Special Report

COLUMBIA/HCA AND THE RESURGENCE OF THE FOR-PROFIT HOSPITAL BUSINESS

(Second of Two Parts)

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COLUMBIA/HCA'S drive to increase its market power by purchasing not-for-profit community hospitals has raised thorny questions. Lately, it has also met escalating resistance. Columbia's deals are notable for the speed, secrecy, and legal ingenuity with which they are accomplished. The company has flying squads of acquisition specialists backed by financial analysts, accountants, lawyers, and consultants and can negotiate a binding letter of intent with a hospital's board of trustees in a matter of weeks. To a town with fiscal strains and a money-losing hospital, Columbia/HCA can look like a white knight. A tax-exempt institution stands to become a tax-paying one. A strapped hospital can gain millions of dollars in capital improvements. The company's acquisitions run the gamut from the hard-pressed local hospital genuinely needing rescue to the robust institution whose executives received an offer they couldn't refuse.

The issues posed by these acquisitions are multiple. Should nonprofit, charitable institutions be sold to for-profit chains at all? Often, land was deeded in perpetuity or a hospital was endowed explicitly to provide charity care. Moreover, the present worth of the hospital represents many decades of philanthropy, foregone taxes, other public outlays, and the contributions of staff members who may have worked at below-market salaries.

Without independent valuation, the conversion to for-profit status can produce a one-time windfall for the acquiring company, which seizes the capitalized value of an institution not previously considered a commodity. From the perspective of Columbia/HCA, the acquiring company takes under-performing assets, connects them to a network, and through the application of entrepreneurial skill, increases their worth. But by removing a key nonprofit institution, the conversion irrevocably diminishes the local stock of noncommercial community health care facilities and fuels the impression that the full commercialization of health care is both desirable and inevitable.

CONVERSIONS AND THE LAW

A conversion usually circumvents the restrictions in a hospital charter, deed, or will by creating a new charitable foundation ostensibly to carry on the hospital's charity mission. The pertinent legal doctrine, known as *Cy Pres,* allows the original form of a public charity to be changed, subject to court approval, but requires the substantive charitable purpose to endure.[33] Typically, Columbia/HCA negotiates a purchase price, obtains control of the hospital assets, sometimes by purchasing as little as 50 percent ownership, and uses part of the proceeds from the sale to set up the new foundation. This action, however, raises other issues: Who should control the foundation? Can it pursue purposes other than health care? Will the foundation, formally or tacitly, be part of the Columbia/HCA family? Does the hospital (now a profit-maximizing company) retain any obligation to provide money-losing community services? What aspects of the deal should be subject to ongoing government supervision? Was the selling price too low, and did trustees or executives of the hospital get excessive financial inducements to promote the sale? Under state and federal law, improper personal gain by trustees of charitable assets, known as "inurement," is illegal.

Columbia/HCA, understandably, seeks to buy these hospitals as cheaply as possible and goes to great lengths to discourage competitive bids. Its letters of intent require secrecy and may mandate severe penalties if the target hospital entertains other offers. This is somewhat ironic, since in a free market the best way to determine an asset's worth is to see what competing buyers will pay. (Columbia's concrete goals as a profit-maximizing corporation complicate its abstract enthusiasm for market principles.)

In practice, not all state attorneys general strictly

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apply the *Cy Pres* doctrine to hospital conversions. In Massachusetts, MetroWest Health, the operator of two community hospitals in Framingham and Natick, was in distress and seeking a partner. Rebuffed by local nonprofit hospitals, a new chief executive, Lawrence Kaplan, negotiated an 80 percent sale to Columbia/HCA. In late 1995, Attorney General Scott Harshbarger intervened to supervise the sale. (Most financial details, however, were not made public. Harshbarger, according to a key aide, accepts the argument that such details are trade secrets.) The attorney general held a public hearing, retained an accounting firm to establish fair market value, extracted from Columbia/HCA a commitment to keep both emergency rooms open for at least three years, and improved other community benefits, including the terms of the foundation.[34]

In Tennessee, by contrast, when Nashville Memorial Hospital was sold in 1994 to Healthtrust (which was later acquired by Columbia/HCA), not only were the details kept secret, but also several trustees of the hospital learned of the sale only after the deal was struck. J.D. Elliott, the hospital chief executive officer who negotiated the sale, was then awarded the presidency of the new foundation. Although a public charity was being sold, the transaction was handled as if it were a private business deal. The Tennessee attorney general did not challenge key terms of the sale, and only ordered them made public after the fact. In Dickson, Tennessee, where Goodlark Hospital was sold in 1995 to Columbia/HCA, the local state representative, Douglas Jackson, served both as a trustee of Goodlark and as its lawyer before its sale and as head of the new foundation afterward. The foundation's first outlay was to book the Nashville Symphony for a free local concert.[35]

When HealthONE, a six-hospital system in Denver, put most of its $550 million in assets into a joint venture with Columbia/HCA, $350 million went to pay off HealthONE's huge debt, the hangover from a previous buyout deal. No money went into a foundation, and Colorado authorities let the deal stand. According to Deputy Attorney General Jan Zavislan, Colorado has no statutory authority to review hospital conversions.[36]

California Deputy Attorney General James Schwartz, in contrast, routinely reviews and modifies terms of sale. Unlike Massachusetts and most other states, California makes all the financial details of such sales part of the public record. Schwartz told me, "We find it highly questionable that anybody would consider these other than public assets open to the public." However, in contrast to Harshbarger, Schwartz claims jurisdiction only over the new foundation, not over the newly converted hospital — which is then free to shift the burden of charity care to the foundation.

The conversion issue has gained particular visibility in California because of the controversial sales of other health care organizations in leveraged buyouts, at sums far below market value.[37] HealthNet, a nonprofit health maintenance organization (HMO), was converted in 1992 to the for-profit Health Systems International at a price widely considered too low. Thirty-three executives of the nonprofit purchased 20 percent ownership of the new company for just $1.5 million. By April 1996 their shares were worth $315 million.[38] Blue Cross of California contrived a conversion in July 1991 through a new for-profit subsidiary, WellPoint Health Networks, which would hold 90 percent of its assets. Since the nonprofit parent company would technically continue to exist, no charitable foundation would be necessary. Blue Cross, whose WellPoint subsidiary soon attained a market value of $2.7 billion, initially offered just $5 million in annual charitable donations. After more than three years of investigation and negotiation, the California corporations commissioner, prodded by Assemblyman Phillip Isenberg, other key legislators, Consumers Union, and the local press, compelled Blue Cross/WellPoint to fund two new public foundations — with assets of $3.2 billion.[39]

A GROWING BACKLASH

The growing resentment of hospital takeovers is part of a broader consumer backlash against other market intrusions into health care, most notably the practice of many HMOs of giving doctors financial inducements to withhold care. In the past year, at least 30 pending deals with Columbia/HCA have been killed or revised by regulatory, civic, physician, or community opposition.

In California, pending bipartisan legislation sponsored by Assemblyman Isenberg would give the state attorney general power to block conversions if he or she found the terms unfair or found that the sale might "create a significant effect on the availability or accessibility of health care services to the affected community."[40] Other state regulators and legislatures have lately become more assertive, as well. In April, in the wake of Columbia's unsuccessful attempt to buy Bishop Clarkson Memorial Hospital in Omaha, Nebraska, and efforts by Regional West Medical Center in Scottsbluff, Nebraska, to find for-profit suitors,[41] Nebraska enacted a law empowering the attorney general to block the conversion of a nonprofit hospital on the basis of any of nine criteria, including conflicts of interest involving board members, whether the proposed sale reflected fair market value, and "whether the purchaser has made a commitment to provide care to the disadvantaged, the uninsured, and the underinsured and to provide benefits to the affected community to promote improved health care."[42] Thus, in Nebraska even a for-profit hospital is required by law to have other than profit-maximizing goals. In June, Michigan Attorney

General Frank J. Kelley sued to block Columbia's proposed acquisition of 50 percent of Michigan Capital Medical Center in Lansing,[43] asserting his general "supervisory power over charitable trusts." And in Houston, Attorney General Dan Morales recently joined a lawsuit filed by the Texas Medical Center, seeking to block a complex deal pending between Columbia/HCA and St. Luke's Episcopal Hospital, on the grounds that it violates deed restrictions that limit the use of most Texas Medical Center property to nonprofit institutions.

Columbia/HCA's most audacious recent foray, in Ohio, breaks its tradition of avoiding the insurance business. In March, Blue Cross and Blue Shield of Ohio, the state's largest insurer, with annual revenues of some $2 billion, agreed to sell 85 percent ownership to Columbia for $299.5 million through a complex venture called BlueCo, legally crafted to avoid the form of a conversion, thus eliminating a payout obligation to policyholders or a charitable foundation. Because $223 million of Blue Cross and Blue Shield reserves would go to the new venture, Columbia/HCA would be buying Blue Cross and Blue Shield largely with the latter's own assets. The National Blue Cross and Blue Shield Association voted on June 13 to revoke the license of the Ohio affiliate to use the famous trademark if the deal goes through. Under the proposed acquisition, Columbia/HCA will pay three top executives of Ohio Blue Cross and Blue Shield over $15 million in severance payments characterized as consulting fees and agreements not to compete, with millions more going as a consulting fee to the Blues' outside lawyer.[44]

On July 11, Ohio Attorney General Betty Montgomery sued to block the transaction pending review by the Ohio insurance commissioner, who regulates mutual insurance companies. Montgomery requested an independent valuation and assurance that the Blue Cross and Blue Shield assets would go to policyholders or for charitable purposes, and she began an antitrust investigation. According to Montgomery, "Fifteen million dollars in severance packages for three officials of an organization founded as a charity, and operated to help the sick and the needy, strikes me as both inappropriate and excessive."[45] Montgomery said she thought Blue Cross and Blue Shield was being sold at "pennies on the dollar."[46]

An earlier class-action suit filed in April on behalf of Blue Cross and Blue Shield policyholders by former U.S. Senator Howard Metzenbaum, chairman of the Consumer Federation of America, characterized the deal as a disguised conversion of Blue Cross and Blue Shield and contended that its entire $302.5 million in reserves properly belongs to policyholders.[47] In reply, attorney Kenneth F. Seminatore, for Blue Cross and Blue Shield, oddly accused Metzenbaum of "advocating the theft of policyholder money."[48] Under the agreement between Columbia/HCA and the Ohio Blues, lawyer Seminatore will collect $3.5 million if the deal goes through.

COMMERCIAL AND POLITICAL HARDBALL

Columbia/HCA has become a lightning rod for criticism not just because of its prodigious growth and scale, but also because of the ferocity of its tactics. When Columbia/HCA began entering markets in earnest, it did not just compete vigorously; it mounted a public-relations campaign to portray nonprofits as social parasites. On at least one occasion, chief executive officer Richard Scott flatly declared that "Nontaxpaying hospitals shouldn't be in business."[49]

The political muscle of Columbia/HCA is legendary. When it enters a community in pursuit of an acquisition, Columbia/HCA lines up blue-chip legal talent, identifies allies among local civic, political, and medical leaders, and spreads around lots of money. In 1995, for example, Columbia/HCA had 33 lobbyists in Tallahassee, Florida.[50] It also leads the list of corporate campaign contributors in Florida. Nationally, its staff is regularly solicited to donate to one of its political-action committees. Legally, the political-action committees are independent of the corporation, but employees of the company solicit their subordinates.

In Fort Myers, Florida, where Columbia/HCA is in fierce competition with the nonprofit Lee Memorial Health System, Lee Memorial officials discovered that Columbia/HCA usually sends members of its local health plan who need specialized children's inpatient care to a hospital in St. Petersburg, over 100 miles away, rather than have the business go to Columbia's local competitor. Dr. John Donaldson, a pediatric otolaryngologist in Fort Myers who has publicly criticized Columbia/HCA, told me, "When you fragment a local system, everyone suffers. And suffers not for the benefit of the patients but for the benefit of [Columbia/HCA chairman] Rick Scott. This degree of competition is pro-Columbia but it's anti-community." In 1994, Columbia/HCA took over as sole provider for the health plan of the Lee County government. It won the business by underbidding Lee Memorial, despite the fact that Lee Memorial's average charges per discharge were about 25 percent below Columbia's, according to data cited in the *Wall Street Journal*.[51] After the *St. Petersburg Times* ran an editorial advocating an antitrust investigation of Columbia/HCA's local acquisitions (amounting to nearly a third of hospital beds in the Tampa Bay area), the chain not only pulled an estimated $800,000 to $1 million worth of advertising from the newspaper, but also pulled the newspaper's sales racks from its area hospitals and refused to permit its sale in hospital gift shops.[52] At Columbia/HCA's Lawnwood Regional Medical Center, in Fort

Pierce, the administrator sent a memo to the medical staff dangling

> an exciting investment opportunity through Columbia/HCA which will be offered to physicians on our medical staff in the coming months. This opportunity will *not* be offered to physicians who are investors in a competing venture with our hospital. . . . I pledge to you that Columbia/HCA will utilize all appropriate resources to insure the failure of any competing surgery center in our community.[53]

Last year Columbia/HCA bought a 50 percent share (and management control) of the Catholic Sisters of St. Augustine Health System, based in Ohio. Trustees of one member hospital, Timken Mercy Medical Center in Canton, were summarily fired for questioning the deal.[54] Recently, after losing a bitter legislative battle to modify Georgia's certificate-of-need law so that it could offer obstetrical and open-heart-surgery services in the Atlanta area, Columbia/HCA pulled 18 of its 19 hospitals out of the state hospital association, which opposed the law.[55]

EFFICIENCY AND CONVERGENCE

From Columbia/HCA's perspective, the company is performing a national service by at last creating a rational and efficient health care system that relies on the discipline of the market. The competitive hardball is just the free market at work. According to Dr. David Manning, a Columbia/HCA executive and previously architect of the TennCare Medicaid system, "Columbia is bringing an efficiency to the market in hospitals that can never be gained by an organization that does not seek to fully integrate the health system. We are well ahead of everyone else in getting our costs under control." Manning insists that such efficiencies do not compromise clinical care. "You don't get the kind of levels of [Joint Commission on Accreditation of Healthcare Organizations] commendation that Columbia gets by skimping on patient care."

According to Dr. Frank Houser, a one-time Georgia public health commissioner who recently became coordinator of Columbia/HCA's physician relations, "We probably measure more things than anybody else in the industry." As Houser explains, Columbia's Meditech data system not only gives primary care doctors and financial planners computerized access to medical records, but also allows sophisticated tabulations and analysis, at the corporate level, to track clinical outcomes and control quality. Houser points to the company's Gallup-poll data on patient satisfaction as further evidence that Columbia/HCA does not skimp on quality.

Drs. Houser and Manning dispute the criticism that Columbia/HCA fails to carry its share of charity patients. As they envision the future, there will be more very tightly managed Medicaid models along the lines of TennCare, in which Columbia/HCA, according to Manning, is well positioned to compete. Columbia's planners describe the multiple benefits of its integrated network almost as if it existed in isolation from the rest of the health care system. Yet, as Dr. Donaldson's comment suggests, even as Columbia/HCA reduces internal costs, its fierce brand of local competition imposes external costs, because it fragments as well as integrates.

The answer to whether Columbia/HCA truly contributes to a more efficient use of health care resources without shifting costs to others or compromising care depends on whose statistics you believe and how you interpret them. Curiously, as Columbia/HCA moves to a totally integrated system, it is reinventing something very like the Kaiser-style prepaid group plans — with doctor, hospital, specialty facility, and perhaps payer all part of the same closed system. But the key difference is that Columbia/HCA is a for-profit company, so money saved by its economies is not necessarily redirected to more efficient patient care, but is dropped to the bottom line to be spent on dividend payments and future acquisitions.

Although Columbia/HCA proclaims its adherence to market discipline, the fundamental source of market efficiency is theoretically the consumer's freedom to shop around. But the system integration so central to Columbia's strategy works not just to produce cost economies but also to *prevent* shopping around and to allow Columbia/HCA to impose conditions that doctors and patients might otherwise resist.

If Columbia's move toward integrated systems is in some respect reminiscent of nonprofit group health plans, the big nonprofits are now in many ways defensively emulating Columbia/HCA and other for-profits. In the face of no-holds-barred competition from Columbia/HCA and other for-profits, it remains to be seen whether community hospitals and teaching hospitals can maintain the distinctive values that Columbia insists have already blurred.

WHAT'S THE DIFFERENCE?

Today, all hospitals, whether corporate or voluntary, operate in an environment increasingly contoured by for-profit institutions. A nonprofit hospital negotiates with for-profit insurers, HMOs, and corporations. To fill beds, it competes with other hospitals — nonprofit and public as well as corporate. It may well have for-profit subsidiaries and coventurers. A market culture and market idiom are becoming pervasive, even among nonprofits. Within living memory, service areas were not called markets; heads of hospitals were administrators, not chief executive officers; hospitals did not advertise for patients; and few hospital administrators spoke of market share, let alone EBITDA (earnings before in-

terest, taxes, depreciation, and amortization). All this has changed, perhaps irrevocably. But if nonprofit hospitals defensively emulate for-profits, their claim to the ethical high ground rings hollow.

VHA, with some 1300 nonprofit hospital affiliates, is leading a public-relations counteroffensive against for-profits,[56] but it also advises nonprofits on how to build integrated systems and win market share ("Are your physician relationships attracting primary care physicians to your system and aligning their incentives with yours?").[57] The nonprofits, however, have an offsetting advantage, in that for-profits have to pay dividends and taxes and often have higher corporate and marketing costs. Yet the competitive game is being played in increasingly convergent ways.

An entire consulting industry now exists, advising hospitals, for-profit and nonprofit alike, on how to maximize market power vis-à-vis payers, partners, and competitors and how to trim costs by relying on less expensive personnel. One of the largest such firms, American Practice Management, serves mainly nonprofits. A recent newsletter of Atlanta-based American Health Consultants, promoting "patient-focused care," approvingly quotes an operations manager at Tenet Corporation's Brookwood Medical Center in Texas: "We determined that more than half the 350 tasks that RNs [registered nurses] perform could safely be performed by an unlicensed person."[58]

Consultants' strategies often conflate the goals of cutting costs and improving quality of care, as if they were one and the same. Such changes pare costs but may introduce discontinuities of care at a time when inpatients are generally sicker and stays are shorter. There is no good statistical evidence that these personnel changes necessarily do measurable harm, perhaps thanks to improved monitoring technology, but a negative effect on hands-on care could easily evade the radar of the standard indicators of outcomes.[59]

My interviews with several nurses and leaders of state and national nurses' associations suggest that although the for-profits often lead the way, the changes at the bedside brought about by the for-profit revolution affect both sectors. A September 1994 lawsuit by the militant California Nurses Association, alleging consumer fraud in the deterioration of nursing care, chose nonprofit Alta Bates Hospital in Berkeley as its target. A 1996 membership survey by the American Nurses Association, which showed rising concern about short staffing, replacement of registered nurses with unlicensed personnel, and kindred problems, did not even bother to differentiate for-profit hospitals from nonprofits.[60]

In Massachusetts, with scant penetration by for-profit chains, the big nonprofits are themselves behaving more entrepreneurially. When two prestigious Harvard teaching hospitals, Brigham and Women's and Massachusetts General, merged to form Partners Healthcare Corporation, the strategic logic would have been familiar in Columbia/HCA's boardroom: maximize physician-referral streams, consolidate market share, increase bargaining power with payers, close duplicative facilities, and trim redundant employees.

Of course, a large teaching hospital is substantially managed by doctors, which helps insulate clinical care from excessive bottom-line pressures. Large teaching institutions are also sheltered in part by the fact that insurers have trouble telling subscribers and physicians that distinguished local hospitals are off limits. Other community hospitals, however, may enjoy no such shelter from competitive forces. For-profit chains are advantaged in this race not just by cost cutting, but also because they have less of a lingering sense of community mission, are more aggressive in managing their payer mix, and can move faster. "They tend to operate hospitals very efficiently," says Jeffrey Otten, the chief executive of Boston's Brigham and Women's Hospital. "It exerts competitive pressure on us to become more cost effective. It makes us re-examine how we are providing care. Academic medical centers are very reluctant to close capacity. We haven't been able to do it through planning; perhaps having an external force like Columbia might be the only way to do it." Dr. Samuel Thier, who heads Massachusetts General Hospital, observes, "Eventually, the capacity has to come out of the system, and the system has to come to a new equilibrium. The issue is whether the academic centers, if they survive, will be in a position to maintain and exert their value systems."

In the near future, we will see either a growing convergence in the behavior of nonprofits and for-profits or a sharper delineation between institutions with a community purpose and those driven by the bottom line.

Convergence would intensify the pincer pressure on medicine from managed-care payers on the one side and profit-maximizing hospitals on the other. It would probably further squeeze patient care and physician autonomy. It would increase the tension between doctors' professional and entrepreneurial roles. It would make a self-fulfilling prophecy of Columbia's often repeated claim that there is no effective difference between the two sectors and that tax exemptions are a waste of public money.

In *Animal Farm,* George Orwell concluded his allegory with the words, "The creatures outside looked from pig to man, and from man to pig, and from pig to man again; but already it was impossible to say which was which."[61] Columbia/HCA insists that medicine is a business, and increasingly imposes its rules on the comptetitive game. If nonprofits are to retain their claim to fiscal and moral difference,

they will need not only to match the chains lawyer for lawyer, ad for ad, market strategy for market strategy, and cost saving for cost saving, but also to be clearer about their own mission. And society, through better regulation and disclosure, will need to fashion clearer ground rules — or cede them to the market.

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