Special Report

A Closer Look: Profiling Foundations Created By Health Care Conversions

Highlights from Grantmakers In Health’s latest survey.

by Malcolm V. Williams and Saba S. Brelvi

Over the past two decades we have witnessed an unprecedented number of transactions in which the assets of nonprofit hospitals, health plans, and health systems have been transferred to another health care organization through sales, mergers, joint ventures, or corporate restructuring. Many of these “conversions,” as they are often called, have led to the creation of new foundations—commonly called “health care conversion foundations.” Their aim is to maintain the level of public benefit presumed to have been provided by the nonprofit organization before the conversion took place.

Most research on conversions has focused on the conversion process rather than on the foundations that emerge. This Special Report presents results from a recent survey of these foundations and provides insight into their current assets, grant-making agendas, and governance.

In 1999 Grantmakers In Health (GIH) conducted an informal survey of 134 foundations regarding their formation, structure, and grant-making activities. Of these, ninety-seven had been surveyed in 1998 and were asked only to provide updated information on assets, grant-making areas, staff size, board size, board members sitting concurrently on the board of the purchasing organization, and existence of a conflict-of-interest policy. Newly established foundations and those that did not respond to the earlier survey were asked to answer a more extensive set of questions concerning the conversion process, community involvement in mission development and grant-making programs, staff and board makeup, and finances. GIH sought to survey the universe of foundations created from the conversion of health care organizations. Responses were collected via mail, fax, and telephone from 112 of the 134 new health foundations. Data on assets, year of formation, and type of organization converted were drawn from other sources for ten foundations that did not respond to the 1999 survey. Findings related to some survey questions thus reflect data from as many as 122 foundations.

This paper touches on only a few of the topics covered in the survey. A complete report was issued by GIH in March 2000.

Results

Foundation size and growth. The total assets of these new foundations exceed $15 billion. The median asset size is $60.5 million; assets range from $2.3 million to $3.5 billion. Conversions of hospitals (accounting for about 75 percent of the new foundations) usually result in smaller foundations with median assets of $41 million, compared with $106 million for those created from health plans and $138.5 million for those created from health systems. Although foundations created from health systems have the largest median assets, the largest foundations are those resulting from health plan conversions; among these fifteen foundations, two have assets of more

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than $1 billion each.

Most of the foundations resulting from conversions were established in the mid-1980s or late 1990s. Over the past five years their ranks have swelled most rapidly; of foundations responding, 72 percent were formed between 1994 and 1999. Those foundations formed during the 1990s have greater current assets than those formed during the 1980s (a median of $74.8 million versus $29.7 million). This difference may reflect the fact that a higher proportion of those foundations formed in the 1990s than in the 1980s resulted from the conversion of health plans and health systems or may reflect larger valuations of assets as a result of pressure by attorneys general and consumer advocacy groups.

Health funding in the community. Foundations fund a wide variety of health activities in their communities with many focusing on health education, disease prevention, and health promotion; access to care; and the delivery of services (Exhibit 1). Many also fund projects targeting specific populations in their communities such as smoking-cessation projects for adolescents and projects to help the elderly obtain prescription drugs.

Regardless of which areas they fund in, these new health foundations have the potential to significantly affect funding for health and health care. If they were to pay out 5 percent of their assets in grants each year (as the Internal Revenue Service requires of private foundations), this would amount to approximately $750 million annually. This is compared with the estimated $1.9 billion that all foundations gave in health and health-related programs in 1995. The recent devolution of responsibility for health care from the federal government to states and localities also creates tremendous potential for these foundations to effect change. Because these new health foundations give almost exclusively for health-related programs in defined geographic areas, they are often the largest source of nongovernmental health funding in a community or state.

Foundations’ independence. A key issue for new health foundations has been the independence of their boards from the organizations involved in the conversions. Concerns of community organizations and regulators about independence stem from the possibility that an ongoing relationship with the converted organization will compromise the foundation’s ability to provide a public bene-

<table>
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<tr>
<th>EXHIBIT 1</th>
<th>Health Grant-Making Areas, By Percentage Of Foundations Involved, 1999</th>
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<tbody>
<tr>
<td>Health promotion, disease prevention, and health education</td>
<td>25%</td>
</tr>
<tr>
<td>Access to care</td>
<td>20%</td>
</tr>
<tr>
<td>Delivery of services</td>
<td>18%</td>
</tr>
<tr>
<td>Maternal and child health</td>
<td>12%</td>
</tr>
<tr>
<td>Improving systems of care</td>
<td>12%</td>
</tr>
<tr>
<td>Substance abuse/mental health</td>
<td>10%</td>
</tr>
<tr>
<td>Healthy families/healthy communities</td>
<td>9%</td>
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<tr>
<td>Aging</td>
<td>6%</td>
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<tr>
<td>Health professions education</td>
<td>5%</td>
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<tr>
<td>Research</td>
<td>5%</td>
</tr>
<tr>
<td>Diseases and disabilities</td>
<td>4%</td>
</tr>
<tr>
<td>Environmental health</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
</tr>
</tbody>
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fit or carry out the mission of the original organization. The issue of independence, however, is complex; it is not always easy to discern how independent a foundation should be from its roots. Nevertheless, we believe that our results shed some light on this issue.

The survey focused on three types of policies and practices related to independence: the existence of reserved seats on a foundation’s board for the purchasing and converted organizations; foundation board members sitting concurrently on the board of the converted organization—whether or not their seats were reserved; and the existence of conflict-of-interest policies for board members. Foundations were not asked to report on the behavior of board members.

Few (12 percent) of the responding foundations reserve board seats for board members of the purchasing or converted organizations. About one-third of respondents (34 percent) have board members who sit concurrently on the board of the converted organization, and one shares board members with the purchasing organization. Slightly more than one-fourth of the foundations with any shared board members, however, were created out of mergers or joint ventures. All but two of the foundations with shared board members maintain conflict-of-interest policies, which require board members to recuse themselves from deciding on grants for organizations with which they are affiliated.

**Foundations resulting from conversions** have enormous potential to affect the health of the communities they serve as well as the field of health philanthropy. It would be instructive for researchers to track these foundations over time to determine whether their strategies and impact differ from those of the foundations established from other sources.

Anne Schwartz, vice president of GIH, and Lauren LeRoy, its president and chief executive officer, graciously assisted the authors in writing this paper.

**NOTES**

1. Health systems include entities comprising a number of health care organizations, whether integrated vertically or horizontally.
2. Health care conversion foundation is not a legal term, nor is it adequately descriptive. The Internal Revenue Service (IRS) classifies these entities as private foundations or public charities. Some transactions between two nonprofit organizations have also led to the creation of foundations.
3. This trend is supported by the *cy pres* doctrine, meaning “as close as possible.” The doctrine supports an application of the assets to a mission as close as possible to that of the original nonprofit.
4. These were identified from several sources, including regional associations of grantmakers, the Council on Foundations, the Foundation Center, consumer advocacy organizations, newspapers, conversations with GIH funding partners, and the trade press.
6. Most foundations reported assets from their last financial audit; others reported assets as of the survey date.
7. The type of organization converted is based on the foundation’s self-report.
8. Respondents were asked only about current assets, not about assets at the time of formation.
9. This calculation is illustrative. Foundations classified by the IRS as public charities and public welfare organizations do not have an annual payout requirement; private foundations are allowed some carryover of distribution requirements. Moreover, some foundations pay out more than 5 percent of their assets annually.
12. Reference to converted organization encompasses both the organizations that were converted from nonprofit to for-profit and those transactions involving nonprofits and/or municipal organizations for which there has been a conversion of mission.