

# Out Of The Frying Pan: New York City Hospitals In An Age Of Deregulation

The right balance of regulation and market forces is needed now more than ever in the city's hospital system.

*by Sharon Salit, Steven Fass, and Mark Nowak*

**ABSTRACT:** For several decades New York City hospitals had been distinguished by their tightly regulated environment, chronically weak finances, high occupancy rates, teaching intensity, dependency on public payers, low managed care penetration, and minimal merger activity. Then in the late 1990s a rapid convergence of forces—the Balanced Budget Act, managed care growth, state deregulation of commercial rates, escalating costs, and plunging hospital occupancy rates—threw the city's hospital industry into turmoil. In this paper we describe this period of turbulent change that has left most of the city's safety-net and small community hospitals near bankruptcy.

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**C**HANGES IN THE HEALTH CARE INDUSTRY in recent years have had a profound effect on local markets throughout the country. The experience of New York City is of interest because of the national prominence of its large teaching hospitals and other distinctive features of its hospital system. New York's hospitals have long been atypical (although perhaps less so compared with hospitals in large East Coast cities such as Boston, Philadelphia, and Baltimore) in their regulatory environment, the extent of their involvement in medical education, their high volume of outpatient services and uncompensated care, their dependence on public payers, the magnitude of philanthropic support they receive, and their weak financial condition (Exhibit 1).

Three decades of state regulation kept the city's hospital industry financially weak but alive and at the same time reinforced the central role of hospitals by restricting entry of potential competitors (for-profit hospital chains and national managed care organizations, or MCOs) into the marketplace. In addition, the city's hospitals

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**EXHIBIT 1**  
**Hospital Industry Characteristics, U.S. And Five Largest Cities, 1999**

	U.S.	New York City	Los Angeles	Chicago	Houston	Philadelphia
Hospital auspice and teaching status						
Percent investor-owned	15.1%	5.0%	37.2%	5.3%	55.2%	0.0%
Percent state/local government	24.2%	20.0%	7.0%	7.9%	6.9%	0.0%
Medical residents per 100,000	2.4	9.3	5.0	6.5	0.9	7.5
Utilization						
Occupancy rates	63.4%	79.8%	66.3%	64.5%	65.3%	72.3%
Admissions per 1,000	118.7	151.9	123.6	149.9	191.7	239.1
Average length-of-stay (days)	5.9	7.5	5.6	6.0	5.7	6.6
ER visits per 1,000	365	448	340	393	436	543
Clinic visits per 1,000	1,452	2,204	899	1,612	1,790	2,909
Finance						
Cost per adjusted admission <sup>a</sup>	\$6,509	\$10,683	\$9,863	\$8,703	\$8,589	\$9,024
Cost per adjusted admission (wage-adjusted) <sup>b</sup>	6,509	8,340	8,638	8,431	8,657	8,251

**SOURCES:** Greater New York Hospital Association, *Health Care Statistics, 2001*, which uses the American Hospital Association's Annual Survey of Hospitals except where otherwise noted.

**NOTES:** ER is emergency room. Medicaid as a percentage of admissions was as follows: U.S. total, 11.2 percent; U.S. urban hospitals, 10 percent; New York City, 34.6 percent. Medicare as percentage of admissions: U.S. total, 42.9 percent; U.S. urban hospitals, 37.1 percent; New York City, 28.6 percent. For U.S. totals, HCIA-Sachs, *The Comparative Performance of U.S. Hospitals: The Sourcebook, 2001* (Baltimore: HCIA-Sachs, 2001). For New York City, New York State Institutional Cost Reports. Measures are medians for hospitals in all groups. Uncompensated care as percentage of admissions: U.S. total, 6.2 percent; New York City, 9.3 percent. For U.S. totals, American Hospital Association Annual Survey of Hospitals, and for New York City, New York State Institutional Cost Reports. Measures are aggregate numbers for all hospitals in the group.

<sup>a</sup> Adjusted admissions include inpatient admissions plus an equivalent number for outpatient services. Cost data were taken from New York State Institutional Cost Reports.

<sup>b</sup> Costs were wage-adjusted by dividing the labor portion of the amount by the Medicare hospital wage index for the metropolitan statistical area in which each city is located.

have long had the highest occupancy rates in the country, which has further served to curb competition.

By the mid-1990s this regulatory balancing act began to break down. Occupancy rates began to fall as the effects of several epidemics (AIDS, tuberculosis, crack cocaine use, crime-related trauma, and homelessness) that had filled the city's hospitals for the better part of a decade subsided and as technological advances and managed care further reduced the demand for inpatient services. Hospitals were suddenly left with large numbers of empty beds just as a new state administration deregulated commercial hospital rates, forcing hospitals to compete for market share by cutting their prices. The city's hospitals grew fiercely competitive and within a mere two years (1997-1998) had reorganized themselves into four large networks—each dominated by one or two major teaching hospitals—in an effort to increase market share, strengthen bargaining leverage over insurers, and rein in costs.

In this paper we describe the transition of New York City's long-stable hospital industry to a more competitive environment and the

impact of market changes on hospitals' financial condition. We also discuss the implications of these changes for access to and delivery of care as well as for future state policy regarding regulatory versus market approaches to its hospital industry.

■ **Data sources and methods.** To assess the impact of these new market forces on the financial condition of the city's hospitals, we analyzed audited financial statements for 1997–1999 for the thirty-six general care private hospitals located in New York City.<sup>1</sup> We also considered changes in the volume of hospital discharges in recent years, since inpatient revenues accounted for 77 percent of total patient revenues at the city's hospitals in 1999.<sup>2</sup> Finally, we analyzed estimates of revenue losses by hospitals as a result of the federal Balanced Budget Act (BBA) of 1997, including subsequent restorations.

To obtain more current information on both national and city-wide trends, we consulted a variety of sources, including the Medicare Payment Advisory Commission (MedPAC) and bond-rating agencies (Standard and Poor's and Fitch IBCA). We also analyzed operating margins from audited financial statements for 2000 for twenty-eight of thirty-six New York City general care private hospitals that have been received to date by the United Hospital Fund of New York. In addition, we had conversations with several hospital officials in the city to discuss developments since 1999.

## The New York City Environment

For more than three decades New York State has had one of the nation's most highly regulated health care systems, its most expensive Medicaid program, and its least profitable hospitals. Although some state regulations were eased by a new state administration in 1995, much of the regulatory system has remained intact. Through its rigid certificate-of-need process (much weakened since 1995), the state restricted the supply of hospital beds and other services to discourage overuse. These controls, along with the major epidemics that filled hospitals during the late 1980s through the mid-1990s, kept hospital occupancy rates high. In addition, state regulations prohibited for-profit hospital chains and discouraged national MCOs from establishing a large presence in the state, thereby protecting existing hospitals although limiting their access to capital.

■ **Rate-setting system.** New York's all-payer hospital rate-setting system was designed to create incentives to reduce lengths-of-stay and hospital costs, although its effectiveness in doing so has been a matter of debate. New York hospitals historically have had among the longest stays and highest costs in the country, but the reasons for this are varied and complex (including such factors as

the cost of living, unionization, case-mix, medical practice styles, and the availability of discharge placement options). Rates also were set at levels intended to barely cover costs, a reason for chronically narrow operating margins at the city's hospitals. Although New York's Medicaid rates have been among the most generous in the nation, many observers believe that commercial rates were lower than those the city's hospitals could have negotiated in the marketplace prior to the late 1990s.

The rate-setting system also sought to redistribute income from more profitable hospitals to safety-net institutions. New York is one of a handful of states to operate statewide pools to subsidize hospitals for their losses from providing uncompensated care. The pools, created in 1983, were funded by assessments on insurers and hospital inpatient revenues and were supplemented by Medicaid disproportionate-share hospital (DSH) payments beginning in 1989. Additional pool payments were targeted to a group of private safety-net hospitals designated by the state as "financially distressed." To qualify, hospitals had to demonstrate a public need for their services as well as financial losses from their provision of uncompensated care to low-income persons.<sup>3</sup>

Until 1997 financially distressed hospitals (including nineteen hospitals statewide and ten in New York City) received pool payments covering up to 100 percent of their uncompensated care losses (compared with an average of about 40 percent for other hospitals). In addition, beginning in 1989 public hospitals in the state received sizable funding through the Medicaid DSH program. Previously, public hospitals had relied mostly on local tax appropriations to fund uncompensated care.

■ **Hospital-centered system.** Although many state regulations were intended to shrink the hospital sector, as one observer noted, "State regulators often found themselves turning to that sector to solve tough policy problems, not only because of the capabilities that the institutions possessed but because that's where the regulatory and financial leverage was."<sup>4</sup> The state's reliance on hospitals, rather than physicians and other community-based providers, to address such issues as providing ambulatory care in low-income communities and designing ways to address the AIDS and tuberculosis epidemics strengthened the central role of hospitals while paying them less than their full costs for these service expansions.

Although state regulators helped to shape a hospital-centered system, the city's hospitals were not passive bystanders. As the largest employer in the New York City metropolitan region, with 217,000 jobs in 1996 (followed by the securities industry with 153,000 jobs) and a generator of numerous additional jobs attribut-

able to allied industries, the city's hospitals, individually and through their sophisticated trade association, have exercised substantial political clout both locally and in Washington.<sup>3</sup> This power base was further cemented in the 1990s by the industry's alliance with the city's largest hospital workers' union.

■ **Physicians' role.** Unlike in many parts of the country, physicians in New York City have not been an independent force in the city's health care system. As would be expected, many of the city's physicians are in hospital-based practices (44 percent, compared with 24 percent in the nation as a whole), and large organizations of community-based physicians have not emerged.<sup>6</sup>

■ **Municipal hospital system.** Another important feature of New York City's hospital system is its municipal hospital system, the largest in the nation, which treats a fifth of hospital admissions and provides close to a third of emergency room and clinic visits in the city. It also provides 45 percent of charity care in the city, a proportion that has remained constant despite a moderate decline in the system's overall share of hospital services in recent years.<sup>7</sup>

Despite the power of the city's hospital industry, a long period of high occupancy rates, historically low managed care penetration, and support for public goods, the city's hospitals have long had among the worst financial ratios in the nation (Exhibit 2). As mentioned, the causes of their poor financial performance are varied and have included state-controlled rates, high levels of uncompensated care, and high volumes of underreimbursed outpatient and graduate medical education (GME) activities.

**EXHIBIT 2**  
**Financial Indicators, By Hospital Category, U.S. And New York City Hospitals, 1997 And 1999**

Indicator	Large urban U.S.		Total NYC		In jeopardy		At risk		Other	
	1997	1999	1997	1999	1997	1999	1997	1999	1997	1999
Operating margin	3.2%	1.5%	0.7%	-0.1%	0.3%	-6.1%	-3.0%	-0.7%	1.8%	1.3%
Current ratio	1.8	1.8	1.1	1.0	1.0	0.7	0.7	0.9	1.5	1.5
Days' cash on hand (short-term sources)	29.0	22.1	8.7	8.0	4.0	3.6	8.5	6.5	29.1	26.7
Average number of days required to pay vendors	65.5	64.0	87.2	92.1	93.3	123.2	112.3	119.9	71.5	70.5
Debt-service coverage ratio	4.5	3.9	1.6	1.5	1.4	0.3	1.1	1.0	2.2	2.1

**SOURCES:** For U.S. hospitals, Center for Healthcare Industry Performance Studies, *2001 Almanac of Hospital Financial and Operating Indicators* (Ingenix Publishing Group, 2001). For New York City, hospital audited financial statements, 1997 and 1999.

**NOTE:** Measures are medians for all hospitals in the group.

## The New Era Begins

■ **HMO penetration rates.** By the mid-1990s some of the forces that had already transformed the hospital industry in other parts of the country began to appear in New York. Permitted to do business in the state in 1985, national for-profit MCOs finally gained a foothold after several false starts.<sup>8</sup> In 1993 New York City had one of the lowest commercial health maintenance organization (HMO) penetration rates in the country, at 14.7 percent.<sup>9</sup> By 1997 the rate had more than doubled to 32.5 percent, approaching the median for U.S. cities with populations of more than one million (36.9 percent).<sup>10</sup> In 1998 the city's HMO penetration rate peaked at 33.5 percent and then dropped to 31.2 percent in 1999.<sup>11</sup> In large metropolitan statistical areas (MSAs) nationally, HMO penetration rates also peaked in 1998 at 38.7 percent and then declined slightly to 38.4 percent in 1999. In the Medicaid program, the percentage of New York City beneficiaries enrolled in managed care rose from 3 percent in 1991 to 29 percent in 2001.<sup>12</sup>

■ **Inpatient rates.** From 1995 through 1999 the city's inpatient census fell by 16.8 percent, more than four times the national decline of 4.0 percent.<sup>13</sup> Thirty-five percent of the census reduction was associated with declines in discharges and lengths-of-stay related to the major epidemics in the city (AIDS, tuberculosis, trauma, substance abuse, and mental illness), and another 6 percent was attributable to a drop in childbirth rates.<sup>14</sup>

■ **Reimbursement rates.** At the same time that hospitals suddenly faced large excess capacity, a number of forces were set in motion that would greatly reduce hospitals' reimbursement rates. The first was the BBA of 1997. The BBA had a particularly harsh impact on New York City hospitals, many of which rely heavily on GME and DSH payments—two provisions of the Medicare program that were targeted for large reductions. At about the same time, a newly elected Republican governor announced his intention to dismantle the state's regulatory system to infuse new market forces into the state's health care system.<sup>15</sup> At his urging, state lawmakers enacted the New York State Health Care Reform Act (HCRA), which took effect in 1997. Two of the changes that followed—deregulation of hospital rates for commercial payers (Medicaid rates continue to be set by the state) and the phaseout of additional uncompensated care pool payments for financially distressed hospitals—were expected to have a major impact on hospital revenues. In addition, the governor continued to expand the state's Medicaid managed care program, which in effect further deregulated rates, since MCOs are exempt from state rate setting. Insurers, newly

liberated from state rate-setting, exerted their power and, at least at the beginning, had the upper hand against an unprepared hospital industry with substantial excess capacity. Although the city's hospitals have tightly guarded information about their rate negotiations, several hospital finance officials privately informed us that rates were as much as a third lower than state-regulated rates and that insurers achieved further payment reductions through utilization review, denials, and payment delays.

■ **Merger activity.** With pressures on revenues coming from all directions—the BBA, rate deregulation, managed care, and inpatient utilization declines—and with rapidly escalating costs, the city's hospitals began competing more aggressively, accelerating cost containment efforts, and engaging in feverish merger activity. By 1996 the city's academic medical centers (AMCs) and other large teaching hospitals began courting each other as possible merger partners. The four large AMCs located in Manhattan began a mating dance, changing partners, it seemed, every several months, until finally pairing off in 1998 into two large networks that each included two AMCs, their respective medical schools, and several teaching as well as community hospitals. Two additional large networks were formed, one anchored by two large Manhattan teaching hospitals and another comprising most of the city's Catholic hospitals. Three-quarters of the city's forty-two private hospitals have joined these four networks, although the nature of the affiliations varies widely.<sup>16</sup>

The mergers were, for the most part, hastily arranged marriages of convenience driven by the need to strengthen bargaining leverage against insurers, increase market share, and achieve modest cost reductions through consolidation of administrative and support functions. Other goals such as clinical integration and elimination of excess capacity were considered off limits because of the power of hospital medical leadership, boards of trustees, unions, and other special-interest groups. "If you try to make changes, physicians will jump ship and take their patients to a competitor," lamented one network's chief executive. It is too early to assess the effectiveness of these networks. There have been reports of administrative cost savings and greater leverage in rate negotiations. Several financially troubled community hospitals have received assistance from networks, but for many community hospitals the advantages of network membership are less apparent. On the other hand, there have been reports of factionalism and conflict within the merged entities. One of the networks has reestablished separate boards of trustees for its two AMCs to retain their distinct identities. Only time will tell whether these rocky marriages hold together and achieve long-term benefits.

## Market Change And Hospitals' Financial Condition

■ **Citywide trends in hospitals' financial condition.** Citywide, all financial indicators deteriorated during the period we studied (Exhibit 2). Operating margins declined the most, and the proportion of hospitals posting operating losses rose from just over 30 percent to 50 percent between 1997 and 1999. Other indicators (current ratio and debt-service coverage) showed modest declines.

Trends in the city paralleled those of large urban hospitals nationally during the late 1990s (Exhibit 2). Some reports suggest that since 1999 these trends may be reversing. MedPAC's March 2001 report to Congress showed that total margins for U.S. hospitals rose from 2.8 percent in 1999 to 5.1 percent in 2000 (based on American Hospital Association survey data through midyear 2000).<sup>17</sup> Since the release of that report, MedPAC has revised these numbers to 3.6 percent in 1999 and 4.7 percent in 2000.<sup>18</sup> MedPAC staff indicated that total margins were unusually low in 1999 in part because many hospitals dropped unprofitable physician practices that year. Because these losses were nonrecurring, it is difficult to project trends based on a comparison of 1999 and 2000. Moreover, operating margins may have stabilized in 2000, because further BBA reductions were delayed through the Benefits Improvement and Protection Act (BIPA) of 2000.

Other sources suggest that hospital industry finances at best have stabilized but may decline further. A recent analysis by Fitch IBCA of audited financial statements for 178 hospitals in its bond portfolio found that fiscal indicators in 2000 were similar to those in 1999.<sup>19</sup> Standard and Poor's wrote in September 2001 that although the not-for-profit health care sector has shown signs of rebounding after declining since 1997, the future outlook "remains clouded...due to underlying cost pressures, potential revenue constraints, and an uncertain stock market."<sup>20</sup> An analysis that we conducted of audited financial statements for 2000 for twenty-eight of the thirty-six private general care hospitals in the city showed that median operating margins were similar in both years (-0.14 percent in 1999 and -0.11 percent in 2000). Our conversations with hospital officials also provided little evidence of a turnaround in the financial fortunes of New York City hospitals. Rising costs, the BBA, managed care, and workforce shortages are expected to continue to put pressure on hospitals. Some of the larger hospitals reported that they fared better in their second round of commercial rate negotiations (most signed three-year contracts in 1997 when rates were deregulated). This was attributed in part to a consumer backlash against managed care and demands for larger provider networks. Hospitals also have benefited

from a 24 percent increase in state uncompensated care pool funding (from \$681 million to \$847 million) that took effect in 2000 and will continue through midyear 2002.

Utilization declines appear to be reversing slightly both nationally and in New York City.<sup>21</sup> In the city, utilization gains have been attributable to modest increases in discharges combined with a slowing of length-of-stay reductions.<sup>22</sup>

■ **Growing disparities among hospitals.** In recent years there have been major changes in the distribution of the city's hospitals by financial condition. In 1994 (the earliest year for which we had citywide financial data) 67 percent of the thirty-six hospitals in our sample had operating margins within 1.5 percentage points of the median for the group, compared with just 36 percent in 1999. In 1999, 22 percent of the hospitals had operating losses exceeding 5 percent, compared with none in 1994.

■ **Growing rates of fiscal stress.** We found that in 1999 nearly one-third of the city's general care private hospitals (eleven of thirty-six hospitals) faced financial problems severe enough to call into question their continuing viability. Another nine hospitals were at risk of developing serious problems. Based on financial indicators and supplemental information from the financial statements, we grouped hospitals into three categories: in jeopardy, at risk, and other (Exhibit 2).

Hospitals in jeopardy included eleven facilities with consistently poor and steadily worsening performance across most financial indicators during 1997–1999. Eight hospitals received auditors' "going concern" warnings in 1999. Strapped for cash, five of the eleven hospitals resorted to short-term borrowing to cover current operating expenses; and eight hospitals defaulted on loan, bond, or pension fund payments. All but two hospitals fell below the minimum debt-service coverage ratio of 1.0 in 1999. At five of the eleven hospitals, high levels of debt in addition to operating losses contributed to inadequate debt-service coverage.

Another nine hospitals fell into the at-risk category as a result of poor performance across most indicators, although performance was not as consistently weak as that of in-jeopardy hospitals. Four at-risk hospitals would have been classified as being in jeopardy had they not received financial assistance from other hospitals. Three of these hospitals obtained this support from networks they had joined. Two had "going concern" warnings in 1999, and a third had several other warning signs in its financial statement. Unlike most hospitals in the city, at-risk hospitals showed improved operating margins between 1997 and 1999. However, all but two hospitals had operating losses or just broke even in 1999.

The sixteen remaining general care private hospitals in the city had stronger financial indicators but showed signs of decline. Specifically, operating margins and cash on hand declined, but other measures remained stable. Nearly all of the hospitals had sufficient working capital, and all had adequate debt-service coverage ratios, although far below national norms.

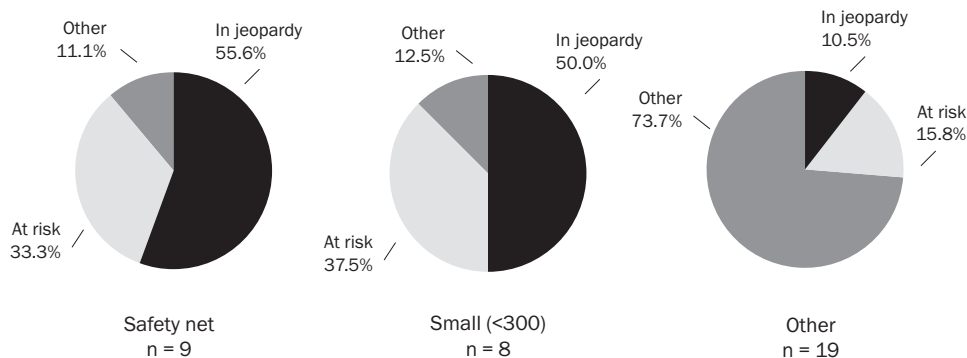
■ **Characteristics of financially troubled hospitals.** The two groups of financially troubled hospitals—in-jeopardy and at-risk hospitals—shared some common characteristics. They were far more likely to be safety-net hospitals and smaller community hospitals (average daily census below 300) (Exhibit 3). They also were more likely to have had major drops in hospital discharges in recent years. All ten of the thirty-six hospitals in the study that had a decline in discharges of 5 percent or more during 1997–1999 were included in the in-jeopardy or at-risk categories. An analysis of growth rates in discharges during that period for all general care hospitals in the city (including the eleven municipal hospitals that also are experiencing severe financial problems) shows that all groups of financially troubled hospitals (municipal, safety-net, in-jeopardy, and at-risk) lost considerable ground to other hospitals, principally the city’s largest teaching hospitals (Exhibit 4).<sup>23</sup>

An examination of changes in uncompensated care pool payments to the city’s nine financially distressed hospitals (one of the original ten financially distressed hospitals merged with a system) during 1997–1999 showed that the phaseout of their additional pay-

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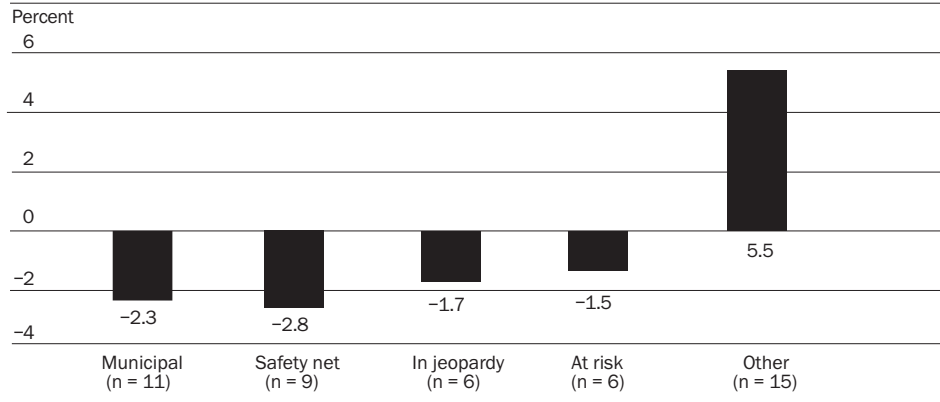
**EXHIBIT 3**  
**Characteristics Of Financially Troubled Hospitals In New York City: Safety-Net, Small Community, And All Other Hospitals, By Financial Performance Category, 1999**



**SOURCES:** New York State Institutional Cost Reports.

**NOTES:** Hospital categories are mutually exclusive. Small hospitals that were also safety-net hospitals were included in the safety-net category. Numbers for financial performance groups: In jeopardy, n = 11; at risk, n = 9; other, n = 16.

**EXHIBIT 4**  
**Percentage Change In Discharges, By Hospital Category, In New York City Hospitals, 1997-1999**



**SOURCE:** New York State Institutional Cost Reports.

**NOTE:** The hospital categories are mutually exclusive. Safety-net hospitals include only private safety-net facilities. Private safety-net hospitals that were also in-jeopardy or at-risk hospitals were included only in the safety-net category.

ments contributed to their deteriorating finances. The proportion of uncompensated care losses covered by pool payments at these hospitals fell from 92 percent in 1997 to 78 percent in 1999, as uncovered costs rose from \$9 million to \$36 million during the period. At seven of the nine hospitals, uncompensated care losses in emergency rooms and clinics declined substantially, suggesting that these hospitals may have responded to the change in pool allocation policy by reducing access for the uninsured. Five of the seven hospitals were located near municipal hospitals that had large increases in outpatient uncompensated care losses during the period. Although, as mentioned, the pools were greatly increased in 2000, additional payments for this group of hospitals were not restored.

We also evaluated the impact of the BBA on the city's hospitals. We did not find that the two groups of financially troubled hospitals had disproportionately high BBA losses. However, given their already tenuous financial condition, even modest BBA losses may have been enough to push them close to bankruptcy.

**What Next?**

In 1997, when they took steps to begin dismantling the state's regulatory system, New York's lawmakers envisioned that the infusion of market forces would "rightsize" the state's hospital industry and lead to the closure or scaling back of unneeded hospitals that had been protected by state policies.<sup>24</sup> Since then, as the result of deregulation and broader national trends, New York City's hospital industry has become more like those in the rest of the country. As financial pressures intensified, the largest and most powerful hospitals

closed ranks, competed aggressively for market share, and left the city's hospital industry increasingly one of haves and have-nots. As has been true nationally, serving the poor in New York City is now much more a recipe for financial failure.

It is not at all clear, given the market power gained by the large networks, that the introduction of competitive forces has had its intended effect of weeding out the least-needed, least-efficient, and lowest-quality facilities in the system. Certainly, the near-universal deterioration of finances at the city's private safety-net hospitals raises questions about the adequacy of the state's targeting of support for public goods. Moreover, the effects on small community hospitals, several of which are geographically isolated and may be vital to ensuring access to care in those communities, raise further questions about the ability of market forces to appropriately target unneeded excess capacity. In short, it is unclear that market forces have achieved the best balance of competition, public interests, and meeting communities' needs.

In New York City, probably more so than in other cities, hospitals have assumed large roles in providing a broad continuum of health care services. In many neighborhoods, especially low-income areas, they have long been mainstays of communities, not just in providing health care but also in providing jobs and general support for local economies, as well as sources of community pride. For these reasons, it has been exceedingly difficult to close hospitals in the city, as a complex set of issues is involved in any decision to do so.

Neither relying only on market forces nor permitting powerful interest groups to prevent downsizing of the system would be good policy. Finding the right balance of regulation and market forces has always been a challenge for New York's health care policymakers, but such a balance is needed more than ever at this crossroads for New York City's hospital system.

## NOTES

1. We chose to use financial statements, rather than other sources such as Medicare cost reports, because they provide detailed information needed to ensure that definitions of revenue and expense items were consistent across hospitals and over time. The explanatory notes and auditors' letters accompanying financial statements also provide a rich source of qualitative information, including evidence of financial support from related organizations such as foundations, research organizations, affiliates, and insurance subsidiaries; unusual actions taken to address serious cash-flow problems (such as defaulting on loans, bond covenants, or employee pension plan payments; or short-term borrowing to cover operating expenses); and auditors' "going concern" warnings, issued when auditors believe that an organization has insufficient resources to remain in operation for another year. We selected five financial indicators that captured the three major aspects of hospital financial performance (profitability, liquidity, and capital debt structure) and that best de-

scribed the financial condition of New York City hospitals. The indicators include operating margins, the current ratio and two of its major components (days of cash on hand and days required to pay vendors), and the debt-service coverage ratio. We selected operating margins instead of total margins because they reflect the performance of a hospital's current operations and exclude nonrecurring income as well as unrealized investment income. We excluded the city's public hospitals, because their data could not be separated from those of the larger municipal system, and also six specialty care hospitals.

2. New York State Institutional Cost Reports.
3. New York State Health Code of Rules and Regulations, Title 10, Section 86-1.66.
4. B. Vladeck, "Paradigm Lost: Health Policy in New York State in the Post-Axelrod Era," President's Letter (New York: United Hospital Fund, September 1991).
5. A. Ilan and Associates, "The Economic Impact of the Academic Medical Infrastructure on New York State and the New York City Metropolitan Region" (Study conducted for the Greater New York Hospital Association, February 1999).
6. American Medical Association, 1999 data.
7. New York State Institutional Cost Reports.
8. J.E. McDonough, *Interests, Ideas, and Deregulation: The Fate of Hospital Rate Setting* (Ann Arbor: University of Michigan Press, 1997).
9. InterStudy *Competitive Edge 4.2, Part III: Regional Market Analysis* (St. Paul: InterStudy Publications, 1994).
10. InterStudy *Competitive Edge 8.2, Part III: Regional Market Analysis* (St. Paul: InterStudy Publications, 1998).
11. InterStudy *Competitive Edge 9.2, Part III: Regional Market Analysis* (St. Paul: InterStudy Publications, 1999); and *Competitive Edge 10.2, Part III: Regional Market Analysis* (2000).
12. Division of Medicaid Services, New York State Department of Social Services; and Division of Medicaid Managed Care, New York State Department of Health.
13. American Hospital Association, Annual Survey of Hospitals, 1995-1999.
14. Analysis conducted by the United Hospital Fund using discharge data from the New York Statewide Planning and Research Cooperative System.
15. Gov. George E. Pataki's Ad Hoc Task Force on New York's Prospective Hospital Reimbursement Methodology, *New Directions for a Healthier New York: Reform of the Health Care Financing System* (Albany: Office of the Governor, December 1995).
16. There are now thirty-six general care, six specialty care, and eleven municipal hospitals within New York City.
17. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Washington: MedPAC, March 2001).
18. Jesse Kerns, MedPAC, personal communication, 7 September 2001.
19. Fitch IBCA, *2000 Median Ratios for NonProfit Hospitals and Health Care Systems* (New York: Fitch IBCA, 22 August 2001).
20. Standard and Poor's, *Health Care Sector Shows Signs of Stability, but Future Remains Clouded* (New York: S&P, 19 September 2001).
21. Kerns, personal communication.
22. United Hospital Fund, "Trends through December 2000," *Hospital Watch* 12, no. 2 (2001): 1.
23. J. Steinhauer, "After Five Years of Fiscal Success, City Public Hospitals Face Deficit," *New York Times*, 23 May 2001.
24. Gov. Pataki's Ad Hoc Task Force, *New Directions for a Healthier New York*.