

# The Impact of For-Profit Medicine on Medicare



By the Office of Senator Chris Murphy  
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## **Introduction**

Created in 1965, Medicare is the key federal program that provides healthcare for approximately 52 million Americans. The program covers hospitalizations, prescription drugs, skilled nursing care, home health benefits and hospice care. While recent estimates have shown that healthcare spending increases have slowed, it's clear that the United States spends an alarming amount on healthcare. National healthcare costs hover around 18 percent of the nation's gross domestic product, and Medicare represents 20 percent of all costs at \$554 billion<sup>i</sup>. Compounding this problem is the fact that, for many industries within the healthcare sector, it is no longer just about taking care of patients. Quite simply, it is big business with billions of dollars of profit at stake.

Over the last decade, the United States has seen a dramatic increase in the number of for-profit healthcare providers. While Connecticut has largely been immune to the national trend towards for-profit hospitals, many parts of the nation are now dominated by investor-owned facilities. Yet things are changing, and now for-profit hospital chains are attempting to come to Connecticut. Over the last couple of years, six hospitals in Connecticut<sup>ii</sup> have explored or taken steps to convert from non-profit to for-profit status, and others are looking into pursuing similar deals. If all of these hospitals were successful in converting, nearly one-quarter of Connecticut's hospitals would be for-profit. This would be higher than the national average and would fundamentally change the face of medicine in the state. Moreover, given the fact that Medicare represents a significant portion of hospital admissions, the federal government has a significant stake in the future of Connecticut hospitals, as well as other for-profit conversions across the nation.

Proponents of for-profit medicine often contend that their services and access to care are the same if not better than at non-profit facilities. For some communities, this may be true. For example, Sharon Hospital is the only for-profit currently operating in Connecticut and many people in the Northwest corner find Sharon Hospital to be a dependable and reliable community provider. The shift to for-profit hospitals may come with benefits to the hospitals and the state in general. However, research demonstrates that there are differences between for-profit and non-profit healthcare providers, and we should expect to see some of these differences play out in Connecticut should the proposed conversions take place.

This report outlines some of that research, with a particular focus on hospitals, and extrapolates what the potential impact would be to Medicare as a result of further hospital conversions in Connecticut and across the nation.

## **Key Findings**

- There has been substantial growth in the number of for-profit hospitals in recent years. A decade ago, only 14 percent of all hospitals in the United States were for-profit. Today, one in five community hospitals are investor-owned.
- For-profit hospitals are more likely to offer financially profitable services. For example, for-profits were 7 percent more likely to provide open-heart surgery than non-profits and 8 percent less likely to offer psychiatric emergency services.<sup>iii</sup> Tests for more than thirty other services yielded similar results. The study also found that for-profits were more responsive to rapid changes in profitability than the other types of hospitals.

- There has been a substantial increase in the number of for-profit long-term care hospitals (LTCHs) and the increase has occurred predominantly in states that already had this specialized level of care. On average, Medicare accounts for two-thirds of all LTCH discharges and pays these hospitals almost \$39,000 per case. From 2003-2011, there was a 60 percent increase in for-profit long-term care hospitals, which corresponded with a 46 percent increase in total spending for these hospitals.
- States with higher percentages of for-profit hospitals spend more per Medicare beneficiary than states with high percentages of non-profit hospitals. In general, for-profit dominant states spend 3 percent more per Medicare enrollee than non-profit dominant states. Many of these states lack a regulatory framework to prevent excessive healthcare facilities and services. This “build it and they will come” mentality not only applies to for-profit hospitals but also to other for-profit operators in these states.
- If per-enrollee spending was at the same rate in the top non-profit states as in the top for-profit states, the Medicare program would have spent nearly \$2 billion more in 2009. If Connecticut’s per-enrollee spending was the same as for-profit spending, Medicare would have spent \$173 million more in that same year for Connecticut beneficiaries.
- Non-profit hospital behavior changes when for-profits are in the same market. This “spill-over” effect could be problematic for the existing network of non-profit hospitals in Connecticut that plan to stay non-profit.
  - Research has found that, the more for-profit hospitals that are in a city, the more non-profit hospitals in that area (1) respond aggressively to revenue-increasing opportunities, (2) adopt profitable services, (3) discourage admissions of unprofitable patients, and (4) reduce resources devoted to treating the patients they do admit. Conversely, the presence of nonprofits in a community is associated with increased quality of care in for-profit nursing homes, reduced mortality rates in for-profit dialysis facilities, and increased trustworthiness of for-profit health plans.<sup>iv</sup>

### **I. For-Profit Healthcare Providers Focus on Profitable Services**

Individual studies vary on whether there are differences between for-profit and non-profit healthcare facilities. Yet, when looking at the research in the aggregate, as Mark Schlesinger and Bradford Gray did in a 2006 Health Affairs study<sup>iv</sup>, it is clear that research tends to show different behavior between non-profit and for-profit hospitals. In this study, the two authors looked at about 275 empirical studies covering hospital care, psychiatric services, nursing home care, home healthcare, treatment of end-stage renal disease, hospice care, rehabilitative services, managed care plans, preventive examinations, and various ambulatory services. They concluded that there are higher mortality rates in for-profit hospitals and renal dialysis facilities. Higher prices are found in for-profit hospitals, and there were higher rates of adverse events in for-profit nursing homes. However, the study also found that for-profits have some advantages—for example, they found substantial evidence that for-profit nursing homes are more efficient and operate at lower costs – and found mixed results on still other services and metrics.

The Schlesinger and Gray study found other consistent themes. For example, for-profits across various healthcare sectors “more aggressively mark up prices over costs and otherwise maximize revenue.” This was true for hospitals, nursing homes, psychiatric hospitals, drug treatment centers, rehabilitation facilities, and health plans. Additionally, research showed that nonprofit organizations appear more trustworthy in delivering services and are less likely to make misleading claims or have complaints lodged against them. However, the study also found that non-profit healthcare generally can be slower to react to change, which the authors point out can be a positive or negative depending upon the situation. Rapid change to better address new market conditions may be important in some instances, but in others it might be too disruptive.

Other research suggests that for-profits are more likely than nonprofits to offer profitable services and less likely to offer unprofitable services.<sup>iii</sup> For example, for-profits were 7 percent more likely to perform open-heart surgery, but were 8 percent less likely to offer psychiatric emergency services. Further, research by the Congressional Budget Office found that non-profit hospitals provided higher rates of uncompensated care than for-profit hospitals, based on a five-state survey.<sup>v</sup>

One example of the investor-owned provider tendency to focus on profitable services has been the incredible growth of for-profit long-term care hospitals. These hospitals specialize in treating critically ill individuals who require an intense level of healthcare with frequent physician and nurse visits for relatively extended periods—more than 25 days, on average. Many LTCH patients rely on ventilators to assist with their breathing and often are transferred from an intensive care unit within a general hospital. Given the fact that these patients are very ill, LTCHs are paid at a higher rate per case than other hospitals and average around \$39,000 per discharge.

As the Medicare Payment Advisory Commission (MedPAC) detailed, the number of LTCHs has grown substantially over the last couple of decades, with much of the growth occurring from 2003-2011 fueled by new for-profit operators. In 2003, there were 202 for-profit LTCHs, 57 non-profit, and 18 operated by the government. By 2011, there were 323 for-profit hospitals, 82 non-profit, and 19 government hospitals. Overall, this represented a 60 percent increase in for-profit LTCHs. This growth in LTCHs corresponded with a 46 percent increase in Medicare spending on LTCHs – from \$3.7 billion in 2004 to \$5.4 billion in 2011. For-profit LTCHs also had higher margins at 8.5 percent in 2011 versus -0.1 percent for non-profit hospitals.

The growth in this industry has occurred in states that allow for a proliferation of for-profit healthcare services in general, but not necessarily where there is a substantial need. As MedPAC noted, “many new LTCHs have located in markets where LTCHs already existed instead of in markets with few or no direct competitors.”<sup>vi</sup> As the map below illustrates, the South has a higher prevalence of LTCHs. Not coincidentally, this is the same area that leads the nation in investor-owned hospitals.

This has led to a real-life example of the famous line from the movie *Field of Dreams*, “if you build it, they will come” in some states. For example, Connecticut has two non-profit LTCHs – the Hospital for Special Care and Gaylord Specialty Healthcare – serving the 3.5 million residents. In contrast, Louisiana has 39 of these facilities even though they only have about 1

million more people than Connecticut. Similarly, Oklahoma has about 225,000 more people than Connecticut but hosts 12 LTCHs, and the city of Houston, home to 1.5 million fewer people than Connecticut, has 11 LTCHs.

Considering that LTCHs are designed to treat the sickest and most complex patients, these discrepancies beg the question: What is happening in these states that is not happening in Connecticut? It is not plausible that these states have exponentially more LTCH-appropriate patients than Connecticut. Instead, the likely explanation is that investor-owned LTCH providers saw opportunities to locate in favorable states and offer incredibly profitable services.

### **Geographic Breakdown of Long-Term Care Hospitals across the United States**



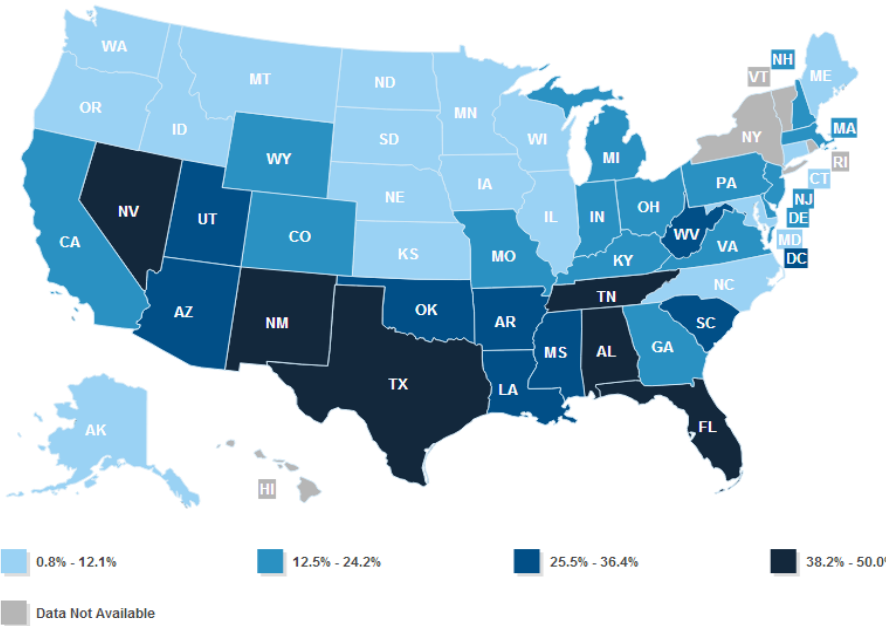
Source: MedPAC analysis of cost report data from CMS.

## **II. Financial Implications of For-Profit Hospitals on Medicare**

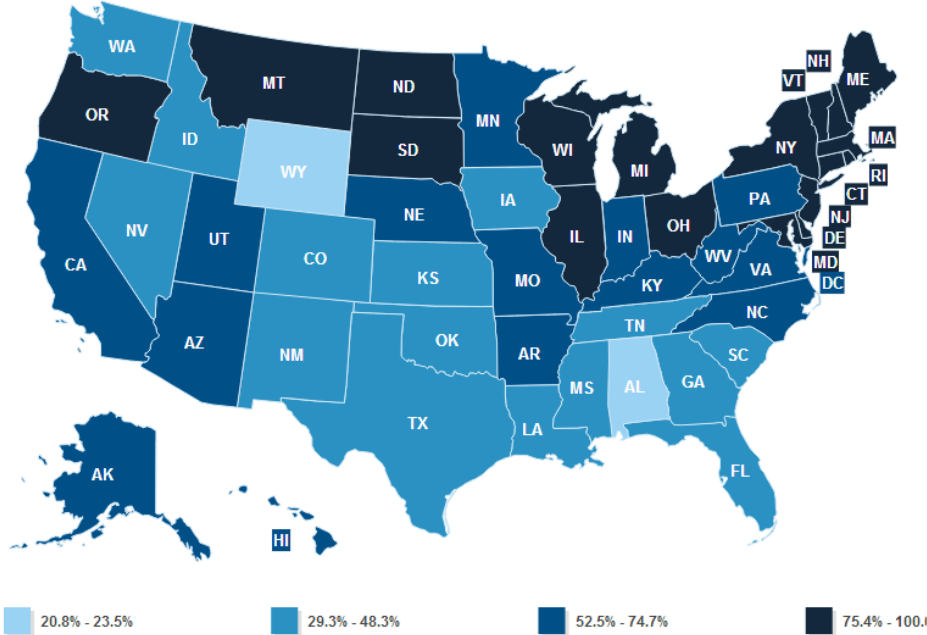
One way to determine if these higher profit margins lead to higher costs for Medicare would be to look at the states where for-profit hospitals make up a larger percentage within that state than the overall national average. According to the Kaiser Family Foundation<sup>vii</sup>, for-profit hospitals made up just over 20 percent of hospitals in the United States in 2011. Non-profits comprised 58 percent, and state and local government hospitals represented the remaining 21 percent. However, when looking at state breakdowns, it is clear that the distribution of for-profit hospitals is uneven. Below are two maps that show the percentage of for-profit hospitals and non-profits. Thirty-one states are below the national average of for-profit hospitals, while 19 states and the District of Columbia are above the national average. In general, for-profits are most prevalent in the South and non-profits dominate care in the Northeast and Midwest.

The top ten states for non-profits include Vermont, Rhode Island, Maryland, Wisconsin, North Dakota, Connecticut, Maine, New York, New Hampshire and Delaware. Of these, several states (New York, Rhode Island and Vermont) are listed as not having any investor-owned hospitals at all. Alternatively, the top ten states for investor-owned hospitals are Nevada, Florida, Tennessee, New Mexico, Texas, Alabama, South Carolina, Utah, Louisiana and Oklahoma. Both categories include both large, populated states and rural states, although there are about 4 million more Medicare beneficiaries in the for-profit states.

### Map of the United States by Percentage of For-Profit Hospitals



### Map of the United States by Percentage of Non-Profit Hospitals



When comparing these two groups of states based on how much Medicare spends per enrollee, it's clear that for-profit dominant states have higher enrollee costs. The two tables below list the average Medicare spending in the top for-profit and non-profit states for 2009 according to the Kaiser Family Foundation.<sup>viii</sup>

The top for-profit states spend approximately 3 percent more per enrollee than the top non-profit states. Taken further, if the spending for non-profit states had been at the for-profit level, the Medicare program would have spent over \$1.85 billion more than it did in that year. In Connecticut, if the Medicare per enrollee spending had been at the for-profit level, the Medicare program would have spent an additional \$173 million caring for beneficiaries. Given the federal fiscal situation and the long-term need to identify greater efficiencies in the Medicare program to strengthen it for future generations, these findings are alarming.

**Table 1: Spending in Top 10 For-Profit States**

<b>Location</b>	<b>Medicare Spending Per Enrollee</b>
New Mexico	\$8,120
Utah	\$8,326
South Carolina	\$9,632
Nevada	\$9,692
Alabama	\$9,718
Oklahoma	\$10,000
Tennessee	\$10,024
Texas	\$11,479
Louisiana	\$11,700
Florida	\$11,893
<b>Average Costs Across Top 10 States: \$10,058</b>	

**Table 2: Spending in Top 10 Non-Profit States**

<b>Location</b>	<b>Medicare Spending Per Enrollee</b>	<b>Medicare Spending Per Enrollee If Non-Profit Spending was at For-Profit Level</b>
North Dakota	\$7,958	\$8,180
Vermont	\$8,719	\$8,963
New Hampshire	\$8,763	\$9,008
Maine	\$8,821	\$9,067
Wisconsin	\$8,908	\$9,157
Rhode Island	\$10,121	\$10,404
Delaware	\$10,421	\$10,712
Connecticut	\$11,086	\$11,396
Maryland	\$11,449	\$11,769
New York	\$11,604	\$11,928
Average Costs Across Top 10 States: \$9,785		Average: \$10,058

**III. Non-Profits Change Behavior to Act More Like For-Profits**

As the research above notes, investor-owned hospitals focus more on profitable services than non-profit hospitals and the states dominated by for-profits have higher costs. Research also shows that the overall healthcare hospital market is impacted when for-profits are prevalent.

For example, research has demonstrated that the proximity of for-profits changes the way non-profit hospitals behave financially, as non-profits start to mimic the for-profits in an attempt to stay competitive. The Schlesinger and Gray study notes, “The more for-profit hospitals in a locality, the more nonprofit hospitals (1) respond aggressively to revenue-increasing opportunities, (2) adopt profitable services, (3) discourage admissions of unprofitable patients, and (4) reduce resources devoted to treating the patients they do admit.”<sup>iv</sup> Another study found that, with the exception of burn care, nonprofits are less likely to offer unprofitable services in high for-profit markets.<sup>ix</sup>

Furthermore, the Schlesinger and Gray study mentions that some have criticized the level of uncompensated care that non-profit hospitals provide, but notes that, if all non-profit hospitals provided uncompensated care at the same rate as for-profit hospitals, the burden of uncompensated care would double for government hospitals.



## Conclusion

There are compelling reasons why communities choose to convert their local hospital to a for-profit and there can be benefits that come along with such a decision. Examples from across the country show that for-profit hospital care can be done right. However, equally important are examples where that has not been the case. As the research highlighted in this report demonstrates, there are obvious differences between the two models when it comes to cost and motivation. Given the growing number of Medicare beneficiaries in the United States and the potential for higher future costs, the federal government has a substantial interest in the proposed conversions of Connecticut hospitals, and more broadly in the shift to for-profit healthcare providers across the nation.

In many states, this conversion process plays out without any public input and little governmental oversight. Thankfully for the residents of Connecticut, any proposed conversion would come with an opportunity for public comment and would have to be approved by state regulators. Importantly, the Connecticut General Assembly recently updated the law that will govern hospital conversions. This process will be very important as Connecticut makes an informed choice about the future of its hospitals.

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<sup>i</sup> Centers for Medicare and Medicaid Services National Health Expenditure Fact Sheet - <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>

<sup>ii</sup> Waterbury Hospital, Saint Mary's Hospital, Saint Francis Hospital, Bristol Hospital and Eastern Connecticut Health Network (Rockville General Hospital and Manchester Memorial Hospital).

<sup>iii</sup> Jill R. Horwitz, Making Profits and Providing Care: Comparing Nonprofit, For-Profit and Government Hospitals, *Health Affairs*, 24, no.3 (2005): 790-801

<sup>iv</sup> Mark Schlesinger and Bradford H. Gray, How Nonprofits Matter In American Medicine, And What To Do About It, *Health Affairs*, 25, no.4 (2006):W287-W303

<sup>v</sup> Congressional Budget Office paper, Nonprofit Hospitals and the Provision of Community Benefits, December 2006 - <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7695/12-06-nonprofit.pdf>

<sup>vi</sup> MedPAC Report to Congress: Medicare Payment Policy, March 2013, [http://www.medpac.gov/chapters/Mar13\\_Ch11.pdf](http://www.medpac.gov/chapters/Mar13_Ch11.pdf)

<sup>vii</sup> Kaiser Family Foundation State Health Facts chart on Hospitals by Ownership Type - <http://kff.org/other/state-indicator/hospitals-by-ownership/#table>. Note that there have been some changes in hospital ownership since 2011.

<sup>viii</sup> Kaiser Family Foundation Medicare Spending Per Enrollee by State for 2009 - <http://kff.org/medicare/state-indicator/per-enrollee-spending-by-residence/>

<sup>ix</sup> Jill Horwitz and Austin Nichols, Hospital Ownership and Medical Services: Market Mix, Spillover Effects and Nonprofit Objectives, *Journal of Health Economics* 924-37