

Health Care Conversion Foundations

Band-Aid Solutions?

By John Hunsaker and Jeff Krehely

Historically, most hospitals and health insurance providers in the United States have been charities or nonprofits. Because the health care provision market cannot simultaneously meet the demand for high-quality, universal access and affordability, a completely profit-driven health care market is undesirable by most of the population. Since their emergence in the 1930s, nonprofit insurers were able to keep premiums down by assessing health care risks and costs based on an entire community, and not on specific individuals.

During the 1970s, nonprofit insurance providers faced tough competition from for-profit companies, which discovered that they could offer cheaper health care to certain individuals by assessing their risk on an individual basis. HMOs, which limit, or “manage,” patient options in doctors and services in order to reduce overhead, also put pressure on nonprofit providers. Soaring health care costs in the 1990s convinced many nonprofit health insurance providers that conversion to for-profit status was necessary for their survival.

Believing that such conversions might result in higher insurance premiums and force low-income individuals to give up their health insurance coverage, state legislatures drafted laws that permitted for-profit conversions only if assets held by the nonprofit provider were directed into a private foundation that served regional health care needs. In particular, these foundations are usually charged with making grants that help increase access to health care and/or promote preventive health care in the same region served by the nonprofit insurer.

As of 2002, dozens of not-for-profit health insurers had converted to for-profit enterprises. The act of conversion raises several questions related to foundation accountability, including the following:

- How do conversion deals and the resulting foundations become political tools?
- Is creating a private foundation the best use of the sale of a not-for-profit health insurer's assets? In other words, can these foundations effectively help fill the gaps in coverage and service that the conversion process creates?
- How should these foundations structure their governance and programmatic areas?

In this era of economic downturn and cutbacks in federal and state budgets, state regulators and policymakers are scrutinizing transactions that may financially impact the regions they represent. The health care conversion process is no exception to this rule. The attempted conversion of CareFirst, the Washington, D.C., region's largest health insurer, with 3.2 million members, and the resulting fall-out exemplify how the conversion process can become highly politicized.

In January 2002, CareFirst filed an application with the insurance administrations of the District of Columbia, Maryland, Delaware and Virginia to convert to for-profit status. In addition to conversion, CareFirst requested approval to be acquired by the for-profit company WellPoint Health Networks for \$1.3 billion (later increased to \$1.37 billion).

In April 2003, Maryland Insurance Commissioner Steve Larsen rejected the deal, citing undervaluation of CareFirst and overcompensation of CareFirst officers. Officers of CareFirst approved their own \$119 million severance package, and some independent estimates valued CareFirst at \$2.27 billion. These facts alone were enough for Larsen to stop the conversion, and health care advocates praised his commitment to making the best decision for Maryland's citizens, free from political pressures. As a result of the uproar, the Maryland State Assembly voted for a measure to remove many of CareFirst's 21 board members and to preserve CareFirst as a nonprofit for at least five years. Simultaneously, Larsen angered D.C.'s insurance commissioner by killing the conversion deal before his jurisdiction had the opportunity to review it. Despite aggressive lobbying by CareFirst urging Maryland Gov. Robert Erlich to veto the restructuring measure, he signed it into law May 22. Unsurprisingly, litigation over the matter is already under way.

In the case of 2002's Empire Blue Cross conversion in New York State, shifting political priorities led to what many view as a temporary fix to the state's shrinking budget, at the long-term expense of New Yorkers. The governor and the New York State Assembly, in a late-night, closed-door session with the SEIU 1199 (New York's

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largest union of health care employees), decided to scrap five years' worth of citizen input gathered through public hearings. In particular, they earmarked 95 percent of monies from the sale of Empire's initial public offering for salary increases for health care workers in the state's budget. Although a foundation would be created from the remaining 5 percent of the sale, its board would consist solely of political appointees of the governor and top members of the state Assembly, in Albany. Although the initial public offering of Empire's assets has begun, a state court has issued an injunction on the transfer of the assets until the constitutionality of the deal has been determined.

Although creating conversion foundations can balance the profit-maximizing motive with a more democratic approach to increasing access to health care, the politicization of the process underscores the challenges in addressing such issues. The U.S. Supreme Court has ruled that legislatures may not control charitable assets, because of legislators' propensity to disburse funds with "the changing tide of politics." The case in New York is still being decided, but without a built-in mechanism that allows for public input on allocation of these public resources, it is unlikely that the foundation will be more than a political tool. In Maryland, by contrast, the government played an exemplary role in preventing a highly suspect conversion from taking place.

Although both of these cases demonstrate how politically charged the conversion process can become, they still leave unanswered the question of whether conversion foundations can help to fill the gaps created when health care coverage transitions from nonprofit to for-profit.

A possible answer to this question is that conversion foundations are not set up to be the solution to health care provision, but rather part of a temporary fix. A study conducted for the Maryland Insurance Commission by a private firm noted that other conversion foundations have most often funded the following:

- Service provision (which accounted for 60 percent of all grants made);
- Barrier-related issues (access to clinics, culturally appropriate care and prevention);
- Providers that receive limited funding from all other sources;
- Research on care, insurance and medical treatments;
- Providing medical information;
- Lobbying and advocacy; and
- Insurance premium subsidization.

These grants are primarily meant to fund underserved and hard-to-reach communities, with the belief that when the nonprofit converts to a for-profit, the so-called "last resort" health insurance provider for lower-income people dissolves. Despite state government oversight in the creation of these foundations, and despite increased initial public participation in the creation of conversion foundations, these foundations differ only slightly from other private foundations. The grant process, while more open, is still closed for most of these foundations. Although the boards of these foundations include more community members, there is no overall public accountability mechanism that allows the grantees or the public any type of recourse on the decisions made.

This problem underscores a larger challenge facing philanthropy: How can foundations truly be accountable to their mission, constituencies and grantees, and to society in general? Because of the challenges of evaluating the effectiveness of foundation grants, it is difficult to determine whether a conversion to a for-profit health insurer—and the resulting foundation—will benefit the people who need health insurance the most.

Ultimately though, no matter how accountable these foundations are, their creation may have little impact on the regions they serve. According to a *Washington Post* editorial from Feb. 9, 2003, "Health care spending in the United States totaled \$1.3 trillion in 2001. Given that the three jurisdictions covered by CareFirst represent 2.4 percent of the U.S. population, their annual share of the country's health care spending works out to about \$31 billion." *The Post* estimated that the \$70 million that a CareFirst conversion foundation would make each year would be equal to about two-tenths of 1 percent of the Washington region's annual health care bill.

Considering the high cost of health care across the country, it is reasonable to assume that the grantmaking of most conversion foundations could not directly meet the needs of all people who are under-insured and the more than 41 million Americans who are uninsured.

Although foundations alone cannot fill gaps in insurance or service, they can fund research, community organizing, public education and advocacy to determine the best way for the public, private and nonprofit sectors to meet these critical needs. ○

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