



If Nonprofit Doesn't Mean "No Profit," How Much is Enough in Health Care?

REPRINT OF *INQUIRY* ARTICLE
VOLUME 42, FALL 2005

The profits and reserves of some high-profile nonprofit health care organizations have been under close watch in some states. Such attention is perhaps not surprising, and may emerge in other environments, because of increasing numbers of uninsured and underinsured people, as well as real or threatened cutbacks in Medicaid eligibility or benefit coverage.

The following discussion is the second of a new feature in *Inquiry* called *Dialogue*, which is a collaboration with the Alliance for Advancing Nonprofit Health Care and offers a variety of voices on current, major issues as they arise in the nonprofit health sector.

To put this *Dialogue* in context, readers may be interested in some examples of certain nonprofit Blue Cross and Blue Shield plans that have been under particular scrutiny:

- In early 2005, after more than three years of criticism by consumer advocates and lawsuits on behalf of subscribers over the reserve levels of the four nonprofit Blue Cross and Blue Shield plans in Pennsylvania, the governor of Pennsylvania announced an agreement whereby the plans would spend \$1 billion over six years from their combined \$4 billion reserves on various community health-related services. Included in these services is the state's adultBasic program, which provides low-cost insurance to low-income workers. Two days afterward, the state

insurance commissioner announced a ruling that the Blues plans' reserves were not inefficient or excessive. The commissioner denied any link between her decision and the governor's agreement with the plans. Some consumer advocates felt that the agreement was an unacceptable trade-off for regulation of the Blues' surplus levels, and litigation on behalf of subscribers continues.

- Nonprofit CareFirst BlueCross BlueShield, serving Maryland, the District of Columbia, and Delaware, announced that out of its projected \$175 million in earnings in 2005 it would spend: \$60 million to reduce premiums or moderate increases by an average of 1.5%; \$22 million to provide subsidized prescription drug coverage for moderate-income seniors; \$8.7 million on new community initiatives to address such areas as patient safety and disparities in health care among different ethnic groups; and \$2.5 million to maintain current levels of contributions to local charities. Some criticized the plan for not spending more on new community initiatives, characterizing the largest piece of the overall plan—premium rate moderation—as merely a competitive move to increase market share. One District of Columbia consumer advocacy group claimed, using a surplus-to-premium volume measure, that the plan had the resources to spend \$41 million to \$61 million on community benefits in the District (compared to the less than \$2 million in 2004). While finding this consumer group's estimate to be unreasonable, the District's insurance department issued a report concluding that, based on the plan's strong financial position, it could do more for the community than it currently was doing, but it was the responsibility of the plan's board of directors to determine the amount of the contribution and the beneficiaries.
- As of Dec. 31, 2004, the reserves of nonprofit Blue Cross and Blue Shield of North Carolina had increased to \$485 million—a result of strong earnings of \$350 million in 2003 and 2004. One bill has been introduced in the state legislature that would allow state regulators to include the plan's level of reserves when considering proposed premium rate increases—a move that the plan argues would give the insurance commissioner wide latitude to micromanage its business. Another bill has been introduced that involves a complex formula for limiting the amount of cash reserves that the plan could keep on hand for unexpected expenses, with any excess going to a state trust fund to buy health

insurance for the uninsured. The plan has argued that the bill was poorly conceived and would be an unconstitutional seizure of assets that would rob its subscribers of their own safety net in order to provide one for the poor.

Any type of nonprofit health care organization that experiences significant positive earnings and/or reserve levels could face such public examination. In fact, soon after this July 13, 2005, discussion was held, San Francisco's new assessor-recorder sent a letter to nonprofit California Pacific Medical Center giving the hospital 30 days to respond to his contention that its revenues had exceeded expenses in 2001, 2002, and 2003 by more than the 10% allowed for a welfare exemption from property taxes. (Net income in excess of 10% used for grants or charity care does not count toward meeting that exemption.) This hospital is also reported to be under investigation by the city's public health department over the amount of charity care being provided to low-income patients.

The participants in the following discussion were: **Mark Bartlett, M.A.**, executive vice president and chief financial officer of BlueCross BlueShield of Michigan in Detroit; **Michael Delucia, Ph.D., J.D.**, senior assistant attorney general and director of charitable trusts in the New Hampshire Attorney General's Office in Concord; **Charles Goheen, M.S.M.**, chief financial officer of the Fallon Community Health Plan in Worcester, Mass.; **John O'Brien, M.B.A.**, president and chief executive officer of UMass Memorial Health Care, Inc., in Worcester; and **Gerald Wedig, Ph.D.**, professor and researcher in organization economics, corporate finance, and governance in health care organizations at the William E. Simon Graduate School of Business Administration, University of Rochester, in New York. **Bruce McPherson, M.H.A.**, executive director of the Alliance for Advancing Nonprofit Health Care, in Washington, D.C., moderated the session.

Bruce McPherson: What do all of you think is driving the increase in public scrutiny of the profits and reserves of nonprofit health care organizations?

John O'Brien: In the nonprofit hospital sector, I think there are a variety of factors that are converging. We are seeing charges in some states against hospitals, especially nonprofit hospitals, of unacceptable billing and collection practices for the uninsured. The public sees some nonprofit hospitals building magnificent structures or undertaking other heavy

investments of capital. The public also sees some health care systems that are doing relatively well, and unfortunately in the hospital world we seem to be a world of haves and have-nots. Some hospitals are generating solid bottom lines, with CEOs earning very high salaries relative to what people expect in nonprofits, while other hospitals are really struggling. In our community (in Worcester) there is a lot of pressure on nonprofits, both providers and colleges, to do more because we have more low-income residents. The bottom line is that a lot of people are raising concerns about our not being accountable enough relative to our charitable purposes.

Mark Bartlett: Our view from a nonprofit health plan perspective is slightly different. In general, I think our surpluses or reserves are always seen as potentially somebody else's money. Any reserve that we hold is watched by various constituents to see if there is any excess that could be potentially theirs. Customers might see any significant reserves as the plan potentially overcharging premiums. Providers might see them as the plan potentially underpaying them for the services they perform. The state might see them as a potential opportunity to do more to help its social mission objectives and/or its budget, and of course you've got employees who would like higher pay, and so forth. So we see ourselves as sitting in a fiduciary role over other people's resources, having to judge how much we need to maintain viability over the long term and how much can be used for other purposes.

Charles Goheen: In our marketplace (in Worcester, Mass.), we've seen an upswing in the underwriting cycles over the past three or four years, with health plans doing better than they did the previous four or five years. At the same time, people are having trouble affording the premiums, so we're under much more of a microscope now as to what those health plan earnings should be. Also, touching on what John O'Brien mentioned earlier, there's a little bit of the haves and have-nots as well on the health plan side. You've got some plans that are doing very well, and people are starting to get concerned that they could grow to really dominate the market. Employers, providers, the smaller health plans, and the regulators are all starting to get concerned about that.

Michael DeLucia: From a regulator's point of view, when the public starts to perceive inappropriate billing practices, excessive management compensation, or other issues of that nature, that is when they come to an attorney general's

office. Members of the public, as you know, can be very vocal, and they come in to ask questions—about what is on the IRS Form 990 (the document that all charitable organizations must submit annually), what is the public obligation of a charity, whether the billing practices are predatory in some way, and so forth. They can be very informed. It is usually over these kinds of significant concerns that the regulator becomes engaged. In my state, New Hampshire, somewhat like Massachusetts, we have a statute requiring that nonprofit hospitals and others justify their status by reporting on the community benefits they provide. That's one means for addressing the accountability issue. I don't believe any of the community benefit statutes are perfect, but they are a start.

But you can still have problems where certain segments of the public wonder about the charitable mission of a particular nonprofit entity that seems to be doing very well financially. That's where some nonprofits have exposure. I had not seen until recently legislators in a state demanding some of a nonprofit's surplus, but I can understand the sentiment. All the states are in a tough budgetary situation, and some legislators and governors out of desperation are going to say, "Well, whose surplus is that?" That's when you're in a very dangerous situation.

Gerald Wedig: I don't think that the general public necessarily understands why nonprofit organizations need to earn a profit. When I teach my MBA students about this subject and pose the question, "Just how profitable does a nonprofit have to be?" I typically receive blank stares, at least to start with. So I'd certainly be surprised if in the general public's eye there is any appreciation of the need to have cushions for risk, to cover needed capital expenditures, and so forth. This ignorance compounds the political concerns.

McPherson: Let's move to this basic question: Starting with nonprofit hospitals and other providers, why do nonprofits need profits and reserves?

O'Brien: Since I arrived at UMass Memorial I have spent a lot of time down in New York with the credit-rating agencies. We receive unbelievable pressure from these agencies on our debt-to-equity ratio and days of cash on hand, and it's a lot worse today than it was three or four years ago. I can't be exact, but I think an A-rated hospital, maybe four or five

years ago, had to maintain 100 days of cash on hand. I'm sure it's 130 days now. I believe that there were four hospital rating downgrades for every upgrade in 2003. So you have a lot of systems wanting to borrow money—doing major renovations and/or expansions, acquiring new technology, or reaching out to communities that may be underserved. What some of them are hearing, however, from Standard & Poor's and Moody's, the bond insurers, is, "Well, you know we expect you to really buff up that balance sheet." So you have that additional pressure for more reserves—to get your margin up, hang on to your cash, build your surplus because you're going to have to borrow \$300 million or \$400 million.

The capital needs have grown exponentially, just in terms of technology. Look at robotics. Everyone is feeling that they have to acquire and install computerized physician order entry systems and electronic medical records tomorrow. A whole new diagnostic imaging platform alone could run \$60, \$70, \$80 million for a larger academic medical center.

The other big need for reserves relates to the uncertainties surrounding future third-party payments. From a provider's standpoint that's our greatest uncertainty, with more than 50% of revenues on average coming from Medicare and Medicaid, with no end in sight to state financial problems. In Massachusetts, Medicaid is now paying us 59% of our costs. Then you go down to Washington and you hear quiet talk about a Balanced Budget Act II. Everyone can look at the federal deficit numbers and figure out that Medicare's going to be taking a hit one of these days. So when you have a significant blip with two major payers that may be 50%, 60%, 65% of your payer mix, you had better be able to withstand that. More and more hospitals appear to be thinking, "Let's keep some money in the bank, even if some capital needs won't be met. Let's hold back here and build some reserves."

McPherson: Why do nonprofit health plans need earnings and reserves?

Goheen: At the Fallon Community Health Plan, we need to continually remind people that we are an insurance company that is assuming a huge amount of risk. We need to build adequate reserves to be able to smooth out that risk. Yet, at least in our market, people tend to focus on the dollars that we're making—approximately \$23 million last year as a relatively small regional health plan. That's what gets the

headline in the paper, not that this was only about 2% of revenue. If people would step back and look at it in that context they'd maybe have a different view. But people tend to just react: "Here is this little health plan making all kinds of money at the expense of everybody else."

Our capital needs for facilities and equipment are certainly smaller than what they are for a big academic medical center like John's, but they are not insignificant. We're looking at potentially doing a major upgrade on our computer system that could easily run tens of millions of dollars. We're also in a very competitive market, looking at potential acquisitions and other growth strategies that would obviously require significant dollars. Like John, we've also been out to the capital market. While our financial position had improved significantly over the last four or five years, we still received a fairly lukewarm response. The potential lenders felt that our reserves weren't yet at a level that they would like to see to lend us money without charging a significant interest rate premium.

Wedig: I think there's an important point being made here in both cases. The kinds of capital needs that John and Charley are talking about are not typically a discretionary call to be made by CEOs and CFOs. The lenders will tell you what the situation is. Consequently, in order to meet their fiduciary responsibility to maintain access to capital, nonprofits must achieve a certain level of earnings just to satisfy the credit market.

Bartlett: While we haven't had any problems at all with the credit market, the area we have had to focus on most significantly is helping people to understand the risk-based capital formulas. That's where we see our biggest capital requirement. For example, with the new Medicare Advantage health benefit products coming into the market, we're looking at a potentially significant growth in premium dollars. In Michigan, we're looking over the next two years at anywhere between \$4 billion and \$6 billion of additional premium. The risk-based capital formulas that are used by regulators for health insurance companies require the full level of capital up front to support that premium increase. Assuming the growth that you take on yields a reasonable earnings margin over five or six years, you'll restore the capital that you consumed with that growth. However, to finance it initially the risk-based capital formulas require you to have a

pretty hefty level of capital on day 1. Even if you don't add membership and your premiums are going up 10% to 14% a year, you have to add capital just to keep pace with the price increase. So our organization—and it's something we have had to work with our public media on—is required to add about \$300 million a year to surplus just to maintain our current capital strength.

McPherson: Where do these risk-based capital formulas come from, Mark?

Bartlett: The formula itself was developed by the National Association of Insurance Commissioners in conjunction with actuaries. The Blue Cross and Blue Shield Association (BCBSA) uses it as part of its plan-licensing process, and states use it as part of their regulatory oversight process. In Michigan, we have legislated minimum and maximum risk-based capital ratios. The minimum is 200% and the maximum is 1,000%. Under BCBSA's licensing process, your financial status is considered to be in jeopardy if you drop to 375%, at which point you enter a monitoring program. If it appears that you are going to be reaching 200%, BCBSA has the authority to de-license you, withdrawing the Blue Cross and Blue Shield name and mark.

McPherson: Are there capital differences between nonprofits and for-profits?

Bartlett: The difference is the for-profit's ability to access additional capital when necessary through the equity markets, whereas nonprofits need to accumulate or borrow it. And as others here have discussed, even the borrowing can be constrained. So the ease, cost, and timeliness with which you are able to get capital is the issue.

Wedig: That's a good point that could be made more or less across the board about for-profit and nonprofit organizations in all sectors. Sometimes I like to use the analogy that the nonprofit has to be its own bank, which is why you'll see all the cash on the assets side to address this capital constraint.

O'Brien: Along those lines, if your bond rating is not all that strong, you may want to go in for limited borrowings, essentially paying as you go. Otherwise, you may get bond covenants that basically are like putting manacles on your wrists as far as running the place, in return for simply getting the bonds insured, or getting a half-decent interest rate. You're right, Gerry, sometimes on some medium-sized

projects we'll bank it ourselves, for which we must have some cash.

McPherson: Given all the capital needs that you have been describing, how do your organizations go about deciding whether, and how much, earnings and reserves can be devoted to community benefits?

Bartlett: Within our organization that discussion generally revolves around a tax equivalent. In other words, if we were subject to state tax, how much would that be? That is also the kind of guideline that most people on the outside would use to gauge our social obligations and commitment.

O'Brien: We don't really focus on the dollar amount of investment in community benefits. We look more at the value. I'm on the American Hospital Association's Foster McGraw Prize Committee for Hospital Excellence in Community Service, and each year we evaluate a couple of hundred health systems that apply for this prize. What we typically look at is the value of what they're adding to the community—the output and not necessarily the total dollar input. It happens that in our local market we are actually investing significant dollars these days because of underfunding of public health and other public programs. We're stepping in to fill the void. It's really all about engaging the community and investing what you can in the quality of life around you. For instance, of the 66 health care providers in Massachusetts we have the most patient-friendly free care and discount pricing policies. We just announced that we are providing 50% discounts to all patients having a family income of up to \$94,000. In addition, if a patient is approved for free hospital care, all of our physicians also will write off the patient's entire bill. This change in policy may or may not end up being very costly to the hospital, but what is most important is the quality of the investment—the result it achieves.

Goheen: Our mission is to make our communities healthy, and everybody who works for this organization is educated on that mission from the beginning. It is really part of the DNA of this place, so it's not just the money that we donate. All employees are expected to participate in the community—volunteer time, participate on local boards, and do whatever they can. As part of our overall budget process, the board looks at how much we are giving back to the community in hard dollars as well as in in-kind support. As

John mentioned earlier, we are in a community that looks to places like UMass Memorial and Fallon to really step up because there is a need that isn't being met by others at this time.

O'Brien: Charley and his team and the UMass Memorial team got together recently to talk about how we could get involved and work together to improve the health of our community around a specific issue. We share very similar values and feel that at some level we have a linked destiny here. If we don't work together and leverage the strengths of the two organizations—despite the fact that we're provider and payer—we'll not only squander an incredible opportunity but also fail to fulfill our missions. Because of our collaboration around community health improvement we should come out of this as stronger organizations.

McPherson: *So where do you think state government fits in from a regulatory perspective regarding the profits, reserves, and community benefits provided by nonprofit health care organizations, given our previous discussion?*

DeLucia: That's a tough question because every state is different. My state, New Hampshire, is fairly conservative and laissez-faire, very different from what you find just a few miles down the road in Massachusetts, with a stronger regulatory ethic. Every attorney general's office has its own way of wrestling with issues. Even so, I think that community benefits is an area where every state should try to craft something where there's balance. Our community benefits statute is fairly direct. It basically says, "We want you to disclose what you're doing. We're not going to penalize you; we want you to inform your community and make the community part of what you're planning and doing." There are no thresholds, minimums, or caps because that's the way we've chosen to do it. I think the latest state to have adopted a community benefits statute is Maryland. That's a state I would watch.

O'Brien: I am a firm believer in community benefit reporting standards, and I believe that all hospitals should be required to annually document exactly what they're doing for the community in terms of uncompensated care, investment in community health improvement efforts, and the like. I supported those requirements when they came to Massachusetts. I don't agree with the Texas approach where

uncompensated care must be at least 5% of your revenues to maintain nonprofit status. I believe in public filings but not hard formulas.

DeLucia: The Catholic Hospital Association provides some fairly clear guidelines on how to quantify community benefit. I think you'll see much more standardization of definitions and interpretations around what community benefit is and isn't.

Wedig: I think there clearly is a role for government to guard against certain abuses that everyone I think would patently agree need to be guarded against, such as private inurement. When it comes to community benefits, I personally favor a more laissez-faire approach, without specific formulas, so that nonprofit health care organizations have the flexibility to address their own business and strategic issues. The best way to go is effective governance (i.e., a strong board with community representation of qualified and informed individuals) along with community benefit reporting requirements as previously discussed. This will ensure that in the long run the organization is responsive to its community as well as its business needs.

O'Brien: I agree with both Gerry and Mike. And, where individual hospitals are not being accountable, where they're not paying attention to many of the components of Sarbanes-Oxley (a 2002 federal law designed to protect investors by improving corporate disclosure practices) or to Form 990 issues and IRS filing requirements, they're doing so at their own peril. I don't have any problem if state attorneys general or other government officials take them to task. I think they are a tiny minority hurting the images of a lot of nonprofits that are doing great things in their communities.

Bartlett: I think the governance is the key—how a not-for-profit entity selects and maintains its board. As I noted earlier, in Michigan we have a unique approach in that the board composition as well as the board selection process is specified by statute. We're required to have a 35-member board with proportionate representation by labor, large employers, governor appointees, providers, individual subscriber representatives, small group representatives, and so on. We have found it to be an exceptional model for ensuring balance and full consideration of issues surrounding community mission.

McPherson: What can be done by a nonprofit health care organization to try to forestall or reduce negative public perceptions surrounding earnings and reserves, or what's being done with them?

Goheen: We have to file our financials with the state every quarter, and there are always stories in the paper the next morning. As a result, we're trying to manage the organization to be in the middle range of our competitors to ensure that there's not a special story about us either making too little money or too much money.

Bartlett: We have recently been doing some interesting studies on this. If you ask a typical person whether Blue Cross Blue Shield of Michigan should have \$2 billion plus of surplus, the answer is "No." If you ask whether the plan should have \$427 per person to cover potential medical claim costs, the answer is "Yes." We're dealing with the same number, just looked at differently. So I think part of the answer is the art of communicating to the typical person in ways that he or she can understand—not in terms of risk-based capital formulas and all that technical stuff.

O'Brien: I think it's all about what you're really doing rather than how you communicate about it. When I get a glitzy brochure in my mail from some not-for-profit, I'm wondering how much it actually cost to publish the brochure. There are so many messages that we send to the community, and far too frequently we look and sound more like big business than we do charitable organizations. The key is how we work or don't work with smaller community-based organizations, how we solicit feedback from the community relative to our performance, and whether there is an illusion of inclusion of the community.

Nonprofit health care providers and payers need to get engaged in their communities in new and better ways. There's a very good example in Massachusetts. There's a lot of concern about the size of Partners Healthcare, which includes Mass General, Brigham and Women's, and other provider components. But the reality is that Partners has a wonderful reputation because it has done some extraordinary things around access and community health improvement in some of our more vulnerable cities like Chelsea and Revere. They have a person leading that organization, Jim Mongan, who has been a real spokesperson nationally and within the state around access for the uninsured and public accountability in health systems. I don't know what Partners made last quarter—probably \$100 million—but that doesn't get a lot of discussion because I think people see a strong organization doing some interesting things for its communities. I think that we just need to get engaged in a way that Partners Healthcare has done very successfully, rather than devoting a lot of time and resources on communication strategies about our profits and reserves and their uses.