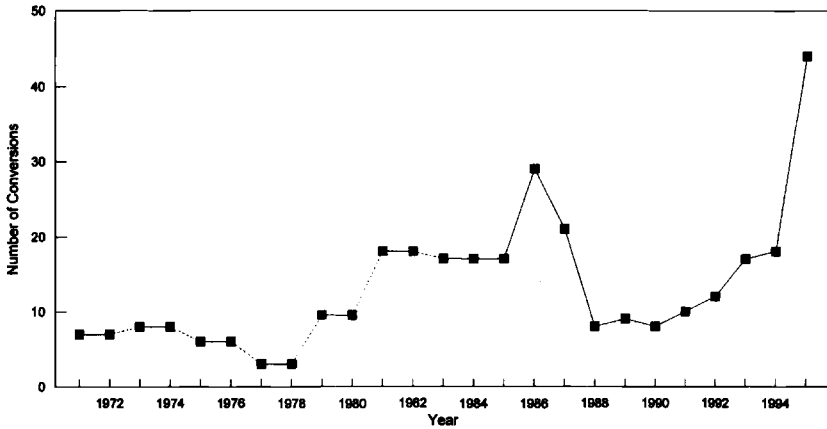
## 2.2 The Magnitude of Hospital Conversions

To understand the magnitude of hospital conversions nationwide, we examine the trend of conversions over the past 25 years. We focus on conversions of general medical and surgical institutions. There are a variety of other types of hospitals—rehabilitation, children's, cancer, tuberculosis, and so forth—that may also change organizational form, but our interest is in the nearly 5,000 general hospitals that form the bulk of the U.S. hospital system. We also focus on private, not-for-profit institutions. Federal, and particularly state and local, hospitals may become private and/or for-profit corporations, but their motives to convert to for-profit status may be very different from those of a private hospital.

Figure 2.3 shows the number of private, not-for-profit hospitals converting to for-profit status between 1970 and 1995. Our data are from the American Hospital Association (AHA) annual surveys, compilations of self-reported information by hospitals. We find conversions by matching hospitals in successive years of the survey and determining which hospitals moved from not-for-profit to for-profit control.<sup>13</sup> Between 1970 and 1984 our data are biannual; we assign half of the two-year change to each year.

The number of conversions was low in the 1970s—about 5–10 per year. As table 2.1 shows, the hospitals that converted were relatively small; 52

13. This method omits hospitals that changed their AHA identification number at the time of the conversion. We use data provided by the AHA to correct this problem.



**Fig. 2.3** Hospital conversions from not-for-profit to for-profit status, 1970-95  
*Note:* Data prior to 1984 are averages over a two-year period.

**Table 2.1** Not-for-Profit to For-Profit Hospital Conversions by Size

| Number of Beds   | Private,<br>Not-for-Profit<br>Hospitals,<br>1980 | Total Conversions by Time Period |         |         |         |         |
|------------------|--|----------------------------------|---------|---------|---------|---------|
|                  |  | 1970-80                          | 1980-87 | 1987-91 | 1991-94 | 1994-95 |
| All hospitals    | 4,991  | 67                               | 137     | 34      | 47      | 44      |
| < 25 beds (%)    | 4  | 3                                | 8       | 0       | 2       | 0       |
| 25-49 beds (%)   | 18   | 21                               | 15      | 38      | 15      | 9       |
| 50-99 beds (%)   | 24   | 33                               | 29      | 26      | 30      | 9       |
| 100-199 beds (%) | 22   | 31                               | 34      | 18      | 30      | 36      |
| 200-399 beds (%) | 20   | 10                               | 13      | 15      | 19      | 34      |
| ≥ 400 beds (%)   | 11   | 1                                | 1       | 3       | 4       | 11      |

*Note:* Authors' calculations based on American Hospital Association annual survey.

percent of the hospitals that converted to for-profit status had fewer than 100 beds, compared to 46 percent of hospitals as a whole. Only 1 percent of the largest hospitals converted to for-profit status, well below their 11 percent share of total hospitals.

In the early and, particularly, mid-1980s, conversion activity increased. There were 29 conversions in 1986 alone. Informal conversations we have had with hospital executives suggest that financial concerns drove the merger activity in this period. When the Prospective Payment System (PPS) for Medicare was implemented in fiscal year 1984, for example, hospital executives worried that their revenues would fall. Industry wisdom also predicted that for-profit medical care would gain in importance, and many hospitals were eager to be in the vanguard of this trend.

By 1988, the Prospective Payment System proved to be less damaging

to revenues than previously feared. The remaining not-for-profit hospitals were likely more committed to the not-for-profit organizational form. As a result, conversion activity slowed; between 1988 and 1991 there were only 8 or 10 conversions each year.

In the 1990s, and particularly in very recent years, conversions have again increased. There were between 12 and 18 conversions per year up through 1994, and an overwhelming 44 conversions in 1995.

Further, the type of hospital converting from not-for-profit to for-profit status has changed markedly over time. This change is most noticeable in the size of the institution. About one-quarter of the converting hospitals in the 1991–94 period had over 200 beds, as did nearly one-half of the converting hospitals in 1994–95. Hospitals with over 200 beds accounted for only about 15 percent of conversions in the 1970s and early 1980s.

There are also clear regional patterns to hospital conversions, as shown in table 2.2. Conversion activity is most prominent in the Southern Atlantic states (principally Florida) and the West South Central states (principally Texas), both Columbia/HCA strongholds. Despite having only one-quarter of the nation's hospitals in 1980, these two regions account for about one-half of the conversions in each time period. Hospitals in the Pacific region (largely California) are also overrepresented in conversions.

There has been very little conversion activity in the Northeast or Middle Atlantic, however. In our sample, there were only 4 conversions in the entire 25-year period in those states, despite the fact that they accounted for 13 percent of the hospitals in 1980. The relative lack of conversions in the Northeast and Middle Atlantic regions likely reflects several factors: tighter regulation in those states; smaller managed care enrollment; and a sense that the hospital industry is substantially overbuilt in those areas.

**Table 2.2** Conversions by Region

| Region                 | Private,<br>Not-for-Profit<br>Hospitals,<br>1980 | Share of<br>Conversions,<br>1970–95 |
|------------------------|--|-------------------------------------|
| All                    | 4,991  | 330                                 |
| Northeast (%)          | 5  | 1                                   |
| Middle Atlantic (%)    | 11   | 0                                   |
| South Atlantic (%)     | 13   | 22                                  |
| East North Central (%) | 18   | 9                                   |
| East South Central (%) | 8  | 11                                  |
| West North Central (%) | 15   | 9                                   |
| West South Central (%) | 13   | 19                                  |
| Mountain (%)           | 7  | 8                                   |
| Pacific (%)            | 11   | 19                                  |

*Note:* Data on conversions are from the American Hospital Association.

## 2.3 Why Are Hospitals Converting?

To date there has been no empirical examination regarding why hospitals increasingly prefer the for-profit over the not-for-profit corporate form. One explanation for conversions is generic: Recent years have seen many more hospital mergers in general, and thus we would expect more conversions of hospitals from not-for-profit to for-profit status. Of course, this raises the question of why there have been so many hospital mergers. Rather than citing simply “increased merger activity,” we instead consider the changes in the medical care marketplace that might drive such behavior. We focus on six explanations for hospital conversions.

### 2.3.1 Financial Status

Perhaps the most commonly mentioned factor in hospital conversions is the financial status of the converting hospitals. There are several related financial reasons that motivate not-for-profit hospitals to sell to or partner with for-profit institutions. These include access to capital, current or expected profit reductions, and relief from debt burden.

#### *Access to Capital*

The most commonly identified reason for conversions is the need to obtain capital, for operations and capital expenditures such as new equipment and buildings. While there are many permutations of the capital-needs argument, all boil down to an inadequate access to capital for necessary expenditures. First, many not-for-profits face absolute limits on accessing capital. Although not-for-profit corporations have access to forms of capital that are unavailable to for-profits—tax-deductible donations and tax-exempt debt—both sources are limited. Donations are limited by donors’ willingness to give, and tax-exempt debt is subject to regulatory restrictions regarding use and amount.<sup>14</sup> Not-for-profit hospitals may find other available financing schemes such as securitization, asset leveraging, and pooling schemes too risky to undertake. Conversions, therefore, may provide needed capital through equity financing and enhanced access to debt.<sup>15</sup> Although not-for-profits may have access to the same sources of taxable debt as do for-profits, many may have unfavorable debt ratings that make the cost of commercial debt prohibitive. Second, equity may also be a cheaper source of capital than those sources easily available to

14. There is a \$150 million limitation on nonhospital debt (e.g., related businesses, clinics, buildings for professional services, efforts to integrate). This limit poses a problem for hospitals that operate under a master bond or debenture indenture, a written agreement under which bonds or debentures are issued, setting forth maturity dates, interest rates, and other terms.

15. For-profit hospitals borrow more debt than do not-for-profit hospitals (Frank and Salkever 1994). After accounting for tax deductions, taxable debt can be less expensive for a for-profit than tax-exempt debt is for a not-for-profit.

not-for-profit hospitals. Therefore, even hospitals that have adequate access to debt may prefer equity financing. The market spread between equity and debt, caused in part by bond insurance and state issuing agency fees, may make equity financing more desirable. High debt levels may also lead to agency problems, as managers of highly leveraged institutions engage in excessively risky activities whose costs they can transfer to bondholders (Jensen and Meckling 1976). Third, even if equity is not an inherently more desirable instrument than debt, equity is perceived as an important currency by those involved in conversions and similar transactions. Hospital administrators hoping to become part of a larger system may find that access to equity generates more consolidation options.

### *Profits*

Current and feared revenue declines have also motivated not-for-profit hospitals to convert. Actual and expected declines may be caused by market-specific changes such as overbedding, demographic changes, or increased competition attributable to reorganization by competitors. Conversions may also provide a way for not-for-profit managers to avoid the risks of operating under new regulatory regimes or delivery systems that are expected to cause lower profits or that may increase the riskiness of hospital profits. Conversion activity increased, for example, with the implementation of the Prospective Payment System in 1984, and again in the 1990s, as managed care began to make substantial inroads in health care delivery.

### *Debt Service*

Not-for-profit hospitals generally fund their capital budgets with tax-exempt debt. For various reasons, such as revenue reductions due to market changes, some hospitals find they are not able to service the debt. Selling to a cash-rich, for-profit buyer provides one way of meeting debt obligations.

### 2.3.2 Increased Efficiency

Patel et al. (1994) suggest that for-profits may achieve greater dynamic efficiency in resource allocation than not-for-profits because they can more quickly enter and exit markets as conditions change. Others maintain that for-profit hospitals are inherently more efficient than their not-for-profit counterparts because of superior management talent. Large for-profit systems also have access to efficiency-producing accounting and data processing systems.

It is important to be clear about the notion of "efficiency." For-profit hospitals are likely to be better at maximizing shareholder value than not-for-profit hospitals are at maximizing operating surpluses. This does not mean that for-profit hospitals are better at promoting *social* interests, or

even the interests of the original not-for-profit hospital, than are not-for-profit hospitals (Reinhardt 1996).

Of course, if all that not-for-profit hospitals wanted from conversions was to obtain access to better management, they might just hire management services from a for-profit firm without actually changing their management orientation. Indeed, Columbia/HCA's joint ventures generally included provisions under which it acts as day-to-day manager and is paid a management fee. The fact that the conversions were more than purchases of management fees suggests that there was more motivating the transaction than just potential efficiency gains.

### 2.3.3 Defensive Strategies

In the face of closure or a threatened takeover by a long-term not-for-profit competitor, directors of failing not-for-profit hospitals may view for-profit partners as their best hope for securing a continuing presence in a community. Neighboring not-for-profit hospitals often have a history of quasi-competitive interactions that make mergers and joining operations difficult.

For-profit buyers often promise to maintain operations at the acquired hospital, although many such promises are temporary or contingent on the good financial health of the hospital. In addition, conversion to for-profit status may release hospitals from cumbersome regulations, such as meeting mandatory community benefit measures, thus allowing them more flexibility to compete.

### 2.3.4 Self-Interest

Not-for-profit managers and directors may obtain job security and personal financial gain from their involvement in conversions. Physicians often favor conversions because the transactions include an opportunity for them to hold an ownership stake in the new entity—a benefit that cannot be offered legally by a not-for-profit corporation.

### 2.3.5 Culture

The individual and collective perspectives, beliefs, and values of hospital directors also influence decisions to sell or partner. For example, people from a business background may have different beliefs about the importance of for-profit and not-for-profit ownership in the medical sector.<sup>16</sup> Furthermore, culture may influence the choice of transaction partner. Local not-for-profit hospitals, for example, may have a long history of fierce competition that makes cooperation difficult. There are particular

16. Typically, economists treat “culture” as a residual explanation for firm behavior. Here, we have in mind a positive theory of why some managers would undertake actions different from other managers.



difficulties associated with merging institutions of various religious affiliations.

### 2.3.6 Mission Change

A conversion may help a not-for-profit hospital change or fulfill its health care mission. Board members may decide that resources that could be better used to improve public health are inappropriately tied to acute care services. Converting a hospital allows board members to liquidate their investment in the hospital and apply both their human efforts and the financial resources they oversee to non-acute care goals.

Since conversion transactions typically produce large foundations, a common trade-off cited by many not-for-profit hospital executives is that between having the not-for-profit hospital in the community or having a for-profit hospital and substantial cash for other purposes. Understanding what this means is somewhat difficult. One interpretation is that the hospital executives want to move forward future profits into current years, which they cannot do on their own. A fair-market sale to a for-profit hospital company would make future profits available immediately. Alternatively, it may be that the managers of the not-for-profits believe they can persuade for-profit hospitals to overpay for their assets. This view seems difficult to believe, however, since most people are on only one hospital board and for-profit hospital executives acquire many hospitals each year and have substantial expertise in negotiating deals. Finally, it may be that for-profit companies are better at managing hospitals than not-for-profit directors, and some of the overall profits from better management can be transferred to the community. What is interesting about this view, however, is how little attention is generally paid to *how* the for-profit company will run the hospital. In many cases, for example, selling board members assert that the buyer promised to keep essential services (such as emergency rooms) open, but such promises are not in writing or, when they are, the promises are insufficiently specified. The transfer of resources to the not-for-profit foundation may thus come at the expense of some valuable hospital services.

## 2.4 Case Studies—Why Convert?

Our case studies yielded two primary explanations regarding why hospitals convert; these findings are summarized in table 2.3. First, financial concerns are quite important in conversions, and these concerns are multifaceted. Expectations about future profits and anticipated problems in servicing debt played a key role in the conversions we studied. Second, board culture or the perceived mission of the board, particularly as generated by a board comprising mainly local business leaders, seems to influence decision making.

**Table 2.3 Rationales for Hospital Conversions**

| Explanation        | Wesley-HCA | Presbyterian/St. Luke's |              |                                 |
|--------------------|------------|-------------------------|--------------|---------------------------------|
|                    |            | Sale to AMI             | Reconversion | Joint Venture with Columbia/HCA |
| Financial          | ***        | **                      | ***          | ***                             |
| Efficiency         | *          | *                       |              | *                               |
| Defensive strategy | *          | *                       |              | ***                             |
| Self-interest      |            |                         | ?            | ?                               |
| Culture            |            | ***                     |              |                                 |
| Mission change     | ***        |                         |              |                                 |

Source: Authors' opinions based on interviews, analysis, and newspaper reports.

Note: Stars indicate the importance of the explanation, as judged by the authors. More important explanations have more stars. Question marks indicate uncertainty, again as judged by the authors. Blanks indicate no evidence.

### 2.4.1 Wesley Medical Center

Three clusters of reasons motivated the Wesley sale to HCA. First, hospital directors and management decided the hospital's mission had been adequately met and that the money invested in the hospital could be better used to improve the health of Kansas's residents. Several of the former directors of Wesley Hospital indicated that they perceived that the choice was between having a hospital and having a hospital plus cash.

Second, culture drove this transaction in at least two distinct ways. Our interviewees characterized the directors as businessmen whose decision to sell was simply a financial decision. Once talks with HCA opened, some directors were attracted by the excitement of dealing with a powerful, for-profit corporation and felt an affinity with HCA's management. They had the opportunity to make a deal that would generate the highest price per bed paid at the time and would put them at the forefront of the conversion trend. Culture also affected the choice *not* to partner with other local not-for-profit hospitals. In Wichita, the most attractive potential not-for-profit partner was a Catholic hospital, a long-time competitor, with whom Wesley was unable to establish joint programs.

Third, while financial issues also motivated the sale, they played a smaller role in the decision than did reasons of mission and culture. While interviewees declared that the conversion was not about a need for money, some stressed the importance of HCA's promises to provide cash for capital development (discussed below). In addition, concerns relating to the viability of operating Wesley under the prospective payment system influenced decision makers. The sale could be understood as a way to transfer the risk of future financial difficulties to more experienced management.

### 2.4.2 Columbia-HealthOne

Different reasons motivated each transaction in HealthOne's corporate history.

#### *Asset Sale to AMI*

Two types of concerns motivated PSL Corporation's initial asset sale to AMI in 1985. One concern was the financial viability of the hospitals. The hospital's debt load, in particular, worried board members. Although the hospital only had approximately \$45 million of outstanding debt, the managers and directors perceived constraints on their ability to access capital markets, and AMI promised access to capital. Indeed, AMI put nearly \$100 million into the acquired hospital system within a five-year period.

The board was also afraid that the advent of PPS and state interest in reviving certificate-of-need requirements would lead to declines in the ability of the hospitals to compete, and it believed AMI could better handle the risk. Also, the board was uncertain about the future of hospitals in Denver.

In addition to financial concerns, culture played an important role in the initial sale. The board was heavily populated by businesspeople who saw the sale to AMI as an opportunity to place their hospital on the cutting edge of a coming health care trend.

#### *Asset Sale to PSL Healthcare Systems*

The reason for AMI's sale was clear—financial distress. AMI was heavily in debt by 1991, and work on a new hospital building had stopped. The construction and hospital management posed a heavy financial burden for AMI.

The reasons behind the not-for-profit buyback are somewhat less clear. Upset by AMI's poor management and history of draining capital from Colorado, old board members reactivated their lingering commitment to the hospital. In fact, the incomplete patient tower exercised a spectral influence over the old board members, many of whom were physicians. Newspaper reports, however, suggested that hospital insiders realized substantial gains from the transaction.<sup>17</sup> PSL, in addition, purchased consulting, financial, and legal services from firms at which the board members worked.<sup>18</sup> The significant overlap between the old hospital board, the local AMI advisory board, and the Colorado Trust board may have been the reason that concern for the hospital's demise was translated into action. But the role of these factors is not completely clear. AMI's advisory

17. "The [PSL-AMI] deal was marred by charges of self-dealing by board members, who allegedly pocketed large transaction fees" (Meyer 1996). PSL Healthcare Corporation denied these reports.

18. Specific examples were reported in the *Denver Post* (Graham 1995).

board had no governing power and interested Colorado Trust board members recused themselves from the decision to support the buyout.

### *Columbia-HealthOne Joint Venture*

This joint venture is perhaps the most typical of all of the transactions we investigated for this paper. It was motivated primarily by financial problems, particularly debt overhang. Presbyterian/St. Luke's assumed a very high debt burden during the AMI buyback (reportedly as high as \$216 million), and it assumed even more debt through subsequent mergers. Thus, HealthOne faced a bleak future, servicing approximately \$360 million of system debt. Virtually everyone we spoke to stressed the importance of the debt overhang as instrumental in the decision to form a joint venture. The poverty of HealthOne might be somewhat overstated, however. While HealthOne was concerned about its bottom line, it significantly increased executive salaries (by 20–33 percent), which were already higher than national averages. Furthermore, it continued to pay board members until the summer of 1994, a controversial and rare practice in the not-for-profit world.<sup>19</sup>

Fears about how an uncertain industry and policy future would affect profits were also quelled by the idea of a joint venture with a wealthy for-profit that had a demonstrated history of generating high profits. In addition, merging with Columbia would bring access to managed care contracts that Presbyterian/St. Luke's wanted to guarantee. For example, Rose Hospital had contracts with two large managed care organizations that were seen as valuable sources of patients. Since Columbia-HealthOne was so big, managed care companies in the Denver area would virtually have to contract with the combined institution, whereas HealthOne on its own might be excluded from managed care contracts.

As in the other transactions, culture and momentum influenced this joint venture. Discussions with other hospitals (Lutheran Medical Center and St. Joseph's Hospital) proved unfruitful for both substantive and timing reasons. In early 1995, when Columbia/HCA bought one potential partner, Rose Hospital, timing pressed the board members. In addition, once the Presbyterian/St. Luke's board began exploring transaction options, it changed its focus from hospital operations to pursuing a reorganization. The momentum of the deal may have influenced the board to complete the transaction.

## **2.5 Case Studies—The Effects of Conversions**

In this section, we consider the effects of hospital conversions on the market for medical care. We divide our discussion into two parts: the effect

19. The Colorado Trust pays its board members approximately \$20,000 each.

of the conversion or joint venture (1) on the study hospital, and (2) on other hospitals and the community as a whole.

The data that we use come primarily from Medicare cost reports, annual reports of hospitals that are filed with Medicare administrators. The cost report data are the only public data source with information on revenues, expenses, and assets of hospitals. We form profits as earnings less patient care costs, excluding interest, taxes, depreciation, and assessments (EBITDA). This measure is standard in the literature; it avoids problems in the measurement of depreciation across institutions. The data may be subject to error. First, the amounts are self-reported and are only verified when Medicare conducts audits. Second, the reports filed during the first few years after a conversion may not accurately reflect financial status because converting entities are entitled to special deductions that obscure conventional profit measures. Finally, recent news reports suggest that Columbia/HCA routinely overestimated its costs to Medicare. If these reports are true, our conclusions regarding profits at the case-study hospitals are conservative since they reflect the enhanced cost estimates.

We focus our analysis on the financial health of the hospitals and the flow of patients to different hospitals. We would also like to examine measures of the quality of medical care, but the data to do this are not available.

Our results, summarized in table 2.4, address changes in the converting institution and other institutions in the market. For-profit buyers (and joint ventures) seem adept at increasing profit margins in converted hospitals—partly because they effectively manage billing to take advantage of reimbursement loopholes, and partly because they reduce staff as a method of reducing costs. Not-for-profit competitors of the converted (or joint-ventured) hospital react by consolidating and copying the billing practices of the new for-profit.

### 2.5.1 Wesley Medical Center

#### *Direct Effects on the Converting Institution*

We begin with the direct effects of the merger on Wesley Medical Center. One of the goals of the conversion was to raise money for capital improvements. Figure 2.4 shows the increase in fixed assets—plant and equipment—at Wesley. Fixed assets at not-for-profit Wesley hospital were about \$80 million in 1985. In 1986, after HCA bought the hospital, fixed assets rose by about \$50 million and remained at that higher level for the next decade. These additional assets were largely new centers for reproductive health and cardiac and pulmonary rehabilitation.

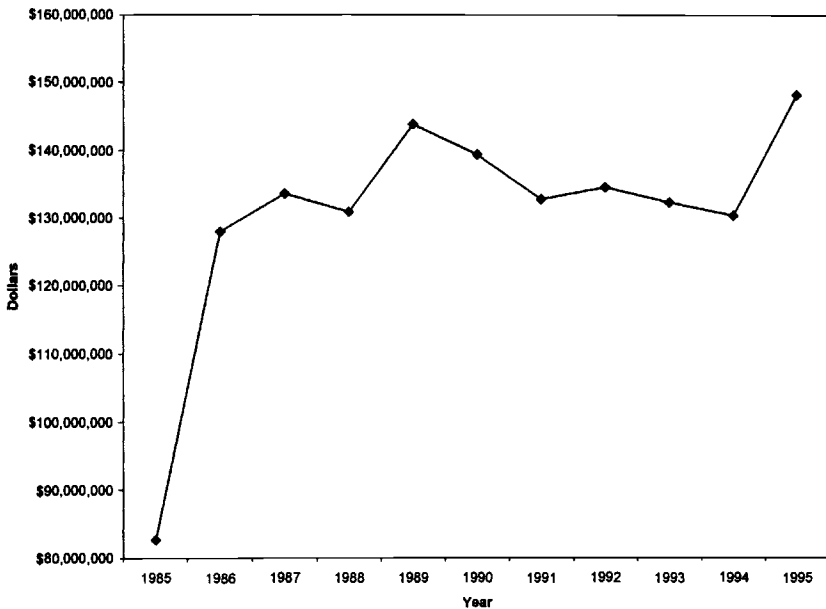
Perhaps more important, however, is the profitability of the resulting institution. Figure 2.5 shows the profit rate at Wesley Medical Center from

**Table 2.4** Effects of Hospital Conversions

|                        | Wesley |                           | Presbyterian/St. Luke's |              |              |
|------------------------|--------|---------------------------|-------------------------|--------------|--------------|
|                        | HCA    | Columbia/HCA              | AMI                     | Reconversion | Columbia/HCA |
|                        |        | <i>Own Institution</i>    |                         |              |              |
| Profits                | ∅      | ↑↑                        | ↓                       | ↑            | ↑↑           |
| Costs                  | ∅      | ↓↓                        | ↑                       | ↓            | ↓↓           |
| Billing management     | ∅      | ↑↑↑                       | ∅                       | ∅            | ↑↑↑          |
| Managed care contracts | ∅      | ∅                         | ∅                       | ∅            | ↑↑↑          |
| Staffing               | ∅      | ↓↓↓                       | ∅                       | ∅            | ↓↓           |
| Infrastructure         | ↑↑     | ↑↑                        | ↑↑                      | ∅            | ↑↑           |
| Physicians             | ∅      | ↓↓↓                       | ∅                       | ∅            | ∅            |
|                        |        | <i>Other Institutions</i> |                         |              |              |
| Patient shares         | ∅      | ∅                         | ∅                       | ∅            | ∅            |
| Consolidation          | ∅      | ↑↑                        | ∅                       | ∅            | ↑↑           |

Source: Authors' opinions based on interviews, analysis, and newspaper reports.

Note: Up and down arrows indicate positive and negative findings, respectively. More arrows indicate stronger findings, as judged by the authors. Zeros indicate no effect.



**Fig. 2.4** Fixed assets at Wesley Hospital

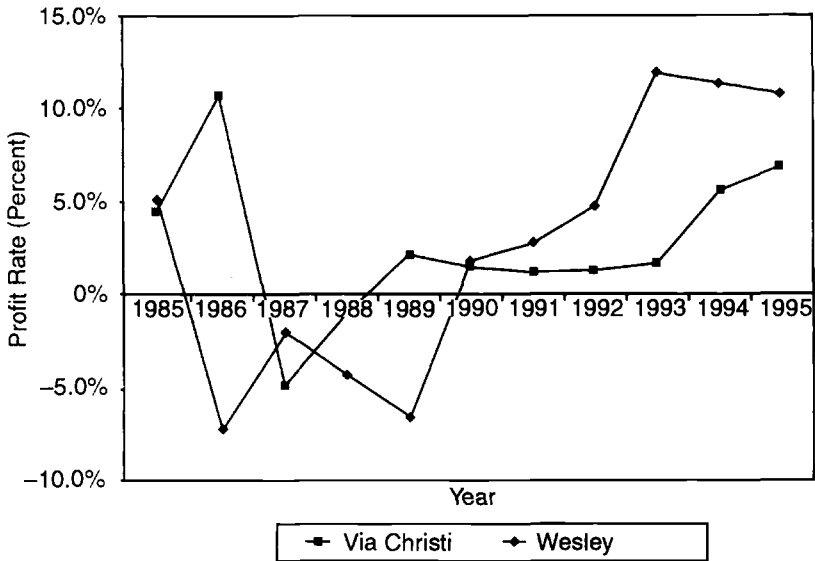


Fig. 2.5 Profit margin at Wichita hospitals

1985 through 1995.<sup>20</sup> Wesley's profits were about 5 percent in 1985. Between 1986 and 1990, under HCA's management, profit rates were negative. Although it appears that HCA was losing money on the hospital, two factors may explain the apparent losses. First, the increase in infrastructure noted above required substantial up-front costs, which reduced short-term profits. In addition, HCA charged the hospital with \$12.4 million in interest expense and deferred loan cost transfers from the parent's \$3.6 billion leveraged buyout by TF Investments, a corporation organized by HCA management. By the early 1990s, after these costs had been incurred, Wesley's profits were about 2–5 percent.

In 1993, Columbia/HCA began managing the hospital, and profits soared. In 1993, 1994, and 1995, Columbia/HCA's profit rates were about 10–15 percent annually.

To give some comparative analysis of profit rates in Wichita, we also show profit rates for Wesley's largest competitors—two Catholic hospitals, St. Francis Medical Center (587 beds) and St. Joseph's Medical Center (388 beds). In 1995, these two hospitals merged to create the Via Christi Medical Center. We form a simulated Via Christi system by combining the two institutions throughout the time period, which we then compare

20. The hospital reported only six months of information in 1985. This might affect profit rates if profits are different in the first and second halves of the year. This is unlikely to be very important, however.

to Wesley's operations. As figure 2.5 shows, profit rates for Via Christi continually averaged about 1–2 percent through 1993.

How could profits increase so dramatically under Columbia/HCA? Two factors are at work. First, Medicare revenues increased. Figure 2.6 shows real Medicare reimbursement per admission between 1985 and 1995. Beginning in 1992, Medicare reimbursement rose dramatically and remained high. While we do not have definitive data on why this occurred, we suspect Columbia-Wesley increased reimbursements by effectively exploiting common Medicare loopholes. To understand these loopholes, consider an example of an elderly patient with a hip fracture. She needs some acute services (e.g., setting the fracture or a hip replacement) and some rehabilitation services (e.g., help learning to walk). Since 1984, Medicare has paid for inpatient admissions on a per-admission basis, paying a single amount for each admission regardless of the services provided. Medicare, however, pays separately for rehabilitation services that are provided independently of a hospital admission. It is not difficult to see the revenue-maximizing strategy. Where traditionally a hospital would provide acute and rehabilitation services in the same admission, the hospital exploiting the loophole will provide the acute services only during the hospital admission and move the patient for the rehabilitation services. For the same total costs,

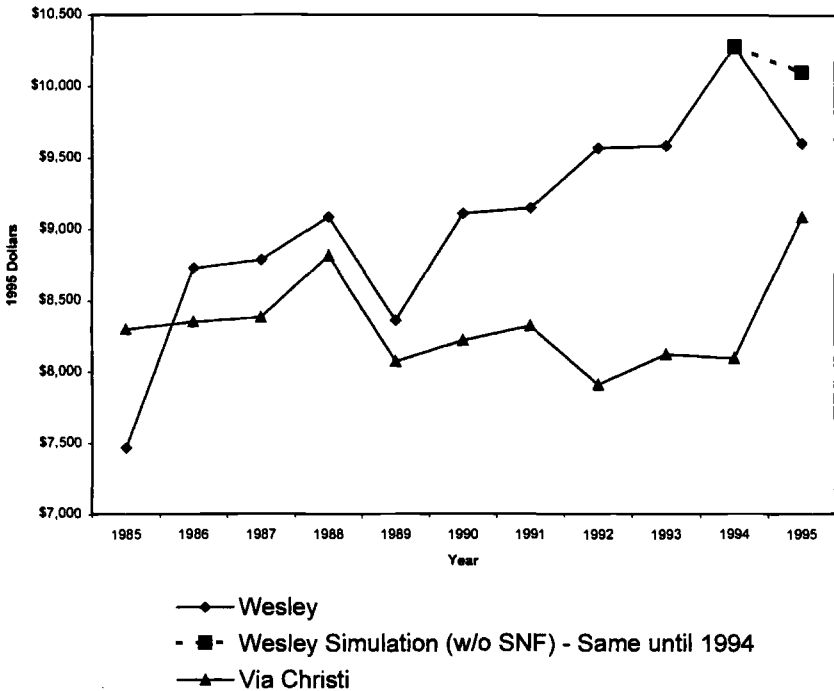


Fig. 2.6 Medicare reimbursement per admission



the hospital collects two payments. Indeed, in 1992 HCA opened its own rehabilitation hospital in Wichita (HCA/Wesley Rehabilitation Center), which could facilitate multiple reimbursements to the hospital for each Medicare recipient treated. We include the rehabilitation center's profits in our calculation of Columbia/Wesley's profits.

Similarly, Columbia opened a skilled nursing facility (SNF) at Wesley in 1995. These facilities provide another mechanism with which to unbundle hospital admissions (Newhouse and Byre 1988). Medicare admissions to Wesley—the hospital and nursing home combined—soared in 1995. It looks in figure 2.6 as if the opening of the SNF lowered Medicare reimbursement per patient. But if we assume that all of the Medicare admissions to the nursing facility were also admissions to the hospital (so that the appropriate denominator is the number of hospital admissions), we find no significant reduction in Medicare reimbursement in 1995.

There are other accounting changes Columbia/HCA might have made. For example, Medicare reimbursement is typically greater if the patient has “complications and/or comorbidities” than if the patient does not have complications or comorbidities. Hospitals will thus search for complications to maximize Medicare reimbursement, a process termed “DRG creep” (Carter, Newhouse, and Relles 1990). Without microdata, however, we do not know how much Columbia Wesley's number of complicated patients increased.

In addition to an increase in Medicare revenues, Columbia/HCA reduced costs. Figure 2.7 shows the growth in revenues and costs per admission between 1985 and 1995. Real costs actually fell in 1993 and 1994, before rising in 1995.<sup>21</sup> Figure 2.8 shows the source of some of this cost reduction. Length of stay in the hospital fell dramatically over this period. Among Medicare patients, for example, average hospital stays fell from 8.1 days in 1992 to 6.6 days in 1995, a 19 percent reduction. Somewhat surprisingly, nursing input did not fall. Licensed practical nurses (LPNs) per patient fell over this period, but registered nurses (RNs) per patient declined only slightly.

In our discussions at Wesley hospital, however, the reduction in nurses and nurses aides was described as a major source of tension between physicians and Columbia. The source of this tension appears to have risen

21. A word for researchers about sources of cost data. We have compared AHA data on costs for Wesley with Medicare cost report data. The AHA data are flawed in several important respects. HCA did not report all its costs when it was running the hospital, with the exception of one year. Thus, costs in AHA reports appeared to plummet when HCA bought the hospital and soared when Columbia began operating. Neither conclusion is true. But the cost report data are not entirely accurate either. In the cost report data, HCA appeared to count routine births (without complications) as discharges when hospitals generally do not do so. As a result, in the cost report data admissions soar under HCA and fall under Columbia. This is also not true. We use the admissions data from the AHA and cost data from the cost reports to adjust for these problems.

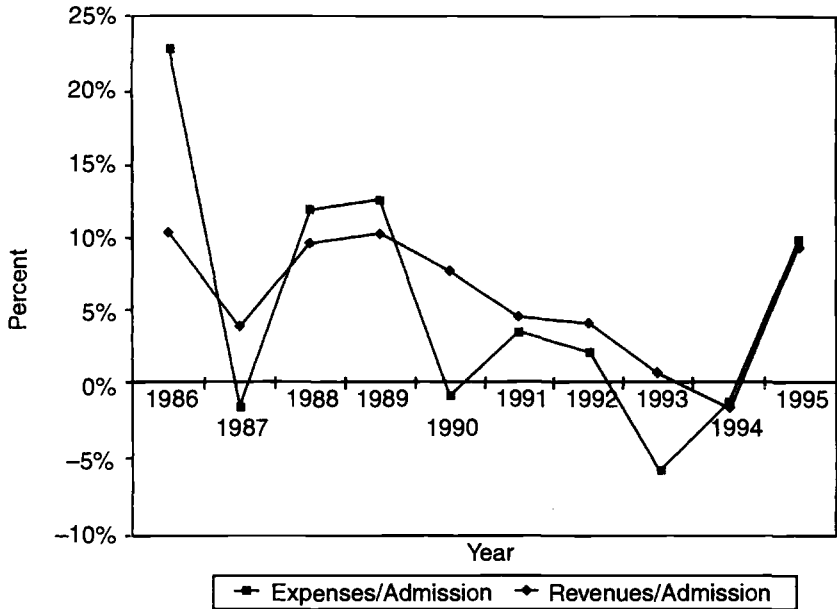


Fig. 2.7 Growth of revenues and expenses per admission at Wesley Hospital

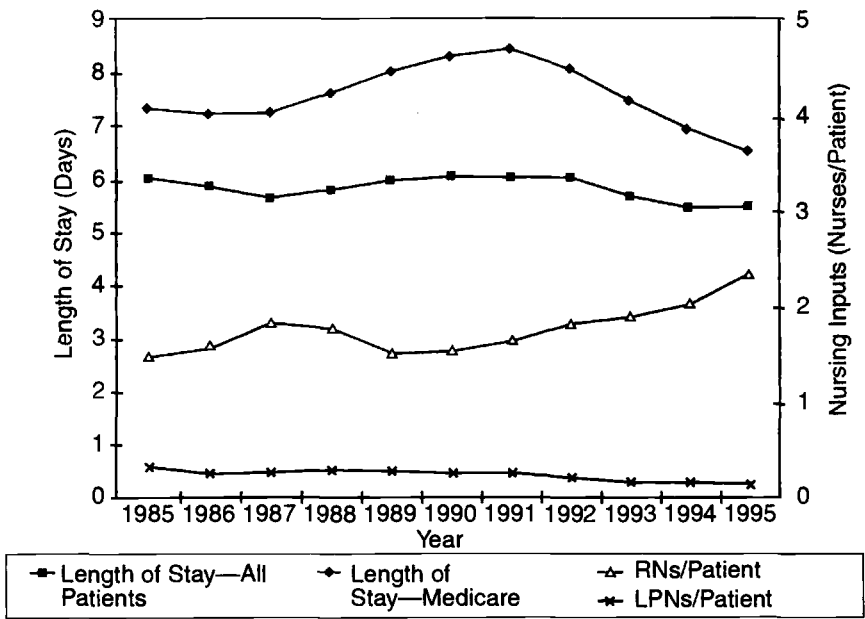


Fig. 2.8 Inputs at Wesley

after 1995. In January 1996, Wesley eliminated 204 positions (136 layoffs, 51 early retirements, and 17 voluntary departures). In January 1997, Wesley announced plans to eliminate 383 more jobs by the end of September 1997.

Indeed, the tension between the hospital and its physicians was sufficiently great that many physicians at Wesley sought alternative practice arrangements. Many moved some of their practice to Via Christi, a relatively simple move since Wichita doctors may easily garner admitting privileges at all of the Wichita hospitals. Some doctors took more drastic measures. In 1995, a group of orthopedic surgeons opened their own hospital, the 11-bed Kansas Surgery and Recovery Center. The Center treats routine, high-reimbursement orthopedic cases (particularly insured patients). The cardiovascular surgeons are building their own hospital as well.

Columbia wanted to entice the physicians to admit only at Wesley by offering them financial interests in the hospital, as it does in many places, but this strategy fared poorly. In fact, the failed negotiations between Columbia and the physicians of the Wichita Clinic—the largest primary care service in the area—have led to a lawsuit by the physicians charging anti-trust violations on the part of Columbia.<sup>22</sup> When the negotiations fell through, Columbia hired about 20 percent of the physicians (13 people, including 40 percent of the family practice department). The remaining physicians claim that Columbia hired the physicians at excessive salaries and bonuses, and with promises to indemnify the doctors for damages resulting from breaches of noncompete clauses with the clinic as a predatory attempt to harm the clinic's business. The clinic also charged Columbia with misappropriating trade secrets such as internal operations information, fiscal performance data, and salary information. Finally, the clinic argued that Columbia tortiously interfered with the physician contracts and the clinic's business expectancy.

To discern how the change to for-profit form affected Wesley's ability to negotiate favorable contracts, we analyzed the hospital's contractual allowances and discounts. If Wesley's new corporate form helped it to exercise market power, this fact might be reflected in these data. This does not appear to be the case, however. Wesley's contractual allowances and discounts rose from 12 percent of charges in 1985 to 43 percent of charges in 1995, while Via Christi's rose from 9 percent of charges to 44 percent of charges in this same period. Contractual allowances and discounts are based on list prices instead of costs and, therefore, may mask some reduction in discounts. The similarity between the for-profit and the not-for-profit's trends is still noteworthy.

22. See *Wichita Clinic, P.A. v. Columbia/HCA Healthcare Corp.*, 1997 WL 225966 (D. Kan. 1997) (denying Columbia/HCA's motion to dismiss).

*Effects on Competitors and the Wichita Market*

The Wesley conversion not only affected Wesley hospital, it also affected the community as a whole. The Wesley conversion seems to have sparked increased consolidation in the hospital market more generally. As noted earlier, St. Francis and St. Joseph's merged in 1995 to form Via Christi Medical Center. Several people speculated that fear of Wesley's success as a for-profit drove the merger between these two institutions. The Catholic hospitals, however, explained that they merged because it was wrong for two Catholic hospitals to compete.

As figure 2.5 shows, the combined institutions have done very well financially. Where the two hospitals forming Via Christi's had combined profits of about 1–2 percent in the late 1980s and early 1990s, the profit rate rose to 7 percent in 1995. The reasons for this increase in profits appear to be similar to those for Columbia/Wesley. St. Francis, for example, opened a rehabilitation unit in 1994; Via Christi acquired a rehabilitation center in 1995; and in 1996, Via Christi planned to open a 36-bed continuing care subsidiary within the hospital, specifically to benefit from long-term acute care reimbursement. The increase in the number of rehabilitation beds in the Wichita area is astounding. In 1985, Wesley hospital had 18 rehabilitation beds and St. Joseph's had 31 rehabilitation beds. In 1991, HCA/Wesley had 26 rehabilitation beds and St. Joseph's had 37 beds. By 1995, Columbia-Wesley Rehabilitation Hospital had 50 rehabilitation beds; Via Christi Rehabilitation Center had 40 rehabilitation beds; St. Francis Hospital had 32 rehabilitation beds; and St. Joseph's Hospital had 38 rehabilitation beds. The number of rehabilitation beds more than tripled between 1985 and 1995.

Similarly, Via Christi also cut costs. As figure 2.9 shows, the average length of stay for all patients, and particularly Medicare patients, fell substantially after 1993. Between 1993 and 1995, for example, the average length of stay for Medicare patients at Via Christi declined by one day.

The experience of our case market offers a new understanding of how the presence of for-profit hospitals affect hospital markets—one that raises an “inverse-Hansmann problem.” Hansmann (1980, 835) argued that the presence of not-for-profit hospitals in markets forces for-profit hospitals to keep quality high. Here, having for-profit hospitals in the market appears to cause not-for-profit hospitals to adopt the same money-making measures employed by for-profits. In this case, most of the measures come at the expense of the government.

Perhaps more important than the amount of rehabilitation care that patients receive is whether acute care patients have access to the most appropriate care. There has been particular concern that for-profit hospitals will shirk on care for the poor, leaving such patients to their not-for-

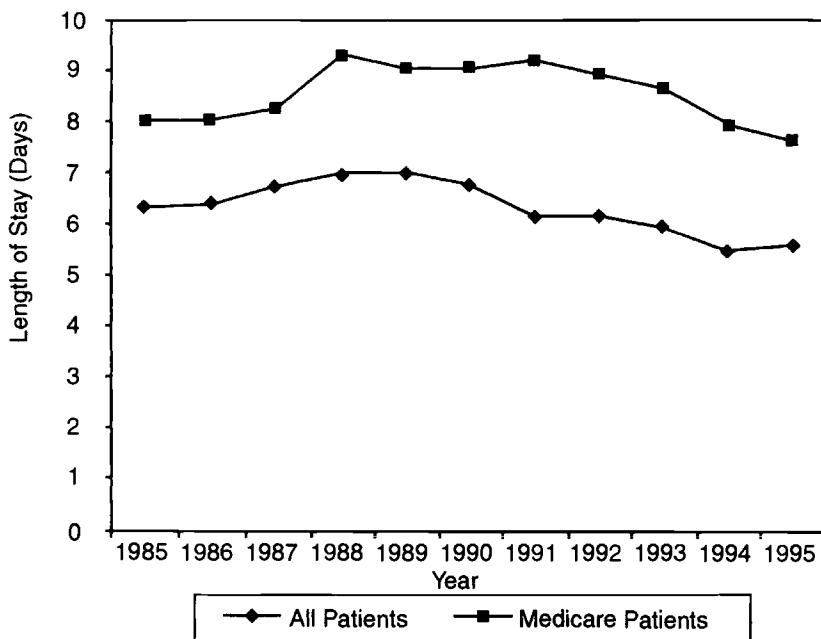


Fig. 2.9 Inputs at Via Christi

profit competitors. Our data do not indicate how much charity care different hospitals provide.<sup>23</sup> It does break out admissions for Medicare and Medicaid patients, however. Figure 2.10 shows the share of all patients, Medicare patients, and Medicaid patients in Wichita admitted to Wesley hospital.

These data do not suggest much cause for alarm. While Wesley's share of the overall Wichita market has been falling, its share of Medicaid patients has been constant or rising. Of course, different trends may be occurring for the uninsured relative to Medicaid patients, but our first pass evidence finds no adverse effect for the Medicaid group.

But some fragmentation of the medical care market is occurring. Wichita has seen an increase in surgi-centers and stand-alone clinics. The new orthopedic clinic, for example, saw no Medicaid patients in its first year of operation (108 patients in total), and one suspects the new cardiology center will also cater to the wealthy and well insured. In addition, the hospitals have attempted to attract low-risk patients to their facilities. In

23. As noted above, hospitals report contractual allowances and discounts on their Medicare cost reports, which include uncompensated care, but they also include discounts to managed care plans and unpaid coinsurance for insured patients.

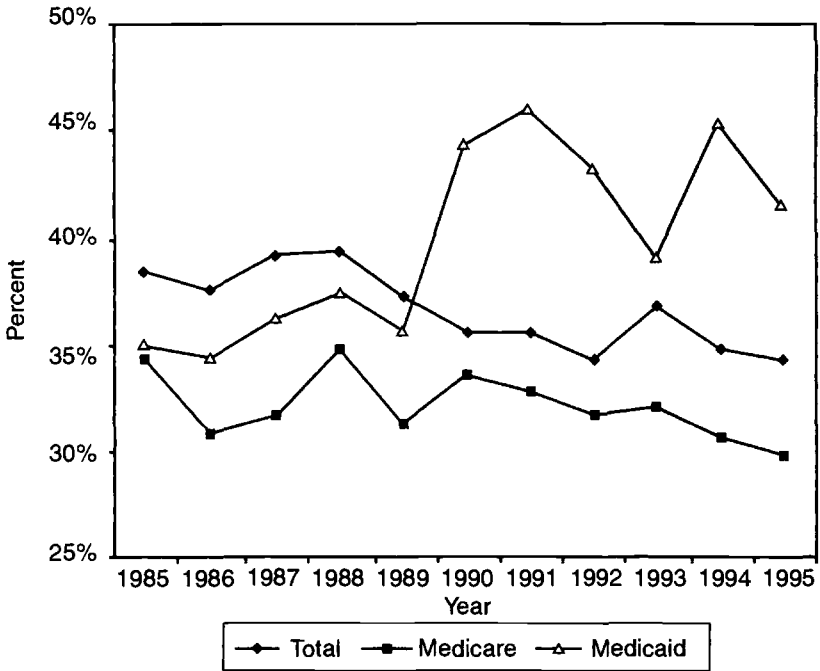


Fig. 2.10 Wesley Medical Center: Admissions as share of total Wichita market

1996, Wesley opened a free-standing birthing center that only admits low-risk patients. Soon thereafter, an independent obstetrics practice group approached Via Christi about opening a similar center on the Catholic campus. If these new ventures survive, there will be some segregation of the health system by class, propagated as much by doctors severing their hospital affiliations as by hospitals establishing independent clinics.

### 2.5.2 Presbyterian/St. Luke's-AMI

#### *Direct Effects on Converting Institution*

Once again, we start with the effect of the conversion on the converting institution. One of the rationales for the asset sale to AMI was to get more capital for Presbyterian/St. Luke's. Figure 2.11 shows the fixed assets of Presbyterian/St. Luke's from 1985 through 1994. From the pre-AMI period through 1990, assets nearly doubled.

To examine Presbyterian/St. Luke's financial performance before and after the sale to AMI, figure 2.12 shows the profit rate for Presbyterian/St. Luke's hospital from 1985 to 1994. We omit data for 1995 because there is no way to separate out profits for these hospitals from the other

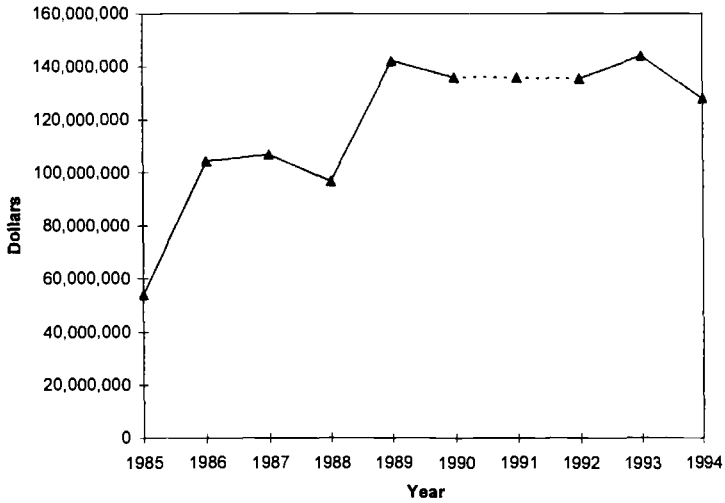


Fig. 2.11 Fixed assets at Presbyterian/St. Luke's

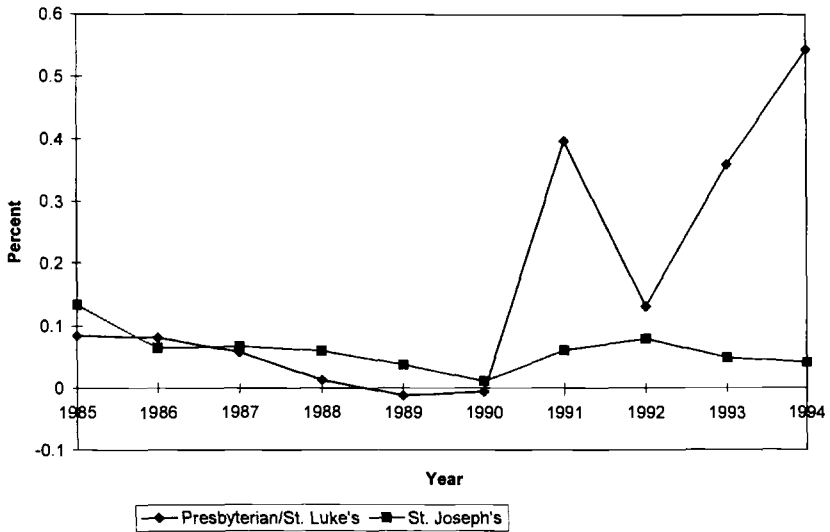


Fig. 2.12 Profit margin for Presbyterian/St. Luke's

parts of Columbia-HealthOne.<sup>24</sup> When Presbyterian/St. Luke's was sold to AMI in 1985, it had average profits of about 8 percent. During the AMI years, 1986 through 1990, profits steadily declined. In 1989 and 1990, the

24. We aggregate the two institutions to form profits prior to 1990, even though profits are reported separately.

hospital lost money. In the five months of 1991 that AMI owned the hospital, the hospital reported extremely large profits, but we suspect that this is an accounting anomaly rather than a true increase in profits. After AMI reconverted to not-for-profit form, reported profit rates increased dramatically. These data, based on Medicare cost reports, seem questionable, however, because the AHA data show much larger costs. We were unable to explain the variance.

As we observed in the Wesley case study, contractual allowances and discounts rose under AMI's for-profit ownership of Presbyterian and St. Luke's. Between 1987 and 1992, contractual discounts climbed from 27 percent to 46 percent of total patient charges. Presbyterian/St. Luke's closest competitor in the Denver market is St. Joseph's hospital (405 beds). Over the same time period, contractual discounts at St. Joseph's rose from 12 to 33 percent. Discounts at Presbyterian/St. Luke's rose somewhat less rapidly than at St. Joseph's, but we do not know if St. Joseph's rose more rapidly simply because it began at a lower base.

Under the control of not-for-profit Presbyterian/St. Luke's, contractual allowances and discounts fell. Between 1992 and 1994, contractual allowances and discounts fell from 46 to 37 percent. At St. Joseph's, in contrast, contractual allowances and discounts rose from 33 to 41 percent of charges between 1992 and 1994.

Given the lack of any discernible increase in profits under AMI, we do not report a detailed analysis of changes in revenues or expenses.

#### *Effects on Competitors and Market*

Denver is a bigger market than Wichita, so the effects of the conversion on the market as a whole were necessarily smaller. As figure 2.12 shows, profit margins at St. Joseph's fell in the late 1980s but then rebounded in the early 1990s.

We also examined the share of Medicare and Medicaid patients going to Presbyterian/St. Luke's. Figure 2.13 shows changes in Presbyterian/St. Luke's share of the patient market before and after the sale. Presbyterian/St. Luke's share of the hospital market was falling over this time period, but it fell disproportionately more for the non-Medicaid population compared to the Medicaid population. After 1991, Presbyterian/St. Luke's share of the market rose among both Medicaid and non-Medicaid patients. The evidence in figure 2.13 does not suggest that care to the poor was cut particularly heavily under for-profit management.

On the whole, the evidence thus suggests relatively small effects of the sale to AMI on operations of Presbyterian/St. Luke's hospital or the Denver market as a whole. Indeed, profits, if anything, fell under AMI's management. This is consistent with the financial difficulties that AMI found itself in by 1991.



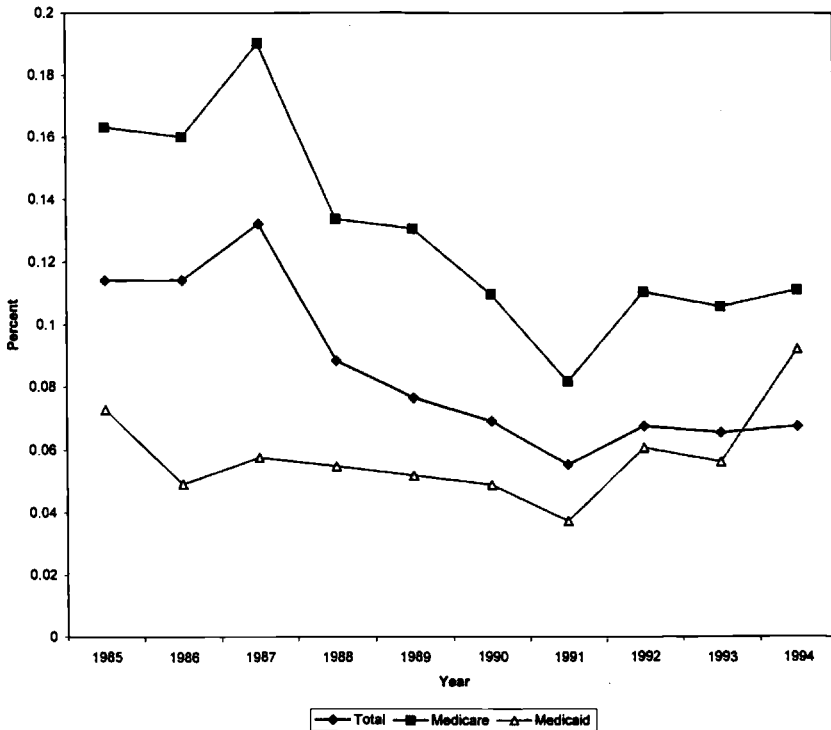


Fig. 2.13 Patient shares in Denver

### 2.5.3 Columbia/HealthOne

Because the Columbia-HealthOne joint venture occurred so recently, we were unable to obtain reliable data regarding the effects of that transaction. But some preliminary information about the effects of the joint venture is available. In 1996 Columbia-HealthOne reported profits similar to those of its not-for-profit competitors. Hospital profits in the Denver area increased an average of 7.2 percent in 1996, and Columbia-HealthOne's profits increased by 7.2 percent as well. For the Columbia-HealthOne system as a whole, reported profits were 3 percent in 1996.

We suspect that Columbia-HealthOne, like Wesley, has attempted to raise profits by aggressively managing government billings. According to the Colorado Hospital Association, Medicare inpatient charges per patient rose by 16 percent in Presbyterian/St. Luke's in 1996, while they had fallen by nearly one-quarter (in nominal terms) in the previous three years. Unfortunately, we do not know about Medicare revenues, so we cannot determine whether the increased charges resulted from higher list prices or increased billable services. Columbia-HealthOne also appears to have

cut costs substantially. Between 1994 and 1996, inpatient costs per admission fell by 3 percent in nominal terms and Medicare average length of stay fell by 1.3 days. The number of full-time equivalent employees per occupied bed fell by 15 percent.

There is some indication that some of these changes were illegal. In October 1997, federal investigators asked two Columbia-HealthOne hospitals to turn over some patient records as part of an investigation of Columbia's billing practices. Columbia-HealthOne has begun to change its management practices. According to one report, 125 Columbia-HealthOne managers who were eligible for bonuses based on 1996 job performance will not be eligible for such bonuses in the future.

The controversy surrounding Columbia/HCA has led some members of the public and some members of the HealthOne board to question aspects of the joint venture. In the fall of 1997, the HealthOne representatives launched efforts to renegotiate the \$370 million loan assumed by the LLC. Although the HealthOne board representatives perceived the approximately 17.5 percent interest rate to be the best they could negotiate at the time of the joint venture, there has been some speculation that the deal might not be renegotiated. The HealthOne faction has also exercised its power to block Columbia-inspired initiatives. For example, newspaper reports indicate that when the Columbia management told the board that it planned to lay off employees, the HealthOne faction voted against the proposal and forced Columbia to recalculate the budget.<sup>25</sup>

One of the striking features of this joint venture is how much of the Denver hospital market it encompasses. In 1996, Columbia-HealthOne accounted for 37 percent of all admissions to Denver hospitals. The Federal Trade Commission reviewed the joint venture but never filed objections to it. Allowing such a large percentage of a market's hospitals to be controlled by one entity raises ordinary monopoly-related concerns as well as the risk that the entity's policies may have negative and particularly widespread effects.

## 2.6 Conclusions

Our case studies suggest two primary explanations why hospitals convert from not-for-profit to for-profit form—(1) financial concerns and (2) board culture and perceived mission. Although we expected to find that financial concerns were important, we learned that such concerns are multifaceted. Expectations about future profits and anticipated problems servicing debt were central to selling directors, as were pessimistic views of government reimbursement policies.

Our results suggest a mixed view of the effects of hospital conversions.

25. The reduction in employment noted above resulted from attrition.

On the one hand, we find some efficiencies associated with conversion to for-profit form. For-profit hospitals cut costs when not-for-profit hospitals cannot do so.<sup>26</sup> For-profits also provide capital or relieve debt burdens, which not-for-profit hospitals could not otherwise do. And we find no evidence that for-profit hospitals reduce quality or cut back on access to the poor, although our measures of these effects are admittedly crude.

But the implications of for-profit organization are not entirely beneficial. For-profit hospitals make money in part by increasing reimbursement from the public sector. This is a gain for the hospital but a loss for society as a whole.<sup>27</sup> And having more for-profit hospitals leads to some fragmentation of the market between rich and poor, although this occurs as much from physician actions as from hospital actions.

Perhaps the most important issue raised by our results is the symbiosis between for-profit and not-for-profit hospitals. Our results show that for-profit and not-for-profit hospitals both influence and are influenced by each other's actions. Years ago, these actions were seen as beneficial; if not-for-profit hospitals maintained high-quality care, for-profit hospitals might have to do the same. But our results highlight the other side of this coin. When for-profit hospitals exploit Medicare loopholes, not-for-profit hospitals learn to do the same, or believe they must copy for-profits to compete. If for-profit hospitals skimp on the quality of care, not-for-profit hospitals might follow suit. The influence of for-profits will only grow as they become a larger part of hospital markets, such as Columbia-HealthOne in Denver. The possibility that for-profit hospitals will encourage not-for-profit hospitals to reduce their public goods provision is a substantial concern as the health care marketplace changes.

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26. These results are somewhat at odds with those of Sloan, Taylor, and Conover (chap. 1 in this volume). Jim Rebitzer's comment on our papers (Rebitzer, in this volume) presents several potential sources of difference. Future research should explore these differences in more detail.

27. It is a loss, rather than a transfer, because raising the money for the payment involves some deadweight loss.

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## Comment on Chapters 1 and 2 M. Kathleen Kenyon

### Introduction

I have been asked to comment on two papers on hospital conversions, the first by Sloan, Taylor, and Conover and the second by Cutler and Horwitz. From my perspective,<sup>1</sup> both of these excellent papers touch on the truth and point to a bigger picture that needs to be addressed much more explicitly. Cutler and Horwitz's in-depth case studies of two conversions of large hospitals, now owned by Columbia, have an almost scene-of-the-crime interest, given Columbia's recent troubles with the Department of Justice. Their conclusions suggest that for-profits are bad role

M. Kathleen Kenyon, J.D., is general counsel of Deaconess Billings Clinic, a tax-exempt integrated health care organization in Billings, Montana.

1. Commenting on two papers on hospital conversions, by economists of this stature, has me somewhat out of my natural habitat. My perspective comes from having investigated and defended hospital mergers (as an antitrust lawyer), watched the industry from a policy perspective (as a Capitol Hill staffer and legislative counsel for a trade association), and served as general counsel to an integrated, not-for-profit health system that owns a hospital and physician group practice.

models, leading not-for-profits that share their markets to follow them in reimbursement maximization, with the federal Medicare coffers as the prime victim. On the other hand, Sloan, Taylor, and Conover, in a disciplined, methodologically complex investigation of a variety of relatively small conversions, come to conclusions that appear to go in the opposition direction. Their conclusions could be seen as a defense of for-profit conversions: For-profits pay (perhaps overpay) a fair price for the hospitals they acquire, invest in much-needed facility improvements, and continue to provide comparable levels of charity care and other services. In contrast to the possible benefits of conversion to for-profit ownership, Sloan, Taylor, and Conover find that, in two instances, conversions of small not-for-profits into larger not-for-profit systems are something of a steal by the larger not-for-profits.

Both studies advance the intelligent discussion of an important policy question that is also politically charged (and, for that reason, resists intelligent discussion). What are the social implications of the growth of the for-profit sector in health care, and, especially, the implications of the conversions of hospitals from not-for-profit to for-profit status?

### **Three Overarching Issues**

#### **Need for Political Economic Context**

I have three overarching gripes about these papers. Both papers cry out for placing the conversions they investigate into the larger political economic context of the health care industry. Hospitals are only one segment of the health care industry (and an increasingly less powerful one). It isn't just hospitals that have been converting to for-profit status and becoming part of large, publicly traded systems; insurers/HMOs and physicians have as well. At one time, all Blue Cross Blue Shield plans were not-for-profit; today many are not, and more are looking toward for-profit conversion. Many of the not-for-profit HMOs formed in the 1970s in the wake of the HMO Act have converted to for-profit status and been merged into large, publicly traded corporations. For-profit insurers have expanded dramatically into managed care products.

Similarly, physicians are consolidating dramatically into ever larger groups. These groups are not, by and large, Mayo Clinic-like foundations (which are not-for-profit, tax-exempt, and dedicated to teaching and research as well as provision of health care); rather, they are managed by multi-billion-dollar physician practice management companies traded on Wall Street.

Furthermore, your local physicians and hospitals have less control over decisions about how and where health care dollars are spent than they did in the past. Health care is becoming like the rest of the economy, with

the purchasers (especially the better informed, larger purchasers—large employers, unions, and government) demanding value and accountability from both the insurance companies (especially managed care companies) and the providers they turn to with their health care dollars. The payers, rather than hospitals and physicians, increasingly hold economic power.

That is the context (dramatically abbreviated and simplified) in which to view hospital conversions and to question their social significance. Placed in that context, it becomes clear that you cannot understand hospital conversions by looking only at hospitals pre- and postmerger. And you cannot understand the social implications of for-profit conversions without looking at the whole industry.

### Need for a More Critical View of Medicare

My second gripe, really a subcategory of the first, is directed primarily toward the paper by Cutler and Horwitz. Their paper is not sufficiently critical of the role of Medicare in health care markets. Medicare is wonderful for at least one reason: It guarantees health care (except outpatient pharmaceuticals, certain preventive services, and a few other important health care benefits) to older Americans. Beyond that, Medicare's method of paying for health care services and the legal barriers to provider integration posed by some Medicare laws and regulations have created or worsened much of the inefficiency in health care, especially for providers trying to provide the full continuum of health care services in order to be able to deliver quality care while controlling costs.

It is a mistake to condemn behavior that appears calculated to increase Medicare reimbursements without a very careful look at whether the behavior being condemned makes sense viewed from other perspectives, such as the perspective of physicians committed to quality care or of commercial payers (the second largest source of hospital revenues, after Medicare). Cutler and Horwitz, for instance, criticize Columbia, and the not-for-profits that arguably follow in Columbia's tracks, for building rehabilitation units and adding transitional care beds, skilled nursing facilities, and home health in order to maximize Medicare reimbursement. The criticism should only be justified if, in a quality-driven, efficient health care system, you would not have, in the numbers you have today, these less-intense alternatives to medical surgical inpatient beds. Based upon conversations with physicians and representatives of well-regarded health plans, I suspect that if you removed Medicare from the picture entirely, and simply had enlightened geriatricians and caring payers designing high-quality, cost-effective health care for older Americans, you would find a heavy reliance on these less-intense, specialized health care alternatives to acute care hospitals. Furthermore, one wonders whether patients would prefer to recuperate in an acute care hospital bed when other less medically intense environments are available.

That stated, it may well be that Columbia built all of those rehab beds, as Cutler and Horwitz suggest, primarily to take advantage of Medicare reimbursement “loopholes.” That subjective intent should not be imputed as the primary motive to others, including other hospitals in Denver and Wichita. If the move toward providing the full continuum of care is good for patients and makes sense as a possible cost saver to more enlightened payers than Medicare, maybe the other hospitals that have added such units are doing so not because of the corrosive influence of the for-profits. Obviously, however, the fact that Medicare has created economic incentives to reduce hospital length of stay, while making another payment for rehab and other step-down units, has undoubtedly made it economically more feasible to build such units. That such building has occurred should not surprise economists or Medicare.

#### Ask the Question Differently and Suggest a Better Explanatory Framework

My third gripe, which follows from the first, is that these papers should have viewed conversions as simply one response to current pressures facing all providers and payers in health care. The bigger question is, How do not-for-profits differ from for-profits, if at all, in their response to economically driven changes in health care? While both papers provide valuable evidence for an explanation, neither takes the step of explicitly suggesting an explanatory framework for future researchers to pursue to answer that question.

Whatever that explanatory framework might be, these papers suggest that it would look at legal, cultural, and contextual factors.

Legally, not-for-profit, tax-exempt hospitals differ from for-profits because they must be organized (“the organizational test”) and operated (“the operational test”) to benefit the community (“the community benefit standard”), and they are prohibited from operating to benefit insiders (private inurement) or other individuals, except incidentally (private benefit). If they abandon any of these basics, they cannot be tax-exempt not-for-profits. These legal requirements have real effects for the daily operations of not-for-profit hospitals and limit their ability to respond to external demands for change in ways that for-profits can.

It is clear from these papers, however, that while all tax-exempt hospitals operate under similar legal constraints, they do not all respond to them in the same way in difficult economic times. Apparently, culture and context matters. Researchers need to come up with a typology of not-for-profit hospitals that captures the cultural variables that matter. They need to identify contextual factors that might explain why culturally similar not-for-profits make different decisions in response to similar economic pressure—factors like the HHI analysis in Sloan, Taylor, and Conover; excess beds in the market; the relative financial size and strength of provid-

ers in the market; the presence of effective employer purchasing coalitions; and how concentrated and entrenched the managed care health plans are in the market.

My guess (supported by some evidence from these papers) would be that not-for-profit hospitals that convert are different from those not-for-profits that do not convert, since hospitals everywhere are, in one way or another, facing increased financial pressures, and most do not convert. I also believe that most, but certainly not all, not-for-profit hospitals are different from for-profit hospitals in measurable ways and that the dramatic expansion of the for-profit sector in health care will have significant social implications that research will eventually identify.

### **Evidence on the Implications of Conversions**

Do we find in these papers evidence that not-for-profit ownership (especially private, not-for-profit ownership), rather than for-profit ownership, makes any difference in responding to increasingly intense financial pressures?

If the only thing you worry about is the dollar value dedicated to charity care (which tax-exempt hospitals are not legally required to provide), the answer is no (and the researchers giving that answer could form a chorus at this point). The research by Sloan, Taylor, and Conover also suggests that the type of services do not, in the exceedingly short time frame they observed, vary significantly between not-for-profits and for-profits, nor do they change significantly postconversion, at least in any direction that would suggest that not-for-profits are more willing to support needed but unprofitable services. I look forward to more long-term data on these matters, but I also believe a more nuanced look is needed. (Sloan, Taylor, and Conover, by dividing services into three categories, including services that are likely to be unprofitable but are important in the community, take a good step toward a more nuanced look.) For instance, timing of entry and exit for important services, where the profitability is unclear, may differ between not-for-profit and for-profit hospitals, at least if you control on the financial depth of the institutions. The dollar value of charity care may not vary based on ownership, but how those dollars are targeted may. Efforts to facilitate and establish connections with outside service providers when the local hospital cannot afford to provide an essential service itself may differ.

In general, I would expect many of the benefits of the not-for-profit organizational form to be hidden in staff time devoted to particular community needs or to involvement in community efforts to address social problems with health consequences. These differences are difficult, but not impossible, to measure. In the long run, communities may find that those differences matter. A board composed of members genuinely motivated



by a mission and committed by law to the community benefit legal standard are simply more likely to look at the long-term interests of their community and to get engaged.

The most interesting evidence from these papers addresses why not-for-profit hospitals that turn to conversion as a solution to their problems do so. (In the next round of research, evidence from those not-for-profits that faced economic challenges and did not convert would be useful.) The answer both papers suggest is “cultural.” Cutler and Horwitz tell us that boards dominated by businesspeople may be more willing to convert to for-profit status and less committed to a not-for-profit, tax-exempt structure. This may be especially so if they can come out of the deal with what they regard as a mission intact at the hospital, in the form of a continuing commitment to charity care by the resulting for-profit hospital, and with money for a foundation that continues to serve the community. If the evidence were stronger that the resulting foundations did a great deal more for the health of the community than pay for unprofitable services and teaching in the now for-profit hospital that the foundation board members used to direct, this mission-plus-money argument might be more convincing. More research is needed on the role of foundations in continuing and expanding their health care missions beyond the bricks and mortar of hospital services.

Both papers suggest that conversions take place in part because the not-for-profit board worries about an uncertain future or is facing community, tax, cultural, regulatory, or political pressures that make it difficult for those hospitals to respond to external financial pressures. Anyone who has been through the pain of changing a long-standing community hospital (which is probably also one of the largest employers in town), on matters as simple as who runs the food service or as difficult as reducing nursing staff as patient length of stay drops, can understand the attraction of putting such matters in the hands of experienced for-profit hospital managers they believe will be less constrained by local pressures. Local not-for-profit boards unable to act and ineffective hospital management, after all, are not likely to have much benefit for the community. On the other hand, does the community lose something when the local hospital (or health plan or physician group) is run day-to-day by corporate managers whose fiduciary obligations run through Wall Street to shareholders who cannot possibly understand the role of that hospital in the community, except as it affects profitability?

We do find some rather intriguing evidence in these papers that conversions worry people. Sloan, Taylor, and Conover, despite finding no significant negative effects of conversions with regard to the general fairness of the deal or loss of services, report communities worrying about a loss of community control when their hospitals converted to either for-profit or larger not-for-profit form. They also report two instances where com-

munity boards turned to large, nearby not-for-profit hospital systems for help out of their financial difficulties, rather than rely upon for-profits—one assumes despite the likelihood that they could have gotten more money out of for-profit conversion. These communities effectively put a very large price tag on the importance of staying not-for-profit, even when doing so still meant a loss of community control. As I write this, there are reports of fierce opposition to a Catholic hospital sale to Tenet, despite Tenet's willingness to pay tens of millions more than another potential purchaser from a Catholic system.

Why are some local and religious communities willing to pay such a high price in order to keep their hospitals not-for-profit? These papers put researchers in a better position to try to build a framework for answering that question, which is just another form of the question of how not-for-profits respond differently than for-profits to the economic pressures in health care. Answering that question will help us struggle politically with the question being asked with increasing frequency and concern: What are the social implications of the growth of the for-profit sector in health care?

## Comment on Chapters 1 and 2 James B. Rebitzer

Nobody knows what really happens when hospitals convert from not-for-profit to for-profit status. Do not-for-profit hospitals offer important medical services to the indigent that for-profit institutions do not adequately provide? Do hard-nosed, for-profit managers impose the organizational discipline needed to control rising health costs? Do hospital conversions transfer the accumulated value of public subsidies to private hospitals at less than market rates? These questions make hospital conversions a lightning rod in the ongoing debate over the role of profits in health care.

The degree of public disquiet over hospital conversions is neatly illustrated by excerpts from magazines at opposite ends of the political spectrum. At one pole, the conservative *Economist* writes:

The travails of America's largest for-profit hospital chain do not prove that profits are bad for health care. It seems only yesterday that Columbia/HCA Healthcare was acclaimed as a model of how a for-profit company could revolutionize health care. Its hard-driving boss, Richard Scott, enriched his investors by buying hundreds of hospitals, closing lots down and making the remainder far more efficient. Now the firm is in the dog house. It denies any wrong-doing, but Mr. Scott has resigned while a posse of investigators looks into allegations that, among

other abuses, the company has been overbilling the Federal Government. Could there be clearer evidence, many people are asking, that health care and the profit motive do not mix? (*Economist*, 2 August 1997)

The *Economist*, true to form, answers this last question in the negative. At the other pole, the liberal, market-skeptical *American Prospect* writes

First it was hospitals and nursing homes, ambulatory care centers and health maintenance organizations. Now it is Blue Cross plans and major teaching institutions. In an accelerating rush to the marketplace, many of America's largest health care nonprofits are being converted into profit-making organizations. . . . if regulators fail to act, the charitable legacy will be lost and more executives of non-profits will become overnight millionaires by capturing the assets for themselves and their investors. (Bell 1996)

The papers by Sloan, Taylor, and Conover and by Cutler and Horwitz are important because they offer some of the first dispassionate and careful assessments of the consequences of hospital conversions. The papers also illustrate the power of well-executed case studies to illuminate issues relating to organizational governance.

Cutler and Horwitz examine two hospital conversions. The first conversion involved Wesley Medical Center in Wichita, and the second involved Columbia/HealthOne in Denver. In the Wesley conversion, Wesley's assets were sold to HCA in 1985, and HCA merged with Columbia to form Columbia/HCA in 1993. The Wesley conversion was accompanied by an increase in fixed assets due largely to new centers for reproductive health, and cardiac and pulmonary rehabilitation. In 1985, Wesley profits were about 5 percent. From 1986 to 1990, profits were negative. In 1993, Columbia/HCA began managing the hospital, and profits in 1993, 1994, and 1995 were 10–15 percent annually (compared to 1–2 percent at Wesley's two biggest competitors in Wichita). This excellent performance was due to an increase in Medicare revenues and a decrease in costs. Columbia/HCA managed to increase Medicare reimbursement by "unbundling" rehabilitation and nursing home services, a practice that may have contributed to Columbia's problems with the federal government. Costs also fell because of a 19 percent reduction in length of stay. There is no compelling evidence that the for-profit Columbia Wesley Medical Center provided fewer services to the poor than not-for-profit Wesley Medical Center.

The second conversion studied by Cutler and Horwitz is Columbia/HealthOne in Denver. The changes in ownership in this conversion are complex. In 1985, Presbyterian/St. Luke's sold its assets to for-profit AMI. Profits declined consequent to this conversion. The hospital reconverted to a not-for-profit in 1991 and merged with another not-for-profit to form HealthOne in 1993. Columbia/HCA and HealthOne formed a joint,

for-profit venture in 1993, Columbia-HealthOne. In 1996, Columbia-HealthOne profits were 7.2 percent, similar to other hospitals in Denver. There is some indication in the paper that Columbia improved profits by aggressively increasing revenues from the government (although some of these tactics may not have been legal), by shortening the length of hospital stays, and by cutting staffing and other costs.<sup>1</sup>

Sloan, Taylor, and Conover ask whether hospital conversions were a good bargain for the private purchasers. This ambitious paper calculated the return on investment and cost of capital for 10 hospital conversions in North Carolina and South Carolina. The profitability of conversions was estimated using a pooled time-series, cross-section regression with data from hospitals in Tennessee. The Tennessee data suggest that hospitals converting from not-for-profit to for-profit status had low profits both before and after conversion. Furthermore, profit margins did not improve much after conversion. Assuming that these Tennessee results also hold for North Carolina and South Carolina, the rate of return to conversions appears to be low. These researchers conclude that, contrary to the concerns expressed in the *American Prospect*, the acquiring organizations likely paid too much for their not-for-profit hospitals. From the Tennessee data, Sloan, Taylor, and Conover also conclude that conversion to for-profit status had no discernable effect on the provision of uncompensated care.

Put side-by-side, the Cutler and Horwitz report appears inconsistent with the findings of Sloan, Taylor, and Conover. The message I take away from Cutler and Horwitz is that of savvy Columbia/HCA acquiring not-for-profits and increasing their value by introducing new managerial practices. The additional profits, however, may be partly the result of transferring value from taxpayers to Columbia shareholders by a clever “gaming” of Medicare. In contrast, the message I take away from Sloan, Taylor, and Conover is that of witless for-profits purchasing poorly performing hospitals at inflated prices. The taxpayers, in other words, are taking the shareholders and their managers to the cleaners.

Can the results of these two studies be reconciled? Perhaps. It is possible that the profit regressions by Sloan, Taylor, and Conover understate the true effect of conversions on profits. Both common sense and the qualitative case studies reported in these papers indicate that it takes time for conversions to substantially influence hospital management. Unfortunately, the Tennessee data do not have a long time-series on most conversions. This problem is confounded by the specification in Sloan, Taylor, and Conover’s regressions. They use a single pre/post dummy variable to identify the effect of conversions. This specification averages early and

1. For a recent analysis of Columbia/HCA’s methods in securing Medicare revenues, see Eichenwald (1997).

later effects and may therefore lead to an underestimate of the true effect of conversions on profits.

One way around the problems posed by the short time-series in Tennessee would be to consider different scenarios about the likely long-term effect of conversion on profits. In making their purchase, investors must have had expectations regarding the level of profitability needed to make money on the new for-profit hospital. For example, most conversions involved hospitals with below-average profits. Would the conversions look like good investments if investors believed that their hospital would eventually attain average industry profit rates? We might learn more about these expectations if Sloan, Taylor, and Conover used their simulations to evaluate a variety of counterfactual assumptions about long-term profit performance. What is the most conservative set of assumptions about future profits required to make the conversion look like a good deal? Do these conservative profit assumptions entail reasonable or unreasonable expectations?

Sloan, Taylor, and Conover's profit estimates may also understate the true return on a conversion investment if the market value of the investment is not reflected in current profits. For example, of all the conversions these researchers studied, the Hilton Head conversion lost the most money, but as they note, Hilton Head was located next door to a large, yet-to-be built, retirement community. The prospective value of this locational advantage is not captured in the profit projections of Sloan, Taylor, and Conover, but it surely should play a role in determining the hospital's purchase price.

Another way to reconcile Cutler and Horwitz with Sloan, Taylor, and Conover is to argue that Columbia/HCA is not representative of the for-profit hospital industry. There is some support for this in Sloan, Taylor, and Conover's sample. The Columbia/HCA conversion involving Providence hospital was the only not-for-profit conversion in the North Carolina and South Carolina sample with a positive rate of return. If Columbia/HCA is special, we cannot at present tell whether it is because they are especially good at managing costs or especially good at gaming the reimbursement system. Either way, the hypothesis that Columbia/HCA performance is unique is worth further investigation.

If the conclusions drawn by Sloan, Taylor, and Conover are correct and for-profit hospitals do overpay for not-for-profits, we need to know why. One explanation might be a "winner's curse." This term describes a competitive environment in which the winning bidders are those that systematically overestimate the value of the assets they are purchasing. A closely related phenomenon of "self-serving biases" has been observed to take place in negotiations. Even experienced lawyers have a tendency to interpret the facts of a case in a light most favorable to their interests (Babcock et al. 1995). If hospitals do not learn to overcome the asymmetric infor-

mation and perceptual biases that sustain a “winner’s curse,” then we can anticipate that the market for not-for-profits will eventually disappear.

Alternatively, it may be that for-profit hospitals made bad purchases because those making the purchasing decisions were otherwise compensated for agreeing to the deal. Although this sort of private inurement is illegal, there is some scattered evidence that it does play a role in some hospital conversions (Kuttner 1996). For example, in Dickson, Tennessee, where Goodlark Hospital was sold in 1995, a local state representative was both the lawyer for Goodlark, a trustee of Goodlark, and the head of the new foundation created with the proceeds of the hospital’s sale (Kuttner 1996).

The opportunity for private inurement as well as the possibility of uncompensated transfers of wealth from public charities to private investors has caused some states to examine hospital conversions closely. In Massachusetts and California, for example, the public and the state attorneys general are very involved in overseeing hospital conversions. In other states, however, conversions take place with much less public scrutiny (Kuttner 1996). We might learn a good deal more about conversions by investigating how different regulatory environments influence the terms of the deals that emerge. In the process, we would also learn valuable lessons about the role that profits play in the delivery of health care services.

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