Investing In The Twenty-First Century Hospital

Legislation proposed to “protect” tax-exempt hospitals may actually hamper their ability to compete, says Columbia/HCA executive.

by David L. Manning

The U.S. health care system is an excellent example of how government action can produce results that benefit its citizens for generations. Unfortunately, new laws currently being considered by several states and Congress, ostensibly to protect the public interest when tax-exempt hospitals sell or form partnerships with investor-owned companies, are motivated by interest groups that feel threatened by health system change. Some of these groups believe that the profit motive is not appropriate in health care. If these parties are successful in stifling the conversion process, nonprofit hospitals will be cut off from the very source of capital that is required to sustain them.

The programs that, in large measure, produced our world-class health care system were the Hill-Burton Act, Medicare, and Medicaid. These programs and a variety of other smaller ones provided the capital needed to build and maintain the nation’s health care infrastructure. Hill-Burton did it by providing direct capital grants to construct hospitals; Medicare and Medicaid did it by providing cost-based reimbursement, which enabled virtually any hospital to obtain unlimited capital (usually debt) by passing the capital cost to government. However, laws now on the books are bringing the era of government-backed capital to an end.

Capital is the vital ingredient that creates, sustains, and renews any enterprise. The fact that government will no longer guarantee access to capital does not diminish the need for capital. On the contrary, the need to develop competing, fully integrated health care systems, together with accelerating technological advances, make the need for capital greater than ever. With government guarantees disappearing, most health care capital must be acquired the “old-fashioned way”: It must be earned, based on the credit worthiness and value of the enterprise.

Sources Of Capital

Equity investment. Equity capital is arguably the most important source of nongovernment-backed capital. Equity investors, unlike debt holders, are willing to be compensated for their capital contributions through the growth in the value of the enterprise and often are willing to allow the earnings of the enterprise to be reinvested, which provides additional capital. Columbia/HCA, for example, routinely reinvests about 95 percent of its earnings in technology, facilities, and strategic acquisitions of additional health care assets. In fact, Columbia/HCA’s capital investment per bed is 41 percent higher than the average for nonprofit hospitals, even after excluding the cost of new acquisitions.

Since 1992 equity investors have infused the nation’s health care system with more than $100 billion. Hospitals are the second-largest beneficiaries of this capital, exceeded only by health maintenance organizations (HMOs). Because of this infusion of new capital...
equity capital and the hospital industry’s ability to refinance old debt on more favorable terms, we have not seen a major shortage of capital in most nonprofit hospitals. What may be an ominous indicator of the coming problem, however, is evident in the concern expressed by the Greater New York Hospital Association at the prospect of curtailing a loan guarantee program of the Federal Housing Administration. In a plea to President Clinton, the association said that scaling back the program “would threaten the economic viability of our hospitals.”

Charitable contributions and tax exemptions. As Medicare completes its transition away from the capital pass-through and state after state transforms its Medicaid program to managed care, tax-exempt health care organizations will be left with only “charitable contributions” and the “tax exemption” on their debt as their sources of capital, to offset the advantages of investor-owned systems’ access to the vast equity capital markets. Clear-thinking executives in the tax-exempt hospital sector recognize that this is not a winning formula as we enter the twenty-first century. They have worked to align their hospitals through an outright sale of the assets or joint ventures with investor-owned companies. Laws that are already in place in most states governed the process and ensured that a reasonable value was paid for the assets that were transferred.

Concerns About Conversions

Some are seeking new laws to “protect” our communities from perceived threats. Generally, these concerns fall into four categories: the impact of nonprofit hospital conversions on the price of health care, quality of care, provision of uncompensated care, and the communities in which they are located.

Price of health care. In the debates surrounding nonprofit hospital conversions we hear the concern that investor-owned hospitals charge more than tax-exempt hospitals charge. Anyone with a casual knowledge of today’s health care system understands that charges are a relic of the past that have little relevance to the real price paid by or on behalf of consumers. A much better indicator is the net price per discharge, which can be obtained from the cost reports of the Health Care Financing Administration (HCFA). The Center for Healthcare Industry Performance Studies (CHIPS) collects and adjusts these data for differences in case-mix complexity and in the cost of living among regions. The CHIPS data for 1995 demonstrate that Columbia/HCA had the lowest net price per discharge ($4,393) compared with other categories of hospitals. Tax-exempt, church-operated hospitals had a net price per discharge of $5,315; investor-owned (non-Columbia) was $4,709; and tax-exempt, other, was $4,516.

The principal reason for Columbia’s competitive prices is a lower cost structure. One recent report found that Columbia’s cost per discharge was more than 5 percent lower than the state median cost per discharge in Florida, Tennessee, and Texas, some of Columbia’s most established markets.

Quality of care. Although the measurement of quality is still evolving, a number of indicators—primarily those of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)—are widely viewed as credible. The JCAHO awards “Accreditation with Commendation” to those hospitals that demonstrate exemplary performance as measured by the rigorous standards of the accreditation process. Investor-owned hospitals, led by Columbia, dominate this important indicator of quality. Some 36 percent of Columbia hospitals have received the award, compared with only 8.5 percent of non-Columbia hospitals. Since 1993 HCIA, Inc., and William M. Mercer, Inc., have developed a model of high performance for general acute care hospitals. The model is used to identify 100 of the top-performing hospitals that excel on measures related to clinical practice, operations, and financial management. The 1996 study uses indicators that stress quality, efficiency, and sustainability. Whereas only 15 percent of U.S. hospitals are investor-owned, 27 percent of HCIA/Mercer’s top 100 hospi-
tals are investor-owned. Columbia hospitals, representing only 7 percent of the nation’s hospitals, make up 17 percent of the top 100 hospitals. Even more impressive, more than one-third of the hospitals in the 1996 top 100 that were also in the 1995 top 100 are Columbia hospitals.

Finally, investor-owned hospitals are constantly measuring patient satisfaction. Each calendar quarter, the Gallup organization surveys hospital patients to determine their level of satisfaction with their hospital experience. About 94 percent of Columbia’s patients were satisfied or very satisfied with the care they received in Columbia hospitals in 1996, compared with 88 percent in a national sample of patients in non-Columbia hospitals.10

Uncompensated care. A recent study by Gary Young and colleagues of seventeen tax-exempt hospitals that were acquired by investor-owned companies between 1980 and 1992 found that the acquired hospitals provided slightly more uncompensated care as investor-owned hospitals than they did when they were under tax-exempt ownership.11 Other data also provide strong evidence that investor-owned hospitals generally provide nearly equivalent amounts of uncompensated care compared with tax-exempt hospitals. The Prospective Payment Review Commission found that tax-exempt and investor-owned hospitals in 1996 provided 4.5 percent and 4 percent, respectively, uncompensated care.12 In addition, data published by the Georgia State Health Planning Agency show that tax-exempt and investor-owned hospitals provided 3 percent and 2.7 percent, respectively, uncompensated care.13

Most of the confusion surrounding this issue comes from proponents of the status quo. By combining the uncompensated care provided by public hospitals with the uncompensated care provided by tax-exempt hospitals, they greatly distort the contribution of tax-exempt hospitals. Most uncompensated care provided by public hospitals is financed with tax dollars. Investor-owned hospitals, as tax payers, have a far greater claim to credit for the care provided at public hospitals than do tax-exempt hospitals that contribute little or nothing to financing these tax subsidies. In fact they receive tax exemptions themselves that offset or more than offset their own uncompensated care costs.

Effect on communities. Another concern is that money will leave the community or that the hospital will be closed if it becomes investor-owned. Still other concerns are that “community benefits” will be lost and local “community” control will be sacrificed and that the charitable assets of nonprofit hospitals will be undervalued.

Money. The concern that money will leave the community is flawed for two reasons. First, many tax-exempt hospitals are not owned by the community. They are instead owned by large, sometimes multistate or even multinational organizations. This concern might be more appropriate when tax-exempt hospitals are acquired by other tax-exempt hospitals, because these acquisitions are subject to virtually no regulatory oversight and often result in control of the charitable assets moving from a local board to an out-of-state organization. Two recent examples are the New England Medical Center’s announcement of its intent to be acquired by LifeSpan, a Rhode Island tax-exempt corporation, and the acquisition of Samaritan Health Systems in Phoenix by Catholic Healthcare West, a California tax-exempt corporation. In both cases, control of both the physical and financial assets moved from a local board to an out-of-state board, which was given full authority to use the assets to benefit its operations in other communities or states.

Second, investor-owned companies, with their access to large amounts of capital, tend to invest more in their hospitals than their tax-exempt counterparts do. This translates into more construction and more state-of-the-art equipment with all of the economic (that is, jobs) and quality-of-care benefits flowing to the local community.

Hospital closure. U.S. hospitals have significant excess capacity, and therefore hospital closures will likely continue to occur. There is no evidence, however, that they are any more
likely to occur under investor ownership than they are under tax-exempt ownership. The American Hospital Association (AHA) reports that during the period 1985–1994 there were 730 U.S. hospital closures. Fewer than 3 percent of these, or twenty closures, involved Columbia hospitals.\textsuperscript{14}

Community benefits. Nonprofit hospitals’ tax exemptions are based on the premise that these hospitals provide community benefits, a poorly defined concept that is subject to various interpretations. These benefits range from uncompensated care to health fairs and sometimes include non-health-related activities. The most comprehensive study of this issue was performed by the Virginia Joint Commission on Healthcare in 1995. The commission quantified everything that could reasonably be considered a community benefit, including the taxes paid by investor-owned hospitals, and concluded that state teaching hospitals provided the highest level of community benefit. The commission further concluded, however, that investor-owned hospitals contributed much more than their tax-exempt counterparts did.\textsuperscript{15}

Valuation. Finally, the issue of the valuation of assets is clearly a valid concern but not one that requires additional law. In every state, the law already requires that the trustees of tax-exempt hospitals guard the assets of these institutions. The valuation of a hospital is a complex undertaking. Trustees routinely obtain independent determinations of value when they consider a proposal for conversion. Legislation that would turn this process over to the government or make oversight so burdensome that it has that effect will essentially politicize what is and should remain a professional judgment. Attorneys general already have sufficient authority to ensure that sound professional judgment is used. In some instances, like the California bill enacted last year (A.B. 3101), improvements in the process of legitimate oversight may be needed. But we should be very cautious about turning valuation over to the political process.

Concluding Remarks

The situation that places nonprofit hospitals’ charitable assets in the highest degree of danger is a political process that by either bureaucratic inertia or political intimidation deprives nonprofit hospital trustees of the ability to protect these assets. It is apparent from available data that the fears being used to justify greater government intrusion are not valid. Increasingly, the best option available for tax-exempt hospital trustees is to sell to or partner with investor-owned hospitals. Without access to the capital that government once guaranteed, the only viable source of capital is investors. If government blocks or unnecessarily complicates the path to this capital, it will imperil the quality of the health care system. We should all work together to lower our rhetoric and look carefully at the facts, to assure that we make the right decisions for ensuring high-quality patient care.

NOTES

4. Ibid.
7. Data for this calculation were obtained from the Center for Healthcare Industry Performance Studies, Columbus, Ohio.
8. The New Competitive Standard for Hospitals.
13. Data were obtained from the Georgia State Health Planning Agency.
14. Personal communication with American Hospital Association staff.