Does The Sale Of Nonprofit Hospitals Threaten Health Care For The Poor?

A before-and-after look at what happens to health care in a community when for-profit corporations acquire nonprofit hospitals.

by Gary J. Young, Kamal R. Desai, and Carol VanDeusen Lukas

Much of the controversy over for-profit ownership in health care focuses on a recent wave of acquisitions of nonprofit hospitals by investor-owned corporations. Nonprofits have been joining investor-owned corporations to obtain the financial resources they need to maintain their viability in an increasingly competitive industry environment. Investor-owned corporations see the acquisition of nonprofit hospitals as an opportunity to build market share and to expand their provider networks. Through these acquisitions, investor-owned corporations are beginning to penetrate new health care markets.

An issue central to the controversy is how the acquisition of a nonprofit hospital by an investor-owned corporation affects the community the hospital serves. Investor-owned corporations have long been accused of placing the bottom line before the community’s welfare. A specific concern is that investor-owned hospitals are less willing than nonprofits are to provide services to persons who are unable to pay for their care.

Several studies have compared investor-owned and nonprofit hospitals in terms of the amount of uncompensated care they provide, yet relatively little research has been done to examine how specific communities are affected when a nonprofit hospital is acquired by an investor-owned corporation. Comparative studies suggest that nonprofits provide on average more uncompensated care than do their investor-owned counterparts, but this difference appears to reflect the locations where investor-owned corporations choose to build and buy hospitals. Investor-owned corporations tend to locate in relatively affluent communities. However, when a nonprofit hospital is acquired by an investor-owned corporation, the hospital continues to serve the same community; only the ownership status of the institution changes. Thus, it is important to measure the provision of uncompensated care by the same hospital in the same community, before and after acquisition.

Here we examine how the acquisition of nonprofit hospitals by investor-owned corporations affects acquired hospitals’ provision of uncompensated care. We focus on acquisitions in California between 1980 and 1992, because of the long presence of investor-owned hospitals there.
DATA AND METHODS
The study used a multiple time-series design with a nonequivalent comparison group. We examined the impact of acquisitions on the level and rate of change in uncompensated care. We included a comparison group to control for secular industrywide trends that might underlie observed changes in uncompensated care following an acquisition.

We selected uncompensated care as an indicator of a hospital’s willingness to provide care to persons regardless of their ability to pay. Uncompensated care consists of two components: charitable care and bad debt. Charitable care is the amount hospitals spend to provide services for which they do not expect payment. Bad debt occurs when hospitals provide care with the expectation that payment will be made, but all or some portion of the payment is never received. In studying nonprofit acquisitions, we decided to focus on uncompensated care rather than charitable care alone for two reasons. First, while charitable care and bad debt are distinguishable conceptually, hospitals vary in terms of how they define charitable care for accounting purposes. For example, some hospitals define charitable care in relation to specific income or asset tests, but other hospitals simply treat all unreimbursed care as bad debt. Thus, some portion of a hospital’s bad debt may actually be charitable care. Second, bad debt may be a function not only of how effectively a hospital manages its accounts receivable but also of its overall commitment to charitable care. Hospitals can exert some control over their bad debt, for example, in the strictness with which they screen patients for ability to pay and the types of services they offer (such as emergency care and drug treatment).

We measured uncompensated care in terms of the dollar amount hospitals deducted from patient care revenue for both charitable care and bad debt, as reported in their financial statements. Because we used dollar amounts rather than, say, the number of unreimbursed admissions, our measure accounts for potential changes in the case-mix of patients receiving uncompensated care. Such a change might occur if an acquired hospital sought to provide uncompensated care to less severely ill (less costly) patients than had been cared for before the acquisition. To account for variations in patient volume and price structure, we standardized our uncompensated care measure by the hospital’s gross patient revenue.

Our data source was cost reports submitted by all hospitals to California’s Office of Statewide Health Planning and Development (OSHPD). This data set consists of audited hospital financial and operating data, including type of ownership, identity of owners (if investor-owned), and service orientation (for example, short-term general).

The study sample consisted of seventeen acquisitions that occurred between 1980 and 1992 in California. Acquisitions were identified on the basis of a change in ownership. We selected for the study only those acquisitions that met the following four criteria: (1) The acquisition was of a private, short-term general nonprofit hospital that had the same ownership status for at least three years before the acquisition; (2) at least three years of data existed on the amount of uncompensated care the acquired hospital provided both before and after the acquisition; (3) the acquired hospital remained part of an investor-owned corporation for at least three years following the acquisition; and (4) the acquired hospital remained a short-term general hospital for at least three years after the acquisition.

For each acquired hospital in the sample, we assembled a comparison group consisting of all private, short-term general nonprofit hospitals in California that were doing business at the time of the acquisition. For each comparison hospital, we assembled six years of pooled, time-series data in a manner comparable to the sample of acquired hospitals. Analysis of these data enabled us to look at each acquisition within the context of other nonprofit hospitals’ provision of uncompensated care at the time of the acquisition.
ANALYSIS

We compared the pattern of uncompensated care for three years before each acquisition to the pattern three years after the acquisition. Specifically, we examined differences in average values and trend values for uncompensated care before and after the acquisition. We calculated the average values as the three-year mean for uncompensated care and calculated the trend values as the slope over the same period. The trend values provided information about the direction and rate of change in uncompensated care.

In addition, for each acquisition we compared the observed change in the uncompensated care measures (average and trend value) with the change that occurred in the comparison group. All of these changes must be examined together to assess the actual impact of an acquisition on the acquired hospital’s behavior and performance. We used t-tests to ascertain the statistical significance of observed differences in the average and trend values. As an additional measure of community benefit, we also determined whether acquired hospitals opened or closed emergency departments in the three years following acquisition.

RESULTS

Of the seventeen acquisitions in our sample, eleven occurred between 1980 and 1986, and six occurred between 1986 and 1992. Zero to three acquisitions occurred in each year within the study’s time frame.

Exhibit 1 presents average and trend values for the acquired hospitals and the comparison group both before and after the acquisition. These values are expressed as a proportion of hospitals’ gross patient revenue. Based on these data, acquisitions did not affect the amount of uncompensated care provided by the acquired hospitals in the sample. The difference between the average amounts of uncompensated care before and after the acquisition (0.16) is not statistically significant. Moreover, the trend values of the acquired hospitals did not change, which indicates no acquisition effect on existing patterns (in terms of direction and rate of change) in the provision of uncompensated care. The preacquisition average values of the acquired and comparison groups indicate that the acquired hospitals provided somewhat less uncompensated care than did their counterparts before the acquisitions. However, this difference did

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**EXHIBIT 1** Percentage Of Hospital Gross Patient Revenue Devoted To Uncompensated Care, Before And After Acquisition

<table>
<thead>
<tr>
<th></th>
<th>Acquired hospitals (n = 17)</th>
<th>Comparison group</th>
<th>Difference between groups</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before acquisition</td>
<td>2.75%</td>
<td>3.41%</td>
<td>0.66% b</td>
</tr>
<tr>
<td>After acquisition</td>
<td>2.91</td>
<td>3.50</td>
<td>0.59</td>
</tr>
<tr>
<td>Difference</td>
<td>0.16</td>
<td>0.09</td>
<td>-0.07</td>
</tr>
<tr>
<td><strong>Trend</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before acquisition</td>
<td>0.27%</td>
<td>0.05%</td>
<td>-0.22</td>
</tr>
<tr>
<td>After acquisition</td>
<td>0.34</td>
<td>-0.01</td>
<td>-0.35</td>
</tr>
<tr>
<td>Difference</td>
<td>0.07</td>
<td>-0.06</td>
<td>-0.13</td>
</tr>
</tbody>
</table>

SOURCE: Authors’ analysis.

a The size of the comparison group sample varies every year (range is from 212 to 229).
b Statistically significant difference, 90 percent confidence interval (t-test).
not persist into the postacquisition period.

To determine whether the effect of an acquisition might vary in relation to community characteristics that influence the demand for uncompensated care, we used the proportion of county residents living in poverty as an indicator of demand for uncompensated care. This information was obtained from the Area Resource File (ARF), which is a compendium of county-level demographic and health care resource data compiled by the U.S. Department of Health and Human Services (HHS). We stratified the seventeen acquired hospitals into two groups: those in counties above (eleven counties) and below (six counties) the state’s median proportion of county residents living in poverty. The comparison hospitals were similarly stratified. For each group we replicated the analysis we performed to assess the acquisition effect on all seventeen acquired hospitals. Mirroring the overall findings, these analyses showed no effects on uncompensated care, as measured by changes in average or trend values, for communities either above or below the statewide median for residents living below poverty.

The study also suggests that acquisition had no effect on the presence of an emergency department in the acquired hospitals. In our sample one hospital added an emergency department, two hospitals closed their emergency departments, and fourteen hospitals did not change their emergency department status in the three years following acquisition.

**CONCLUSIONS AND POLICY IMPLICATIONS**

The study results suggest that the acquisition of nonprofit hospitals by investor-owned corporations does not lead uniformly to less uncompensated care among the acquired hospitals. We found no evidence that acquired hospitals provide on average less uncompensated care than they did before the acquisition. The results are consistent with prior research that indicates that investor-owned hospitals provide no less uncompensated care than do nonprofits, given their locational choices, which typically are in relatively affluent communities. Our study goes further by examining changes in ownership while holding community constant and finds that when investor-owned corporations acquire nonprofit hospitals, they maintain the level of uncompensated care that existed before the acquisition.

Several study limitations should be noted. First, the study reflects the experiences of one state—California—that has adopted a market-oriented posture toward the delivery of health care services. Given the state’s pro-competitive environment, nonprofit hospitals in California may not be representative of their nonprofit counterparts in other parts of the country where market forces are less prominent. However, in such a competitive market one might expect investor-owned hospitals to be even more inclined to cut uncompensated care so as to maintain their profit margins. Nevertheless, our analysis should be replicated using data from other states.

Second, uncompensated care is only one indicator of a hospital’s commitment to community service. For example, hospitals may establish various community outreach programs such as health promotion and screening initiatives, the cost of which cannot be ascertained from the type of cost report data on which our study is based. We hope that additional research will be conducted to investigate the broader community impact of acquisitions of nonprofit hospitals by investor-owned corporations.

Third, uncompensated care includes not only charitable care but also bad debt, which is influenced in part by how effectively a hospital manages its accounts receivable. This
limitation in our ability to measure true charitable care may be a source of bias. However, previous research suggests that one of the potential benefits hospitals gain from being acquired by an investor-owned corporation is improved debt collection procedures. Consequently, we would expect acquired hospitals to experience a decline in the amount of bad debt they carry and thus a decline in their overall level of uncompensated care. Accordingly, our measure of uncompensated care may actually underestimate the amount of charitable care that acquired hospitals provide following an acquisition.

As a final caveat, we confined our post-acquisition analysis to a three-year period. In some acquisitions the corporation agrees to maintain uncompensated care at its existing level for a specified period. Thus, investigators seeking to replicate our study should consider a longer time frame if possible.

The prospect of investor-owned corporations acquiring nonprofit hospitals has raised much concern among the residents of many communities who fear that acquired hospitals will reduce their commitment to community service. Our study suggests that, at least in terms of uncompensated care, these fears may not be warranted. Acquisitions may affect other community benefits that were not measured in the study—and those should be examined carefully. However, this study suggests that if California patterns hold in other places, the acquisition of a nonprofit hospital by an investor-owned corporation will not affect the acquired hospital’s existing level of uncompensated care.

NOTES
5. Lewin et al., “Setting the Record Straight,” GAO, Nonprofit Hospitals; and Norton and Staiger, “How Hospital Ownership Affects Access to Care.”
7. F. Sloan, J. Valvona, and R. Mullner, “Identifying the Issue,” in Uncompensated Hospital Care: Rights and Responsibilities, ed. F. Sloan, J. Blumstein, and J. Perrin (Baltimore: The John Hopkins University Press, 1984), 16–53. Following standard practice, we also subtracted gifts and subsidies hospitals received for charity care. These represented only a very small percentage of total uncompensated care deductions among the hospitals studied.
9. Trend = (Uncompensated CarePeriod(3) - Uncompensated CarePeriod(1))/2.
10. Alexander et al., “The Short-Term Effects of Merger on Hospital Operations.”
11. Results are available from the authors at Management Decision and Research Center (152-M), VA Medical Center, 150 South Huntington Avenue, Boston, Massachusetts 02130.