A FRESH LOOK AT HEALTH LEGACY FOUNDATIONS
Philanthropy, Public Policy and Hospital Conversions in the Aftermath of the ACA

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I. REVISITING NONPROFIT HEALTHCARE CONVERSION PROCEEDS

II. CONCEPTUALIZATION AND TRENDS
   A. DEFINITION AND NAME
   B. TRENDS
      1. Methods
      2. Endowment Timeline

III. THEORETICAL AND LEGAL FRAMEWORK

IV. ONGOING PUBLIC POLICY CONCERNS
   A. COMPLEXITY AND LENGTH OF TIME INVOLVED IN ESTABLISHMENT
   B. CONTROVERSY REGARDING INITIAL ENDOWMENT
      1. Private Inurement
      2. Asset Valuation
      3. Tax-Exempt Status
      4. Mission

V. GEOGRAPHIC DISTRIBUTION AS AN EMERGING ISSUE
   A. REGIONAL CLUSTER
   B. RESTRICTED SERVICE AREAS
      1. Governance and Management
      2. Community Relations
      3. Grantmaking

VI. REGULATORY RESPONSE

VII. CONCLUDING DISCUSSION
More than $23 billion of new charitable wealth has flowed into communities nationwide over the past three decades as a result of nonprofit healthcare entities selling their assets, often to for-profit firms. Proceeds from these sales most often establish new healthcare conversion foundations, also known as health legacy foundations (HLFs). Forty-two percent (42%) of these philanthropic heavyweights operate in the South, and many restrict their grantmaking programs to small, often rural or suburban areas, usually the converting hospital’s service area (Grantmakers in Health 2002, 2009a; Nauffts 2001; Southeastern Council of Foundations 2006). For many communities whose stand-alone hospital struggled to compete in the increasingly market-oriented healthcare arena, conversion means that a better-capitalized for-profit entity now provides hospital services while a foundation manages the multi-million dollar windfall generated from the hospital’s sale. Today at least 245 HLFs are pumping nearly $1 billion worth of grant funding into communities every year as a result of these conversions. Without doubt, such a force has significant potential to affect healthcare delivery systems in communities across the nation.

Since the passage of healthcare reform legislation in 2010, the number of nonprofit hospitals selling to for-profit acquirers has spiked, justifying a fresh investigation into the realm of healthcare conversion proceeds. The transfer of billions of dollars into HLFs raises significant questions about how to ensure that communities benefit as much as possible from conversion transactions. Accordingly, a literature review and analysis of foundation data were undertaken to address the following research question: **What characteristics define and distinguish HLFs, and do these characteristics warrant special public policy consideration?** Guided by a framework of nonprofit organizational theory and legal doctrine, this paper will first discuss the contemporary issues that call for a fresh look at HLFs. Second, information about the conceptualization of and trends in HLF establishment will be provided, followed by a discussion of the theoretical and legal framework driving the investigation. The next section will review some of the ongoing public policy issues related to HLFs, focusing on the complexity and length of time involved in HLF establishment and the amount of public controversy plaguing their initial endowment. A newly emerging trend in HLF formation will then be discussed: geographic distribution. After discussing some of the regulatory responses to HLF establishment, the paper will conclude with brief recommendations for further research.

I. A FRESH LOOK AT NONPROFIT HEALTHCARE CONVERSION PROCEEDS

Prior to the passage of healthcare reform legislation in the spring of 2010, the mid to late 1990s indisputably represented the heyday of nonprofit healthcare conversions. Recent trends, however, suggest that HLF creation may be on the cusp of a grand reemergence. Hospital merger and acquisition activity began to increase shortly after the Patient Protection and Affordable Care Act of 2010 (ACA; P.L. 111-148) was enacted, and it shows no signs of slowing (Commins 2011; Irving Levin Associates 2011a). In 2010, 77 deals took place—the most since 2001—and 55 deals were reported in the first six months of 2011 alone (Irving Levin Associates 2011a; Mathews 2011). Industry analysts anticipate that 2011 may even break all previous records for healthcare merger and acquisition activity, particularly given the increasing attractiveness of nonprofit hospitals as purchase targets (Irving Levin Associates 2011b; Pizzi 2011; The Associated Press 2011).

Indeed, nonprofit hospitals have emerged as prime investment opportunities for for-profit acquirers, with healthcare reform frequently cited as a contributing factor (e.g., Blesch 2011; Commins 2011; de la Merced 2010; Galloro 2011; Irving Levin Associates 2011b; Mathews 2011; Pear 2010; Spielman 2011). Although uncertainty still looms with regard to
how the ACA will be implemented, reform stipulates new requirements for nonprofit hospitals to justify their tax-exemption (Folkemer et al. 2011; Williams 2010). Coupled with ongoing demands to modernize technology, such pressure may lead nonprofit hospitals—already struggling with a diminishing ability to access capital—to question the value of nonprofit status (Pizzi 2011; Spielman 2011). These and other challenges were noted as Moody’s Investors Service announced its negative outlook for nonprofit hospitals in both 2010 and 2011 (Martin 2010; Spielman 2011). Other stressors plaguing nonprofit hospitals include rising debt, slow revenue growth, and precarious financing structures, with smaller and stand-alone hospitals proving to be most vulnerable to takeover (Cheung 2011; Commonfund 2011; Goldstein 2011; Pizzi 2011; Spielman 2011).

Smaller and stand-alone hospitals are especially susceptible because healthcare reform is encouraging consolidation (Galloro 2011; Irving Levin Associates 2011b; Pear 2010). According to Irving Levin Associates (2011b), the ACA has led hospitals to conclude that there is safety in numbers. Not only will regionally integrated systems facilitate the work of accountable care organizations, but they will also enable hospitals to reap the rewards conferred by economies of scale (Cheung 2011; Irving Levin Associates 2011b; Mathews 2011; Pizzi 2011). Distressed nonprofit hospitals are also battling a barrage of obstacles affecting all hospitals, including fewer paying patients, greater reliance on already-overwhelmed Medicare and Medicaid programs, and stressed revenues from all sources. Not surprisingly, the infusion of cash, access to capital, and increased market share that consolidation with a for-profit corporation may offer can be an attractive option. By the same token, investors are attracted by opportunities to enter new geographic markets, diversify payer mix, and improve bargaining positions—as well as to take advantage of the increase in insured patients expected with ACA implementation (Commins 2011; de la Merced 2010; Pizzi 2011). Last year’s biggest hospital deal represents a nonprofit to for-profit conversion, with Vanguard Health Systems purchasing Detroit Medical Center for $1.3 billion (Commins 2011; Irving Levin Associates 2011a). Interestingly, private equity firms have begun to play an increasingly visible role in nonprofit hospital acquisitions (Blesch 2011; Galloro 2011). Cerberus Capital Management closed the second biggest hospital deal of 2010 with its purchase of Caritas Christi Health Care for $830 million and has since struck at least seven more hospital deals (Mathews 2011). While apprehension about monopolistic behavior has been widely promulgated (e.g., Blesch 2011 and Pear 2010), the issue of preserving charitable assets has been largely overlooked.

II. CONCEPTUALIZATION AND TRENDS

A. DEFINITION AND NAME

Philanthropic professionals have grappled with how to describe and what to call the nonprofit residual of conversions. Most converting hospital boards opt to endow new foundations, but some invest the funds in existing public charities, private foundations, or even governmental entities. The affinity organization devoted to assisting HLFs and other foundations that fund health purposes, Grantmakers in Health (GIH), adopted a comprehensive definition, which this paper employs for its discussion:

Foundations formed from health care conversions, to include foundations created when nonprofit health care organizations convert to for-profit status; foundations created when nonprofit health care organizations are sold to a for-profit company or another nonprofit organization; those created when assets are transferred through mergers, joint ventures, or corporate restructuring activities; and existing foundations that receive additional assets from the sale or conversion of a nonprofit health care organization. (2007, p. iii)
Not surprisingly, selecting a name that succinctly reflects these components has proven challenging. The philanthropic sector has referred to these organizations—which include both private foundations and public charities—with little consistency, although the more popular terms include healthcare conversion foundations, hospital conversion foundations, and new health foundations. Executives from The California Wellness Foundation, founded in 1992 with the conversion of Health Net, have argued that differentiating foundations endowed with conversion proceeds from any other type of independent foundation only serves to subject their work to unnecessary scrutiny (Yates and David 2000). On the other hand, during a 2006 assembly of health foundation leaders throughout the Southeast, CEOs set out to develop a moniker that would serve as an apt descriptor for the unique lineage of the foundations they served (Southeastern Council of Foundations 2006). Participants unanimously chose the term health legacy foundations (HLFs) because the name alludes to organizations’ historical roots without explicitly committing them to any specific grantmaking priorities. As discussed at the assembly, the new term does not imply a commitment to fund health or healthcare, however broadly or narrowly these terms may be perceived. Others attending the assembly shared that the name offers a fresh new identity for these foundations and facilitates independence from both the “old” and “new” healthcare entities (Southeastern Council of Foundations 2006). Furthermore, some evidence indicates that the name health legacy foundation is catching on beyond the Southeast U.S. and even beyond the philanthropic sector. A recent article in The Weekly Standard citing the wave of health insurance companies converting to for-profit status referred to the resulting foundations as health legacy foundations (Alexander 2007). The term is also increasingly used in journal articles and other publications (e.g., Harrell 2009; Needleman 2001).

**B. Trends**

1. **Methods.** In 2009 GIH noted that 197 HLFs were known to exist (2009a). To obtain an updated count of HLFs operating in the U.S. today, multiple rosters published by GIH were first cross-referenced (GIH 2005, 2007, 2009a). An extensive online search of HLFs was also undertaken by examining rosters of regional associations of grantmakers and querying organizations online through the Urban Institute’s National Center for Charitable Statistics (NCCS), GuideStar, and the Foundation Center. IRS Form 990s, HLF websites and annual reports were reviewed to determine total assets and grant dollars paid. Information about the type of converting entity and date of HLF establishment was obtained through foundation and healthcare organization websites, as well as Form 990s. Employer Identification Numbers were recorded and sorted to weed out duplications resulting from foundations that changed names after formation. Whenever possible, the year during which the bulk of the proceeds were transferred to an HLF was recorded as the date of establishment. Although a number of HLFs were incorporated prior to 1980, the earliest known transfer of healthcare conversion proceeds took place in 1981, forming Andalusia Health Services, Inc., in Andalusia, Alabama. Examples of HLFs with earlier dates of incorporation include nonprofit hospital foundations that remained intact after the hospital was sold. Upon receiving nonprofit sale proceeds, these foundations changed their primary roles from hospital fundraisers to that of community-wide grantmakers.

2. **Endowment Timeline.** The search for HLFs uncovered a total of 245 organizations that have been endowed with proceeds from the sale, merger, lease, or other restructuring of nonprofit healthcare entities. As shown in Figure 1, most HLFs were established during the mid to late 1990s. Among all HLFs known to be in operation today, nearly half (49%) were
endowed with nonprofit conversion proceeds between 1994 and 1999. Only 49 HLFs (20%) were established between 2002 and 2010. Hospitals and health systems constitute 83% of all types of converting entities, followed by 14% health insurance plans and 3% nursing homes, rehabilitation facilities, and other specialized care organizations.

Trends in HLF endowment logically follow the dates of hospital conversion activity, which also peaked in the mid-1990s. Nonprofit hospitals changed ownership—many converting to for-profit status—for a variety of reasons, including financial hardship, market incentive structures, excessive regulations, the need to improve efficiency, the need to access capital, and the desire to expand market share (Claxton et al. 1997; Collins, Gray, and Hadley 2001; Goddeeris and Weisbrod 1998; Gray 1993; Hollis 1997; Spielman 2011). Between 1994 and 1997, 206 nonprofit healthcare entities converted to for-profit status, compared to just 147 total such conversions in all preceding years (Duke University 1998). Although conversion activity slowed in the late 1990s, 134 nonprofit hospitals converted to for-profit status between 2000 and 2008 (Ramamonjiarivelo, Weech-Maldonado, and Menachemi 2011). Perhaps most significantly, given the flurry of mergers and acquisitions since the passage of the ACA, 2011 may prove to be a record year for hospital conversions, with a slew of new HLFs just around the corner.

Figure 1. Number of HLFs by Endowment Date

The rapidity with which some of these transactions occurred during previous conversion spikes seems to have been designed to mask underhanded deal-making, some of which resulted in stockholders of the for-profit acquirers benefitting at the expense of the community (Cryan and Gardner 1999). Nonprofit to for-profit trends slowed in the late 1990s, with some ownership conversion attempts failing in the early 2000s. State officials in both Maryland and Kansas, for example, rejected Blue Cross proposals to convert their nonprofit operations to for-profit status. Proposals to convert Blue Cross plans in New Jersey and North Carolina were also withdrawn (Robinson 2004). While some conversions were successful, by the mid-2000s, nonprofit conversions clearly were no longer popular.
Consequently, few scholarly publications have addressed nonprofit conversions or HLFs in the past five or six years. Even the two public advocacy groups—Consumers Union and Community Catalyst—that worked assiduously to protect the public’s interest in conversion transactions appear to have moved on to other health policy controversies. However, given the recent rise in conversion trends, the birth of many new HLFs is imminent. This paper draws attention back to the issue of conversion proceeds. The extent to which this money can be used to benefit communities demands the attention of public policy analysts.

III. THEORETICAL AND LEGAL FRAMEWORK

The contrasting theoretical underpinnings of nonprofit organizations versus for-profit corporations help to explain the controversial nature of conversions and the motive to preserve charitable assets. Furthermore, examining the theories behind HLFs’ beginnings sheds light on their distinguishing characteristics. For-profit entities, obligated to pursue profit-oriented missions for their investors, are incentivized by efficiency and are therefore more likely to reduce or eliminate unprofitable services. In contrast, nonprofit organizations are bound by their charters and by their tax-exempt status to pursue a charitable purpose. In principle, nonprofit healthcare organizations are supposed to be more likely than their for-profit counterparts to provide more health services that benefit communities. Nonprofit hospitals, for example, are expected to provide more uncompensated care, provide more services that are unprofitable (such as substance abuse recovery), offer services for lower prices, provide medical education, and enable community ownership and continuity with less interest in expansion outside the community. Similarly, nonprofit insurers are expected to implement community-rated plans and shift costs from those who are unable to pay to those who are able to pay. Nonprofit insurers are also expected to invest surpluses in services that might not otherwise be economically viable (Horwitz 2007; Marsteller, Bovbjerg, and Nichols 1998; Needleman 1999, 2001; Schlesinger, Mitchell, and Gray 2004).

When a nonprofit healthcare entity converts to for-profit ownership, multiple and potentially overlapping areas of law come into play, including state and federal tax law and corporate law, among others (Shriber 1997). Conversion transactions are largely the purview of state authorities, and the mechanics of conversion vary considerably across states. At least three legal doctrines address the preservation of assets for the nonprofit entity’s charitable purpose. First, according to charitable trust doctrine, a nonprofit organization’s assets must always be dedicated to the originally intended charitable purpose. Second, should this purpose no longer be feasible to pursue, the _cy pres_ doctrine applies, through which courts may rule that the assets may be transferred to another organization to pursue a purpose that is similar to the original purpose. Third, common law doctrine and/or state statutes authorize state attorneys general to protect charitable assets for the public interest. In accordance with the legal doctrines by which they are established, HLFs are sometimes required not only to serve some general charitable purpose but also more specifically to focus on healthcare, although the definition of _healthcare_ has been subjected to broad interpretation (Bell, Snyder and Tien 1997; Duke University 1998; Horwitz and Freemont-Smith 2005; Shriber 1997; Standish 1998; U.S. General Accounting Office 1997).

Because of the philanthropic history associated with the source of the endowed funds, HLFs may theoretically differ from other types of foundations. Nonprofit hospitals, for example, were typically formed by raising capital, but unlike the capital raised for corporate ventures, the funds raised for a nonprofit hospital were contributed by philanthropic groups and individuals. Philanthropic funds for nonprofits and public subsidies for government hospitals were almost universal before the 1960s, when access to the tax-exempt bond
market, public insurance for hospital debt and patient revenues made possible by Medicare and the growth of private insurance enabled hospitals to access the capital markets for expansions, mergers and acquisitions (Cohodes and Kinkead 1984; Starr 1982). Many religious groups (such as Catholic orders and Presbyteries) and civic organizations (such as Shriners) established healthcare institutions, as did individual donors. Charitable funding for these hospitals did not stop after they began operation. Instead, their assets were amassed through years of charitable contributions, special tax exemptions, and volunteer effort. Though the mission and start-up of HMOs and health plans (often organized as mutual benefit corporations rather than public charities) may differ from that of hospitals, their assets have also been held in trust for the public (Bell, Snyder, and Tien 1997; Standish 1998; Tien 1997). The consequence of these origins is the widespread conviction that HLFs are uniquely obligated to preserve the historical integrity of these healthcare institutions as well as to fulfill the legal requirements regarding the preservation of charitable assets.

IV. ONGOING PUBLIC POLICY CONCERNS

HLFs respond to these unique obligations in a variety of ways, many of which will be discussed in the following section. Some of most salient public policy issues previously identified in the literature are related to the complexity and length of time involved in establishing an HLF and controversies plaguing the initial endowment. Each of these issues indicates a need for special public policy consideration of healthcare conversion proceeds.

A. COMPLEXITY AND LENGTH OF TIME INVOLVED IN ESTABLISHMENT

Overall, establishing a new HLF is more complicated and time-consuming than establishing other types of private foundations and public charities, primarily because its inception is directly tied to the conversion process. Whereas the initial endowment of other types of foundations usually entails a one-time, straightforward transfer of assets from a wealthy donor or corporation to a foundation, endowing an HLF involves a series of intricate financial transactions and a multitude of stakeholders with possibly competing agendas. According to Shriber (1997), conversion processes may be complex by design. Because conversions that are structured in a straightforward manner are easier to regulate, corporate buyers are motivated to structure their deals in an overly complicated manner, preferring mergers, leases, joint ventures, or corporate restructuring to full-scale conversions. Interestingly, joint ventures seem to be the mode of choice in the current wave of conversion activity (Galloro 2011; Modern Healthcare 2011). Generally speaking, the more complicated a transaction, the more room for debate about whether a conversion has actually occurred (Claxton et al. 1997; Cryan and Garner 1999). The joint venture between the Colorado Health Foundation (CHF) and HCA confirms this point. Community stakeholders claim that CHF’s and HCA’s joint ownership of numerous Denver hospitals has protected the community’s interest, but CHF’s recent $1.45 billion deal to relinquish more of the nonprofit’s share to HCA has incited arguments about who has controlling interest. Stakeholders have petitioned the attorney general to officially declare the recent deal a conversion so that charitable assets can be protected under Colorado’s conversion statute (Booth 2011).

From the pre-sale preparations to the post-conversion procedures involved in setting up a foundation, the establishment of an HLF may take many years (Hall and Conover 2003). To this point, Baker (2001) finds a significant gap between the number of conversions and the number of HLFs that have been formed. She notes that between 1994 and 1999, for example, less than half of the 250 nonprofit to for-profit hospital conversions had spawned HLFs. Similarly, although 134 conversions took place between 2000 and 2008
(Ramamonjiarivelo, Weech-Maldonado, and Menachemi 2011), only 64 HLFs were endowed during this same time period. This lag time may be due, at least in part, to the lengthy amount of time involved in conversion processes and HLF start-up. More to this point, one GIH official notes that once a conversion transaction takes place, it can take up to five years before a foundation is ready to make grants (Nauffts 2001). A new Arkansas HLF, Fort Smith Regional Healthcare Foundation, provides an example. Although the foundation was finalized in November of 2009, the director anticipated that two additional years of work would likely be required before the foundation could launch its grantmaking programs. Among the reasons cited for the delay are steps necessary to close out the nonprofit corporation, including terminating the hospital’s benefit plan and addressing land holdings issues (Whalen 2010). Conversion agreements might also require time-consuming attention (Consumers Union U.S. and Community Catalyst 2004). Something as seemingly innocuous as starting up a free clinic might violate no-compete clauses (Baker 2001; Nauffts 2001). Without question, the processes involved in establishing HLFs call for policy intervention to ensure clarity in transactions and to ensure that charitable assets are re-deployed for the community’s benefit in a timely manner.

B. CONTROVERSY REGARDING INITIAL ENDOWMENT

Scholars and community advocates have identified a number of public controversies associated with the initial endowment of HLFs. Four specific impediments to communities receiving full benefit from conversion proceeds will be reviewed in this section: private inurement, asset valuation, tax-exempt status, and mission. Each of these issues has spawned considerable controversy and warrants careful policy consideration.

1. Private Inurement. The issue that ignites perhaps the greatest amount of controversy pertaining to HLF endowment is private inurement. As organizations exempt under Section 501(c)(3) of the Internal Revenue Code, HLFs are prohibited from operating or using earnings to inure to the benefit of private shareholders or individuals (U.S. Department of the Treasury 2010). Although private inurement is a concern with all types of philanthropic foundations, it is especially controversial during the endowment phase of HLFs. The controversy is rooted in the source of the wealth that establishes the foundation. Every dollar that benefits private individuals and private acquirers in the conversion deal is a dollar that can no longer be used to endow the HLF for the community’s benefit. Lines may become blurred—or even intentionally crossed—in the conversion to for-profit ownership, when tax-exempt status is being relinquished. Particularly in some of the earlier conversions, private inurement issues spurred community members and public advocacy groups into action, with controversy-hungry media in tow. Some of the ways employees and board members of nonprofit healthcare entities have allegedly benefitted from the conversions include accepting generous “consulting” fees from for-profit acquirers, purchasing low-price stock options, accepting lucrative severance pay and/or benefits, and employment with the new for-profit entity or HLF (Cryan and Gardner 1999; Duke University 1998; Miller 1997; Needleman 1999; Tien 1997). In addition to individuals receiving inurement from conversion transactions, for-profit acquirers have also benefitted excessively from the sale of the nonprofit healthcare entity in a number of ways, one of the most egregious of which has been undervaluation of nonprofit assets (Bader 1996; Tien 1997).

2. Asset Valuation. Bader (1996) finds that in many nonprofit hospital deals performed through the mid-90s, communities were shortchanged because they received payment far below the actual value of the hospitals. The choice of valuation methodologies provides some insight into such undervaluation. Investment bankers most often determine the value of hospitals by calculating the hospital’s earnings before interest, taxes, depreciation, and
amortization (EBITDA) for the preceding twelve months. EBITDA is then multiplied by a factor to calculate the value of the hospital (Anderson 1997). This multiple varies according to the hospital’s debt, age of facilities, market share in the community, and other factors. For nonprofit hospitals, investment bankers have generally determined this multiple to range between four and seven (Anderson 1997; Duke University 1998). By comparison, the multiplier for for-profit hospitals averages between 15 and 25, though there is limited evidence to suggest that the much higher multiple for for-profit hospitals is justified (Anderson 1997). Efforts to keep negotiated sales confidential and to prevent competing bids from being offered has also contributed to the valuation controversy (Needleman 1999). Bell, Snyder, and Tien (1997) discuss how public disclosure prevented a California HMO, Health Net, from valuing its assets too low. Initially, the HMO was to be sold for $104 million, but disclosure led to a sale price of $300 million in cash and an 80% equity interest in the for-profit business. The combined value of the cash and stock endowed The California Wellness Foundation, whose assets have spawned more than $780 million in grants over the past 20 years and are now valued at nearly $900 million (The California Wellness Foundation 2011; Urban Institute 2011). Needless to say, valuation methods must be fair and fully disclosed to ensure that HLFs are appropriately endowed.

3. Tax-Exempt Status. The third issue regarding HLF endowment that has triggered public controversy is the structure of the new foundation, or the tax-exempt status it seeks upon initial endowment. Although the most popular option for conversion proceeds is to form a brand-new HLF (as opposed to giving funds to an existing entity), these new organizations may take one of several structures. Apart from giving proceeds to the government, HLF board members have two options for their nonprofit form: 501(c)(3), which encompasses public charities and private foundations, or 501(c)(4), which includes social welfare organizations (Consumers Union West Coast Regional Office/Community Catalyst 1999; Standish 1998). With the strictest requirements for grant payout, lobbying, and public accountability, the 501(c)(3) private foundation form is generally preferred for HLFs (Consumers Union U.S. and Community Catalyst 2004). To the relief of public advocacy groups, less than 4% of HLFs have been designated as 501(c)(4) organizations, which generally have no charitable distribution requirements. However, almost half of all HLFs with 501(c)(3) tax-exempt status are classified as public charities, which also have fewer public accountability standards than private foundations (Grantmakers in Health 2009a). Whether these foundations choose to become public charities to—as examples—avoid the payout requirement (i.e., to annually distribute at least five percent of net investment assets in the form of grants or other qualifying distributions) or to leverage other contributions through fundraising is unclear (White 2000). Nevertheless, many new HLFs start out as public charities but find it too difficult to raise sufficient funds to pass the public support test (i.e., to garner a significant percentage of total revenue from individual donations and other public sources) so their status eventually reverts to that of private foundations. For HLFs with a large corpus, it is especially hard to pass the public support test (Consumers Union West Coast Regional Office/Community Catalyst 1999; Nauffts 2001). The issue of tax-exempt status is so important that some states have adopted laws regarding HLF structure. California, for example, allows HLFs to temporarily accept 501(c)(4) status so that foundations may gradually monetize their stock holdings in for-profit entities, but state law requires that these foundations be subjected to the same requirements as 501(c)(3) organizations (Butler 1997).

4. Mission. The final public policy issue that continues to cause concern and controversy is the mission of HLFs. Whereas the missions of other types of foundations rarely provoke controversy, HLF missions—as well as how they are pursued—are subject to intense scrutiny
and have incited media firestorms. The controversy stems from the presumption that conversion proceeds will be used to preserve the charitable legacy of the converting healthcare entity. Although HLF funds are, in theory, more likely to be used for charitable healthcare purposes, in practice HLFs define healthcare broadly and pursue a wide variety of missions. The use of HLF funds to pursue missions that do not address urgent needs—such as healthcare, homelessness, and hunger—are particularly controversial. To provide an example, The Jackson Foundation—formed when HCA purchased Goodlark Regional Medical Center in 1995—operates in Dickson County, Tennessee, where the population was just under 50,000 in 2010 (The Jackson Foundation 2011; U.S. Census Bureau 2010b). A giant in the county’s nonprofit sector, The Jackson Foundation reported for 2009 nearly $70 million in total assets, ten times that of the next-largest nonprofit organization (Urban Institute 2011). Some of the projects supported to date with these funds include the purchase of two new airplanes (to provide high school students with flying lessons), a 54-foot by 30-foot space shuttle model (used as a teaching aid), and a $15-million Renaissance Center, replete with world-class technological and artistic wonderments, to include laser light shows simulcast to the music of Pink Floyd (Jaffe and Langley 1996; The Jackson Foundation 2011). Responding to criticism over how the foundation has used conversion proceeds, the foundation’s president replied that the foundation’s goal was to “do the extraordinary” (Jaffe and Langley 1996). Meanwhile, the percentage of Dickson County students participating in the Free and Reduced Lunch Program increased every year since the Renaissance Center opened and the percentage of children receiving Food Stamps has nearly doubled (Annie E. Casey Foundation 2010).

Even if an HLF pursues a narrowly defined mission directly related to healthcare, it may face yet another controversy. Potentially one of the best ways to impact healthcare would be to work with local hospitals. However, funding a nonprofit hospital in the area would constitute helping a competitor of the converted entity. Along these same lines, using funds to work with the for-profit acquirer raises conflict-of-interest questions and might also violate both the terms of the conversion agreement and the HLF’s tax-exempt status. Although foundations can legally support for-profit businesses (as long as funds are used for a charitable purpose), many HLFs may try to avoid conflicts of interest by funding only public charities (Bader 1996). Relationships between HLFs and their acquirers remain complicated, however. A thin line separates grants paid directly to hospitals from those that may be paid to independent nonprofit organizations but still benefit the for-profit hospital’s bottom line. For example, by establishing or supporting indigent health clinics in a community, HLFs are reducing the number of indigent patients who seek care at the hospital. Indeed, emergency rooms are less crowded if there are medical clinics in the vicinity that provide free or low-cost care (Bader 1996). In this light, HLFs face a unique policy paradox that no other type of foundation encounters.

V. GEOGRAPHIC DISTRIBUTION AS AN EMERGING ISSUE

In addition to the public policy concerns that emerged during previous waves of healthcare conversions, an analysis of recent HLF trends reveals yet another issue that warrants special policy attention: geographical distribution. HLFs—particularly those established with hospital conversion proceeds—are clustered within the southern states and generally restrict their giving to small geographical service areas. Both of these characteristics lend HLFs to a number of distinct policy considerations.
Figure 2. HLF Assets by U.S. Census Region

Source: authors’ analysis of IRS Form 990s for 2010 or most recent year available, accessed through the Urban Institute’s online search engine, 2011. Financial statements accessed through foundation websites supplement the analysis.

A. REGIONAL CLUSTER

The South U.S. Census Region, representing 37% of the nation’s population and comprising 16 states and the District of Columbia, has never been a major philanthropic player, with combined total assets and the number of foundations trailing aggregate numbers of other regions (Foundation Center 2011; Nielsen 2008; U.S. Census Bureau 2010a). Today only 21 southern foundations rank among the top 100 (by asset size), and their combined assets represent just 14% of the total net worth of the top 100 foundations (authors’ analysis of Foundation Center data, 2011). Although lacking in the fruits of other types of private foundations, the South is home to the greatest concentration of HLFs. As shown in Figure 2, at least 102 HLFs (42%) holding more than $7 billion in assets are located in southern states. By contrast, the Northeast region—a hub of some of the largest and most visible health-related foundations (such as the Robert Wood Johnson Foundation and The Commonwealth Fund)—houses only 38 HLFs that have less than one-third of the total assets reported by their southern counterparts. Although the western states hold the greatest dollar value of HLF assets, only 41 HLFs are located in this region. The extraordinary average asset value of $222 million per HLF is explained by the fact that nearly half of all HLF assets in the West resulted from a single healthcare conversion. Both The California Endowment (with more than $3.6 billion in assets in 2010) and The California Healthcare Foundation (with more than $700 million in assets in 2010) were formed in 1996 with the nonprofit to for-profit conversion of Blue Cross of California (The California Endowment 2011; Urban Institute 2011).

Regardless of total assets, when comparing the number of HLFs across regions, the geographical dispersion of these foundations parallels the landscape of community hospitals. For example, as shown in Table 1, 17% of all HLFs and 18% of community hospitals are located in the West. Not surprisingly, the regional cluster of HLFs in the South appears to be largely a function of the number of community hospitals located in the region. Home to 42% of all HLFs and 39% of community hospitals, the South also shows the lowest proportion of nonprofit hospitals, only 43% in 2009. Whereas nearly one-third of all community hospitals operating in the South are owned by investors, only 9% of hospitals in the Midwest and Northeast are for-profit. Although the Northeast represents the greatest proportion (86%) of
nonprofit hospitals, the greatest number of nonprofit hospitals (992) is found in the Midwest. Without doubt, future research is warranted to uncover how the current wave of merger and acquisition activity will alter the landscape of both hospital ownership and HLF endowment across all regions of the nation.

Table 1. HLFs and Community Hospital Ownership Type by U.S. Census Region

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*Authors’ analysis

Because nonprofit hospital conversions and their resulting HLFs are geographically clustered in the South—a region rife with significant health problems—these foundations warrant special policy attention. For years the limited fundraising capacity of southern nonprofit organizations has hindered their ability to provide healthcare and other services in the region. Now, with an annual payout of more than $250 million (authors’ calculations based on IRS Form 990s and foundation financial statements), HLFs provide new hope for addressing healthcare needs, which are critical in the southern states. Individuals living in the region have significantly higher rates of obesity, hypertension, end-stage renal disease, coronary heart disease, congestive heart failure, stroke, cognitive impairment, many types of cancer, and higher rates for mortality from all causes (Cooper et al. 2000; U.S. National Institutes of Health 2010; Wadley et al. 2011). Many of these health indicators may be tied directly to socioeconomic disparities, and the challenge that lies ahead is unquestionably daunting. However, the existence of a substantial corpus of philanthropic funds that originated from prior community health efforts can be a critical resource for addressing health disparities, if effectively used. Appropriate public policies can facilitate the use of HLF grant funds for such worthwhile healthcare purposes.

B. RESTRICTED SERVICE AREAS

In addition to the heavy concentration of HLFs in the South, a second geographic characteristic is their restricted service areas. The vast majority of HLFs (88%) only fund projects and programs within limited geographical confines, typically mirroring the service area of the converting nonprofit healthcare entity (Grantmakers in Health 1999, 2009a). As shown in Figure 3, although the majority of HLFs within in each region have been established with nonprofit hospital proceeds, the percentages vary by region. In the West and Northeast, many HLFs were formed from health plan conversions, which normally serve a much larger geographic region than hospitals. Their resulting foundations also tend to benefit larger areas, as demonstrated by the statewide efforts of The California Endowment and Caring for Colorado, among others. In the South, however, 91% of all HLFs were formed from nonprofit hospital transactions. In benefitting residents of the converting nonprofit hospital’s service
area, grantmaking may be limited to relatively small populations, especially in suburban communities where the converting hospital was the sole provider. Interestingly, smaller hospitals (i.e., up to 199 beds) account for 73% of all hospital conversions between 2000 and 2008 (Ramamonjiarivelo, Weech-Maldonado, and Menachemi 2011).

**Figure 3. Sources of HLF Endowment by U.S. Census Region**

![Sources of HLF Endowment by U.S. Census Region](image)

The recent rash of conversions among smaller and stand-alone nonprofit hospitals will no doubt result in many communities—some of which previously had few philanthropic resources—suddenly gaining a substantial source of charitable wealth. In South Carolina, for example, the Chester Healthcare Foundation was established in 2006 with proceeds from the lease of Chester County Hospital and Nursing Center to Health Management Associates (Chester Healthcare Foundation 2011). Endowed with nearly $29 million, today the foundation has nearly five times the assets of the county’s next-largest private foundation. Remarkably, grants are limited to organizations that benefit only the residents of Chester County, whose population is barely 33,000 (Chester Healthcare Foundation 2011; Urban Institute 2011; U.S. Census Bureau 2010b). The McKenna Legacy Foundation of New Braunfels, Texas, provides another example. Restricting its grants to New Braunfels, which has fewer than 60,000 people, this new foundation reports nearly $75 million in assets and has awarded more than $7 million in funding since its inception in 2008 (McKenna Legacy Foundation 2011; Urban Institute 2011; U.S. Census Bureau 2010b).

Indeed, numerous examples of local communities benefitting from HLFs have begun to emerge, and the presence of HLFs is rapidly altering the landscape of philanthropy across many states. At least 19 HLFs have been formed in Ohio, with combined assets of more than $1.23 billion. Representing some of the largest grantmakers in Virginia, 18 HLFs have come on the scene in the Commonwealth, with $1.25 billion in new charitable wealth. In South Carolina, five of the top ten largest foundations were endowed with nonprofit conversion proceeds: Community Foundation of the Lowcountry, Drs. Bruce and Lee Foundation, J.
Marion Sims Foundation, Mary Black Foundation, and Sisters of Charity Foundation of SC (Foundation Center 2011; GuideStar 2011). Today the combined assets of these five foundations total nearly $400 million, providing grant funds that benefit some of the poorest areas in the nation. While these philanthropic heavyweights provide a boon to many communities, operating in a geographically restricted area—particularly those with small populations—lends itself to a host of policy concerns pertaining to governance and management, community relations, and grantmaking.

1. **Governance and Management.** Obstacles related to operating within narrower and/or more rural areas begin with the healthcare conversion process. Miller (1997) finds that Wall Street firms and other financial advisors representing profit-oriented acquirers may have taken advantage of less sophisticated community boards in the conversion process. While HCA, Tenet and other large-scale acquirers are flanked by corporate attorneys and skilled advisors, nonprofit healthcare boards typically only encounter this type of deal once in a lifetime. A second obstacle concerns compensating board members for their HLF board service. As Bader points out (1996), funds to reimburse board members for participating in national meetings of foundations may be justified, but participating in local meetings to address problems that plague one’s own community is more controversial. Yet another obstacle concerns terms of board service. To help reduce conflicts of interest, Consumers Union and Community Catalyst (2004) recommend that individuals should not serve on boards of the hospital and the HLF simultaneously. Also, HLF trustees would ideally have grantmaking expertise or a working knowledge of the nonprofit sector. Some state laws (e.g., Nebraska and California) even require foundation directors to have appropriate philanthropic experience (Butler 1997). These standards may be difficult to attain, however, especially in a small area where the number of people with desired experience is limited.

2. **Community Relations.** In spite of the potential for conflicts, some communities may prefer the continuity of having hospital board members or employees serve in some capacity with the new HLF. This continuity gives the public some assurance that people are familiar with the conversion ins and outs and with community needs (Duke University 1998). Demonstrating awareness of and responsiveness to the community may be a particularly high priority for HLFs formed from nonprofit hospitals. In fact, some feel as though HLFs are more accountable than other private foundations because they are geographically restricted. One GIH executive points out that perhaps because of the controversy surrounding establishment issues, HLFs may be more responsive to communities than other foundations (Nauffts 2001). Another philanthropic professional lauds the community advisory committees formed by some HLFs and argues that they should serve as a model for other foundations (Cohen 2006).

3. **Grantmaking.** Even with strong community ties, HLFs may find grantmaking to be particularly daunting within limited geographical confines. Many HLFs come on the scene as grantmaking behemoths in communities that previously had little charitable wealth. With a sizable corpus and a minimum payout requirement, finding qualified applicants may be challenging. The nonprofit infrastructure can be grossly underdeveloped, with few nonprofit professionals in the community having been trained to manage sizable grants. As an example, the newly established Kansas Health Foundation had to backpedal after making plans to construct a $15 million, state-of-the-art molecular biology center. The scientific infrastructure was not available to support such an endeavor, a fact that eventually led the HLF to engage in organizational development (Bader 1996). Finding themselves in similar situations, many other HLFs have dedicated resources to assessing community needs and building nonprofit capacity. Dozens of HLFs also recently provided capacity-building funds
during the Great Recession, when numerous local charities—particularly grassroots agencies—struggled to stay in business (Grantmakers in Health 2009b).

Under-developed nonprofit infrastructure might also play a role in HLFs choosing to award grants for purposes that appear to be unrelated to healthcare. HLFs that enter the philanthropic scene with substantial assets may have difficulty meeting their payout requirement through responsive grantmaking (i.e., the total amount requested by preferred organizations may fall short of the amount an HLF intends to award with its interest earnings). Nevertheless, using healthcare conversion proceeds for purposes other than healthcare—especially in light of significant health needs—has fueled the regulatory response.

VI. REGULATORY RESPONSE

Because of the multitude of concerns pertaining to the establishment and operation of HLFs, a number of regulations have been adopted to address the healthcare conversion process and the appropriate use of resulting proceeds. Most certainly, increased oversight is evidence of hard-fought battles waged by public advocacy groups. When some of the earliest conversions began taking place, Consumers Union and Community Catalyst helped to educate stakeholders and regulators about potential risks and benefits. In the late 90s, they formed the Community Health Assets Project, through which they provide free technical assistance to those affected by conversion transactions (Consumers Union U.S. and Community Catalyst 2004; Tien 1997). Despite this increased awareness, many scholars have asserted that regulatory oversight remains grossly inadequate. Miller (1997) bemoaned the lack of federal regulation and argued that decisions detrimental to healthcare and charitable institutions may be made without it. Oversight has, by default, largely fallen on the shoulders of states’ attorneys general, but this authority is subject to a number of limitations (Claxton et al. 1997; Horwitz and Freemont-Smith 2005; Miller 1997; Shriber 1997). One such limitation concerns the vastly different ways attorneys general interpret the duty to protect charitable assets, as exemplified by the recent conversion of Empire Blue Cross and Blue Shield of New York. Horwitz and Freemont-Smith (2005) believe that the State of New York violated the U.S. Constitution by directing the disposition of charitable funds. They point out that the New York legislature (rather than the courts) conditioned the approval of the conversion based on the transfer of 95% of these charitable assets to the state’s treasury. Furthermore, instead of protecting the charitable assets of the nonprofit insurance company, New York’s attorney general supported this legislative decision. Funds that could be used for charitable purposes long-term may instead be used to offset temporary budget shortfalls. On a national scale, billions of dollars that could potentially provide charitable services for future generations may be jeopardized if the courts uphold that states may claim nonprofit conversion proceeds.

While better oversight among attorneys general may result in more appropriate use of funds (DeLucia 2001), as Consumers Union has pointed out, attorneys general often lack sufficient resources to review and act on these complex transactions. The ideal amount of oversight requires more funding, time, and training than most state officials can muster. In light of these restrictions, attorneys general may choose to require nonprofit healthcare entities to hire attorneys or consultants with expertise in conversions. Such requirements, though, may result in exorbitant costs to nonprofit organizations, which are often already mired in financial dire straits (Cryan and Gardner 1999). In New Jersey, even though the exemplary Community Healthcare Assets Protection Act passed in 2000 allows for public inspection of conversion documents, the cost of public participation must be largely borne by
consumers. To review materials, consumers must travel to Trenton and pay hefty costs to copy materials (Siman and Steinhagen 2007).

Offering a drastically different perspective about the regulation of nonprofit healthcare conversions, Hyman (1998) argues that the level of government oversight is overkill. He asserts that transactions are already bound by corporate law, common law, and charitable trust law, and that nonprofit boards must fulfill their fiduciary duties to protect charitable assets. Moreover, some states require advance notice to the state attorney general, waiting periods, or even formal court approval prior to conversion, and a number of state agencies (such as Departments of Corporations) have been granted authority to review transactions. Hyman further points out that healthcare conversions of all types regularly occur (including many for-profit to nonprofit conversions), and that even during the rush of conversions in the late 20th century, for-profit institutions never represented more than 15% of community hospitals. Addressing the regulation of conversion foundations, Hyman argues that foundations can provide a greater level of community benefit by pursuing their own self-defined missions rather than merely following prescribed objectives. In short, although Hyman readily admits there have been a few anecdotal instances in which conversions have gone awry, he claims that “…we are making a mountain out of a molehill” (p. 777).

VII. CONCLUDING DISCUSSION

Hyman is surely not alone in his belief that HLFs should be free to serve their communities however they deem most appropriate. Goddeeris and Weisbrod (1998) similarly argue that the principles of economic efficiency support pursuing a mission where funds produce the greatest value. The President of The Jackson Foundation in Dickson, TN, would also very likely concur, as would other HLF trustees and staff that want to remain unencumbered in how they carry out their business. However, careful oversight of charitable assets—particularly in light of newly emerging trends—can help prevent molehills from becoming mountains too high to climb. As of 2009, the percentage of investor-owned hospitals in the U.S. had climbed to 20% (up from 15% in 1999, 14% in 1989, and 12% in 1979), and the record-breaking pace of conversions sparked by the ACA will undoubtedly continue the upward trend in HLF formation (American Hospital Association 2011). As Miller (1997) cautions, deals made at such a frenetic pace can quickly go awry. Some foundations formed during the previous conversion surge had to muster their assets to buy back their hospitals when corporate owners put them up for sale. Ganguly (2005) also points out that foundations cannot possibly compensate for losses individuals and small groups suffer when they lose their nonprofit insurer. How policymakers can best protect communities from such losses while also empowering them to “do the extraordinary” is the public policy dilemma that requires greater attention as communities continue to ride the current wave of conversions.

Without a doubt, HLFs warrant special policy consideration, and recent conversion activity should ignite a sense of urgency among stakeholders and policymakers—especially throughout the South—to examine the adequacy of existing policy. Only by delving into the complex and controversial nature of HLFs can analysts find the answers to critical policy questions. Further study should build on these distinct characteristics, investigating how the charitable landscape has changed in local communities where HLFs have been established. Information about how HLFs have affected communities is essential for further policy development. Now that the bulk of existing HLFs have been in operation for a full decade, longitudinal studies could provide insight into whether HLFs have been effective in pursuing their defined missions. Have they, indeed, achieved the extraordinary? And if so, at what cost?
REFERENCES


