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Crossroads in Hospital Conversions — A Survey of Nonprofit Hospital Conversion Legislation

*Kevin F. Donohue**

INTRODUCTION

Since the turn of the century, nonprofit community hospitals have been the core of the American health care delivery system.¹ These hospitals, also known as voluntary hospitals, were originally established by religious societies and supported primarily through philanthropic donations.² Modern nonprofit hospitals are the recipients of substantial community investment in the form of charitable contributions, tax exemptions and volunteer time.³ Nonprofits provide the vast majority of teaching, research, education and technological development, as well as a disproportionately greater share of intensive care and neonatal units, burn centers and children's hospitals.⁴ Often, these services are provided despite their lack of profitability. In addition, nonprofit community hospitals provide the majority of care for their community's indigent population.⁵ The importance of the nonprofit community hospital to American culture is apparent

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1. See Vincenzo Stampono, Note, *Turning Patients into Profit: Nonprofit Hospital Conversions Spur Legislation*, 22 SETON HALL LEGIS. J. 627, 631 (1998).

2. See James J. Fishman, *Checkpoints on the Conversion Highway: Some Trouble Spots in the Conversion of Nonprofit Health Care Organizations to For-profit Status*, 23 IOWA J. CORP. L. 701, 704 (1998).

3. See Linda B. Miller, Robert A. Boisture & Thomas M. Barry, *State Attorneys General's Authority to Police the Sale and Conversion of Not-for-Profit Hospitals and HMO's: The Legal Basis for Oversight and Proposed Guidelines*, 1995 Charitable Trusts and Solicitations Seminar, Sept. 19, 1995, Williamsburg, VA, § 1, at 2.

4. See *id.* § 1, at 3-4.

5. See *id.* § 1, at 3-4.

from the various federal and state statutes providing tax-exempt status for these charitable organizations.⁶ Regulation of charitable entities can be traced to English common law and the Statute of Charitable Uses.⁷ Today, nonprofit entities are regulated by both state and federal government.

Until the early 1990s, the conversion of nonprofit hospitals to for-profit entities was rare.⁸ Since 1990, conversions have dramatically increased.⁹ Between 1990 and 1996, national surveys estimate that 192 of the more than 5,000 nonprofit hospitals in the United States converted to for-profit status.¹⁰ In the first six months of 1995, more than forty nonprofit hospital sales were announced (either in negotiation or by signed letters of intent) by Columbia/HCA alone.¹¹ That same year, forty-eight tax-exempt hospitals actually changed their status to tax-payers.¹² In 1996, more than sixty nonprofit hospitals converted.¹³

Conversions have been prompted by a combination of aggressive for-profit competition, industry-wide pressures to control costs and reduced Medicare payments.¹⁴ Most of these transactions have been carried out between boards and executives of the selling hospitals and representatives of the for-profit purchasers and were not routinely subject to public disclosure.¹⁵ Most of the hospital conversions from 1994 through 1996 were completed by three for-profit corporations: Columbia/HCA

6. See Stampone, *supra* note 1, at 633.

7. See *id.* at 632.

8. See David A. Hyman, *Hospital Conversions: Fact, Fantasy and Regulatory Follies*, 23 J. CORP. L. 741, 753 (1998).

9. See *id.* at 754.

10. See *Not-For-Profit Hospital Conversion Issues Prompt Increased State Oversight*, GAO/HEHS-98-24, Dec. 1997, at 1 (visited Jan. 6, 1998) <<http://www.gao.gov/whatsnew.htm>> [hereinafter "GAO Report"].

11. See Miller, *supra* note 3, § 1, at 1.

12. See Sandy Lutz, *1995: A Record Year For Hospital Deals*, MOD. HEALTHCARE, Dec. 18, 1995, at 43.

13. See GAO Report, *supra* note 10, at 5. See also Bruce Japsen, *Another Record Year For Deal Making: Activity Among Medium-Size Companies Fuels Continued Drive Toward Consolidation*, MOD. HEALTHCARE, Dec. 23, 1996, at 37.

14. See Natalie Seto, Kathy Collins & Bess Karger Weiskopf, *Protecting Health, Preserving Assets*, COMMUNITY CATALYST, Oct. 1997, at 1. See also Lawrence E. Singer, *The Conversion Conundrum: The State and Federal Response to Hospitals' Changes In Charitable Status*, 23 AM. J.L. & MED. 221, 225 (1997).

15. See *id.* at 5. See also GAO Report, *supra* note 10, at 5, 8.

Healthcare Corporation, Tenet Healthcare Corporation, and Quorum Health Group.¹⁶

Common types of conversions include: (1) conversions in place,¹⁷ (2) asset sales,¹⁸ (3) mergers and joint ventures,¹⁹ and (4) drop-down conversions.²⁰ Most nonprofit hospital conversions have been structured as asset sales.²¹ Recently, however, a number of conversions have been structured as joint ventures, which involve the contribution of nonprofit assets to a for-profit partnership in exchange for cash and ownership in the new venture.²² Many of the joint ventures require only a portion of the asset value to be paid at the time of conversion—often as little as fifty percent.²³ The balance of the asset value is held as an interest in the new for-profit venture, placing the charity's assets at risk for the economic benefit of the for-profit purchaser.²⁴ Despite their form, these transactions contain a common thread—nonprofit hospitals' assets are sold or transferred to facilitate the operation of for-profit enterprises.

Historically, conversion oversight was most often conducted by state offices of the attorney general pursuant to general common law authority to protect public assets.²⁵ The conversion mania of the early 1990s provoked a widespread movement to control and limit the sale of nonprofit health care assets.²⁶ Leg-

16. Between 1994 and 1996, Columbia reported 50 nonprofit hospital acquisitions, joint ventures and lease arrangements. Tenet reported 10 while Quorum reported 12. See GAO Report, *supra* note 10, at 7-8.

17. For the purposes of this article, conversion refers to the transformation of a nonprofit hospital assets to for-profit enterprises through the sale or transfer of ownership or control of charitable assets. For a concise description of these forms of conversion refer to Singer, *supra* note 14, at 232-34 and Fishman, *supra* note 2, at 714. For the purposes of our discussion, a conversion in place takes place when a nonprofit corporation amends its articles of incorporation to add for-profit powers and to delete nonprofit restrictions.

18. Asset sales occur when a nonprofit sells its charitable assets to a for-profit entity.

19. Mergers and joint ventures occur when the nonprofit, contributing charitable assets, either merges or enters into partnership with a for-profit entity.

20. Drop-down conversions occur when a nonprofit transfers some of its charitable assets to a for-profit subsidiary.

21. Asset sales result in the actual sale or transfer of the nonprofit hospital's assets, name and accounts to a for-profit purchaser for cash, stock, notes or other property. GAO Report, *supra* note 10, at 7-8.

22. See GAO Report, *supra* note 10, at 7. There are additional methods of conversion, including lease arrangements and corporate restructuring.

23. See Miller, *supra* note 3, at § 1, at 1.

24. See *id.*

25. See Singer, *supra* note 14, at 223.

26. See *id.*

islative action was spurred by the secrecy that surrounded conversion activity, the perception that the assets were routinely undervalued and the suggestion that these transactions often involved self-dealing.²⁷

More than two-thirds of the states have introduced legislation that would grant state attorneys general wide latitude in reviewing and approving proposed conversions of nonprofit health-related entities to for-profit operating systems.²⁸ However, some of this legislative initiative has been based more on political than practical agendas. The conversion "problem" has been at times more anecdotal than factual.²⁹ Fear of a change in the method of delivering health care has overshadowed current economic realities that render marginal nonprofit hospitals inviable. While the volume of conversions has diminished in the wake of multiple federal and state investigations launched against Columbia/HCA,³⁰ federal and state vigilance remains necessary to preserve nonprofit hospital assets and to safeguard the multi-million dollar foundations that emerge as a result of conversion activity. Notwithstanding the need for oversight, excessive regulation should not be implemented to thwart necessary market consolidations and continued health care reform.³¹

The critical issue is not the form of the American health care delivery system, but the quality and quantity of the health care delivered. Viewed in this light, nonprofits have had a legitimate and beneficial role in ensuring access to good, affordable health care. In recent years, managed care has exerted tremendous cost-cutting pressure on hospitals.³² Small independent hospitals are often at a disadvantage when negotiating managed care contracts.³³ This factor alone may render independent community hospitals obsolete.³⁴ Simultaneously, low interest rates and restrictions on the use of tax-exempt bond issues limit the ability

27. See Phillip P. Bisesi, Comment, *Conversion of Nonprofit Health Care Entities to For-Profit Status*, 26 CAP. U. L. REV. 805, 820 (1997).

28. Since 1997, 90 bills covering conversions of hospitals, health plans and health maintenance organizations have been introduced in 34 states. See D. Ward Pimley, *Hospital Conversions: States Slow Pace Adopting Conversion Laws, But AGs Diligently Guard Charitable Trusts*, HEALTH L. REP. (BNA), Aug. 13, 1998, at 1279.

29. See generally, Hyman, *supra* note 8. Compare generally the observations in the GAO Report, *supra* note 10, to those contained in Miller, *supra* note 3.

30. See Pimley, *supra* note 28, at 1279.

31. See Bisesi, *supra* note 27, at 806.

32. See *id.* at 820.

33. See Stampone, *supra* note 1, at 644.

34. See *id.*

of nonprofit hospitals to raise needed capital.³⁵ Conversely, for-profit entities have relative ease in accessing private and public equity markets to raise capital for facility replacement and expansion.³⁶

The practical economic handicaps facing nonprofit hospitals often leave hospital closure as the only alternative to a nonprofit's conversion to for-profit status. Consumer groups rarely adequately consider this economic reality. Closure would almost certainly reduce the market value of the charitable assets and completely eliminate access to the very care that is asserted as a primary focus of consumer groups. Rather than focusing on the prohibition of conversions, it is more critical to ensure continued access to quality health care services in the local community and to provide for adequate regulation and monitoring of post-transaction activities. Appropriate restrictions on the subsequent use of conversion proceeds will guard against a much greater squandering of charitable assets.

If the economic pressure being exerted on nonprofit hospitals by the combination of health care reform and managed care cost-cutting is acknowledged, the issue becomes not how to impede conversions but rather how to maximize public benefit. State and federal controls need to concentrate on two major components of the conversion process: (1) ensuring that fair value is paid for charitable assets, and (2) establishing an ongoing and effective system to regulate and monitor the subsequent use of the conversion proceeds.

While there is always a possibility for abuse by "insiders"³⁷ related to price negotiations, there is little empirical data to seriously suggest that directors of nonprofit hospitals do not attempt to determine an appropriate sales price, which is the

35. Following the Tax Reform Act of 1986, a nonprofit hospital's ability to raise capital for future endeavors was severely restricted. This Act reduced the amount of a tax-exempt bond issuance that a nonprofit hospital could allocate to non-exempt business operations, such as the building of medical office buildings, from 25% to 5%. See I.R.C. § 145(a) (1998). See also Singer, *supra* note 14, at 227; Fishman *supra* note 2, at 713.

36. See Fishman, *supra* note 2, at 712-13.

37. Insiders are persons whose relationship with a nonprofit entity allows them the opportunity to make use of the charitable organization's income or assets for personal gain or benefit. Within the nonprofit hospital setting, these individuals typically include officers, directors, board members and, under certain circumstances, physicians on the medical staff. An insiders' receipt of prohibited "benefits" is known as private inurement. Private inurement is strictly prohibited and disqualifies an organization from tax-exempt status. See I.R.C. § 501(C)(3). See also 1980 G.C.M. 38,459 (July 31, 1980); Treas. Reg. § 1.501(c)(3)-1(c)(2).

result of many subjective considerations.³⁸ At times, a lower sales price may be legitimate in exchange for contractual commitments from the purchaser to provide certain minimal levels of health care to the indigent, above those mandated by existing state or federal law.³⁹

The Association of Attorneys General, as well as a number of prominent consumer groups, has developed model conversion codes and checklists for states to use as guidelines when considering specific legislative enactments.⁴⁰ The most detailed and specific, the Model Code developed by the Association of Attorneys General,⁴¹ will be considered.

This article will begin its analysis in Section I by discussing the historical and current status of conversion activity. Foundations resulting from conversion activity will also be reviewed. Section II will analyze and critique the National Association of Attorneys General's ("NAAG") Model Conversion Code. Thereafter, Section II will survey the seventeen states, and the District of Columbia, that have enacted legislation relating to the sale of nonprofit hospital assets.⁴² The survey will endeavor to collate the similarities, note the disparities and question the statutory omissions. Where appropriate, a short comment and comparison will be made between the Model Code and the trends that have developed in the state enactments.

Although there are many approaches to analyzing model codes and state-specific legislation, Section II will focus on the preservation of charitable assets and the public's interest in continued access to affordable health care services, by addressing six issues: (1) the scope of the statutes to determine the specific transactions covered; (2) notice requirements—for those statutes that require governmental approval, time limitations and public hearing requirements will be considered; (3) the provisions relating to valuation of the nonprofit's assets; (4) community impact assessments and access-to-care provisions; (5)

38. See GAO Report, *supra* note 10, at 11-14.

39. This group includes the working poor who lack or have inadequate health insurance and do not qualify for Medicare or Medicaid coverage benefits.

40. See Seto, *supra* note 14, at 56. The National Association of Attorneys General submitted a draft model act with commentary at the NAAG Summer Meeting in Durango, Colorado, July 11-16, 1998. See Miller, *supra* note 3, at § 4.

41. See *id.*

42. This article will discuss the District of Columbia legislation as though it were a sovereign state because the preservation of charitable assets and access-to-care issues are identical.

enforcement and monitoring provisions; and (6) restrictions on the subsequent use and disposition of the conversion proceeds.

Section III will briefly discuss federal avenues of oversight available to protect nonprofit assets. Section IV will conclude with a recommended course of action to implement adequate safeguards to insure that the nonprofit hospital's assets are maximized and that the subsequent use of conversion proceeds continues to fulfill the original charitable mission of the nonprofit hospital.

I. THE HISTORICAL AND CURRENT STATUS OF CONVERSION ACTIVITY

In order to fully understand the development of conversion legislation, a short overview of states' pre-existing authority to protect charitable assets is warranted. Common law authority to protect charitable assets stems primarily from two charitable trust law doctrines: *parens patriae*⁴³ and *cy pres*.⁴⁴ State statutory authority is established through the enactment of nonprofit corporation legislation.

A. Charitable Trust Law

Parens patriae refers to "the power of the state to protect the public's interest in assets pledged to public purposes."⁴⁵ It authorizes the state attorney general to bring suit to enforce charitable trusts and protect charitable assets from misapplication.⁴⁶ The common law concept of *parens patriae* also provides attorneys general with the authority to oversee charities as the representative of the public.⁴⁷ While attorneys general cannot prohibit a nonprofit hospital from converting to for-profit status, they can regulate the transaction to insure that limitations on

43. This doctrine literally means "parent of the country" and traditionally refers "to the role of the state as sovereign and guardian of persons under legal disability. It is the concept utilized to protect quasi-sovereign interests such as health, comfort and the welfare of the people, interstate water rights and general economy of the state." BLACK'S LAW DICTIONARY, 1003 (5th ed., 1979).

44. The translation of this term is "as near as [possible]." It refers to a "rule for the construction of instruments in equity, by which the intention of the parties is carried out as near as may be, when it would be impossible or illegal to give it a literal effect." BLACK'S LAW DICTIONARY, 349 (5th ed., 1979).

45. See Shannon McGhee Hernandez, *Conversions of Nonprofit Hospitals to For-Profit Status: The Tennessee Experience*, 28 U. MEM. L. REV. 1077, 1096-00 (1998).

46. See *id.* See also RESTATEMENT (SECOND) TRUSTS § 391, at 279 (1959).

47. See Bisesi, *supra* note 27, at 813.

the disposal of charitable assets are respected.⁴⁸ Attorneys general do not have the inherent authority to prohibit either the sale of charitable assets or the dissolution of a charitable trust.⁴⁹ Charitable trust law, however, does limit the alternative uses of “converted” charitable assets.⁵⁰

While charitable corporations such as nonprofit hospitals are not the equivalent of a charitable trust,⁵¹ the assets of a charitable corporation are typically impressed with a charitable trust limiting the disposition of the charitable assets.⁵² Thus, while a hospital may be authorized to sell its assets, the use of the sales proceeds is normally limited by the nonprofit’s bylaws and mission statements.⁵³ While courts usually grant nonprofit directors broad discretion in managing day-to-day operations, this deference is not extended to fundamental changes in the nonprofit corporation’s purpose or mission.⁵⁴

48. *See id.*

49. *See Singer, supra* note 14, at 238.

50. *See Hernandez, supra* note 46, at 1096.

51. A charitable trust is “a fiduciary relationship with respect to property arising as a result of a manifestation of an intention to create it, and subjecting the person by whom the property is held to equitable duties to deal with the property for a charitable purpose.” RESTATEMENT SECOND OF TRUSTS § 348 (1959). *See Bisesi, supra* note 27, at 807-808. A nonprofit corporation is created by state nonprofit statutory authority and governed by its articles of incorporation and by-laws. *See id.*, at 808. Although trusts are governed by common law and statutory rules for trusts, the rules applicable to nonprofit corporations and trusts are similar. *See id.* To the extent a nonprofit corporation desires to qualify for federal tax-exempt status, it must be organized and operated exclusively for charitable purposes. *See supra* note 37.

52. *See Miller, supra* note 3, § 2, at 6. A California case has explained that “the assets of a corporation organized solely for charitable purposes must be deemed to be impressed with a charitable trust by virtue of the express declaration of the corporation’s purposes, and notwithstanding the absence of any express declaration by those who contribute such assets as to the purpose for which the contributions are made.” *Queen of Angels v. Younger*, 66 Cal. App. 3rd 359, 364 (1977). *See also Taylor Baldwin*, 247 S.W.2d 741, 750 (Mo. 1952); *Miller, supra* note 3, § 2, at 9. The California Appellate Court went on to explain that the Queen of Angels Hospital had represented itself to donors, the public and state and federal tax authorities as a hospital, and that its attempt to lease its facilities to another organization constituted the abandonment of its charitable purposes and thereby violated the trust imposed on its assets. *See* 66 Cal. App. 3d at 364.

53. *See Miller, supra* note 3, § 2, at 6, and see also cases cited therein. *See generally, Attorney General v. Hahnemann Hospital*, 494 N.E.2d 1018 (Mass. 1985).

54. *See Miller, supra* note 3, § 2, at 2-3. While nonprofit directors are entitled to the protection of the business judgment rule, whereby the courts will not second guess the objective reasonableness of the director’s decision, this rule will only be applied where the directors can demonstrate that they have met the appropriate process requirements imposed by the duty of care, such as obtaining the assistance of competent experts and considering all competing offers. *See Smith v. Van Gorkom*, 488 A.2d 859, 873 (Del. 1985). *See also Paramount v. QVC*, 637 A.2d 34 (Del. 1993).

The doctrine of *cy pres*, which literally means “as nearly as possible,” requires a trustee to secure court authorization to deviate from the original trust purpose.⁵⁵ Under the doctrine of *cy pres*, a nonprofit charitable corporation is required to obtain court approval before proceeding with any fundamental change in its corporate purpose or mission.⁵⁶ Traditionally, before a nonprofit corporation will be granted authority to alter its original corporate mission, a court must find that the original mission of the nonprofit or the intent of the donor is impossible, impractical or illegal to carry out.⁵⁷ The attorney general’s historic duty to supervise, enforce and protect the public interest in charitable trusts automatically renders him a party to any *cy pres* proceeding.⁵⁸ Although the states do not apply the *cy pres* doctrine uniformly,⁵⁹ a strict application would curtail most nonprofit hospital conversions, because conversion proceeds are not typically dedicated to the organization’s original purpose—inpatient hospital services.⁶⁰

Arguably, the common law charitable trust doctrine⁶¹ and the requirement of *cy pres* together normally would require that foundations created through the sale of charitable assets adopt a mission statement closely related to the nonprofit’s original mission statement.⁶² Historically, courts took a strict view relating to the use of charitable assets and required the trustee to establish: (1) that it was impossible or at least impractical to accomplish the stated purpose of the trust, and (2) that the proposed

55. See Hernandez, *supra* note 45, at 1096.

56. See Miller, *supra* note 3, § 2, at 2. *Cy pres* is an equitable doctrine under which courts may authorize trustees to use charitable assets in a way different, but as near as possible, from that intended by the donor, if the donor’s intended use has become impossible or impractical. See *id.*, § 2 at 5. See also RESTATEMENT (SECOND) OF TRUSTS § 399 (1959); FISHMAN, *supra* note 2, at 716; Hernandez, *supra* note 45, at 1096; Naomi Ono, *Boards of Directors under Fire: an Examination of Nonprofit Board Duties in the Health Care Environment*, 7 ANNALS HEALTH L. 107, 130-33 (1998).

57. Bisesi, *supra* note 31, at 810. Some states also recognize the doctrine of deviation, which is similar to *cy pres* but has less stringent standards. This doctrine allows a charitable entity a restriction on its charitable assets if the restriction would defeat the intended charitable purpose of the gift. See *id.*

58. See *Brown v. Memorial National Home Foundation*, 329 P.2d 118, 132 (Cal. Ct. App. 1958); See also Miller, *supra* note 3, § 2, at 3, 15.

59. See generally *id.*

60. See Hernandez, *supra* note 45, at 1097.

61. The charitable trust doctrine creates a strict fiduciary requirement that converted charitable assets continue to serve the stated mission of the charity. See RESTATEMENT (SECOND) OF TRUSTS § 372 (1959). See also Hernandez, *supra* note 45, at 1096; Ono, *supra* note 56, at 131.

62. See Laurie Larson, *How Does Your Foundation Grow?*, 51 TRUSTEE 11, 12.

alternative use of the trust assets came as close as possible to the original intent of the donor. More recently, a growing number of states have not strictly or uniformly enforced this principle as it applies to the subsequent disposition of hospital conversion proceeds.⁶³

B. Legislative Authorization for Nonprofit Corporations

In more recent times, state nonprofit corporate law enactments⁶⁴ have generally eased the restrictions relating to a nonprofit corporation's dedication of its charitable assets upon dissolution.⁶⁵ The Revised Model Nonprofit Corporations Act simply requires that a nonprofit corporation, upon dissolution, distribute its assets in accordance with its articles of incorporation or by-laws.⁶⁶ In addition, most state nonprofit statutory authority does not require the nonprofit entity to report to the attorney general or secure court approval before distributing its assets to another charitable organization.⁶⁷ To the extent that a nonprofit hospital is established under a state's nonprofit corporate code, general prohibitions on conflicts of interest and legislative restrictions on the disposal of assets on dissolution would provide limited authority to oversee hospital conversions.⁶⁸

Attorneys general, in recent years, have become increasingly more aggressive in protecting charitable assets, even without specific statutory authority. This increased oversight is justified, because the sale of a nonprofit hospital's assets results in a fundamental change in the hospital's corporate purpose and mission. However, such initiatives taken by attorneys general may

63. See Hernandez, *supra* note 45, at 1096 (citing Thomas Silk, *Conversions of Tax-Exempt Nonprofit Organizations: Federal Tax Law and State Charitable Law Issues*, 13 TAX-EXEMPT ORG. TAX REV. 745, 746 (1998) (predicting a judicial softening of the doctrine of *cy pres*)). See generally Bisesi, *supra* note 27, at 837.

64. "The Revised Model Code Nonprofit Corporations Act ("RMNCA") essentially defines a public benefit corporation to mean the same entity as a charitable organization under section 501(c)(3) of the Internal Revenue Code." Bisesi, *supra* note 27, at 810 (citing RMNCA §§ 1.40(28), 17.07(3) and (4) (1987)). Most states exempt charitable entities that qualify for federal tax-exemption from income, real property and sales taxation. See *id.* at 811.

65. See Hernandez, *supra* note 45, at 1097.

66. See *id.* See also RMNCA § 14.069(a)(5) (1987). The revised act eased the restrictions found in the original model act, which required that the asset of a charitable corporation, upon dissolution, be transferred to an entity engaged in substantially similar activities. See *id.* at § 46.

67. See Bisesi, *supra* note 27, at 810.

68. See GAO Report, *supra* note 10, at 23. The assets of nonprofit corporations are often viewed as being held in public trusts.

have lulled some states into a false sense of security that specific legislative action is unnecessary.⁶⁹

Conversion legislation is still needed, because the application of common law doctrines and nonprofit legislation can result in significant disparities in the discretion afforded the nonprofit hospital in the subsequent disposition of conversion proceeds. Strict application of *cy pres* would limit the use of conversion proceeds to inpatient hospital services. Liberal nonprofit legislation would allow conversion proceeds to be utilized for any activity authorized by the nonprofit hospital's articles of incorporation or by-laws. Conversion legislation is necessary to ensure that the proceeds resulting from the sale of nonprofit hospital assets are either distributed to other charities with substantially similar missions or used for the provision of health care in the affected community.

C. Foundation Activity

The majority of conversion transactions result in the creation of foundations to receive and administer conversion proceeds. Since 1973, eighty-one conversion foundations⁷⁰ have been created with assets totaling \$9.3 billion.⁷¹ Net proceeds reported from the fourteen conversions reviewed by the GAO totaled \$930 million.⁷² Twelve of those non-profit hospitals directed their sales proceeds to charitable foundations that adopted broadly defined missions primarily focusing on health and wellness.⁷³ The for-profit hospital or joint venture boards that result from conversions are typically responsible for monitoring and ensuring compliance with transaction obligations.⁷⁴

Despite the enormous shifting of charitable assets, there is little in the way of legal precedent for these transactions.⁷⁵ Indi-

69. See Pimley, *supra* note 28, at 1280.

70. Foundations can be public or private charities. Private charitable foundations must place their capital in endowments and invest the principal. Private foundations must pay annual excise taxes on their net investments and must issue grants minimally amounting to five percent of their calculated total assets. See I.R.C. §§ 4940-45. Private charitable foundations must raise a certain percentage of their money from public donations and demonstrate that they are serving community needs. See *id.*

71. More than half of these have been created in the last three years. See Larson, *supra* note 62, at 12.

72. See GAO Report, *supra* note 10, at 5. See also Miller, *supra* note 3, § 1, at 1 (concluding that most hospital conversions result in the creation of foundations).

73. See GAO Report, *supra* note 10, at 5.

74. See *id.*

75. See Miller, *supra* note 3, § 1, at 2.

viduals attempting to develop appropriate structure, board composition, or missions for newly created foundations often find no regulatory guidance.⁷⁶ Use of charitable assets is typically defined by the mission the foundation adopts, which often is not required to have a limited focus.⁷⁷ Foundation governance differs from hospital governance in that it requires a more hands-on approach in determining adherence to its mission and gauging the continued health needs of the community.⁷⁸ Foundation boards do not routinely seek, through public forums or needs assessments, community input relating to the subsequent use of conversion funds.⁷⁹ Community input was obtained in only six of the fourteen conversions studied by the GAO.⁸⁰

According to the GAO Report, most foundations focused on health and wellness, but funding for non-health related activities including education, public safety, arts and religious activities, was also provided.⁸¹ Conversion proceeds have been used for non-health related projects such as: building schools, supporting an aerospace program, and financing arts, education and technology centers.⁸² The sale of the Tennessee hospital, Goodlark Regional Medical Center, is illustrative. That sale resulted in the creation of the Jackson Foundation, whose proceeds were used, in part, to fund an aerospace program and a technology center fostering programs in math and science.⁸³ Foundation funds from another Tennessee conversion purchased airplanes so that students at the local school could take flying lessons.⁸⁴

Some foundation boards oppose using foundation money to fund acute medical care. Rather, they argue foundation grants should take the long view, and concentrate on programs such as primary care education, disease prevention, public health and health policy, and research. They argue that continued indigent care and medical education costs should be part of the negotiated responsibility of the for-profit purchaser, or else the foundations will simply be funneling the purchase price back to the purchaser.⁸⁵

76. *See id.*

77. *See* GAO Report, *supra* note 10, at 18.

78. *See* Larson, *supra* note 62, at 12.

79. *See* GAO Report, *supra* note 10, at 5.

80. *See id.*

81. *See id.* at 18.

82. *See id.* at 5, 18-20.

83. *See id.* at 19-21.

84. *See* Seto, *supra* note 14, at 13.

85. *See generally* Larson, *supra* note 62, at 12.

This position, however, ignores the original basis for extending tax-exempt status to the converting hospital—the provision of acute inpatient health care to the local community, including its indigent population. Taking into account the basis of tax-exemption, the more persuasive view is that conversion proceeds belong to the affected community in which the assets were generated and that foundation grant activity should be restricted to the alleviation of acute sickness and disease in the local community. Ambitious goals that extend beyond the community, such as fostering appropriate national health policies and formulating general education programs, are akin to lobbying and should not be funded with conversion proceeds.⁸⁶

Recognizing these conflicting philosophies, a number of state conversion enactments declare that nonprofit health facilities, including nonprofit hospitals, hold their assets in trust for the public, and that those assets are irrevocably dedicated, as a condition of their tax-exempt status, to the specific charitable purposes set forth in the nonprofit's articles of incorporation.⁸⁷ Only thorough regulation and continuous monitoring will provide consistency to the administration and preservation of conversion proceeds. With proper oversight, the public can be assured that foundation grant-making activities serve the ongoing health care needs of the affected community.

II. ANALYSIS OF NAAG'S MODEL CONVERSION ACT AND CURRENT STATE ENACTMENTS

A. NAAG's Model Conversion Act

The National Association of Attorneys General (“NAAG”) issued draft model legislation on March 31, 1998, outlining a suggested statutory framework to regulate conversion activities of nonprofit hospitals.⁸⁸ This legislation is intended to protect the public's interest in the charitable assets of nonprofit hospitals by rigorously enforcing charitable trust laws.⁸⁹ The NAAG's Model Act is the most comprehensive model legislation. It seems to represent a consensus among the country's attorneys

86. See generally *id.* A tax-exempt corporation is prohibited from engaging in lobbying activities. See I.R.C. § 501(c)(a)(3).

87. See CAL. CORP. CODE § 5913 (West 1998) (historical notes referring to § 1 of Stats. 1996, c. 1105 (A.B. 3101)); D.C. CODE ANN. § 32-551(1)-(7) (1981); LA. REV. STAT. ANN. § 2115.11 (West 1998); WASH. REV. CODE. § 70.45.010 (1998).

88. See *Model Guidelines: NAAG Issues Model Conversion Guidelines Requiring Notification, Approval of State AGs*, HEALTH L. REP. (BNA), Apr. 9, 1998, at 585.

89. See *id.*

general, pursuant to their *parens patriae* authority,⁹⁰ as to the issues that the states consider important in the conversion of nonprofit hospitals. The legislation is designed to provide sufficient flexibility so that it can be adapted to each state's unique trust laws.⁹¹ The Executive Director and General Counsel of NAAG, Christine T. Milliken, explained that the primary goal of the Model Act is to insure that health care transactions are open to public comment and scrutiny.⁹²

1. Scope

The Model Act defines a nonprofit health care conversion transaction as:

the sale, transfer, lease, exchange, optioning, conveyance, or other disposition of a material amount of a nonprofit health care entity's assets or operations to a for-profit corporation, mutual benefit corporation or other person; and (2) the transfer of control or governance of a material amount of a nonprofit health care entity's assets or operations to a for-profit corporation, mutual benefit corporation or other person.⁹³

This language is designed to be all-inclusive. Considering the developing trend to accomplish conversions by utilizing a partnership or joint venture format, the expansive definition is warranted. Despite its broad scope, the Act contains a significant omission—the lack of a concise quantitative definition of a “material amount.” Although transactions involving fifty percent or more of a nonprofit's assets would undoubtedly fall within the parameters of this provision, an open issue remains—whether the initial threshold for statutory disclosure and compliance begins with transactions involving twenty, thirty or forty percent of a nonprofit hospital's assets. This provision also fails to consider the effect of multiple transactions involving related parties over a short period of time.

90. For the definition of this term see *supra* note 43.

91. See *Model Guidelines*, *supra* note 88, at 585.

92. See Christine T. Milliken, Comments on Model Healthcare Conversion, NAAG, Mar. 31, 1998. Ms. Milliken also noted, “The general principal behind charitable trust laws is that such trusts are not private business entities, and that the public, therefore, has a greater interest in how those trusts are treated because of its investment in them and its reliance on their services.” *Id.*

93. See PROPOSED MODEL ACT FOR NONPROFIT HEALTHCARE CONVERSION TRANSACTIONS, NAAG, Mar. 31, 1996, at § 1.02 (“NAAG MODEL ACT”). A person includes any individual, partnership, trust, estate, corporation, association, joint venture, joint stock company, insurance company, or other organization. See *id.* at § 1.04.

A better approach would require disclosure and approval when the nature of governance at the nonprofit institution is affected. This threshold occurs at levels significantly below a fifty percent change in ownership or control. Reporting requirements should be activated: (1) when a transaction involves the sale of twenty percent or more of a nonprofit's assets; (2) at any amount if the asset sale will change the nature of the services historically provided by the nonprofit entity; or (3) when the community's representation on the nonprofit's hospital board is diluted. Additionally, multiple transactions occurring within a five-year period between related parties should be evaluated collectively to determine if the aggregate purchases amount to a twenty percent change in ownership or control or change the nature of services historically provided by the nonprofit entity.

2. Notice, Public Disclosure and Approval

(a) Notice

The Model Act requires that the nonprofit hospitals provide written notice to, and obtain the approval of, the attorney general prior to entering into any nonprofit health care conversion transaction.⁹⁴ Notice must include all information that the attorney general determines is required.⁹⁵ Within sixty days of a completed written notice, the attorney general is required to notify the nonprofit health care entity in writing of its decision to approve or disapprove the proposed transaction.⁹⁶ The attorney general may extend the period an additional ninety days to obtain necessary information to complete his review, contract with consultants or receive advice from federal or any other state agency.⁹⁷ The failure to "provide timely information" requested by the attorney general is sufficient grounds to disapprove a conversion transaction.⁹⁸ All documents submitted to the attorney general in connection with the proposed nonprofit health care conversion are deemed public records.⁹⁹

94. See *id.* at § 2.01. This section provides for alternative notice to the appropriate court on the advice of the attorney general in mandatory *cy pres* proceeding states.

95. See *id.*

96. See *id.* at §§ 3.01, 6.02 and 7.01.

97. See *id.*

98. See *id.* at § 6.02

99. See *id.* at § 8.01. This section includes language to safeguard trade secrets or other commercially competitive information. Some commentators claim that public participation and disclosure in the sales transaction could be detrimental to the value of the selling hospital or result in disclosure of trade secrets. See also GAO Report, *supra* note 10, at 18. However, research reveals no hard data to support this concern.

While the mechanics of the notice requirement are adequate to provide the parties with an expected review timetable, the Model Act does not enumerate the specific documentation that is to be included in the notice submission. Rather the Act provides the attorney general with discretion to determine "required" documentation. Although the Model Act authorizes the attorney general to adopt regulations or to establish protocols, it does not require him to do so.¹⁰⁰ If conversion legislation fails to enumerate the documentation necessary to complete the notice requirement, the attorney general should be required, prior to enforcement, to develop and publish detailed regulations itemizing the expected submissions. A more expedient approach would be to enumerate the usual and customary documentation that is expected of the parties while allowing for supplemental document requests based on the particular conversion application. Standardization will provide a framework for evaluating competitive bidding and will reduce the likelihood of due process challenges stemming from inconsistent enforcement.

Despite the discretion granted the attorney general in approving conversion transactions, another shortcoming of the Model Act is its failure to require the parties to include specific provisions in the transaction documents detailing: (1) the minimum level of continued health care services that the purchaser will provide to the affected community and (2) the intended use of the conversion proceeds by the seller. The statute should prohibit deviation from these representations absent court approval.

More flexibility could be added to the approval process if the attorney general were authorized to extend conditional approval. Conditional approval authority would provide the attorney general with sufficient leverage to "rewrite" limited aspects of the conversion transaction to ensure that fair value is paid for the charitable assets and that an effective system to regulate and monitor the subsequent use of conversion proceeds has been established.

To the extent that trade secrets are a concern, public notice of sale and solicitations for bidding could be commenced without disclosure of trade secrets. Thereafter, once appropriate confidentiality agreements are executed, limited disclosure of confidential or sensitive information could be disclosed to only the most serious bidders.

100. See NAAG MODEL ACT § 6.01.

(b) *Public Disclosure*

The Model Act requires, prior to issuance of a written decision, that the attorney general publish written notice and conduct at least one public meeting in the county where the nonprofit entity is located.¹⁰¹ The purpose of the hearing is to solicit comments from interested persons desiring to make statements concerning the proposed conversion.¹⁰² Requiring publication only fourteen days prior to the public hearing has two shortcomings: (1) it provides insufficient time for community groups and other interested persons to become familiar with the details of the proposed transaction or to seek alternative solutions to the sale of charitable assets; and (2) it does not require the nonprofit hospital or the acquiring entity to provide public notice of the intent to enter into a conversion transaction.

Additionally, the Model Act fails to state the purpose for soliciting public comment. There is no requirement that the transacting parties respond to legitimate public inquiry. Nor does the statute explain how public sentiment is to be factored into the approval process. Conversion legislation should require an explicit response to legitimate community concerns relating to the valuation of charitable assets and the continued access to affordable health care. The use of conditional approval authority would be an excellent method for an attorney general to convert community input into mandatory conversion commitments.

(c) *Approval*

The Model Act provides an outline for the attorney general to use when determining whether a proposed transaction should be approved. The attorney general must consider: (1) whether the proposed transaction will result in a breach of fiduciary duty, including conflicts of interest; (2) whether the transaction will result in private inurement; (3) whether the nonprofit health care entity will receive full and fair market value for its charitable and social welfare assets or whether the value has been manipulated by parties to the transaction; (4) whether the proceeds of the proposed transaction will be used in a manner consistent with the trust under which the assets are held and will be independent of the control of the acquiror or its related entities; (5) whether sufficient information has been provided, upon rea-

101. *See id.* at § 4.01.

102. *See id.*

sonable request, to evaluate the transaction and its effects on the public; (6) whether the health care entity exercised due diligence in disposing of nonprofit health care assets, in selecting the acquiring entity and in negotiating the terms and conditions of the conversion; (7) whether the terms of any management or services contracts negotiated in conjunction with the proposed transaction are reasonable; and (8) whether any foundation established to hold the proceeds of the sale will be broadly based in and representative of the affected community.¹⁰³

These criteria cover the basic issues likely to arise when considering the propriety of a nonprofit hospital's request to dispose of charitable assets. Authorization to seek the advice of other state and federal agencies allows the attorney general to utilize existing governmental expertise without duplicating expenses. It fosters a multi-disciplinary approach to evaluating conversion proposals by allowing state charitable law and health care issues to be considered in tandem with federal tax-exempt requirements and prohibitions.¹⁰⁴ If these review elements are thoroughly explored with the transacting parties, they are sufficient to insure that a fair price is received for charitable assets.

However, general criteria, such as requiring foundations to be broadly based in the community, are insufficient to safeguard foundation assets. Conversion legislation should limit the parties' post-transaction representation on newly created foundation boards to twenty percent. Statutory safeguards restricting and monitoring the use of the conversions funds should also be included in all legislation. Grant-making activities should be limited to the ongoing health care needs of the affected community. Before a conversion is approved, the foundation should be required to establish an effective ongoing system to regulate, monitor and disclose potential conflicts of interest. The attorney general's review must include a verification that the foundation has adopted a mission statement comparable to the mission of the converting hospital.

3. Valuation

The Model Act mandates that the attorney general consider whether the nonprofit health care entity is receiving full and fair

103. *See id.* at § 5.01(1)-(10).

104. A discussion of relevant tax-exempt requirements and prohibitions can be found in Section IV(B), Federal Tax Consideration.

market value¹⁰⁵ for its charitable assets.¹⁰⁶ To assist in making this determination, the attorney general may, within the time period designated, contract with, consult, and receive advice from any agency of the state or federal government.¹⁰⁷ It also retains the sole discretion to contract with appropriate experts or consultants to review the proposed conversion transaction.¹⁰⁸ The attorney general is entitled to reimbursement from the nonprofit entity for all reasonable and actual costs incurred in reviewing a proposed conversion transaction, including attorney fees at the attorney general's billing rate for state agencies.¹⁰⁹ The nonprofit's failure to promptly reimburse the attorney general for all costs incurred in the review of the proposed transaction is sufficient grounds to disapprove the conversion.¹¹⁰

Pursuant to the attorney general's authority to adopt regulations facilitating the conversion review, a standard document submission list and review protocol should be implemented prior to enforcing conversion legislation. Determinations of fair value would be significantly more accurate if the parties to the transaction were required to disclose: (1) all contract documents, including schedules and warranties; (2) promises or discussions of future employment or consulting agreements; and (3) any limitations relating to the board of any subsequently created foundation or to representation of the parties, or their affiliates thereon.

If the for-profit purchaser is permitted to acquire substantial, but not necessarily majority, representation on the board of a newly created foundation, then the true value of transaction commitments can be jeopardized. There is an inherent conflict of interest between a for-profit's desire to maximize profit and a charitable foundation's mission to serve the health care needs of the community. Although post-transaction enforcement by the

105. The IRS and valuation consultants cite the income, market, and cost approaches as generally accepted methods for valuing hospital assets. See GAO Report, *supra* note 10, at 9.

106. See NAAG MODEL ACT § 5.01(3).

107. See *id.* at § 7.01(1).

108. See *id.* at § 7.01(2). Expert or consultant costs incurred are the responsibility of the nonprofit health care entity providing notice pursuant to this statute. See *id.* at § 7.02. This section further provides that the attorney general shall be exempt from statutory bidding procedures, but costs incurred pursuant to this section shall not exceed an amount that is reasonable and necessary to conduct the review. In theory this section would allow a nonprofit entity to challenge costs incurred by the attorney general to the extent that they exceed what would be considered fair and reasonable.

109. See *id.* at § 7.03.

110. See *id.* at § 7.04.

foundation is always problematic, maintaining foundation independence is the only viable method to remove the influences of the surviving for-profit entity so that vigorous enforcement of transaction obligations is at least possible.

It is important to note that attorney general review does not result in an affirmative finding that fair market value has been received. Assuming, however, that the transacting parties provide full and fair disclosure of the transaction to the attorney general, the parties should have a measure of confidence that a post-acquisition review or claim of excess benefit will not ensue.

4. Community Impact Assessments and Access to Care Provisions

The Model Act's primary provisions neither include nor recommend that states adopt health impact considerations as part of the conversion approval process. Rather, the Model Act provides an optional section for those states "who deem it appropriate" to consider health impact issues as part of their conversion review process.¹¹¹ The optional provisions direct the attorney general to determine whether the proposed conversion transaction may have a significant effect on the availability or accessibility of health care services to the affected community.¹¹² The attorney general is to consider: (1) whether sufficient safeguards have been included in the conversion documents to ensure the community has continued access to affordable care;¹¹³ (2) whether the transaction is likely to have an adverse effect on the access, availability or cost of health care services in the community;¹¹⁴ (3) whether health care providers have been offered an opportunity to invest in the acquiring entity;¹¹⁵ and (4) whether the acquiring entity has made a commitment at least comparable to the nonprofit entity to provide health care to the disadvantaged, uninsured and underinsured, as well as providing benefits to the community to promote health care.¹¹⁶

Optional provisions are inherently problematic. The term "optional" suggests that these considerations are unnecessary or less important. However, from the public's perspective, affordability and access to health care are of primary importance.

111. *See id.* at § 5.02.

112. *See* NAAG MODEL ACT § 5.02.

113. *See id.* at § 5.02(1).

114. *See id.* at § 5.02(2).

115. *See id.* at § 5.02(3).

116. *See id.* at § 5.02(4).

An additional shortcoming is that the Model Act authorizes the attorney general to consider the health care activities and funding of the nonprofit entity or its successor foundation, including medical education, research and teaching programs, when evaluating the for-profit purchaser's compliance with community health care commitments.¹¹⁷ This provision is fraught with danger and potential abuse. At best, it blurs the purchaser's independent responsibility to provide affordable health care to the affected community. At worst, it creates a conduit to funnel a portion of the purchase price back to the purchaser by reducing the purchaser's financial obligation to provide affordable health care to the affected community's indigent population.

To insure that collusion does not invade the transaction or allow the resulting foundation to become a mere extension of the for-profit purchaser, the rights, duties and responsibilities of seller and purchaser should be distinct and separately evaluated. The obligations of the nonprofit hospital, or any subsequently created foundation, to continue its charitable mission should never be tied to the obligations and undertakings of the acquiring entity. Charitable funds should not be dissipated to offset for-profit obligations.

The operation of a for-profit health care facility should entail separate and distinct requirements to provide minimum levels of community-based health care to the indigent and underinsured population as a condition of continued licensure and participation in federal health care programs.¹¹⁸ However, the imposition of the charitable obligations on the for-profit must be balanced by the fiscal restraints spawned by the reduction in Medicare payments and other health care reforms. It is equally inappropriate to burden the purchaser with unrealistic obligations as it is to allow the purchaser to underwrite for-profit obligations with charitable funds.

The best protection for the public is to specifically identify and enumerate the independent obligations of each party to the

117. *See id.*

118. There are minimally mandated federal health care provisions such as The Emergency Medical Treatment and Active Labor Act ("EMTALA"). This statute was enacted in response to widespread patient dumping. It requires that any hospital that accepts Medicare payments and that operates an emergency room, undertake "an appropriate medical screening examination" of individuals who present themselves to the hospital's emergency room to determine whether that individual has an emergency medical condition. If so, the hospital is required to stabilize the individual before effectuating a transfer. *See* 42 U.S.C. § 1395dd *et seq.* (1997).

conversion. The inclusion of these undertakings in the transaction documents provides a basis for the attorney general and community groups to enforce the obligations post-acquisition.¹¹⁹ Otherwise, continued care provisions may become meaningless because the nonprofit entity may not maintain a vested interest in enforcement once it has received the conversion proceeds.

Finally, the Model Act does not specifically direct the attorney general to consider the continued economic viability of the nonprofit hospital in the event that conversion is disapproved. Viability should be a fundamental consideration when evaluating any conversion transaction. It is not only a crucial element in determining a fair value for the assets sold, but it is also pivotal in determining whether the affected community is likely to receive continued access to affordable health care.

5. Enforcement/Monitoring and Remedies/Penalties

The Model Act provides that any conversion transaction that violates the notice, review or approval requirements shall be null and void and that each member of the governing boards and the chief financial officers of the parties to the conversion transaction are subject to a civil penalty of up to \$1,000,000.¹²⁰ The attorney general is authorized to institute proceedings to impose such a penalty.¹²¹ In addition, no permit to operate a hospital may be issued or renewed if a nonprofit health care conversion transaction is entered into in violation of the Act.¹²² Finally, the Model Act explicitly states that nothing in the Act shall be construed to limit the common law authority of the attorney general to protect charitable trusts and charitable assets.¹²³

119. The Model Act attempts a similar concept by requiring the conversion transaction to demonstrate that the public's interest will be served, especially considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents. See NAAG MODEL ACT § 5.02(7). However, this section fails to independently delineate the responsibility of the contracting parties.

120. See *id.* at § 9.01. These penalties are in addition to, not a replacement for, any other civil or criminal actions, under either common law or statutory law, including rescinding the transaction. See *id.* at § 9.02. The health care entity is required to provide and certify that each member of the board of trustees of the nonprofit health care entity was provided a copy of the Model Act when the entity provided its initial conversion notice to the attorney general. See *id.* at § 2.01.

121. See NAAG MODEL ACT § 9.01.

122. See *id.*

123. See *id.* at § 9.02.

The remedy provisions of the Model Act are excellent. They not only invalidate the transaction but also impose personal liability upon the officers and directors of the transacting parties. The substantial monetary penalty is an effective deterrent to unauthorized conversions. The impact of conversion legislation could be strengthened if conversion legislation included similar penalties for providing false or misleading information to the attorney general during the notice and approval process.

Considering the challenge of monitoring and enforcing post-transaction commitments, the conversion legislation should authorize private individuals to bring relator or *qui tam* suits¹²⁴ on behalf of the state to insure that the public receives the full benefit of transaction obligations and to insure that the conversion proceeds are used for appropriate health care activities.

6. Restrictions on Subsequent Use and Disposition of Conversion Proceeds

The Model Act does not include, or recommend as an option, any statutory provisions providing for the monitoring or regulating of the use or disposition of conversion proceeds. Nor does the Model Act require formal disclosure of the foundation's mission statement or the protocol for grant-making as part of the approval process.

Because the creation of the nonprofit hospital's assets resulted from the provision of health care in the community, conversion legislation should establish a mechanism to assess and monitor the health care needs of the affected community. Once these needs are determined, foundation funds should be restricted to meet them. Conversion legislation should also provide regulatory guidance and explicit limitations on the use of

124. *Qui tam* actions, translated as "who as well. . .," are claims "brought by an informer, [also known as a "relator"] under a statute that establishes a penalty for the commission or omission of a certain act, and provides that the same shall be recoverable in civil actions, part of the penalty to go to any person who will bring such action and the remainder to the state or some other institution." BLACK'S LAW DICTIONARY 1126 (5th ed. 1979). The False Claims Act is an excellent illustration of the use of *qui tam* provisions that have successfully encouraged employees and others to report instances of fraud against the federal government. See generally, 31 U.S.C. §§ 3729 *et seq.*; Efreem M. Grail, "Qui Tam" Insurance and the False Claim Act Settlements, ABA HEALTH LAW., Oct. 1998, at 16. *Qui tam* suits are also referred to as a relator action. A relator is a private party authorized to bring suit in the name of the state or attorney general when the right to sue is vested exclusively in the attorney general. See Miller, *supra* note 3, § 2, at 17. See also Brown v. Memorial Nat'l Home Found., 329 P.2d 118 (Cal Ct. App. 1958).

conversion proceeds in order to provide guidance to the foundation board. The failure to promulgate effective procedures to monitor post-transaction activities invites abuse, conflicts of interest and misdirected philanthropy. The use of charitable funds for planes, playgrounds and museums, even if well intended, jeopardizes the public's ability to ensure adequate health care services for the affected community's under-insured and uninsured residents. The need to limit the focus of newly created foundations is even more critical in situations where the for-profit purchaser reduces the services formerly provided by the nonprofit entity or is less committed to providing necessary health care to the indigent.

Representation by the former hospital's officers and directors and the purchaser's affiliates on foundation boards should be limited to no more than twenty percent to impede any attempt by the parties to control the activities of the foundation. The remaining eighty percent should be broadly representative of the affected community. A representative of the attorney general should be appointed to the board of any resulting foundation for a minimum of five years.¹²⁵ Attorney general participation in newly created boards will provide the state with prior notice of the foundation's intended grant-making activities before monies are actually allocated. To maintain a community focus, newly created foundations should be required to conduct an annual "needs assessment" study and to file a detailed annual report for a similar five year period. This report should disclose all grant-making activities and include an explanation of how these activities have addressed the health care needs of the affected community. To encourage community input in foundation activities, the annual report should be immediately available to the public.

While broadening the original mission of a nonprofit hospital may be justified in certain situations, such alterations should only be permitted upon petition and approval of the courts where the attorney general, as a necessary party to the proceedings, can protect the public's interests. Foundations desiring to deviate from the community-focused health care mission out-

125. See Fishman, *supra* note 2, at 732-33.

lined in the parties' approved conversion submission should be required to do so in mandatory *cy pres* proceedings.¹²⁶

B. State Conversion Legislation

Although common law and nonprofit corporation statutory law provide state attorneys general limited authority to monitor the conversion or dissolution of nonprofit entities,¹²⁷ the myriad social and legal issues that arise when nonprofit health care entities convert to for-profit has prompted a significant number of states to consider legislation specifically addressing the health care industry. As of September 1997, thirty-five states had considered, and nineteen states had enacted, legislation governing nonprofit health care related conversions, mergers and acquisitions.¹²⁸ Statutory enactments regulate conversion activity of health maintenance organizations ("HMO"), nonprofit and public hospitals and nonprofit insurance companies.¹²⁹ This article will limit its analysis to legislation regulating the sale or conversion of nonprofit hospitals to for-profit entities.¹³⁰

As of November 1998, seventeen states (Arizona, California, Colorado, Connecticut, Hawaii, Georgia, Louisiana, Maryland, Nebraska, New Hampshire, Ohio, Oregon, Rhode Island, South Dakota, Virginia, Washington, and Wisconsin) and the District of Columbia have enacted legislation specifically regulating the sale of nonprofit hospitals to for-profit entities.¹³¹ This section

126. These limitations may present sensitive issues for hospitals with religious affiliations desiring to utilize conversion proceeds for apostleship. However, foundation funds should never be used to foster religious or political agendas.

127. See GAO Report, *supra* note 10, at 6.

128. See Seto, *supra* note 14, at 2.

129. See generally Fishman, *supra* note 2, at 715.

130. It should be noted that many of the same issues arise with the conversion of other types of nonprofit health care entities. The most significant issues common to all types of nonprofit conversions are the determination of fair market value of the charitable assets, the subsequent use of sale proceeds and the continuation of access to health care, insurance and other health-related services. Thus, many of the comments advanced in this paper are appropriate when considering the consequences of converting other nonprofit health care related entities. Although this article limits its analysis to the application of the conversion statutes to nonprofit hospitals, there are numerous conversion statutes that apply to nonprofit HMO, nonprofit to nonprofit mergers, and mutualization of hospital and medical service corporations.

131. See ARIZ. REV. STAT. §§ 10-2591 to 10-2594 (1997); CAL. CORP. CODE §§ 5913-5919 (West 1998); COLO. REV. STAT. § 10-16-324 (1998); 1997 CONN. ACTS 188 (Reg. Sess.); 1998 CONN. ACTS 36 (Reg. Sess.); D.C. CODE ANN. §§ 32-551 to 32-560 (1998); GA. CODE ANN. §§ 31-7-400 to 31-7-412, 31-7-89.1 (1997); HAW. REV. STAT. §§ 323D-1 to 323D-12 (1997); LA. REV. STAT. ANN. §§ 40:2115.11 to 40:2115.22 (West 1998); MD. CODE ANN., STATE GOV'T. §§ 6.5-101 to 6.5-307 (1998); MD. CODE ANN., HEALTH-GEN. § 19-327 (1998); NEB. REV. STAT. §§ 71-20,102 to 71-20,114

will analyze the state legislation collectively—collating the similarities, noting the disparities and questioning the omissions. It will follow the same format utilized in the previous section to facilitate comparisons to the Model Act.¹³²

Some of the enactments include statements of state interest. Four states begin their legislation with the specific recognition of the state's inherent interest in assuring the continued accessibility and affordability of health care facilities.¹³³ Washington and Louisiana recognize the state's responsibility to protect the public's interest in nonprofit hospital assets and to ensure that these assets are managed prudently and safeguarded consistent with their missions.¹³⁴ The District of Columbia requires that charitable health care entities hold their assets in trust and that those assets are irrevocably dedicated to the specific charitable purposes set forth in the entity's articles of incorporation.¹³⁵ Furthermore, the District of Columbia, recognizing that transfer of nonprofit assets directly affects their charitable uses and may adversely affect the public as the beneficiary of charitable assets, considers specific legislative oversight a necessity.¹³⁶

1. Scope

The vast majority of states define hospital conversions broadly.¹³⁷ Typically, conversion acquisitions encompass any person or group of persons who secures either an ownership or a

(1996); N.H. REV. STAT. ANN. §§ 7:19 *et seq.* (1997); OHIO REV. CODE ANN. §§ 109.34, 109.35, 109.99 (Anderson 1997); OR. REV. STAT. §§ 65.800-65.815 (1997); R.I. GEN. LAWS §§ 23-17.14-1 to 23-17.14-31 (1997); S.D. CODIFIED LAWS § 47-24-17 (Michie 1999); VA. CODE ANN. §§ 55-531 to 55-533 (Michie 1997); WASH. REV. CODE §§ 70.44.007, 70.44.240, 70.44.300 (1997); WIS. STAT. §§ 50.35, 165.40 (1997); 1997 WIS. LAWS 93.

132. The six major categories previously outlined include: (1) the scope of the legislation, (2) notification, public disclosure and approval requirements, (3) valuation of nonprofit hospital assets, (4) community impact assessment and access to care considerations, (5) enforcement, monitoring and penalties provisions, and (6) restrictions on the subsequent use of charitable assets.

133. See CAL. CORP. CODE § 5913 (see historical notes referring to Sec. 1 of Stats. 1996, c. 1105 (A.B. 3101)); D.C. CODE ANN. § 32-551(1)-(7); LA. REV. STAT. ANN. § 40:2115.11; WASH. REV. CODE 70.45.010.

134. See LA. REV. STAT. ANN. 40:2115.11; WASH. REV. CODE 70.45.010.

135. See D.C. CODE ANN. § 32-551(2).

136. See D.C. CODE ANN. § 32-551(4).

137. See ARIZ. REV. STAT. § 10-2592(A); CAL. CORP. CODE § 5914(a)(1); 1997 CONN. ACTS 188(1)(4); D.C. CODE ANN. § 32-552(3); LA. REV. STAT. ANN. § 40:2115.12(1); NEB. REV. STAT. § 71-20, 103(3); N.H. REV. STAT. ANN. § 7:19-b(a); OHIO REV. CODE ANN. § 109.34(A)(4); OR. REV. STAT. § 65.803(1)(A), (B); R.I. GEN. LAWS § 23-17.14-4(6); VA. CODE ANN. § 55-331; WASH. REV. CODE § 70.45.020(3).

controlling interest in a hospital by purchase, merger, lease, gift,¹³⁸ consolidation, joint venture or otherwise.¹³⁹

The threshold level of acquisition necessary to trigger the disclosure and approval requirements found in state conversion legislation varies from the nonspecific “material” or “substantial” amount to specific percentages. Other states consider conversion transactions as part of the acquiror’s total interest in the nonprofit hospital when determining whether approval for the purchase is required.

Three states define a regulated acquisition as:

any acquisition by a person or persons of an ownership interest in a hospital whether by purchase, merger, lease, gift or otherwise, which results in a change of ownership or control of twenty percent or greater or which results in the acquiror holding a fifty percent or greater interest in the ownership or control of a nonprofit hospital.¹⁴⁰

Rhode Island expands the terms “ownership and control” to include “possession,” suggesting that an acquisition that is less than a purchase and sale can nevertheless fall within the purview of the conversion regulation. Rhode Island’s legislation is also activated when the removal, addition or substitution of a partner results in a new partner gaining or acquiring a controlling interest.¹⁴¹ Louisiana increases the level of acquisition necessary to activate state oversight to thirty percent.¹⁴²

Ohio, using the term “transaction”¹⁴³ in lieu of “conversion,” includes the most conservative threshold provision—twenty percent. Ohio also considers the combined effect of multiple transactions occurring within a twenty-four month period when calculating the percent threshold.¹⁴⁴ The New Hampshire threshold is twenty-five percent, but changes in membership of

138. See NEB. REV. STAT. § 71-20, 103(3).

139. See OHIO REV. CODE ANN. § 109.34 (A)(4).

140. See NEB. REV. STAT. § 71-20,103(3); HAW. REV. STAT. § 323D-A; WASH. REV. CODE § 70.45.020(3). Acquisitions of nonprofit hospitals by other nonprofit hospitals who maintain similar charitable purposes are exempt from the statute’s regulation. See WASH. REV. CODE § 70.45.020(3). See also OHIO REV. CODE ANN. § 109.34(A)(4).

141. See R.I. GEN. LAWS § 23-17.14-4 (6).

142. See LA. REV. STAT. ANN. § 40:2115.12 (1). The statute is also activated when an acquisition results in a 50% ownership or controlling interest in a nonprofit hospital.

143. See OHIO. REV. CODE ANN. § 109.34(4).

144. See *id.* Wisconsin has a similar 20% threshold for conversion activation but overall cumulative possession of a 50% ownership or control activates oversight.

the governing body occurring through regular elections or the filling of vacancies is excluded.¹⁴⁵

Georgia has a more liberal threshold—fifty percent or a lesser amount if, when combined with one or more transfers between the same or related parties occurring within a five-year period, constitutes a purchase or lease of at least fifty percent of a nonprofit's assets.¹⁴⁶

The remaining states take a less exacting qualitative approach. Maryland and Arizona require a substantial or significant disposal of a nonprofit health entity's assets for their threshold.¹⁴⁷ Arizona also includes a monetary threshold of at least one million dollars of book value of a nonprofit's assets.¹⁴⁸ The District of Columbia's and California's criterion is a "material amount,"¹⁴⁹ while Virginia and Maryland require the disposition of all or substantially all of the nonprofit hospital's assets.¹⁵⁰ Oregon and Connecticut employ the terms "significant"¹⁵¹ and "material,"¹⁵² respectively, in lieu of material or substantial.

Qualitative terms such as "material," "significant" or "substantial" are unnecessarily vague. The difficulty with using a monetary threshold based upon book value is that depreciated book values may bear no relationship to the assets' fair market value. A qualitative threshold will invite challenges to the statute's application and will divert the focus from protecting charitable assets to defining the scope of the legislation. The need to protect the public's interest in charitable assets and to preserve continued access to affordable health in the affected community mandates a lower-end quantitative threshold, as adopted by Ohio and Wisconsin. Considering the overall value of an average nonprofit hospital's infrastructure, the conversion of twenty percent of a nonprofit hospital's assets is almost certain to alter

145. See N.H. REV. STAT. § 7:19-b(I)(a).

146. See GA. CODE ANN. § 31-7-400(2)(A), (B).

147. See MD. CODE ANN., STATE GOV'T. § 6.5-101.(b)(1); ARIZ. REV. STAT. § 10-2592(A). Arizona also regulates acquisitions by nonprofit entities that are not part of a common line of ownership, but excludes transactions that are used to refinance assets already owned by the party. See *id.* at § 10-2592(C)(2), (3).

148. See ARIZ. REV. STAT. § 10-2592 (C)(1).

149. See D.C. CODE ANN. § 32-552(3); CAL. CORP. CODE § 5914(a)(1). The California statute does not apply if the agreement or transaction is in the usual and regular course of the hospital's activities or if the attorney general provides the corporation a written waiver of review for the proposed agreement or transaction. See *id.* at § 5914(c).

150. See VA. CODE ANN. § 55-531.

151. See OR. REV. STAT. § 65.803(1)(a).

152. See 1997 CONN. ACTS 188, § 2A.

the nature of the services historically provided by the nonprofit institution. Although a change in the nature of a nonprofit's governance is less quantifiable, the conversion of twenty percent of a nonprofit hospital's assets is likely to affect control or governance of that institution by introducing a new entity with profit motivations and substantial voting power.

To be most effective, conversion statutes need to include a provision, similar to Ohio's, regulating the cumulative purchases of related entities within a five-year period. Cumulative thresholds will avoid systematically timed purchases.

2. Notice, Public Disclosure and Approval

(a) Notice

Like the Model Act, most states require that notice of the transaction be provided to the state's attorney general.¹⁵³ A minority of states require notice of the transaction to be given to the attorney general and one or more other state agencies. Arizona, Nebraska and Rhode Island require that notice be given to the attorney general and the Department of Health and Human Services.¹⁵⁴ Arizona also requires that notice be given to the Corporation Commission. Connecticut directs that notice be given to the attorney general and the Commission of Health Care Access.¹⁵⁵ Finally, New Hampshire requires that notice be given to the attorney general and the Director of Charitable Trust.¹⁵⁶

Although the attorney general should maintain primary responsibility for approving conversion transactions, requiring the transacting parties to provide notice to health departments and charitable trust agencies is an excellent method to foster a multidisciplinary approach to evaluating the probable effects of a

153. See CAL. CORP. CODE § 5913; COLO. REV. STAT. § 6-19-103(1); GA. CODE ANN. § 31-7-401; LA. REV. STAT. ANN. § 40:2115.13(A)(1); OHIO REV. CODE ANN. § 109.34(B); OR. REV. STAT. § 65.803(1); VA. CODE ANN. § 55-532. The District of Columbia requires that notice be given to the Health Planning and Development Agency, which is responsible for forwarding the notice to Corporation Counsel, the equivalent of the state's attorney general. See D.C. CODE ANN. §§ 32-552(1), 32-553. South Dakota requires notice to be given to the Secretary of State. See S.D. CODIFIED LAWS § 47-24-17.

154. See NEB. REV. STAT. § 71-20,103; R.I. GEN. LAWS § 23-17.14-5. Washington requires that notice be sent to the Department of Health, which is charged with the responsibility of forwarding the notice to the attorney general. See WASH. REV. CODE § 70.45.030(1).

155. See 1997 CONN. ACTS 188, § 2(A).

156. See N.H. REV. STAT. § 7:19-b(III).

conversion transaction. These agencies possess specialized expertise that can expedite the evaluation of the multiple issues involved in conversion activity. While the attorney general may be best suited to determine whether fair value will be received for charitable assets, the Department of Health is likely to be more experienced in evaluating concerns about access to and quality of health care. The Departments of Corporations and Revenue and the Director of Charitable Trusts are likely to have greater expertise in monitoring and safeguarding the subsequent use of conversion proceeds. An integrated approach to evaluating conversions will also provide consistency in the state's approach to nonprofit hospital conversions.

The substance of the notice requirements varies from the submission of the actual transaction documents to the mere notice of the intention to purchase nonprofit hospital assets. Eight states require detailed applications that include the actual transaction documents.¹⁵⁷ Five states require only a general summary of the transaction documents.¹⁵⁸ The District of Columbia and California do not specify the documentation that must be included in the notice.¹⁵⁹

A number of states require the submission of expert reports and certain business records in addition to transaction documents as part of the notice application. Five states require a fairness evaluation by an independent expert to be included in the parties' notice application.¹⁶⁰ Georgia requires that the nonprofit entity submit its by-laws, articles of incorporation and any donative documents for gifts of \$100,000 or more.¹⁶¹ Maryland requires that a financial and community impact analysis conducted by an independent expert be included in the notice.¹⁶²

157. See 1997 CONN. ACTS 188, § 2(b); GA. CODE ANN. § 31-7-402; HAW. REV. STAT., § 323D-B(B), (C); MD. CODE ANN., STATE GOV'T. LEGIS. § 6.5-201(b); NEB. REV. STAT. § 71-20.104; N.H. REV. STAT. § 7:19-b(III); WASH. REV. CODE § 70.45.030(2); WIS. STAT. § 2-165(3).

158. See ARIZ. REV. STAT. § 10-2593(A)(3); LA. REV. STAT. ANN. § 40:2115.13(B)(2) (the summaries are public records); OHIO REV. CODE § 109.34(B); OR. REV. STAT. § 65.805(1) (the summaries are not public records, but the attorney general has the authority to determine what documents will become public records); R.I. GEN. LAWS § 23-17.14-6 (the detailed descriptions of the documents are public records).

159. See CAL. CORP. CODE § 5914(b); D.C. CODE ANN. § 32-553.

160. See 1997 CONN. ACTS 188, § 2-(b)(5); GA. CODE ANN. § 31-7-402(a); LA. REV. STAT. ANN. § 40:2115.13(B)(2)(vi); OHIO REV. CODE § 109.34(c)(1); WIS. STAT. § 2-165.40(3)(6).

161. See GA. CODE ANN. § 31-7.402(a).

162. See MD. CODE ANN., STATE GOV'T. § 6.5-201(b)(6).

New Hampshire requires that all compensation that is to be paid as part of the transaction be disclosed along with the minutes from the board of director's meeting approving the transaction.¹⁶³

All of the above special requirements provide critical information necessary for state officials to evaluate the major effects of conversion and important for the community to understand the effects of the conversion. Thus, such requirements should be included in all conversion legislation to maximize the protection of the public's interest in charitable assets and to preserve continued access to affordable health care. The completeness of the notice is directly correlated to the protection afforded the public.

The timetable for disclosure prior to the completion of the transaction varies considerably among the states with no clear trends in development. Wisconsin requires notice thirty days before an offer to purchase or lease is made.¹⁶⁴ Virginia requires notice sixty days before the parties complete the transaction.¹⁶⁵ Arizona and Georgia require the notice to be filed ninety days before the parties' anticipated closing of the transaction.¹⁶⁶

Other states provide a timetable for the attorney general's consideration of the transaction following notice. In Connecticut, the attorney general has twenty days from receipt of notice to determine if the transaction involves a material amount of assets.¹⁶⁷ Hawaii and Nebraska provide that the attorney general must determine if review is appropriate within twenty days of receipt of notice.¹⁶⁸

A number of states require that the attorney general determine if the application is complete within a specific timetable. Louisiana and Washington provide that the attorney general determine if the application is complete within fifteen days of receipt.¹⁶⁹

163. See N.H. REV. STAT. ANN. § 7:19-b(III).

164. See WIS. STAT. § 165.40(2)(b).

165. See VA. CODE ANN. § 55-532.

166. See ARIZ. REV. STAT. § 10-2593(A); GA. CODE ANN. § 31-7-401 (requiring that the notice be filed by both parties to the transaction).

167. See 1997 CONN. ACTS 188, § 3(a).

168. See HAW. REV. STAT. § 323D-C(B); NEB. REV. STAT. § 71-20.105(2).

169. See LA. REV. STAT. ANN. § 40:2115.14(B)(1); WASH. REV. CODE § 70.45.040(1).

(b) Public Notice

Most states require publication of the notice and at least one public hearing to receive public comment and to take testimony. Five states require the attorney general to publish notice of the transaction within five days of the receipt of an application in a paper of general circulation in the area where the nonprofit hospital is located.¹⁷⁰ Five states require notice to be published within ten days.¹⁷¹ Rhode Island also requires that the initial notice publication include the scheduled date for public hearing on the conversion.¹⁷² New Hampshire does not include a specific timetable for the publication of the notice.¹⁷³

Considering the administrative limitations of most government offices, it is crucial not to streamline the review process to the point that short review periods affect the attorney general's substantive oversight. While there is a range of reasonableness as it relates to notice publication, the ultimate goal is to provide the attorney general and the public with sufficient notice of the transaction so that the community groups and other interested persons have sufficient time to study the transaction details and to formulate alternative strategies. Yet, unnecessarily extended notice periods can be counter-productive and frustrate appropriate health care consolidations. A balanced approach should be employed to facilitate an expedient but thorough approval process.

An attorney general should be in a position to disclose whether the application is complete within a fifteen-day period. Once the application is complete, public notice of the transaction at least forty-five days prior to conducting a public hearing should be sufficient time for interested community groups to evaluate the terms of the transaction and explore alternatives to conversion. That same forty-five day period should provide ample time for other health care entities to formulate competitive bids.

170. See NEB. REV. STAT. § 71-20.105(1); WASH. REV. CODE § 70.45.040(2); WIS. STAT. § 165.40(3)(c); HAW. REV. STAT. § 323D-C(A); LA. REV. STAT. ANN. § 40:2115.14A(1). Ohio requires the nonprofit entity to publish the notice within seven days of submitting an application. See OHIO REV. CODE § 109.34(F).

171. See 1997 CONN. ACTS 188, § 2(C); GA. CODE ANN. § 31-7-404; MD. CODE ANN., STATE GOV'T § 6.5-202(A); R.I. GEN. LAWS § 23-17.14-7(b)(1); VA. CODE ANN. § 55-532.

172. See R.I. GEN. LAWS § 23-17-7(b)(1)(c).

173. See N.H. REV. STAT. ANN. § 7:19-b(IV).

(c) *Public Disclosure*

The public's access to the submitted conversion application and supporting documents varies considerably among the states. Wisconsin provides that the application and all supporting documents are public documents.¹⁷⁴ Maryland provides that the submissions are public documents unless deemed confidential.¹⁷⁵ Oregon and Rhode Island provide that public disclosure of the notice documentation is left to the discretion of the attorney general.¹⁷⁶ South Dakota's statute is a notice only legislation and does not require either public disclosure or public hearings.¹⁷⁷

While complete disclosure is always preferred, the primary goals of reviewing conversion transactions should be: (1) to insure that fair value is paid for charitable assets and (2) to establish an ongoing and effective system to regulate and monitor the subsequent use of conversion proceeds. These goals can be best achieved with Rhode Island's balanced approach of preserving the public's right to disclosure with the transacting parties' need to protect trade secrets and other confidential information. Rhode Island places the burden on the contracting parties to identify and then to establish the basis of any confidentiality claim.¹⁷⁸ Absent the assertion that particular documents or schedules should be privileged, all submissions should be public documents.

While most states that have enacted conversion legislation require a public hearing to consider the propriety of the intended conversion, there is no consistent timetable for conducting hearings. Colorado, Louisiana and Nebraska require a hearing to be held within thirty days of a completed application.¹⁷⁹ California and Connecticut require one or more hearings but provide no specific scheduling timetable.¹⁸⁰ Washington requires the hearings to be completed within forty-five days of the receipt of the conversion application and upon ten days prior notice.¹⁸¹ Ore-

174. See WIS. STAT. § 165.40(3)(b).

175. See MD. CODE ANN., STATE GOV'T. § 6.5-201(c).

176. See OR. REV. STAT. § 65.805(2); R.I. GEN. LAWS § 23-17.14-6(33)(C).

177. See S.D. CODIFIED LAWS § 47-24-17.

178. See R.I. GEN. LAWS § 23-17.14-6(33)(C).

179. See COLO. REV. STAT. § 6-19-404(1); LA. REV. STAT. ANN. § 40:2115.15(A); NEB. REV. STAT. § 71-20.106 (specifically requiring that 10 days prior notice be given for the hearing date).

180. See CAL. CORP. CODE § 5916; 1997 CONN. ACTS 188, § 6.

181. See WASH. REV. CODE § 70.45.050.

gon simply requires the hearings to be held upon fourteen days notice.¹⁸² Wisconsin provides two timetables: (1) if the transaction involves a single hospital, a hearing must be completed within thirty days; but (2) if the transaction involves a hospital system, a hearing must be held within 120 days.¹⁸³ Hawaii and the District of Columbia provide for discretionary hearings.¹⁸⁴ Finally, the Virginia and South Dakota statutes do not provide for public hearings.¹⁸⁵

Again, the specific scheduling date should be the result of compromise. It should balance the public's need for a sufficient time to evaluate the transaction and the transacting parties' need for closure. Unnecessarily protracted reviews merely increase costs without adding value to the review process. A public hearing conducted upon forty-five days public notice following the filing of a completed application should provide the attorney general and the public with sufficient time to prepare. A second public notice, fourteen days prior to the public hearing date published in a paper of general circulation in the affected community and in the principal places of business of the contracting parties, should be adequate to protect the public.

The majority of states give the reviewing entity discretion to determine the appropriate scope of its review. Eight states allow the reviewing body to request additional information, issue subpoenas, take sworn statements and conduct depositions as part of the required public hearings.¹⁸⁶ Nine states allow the attorney general to retain independent experts at the parties' expense to evaluate the propriety of the transactions.¹⁸⁷

182. See OR. REV. STAT. § 65.807(1).

183. See WIS. STAT. § 165.40(3)(d).

184. See D.C. CODE ANN. 1981 § 32-556(b) (The District of Columbia does not provide a timetable for discretionary hearings); HAW. REV. STAT. § 323D-D (Hawaii requires that if a hearing is conducted that it be completed within 60 days of notice of the application).

185. See S.D. CODIFIED LAWS ANN. § 47-24-17; VA. CODE ANN. § 55-532 (requiring public notice of pending transaction in the local newspaper).

186. See D.C. CODE ANN. § 32-556; HAW. REV. STAT. § 323D-D(A); MD. CODE ANN., STATE GOV'T. § 6.5-203(A)(2)(D); NEB. REV. STAT. § 71-20,106; R.I. GEN. LAWS § 23-17.14-14; WIS. STAT. § 165.40(3)(F); WASH. REV. CODE § 70.45.050; 1997 CONN. ACTS § 4(b).

187. See CAL. CORP. CODE § 5919(a)(1); D.C. CODE ANN. § 32-556(c); GA. CODE ANN. § 31-7-405(b); NEB. REV. STAT. § 71-20,108(5); N.H. REV. STAT. ANN. § 17:19-b(IV) (limiting the retention of experts to the transactions involving assets in excess of \$5 million); OHIO REV. CODE ANN. § 109.35(c); OR. REV. STAT. § 65.813; R.I. GEN. LAWS § 23-17.14-13; VA. CODE ANN. § 55-532.

None of the statutes limit the scope of expert's evaluations.¹⁸⁸

There has been no reported judicial decision examining the scope, weight or use of expert reports in the approval process. The attorney general's discretion as to the use of experts should extend to the scope of his undertaking. Depending on the expertise of the attorney general's office and the involvement of other states agencies, the use of experts should include: (1) determining whether fair value will be received for the nonprofit assets; (2) evaluating the transaction's likely effect on the community's access to affordable quality health care; and (3) verifying that post-transaction use of the conversion proceeds will be consistent with the original mission of the nonprofit hospital.

(d) Approval

A clear majority of states that have adopted conversion legislation require that the reviewing entity approve the transaction before the parties may complete the transaction.¹⁸⁹ A few of these states provide that inaction on the part of the attorney general beyond the approval period confers approval.¹⁹⁰ By contrast, four states have passed conversion legislation that does not require the reviewing entity to approve the transaction.¹⁹¹ Colorado takes a middle road and gives the attorney general authority to file suit to enjoin the conversion.¹⁹²

188. Arguably, an expert's analysis could include: (1) evaluating the sales price to determine if the nonprofit is receiving fair value for its assets; (2) checking for conflicts of interest to determine if private benefit or private inurement would result from the transaction; (3) conducting access to care studies to determine if the transaction would result in the denial of medical care to the uninsured or underinsured; and (4) appropriate needs analysis to evaluate the intended or disclosed use of the sales proceeds.

189. See CAL. CORP. CODE § 5914; 1997 CONN. ACTS 188, § 3 (requiring approval if the attorney general determines the transaction involves a material amount of assets); D.C. CODE ANN. § 32-553(a); HAW. REV. STAT. § 323D-B; LA. REV. STAT. ANN. § 40:2115.11; MD. CODE ANN., STATE GOV'T. § 6.5-102; NEB. REV. STAT. § 71-20,107(1); N.H. REV. STAT. ANN. § 7:19-b(IV); OHIO REV. CODE ANN. § 109.34(B); OR. REV. STAT. § 65.803(1); R.I. GEN. LAWS § 23-17.14-5; WASH. REV. CODE § 70.45.030; WIS. STAT. § 165.40(2)(a).

190. See HAW. REV. STAT. § 323D-E(B); NEB. REV. STAT. § 71-20,107(1); N.H. REV. STAT. ANN. § 7:19-b(IV).

191. Arizona and Georgia require that a report of the public hearing be prepared, which may provide formal disclosure, but lack any approval requirement. See ARIZ. REV. STAT. ANN. § 10.2593; GA. CODE ANN. § 31-7-401. South Dakota and Virginia have no hearing or approval requirements. See S.D. CODIFIED LAWS § 47-24-17; VA. CODE ANN. § 55-532.

192. See COLO. REV. STAT. § 6-19-103(2).

Conversion legislation that simply requires disclosure of the intent to convert charitable assets or the preparation of a report on the public hearing elevates form over substance. Notice-only conversion statutes do not protect charitable assets, because they do not require the payment of fair value for charitable assets or establish an ongoing and effective system to regulate and monitor the subsequent use of the conversion proceeds. Explicit approval mechanisms are essential to effective conversion legislation.

Conferring approval upon inaction is also potentially dangerous. Although state agencies strive for punctuality, they have limited resources, and inadvertent delays occur. Timetables should never substitute for substantive approval. To insure the public and parties have been adequately informed, the attorney general should be required to issue not only a decision but the basis for that decision before the conversion is allowed to proceed. From the parties' perspective, requiring formal written decisions from the attorney general will facilitate judicial review.

3. Valuation

(a) *Determining Fair Market Value for Nonprofit Hospital Assets*

Except for the few states with notice-only statutes,¹⁹³ the remaining states have enacted provisions attempting to establish mechanisms for assuring that the sale of nonprofit hospital assets results in the purchaser paying fair market value for nonprofit hospital assets.¹⁹⁴ Although state legislation does not and realistically could not require a particular method or formula for calculating specific values for charitable assets, most states attempt to provide the reviewing entities with sufficient discretion so that a reasonable review of the transaction can be completed in a timely fashion. The true challenge of conversion legislation is evaluating unique enterprises. The attorney general is called upon to quantify a nonprofit hospital's market share, payor mix, managed care contracts, sophisticated equipment, goodwill and

193. See S.D. CODIFIED LAWS § 47-24-17; VA. CODE ANN. § 55-532.

194. Fair market value is defined as "the amount at which property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having reasonable knowledge of the relevant facts. . . ." or "the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition." BLACK'S LAW DICTIONARY 537 (5th ed. 1979).

“strategic position” in a rapidly changing health care market.¹⁹⁵ The attorney general’s tenacity is as crucial as the specific authority bestowed.

The most common provision found is the requirement that the attorney general determine whether the nonprofit hospital is receiving fair market value for its assets.¹⁹⁶ Seven states require that the application include or reflect that an independent expert’s fairness evaluation was utilized in determining appropriate evaluations.¹⁹⁷ Hawaii merely requires the attorney general to consider, when evaluating the transaction, whether the seller used an independent expert to determine the fair value of its charitable assets.¹⁹⁸ Five states require the specific determination that the nonprofit hospital’s assets were not manipulated to decrease their value to facilitate the sale.¹⁹⁹

Except for the notice-only statutes, existing conversion legislation adequately authorizes the attorney general to determine whether fair market value has been received for a nonprofit’s assets. Although such a determination is crucial to protecting the public, solely focusing on this calculation could result in unintended consequences. The determination of the actual fair market value of the nonprofit hospital’s assets should be the starting point of the evaluation, not its conclusion. The goal should be to achieve a fair value, but not necessarily the highest value, after careful consideration of all aspects of the conversion transaction.²⁰⁰

195. See Miller, *supra* note 2, § 3, at 5.

196. See CAL. CORP. CODE § 5917(c); 1997 CONN. ACTS 188, § 4(a)(4); D.C. CODE ANN. § 32-553(c)(9); GA. CODE ANN. § 31-7-406(6); HAW. REV. STAT. § 323D-F(5) (requiring reasonably fair value); LA. REV. STAT. ANN. § 40:2115.17(B)(4) (requiring fair value); MD. CODE ANN., STATE GOV’T. § 6.5-301(D); NEB. REV. STAT. § 71-20,108(5) (requiring fair value); OHIO REV. CODE ANN. § 109.35(B)(2); OR. REV. STAT. § 65.811(3); R.I. GEN. LAWS § 23-17.14-7(17); WASH. REV. CODE § 70.45.070(5).

197. See 1997 CONN. ACTS 188, § 4(a)(2)(C); D.C. CODE ANN. § 32-553(c)(3); GA. CODE ANN. § 31-7-406(4) (requiring that the seller retain an independent expert to complete a fairness evaluation); NEB. REV. STAT. § 71-20,108(5); OHIO REV. CODE ANN. § 109.35(B)(2) (placing an affirmative duty on the parties to update the attorney general with information that may affect the ultimate valuation of the nonprofit assets); WASH. REV. CODE § 70.45.070(5); WIS. STAT. § 165.40(F).

198. See HAW. REV. STAT. § 323D-F(3).

199. See CAL. CORP. CODE § 5917(d); 1997 CONN. ACTS 188, § 4(a)(5); D.C. CODE ANN. § 32-553(c)(9); GA. CODE ANN. § 31-7-403(4); R.I. GEN. LAWS § 23-17.14-7(23).

200. Rhode Island’s legislation provides the most comprehensive criteria for evaluating the propriety of conversion applications. It enumerates an exhaustive checklist that if followed will result in the most comprehensive review of conversion activity. Its

The highest value does not always represent the best alternative when selling health care assets. Rather, the continued delivery of health care services may be the highest priority. Nonprofit hospitals should properly consider, in addition to the bid amount, the purchaser's "managed care network presence in the community, corporate culture, reputation for providing quality care, and access to capital" in accepting a particular offer from a for-profit company.²⁰¹ The purchase price should reflect the fair market value of the assets sold and the contractual commitments of the purchaser to maintain minimal levels—above those mandated by existing state and federal law—of quality health care to the indigent in the affected community. Securing commitments from the purchaser to continue medical services that are not profitable or that target indigent populations may require an adjustment in the purchase price.

(b) *Placing Charitable Assets at Risk*

When the purchase price is not paid in cash at the time of the conversion, important questions concerning the nature of the charitable assets arise: (1) are charitable assets being placed at unreasonable risk; and (2) are the charitable assets still considered in the charitable stream or are they accruing to the benefit of private individuals?²⁰² Seven states require the reviewing entity to determine whether charitable assets will be placed at unreasonable risk due to financing arrangements or joint ventures.²⁰³ Georgia requires the parties to disclose at public hearing whether the nonprofit hospital is providing any financing for the transaction.²⁰⁴ The District of Columbia's statute is more comprehensive, requiring the reviewing entity to specifically determine that the buyer is financially sound and has the management expertise to operate the health care entity.²⁰⁵

Safeguarding charitable assets requires that financing arrangements are carefully scrutinized and closely monitored. The

thoroughness is a tribute to the state—for it recognizes not only the complexity but also the importance of the issues raised when nonprofit hospitals convert to for-profit. See R.I. GEN. LAWS § 23-17.14-7.

201. GAO Report, *supra* note 10, at 13.

202. See Miller, *supra* note 3, § 2, at 3.

203. See 1997 CONN. ACTS 188, § 4(6); D.C. CODE ANN. § 32-553(10); LA. REV. STAT. ANN. § 40:2115.17(B)(5); MD. CODE ANN., STATE GOV'T. § 6.5-302(E)(7); NEB. REV. STAT. § 71-20,108(6); WASH. REV. CODE § 70.45.070(6); WIS. STAT. § 165.40(4)(e).

204. See GA. CODE ANN. § 31-7-406(7).

205. See D.C. CODE ANN. § 32-553(6).

value of the purchase price can be greatly affected by the purchaser's financial security. Nonprofit conversion should be evaluated like any other business transaction. If the purchaser cannot demonstrate sufficient financial stability, the conversion should be disapproved.

(c) *Conflicts of Interest*

Though some argue that the only plausible method to ensure that conflicts of interest do not arise from the sale of nonprofit assets is to ban conversion, a prohibition would inhibit necessary consolidation as part of continued health care reform. Market conditions, over-supply of hospital beds in certain regions, and the economies of scale point toward continued consolidation as one method of stemming the rising cost of health care. The only prudent solution is to closely monitor and to require disclosure of potential conflicts of interest.

Seven states require that the parties disclose conflicts of interest.²⁰⁶ New Hampshire requires that the seller also certify that it has acted in good faith and consistent with its fiduciary duties.²⁰⁷ Three states require that the parties disclose whether any health care providers were provided the opportunity to invest in the transaction.²⁰⁸ While the majority of the states require the attorney general to specifically determine whether the management contracts are fair,²⁰⁹ Rhode Island requires disclosure of salary and severance provided to officers, directors and board members.²¹⁰ California imposes stricter controls on conflicts of interest by prohibiting board members from receiving compensation from the purchaser for a period of two years following the transaction.²¹¹

206. See 1997 CONN. ACT 188, § 4(a)(3); D.C. CODE ANN. § 32-553(7); HAW. REV. STAT. § 323D-76(4); LA. REV. STAT. ANN. § 40:2115.17(B)(3); NEB. REV. STAT. § 71-20,108(4); N.H. REV. STAT. ANN. § 7:19-b(II); OHIO REV. CODE ANN. § 109.34(B)(3) (requiring disclosure of all contracts and agreements between the parties and their officers, directors and other fiduciaries); WIS. STAT. § 165.40(4)(d).

207. See N.H. REV. STAT. ANN. § 7:19-b(III).

208. See GA. CODE ANN. § 31-7-406(13); NEB. REV. STAT. § 71-20,109(3); R.I. GEN. LAWS § 23-17.14-11(4).

209. See D.C. CODE ANN. § 32-553(11); GA. CODE ANN. § 31-7-406(8); HAW. REV. STAT. § 323D-76(7); LA. REV. STAT. ANN. § 2115.17(B)(6); MD. CODE ANN., STATE GOV'T. § 6.5-301(E)(8); NEB. REV. STAT. § 71-20,108(7); R.I. GEN. LAWS § 23-17.14-7(14); WASH. REV. CODE § 70.45.070(7).

210. See R.I. GEN. LAWS § 23-17.14-6(23).

211. See *Bill Banning Officer Compensation from Nonprofit Conversions Signed by Wilson*, HEALTH L. REP. (BNA), Oct. 23, 1997, at 1632.

A complete prohibition against board members receiving compensation post-acquisition may impede necessary conversions. Even where a nonprofit hospital is inviable, self-interest on the part of board members may frustrate an otherwise appropriate conversion. Full disclosure of management contracts, board compensation and ownership interests will allow the attorney general to determine if the purchase price represents fair value for the assets sold. It will also permit the attorney general to determine whether private inurement or private benefit will likely result from the transaction and thereby jeopardize the nonprofit entity's federal tax-exempt status.²¹²

(d) *Inurement and Private Benefit Issues*

Only three states require that the attorney general make a specific determination that no inurement or private benefit will result from the transaction.²¹³ This is a critical element in determining whether conflicts of interest exist. Providing any amount of remuneration above reasonable value for services rendered improperly siphons away charitable assets that should be devoted to the continued provision of health care services in the affected community. To protect the nonprofit's tax status, all conversion legislation should require that inurement and private benefit issues be carefully evaluated.²¹⁴

(e) *Due Diligence*

The overwhelming majority of states require the parties to demonstrate either in written summaries or during public hearing that due diligence was used in selecting the buyer, evaluating alternatives and negotiating the terms of the agreement.²¹⁵ Nebraska, Rhode Island and Washington require that the review-

212. See *infra* at Section III, Federal Avenues of Conversion Scrutiny, for a discussion of private inurement and private benefit issues.

213. See CAL. CORP. CODE § 5917(b); MD. CODE ANN., STATE GOV'T. § 6.5-301(B)(3); OR. REV. STAT. § 65.811(2).

214. Rhode Island requires a determination that the transaction will not jeopardize the tax status of the seller. See R.I. GEN. LAWS § 23-17.14-7(21).

215. See ARIZ. REV. STAT. § 10-2593(F)(4); 1997 CONN. ACTS 188, § 4(2); D.C. CODE ANN. § 32-553(c)(2); GA. CODE ANN. § 31-7-406(3); R.I. GEN. LAWS § 23-17.14-7 (c)(2); N.H. REV. STAT. ANN. § 7:19-b(II)(a); NEB. REV. STAT. § 71-20,108(2); HAW. REV. STAT. § 323D-F(2); WIS. STAT. § 165.40(4)(b); WASH. REV. CODE § 70.45.070(2); MD. CODE ANN., STATE GOV'T. § 6.5-302(E)(IV); COLO. REV. STAT. § 6-19-403(1)(d).

ing entity make this determination.²¹⁶ New Hampshire requires a determination that the transaction is in the best interest of the charitable trust,²¹⁷ while Georgia requires that it be consistent with the intent of the donors.²¹⁸ A thorough due diligence analysis should be the starting point of all conversion reviews.

4. Community Impact Assessment and Access to Care Provisions

The majority of states require the attorney general to consider whether the conversion is likely to cause a significant disruption in the affected community's access to affordable health care services.²¹⁹ However, most of the legislation does not mandate that the transaction be disapproved upon an affirmative finding of disruption.²²⁰ Five states require that the reviewing entity determine if the affected community is assured continued access to affordable health care and whether the purchaser is committed to providing care to the affected community's underinsured and uninsured residents.²²¹ California and Oregon merely require a determination of whether the transaction will significantly affect the availability of or access to health care services in the affected community.²²² Arizona requires that the parties submit at the public hearing a written report, detailing whether the transaction is likely to have an adverse reaction on access, availability or cost of health care.²²³

216. See NEB. REV. STAT. § 71-20,108(2); R.I. GEN. LAWS § 23-17.14-7(c)(2); WASH. REV. CODE § 70.45.070(2); LA. REV. STAT. ANN. § 40:2115.17(B); MD. CODE ANN., STATE GOV'T. § 6.5-203(E)(IV).

217. See N.H. REV. STAT. § 7:19-b(II)(b).

218. See GA. CODE ANN. § 31-7-406(2).

219. See ARIZ. REV. STAT. § 10-2593(F)(2)-(3); 1997 CONN. ACTS 188, § 5(b); GA. CODE ANN. § 31-7-406(11); R.I. GEN. LAWS § 23-17.14-8(b)(2); N.H. REV. STAT. ANN. § 7:19-b(III); NEB. REV. STAT. § 71-20,109; HAW. REV. STAT. § 323D-77(1); WASH. REV. CODE § 70.45.080; LA. REV. STAT. ANN. § 40:2115.18; MD. CODE ANN., STATE GOV'T. § 6.5-301(E)(7); OR. REV. STAT. § 65.811; COLO. REV. STAT. § 6-19-403(1)(b).

220. See *id.*

221. See ARIZ. REV. STAT. § 10-2593(F)(2); LA. REV. STAT. ANN. § 40:2115-18(2); NEB. REV. STAT. § 371-20,109(2); HAW. REV. STAT. § 323D-77(2); WASH. REV. CODE § 70.45.080.

222. See CAL. CORP. CODE § 5917(h); OR. REV. STAT. § 65-811(7). Colorado's attorney general may consider if the transaction will result in continuing access to care, but lacks approval or disapproval authority. The attorney general's only option is to seek redress in the circuit court. See generally COLO. REV. STAT. §§ 6-19-403(1)(b), 6-19-402, and 6-19-103.

223. See ARIZ. REV. STAT. § 10-2593 (F).

Georgia takes a different approach and requires the seller to certify, and to disclose during the public hearing, whether sufficient safeguards are in place to assure the public that the transaction will not adversely affect the availability and accessibility of health care services.²²⁴ Georgia also requires the buyer to disclose whether it has negotiated enforceable commitments for the continuation of health care services to the disadvantaged, underinsured and uninsured community.²²⁵

Rather than relying upon undefined commitments, the District of Columbia, Hawaii and Rhode Island attempt to quantify the minimum level of indigent care required to be provided by the purchaser. In the District of Columbia, the parties must certify that for five years following the transaction, the percentage of bad debt and charity care will be equal to or greater than the average amount for the two years before the transaction.²²⁶ Rhode Island requires the "new" hospital to include in its transaction documents the level of the community benefit and charity care it intends to provide for a five-year period after the transaction.²²⁷ Before the purchaser can eliminate or significantly reduce emergency room or primary care services, it must apply for approval from the Department of Health.²²⁸

Requiring the parties to disclose the specific level of care expected from the purchaser in the conversion documents will enhance the attorney general's effectiveness in enforcing contractual commitments following the transaction. Forcing the purchaser to seek court approval before eliminating or significantly reducing crucial health care services to the affected community is an effective system to monitor and control post-transaction activities. Detailed disclosures will facilitate post-transaction enforcement of the parties' contractual obligations and commitments.

224. See GA. CODE ANN. § 31-7-403(b)(8). Maryland has a similar concept requiring the attorney general, when determining whether the transaction is in the public's interest, to consider whether there are sufficient safeguards to ensure that the affected community will have continued access to care. See MD. CODE ANN., STATE GOV'T. § 6.5-301(E)(7).

225. See GA. CODE ANN. § 31-7-406(12).

226. See D.C. CODE ANN. § 32-356(b)(2)(A).

227. See R.I. GEN. LAWS § 23-17.14-6(a)(21). Hawaii requires the reviewing entity to consider whether the purchaser has committed to providing the similar level of health care services previously provided by the nonprofit hospital to the affected community. See HAW. REV. STAT. § 323D-77(2).

228. See R.I. GEN. LAWS § 23-17.14-18; HAW. REV. STAT. § 323D-82(a).

5. Enforcement/Monitoring and Remedies/Penalties

Overall, current state enactments do not sufficiently emphasize the enforcement and monitoring of post-conversion activities. Often enforcement provisions are entirely absent or are inadequate to establish a procedure to systematically monitor the parties' post-transaction activities.

(a) *Enforcement of Contractual Obligations*

Approximately half of the states enacting legislation failed to include provisions specifically providing for the enforcement of the parties' contractual obligations.²²⁹ Six states provide that hospital licensure should be refused or revoked if a transaction is completed without proper approval.²³⁰ Six states include general provisions authorizing the enforcement of the statute through judicial proceedings.²³¹

In Colorado and Washington, if the attorney general receives information that the parties are not properly fulfilling their transaction obligations, he may institute proceedings in the district court to require corrective action.²³² In Hawaii, if the State Health Planning and Development Agency receives information that the acquiring entity is not fulfilling its commitments to the affected community, it may institute proceedings to revoke the license issued to the purchaser.²³³ Louisiana and Nebraska provide that if the buyer is not in compliance with transaction covenants, the attorney general may petition to have the hospital's operating license revoked.²³⁴ Rhode Island requires that all hospitals meet minimum requirements for charity and uncompensated care as a condition of continued licensing, but the statute does not include a provision that would grant the reviewing entity authority to enforce the parties' other contractual undertakings.²³⁵

229. See ARIZ. REV. STAT. § 10-2593; CAL. CORP. CODE § 5915; N.H. REV. STAT. ANN. § 7:19-b; OR. REV. STAT. § 65.815; R.I. GEN. LAWS § 23-17.14-30; S.D. CODIFIED LAWS ANN. § 47-24-17; VA. CODE ANN. § 55-532; WIS. STAT. § 165.40(6).

230. See 1997 CONN. ACTS 188, § 8; D.C. CODE ANN. § 32-355; GA. CODE ANN. § 31-7-408; HAW. REV. STAT. § 323D-80; LA. REV. STAT. ANN. § 40:2115.20; MD. CODE ANN., STATE GOV'T. § 6.5-305; R.I. GEN. LAWS § 23-17.14-30

231. See OHIO REV. CODE ANN. § 109.35(G)(3); COLO. REV. STAT. ANN. § 6-19-407(3); WASH. REV. CODE § 70.45.90; D.C. CODE ANN. § 32-559; NEB. REV. STAT. § 71-20,110; GA. CODE ANN. § 317-407.

232. See COLO. REV. STAT. § 6-19-407; WASH. REV. CODE § 70.45.100.

233. See HAW. REV. STAT. § 323 D-H.

234. See LA. REV. STAT. ANN. § 40:2115.20; NEB. REV. STAT. § 71-20,110.

235. See R.I. GEN. LAWS § 23-17.14-15.

(b) *Monitoring Compliance*

Monitoring the parties' post-transaction activities is an indispensable element of enforcement. Yet only three states, Louisiana, Colorado and Washington, have established reasonable mechanisms to monitor and evaluate compliance with transaction covenants. Colorado and Washington require that the buyer and seller submit periodic reports demonstrating compliance with transaction covenants.²³⁶ The reviewing entity may also subpoena information and conduct on-site compliance audits. Upon information that the parties are not in compliance, the reviewing entity may conduct a hearing and, if appropriate, secure corrective action.²³⁷ Thereafter, the reviewing entity may suspend or revoke the hospital's license or proceed with judicial proceedings to compel compliance.²³⁸ Louisiana's attorney general may require annual reports from the buyer and seller for up to five years to ensure compliance with transaction covenants.²³⁹ Maryland only requires the charitable entity that receives conversion proceeds to submit an annual report detailing its grant making and other charitable activities.²⁴⁰

To be effective, conversion legislation needs to empower the attorney general with authority to require strict performance of contractual obligations by the corporate entities and to impose civil monetary penalties against the individual corporate officers and directors for circumventing those obligations. All conversion legislation should include both explicit enforcement authority and mechanisms to determine whether community obligations have been met. Conversion statutes should include mandatory annual reports for a minimum of five years following conversion. During this period, the parties should be required to demonstrate compliance with all contractual obligations. Legislation should provide for an automatic license revocation for the failure to file required annual reports. The attorney general should have discretion to extend the reporting requirements to the point at which all transactional commitments have been satisfied.

236. See COLO. REV. STAT. ANN. § 6-19-405; WASH. REV. CODE § 70.45.100.

237. See COLO. REV. STAT. ANN. § 6-19-405; WASH. REV. CODE § 70.45.100.

238. See COLO. REV. STAT. ANN. § 6-19-405; WASH. REV. CODE § 70.45.100.

239. See LA. REV. STAT. ANN. § 40:2115.19.

240. See MD. CODE ANN., STATE GOV'T. § 6.5-306(B).

To augment state oversight of post-transaction activities, conversion legislation should also include *qui tam* provisions.²⁴¹ These provisions would allow individuals and community groups to bring suit on behalf of the attorney general in the event the purchaser fails to honor its transaction commitments. Providing standing to community watch groups and employees is an inexpensive and effective system to supplement attorney general supervision.

(c) Remedies and Penalties

States have given insufficient attention to remedy and penalty provisions. Seven states contain no penalty provisions for violating provisions of the conversion statute.²⁴² While the attorney general may be able to enforce certain specific transaction obligations under his inherent common law authority,²⁴³ research reveals no reported judicial decisions in which any reviewing authority attempted to enforce transactional obligations arising out of hospital conversion legislation. The absence of specific remedies and penalties suggests a lack of commitment on the part of states to monitor post-transaction activities. The lack of resolve to rigorously enforce conversion legislation may raise uncertainty among state officers as to the extent of their enforcement authority and signal to the transacting parties that post-conversion oversight will be lax.

Only Connecticut and Georgia provide that any agreement without approval is void.²⁴⁴ Washington authorizes its attorney general to refuse the filing of any transaction documents entered into without the requisite approval.²⁴⁵ Although the majority of states provide for the revocation or denial of a license to operate a hospital following an unauthorized conversion,²⁴⁶ too few of the enactments impose significant monetary penalties against the parties and their officers and directors for violation of notice, disclosure and approval requirements. Because the denial

241. For a definition of this term see *supra* note 124.

242. See ARIZ. REV. STAT. § 10-2593; CAL. CORP. CODE § 5917; COLO. REV. STAT. § 6-19-407; NEB. REV. STAT. § 71-20,111; OR. REV. STAT. § 65.809; S.D. CODIFIED LAWS ANN. § 47-24-17; VA. CODE ANN. § 55-533.

243. For a definition of these terms see *supra* notes 43, 44.

244. See 1997 CONN. ACTS 188, § (2)(a); GA. CODE ANN. § 31-7-412.

245. See WASH. REV. CODE § 70.45.090(1).

246. See 1997 CONN. ACTS 188, § 8; GA. CODE ANN. § 31-7-412; HAW. REV. STAT. § 323D-80(1); LA. REV. STAT. ANN. § 40:2115.20; MD. CODE ANN., STATE GOV'T. § 6.5-305; NEB. REV. STAT. § 71-20,112; N.H. REV. STAT. § 7:19-b(V); WASH. REV. CODE. § 70.45.100; WIS. STAT. § 165.40(6)(a).

or revocation of a hospital's license denies the community access to health care, enforcement provisions must include monetary penalties as an alternative to hospital closure. Significant monetary penalties that can be readily assessed against the corporate entities and their officers and directors without disrupting access to health care would be an effective deterrent to unauthorized conversions.

The District of Columbia has a more realistic approach to enforcement. There, the corporation counsel may enjoin any person or party from offering, developing or operating a hospital without notice to and approval of corporation counsel.²⁴⁷ Corporation counsel may also impose daily fines from \$2,500 to \$10,000 for each day an unauthorized activity continues and against any party convicted of violating its transaction covenants.²⁴⁸

New Hampshire authorizes the Director of Charitable Trusts to bring judicial proceedings to enjoin or void a conversion transaction that occurs without proper notice or with deceptive or materially inaccurate notice.²⁴⁹ Ohio employs similar language but also authorizes the attorney general to assess a monetary penalty not to exceed \$10,000,000 for any transaction occurring without appropriate approval.²⁵⁰ Georgia provides for the imposition of fines against the individual board members and the chief executive officer, up to \$50,000 and imprisonment for up to one year for completing a conversion in violation of the statute.²⁵¹

Rhode Island authorizes its attorney general to refuse to issue, suspend or revoke, a hospital's license if a person is found guilty of knowingly or fraudulently giving false information during the approval process or failing to comply with statutory requirements.²⁵² In addition, the superior court may impose fines of up to \$1,000,000 or five years imprisonment.²⁵³ In Ohio, if a board member, director, officer or other fiduciary is convicted of entering into a transaction without approval, it is considered a third degree felony.²⁵⁴

247. See D.C. CODE ANN. § 32-559.

248. See *id.*

249. See N.H. REV. STAT. ANN. § 7:19-b(V).

250. See OHIO REV. CODE ANN. § 109.35(G)(3).

251. See GA. CODE ANN. § 31-7-412.

252. See R.I. GEN. LAWS § 23-17.14-30.

253. See *id.*

254. See OHIO REV. CODE ANN. § 109.99(D).

Effective penalties and remedy provisions must not only include the authority to void the transaction and revoke hospital licenses, but also provide for significant monetary penalties to be asserted against the entities and their officers and directors for failure to satisfy conversion requirements. Since the affected community's need for continued access to health care makes hospital closure imprudent, fines up to \$10,000,000 against the contracting entities and \$1,000,000 against the entities' officers and directors should provide a sufficient deterrent to unauthorized conversions. For the failure to satisfy conversion commitments or for the misuse of conversion proceeds, daily fines should be imposed. An alternative to establishing a specific daily fine, such as \$10,000 per day, per occurrence, would be to establish fines in proportion to the value of the commitments broken and charitable funds misappropriated. It is also imperative that post-transaction penalties allow for the assessment of personal liability against the parties' officers and directors for the failure to meet contractual obligations and for the misuse of conversion proceeds.

6. Restrictions on Subsequent Use and Disposition of Charitable Assets

The failure to institute strict restrictions on the use of conversion proceeds and to require the ongoing monitoring of grant-making activities supported by conversion proceeds is the greatest shortfall of current state conversion legislation. With minor exceptions, the current enactments are woefully inadequate to protect the staggering amount of converted charitable assets.

(a) *Control of Conversion Proceeds*

Only a few states regulate or control the use of conversion proceeds. Four states simply require the reviewing entity to consider, as part of the approval process, whether control of conversion proceeds will be independent of the parties to the transaction.²⁵⁵ Connecticut and Colorado require that an amount equal to the fair market value of the charitable assets be

255. See LA. REV. STAT. ANN. § 40:2114.17(B)(7); NEB. REV. STAT. § 71-20,108(8); WASH. REV. CODE § 70.45.070(8); HAW. REV. STAT. § 323D-76(8). Colorado requires that the parties set aside proceeds from the transaction in an amount equal to the fair market value of the charitable assets and distribute them to a charitable organization independent of the parties and broadly representative of the affected community. See COLO. REV. STAT. § 6-9-403(e) to 6-9-403(f). New Hampshire has a similar requirement, unless the seller is a New Hampshire charitable trust, in which case it can retain the sales proceeds. See N.H. REV. STAT. ANN. § 7:19-b(II)(f).

transferred to an organization selected by the superior court and unaffiliated with the parties to the transaction.²⁵⁶ The District of Columbia's corporation counsel has the authority to require that conversion proceeds are placed in an appropriate charitable trust.²⁵⁷ Ohio requires that the sales proceeds be dedicated and transferred to one or more existing charitable organizations, or if specifically authorized, to a charitable foundation.²⁵⁸ Maryland requires that sixty percent of the fair market value of the charitable assets of the nonprofit hospital be distributed to public or nonprofit charities dedicated to serving the unmet health care needs of the affected community and to promoting access to and quality of care.²⁵⁹

While directing conversion proceeds into an independent foundation or charitable organization is a prudent first step, additional safeguards are necessary. To maintain the independence of these organizations, participation of the parties and their affiliates on the boards of these charities should be limited to twenty percent. To ensure that necessary health care services are provided, the remaining board members should be broadly representative of the affected community. To facilitate systematic oversight, a representative of the attorney general should be an automatic appointment to a newly created board for a minimum five-year period.²⁶⁰

(b) *Limitations on the Subsequent Use of Conversion Proceeds*

Ten states simply require, without providing guidelines, that the attorney general determine if the proposed use of the sales proceeds is consistent with the nonprofit hospital's charitable purpose.²⁶¹ Virginia lacks any provisions regarding the subse-

256. See COLO. REV. STAT. § 6-9-403(e) to 6-9-403(f); 1997 CONN. ACTS 188, § 4(8).

257. See D.C. CODE ANN. § 32-554(a).

258. See OHIO REV. CODE ANN. § 109.35(F)(1).

259. See MD. CODE ANN., STATE GOV'T. § 6.5.301(b)(2)(ii). Maryland provides that before a charitable entity can receive conversion funds, it must establish a mechanism for avoiding conflicts of interest. See *id.*

260. See *supra* note 125.

261. See CAL. CORP. CODE § 5917(e); HAW. REV. STAT. § 323D-76(8); LA. REV. STAT. ANN. § 40:2115.17(B)(7); NEB. REV. STAT. § 71-20,108(8); N.H. REV. STAT. ANN. § 7:19-b (II)(e); OHIO REV. CODE ANN. § 109.35(3); OR. REV. STAT. § 65.811(4); WASH. REV. CODE § 70.45.070(8). Ohio differs to the extent that the use of the proceeds must be consistent with the charitable trust to which it is subject. South Dakota has a similar concept—it requires that the notice to the Secretary of State include an

quent use of the sales proceeds.²⁶²

Some states require the parties to state their intended post-transaction use of conversion proceeds. Arizona, Georgia and Rhode Island require the original conversion proposal to disclose the intended use of the sale proceeds.²⁶³ Arizona also requires the parties to describe the resources that will remain in the community and whether they will be deposited in a community benefit organization.²⁶⁴ Rhode Island requires the buyer to include in its application a statement specifying the manner in which it intends to fulfill the hospital's charitable objectives.²⁶⁵ Colorado mandates that the charitable mission and function of the nonprofit organization receiving conversion funds reflect the historical charitable purposes of the nonprofit entity proposing the conversions.²⁶⁶

Connecticut and the District of Columbia restrict the use of conversion proceeds to health care services broadly consistent with the original purpose of the selling entity in the affected community.²⁶⁷ Maryland's method of monitoring the activity of the foundation is to require the charitable trust to submit annual reports regarding its grant-making and other charitable endeavors.²⁶⁸

Whether the conversion proceeds are administered by the existing nonprofit organization or are placed in a new foundation, safeguards must ensure that the ongoing health care needs of the affected community, especially the needs of the uninsured and underinsured population, are met. To accomplish this, conversion legislation should require the entity receiving conversion proceeds to conduct a "needs" analysis to determine the health care services most needed by the affected community and to submit a plan to meet these needs before conversion funds are expended. Except for Maryland, Colorado, Washington and Louisiana, there are no ongoing annual reporting requirements

explanation of how the transaction "furthers the purpose of the nonprofit corporation." See S.D. CODIFIED LAWS ANN. § 47-24-17(4).

262. See VA. CODE ANN. § 55-531.

263. See ARIZ. REV. STAT. § 10-2593(F)(5); GA. CODE ANN. §§ 31-7-403(b)(7); R.I. GEN. LAWS § 23-17.14-7(c)(25).

264. See ARIZ. REV. STAT. § 10-2593(F)(1).

265. See R.I. GEN. LAWS § 23-17.14-6(a)(21).

266. See COLO. REV. STAT. § 6-19-403(1)(i).

267. See 1997 CONN. ACTS 188, § 4(8)(B); D.C. CODE ANN. § 32-553(c)(12).

268. See MD. CODE ANN., STATE GOV'T. § 6.5-306(b).

placed upon the nonprofit health care institution mandating that grant making be justified.²⁶⁹

III. FEDERAL AVENUES OF CONVERSION SCRUTINY

Conversion transactions are resulting in the largest redistribution of charitable assets in history.²⁷⁰ The sheer magnitude of these funds requires a comprehensive state and federal strategy to avoid the dilution and misappropriation of charitable assets.²⁷¹ Yet, for the most part, individual states, not the federal government, review and regulate nonprofit hospital conversion activities.²⁷² Currently, there are no federal agencies that require notification of or regulate the conversion approval process. Federal scrutiny, if undertaken, most often occurs after conversions have been completed and rarely focuses on health care quality and access issues or on restricting the use of conversion proceeds.²⁷³ What supplemental federal oversight exists is potentially available from two primary sources: (1) antitrust screening by the Department of Justice or the Federal Trade Commission; and (2) Internal Revenue Service scrutiny stemming from tax-exempt operational requirements prohibiting private inurement and private benefit.

A. Antitrust Considerations

Although antitrust laws are not specifically directed toward nonprofit hospital conversions, they are generally intended to promote competition by limiting business activities that substantially lessen competition.²⁷⁴ As such, in order for conversion activity to activate federal antitrust scrutiny, the transaction would need to result in a monopoly or the restraint of trade or commerce.²⁷⁵ One federal health care official explained that the Department of Justice and the Federal Trade Commission oversee nonprofit hospital conversions.²⁷⁶ However, since hospital conversions are viewed for antitrust purposes in the same manner

269. See COLO. REV. STAT. ANN. § 6-19-405; LA. REV. STAT. ANN. § 40:2115.19; MD. CODE ANN., STATE GOV'T. § 6.5-306(b); WASH. REV. CODE § 70.45.100.

270. See Miller, *supra* note 3, § 2, at 1.

271. See *id.* at 1, 2.

272. See Singer, *supra* note 14, at 224.

273. See Fishman, *supra* note 2, at 717; Miller, *supra* note 3, § 2, at 1.

274. See generally, Sherman Act § 1, 15 U.S.C. § 1 (1994); Clayton Act § 7, 15 U.S.C. § 18 (1994).

275. See Sherman Act § 1; Clayton Act § 7.

276. See GAO Report, *supra* note 10, at 30. See also GAO Examines Nonprofit Hospital Conversions, HEALTH LAW. NEWS, Feb. 1998, at 23.

as other types of mergers and acquisitions involving two or more nonprofit entities, they do not ordinarily violate antitrust guidelines.²⁷⁷

According to the GAO Report, since 1993 the FTC has brought only three antitrust enforcement actions involving nonprofit hospital conversions.²⁷⁸ Unless a nonprofit hospital conversion creates an entity with a market share that impermissibly reduces competition, it is unlikely that either the Department of Justice or the Federal Trade Commission will review the transaction. Even where antitrust questions arise, the focus of these agencies is to preserve competition rather than charitable assets.²⁷⁹ It is unlikely either of these entities is authorized to require that fair value is paid for charitable assets or that an ongoing system to regulate and monitor the use of conversion proceeds is established. Yet, antitrust enforcement can be an additional avenue of protection when the sale of the nonprofit hospital or hospital system will result in substantially reduced competition. In these situations, antitrust challenges can be raised to preserve competition and to lessen the likelihood that the purchaser will discontinue needed health care services to the affected community.

B. Federal Tax Considerations

Typically, Internal Revenue Service (“IRS”) officials consider the states to be in the best position to oversee problematic hospital conversions.²⁸⁰ Nevertheless, the IRS is responsible for enforcing federal tax laws that apply to the status and operation of tax-exempt organizations, including nonprofit hospitals and foundations.²⁸¹

The Internal Revenue Code exempts from federal income tax entities that are “organized and operated exclusively” for religious, charitable, educational or scientific purposes, provided that no part of the organization’s net earnings inure to the bene-

277. See GAO Report, *supra* note 10, at 30. The FTC has investigated only 10 proposed acquisitions by for-profit hospital and in three blocked the merger or required divestiture as a condition for allowing the transaction to proceed. See *id.* at 30-31.

278. See *id.* at 5-6.

279. For an overview of the federal government’s approach to antitrust activity in the health care industry see DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996).

280. See GAO Report, *supra* note 10, at 28.

281. See *id.*

fit of any private shareholder or individual.²⁸² The operation of a hospital and the advancement of health both qualify as charitable activities.²⁸³ The organizational requirement merely entails that the institution properly organize itself as a nonprofit organization under the relevant state nonprofit corporate law. It is accomplished by including “magic language” in the entity’s articles of incorporation and by-laws restricting its activities to purposes exempt under the Internal Revenue Code.²⁸⁴ The operational requirement prohibits a nonprofit organization from engaging in private benefit or private inurement.²⁸⁵ If a charitable organization allows its earnings to inure to the benefit of private individuals, it forfeits its tax-exempt status.²⁸⁶

In a conversion transaction, private benefit can occur when the sale of nonprofit assets benefits the purchaser more than incidentally.²⁸⁷ Typically, private benefit accrues to the purchaser when nonprofit assets are sold for less than fair value. Undervaluing charitable assets does not serve the purpose of qualitatively furthering the hospital’s tax-exempt purpose and results in a quantitative benefit to the purchaser that is more than incidental to the public benefit achieved.²⁸⁸

282. See I.R.C. § 501(c)(3).

283. See Rev. Rul. 69-545, 1969-2 C.B. 117; Gen. Couns. Mem. 39,598 (Jan. 23, 1987); Singer, *supra* note 14, at 245; Bisesi, *supra* note 27, at 815 (citing the RESTATEMENT (SECOND) OF TRUSTS § 368 (1959)); Fishman, *supra* note 2, at 704.

284. See Singer, *supra* note 14, at 245.

285. See I.R.C. § 501(c)(3); Treas. Reg. 1.501(c)(3)-1(d)(ii). Although the requirements for finding inurement or private benefit are similar, they differ in two respects. First, inurement only applies to “insiders.” Insider are individuals whose relationship with the organization offers them the opportunity to make use of the organization’s income or assets for personal gain. Second, even a minimal amount of inurement disqualifies an organization for tax-exempt status. Inurement arises where a financial benefit represents a transfer of the organization’s financial resource to an individual solely by virtue of the individual’s relationship with the organization, without regard to accomplishing an exempt purpose. See Gen. Couns. Mem. 38,459 (July 31, 1980). On the other hand, private benefit must be more than quantitatively or qualitatively incidental to the activities of the exempt organization to jeopardize the entity’s tax-exempt status. To be incidental in a qualitative sense, the benefit must be a necessary concomitant of the activity that benefits the public at large. That is, the activity can only be accomplished by benefiting certain private individuals. To be incidental in a quantitative sense, the private benefit must not be substantial after considering the overall public benefit conferred by the activity. See Gen. Couns. Mem. 39,598 (Jan. 23, 1987) & 377,89 (Dec. 18, 1978). See also Rev. Rul. 69-545.

286. See Gen. Couns. Mem. 39,598 (Jan. 23, 1987) & 377,89 (Dec. 18, 1978). See also Rev. Rul. 69-545.

287. See Singer, *supra* note 14, at 245-46.

288. See *id.* at 246.

Private inurement can occur when an officer, director or any other individual in a position to control or influence the decisions of the nonprofit hospital receives a benefit, financial or otherwise, from the hospital that is disproportionately greater than the services he has rendered to the organization.²⁸⁹ Typically, private inurement occurs when individuals with influence over the nonprofit hospital's activities receive lucrative offers for ownership interests in the purchasing entity, promises of future employment or consulting contracts in exchange for facilitating the conversion.

If a tax-exempt organization sells its assets for less than fair value or allows insiders to benefit from the conversion, the tax-exempt status of the nonprofit hospital is jeopardized because it is no longer operating exclusively for its charitable purpose.²⁹⁰ Historically, since revocation of a hospital's tax-exempt status would likely result in the hospital's closure or bankruptcy and would not penalize the individuals who profited at the expense of the public, the IRS has rarely imposed this sanction.²⁹¹

In 1996, Congress enacted a law to provide closer scrutiny of insider "excess benefit" deals.²⁹² For the first time, the IRS was authorized to impose an excise tax,²⁹³ also known as an intermediate sanction, on individuals and organization managers who receive economic benefits in excess of the consideration received by the nonprofit organization.²⁹⁴ In the conversion setting, individuals who fail to pay fair value for nonprofit hospital assets or who receive a benefit beyond the value of the services they rendered the nonprofit entity would be involved in an excess benefit transactions.²⁹⁵ Such individuals may be assessed a

289. See *id.*; Treas. Reg. § 1.501(c)(3)-1(c)(2).

290. See Bisesi, *supra* note 27, at 825.

291. See Singer, *supra* note 14, at 247.

292. See I.R.C. § 4958 (1998). See also Meri-Beth Robertson, *IRS closely examines insider 'excess benefit' deals*, 146 N.J.L.J. S-12 (1996).

293. The IRS is initially authorized to impose a 25% tax on the excess benefit received. If the excess benefit is not corrected within the tax period, an additional tax equal to 200% of the excess benefit may be imposed. Under certain circumstances, organizational managers who participate in the excess benefit, but do not receive the actual benefit, can be assessed a tax of 10% of the benefit bestowed, up to \$10,000 for each transaction. See I.R.C. § 4958 (a), (b); Singer, *supra* note 14, at 247-48.

294. See Singer, *supra* note 14, at 247.

295. An excess benefit transaction is a transaction in which the tax-exempt organization provides an economic benefit, directly or indirectly, to a disqualified person, that exceeds the value of the consideration received by the organization. See Singer, *supra* note 14, at 247; Ono, *supra* note 56, at 121.

personal tax liability equal to twenty-five percent of the excess benefit received.²⁹⁶

This enactment permits federal oversight of nonprofit hospital conversions through the vigorous enforcement of intermediate sanctions. If state conversion legislation requires detailed submissions as part of the approval process, the IRS is positioned to evaluate and determine whether the purchase price results in an excess benefit for the purchaser. The same detailed conversion submissions would provide a basis to determine whether any post-conversion commitments made to individuals with influence over the nonprofit hospital amount to private inurement. The state attorney general could use federal tax-exempt rulings to require modifications to the conversion agreement or to disapprove the transaction. Detailed post-transaction reporting requirements as to grant-making activities would deter private benefit or private inurement by providing ample documentation to facilitate periodic IRS audits.

At best, IRS enforcement of tax-exempt regulations can help protect charitable assets but not community access to health care. The IRS is authorized to evaluate the details of the conversion transaction for private benefit and private inurement issues and can insure that charitable assets are not diverted to private hands.²⁹⁷ However, the IRS can neither require that the community be informed of hospital conversion activity nor restrict the use of conversion proceeds to the provision of health care in the affected community.²⁹⁸ As a result, federal tax considerations alone cannot adequately safeguard the community's continued access to affordable health care.

296. See I.R.C. § 4958(a)(1); Singer, *supra* note 14, at 248; Bisesi, *supra* note 27, at 812-13.

297. The IRS can pursue another avenue of oversight when the conversion activity results in a joint venture between the nonprofit hospital and for-profit entity. To maintain tax-exempt status, the nonprofit's participation in the joint venture must advance the nonprofit's charitable purpose and may not result in more than an incidental benefit to the for-profit partner. This usually will require that the nonprofit exercise control over the day-to-day activities of the joint venture. Continued use of the joint venture conversion form may decrease due to the for-profit entity's unwillingness to relinquish control of the venture. The nonprofit entity also has a additional disincentive for choosing the joint venture conversion structure. Income earned by a nonprofit organization from the joint venture may be subject to income tax under unrelated business income tax rules. While these guidelines may make joint ventures less attractive, they are not likely to curtail nonprofit hospital conversions, which most often utilize the direct sale format. See Gen. Couns. Mem. 39,598 (Jan. 23, 1987); Gen. Couns. Mem. 37,789 (Dec. 18, 1978); GAO Report, *supra* note 10, at 29.

298. See GAO Report, *supra* note 10, at 17.

In view of these limitations, and based in part on the GAO report, Representative Fortney “Pete” Stark (D-Calif.), ranking minority member of the House Ways and Means Health Subcommittee, introduced federal conversion legislation known as HR 443, the “Medicare Non-Profit Protection Act of 1997.”²⁹⁹ This legislation would require federal approval of nonprofit hospital conversions as a condition of continued participation in the Medicare program. At present, the bill, which was referred to the Health Subcommittee on January 21, 1997, has received no further action.³⁰⁰

Though an independent federal approval process for nonprofit conversions would likely create redundancies, it would add substantial expertise, potentially streamlining the valuation of charitable assets. In addition, comprehensive federal legislation would establish national standards for regulating nonprofit hospital conversions.

Yet, to avoid impeding necessary conversions and to foster continued health care reform, a better approach may be to allow the individual states to coordinate conversion approval while simultaneously integrating federal expertise into the evaluation process. An IRS review and approval of the transaction for private benefit and private inurement issues could assist states in the determination that fair value is paid for charitable assets and that conversion proceeds continue to be used for appropriate charitable purposes. Federal legislation requiring the purchaser to maintain minimum levels of health care services to the affected community as a condition of continued participation in the Medicare program could greatly assist a state in assuring that the affected community will continue to receive necessary health care services. Even absent additional federal legislation, the IRS is poised to supplement state nonprofit conversion legislation. What is necessary is the resolve to aggressively apply existing tax-exempt operational requirements to the conversion approval process.

IV. CONCLUSION: PROTECTION OF NONPROFIT CHARITABLE ASSETS BY CURRENT CONVERSION STATUTES

Although the nonprofit community hospital historically has been the backbone of the American health care delivery system,

299. *Reps. Stark, Coyne Say GAO Report Supports Oversight of Hospital Transactions*, HEALTH L. REP. (BNA), Jan. 8, 1998, at 56.

300. *See id.*

health care reform requires that we focus on the quality and quantity of the health care being delivered to our communities rather than the form of the health care institution. Though conversion activity may not warrant encouragement, the cost-cutting pressures of managed care, reduced hospital inpatient stays and reduced Medicare payments all necessitate that nonprofit hospital conversions be accepted.

Notwithstanding this acceptance, the tenacious enforcement of conversion legislation by state attorneys general is crucial to the preservation of charitable assets. State conversion legislation must concentrate on the two major issues: (1) insuring that fair value is received for charitable assets; and (2) establishing an ongoing and effective system to regulate and monitor the subsequent use of conversion proceeds.

Fair value is achieved by striking a balance between receiving fair market value for nonprofit hospital assets and securing enforceable commitments from the purchaser to maintain a certain level of health care services to the affected community, above those mandated by existing state and federal law. To preserve the community's investment in the nonprofit hospital, the subsequent use of conversion proceeds should be restricted to the provision of necessary health care services—not necessarily inpatient care—in the affected community.

Collectively, conversion legislation has begun to fill the gap between the states' inherent authority to protect charitable assets and its obligation to maintain access to and quality of health care for its communities. Supplementing these initiatives with aggressive enforcement of federal tax-exempt operational requirements will provide the needed mechanisms to preserve and protect nonprofit hospital assets. While none of the current conversion enactments successfully addresses all the issues that arise when a nonprofit hospital pursues conversion, Rhode Island comes the closest. Rhode Island's statute dutifully endeavors to list all the potential issues that should be considered during the approval process. Yet, even Rhode Island's legislation could be improved.

A synthesis of the best elements found in the various state enactments and model codes would result in an optimal nonprofit hospital conversion statute. There is little doubt that the more thorough the approval process, the greater the likelihood the state will be successful in preserving charitable assets. Optimum conversion legislation would include the following:

1. Reporting requirements: (1) when a transaction involves the sale of twenty percent or more of a nonprofit's assets, or (2) at any amount if the asset sale will change the nature of the services historically provided by the nonprofit entity. Multiple transactions occurring within a five-year period between related parties would be evaluated collectively to determine if the aggregate purchases amount to a twenty percent change in ownership or control or change the nature of services historically provided by the nonprofit entity.

2. Disclosure of the purchaser's commitments to continue health care services in the affected community following the conversion. Itemizing the purchaser's representations in the transaction documents will enhance the attorney general's effectiveness in enforcing contractual obligations.

3. Court authorization. The purchaser should be required to secure court authorization before eliminating or significantly reducing crucial health care services to the affected community. Court approval will provide an effective system to monitor and control the purchaser's post-conversion conduct.

4. Effective enforcement authority. In addition to the ability to void the transaction and revoke hospital licenses, the attorney general should have the authority to impose significant monetary penalties against the contracting entities and their officers and directors for failure to secure the requisite approval. Fines up to \$10,000,000 against the contracting entities and \$1,000,000 against the entities' officers and directors would provide a sufficient deterrent to unauthorized conversions.

In addition to empowering the attorney general with authority to require strict performance of contractual obligations by the parties, conversion legislation should impose substantial civil monetary penalties against individual corporate officers and directors for circumventing transaction obligations. For failure to satisfy conversion commitments or for the misuse of conversion proceeds, daily fines should be imposed. An alternative to establishing a specific daily fine, such as \$10,000 per day, per occurrence, would be to establish fines in proportion to the value of the commitments broken and charitable funds misappropriated. To be effective, legislation must include mechanisms to detect whether community obligations are being met.

5. Annual reporting requirements. The purchaser should be required to demonstrate compliance with all contractual obligations for a minimum of five years following conversion. Any

entity receiving conversion proceeds should be required to disclose all grant-making activities and to demonstrate that those expenditures are meeting the health care needs of the affected community for a similar period. The attorney general should retain the discretion to extend the reporting requirements until all transactional commitments have been satisfied. Legislation should provide for the automatic revocation of the purchaser's operating license for the failure to file annual reports.

6. *Qui tam* provisions. Authorizing individuals and community groups to initiate suits on behalf of the attorney general in the event that the purchaser fails to honor transaction commitments or the seller fails to restrict the use of conversion proceeds to the provision of health care services in the affected community will inexpensively, but effectively, enhance attorney general oversight of post-transaction activities.

7. Preserve foundation independence. Participation of the parties and their affiliates on the boards of any charity receiving conversion proceeds should be limited to twenty percent. The remaining board members should be broadly representative of the affected community. A representative of the attorney general should be an automatic appointment to newly created boards for a minimum five-year period. A newly created foundation should also be required to file an annual report with the attorney general, demonstrating that its activities and grants have furthered the former nonprofit hospital's charitable mission.

Current conversion legislative initiatives should be applauded for their accomplishments. However, adequate safeguarding of nonprofit hospital assets remains elusive. Attorney general initiative, rather than complacency, should ignite a renewed commitment to maximize the public's benefit in conversion proceeds by restricting grant-making activities to the provision of health care services in the affected community.