Working Paper Series

HEALTH CONVERSION FOUNDATIONS

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This paper exists because James Allen Smith, who in my estimation knows just about everything about foundations that is worth knowing, told me that he knew very little about conversion foundations when I was trying to choose between paper topics for his foundations and public policy course at Georgetown. I owe Jim thanks not only for steering me toward a fascinating subject, but for being a wonderful teacher, advisor, and friend.

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Conversions are the byproduct of a profound transformation in American health care – the transfer from public to private, from nonprofit to for-profit enterprise – an equity shift that has resulted in the largest and fastest transfer of charitable assets in history.

- Mark Dowie[1]

In the decade since President Clinton sought to secure health insurance for all Americans, coverage has generally moved in the opposite direction intended by the president and underlying public opinion.

- Thomas R. Oliver and Jason Gerson[2]

INTRODUCTION

Recent news about our health care system should convince anyone that the US is in the throes of a health care crisis. Health care costs are in their fourth consecutive year of double-digit increases and are expected to rise 22% next year.[3] Health insurance costs have been rising rapidly in recent years: Costs for employers are expected to rise 16% this year, and double-digit increases will probably continue through much of the decade, as the population ages and the demand for prescription drugs and expensive tests and specialists increases.[4]

The average premium that workers pay for family coverage has jumped nearly 50% in only three years, to $201 per month.[5] The average worker will spend $2,412 in premiums for family coverage, up 49% since 2000.[6] Out-of-pocket expenses such as deductibles and copayments for drugs are up even more sharply over the same period, and have more than doubled over the past five years for employees of large companies.[7] 44% of large companies now tack on a separate deductible for each hospital admission. Many small business are instituting even more draconian cuts or dropping coverage altogether – only 65% of companies with fewer than 200 employees offered coverage this year.[8]

Even in large firms, which are far more likely than small ones to offer health coverage, the number of uninsured workers has increased sharply over the past 15 years. As of 2001, 9.6 million Americans – 26% of the nation's total uninsured – worked for or were dependents of employees of large firms, an increase of more than 50% since 1987.[9] Uninsured workers in large businesses, like all uninsured Americans, are disproportionately low income, and low-income workers (those below 200% of poverty) are three times more likely than middle- or high-income

[1] Dowie, p. 82.
[2] Oliver and Gerson, p. 3.
[3] Freudenheim.
[4] "Get Used to the Pain: Another Round of Double-Digit Hikes in Health-Care Costs Is in the Mail," p. 42.
[5] Ibid.
[6] Ibid., p. 43.
[7] Ibid.; and Freudenheim.
[8] "Get Used to the Pain: Another Round of Double-Digit Hikes in Health-Care Costs Is in the Mail," pp. 42-43; and "Number of Uninsured Workers in Large Firms Up Sharply."
[9] Glied, Lambrew, and Little, p. vii.

workers to be uninsured.[10] Nearly half – 46% of low-income workers are uninsured for some time during the year.[11]

Even during the late 1990s, despite a strong economy and tight labor market, the proportion of the nonelderly population insured through employer-sponsored health plans decreased; workforce changes since then, such as stagnant wage growth and the nationwide declines in manufacturing jobs and unionization rates, have contributed to the trend, as have stricter insurance policies.[12] Workers have been forced to shoulder larger proportions of health insurance costs, access to health insurance for part-time workers has declined, the use of contingent workers has increased, waiting periods have increased, the gap between skilled and unskilled wages has increased, and public insurance coverage has decreased as an effect of welfare reform.[13]

Insurers, increasingly focused on the bottom line, have been tightening guidelines, moving out of unprofitable markets, and raising prices. Private employer-sponsored insurance rates are rising at more than three times the rate at which medical-care inflation is rising.[14] Health insurers, focused on rebuilding profits after a price war in the late 1990s, are prospering; Aetna, for example, expects to earn $900 million in operating profits this year.[15] While they will likely raise their premiums less next year, experts say that the increase will still be in the double digits.[16]

Medicaid, the health program for 51 million Americans, has been squeezed by states faced with a third consecutive year of fiscal distress. Twenty-five states have restricted eligibility, 18 have reduced benefits, and 17 have increased copayments. Five states reduced and 36 froze payment rates for doctors; and nine states reduced and 22 froze payments to hospitals. At the same time, rising unemployment and a sluggish economy have reduced income for millions, increasing the number of people eligible for Medicaid, which has also seen an increase in enrollment of the elderly and the disabled. Doctors complain that Medicaid pays them less than most other insurers, and many refuse to take Medicaid.[17]

Primarily because of the booming cost of prescription drugs, Medicare covers a smaller portion of health care expenses than at any time since the program was established in 1965. The elderly spent 22% of their median income for health care last year – a greater proportion of their income than the 20% they spent before the advent of the program.[18]

[10] Ibid., pp. 4, 16.
[11] Ibid., p. 4.
[12] Ibid., p. 9; and Oliver and Gerson, p. 6.
[13] Glied, Lambrew, and Little., p. 14; and Oliver and Gerson, p. 6.
[14] "Why Your Premiums Are Still on the Rise."
[15] "Get Used to the Pain," p. 42.
[16] "Why Your Premiums Are Still on the Rise."
[17] Pear.
[18] Freudenheim.

The number of uninsured Americans is at an all-time high at 43.6 million, up 2.4 million since last year and nearly 4 million (a 10% jump) in the past two years.[19] Certain populations are especially at risk of being uninsured: 28.1% of young adults, 30.7% of the poor, 33.2% of Hispanics, 19% of blacks, and 8.2% of Asian and Pacific Islanders were uninsured in 2001; by contrast, 11.7% of children, 10% of non-Hispanic whites, and .8% of adults 65 and older were uninsured.[20]

With the devolution of responsibility for health care from the federal government to states comes considerable variation in insurance coverage across states. In 2001, the percentages of uninsured ranged from about 7% in Rhode Island and Minnesota to about 23% in Texas and New Mexico.[21]

Billions of dollars in uninsured people's health costs have historically been absorbed by nonprofit hospitals and insurers and federal programs, but the health care landscape is changing in ways that highlight the fragility of health care systems, raise questions about health care institutions' accountability, and affect all community members, particularly low-income people, the uninsured, and those covered by Medicaid. Aggressive competition by for-profit providers, together with industry-wide pressure to reduce costs, is reshaping local delivery systems as what was once a system comprised almost exclusively of nonprofit institutions and providers has become increasingly for-profit through conversion. Over the past two decades, many nonprofit health care organizations have sought to strengthen their market positions and gain access to capital by becoming for-profit companies, either by corporate restructuring or by transferring assets through sales, mergers, or joint ventures.

THE CONVERSION TREND

The phenomenon of nonprofit to for-profit conversion in the health industry represents the largest redeployment of charitable assets in history.[22] Because the converting nonprofit health organization is presumed to have provided public benefit before the conversion and because the nonprofit assets have been built by and on behalf of the public, state laws typically require that converting organizations preserve their charitable assets in order to maintain the level of public benefit provided before the conversion. Often these assets are used to endow a new foundation. These foundations – commonly called conversion foundations – are the subject of this paper. Over the past two decades, billions of dollars in charitable assets have transferred from the health care industry into organized philanthropy, and billions more will no doubt do so.

The trend of health conversions is a very recent but quickly accelerating one: The first conversion foundation was created in 1973, and over the next ten years, only four were created; most were established in the mid-1980s or mid- to late 1990s. Most are fewer than ten years old: 59% were formed between 1994 and 1999, and an additional 11% since 1999.[23]

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[19] "Get Used to the Pain: Another Round of Double-Digit Hikes in Health-Care Costs Is in the Mail.", pp. 42-43; and "Number of Uninsured Workers in Large Firms Up Sharply."
[20] Oliver and Gerson, p. 5.
[21] Ibid., p. 6.
[22] "Health Care Conversion Foundations: Regulation, Impacts, and Unanswered Questions."
[23] Shiroma, p. 2.

According to Grant Makers in Health, as of May 2003, there are more than 165 new health foundations (several were too new to participate in the survey and are not included in this figure). There were 148 in 2002. Total assets of the 165 are just over $16.4 billion, up from $15.3 billion in 2002; assets of individual foundations range from $1.56 million to $2.89 billion; and the median is $46.5 million.[24]

The following summary, which does not include the latest two years' figures, nevertheless gives a sense of the growth of conversion foundations[25]:

Year of Conversion	Number	Total Assets*	Mean Assets*
1973	1	$ 30.7	$ 30.7
1977	1	47.0	47.0
1981	1	2.3	2.3
1983	1	18.5	18.5
1984	12	504.6	0.0
1985	5	1,043.8	208.8
1986	4	147.7	36.9
1987	3	178.7	59.5
1988	1	18.7	18.7
1989	1	9.0	9.0
1990	2	180.8	90.4
1991	1	96.3	96.3
1992	3	1,064.7	354.9
1993	2	81.6	40.8
1994	11	994.6	90.4
1995	24	2,517.9	104.9
1996	21	5,521.2	262.9
1997	18	621.8	34.5
1998	12	1,267.2	105.6
1999	9	495.5	55.1
2000	4	288.7	72.2
2001	2	148.5	74.3
Total	**139**	**$15,279.8**	**$109.9**
*** in millions**			

Conversions of hospitals account for 68% of the 165 conversion foundations now in existence, conversions from health plans for 18%, and conversions from health systems for 8%. Most (52%) are public charities; 43% are private foundations, and the rest are either social welfare organizations or have funds controlled by local governments. They operate in 38 states; more than half (61%) are located in ten states. Most dedicate some or all of their grant making to health, human services, or other health-related areas.[26]

[24] "A Profile of New Health Foundations," p. 3.
[25] "Findings from the 2001 Survey of New Health Foundations."
[26] "Findings from the 2001 Survey of New Health Foundations."

One can get a fuller sense of the magnitude of the conversion trend – and the number of Americans it could affect – by looking at Blue Cross and Blue Shield (BCBS) conversions. Historically nonprofit entities, BCBS plans in 1997 insured 68.6 million people in 50 states. At the same time, BCBS plans in 32 states were undergoing or planning to undergo restructuring, much of which is from nonprofit to for-profit health plans or mutual insurance companies. And the number of health plan conversions is growing relative to the number of conversions of other types of organizations.[27]

About 15% of 5,200 hospitals in the US are for-profit; the rest, with an estimated asset value of almost $200 billion, are potential conversion candidates. The net worth of nonprofit health insurers, including the unconverted Blues, is about $92 billion – close to the asset value of all existing private foundations.[28]

As cost containment and other competitive pressures fuel further health industry restructuring, the number of new health conversion foundations will surely grow. Because of the magnitude of the changes taking place and the important questions conversion raises about the fragile nature of our health system and the absence of public accountability of health care institutions, the conversion trend has been attracting considerable public attention.

Cy Pres Doctrine and Public Benefit

The legal doctrine known as *cy pres* (from the Norman French phrase *cy pres comme possible*, meaning "as near as possible") requires that the assets of a charitable organization forever be used for a purpose as close as possible to the organization's original charitable mission when the charity's original purpose becomes impractical, unlawful, or impossible. Federal and most state laws require that the value of assets remain in the charitable stream, although application of the *cy* pres doctrine varies from state to state.

The mere fact of being a nonprofit does not guarantee that a hospital, HMO, or insurer actually provides community benefits such as offering policies to high-risk individuals, providing coverage to small business employees, offering premium discounts for low-income subscribers, providing free health screenings and flu shots. Until recently, it was left to health care institutions to decide how much money to devote to community benefits and what benefits to provide. In many states, BCBS insurers, for example, have operated in manners that are almost indistinguishable from those of their for-profit competitors.

Generally speaking, though, nonprofits and for-profits behave in fundamentally different ways and many, if not most, nonprofit hospitals and insurers have provided substantial community benefits, and in many communities they provide the only access to health care for vulnerable populations. Hospitals in particular provide services and access in response to community need, and profits are invested back into the community through expanded service. They are

[27] Seto, Collins, and Weiskopf, p. 12.
[28] Dowie, p. 83.

community-owned institutions and are the products of substantial community investment in terms of charitable contributions, foregone taxes, and volunteer time.

Aside from the effects on community benefits for vulnerable populations, restructuring will ultimately affect access to health care for all members of a community given that hospital conversion often results in cuts in staffing, discontinued services, longer travel times, or hospital closures. Not only have nonprofit hospitals provided greater breadth of services and the majority of care for chronic illnesses and indigent populations, but they have historically provided the vast majority of teaching, research, education, and technological development. Investor-owned hospitals look different by virtue of ownership, structure, and accountability, and investor interests are not the same as community interests. Consumers Union has questioned whether unprofitable services such as trauma and prenatal care remain in place when a conversion happens.

While conversions constitute a threat to community benefits, the public scrutiny now being cast on conversion transactions can create many opportunities for consumers, consumer advocates, and communities protect those benefits. To the extent that communities have a voice in the allocation of community resources, engage in public debate about the transformations in the field, and participate in shaping public health policy, resources can be protected and dedicated to charitable health care and increased access to health care for all.

Many questions remain: Do public assets remain devoted to the purpose for which nonprofit status was originally granted, and not redirected toward private gain? Will insurance be available to people not covered by other companies? Will indigent patients be cared for? Will teaching hospitals and health care research survive? Will social equity be addressed? Answers to these questions depend on increased attention on the part of many people, including citizens, advocacy groups, and state regulatory agencies, courts, and legislatures, as well as on the effectiveness of conversion foundations themselves.

The Foundations

The term "conversion foundation" does not begin to suggest the great diversity of organizations that result from conversion transactions. The smallest has assets of about $1.5 million; the largest, nearly $3 billion; several conversion foundations are among the 50 largest foundations overall.[29] There is also considerable diversity in tax status choices and foundation structures.

Conversion foundations have no separate legal or tax category either. Most are private foundations or public charities, but a growing number are social welfare organizations. There are 86 public charities, 71 private foundations, six social welfare organizations, and two in which funds are administered or controlled by local government agencies.[30] Most –112 – were created by hospital conversions; 29 by health plan conversions, 13 by health system conversions; several by conversions of more than one type of health care organization; and several by conversions of organizations such as rehabilitation centers, nursing homes, and blood banks.[31]

[29] "A Profile of New Health Foundations."
[30] Ibid.
[31] Ibid.

Most have health-related missions, from narrow definitions of health to broad, including prevention, community wellness, strategic engagement, and systemic change for poor and marginalized people. In 2001, though, 18% of the 139 conversion foundations then existing made less than 50% of their grants in health, and two made no health grants at all.[32] A few are operating foundations with limited grant making.[33]

Commonly funded areas include delivery of services, child and adolescent health, and health education and prevention. Some focus on specific populations, such as the elderly, minorities, or children. Access to care, mental health, substance abuse, racial and ethnic disparities in health, the weakened public health system, and the uninsured are beginning to attract more conversion foundation funding, and they are taking a leadership role in addressing these issues.[34] Most focus within specific geographic limits, and some give statewide.

Mark Dowie calls conversion foundations some of "the most exciting players in health philanthropy. Not only do they fund long-neglected areas like health promotion, disease prevention, and public health, but they are also increasingly directed by trustees they serve rather than by overnight millionaires and the managers of new for-profit entities (as earlier conversions were)…. [Most are] better informed, more imaginative, and more responsive to community needs than traditional health foundations."[35] Most, according to Grant Makers in Health, involve the community in the development and ongoing operation of the foundations.[36]

Protecting the Public Interest: Some Stories

The relative secrecy surrounding many early conversion transactions has led to a good deal of controversy about how nonprofit assets are valued and what was done with them – as have revelations about cases of private inurement; conflicts of interest involving trustees and grantees; boards stacked with the directors from the newly converted for-profit entity; board members with no grant-making experience; lavish spending on trustee meetings, compensation, and offices; grant making to for-profit corporate health care companies and consultants; and grant making with no health benefit. Even in a number of cases in which the foundation created by the conversion has gone on to include community input and to make significant commitments to health care for vulnerable groups, the earlier stages of the transaction have been characterized many of these same problems and by years of legal and political wrangling.

[32] "Findings from the 2001 Survey of New Health Foundations."
[33] Ibid.
[34] "Findings from the 2001 Survey of New Health Foundations."
[35] Dowie, pp. 82-83.
[36] "Findings from the 2001 Survey of New Health Foundations."

THE IMPORTANCE OF VALUATION

Greater Delaware Valley Health Care Center

In 1984, three top officials of the Greater Delaware Valley Health Care Center in Pennsylvania brought the center from its nonprofit owner for $100,000. State regulators required that the new owners pay the purchase price to other nonprofit health facilities in the area. Two years later, the owners sold the for-profit company on the open market for $20 million.

The following year, the owners bought Group Health of St. Louis, a nonprofit HMO, for $4 million and issued themselves stock valued at thirty-three cents a share. They donated the $4 million to charitable organizations providing health care in the St. Louis area. A year later, a quarter of the new company's stock was sold for $10 million ($14.28 a share, almost forty-five times the original price).

The California Wellness Foundation

In 1991, HealthNet, a 900,000-member HMO in California, decided to convert and valued itself at $104 million. Consumers Union said that this was not nearly enough and persuaded state regulators to increase the price to $300 million plus 80% of the stock in the new for-profit company. The California Wellness Foundation is now worth almost a billion dollars.

In 1992, 20% of the stock in the new entity was bought for $1.5 million by 33 executives. Four years later, their shares were worth more than $300 million. Former HealthNet CEO Roger Greaves' $300,000 investment grew to more than $30 million – a 10,000% gain.

Mark Dowie, *American Foundations: An Investigative History*, pp. 81-82, 85.

Davies Medical Center, San Francisco:
A Case of Private Inurement

Gregory Monardo succeeded his father running Davies Medical Center, a small nonprofit San Francisco hospital. Monardo's salary was paid by Franklin Holding Corp., a private foundation that owned the hospital. Payments to Monardo grew from $312,000 in 1995 to $470,000 in 1997, while Davies Medical Center struggled to compete with larger hospitals.

Franklin Holding sold the medical center to a health care company for $29 million in 1998. Monardo took home $3.5 million from the foundation that year; it was two years before the state attorney general would begin to routinely review transactions involving sales of nonprofit hospitals. Two trustees of Davies Medical Center say that they do not recall voting on the $3.5 million payout. Monardo also took a $350,000 home loan from Franklin Holding in 1988, despite the fact that personal loans to foundation trustees are not permitted by the IRS.

Monardo still runs Franklin Holding (as of October 9, 2003), where he was paid $47,000 a year in 2001 for four hours of work per week. He also runs a new foundation that was created after the hospital sale. Franklin Holding had $24 million in assets in 2001, and has recently made grants to the new foundation and a number of Texas causes, including the Junior League of San Antonio, home of a trustee of both foundations who was on the Davies hospital board at the time of the sale.

Beth Healy, "Foundation's Sale of Nonprofit Hospital a Windfall for One Trustee."

BLUE CROSS BLUE SHIELD CONVERSIONS:
A RANGE OF USES FOR THE PROCEEDS

California: WellPoint Health Networks converted in 1996, creating two foundations whose assets now total more than $4 billion. The California HealthCare Foundation conducts health policy research related to California; the California Endowment makes grants to charitable organizations in the state.

Kentucky: Legislators created the Foundation for a Healthy Kentucky as well as a separate private foundation that will accept assets from future conversions.

New York: The state is using 95% of the money from Empire BlueCross BlueShield's conversion – more than $950 million – to fund a three-year salary increase for health care workers. 5% will be used to establish a small foundation dedicated to expanding access to health coverage. The legislation was not made available for public review or comment, and was passed at 4:30 in the morning.

Virginia: No foundation was created; assets from the conversion of Trigon Healthcare went directly into the state's coffers.

Wisconsin: A foundation was created to transfer funds to two medical schools; 65% of the money is to be used for medical research and education, the remaining 35% for public health initiatives.

"Charitable Foundations Formed by Conversions Take Many Forms."

"FYI: Health Institution Transactions Report," May 2002.

The Foundation for a Healthy Kentucky:
Years of Legal Wrangling Produces a Foundation

In 1993, Kentucky BCBS (BCBSKY) merged with Anthem Insurance Companies Inc., a for-profit mutual insurance company. The deal was approved, without consideration of BCBSKY's charitable assets, by the state department of insurance. Kentucky had not yet enacted any statutes to regulate nonprofit conversions and protect charitable assets.

In 1996, after a routine investigation raised questions about Anthem's use of reserves, Department of Insurance Commissioner George Nichols asked state Attorney General Albert Chandler to audit the merger. In March 1997, Anthem sued the AG and the insurance commissioner, charging that the investigation exceeded their scope of authority, but the agencies relied on the common law power of the courts to impose provisions to protect charitable trusts.

In October of that year, Chandler, supported by a coalition of local consumer groups called Kentuckians for Health Care Reform, in turn filed suit against Anthem, seeking to recover millions of dollars in charitable assets that Anthem had converted to its own for-profit use and to reimburse policy holders for premium increases that violated the Consumer Protection Act. Anthem launched a PR campaign against Chandler's lawsuit and the consumer groups, threatening higher premiums and less financial security if the AG prevailed. In March 1998, the commissioner of insurance ruled that Anthem conducted a "highly misleading" campaign, but took no action.

In the Spring of 1998, a trial court dismissed the AG's Consumer Protection Act claims, but a year later, a unanimous appellate court reversed the dismissal and ruled that the AG should have the opportunity to

investigate and bring to trial the consumer protection claims against Anthem. Anthem filed motion for summary judgment asking the trial court to dismiss charitable trust claims without a trial, a motion Chandler opposed. Consumer groups filed three amici curiae supporting the AG; Anthem opposed the briefs and asked the judge not to consider them, but in November, the judge ruled against Anthem, accepting all three briefs. In March 1999, the court heard Anthem's motion for summary judgment, and in May denied it, allowing the case to proceed. The attorney general would therefore have the opportunity to prove that BCBSKY had held charitable assets and to determine the value of those assets.

At the end of 1999, Chandler and Anthem announced settlement of the charitable trust issue. Anthem agreed to place $45 million that had accumulated prior to sale into a newly created foundation that would be used to fund unmet health care needs of Kentuckians. An advisory board was to be appointed by the Franklin Circuit Court on the nomination of the AG and was to make recommendations to the court about the structure and composition of the new foundation.

In February 2000, members of the Kentucky General Assembly began a legislative effort to challenge the enforcement authority of the AG and the court's jurisdiction over the charitable assets. HB 629 provided that the $45 million would be subject to governmental controls and, in effect, made the foundation a quasi-governmental entity. The bill stipulated that all future charitable assets from similar settlements pursued by the AG as well as public assets obtained through class action suits would be placed under the control of a newly created governmental entity called the Charitable Asset Administration Board. A provision was included that prohibited any state public official, including the AG, from challenging the constitutionality of the legislation. More than 40 groups, including state and national consumer advocates, state community foundations, and the National Council for Responsive Philanthropy, launched a campaign to urge Governor Patton to veto the legislation. The editorial pages of the Lexington Herald-Leader and the Louisville Courier-Journal also urged him to veto. But HB 629 was passed by both houses and signed into law by the governor in April 2000.

In September 2000, Governor Patton appointed the 34-member Charitable Health Care Trust Advisory Committee. Meant to be diverse both geographically and demographically, the committee includes individuals from universities, provider groups, businesses, philanthropies, and consumer groups that were involved in the fight to preserve the charitable assets that were almost lost during the merger. It was the committee's task to establish a foundation. After several meetings to discuss key elements of the structure and composition of the foundation, the committee approved the articles of incorporation and by-laws. Early in 2001, the Franklin Circuit Court approved the articles of incorporation and by-laws to establish the Foundation for a Healthy Kentucky, a public charity.

The foundation has a community advisory committee, a 31-member committee of state residents who advise the board and serve as a link between the foundation and the public. Two of the foundation's 15 directors are appointed by the governor; one is appointed by Anthem (and cannot be an employee of Anthem); 12 are elected and are composed of seven representative directors (who represent the state supreme court districts) and five at-large directors. Any state resident can make nominations; a nominating committee elected by the community advisory committee reviews all nominations received and narrows the list to a slate of candidates for review and endorsement by the community advisory committee. The community advisory committee in turn presents a slate of two candidates per vacancy to the board, which elects members.

"Conversion and Preservation of Charitable Assets of Blue Cross and Blue Shield Plans: How States Have Protected or Failed to Protect the Public Interest."

"FYI: Health Institution Transactions Report," April 30, 2001.

http://www.healthyky.org.

CAREFIRST BLUE CROSS BLUE SHIELD IN MARYLAND:
A DEAL FALLS THROUGH AND A FOUNDATION CLOSES

In January 2002, CareFirst, the nonprofit holding company for the nonprofit Blue Cross and Blue Shield plans in Maryland, Delaware, and the District of Columbia, filed an application to convert to for-profit status and be acquired for $1.37 billion by WellPoint Health Networks, the owner of Blue Cross of California and Blue Cross and Blue Shield of Georgia.

Maryland Insurance Commissioner Steven Larsen, who has regulatory authority over insurance plan conversions, undertook a 14-month review process that, according to Community Catalyst, can serve as a model to other states. The process included 15 days of hearings, eight opportunities for public comment held across Maryland, seven expert reports evaluating the proposal (he hired independent consultants to perform a comprehensive health impact study, valuation report, due diligence analysis, and review of CareFirst executives' compensation packages), and review of more than 87,000 pages of documents. The commissioner heard from more than 250 people during the public comment sessions and received more than 300 written comments from citizens. He kept consumer advocacy coalitions updated on the progress of the review process and throughout the process, documents including transcripts, reports of experts, and written documents were posted on the department Web site.

Maryland community coalitions, which had been preparing for the proposed conversion for almost a year before the application was filed, worked with coalitions in Delaware and DC as well. They opposed the deal because of large compensation packages for CareFirst executives, lack of local control over the Blues plans, the purchase price valuation, and potential changes in service and premiums.

The CareFirst proposal also provoked a flurry of legislation in the 2002 session of the Maryland General Assembly, some of which related to the charitable entity that would result from the conversion. The Maryland Health Care Foundation had been created by the state legislature in 1997 to hold the assets of for-profit conversions of hospitals and health insurers and to use those funds to improve access to care for those who cannot afford it. But members of the state legislature began to have doubts about turning over all of the $1 billion that would have gone to the foundation as a result of the CareFirst sale and amended the existing law to create a trust within the foundation called the Maryland Health Care Trust. The trust would hold the money from the conversion and the legislature would control the charitable assets placed in the trust, exercising more control over the trust than it could over the foundation. The plan was to use the money for public purposes such as covering people who cannot afford health insurance.

The foundation had received $500,000 in start-up money from the state, almost $2 million in its first year from the conversion of a mental health plan, and a small portion – $3.5 million – of the state's proceeds from the national tobacco settlement. The foundation's board, appointed by the governor, had a number of public officials as members. The foundation provided funding to launch some programs, including Medbank, which distributes medications to people who cannot afford them, and a pediatric dental clinic in Carroll County.

In March 2003, the insurance commissioner denied CareFirst's proposal, finding it not in the public interest and citing the board's failure to uphold the nonprofit mission. He also cited as disqualifying factors a rigged auction for CareFirst that did not produce fair market value and management and board bonuses that constitute private inurement. Other factors in his decision included failure to provide enough information to make a comprehensive health impact study possible; lack of board due diligence in deciding to convert, selecting the bidder, and negotiating terms and conditions of the transaction; failure to disclose conflicts of interest of officers, directors, and experts; and negative impact on the availability and affordability of health care in Maryland. He also cited several issues related to the foundation:

- "Conversion Foundations have limited ability to make systemic changes or improvements. They can impact specific communities or problems.
- Maryland law creates a confusing governance structure for the disposition of conversion proceeds. Only the Legislature may spend conversion proceeds, and such spending shall be on efforts to improve 'health status.' The Foundation, however, is charged with addressing 'access' to health care. Programs to improve 'health status' may not address problems relating to 'access' that could arise from the transaction."

Following the decision, legislation was passed and signed into law recommitting CareFirst to its nonprofit, charitable mission, provoking a flurry of lawsuits: The same day the governor signed the bill, the Blue Cross Blue Shield Association filed suit to terminate CareFirst's license to use the BCBS trademark, arguing that the legislation constituted a state takeover of CareFirst, which violates BCBS Association licensing rules. The state Attorney General in turn filed an injunction to stop the association, and CareFirst filed suit against the state arguing that the law is unconstitutional.

The suits were combined and moved to federal district court in Baltimore, and settlement was reached restoring CareFirst's license and amending the law so that fewer CareFirst board members would be replaced, executive pay would be comparable to other nonprofit executives, and banning conversion for five years. In July 2003, the new insurance commissioner, Alfred Redmer, released a report outlining several state insurance law violations committed by CareFirst, including operating a nonprofit as a for-profit, corporate mismanagement, board failure to carry out their fiduciary duties, and failure to retain independent consultants during the conversion. The commissioner planned to issue civil charges against the company's top management and board. And most recently, the US Attorney's office for Maryland, the FBI, and a federal grand jury have issued subpoenas to CareFirst, WellPoint, and the insurance administration as part of a federal investigation into possible mismanagement during the proposed conversion.

While CareFirst had pointed to the $1 billion that would go to the foundation or other programs as a reason the state should approve the transaction, a consultant to the insurance commissioner questioned how control and accountability would be divided between the foundation, the trust, and the legislature. The foundation announced plans to close in October 2003, given a lack of funding.

"CareFirst Conversion to For-Profit Status and Sale."

"Conversion and/or Sale of a Non-Profit Health Services Plan: An Explanation of the Process."

"FYI: Health Institution Transactions Report," September 7, 2001, May 2002, March 2003, and August 2003.

"Maryland Insurance Commissioner Denies CareFirst Conversion and Sale," press release dated March 5, 2003.

"Proposed Conversion and the Legislative Response."

William M. Salganik, "Out of Cash: A State Health Care Foundation That Was to be Financed through the Conversions of Nonprofit Hospitals and Insurers is Shutting Down."

BCBS MUTUAL OF OHIO:

Public Scrutiny Stops a Sweetheart Deal

In early 1996, Columbia-HCA Healthcare, the nation's largest for-profit hospital chain, announced plans to form a joint venture with BCBS Mutual of Ohio, the state's largest nonprofit health insurer. The Blues proposed to sell 85% of their assets to Columbia for $299.5 million, $19 million of which would go to BCBS executives, trustees, attorneys, and for concluding noncompetition agreements. Policy holders sued against the deal, the state attorney general opposed it, and the national BCBS association revoked the Ohio organization's license. A federal judge ruled that the new entity could not use the Blue Cross or Blue Shield trademarks, and the state department of insurance rejected the merger.

Mark Dowie, *American Foundations: An Investigative History*, p. 85.

BLUE CROSS BLUE SHIELD OF WISCONSIN:
PUBLIC INPUT HAS LIMITED EFFECT

Rumors of a conversion by Blue Cross Blue Shield United of Wisconsin (BCBSUW) began circulating in 1998, and community groups throughout the state called for caution, urged regulators and BCBSUW to determine the full fair market value of the health plan through an independent valuation, and recommended that regulators hold public hearings to determine how the money should be used.

But in June 1999, BCBSUW announced conversion plans that included "donation" of $250 million to the Medical College of Wisconsin and the University of Wisconsin Medical School (which trains about half the state's physicians). Governor Tommy Thompson and AG James Doyle supported the deal, and the proposal was filed with the Office of the Commissioner of Insurance (OCI) for review. Community coalitions argued that the assets belonged to the community, not to BCBSUW executives, and that the assets were not the executives' to donate.

In response to consumer groups' concerns, Commissioner of Insurance Connie O'Connell required that 35% of the funds be used by the medical schools for public health, but also allowed a committee to change and even eliminate the allocation by a two-thirds vote. Consumer advocates filed suit to block the proposal, arguing that the law required the money to go to an independent foundation.

Public hearings were held for a year, during which BCBSUW argued that it was not and had never been a charity and thus was not subject to the law of charitable trust, even though state law had deemed nonprofit health plans to be charitable and benevolent corporations for much of BCBSUW's history. O'Connell appointed a three-member appraisal committee to help examine the conversion proposal; committee members were the executive director of the Wisconsin Investment Board, which managed investment for state assets; a certified public accountant and chair of the Insurance Committee of the Wisconsin Institute of Certified Public Accountants; and the state's deputy commissioner of insurance. The committee hired an investment banking firm to provide technical expertise to the agency and the committee on some of the financial aspects of the plan.

The lawsuit ended up before a Dane County Circuit Court judge who ruled that the doctrines of charitable trust and *cy pres* do not apply to BCBSUW. He ruled that the Wisconsin statute regulating health care conversions did not specifically incorporate the charitable trust and *cy pres* parts of the Wisconsin code, so the legislature did not intend these doctrines to apply to health care conversions; that the assets were not acquired with donative intent, but from premium payments from policy holders; that the state statute limits entities eligible to bring a *cy pres* action, and the community coalition was not among them; and

that *cy pres* did not apply because the purpose of BCBSUW had not become impractical, unlawful, or impossible because BCBSUW would continue to operate as a health plan, albeit a for-profit one. The judge also ruled that Wisconsin's unique statutory scheme gave the insurance commissioner great discretion to approve the conversion plan, and that substantial evidence supported the commissioner's decision.

The commissioner's March 2000 order approving the conversion did not place a definite value on the company. Instead, O'Connell said: "A determination of the current value of the stock will not be indicative of the dollar amount ultimately achieved. For that reason the Appraisal Committee and my decision placed the focus on assuring [that] the definitive valuation event, when the first stock sale occurs, will produce a fair and reasonable result." The conversion date would coincide with the first stock sale, at which time a dollar amount would be determined.

Saying that the resounding themes of the public input she received "were for funds to be made available for local and community public health initiatives, medical research and provider education and access," O'Connell modified the conversion plan to provide greater public input into the use of the funds, establish independent foundation governance (by a board whose original members would be appointed by the commissioner), ensure full and fair valuation, and earmark 35% of the conversion proceeds to address public health needs in collaboration with community organizations. She added, "The existing infrastructure and public nature of the medical schools, board of regents and board of trustees will result in the most efficient and effective use of the conversion funds. With the added public participation and oversight for the use of these funds that is included in my decision, I am confident that the many health needs of the citizens of our State will receive proper consideration." The foundation, a 501(c)(4), exists only to provide a vehicle to realize the full value of BCBSUW and transfer those funds to the two medical schools.

"Amended and Restated Articles of Incorporation of Wisconsin United for Health Foundation, Inc."

"Amended and Restated Bylaws of Wisconsin United for Health Foundation, Inc."

"Appraisal Committee for Blue Cross Conversion Proposal Appointed."

"Blue Cross/Blue Shield News," press releases dated August 22, 2002, and May 9, 2003.

"FYI: Health Institution Transactions Report," April 30, 2001.

"FYI: Health Institution Transactions Report," September 7, 2001

Gorham, Barbara, and Nomita Ganguly, "Wisconsin Blue Cross Conversion: $250 Million for Medical Schools," pp. 10-12.

"Insurance Commissioner Modifies and Approves Blue Cross and Blue Shield Conversion Plan."

Letter dated January 8, 2001, from Stephen E. Bablitch of BlueCross & BlueShield United of Wisconsin to Guenther Ruch of the Wisconsin Office of the Commissioner of Insurance.

"The Wisconsin Partnership Fund for a Health Future, 2003-2008 Five-Year Plan," April 16, 2003.

THE NEED FOR GOVERNMENT ACTION AND OVERSIGHT

Early conversions, which occurred with minimal government oversight or public watchdog activity, resulted in substantial undervaluation of assets of converting entities and foundations that were significantly smaller than they might have been if more rigorous standards of valuing assets were in place. Government oversight and public scrutiny have increased greatly, but much more progress is needed. Regulation is needed not only to be certain that assets are fully valued and transferred in their entirety to the conversion foundation, but to ensure that the resulting foundation remains faithful to the original purposes of the nonprofit corporation. The effectiveness of conversion foundations depends on government oversight of and public input into their establishment and their work.

Many state attorneys general have sought greater regulatory powers, and a number of state legislatures have passed laws governing conversion transactions. Some states have also negotiated with for-profit buyers to provide specific levels of charity care or special services. The objectives of any government entity's action and oversight should be safeguarding the value of the charitable assets, protecting the community from loss of essential health care services, and ensuring that the proceeds of the transaction are used for appropriate charitable purposes.

Provisions for safeguarding the value of charitable assets should include independent review of the fairness of the transaction, disclosures of conflicts of interest, and development of a valuation report. Provisions for protecting the community from loss of essential health care services should include development safeguards for continuing essential health care services, and public hearings or other solicitation of public comment. Provisions for ensuring that the proceeds of the sale are used for appropriate charitable purposes should include ensuring that the sale proceeds are not used for the private benefit of the for-profit purchaser, determination of the charitable purposes for which the sale proceeds will be used, and governance and oversight of the nonprofit entity that receives the sale proceeds.[37]

There is a broad range of business combinations possible – including outright sale of a nonprofit entity to a for-profit buyer, merger and consolidation of nonprofit entities, merger of entities in noncontiguous states, joint ventures, and creation of mutual holding companies, to list a few – and each has different implications. In some joint venture conversions, for example, only a portion of the asset value – as little as 50% – is paid at the time of conversion, and the balance is held as an interest in the new for-profit organization.[38] It is therefore crucial that agencies construe conversion activity broadly in order to ensure that their regulations, laws, and decisions govern all activity likely to result in a change from nonprofit to for-profit status.

State Regulators

Responsibility for ensuring that the charity receives fair market value for the assets being converted, that the transaction is fair to the charity, and that there is no private inurement resides

[37] "Proposed Guidelines for State Regulators' Oversight of Sale and Joint Venture Transactions in which the Assets of Nonprofit Hospitals or HMOs are Transferred to For-Profit Enterprises."
[38] "The Case for an Activist Approach by State Charity Regulators in Overseeing For-Profit Conversions of Nonprofit Hospitals and HMOs."

first with the state attorney general, who in many cases is the only party with standing and is therefore the sole representative of the community interest. As can be seen in a number of the stories above, AGs are in many cases taking this responsibility and their leadership role very seriously, even stopping deals from taking place.

Other regulatory agencies may also have responsibility, depending on the type of entity undergoing conversion. In Wisconsin and Maryland, for example, state commissioners of insurance were the responsible parties in conversion of the state Blue Cross Blue Shields. In California, HMOs and insurance plans are overseen by a state department of corporations; the attorney general oversees all other nonprofit corporations, including hospitals and health care facilities. When responsibilities are split, those responsibilities should be clearly delineated and the agencies should work closely together to examine the transaction.

National associations of regulators understand the importance of their members' roles in conversion transactions and have taken action to protect the public interest. The National Association of Attorneys General, for example, passed a resolution stating: "the proposed uses of the proceeds of the transaction should be consistent with the charitable purpose for which the assets are held by the nonprofit health care entity," has developed principles of oversight, and has written model legislation for hospital conversions.[39] The National Association of Insurance Commissioners (NAIC), whose licensing agreements govern the Blue Cross Blue Shield trademark, has a BCBS conversion work group and has at times threatened to revoke plans' use of the trademark. NAIC also has 13 consumer representatives from the nonprofit advocacy community to ensure that consumers' voices are heard in the organization.

In overseeing conversion transactions, state charity regulators are also working with and providing leadership to other government agencies. Some have taken the position that a nonprofit hospital, insurance plan, or other entity proposing to convert to for-profit status must obtain advance court approval in a *cy pres*-type proceeding. In California, the Blue Cross conversion that resulted in creation of the California Endowment and the California HealthCare Foundation triggered a change in state law because of the leadership of the Commissioner of Corporations, who in 1994 reformed the departmental practice of undervaluing public assets in HMO conversions. Before that, oversight had been lax and the department was widely viewed as allowing undervaluation of assets. After the transaction was completed in 1996, the legislature passed a bill codifying the Department of Corporations standards used to review the conversion and enacted similar requirements of conversion of nonprofit hospitals.[40]

State Legislatures

Recognizing the potential for negative community-wide effects of conversion transactions in the absence of public debate or input, states have responded legislatively, but there is a long way to go. A flurry of legislation between 1995 and 1997 resulted in 19 states passing 21 laws, most of which clarified the public's rights under existing charitable trust and nonprofit law.[41] 28 statues

[39] Dowie, p. 84; and "The Sale and Conversion of Not-For-Profit Hospitals: A State-by-State Analysis of New Legislation," Introduction.
[40] Ferris and Graddy, pp. 16-17.
[41] Seto, Collins, and Weiskopf, p. 2.

now have a conversion law that covers either nonprofit hospitals and insurers or both; 23 states (including DC) have laws governing hospital conversions, and ten (including DC) have laws governing HMO conversions.[42]

Most of the laws on the books define a process for state oversight and review that includes approval by the Attorney General and/or other state agencies, specify a time frame for notification and submission of information by the parties to the transaction, and define action by the state. State laws vary greatly both in their application of *cy pres* doctrine to the proceeds and in involvement of the public; while many stipulate that the proceeds be used to support and promote health care in the community, only a few require that a public hearing be held as part of the decision, and some do not even require public disclosure of the transaction.[43]

The following brief summary of some of the provisions in the laws that have been enacted to date gives some indication of how much more needs to be done to protect the public interest and prevent the kinds of problems that have hitherto plagued conversion transactions:

- Regulator considers health impact: 17 states provide for consideration; 6 require
- Require parties to transaction to analyze health impact: 6 states
- Acquirers must submit a community benefit plan or maintain free care: 7 states, including DC
- Consider acquirer's commitment to providing free care: 5 states
- Require monitoring of impact on health care: 7 states
- Prohibit private inurement: 11 states
- Consider private inurement: 9 states, including DC
- Consider conflicts of interest between parties: 14 states, including DC
- Consider conflicts of interest in patient referral: 5 states
- Require regulator to obtain independent valuation of assets: 3 states, including DC
- Require that public hearing be held: 10 states
- Consumers have standing to appeal approval: 2 states, one of which only implies that consumers do
- Require charitable set-aside: 22 states, including DC
- Require foundation independence: 10 states, including DC[44]

Some laws also grant explicit enforcement power to the regulators charged with overseeing conversion transactions.[45] The strongest provisions give regulators the means not only to enforce the law during the conversion process, but also the means to enforce free care and community benefit agreements and to ensure that conversion foundations serve the public interest.[46]

Only a handful of the new laws define conversion broadly enough to encompass a wide range of transactions. Very few counteract the potential conflicts between the interests that the profit

[42] "Conversions: A Compendium of State Laws," pp. 1-3; and "Conversion Model Act," p. 1.
[43] "The Sale and Conversion of Not-For-Profit Hospitals: A State-by-State Analysis of New Legislation," Part I: Common Elements in Hospital Conversion Legislation.
[44] "Conversions: A Compendium of State Laws," pp. 4-8.
[45] Seto, Collins, and Weiskopf, pp. 2-3.
[46] Ibid., p. 17.

motive introduces into hospital management and those of patients. Very few make stipulations regarding the foundation created by the conversion, and even fewer look beyond such basic questions as independence or tax classification of the resulting entity.

More – and more comprehensive – laws are needed to protect consumer interests throughout the conversion process, give consumers the opportunity to participate and speak out in a conversion, give regulators a direction and process for reviewing an extremely complicated transaction, and regulate the establishment and governance of the foundation and its charitable activities.

The following general questions can be used to gauge the soundness of laws relating to conversions:

- Protecting the community's access to, and the quality of, health services:
  - Does the law require that regulators analyze the impact of the transaction on the community?
  - Can regulators withhold approval if the health impact is negative?
  - Is the acquiring party required to submit a community benefits plan that must meet regulatory approval?
  - Is the acquiring party required to make a commitment to free care?
- Protecting charitable assets:
  - Was the nonprofit properly valued?
  - Was the money set aside for charitable purposes?
  - Was the community involved in those decisions?
  - Is community involvement mandated for the long term?[47]

Laws should require:

- that regulators conduct analysis of the impacts of the transaction on community health and local health delivery systems
- that regulators withhold approval if health impacts are negative
- that the acquiring party submit a community benefits plan that must meet with regulatory approval
- that the acquiring party make a free care commitment
- that public hearings be held in the affected community
- establishment of criteria for making conversion filings public
- independent valuation of charitable assets
- that regulators monitor and enforce agreements and commitments
- that regulators have enforcement mechanisms such as criminal and civil penalties and license revocation and denial
- that the full value of the conversion be turned into a conversion foundation
- that the resulting foundation be a 501(c)(3) or a public charity
- that the resulting foundation be independent of the parties to the transaction, or at least from the for-profit acquirer
- that the endowed foundation and its charitable activities not be viewed as fulfilling community benefit requirements imposed on the for-profit acquirer
- that a regulator monitor the foundation and its activities after the transaction

[47] "Health Care Conversions and Philanthropy: Regulation, Impacts, and Unanswered Questions."

- that the foundation have a particular mission or be limited in its grant-making priorities
- that foundation governance be broadly based in the community served by the healthcare entity
- that the foundation board be comprised of individuals with experience in pertinent areas such as foundations and health care
- that the foundation board conduct a public hearing to solicit comments on the proposed mission statement, program agenda, corporate structure, and strategic planning (15-16)
- that most of the foundation's grant making be focused in the community served by the converting healthcare entity
- that the foundation's grant making emphasize vulnerable populations (Washington's law, for example, stipulates that proceeds be used for "charitable health purposes consistent with the nonprofit corporation's original purpose, including providing health care to the disadvantaged, the uninsured, and the underinsured, and providing benefits to promote improved health in the affected community." Maine's law stipulates that the foundation's mission "must include, but is not limited to, serving the state's unmet health care needs, particularly with regard to medically uninsured and underserved populations and providing access to care and improving quality of care for those populations.")[48]

Courts

As can be seen in the case stories above, much conversion activity has taken place in the courts, but more as a result of challenges to aspects of transactions than because of any systematic inclusion of the courts in the process. Some regulators, though, are requiring that the converting entity obtain advance court approval in a *cy pres*-type proceeding. Such involvement of the courts at particular points in the conversion process could help prevent so many contentious lawsuits and protect the public interest.

The Importance of Ongoing Community Input

Community groups have been increasingly involved in – and have had important effects on – conversion transactions, providing input to regulators and others about asset and service preservation, about the community benefits plans required by some of the new laws, and, more recently, about the new health philanthropies.

By the time a conversion transaction is approved, basic questions about the foundation's structure and orientation are often complete. Community groups should therefore not wait until the foundation begins to operate, but should be involved in these decisions during transaction negotiations and initial public review periods. In early conversions, the responsibility for developing the foundation plan was often left to trustees of the converting nonprofit organization, but this approach did not adequately recognize the community stake in nonprofit assets or provide for broad input. The people most directly affected by the conversion and targeted to benefit from the foundation's activities were left out of the planning process entirely. More recently, particularly in highly visible cases, regulators and some new laws have

[48] Seto, Collins, and Weiskopf, pp. 16-17.

encouraged broader participation in early planning. New Hampshire, for example, is requiring health insurance plans to convene community focus groups to determine the best use of foundation assets.[49]

Some say that this is where community input should stop: Gary L. Yates, President and CEO of The California Wellness Foundation (TCWF), and Thomas G. David, the Foundation's Executive Vice President, agree that "conversions should receive careful scrutiny from a variety of stakeholders, including those who have the most difficulty obtaining access to health care – the uninsured and traditionally underserved," and note that TCWF's asset base is three times the original figure offered by the company largely because of public scrutiny of the transaction. TCWF, in fact, has made grants to Consumers Union to support its work in casting light on conversion deals. But, they say, "the critical time for that input is *before* the conversion is approved. Once the new philanthropic organization has been created, it should operate as does any other private foundation, with the trustees charged with the responsibility for good stewardship."[50]

But planning for these foundations should have the same level of community oversight and input as the conversion transaction itself. Because of the public nature of the source of assets, these foundations are different from most private foundations, which were established on the basis of personally amassed fortunes. They are in essence public trusts and should be structured so that the public has a voice in their missions and governance.

Choices about the structure, mission, and grant-making focus should be made through processes that encourage public dialogue, engage diverse elements of the community, and foster consensus about community health improvement goals. It is essential to include community members with unmet health needs and their representatives in the foundation planning process.

Many new conversion foundations have viewed as important the search to find ways to involve their communities in setting grant-making priorities, even though they are not required by law to do so. A number of foundations require that board members be broadly representative of the community that is served, and some (such as the Foundation for a Healthy Kentucky, discussed above) are establishing community advisory committees as an accountability measure, to ensure community participation. A community advisory committee can establish a "program of community outreach activities to assess community needs, encourage participation by communities and individuals that are intended to benefit from [the foundation's] activities, and listen to, and obtain feedback from, members of the community about [the foundation's] grantmaking goals and activities."[51] It can also function as a permanent nominating committee to the board for its selection of new board members.

[49] "Charitable Foundations Formed by Conversions Take Many Forms."
[50] Yates and David.
[51] "Model By Laws for 501(c)(3) Foundations," p. 5.

THE IMPORTANCE OF COMMUNITY INPUT

The San Angelo, Texas community hospital was sold in 1995 to Columbia-HCA. About $57 million went to a conversion foundation to benefit residents. But by 2000 more than a quarter of the 102,000 residents of the town had no health insurance and little access to health care, and many more were substantially underinsured. Meanwhile, the San Angelo Health Foundation made a $200,000 grant for an alumni center at the state university and another $200,000 grant to establish a new animal shelter.

Annette Fuentes and Rosemary Metzler Lavan, No Health, No Weatlth."

The Role of Traditional Philanthropy

The input of already established foundations in conversion transactions is also important for a number of reasons. The issues at stake in conversions in many cases bear directly on the experience and work of established foundations, especially of those that are concerned about reduction in the capacity of the health and human services safety net. Foundations can provide an informed perspective in public discussion about the changes taking place in the health care industry, and many of the questions that arise in the formation of new foundations are in areas where local foundations have direct experience and relevant expertise. They have longstanding relationships with nonprofit health care organizations, and understand how limited funds can be used to achieve results. Their participation is especially important given the limited experience many regulators have with nonprofit conversions. Working with other community leaders and institutions, philanthropic leaders can contribute through such activities as:

- organizing or cosponsoring meetings about nonprofit conversions
- joining with other community leaders and institutions in reviewing the terms of proposed conversion transactions
- reaching out to other parts of the community – such as businesses, academic institutions, government, and media – to strengthen and broaden participation in local service and consumer coalitions
- providing funding to support the organizing, research, and action agendas of community coalitions formed in response to conversion proposals
- contributing to discussions about the potential impact of proposed conversions on health services in the community and about community needs
- providing perspective on the ability of the nonprofit sector to absorb costs of uncompensated care
- working with regulators reviewing conversions to expand their understanding of the role of philanthropy and the characteristics of effective grant making
- providing technical assistance and operating funds for local coalitions that participate in the operation of new conversion foundations or that address issues of health care quality and accessibility[52]

[52] "Nonprofit Health Care Organization Conversions: Participation by Philanthropic Leaders."

COMMUNITY INPUT:
A ROLE FOR RAGS

The New Mexico Association of Grantmakers (NMAG) was a key player in the conversion of New Mexico Blue Cross/Blue Shield. $20 million in assets were put into a foundation to fund health care needs in the state. NMAG represented the philanthropic sector in public hearings held by the state superintendent of insurance and the attorney general about the conversion, and brought together representatives of Consumer's Union, Health Action New Mexico (an advocacy group), and the attorney general's office. Members of NMAG worked with the AG and the superintendent of insurance to ensure a fair valuation of the BCBS assets and helped the two regulators put together the Advisory and Planning Committee, which oversaw establishment of the foundation.

"Working Together."

"Blue Cross Blue Shield Update."

Recommendations: Formation and Governance Issues

In order to safeguard the public interest, it is essential that establishment of a conversion foundation incorporate a planning process that involves the perspective and expertise of local consumers and health care advocates; a mission statement that dedicates foundation assets to the purposes of the former nonprofit; a selection process that establishes the foundation's governing board as separate from both the former nonprofit and the purchaser, reflects community diversity, and has appropriate expertise and experience; an organizational structure that is transparent and publicly accountable; strict term limits and strong conflict of interest policies for board members and other advisors; and a commitment to community health improvement.

Public charities often require that a substantial majority of governing board members be "public" members, a requirement that conversion foundations too should write into their articles of incorporation. The board should reflect community diversity in both the generally understood sense of racial/ethnic diversity – an area in which foundation boards are distinctly *not* representative of either the general population or the populations they serve (in 2000, foundation boards were 89.5% white, 6.3% black, 2.5% Hispanic, and 1.7% other, whereas 27% of the population is black, Hispanic, or Asian)[53] – and in the sense of people with a broad range of interaction with the health care system. Board participants should therefore include local community members – particularly members of the populations traditionally served by the converted entity – health care and consumer advocates, and health care practitioners (including community health workers, health clinic providers, and others with strong community connections).

Gary Yates and Thomas David of The California Wellness Foundation argue that even the term "conversion foundation," suggesting as it does that these are a distinct type of foundation, is a problem, because referring to conversion foundations as a group "only serves to give credence to a mistaken belief in some circles that [they] are different from other private independent

[53] "Foundation Boards: Composition and Compensation"; and Gardy, p. 25.

foundations." They note that there is no state or federal legal distinction based on whether an entity was created by a conversion and that in California, at least, "the conversion process involving health care entities is now aggressively regulated…, either by the Attorney General or by the Department of Corporations," whose task is "to ensure that the charity receives fair market value for the assets being converted, that the transaction is fair to the charity, that there is no private inurement, and that certain other criteria are met depending upon the applicable statute and regulation." Use of the term, they say, only encourages the perception that conversion foundations' assets are public rather than that they serve as trusts of funds dedicated to charitable purpose.

Which is exactly right: The public *is* in essence the donor of the assets in the case of a conversion, the foundation *is* a public trust, and the foundation should be structured so that the public has a voice in mission and governance. Because of the high level of public scrutiny they rightly receive and because of the public nature of the assets with which they are established, conversion foundations must therefore face accountability issues head on. If anything, they should be even more accountable to the public than other foundations.

Most conversion foundations, as discussed above, are public charities. While this choice may depend on the nature and purpose of the organization, establishment as a private foundation – with the stricter rules of accountability to which foundations are subject – is preferable for protecting the public interest for a number of reasons.

- Public charities must meet the test of public support, with more than one-third of their annual funding coming from qualifying gifts, grants, contributions from diverse sources, membership fees, gross receipts from admissions, sales of merchandise, performance of services, or furnishing of facilities in activities related to the exempt functions. Many foundations initially qualify as public charities in the period immediately following the conversions, but the size of their endowments makes it difficult to raise enough funds to meet the public-support test once the advance ruling period ends. They also end up competing for funding with groups that are also trying to find resources to stay in existence – the very groups they could be supporting.
- Public charities are not limited in the amount of stock they can hold in one corporation (as long as the public-support test is met). Given the risk that a conversion foundation may be too closely associated with the for-profit parties to the transaction, the stricter rule applied to 501(c)(3) foundations, which are prohibited from holding more than 20% of the voting stock of any corporation or 20% of the profit interest in any partnership, is preferable. Add to this the fact that foundations are taxed on investments that jeopardize their charitable purposes, and the safeguards are stronger.
- Public charities are not subject to 5% payout rule, which ensures a minimum level of charitable expenditures.
- While public charities are subject to prohibitions against private inurement and excess benefit to a private business, they:
    - are not subject to rules about self-dealing, which happens when people make improper financial gains through their ties to nonprofit groups;
    - are not subject to restrictions on outside business holdings or limits on grants to individuals and government officials;

- do not have to pay out the minimum 5% of net assets to charities;
- are not restricted from lobbying either directly or through grants made to nonprofit groups specifically for lobbying purposes; and
- are not prohibited from making certain types of loans.[54]

Social welfare [501(c)(4)] organizations, which constitute an increasing number of new conversion foundations, are even less accountable to the public than 501(c)(3) foundations. Part of a broad tax category that includes political or lobbying groups like Common Cause and the NRA, social welfare organizations are not obliged to spend any portion of their assets on charitable activities and are not required to report the same detailed information as private foundations on their tax forms. Until the 1996 Taxpayers Bill of Rights was enacted, federal tax law did not even prohibit private inurement by a c4, and there were conversion deals that benefited the officers, directors, and high-level executives of entities that converted. Now no part of the net earnings of a social welfare organization can inure to the benefit of any private interest.[55]

Even for those entities that are not incorporated as 501(c)(3) private foundations, articles of incorporation should be drafted to include the specific private foundation prohibitions so that they apply to the new entity as a matter of corporate law.

Establishment of a large state foundation that accumulates the proceeds of more than one conversion transaction, such as the Maryland Health Care Foundation, is not a good idea, as the very legislature that established the foundation determined. In the mid-1990s, a California bill to place the assets of all health conversion foundations into one large public foundation, which had been passed by the state assembly, fortunately died in the state senate.[56] Conversion foundations should be rooted in the same community that was served by the converting organization. In the case of statewide Blue Cross Blue Shield or other health plans, the foundation would of course serve the entire state, but more locally focused health care institutions should give rise to equally locally focused foundations. Negotiation during the conversion approval process of community benefit plans is one essential part of ensuring that the health care needs of communities are met; ensuring that the conversion foundation's mission and grant making are focused on those local community health care needs is the other.

Recommendations: Grant Making and Policy Issues

More than 90% of all foundations make grants in health, and health-related grant making is second only to education-related grant making. Much of that funding – especially the largest grants – is going to universities and hospitals for medical research and education.[57] Some conversion foundations have funded programs in health services for the working poor, and several have created hospitals that have earmarked funds for indigent care and other services not offered by new for-profit hospitals. "These investments are particularly vital to communities struggling to fill the gap in needed services created by the devolution of government welfare

[54] "Federal Tax Designation for Foundations Created from Conversions," pp. 1-3.
[55] Ibid., p. 2.
[56] Yates and David.
[57] Dowie, p. 74.

programs. Conversion foundations of all types have, in fact, played a central role in the massive readjustments required of state and local governments saddled with responsibilities abdicated by Washington."[58] But James Ferris and Elizabeth Graddy's 2001 survey of health foundations in California – where more than half of all conversion assets reside – shows that:

> [T]he scope of the grantmaking by the health conversion foundations is virtually indistinguishable from [that of] other health funders…. The health funding priorities, grantmaking strategies, and funding methods of health conversion foundations are not substantially different from other foundations in this study. For example, over 50 percent of … foundations place priority on broad-based health programs such as health promotion and education, healthy families and communities, healthcare access, and service delivery. Within these funding priority areas, there is an emphasis on program support, as opposed to core operating support, for pilot or established exemplary programs, and for capacity building and technical assistance.[59]

Because conversion foundations are part of a trend of increasingly limited access to affordable health care, particularly for people with already limited access, they have a special obligation to engage in grant making and other program activities that focus on the needs of underserved populations.

This is not to say that they should only be in the business of direct provision of health services, nor should foundations encourage the public sector or other health care institutions to reduce their commitments to health services. They should balance direct service needs against investments in prevention, public education, applied research, service evaluation, development of new delivery models, documentation projects, advocacy, policy development, and other initiatives directed at system improvement and reform.

There are debates about the proper interpretation of the *cy pres* doctrine as it relates to conversion foundations, which some state regulators and advocates interpret narrowly to mean that assets should be used to pay for health services or to purchase insurance for the uninsured; others argue for broader missions that allow for programs that aim at shaping systems to be more responsive to community needs and to create greater access.

The amount of money needed to provide all citizens with health insurance or health care services is enormous. In 2000, while foundations spent an estimated $4.46 billion on health, this was only a tiny fraction of the more than $1.5 trillion spent annually on health services and programs.[60] In California, public health funding exceeds $200 per person, but health philanthropy totals less than $10 per person.[61]

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[58] Dowie, p. 83.
[59] Ferris and Graddy, p. 20.
[60] Oliver and Gerson, p. 3.
[61] Ibid., p. 26; and Ferris and Graddy, pp. 18-19.

Conversion foundations can play a role in addressing gaps in services and consider funding for urgent direct care needs, but they cannot and should not replace essential services and community benefits that should be negotiated for as part of the transaction review. Given their very limited resources – a mere drop in the bucket, in fact, relative to overall health spending – foundations cannot begin to replace services that may be lost due to escalating health care costs, conversions, and other trends.

And given the critical state of the country's health care industry and the tens of millions of Americans with increasingly limited access to health care, conversion foundations should focus substantial portions of their grant making and other activities on health policy. In this way, they can leverage limited resources, influence policies and programs that reach a larger population than can be served directly by foundation programs, bring demonstration projects to scale, provide resources for sustaining programs beyond short-term grant periods, and help ensure that government programs are effective.[62]

Health policy-related grant making is concentrated in a small number of foundations; the top 25 funders in the field awarded 96.8% of all health policy grants in 1995. That year, the Robert Wood Johnson Foundation alone awarded 44.6% of all health policy grants, more than three times that of the second largest, The California Wellness Foundation. The establishment of TCWF in fact fueled substantial growth of support for health policy activities, because the foundation included health policy as a central program focus; it gave more than 1/7 of all grant dollars in health policy in 1995.[63]

Because of the increase in state responsibility for the nation's health care programs, foundations have expanded their health policy funding to state and local activities, where their potential to effect change is great. In 1995, $39.1 million (or 39%) of health policy dollars went to state and local programs, in contrast to only $6.4 million (or 21%) of health policy dollars in 1990. And 40% of health policy grant dollars in 1995 were for particular population groups such as children and youth and ethnic and racial minorities.[64]

Conversion foundations should focus in particular on the insurance crisis being faced by 43.6 million Americans, through efforts aimed at improving employer-sponsored coverage, bolstering public programs such as Medicaid and the State Children's Health Insurance Program, and developing initiatives to provide coverage for individuals who do not qualify for employer-sponsored or public programs. Insurance coverage is a critical step in assuring equitable access to health services; being uninsured reduces use of medical care by as much as 50%. The uninsured make fewer visits to the doctor, use emergency room care more frequently, are more often hospitalized for chronic conditions than their insured counterparts. They are several times more likely to lack a regular source of care, to delay or not receive needed care, and to fail to fill prescriptions because of the cost. They are less likely to report that they are in excellent or very good health, and more likely report that their health is only good, fair, or poor. The uninsured tend to have later intervention and poorer outcomes from diseases such as cancer, cardiovascular

[62] "Strategies for Shaping Public Policy: A Guide for Health Funders," p. 1.
[63] Oliver and Gerson, p. 3.
[64] Ibid., p. 4.

disease, and diabetes; babies born to uninsured mothers have lower survival rates; and individuals who are uninsured for long periods of time have significantly higher risks of dying.[65]

Local foundations should respond to local events and practice locally strategic philanthropy that includes influencing public agendas and policies. Most conversion foundations do make grants in a limited geographic area, where they have the greatest potential to effect change at the state and local levels. They are often the largest source of nongovernmental health funding in a community or state; in Tennessee, for example, the largest and second-largest foundations in the state were created through conversions

At the same time, the need for new national policies that ensure greater, not less, access to health care for Americans is great. Conversion foundations, as new and disparate as they are, as locally focused as they are, and as unsettled as the field is, are a long way from being able to work together and with other foundations to effect policy change at the national level. But even as they find their way, they can and should begin to point the way and to work with other conversion foundations, advocates for the underserved and consumers, traditional philanthropy, and policy makers to change the systems under which we currently operate – systems that are not working.

> In the first century of American health philanthropy almost everything was tried and funded. Only two areas have remained unchallenged by foundations. One is the preeminent role of hospitals in health care; the other is the resistance to a single-payer health care system or national health plan. While every other country in the developed world has found ways to assure some health care to most of its citizens, about 44 million Americans remain uncovered, languishing helplessly between the extremely poor and aged who are covered by Medicare and Medicaid and those who are either employed with generous benefits or affluent enough to buy their own costly health insurance…. To some degree this situation is a result of actions taken by American foundations – not because they have aggressively opposed a national health plan but because their funding of systems research and the development of health care delivery models quite deliberately excludes anything that sounds like socialized medicine.[66]

[65] Ibid., pp. 4-5.
[66] Dowie, p. 76.

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