

PROFIT POTENTIAL

Revisiting New York's Restrictive
Hospital Ownership Laws

By Bill Hammond

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ABOUT THE AUTHOR

Bill Hammond is the Empire Center's director of health policy.

An award-winning journalist with almost three decades of experience, Bill most recently worked as a columnist and editorial board member at the *New York Daily News* from 2005 to 2015. He has written extensively about the financial struggles of hospitals, the danger of medical errors, abuse and neglect of mental patients, controversies about managed care, the halting process of President Obama's health reform law and the many attempts at Medicaid reform by Governors Pataki, Spitzer, Paterson and Cuomo.

Before joining the *News*, Hammond previously wrote for *The New York Sun*, *The Daily Gazette* of Schenectady and *The Post-Star* of Glens Falls. His work has also appeared in *The Wall Street Journal*, POLITICO New York, the *New York Post* and *The 74*.

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EXECUTIVE SUMMARY

An unusual feature of New York’s health care system is its lack of for-profit hospitals, which are common in the rest of the country.

Their absence is the result of unique state laws, which effectively ban hospital ownership by publicly traded corporations and discourage for-profit ownership generally.

This policy not only sets New York’s hospital industry apart from those in most other states, but also from the rest of the state’s health care system, where for-profit ownership is prevalent.

Much has changed about hospitals, and health care generally, since these laws took their current form in the mid-1960s – raising the question of whether they are well-suited to 21st century conditions.

In recent years, Governor Andrew Cuomo and others have proposed authorizing for-profit ownership of a limited number of hospitals as a way of spurring private investment in financially troubled facilities. One such demonstration project passed the state Senate in 2015 but was not taken up by the Assembly.

Opponents of the proposals raised concerns that for-profit hospitals would tend to provide lower-quality care, charge higher prices and avoid serving lower-income and uninsured populations.

Beyond the limited debate on those measures, the effectiveness of the state’s hospital ownership laws has gone largely unexamined.

To explore the merits of the current policy, this report:

- Analyzes nationwide financial and quality data to compare the condition and performance of New York’s hospital industry to those of other states.
- Surveys the research literature on differences between for-profit and not-for-profit hospitals.
- Estimates the lost revenue associated with the tax exemptions of not-for-profit hospitals.
- Explores the value of “community benefits” reported by 20 of the state’s largest not-for-profit hospitals.
- Inventories the state’s increasing expenditures on capital grants for hospitals and other health care facilities.
- Reviews the effect on New York’s dialysis clinics when corporate, for-profit ownership was authorized in 2007.

Overall, this report finds no evidence that ownership restrictions have produced a public benefit in terms of the quality, cost or accessibility of hospital care. To the contrary, New York’s hospitals are characterized by lower quality scores,

Chart 1. How New York’s Hospitals Stack Up

Benchmark	Metric	Ranking
Average CMS Hospital Compare star rating	2.32 out of 5	50 th
Average <i>Consumer Reports</i> Safety Score	48.7 out of 100	47 th
Percent graded “A” by Leapfrog	5.8%	48 th
Aggregate operating margin*	-10%	49 th
Aggregate liabilities-to-asset ratio*	72%	50 th
Unpaid care as a percentage of NFP revenues	1.9%	42 nd
Average length of stay**	6.9 days	45 th
30-day readmission rate	16%	50 th
Average age of plant*	15.9 years	46 th
Per capita hospital spending**	\$3,633	14 th

*Sources: CMS Hospital Compare, Consumer Reports, Leapfrog Group, CMS hospital cost reports, American Hospital Association, CMS National Health Expenditures * 2015 **2014*

higher spending and more economic segregation than their national peers. This suggests that restricting ownership has not been an effective regulatory approach. (See Chart 1.)

On the question of comparative quality between for-profit and not-for-profit hospitals, the evidence is mixed – with some research showing that for-profits tend to be of lower quality than not-for-profits, on average, and other research showing little or no difference. Meta-studies indicate that the former outnumber the latter.

Behind those averages are variations in performance among all ownership types, with some for-profit hospitals meeting high standards, and some not-for-profits falling short. A policy that discriminates on the basis of for-profit ownership will thus exclude high-quality for-profit hospitals while failing to exclude low-quality not-for-profits.

On accessibility to the poor, federal financial data show little if any difference between for-profits and not-for-profits. Both ownership categories treat Medicaid patients and provide free care for the poor at roughly the same rate – a pattern that could be expected to apply in New York as well.

Financially, authorizing for-profit ownership would have certain inherent advantages. By definition, for-profit hospitals are not tax-exempt and therefore generate revenue for government – revenue that could be particularly significant at the local level. For-profits also tend to have higher operating margins and readier access

to capital funds, meaning they are less likely to need government assistance to modernize facilities and maintain fiscal health.

With the industry nationwide in a period of consolidation, many New York hospitals are contemplating changes in ownership, such as joining networks or being acquired by larger institutions. Others are struggling with operating losses and heavy debt loads that put them in jeopardy of closure.

Authorizing for-profit ownership would potentially give hospital leaders facing these situations a broader menu of options. It would open the door to previously untapped sources of capital and—if and when an institution chooses to become for-profit—provide additional tax revenues for state and local government.

A 2014 study in the *Journal of the American Medical Association* found that hospitals converting to for-profit ownership generally improved their financial strength without significantly affecting their quality of care or the share of low-income and minority-group patients they treated.

Changing ownership laws, by itself, would not be enough to fully address the issues of quality, financial condition and access facing New York's hospitals—which deserve further exploration. However, the evidence suggests that the potential benefits of allowing for-profit investment in hospitals would outweigh the potential risks.

Key findings:

- Despite a concentration of world-famous institutions in Manhattan, New York's hospitals collectively rank at the bottom of the federal government's quality ratings and score substantially lower than the national average on other major report cards.
- The amount of free care provided by New York's not-for-profits in 2015—1.9 percent of operating revenues—was a third lower than the national averages for both not-for-profits and for-profits.
- As of 2014, New York's per capita spending on hospital care was 19 percent higher than the U.S. average.
- Tax exemptions for New York's not-for-profit hospitals likely cost federal, state and local governments about \$2 billion a year.
- In spite of high spending on hospital care and their tax-exempt status, New York's hospitals collectively had the sixth-lowest profit margins, and the highest ratio of liabilities to assets, among the 50 states as of 2015. These factors compromise the hospitals' ability to raise capital.
- Hospitals are increasingly relying on government funds to finance capital projects. In just the past five years, the state has allocated \$3.8 billion in capital grants to hospitals and other health care providers.
- While for-profit hospitals score lower, on average, than not-for-profit hospitals nationwide, they score higher, on average, than New York hospitals of all types.

FOR-PROFIT VS. NOT-FOR-PROFIT

The primary difference between not-for-profit and for-profit hospitals lies in their respective governing structures.

For-profit hospitals are controlled by boards of shareholders with a fiduciary obligation to seek return on investment, while not-for-profits are overseen by boards of community volunteers with a duty to fulfill an institutional mission, i.e., providing medical care.

Another important difference is tax status: Not-for-profit hospitals are exempt from most federal, state and local taxes; for-profit hospitals are not. In return for their tax exemptions, not-for-profit hospitals are obliged to provide certain charitable benefits – although the standards for fulfilling that requirement are vague.

A third distinction concerns access to capital: Not-for-profit hospitals are eligible to borrow money through tax-exempt bonds, which carry lower interest rates than taxable bonds. For-profit hospitals, on the other hand, have the ability to raise capital funds by issuing stock, which can be a significant advantage.

Beyond these internal distinctions, both ownership types engage in effectively the same business: delivering medical care in return for payment. Both are subject to the same public health laws and regulations, negotiate fees with the same insurance plans, hire from the same pools of professionals and, to a large degree, serve the same types of patients. Both need to operate in the black to survive over the long term, and therefore take steps to maximize revenue while controlling costs.

The smallest category is government-owned hospitals, which are controlled, directly or indirectly, by elected officials and are legally accountable to the public. Often, they have a mandate to provide free or discounted care to the poor. They are exempt from taxation and, in many cases, receive direct subsidies from public funds to offset operating losses.

Ownership type does have some influence on hospital behavior. Research has shown that government hospitals are the most likely to offer unprofitable types of medical care, while for-profit hospitals are the least likely to do so.¹ Some comparative research has found that not-for-profit hospitals tend to outperform for-profits on measures of quality; other research suggests that the performance gap is small or nonexistent. (See *“What the Research Says,”* page 19.)

These patterns are not uniform: On quality report cards, there are high-scoring for-profit hospitals and low-scoring not-for-profits. Some for-profit hospitals provide a substantial amount of free care to the indigent, while some not-for-profits provide little or none.

To further blur the lines, many not-for-profit hospitals own for-profit subsidiaries, such as parking garages or medical office buildings, or contract with for-profit companies to provide management services.

Regardless of their not-for-profit status, New York hospitals are some of the biggest businesses in the state, employing hundreds of thousands of people and generating billions of dollars in revenue. The highest-paid not-for-profit hospital CEOs in New York received more than \$4 million in salary,² comparable to what some Fortune 500 executives make.

HOW NEW YORK'S LAW WORKS

New York's restrictions on for-profit ownership derive from three provisions of Article 28 of the Public Health Law, which regulates hospitals, nursing homes and other major health care facilities.³

The first provision, Section 2801-a(3), says that anyone seeking to own a hospital, even in part, must undergo a review of "character, competence, and standing in the community" by the state's Public Health and Health Planning Council, a branch of the Health Department. This review must include a check of the would-be owner's previous record as a health care provider.

The second provision, Section 2801-a(4), provides that all owners of a for-profit hospital must be "natural persons" – that is, no shares can be owned by corporations, such as investment banks or pension funds.

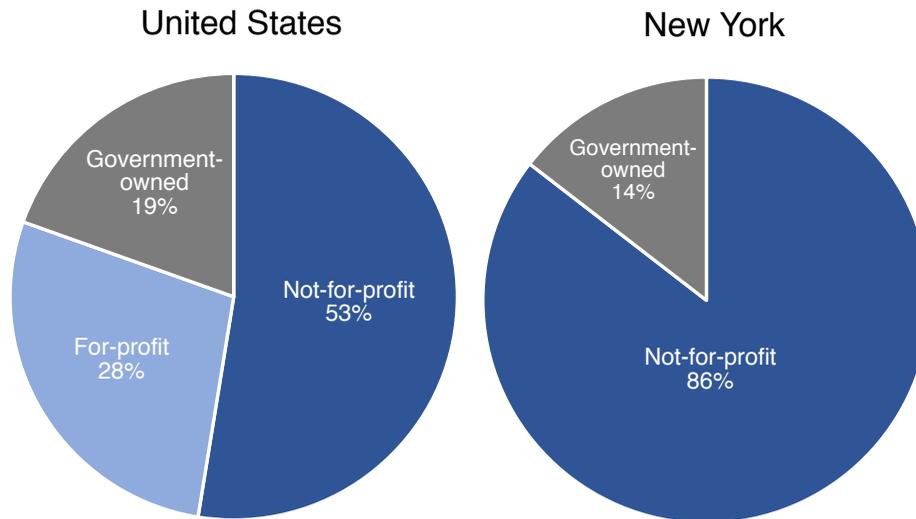
The third, also in subsection a(4), says any sale or transfer involving 10 percent or more of a hospital's value must be approved in advance by the state. For smaller transactions, the state must be given 90 days' advance notice.

Taken together, these three rules – mandatory background checks, no corporate ownership of shares and advance notice or approval of stock sales – make it impossible for publicly traded corporations to own hospitals in the state. Such companies have potentially thousands of stock holders who may or may not be natural persons, and their shares are bought or sold at a moment's notice, a system incompatible with background checks or state approval of ownership transfers.

The law theoretically leaves the door open to hospital ownership by some privately held companies – those with relatively few owners, each of which is a natural person who is willing to undergo a background check and accept limits on his or her future ability to sell shares. This model is common among the state's nursing homes.

However, for-profit ownership on those terms appears to have proven unviable in New York's hospital industry. The amount of capital necessary to buy and own a hospital is much larger than it would be for a nursing home. This makes it a

Figure 1. Hospital Ownership



Source: CMS hospital cost reports, 2015

riskier and less attractive investment for small groups of individuals, especially when they need the state’s approval before liquidating their investment at in the future.

The state’s last for-profit hospital to operate on those terms—Parkway Hospital in Queens—struggled financially for several years before closing its doors in late 2008.⁴

A NATIONAL OUTLIER

Due in large part to its ownership restrictions, New York is one of only a handful of states, and by far the largest, without a single for-profit hospital.⁵

Nationwide, for-profit hospitals are commonplace, representing 28 percent of institutions. The rest are not-for-profit (53 percent) or government-owned (20 percent). In New York, 86 percent of hospitals are not-for-profit, and the remainder are government-owned.⁶ (See Figure 1).

The precise ownership type of each for-profit hospital is not clear from federal data. However, seven of the eight largest for-profit hospital companies in the country—controlling more than 500 hospitals among them⁷—are publicly traded. The largest, HCA of Nashville, Tennessee, owns 177 hospitals in 20 states.⁸

In other states, changes in ownership status are common. A 2014 study in *The Journal of the American Medical Association* found 183 not-for-profit hospitals and 54 public hospitals that switched to for-profit ownership during the eight-year period from 2003 to 2010.⁹ No such conversions occurred within New York.¹⁰

Among other health care providers in New York State, as in the rest of the country, for-profit ownership is common, and in some cases dominant.

Sixty percent of the state's nursing homes are owned by for-profit companies,¹¹ along with two-thirds of its dialysis centers.¹² Many if not most private-practice physicians work in for-profit partnerships, which are increasingly consolidating into multi-specialty groups that compete with hospitals for outpatient surgery and other procedures.

Crystal Run Healthcare of Middletown includes more than 400 doctors in 50 specialties.¹³ With 2,300 employees at 25 locations,¹⁴ it ranks among the 10 largest private-sector employers in the Hudson Valley.¹⁵ (In January, Crystal Run finalized a partnership with Bronx-based Montefiore Health System.¹⁶)

For-profit and corporate ownership is also common if not dominant in the broader health care industry, including drug makers, medical equipment suppliers, pharmacies, clinical laboratories and insurers.

New York's restrictions on for-profit hospital ownership are thus an exception to the norm, both nationally and within the state. To justify continuing such a policy, lawmakers should verify that it serves to measurably improve health care — or that changing the policy would foreseeably worsen health care.

Previous comparative studies of hospital ownership have measured variation at the institutional level, looking at the relative performance of for-profit, not-for-profit and government-owned facilities on benchmarks of quality, cost, access and other indicators. An overview of that research is summarized below.

However, this analysis is primarily focused on the costs and benefits of a statewide policy, not institutional practices. Thus, it also looks at performance benchmarks by state, comparing the numbers for New York (with its unique restrictions) against data from the rest of the country.

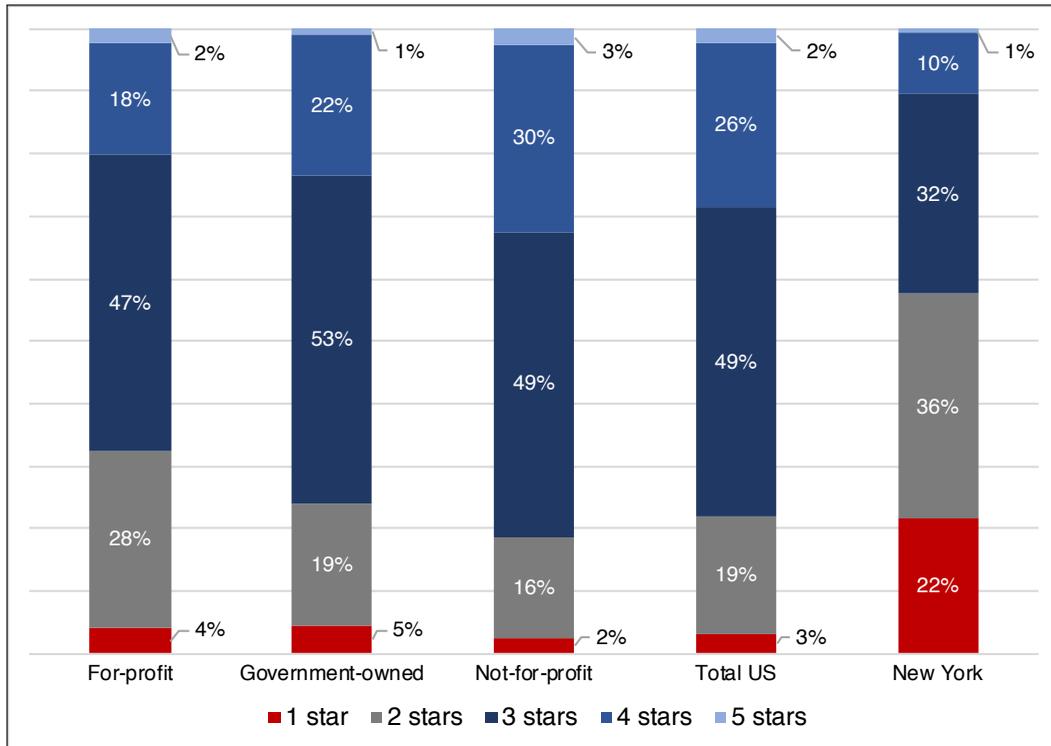
INTERROGATING NEW YORK'S POLICY

Have restrictions on for-profit hospital ownership resulted in higher quality care? On major hospital report cards, New York's average scores rank at or near the bottom.

If a policy of discouraging for-profit hospitals were effective in promoting better care, it would be expected that quality indicators for New York's hospitals would compare favorably to those of other states, where for-profit hospitals are common.

A review of hospital report cards shows the opposite: New York's hospitals, as a group, rank at or near the bottom.

Figure 2. Distribution of Hospital Compare Star Ratings, New York vs. U.S.



Source: CMS Hospital Compare

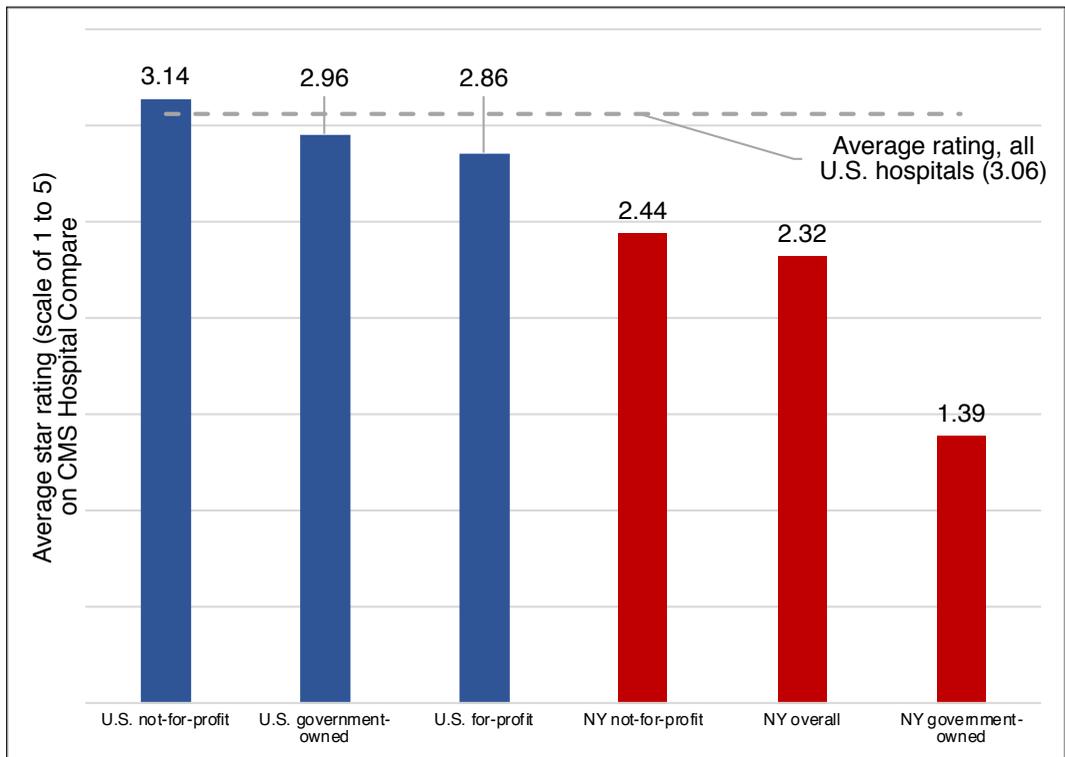
To be sure, New York is home to some of the best-regarded hospitals in the world. Of the 20 institutions on U.S. News & World Report’s 2017-18 Best Hospitals Honor Roll, three are located in New York City—New York-Presbyterian, Mount Sinai and NYU Langone—more than any other single city in the country.¹⁷ Memorial Sloan Kettering in Manhattan is the magazine’s second-best-ranked cancer center.

Taken as a whole, however, New York’s hospitals receive poorer average report card grades than those of most other states.

The federal Hospital Compare report card, published by the Centers for Medicare & Medicaid Services, recently began giving each institution a star rating based on 64 measures of quality—with one star being the lowest rating, and five the highest.¹⁸

The 153 New York hospitals graded by Hospital Compare as of early December 2017 received an average rating of 2.32 stars, the lowest among the 50 states. Only one institution in the state, the Hospital for Special Surgery in Manhattan, received the highest rating of 5 stars. Eighty-eight New York hospitals, or 58 percent of those rated, scored in the bottom two categories, compared to 22 percent for the nation as a whole.¹⁹ (See Figure 2.)

Figure 3. How New York’s Hospital Quality Stacks Up



Source: CMS Hospital Compare

Helping drag down New York’s average are especially low-scoring government-owned hospitals, with an average of 1.39. But the state’s not-for-profits, averaging 2.44 stars, would still rank 49th on their own.²⁰ (See Figure 3.)

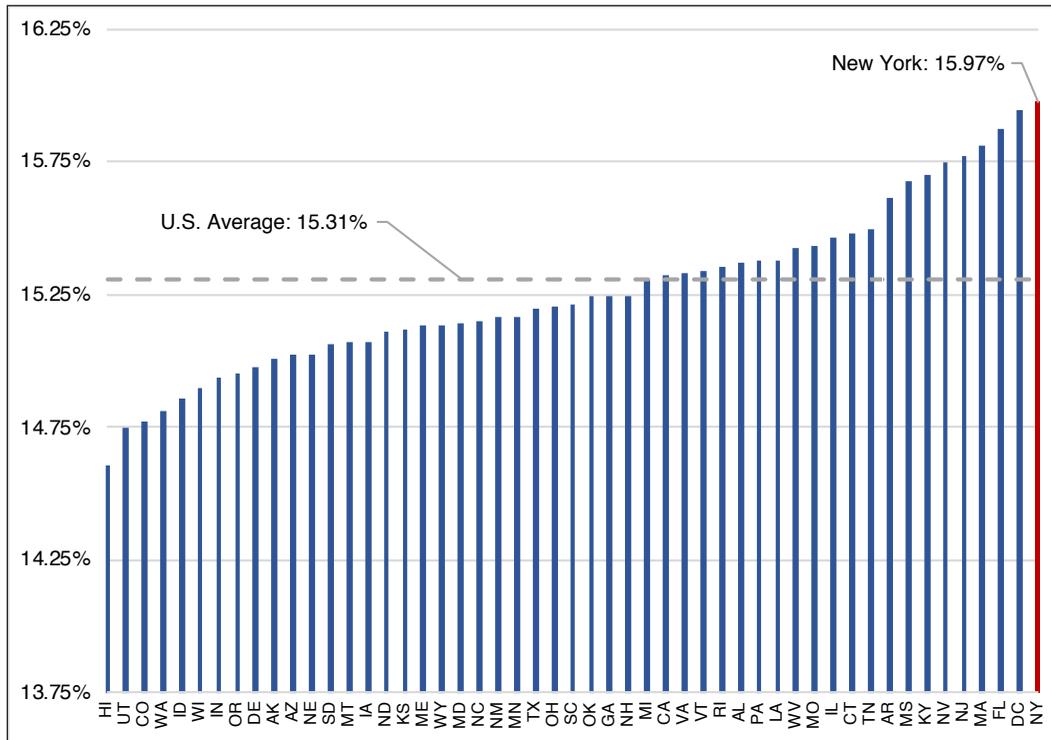
Other report cards paint a similarly unflattering picture of New York’s hospital system.

Based on “safety scores” published by *Consumer Reports* magazine, New York’s hospitals collectively rank 47th out of 50 states. Their average score was 47.2 out of 100, below the national averages for not-for-profit hospitals (53.9), public hospitals (51.1) and for-profit hospitals (50.0).²¹

Likewise, Leapfrog Group’s Hospital Safety Grades for spring 2018 ranked New York 48th out of the 50 states, with only 5.8 percent of hospitals receiving an “A.” Leapfrog does not break its grades down by ownership type.²²

Another common benchmark of overall hospital quality is the share of discharged patients who are readmitted within 30 days – which can be a sign of unsuccessful treatment or poor discharge planning. On this measure, based on federal data gathered by *Consumer Reports*, New York ranks last among the states.

Figure 4. Average 30-Day Readmission Rate by State, July 2015 – June 2016



Source: Consumer Reports

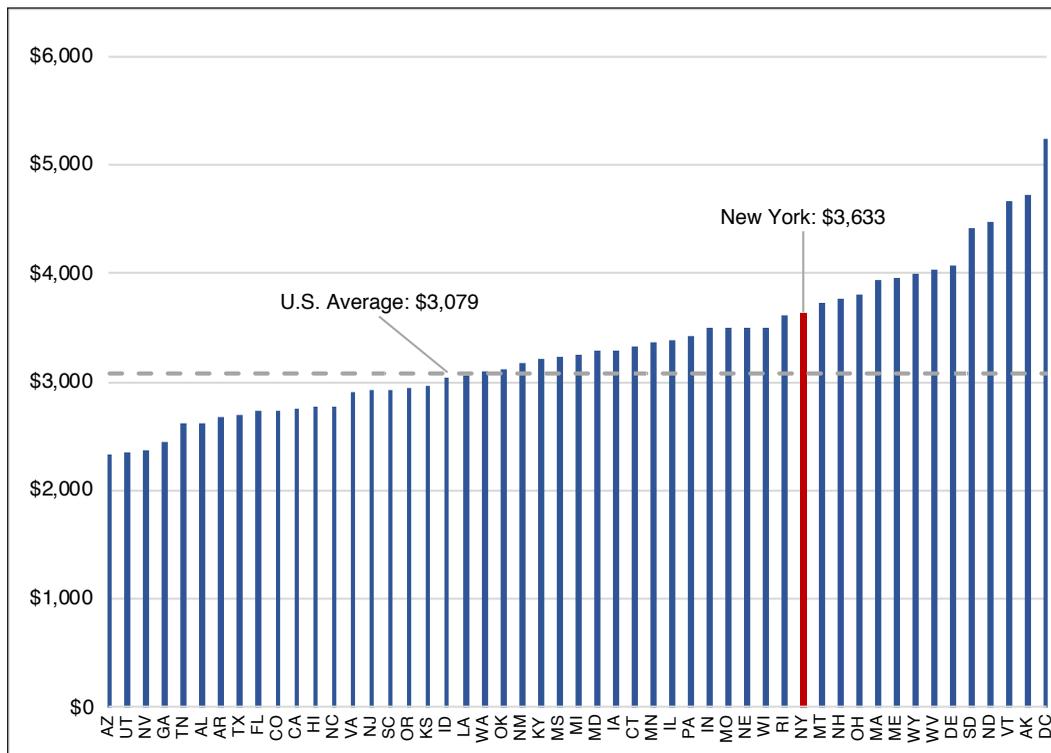
For the 12 months ending in June 2016, the average readmission rate for New York’s hospitals was 16.0 percent, compared to a national average of 15.3 percent.²³ That 0.7 percent gap between the state and national rates equates to about 15,000 more New Yorkers having to go back to the hospital after being discharged. (See Figure 4.)

Hospital officials warn that rating systems can oversimplify the complexities of health care in ways that are misleading and unfair.²⁴ Perhaps the most salient objection is that the major report cards do not adjust for socioeconomic status. Successfully treating patients who are poor or homeless, for example, can be especially challenging, and hospitals serving low-income neighborhoods generally receive lower quality scores.

It seems unlikely, however, that socioeconomic factors would fully explain why New York’s hospitals underperform those in much poorer, lower-spending states, such as Mississippi, New Mexico and Louisiana. (See “Do New York’s hospitals face unusual demographic challenges that would explain their low quality scores?,” p. 16.)

The evidence suggests that discouraging for-profit ownership, in and of itself, has not been effective in assuring high-quality hospital care.

Figure 5. Per Capita Hospital Spending by State, 2014



Source: CMS National Health Expenditures

Has the current policy resulted in lower hospital costs? New York has higher-than-average hospital spending and employment levels.

Along with low quality ratings, New York’s hospital system is characterized by high costs.

According to National Health Expenditures data from 2014, New York spent \$3,633 per capita on hospital care, which was 18 percent higher than the national average of \$3,079 and 14th highest among the states.²⁵ (See Figure 5.)

During the 10 years ending in 2014, the state’s per capita hospital spending rose by 44 percent, which was faster than per capita spending on prescription drugs and non-durable products (41 percent) or on physician and clinic care (36 percent).²⁶

New York’s high hospital spending could be partly explained by the state’s generally high cost of living and regulatory environment, which would tend to raise hospitals’ expenses for wages, energy and liability insurance. Indeed, New York’s overall health expenditures were 22 percent higher than the national average in 2014.²⁷

At the same time, the state's hospitals show signs of inefficiency. A common benchmark for hospitals is how long patients typically stay in the hospital before being discharged. New York's statewide average length of stay in 2014 was 6.9 days, a day-and-a-half longer than the national average of 5.5 and tied with Hawaii at sixth-highest among the states.²⁸

Another potential sign of inefficiency is found in employment data. As of 2016, there were 1,868 hospital employees per 100,000 New York residents, 20 percent higher than the national average.²⁹

There is little evidence to support the notion that restrictions on ownership have controlled costs.

Has the current policy resulted in broader access to hospital care for the poor? When adjusted for New York's higher Medicaid enrollment, the state's not-for-profit hospitals are no more accessible to the poor than non-government-owned hospitals in other states.

New York's not-for-profit hospitals collectively treat more Medicaid patients than their national counterparts. However, this appears to be almost entirely due to the unusual size of New York's Medicaid program.

New York's version of Medicaid – the government-sponsored health plan for the poor and disabled – is more than half-again larger than the national average. It covers 33 percent of the state's population compared to 21 percent for the country as a whole.

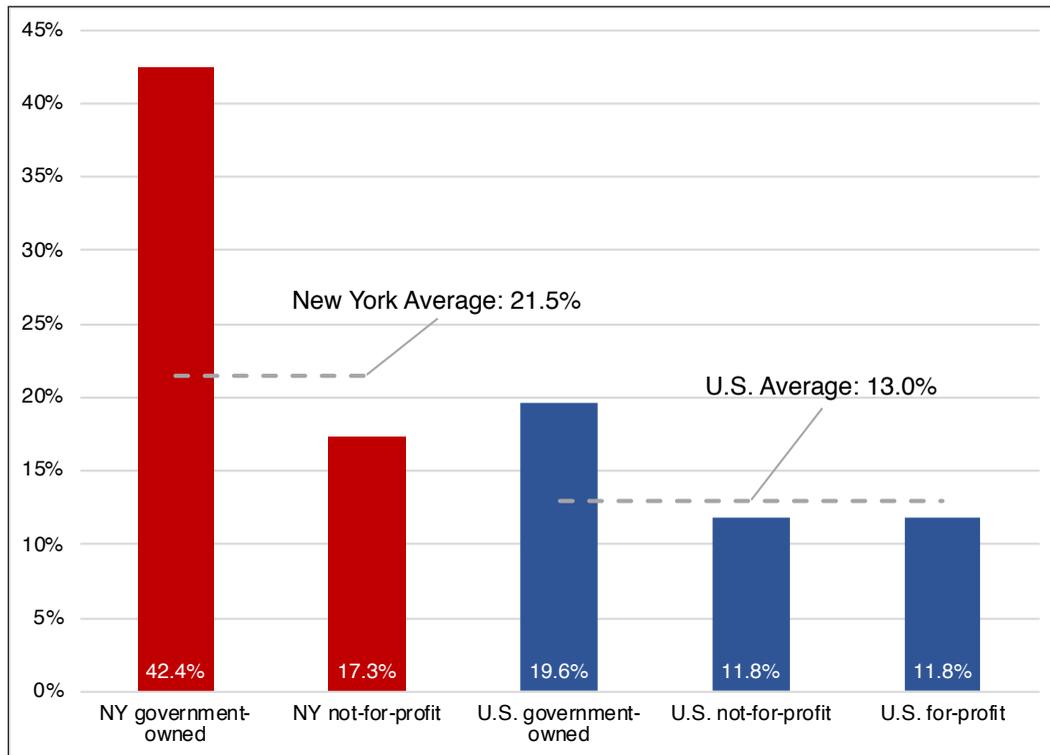
In financial terms, Medicaid accounted for 22 percent of hospitals' 2015 patient revenue in New York, compared to 13 percent nationwide.

Government-owned hospitals generally devote a larger share of their resources to treating Medicaid patients than private hospitals, whether for-profit or not-for-profit. In New York, that disparity is larger than for the country as a whole.

Nationwide in 2015, Medicaid accounted for 20 percent of revenue for government-owned hospitals and 12 percent of revenue for both for-profit and not-for-profit hospitals. Put another way, government-owned hospitals treated Medicaid patients at 151 percent of the average rate, while for-profit and not-for-profits treated them at 91 percent of the average rate. (See Figure 6.)

In New York, Medicaid accounted for 42 percent of revenue for government-owned hospitals and 17 percent for not-for-profits. Thus, New York's government-owned hospitals treated Medicaid patients at almost double the statewide rate (197 percent) while its not-for-profit hospitals treated them at 80 percent of the statewide rate.

Figure 6. Share of Revenues from Medicaid for Selected Hospital Categories



Source: CMS hospital cost reports, 2015

Proportionately, the disparity in care provided to Medicaid recipients between government-owned and private hospitals is greater in New York than in the nation as a whole. This suggests that excluding for-profit hospitals has not led to greater equality of access for the poor.

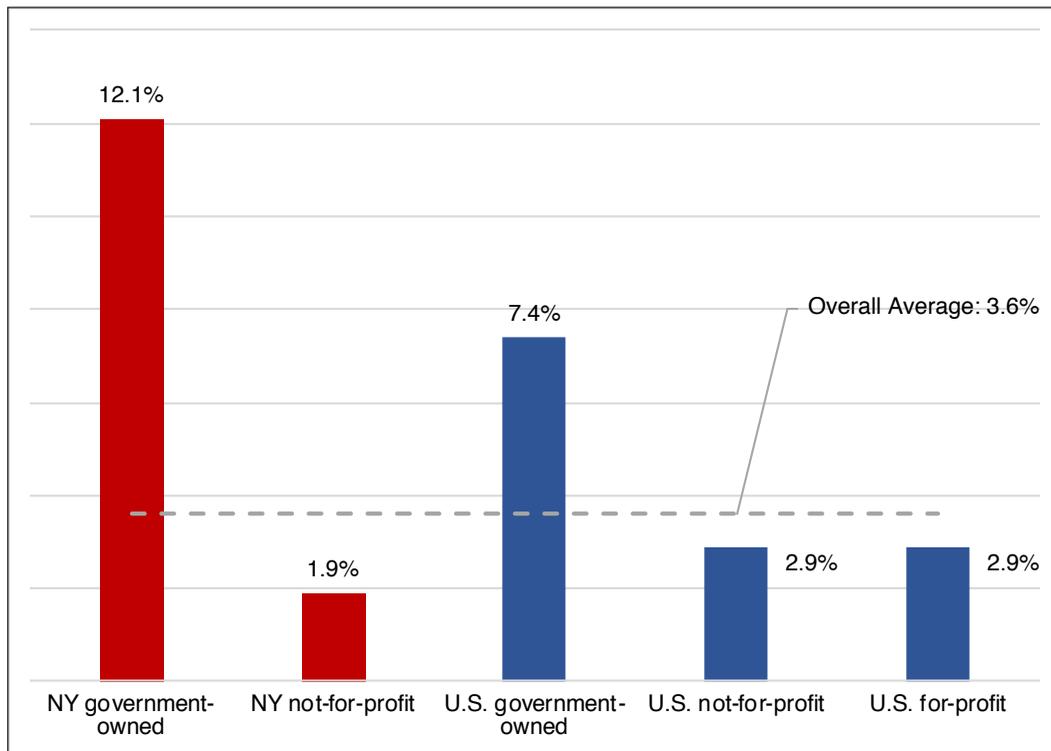
**Has the current policy resulted in greater availability of free care?
New York’s not-for-profit hospitals provide less uncompensated care than the national average, and less than for-profits in other states.**

Hospitals of all kinds are legally required to provide certain kinds of critical medical care regardless of a patients’ ability to pay. However, the amount of free care provided varies widely from institution to institution, based in part on local poverty and uninsured rates, but also based on ownership type.

Nationally, government-owned hospitals devote the largest share of their resources to free care, with private hospitals, both not-for-profit and for-profit, providing considerably less.

In New York, government-owned hospitals provide a larger share of uncompensated care than their counterparts in other states. Meanwhile, New York’s private

Figure 7. Uncompensated Care as a Share of Patient Revenue, 2015



Source: CMS hospital cost reports, 2015. (Uncompensated care = charity care + bad debt.)

hospitals—which are all not-for-profit—provide less uncompensated care than their peers nationwide.

By one measure of free care, New York’s not-for-profits are roughly on par with for-profit hospitals in other states. But by another measure, New York’s not-for-profits provide substantially less free care than for-profit hospitals in other states.

The first measure focuses on charity care—free services provided to patients who lack insurance and cannot afford to pay their full fees. The charity care provided by New York not-for-profit hospitals equates to just over 1 percent of patient revenue, compared to national averages of 1.5 percent for not-for-profits nationwide and just under 1 percent for for-profits.

The second measure is uncompensated care, which includes both charity care and so-called bad debt—which is the uncollected fees from patients who have insurance, but who fail to pay their full copayments and deductibles.

By this measure, the difference between New York and national norms becomes starker. The uncompensated care collectively provided by New York’s not-for-profits amounts to 1.9 percent of patient revenue—a third less than the 2.9 percent rate provided by both for-profit and not-for-profit hospitals nationwide. (See Figure 7.)

Nationally, government-owned hospitals provide uncompensated care about two and one-half times the rate of private hospitals, both for-profit and not-for-profit. In New York, the gap in uncompensated care between government-owned hospitals and not-for-profit hospitals is a factor of more than six.

One byproduct of the gaps in Medicaid care and uncompensated care is racial segregation in New York's hospital system, because minority groups are more likely to be on Medicaid and more likely to be uninsured than whites. A 2017 study found that black patients in New York City were two to three times less likely than whites to be treated at academic medical centers. In Boston, by contrast, black patients were overrepresented at academic medical centers.³⁰

This evidence suggests that New York's policy of discouraging for-profit hospitals is failing to foster charity care by not-for-profit hospitals and failing to avert segregation along economic and ethnic lines.

How does the quality of for-profit hospitals compare to not-for-profits? There is evidence that for-profit hospitals provide lower-quality care, on average, than not-for-profit hospitals—a gap that may have gotten smaller in recent years.

An informal review of comparative research on hospital ownership finds a mix of results. Studies showing higher performance among not-for-profits appear to outnumber those showing higher performance among for-profits. However, the variation within the two categories is greater than the difference between them. This means that higher-ranked for-profit hospitals outperform the lower-ranked not-for-profit hospitals, and vice versa. (See *"What the Research Says,"* p. 19.)

Some of the more recent research has found relatively little difference in quality between for-profits and not-for-profits, possibly suggesting that changing regulatory and market pressures have reduced the performance gap.

A 2014 study found, for example, that not-for-profit and government-owned hospitals converting to for-profit status improved their financial condition relative to a control group that did not convert, but saw no significant change in care quality or mix of patients.⁴⁰ The authors noted that these results contrasted with earlier research:

Most of the data on conversions are from the 1990s, and those data generally suggest that conversions were associated with higher [profit] margins but also higher mortality rates. However, these transitions took place during an era when national efforts such as the Hospital Compare program designed to monitor hospital quality were not yet in existence and prior to the emergence of powerful advocate groups focused on quality and safety, such as the Leapfrog Group. Thus, whether prior findings on conversions would hold today is unclear.⁴¹

Continued on page 17

Do New York’s hospitals face unusual demographic challenges that would explain their low quality scores?

The state’s population is not dramatically out of line with national norms on key measures and is healthier than average in some respects.

New York’s demographic profile includes concentrations of certain diseases, such as asthma and HIV, and a high poverty rate when adjusted for the cost of living. These and other factors could help to explain low quality scores and high costs for the hospitals treating those populations.

At the same time, the state offers unusually generous health coverage for low-income residents, and its population is healthier than average in some respects.

For example, the share of New Yorkers living below the Census Bureau’s “supplemental poverty measure” (a poverty level that is adjusted by the regional cost of food, clothing, shelter and utilities) was 17.9 percent for 2013 through 2015, the third highest among the 50 states.³¹ (New York’s unadjusted federal poverty rate for 2014 through 2016 was 13.4 percent, slightly below the national rate of 13.7 percent.³²)

However, the state’s Medicaid program covers about 33 percent of the population, which, as of 2015, was also third highest in the country. While the state’s adjusted poverty rate was about three percentage points higher than the national average, its Medicaid penetration rate was more than 10 points higher. Medicaid pays hospitals less than other insurers, but the broader coverage New York provides to

lower-income residents at least partly offsets the additional hospital expenses associated with treating the poor.

The share of New Yorkers lacking health insurance in 2016 was 6.1 percent, two-and-a-half points lower than the national average.³³

New York’s median age for 2016, 38.2, was only modestly higher than the national average of 37.7.³⁴ As of 2010, New York’s life expectancy at birth was 80.5 years, 1.6 years longer than the national average and seventh highest among the states.³⁵

New York’s adult obesity rate for 2016³⁶ and diabetes incidence rate for 2015³⁷ were both below average.

The state’s asthma and HIV rates are above average, but not extremely so. Eight states have more adult asthma and seven states have more HIV.³⁸

An estimated 3.5 percent of New York’s population in 2014 were undocumented immigrants. This was 0.4 points higher than the national average, but ranked behind eight other states and the District of Columbia.³⁹

Although this is not a comprehensive list of potential factors, demographics in and of themselves do not readily explain why New York’s hospital scores would rank so far below average.

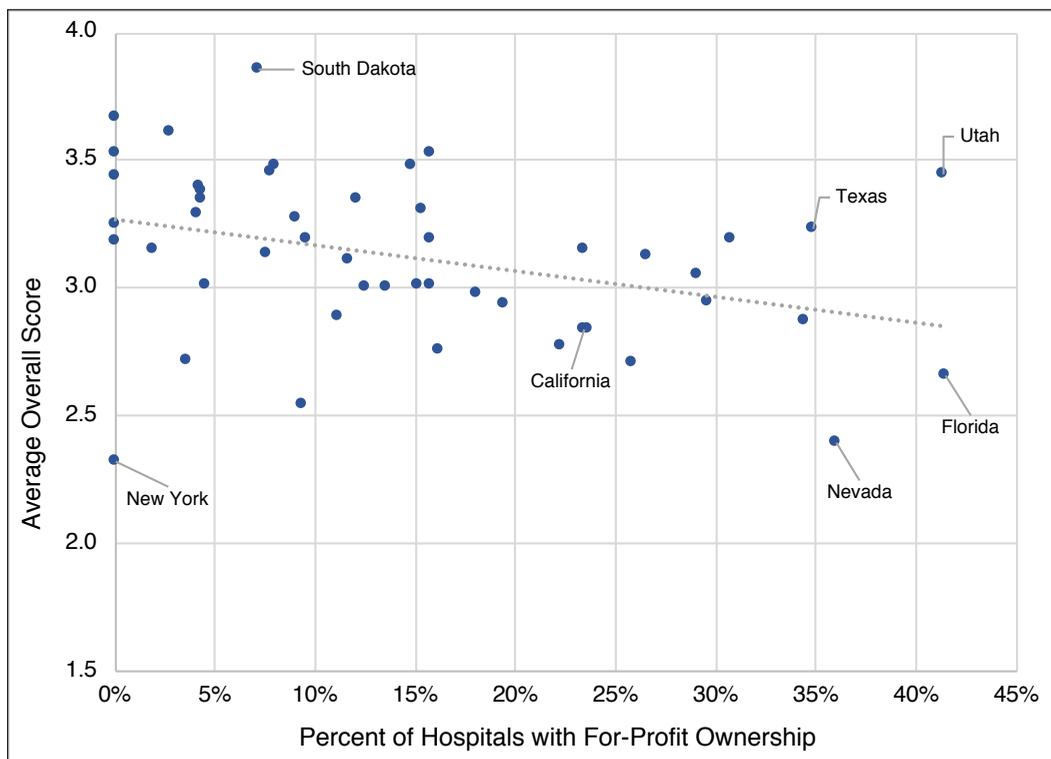
A related hypothesis is that for-profit hospitals may be especially responsive to programs that link reimbursement to quality benchmarks. A 2013 study analyzed data from almost 3,000 hospitals that participated in Medicare’s Hospital Inpatient Value-Based Purchasing Program, which offered higher reimbursement to facilities that achieved certain quality measures. Focusing on the hospitals’ performance on emergency care measures, the study found that for-profit hospitals as group achieved higher composite scores than not-for-profit and government-owned hospitals.⁴²

A nationwide comparison of ownership types using Hospital Compare data finds that not-for-profit hospitals received the highest average score of 3.14 stars. That was about two-tenths higher than the average for government-owned hospitals (2.96) and three-tenths higher than the average score for for-profits (2.86).⁴³

This points either to a continued performance gap, differences in the populations served or both. As the 2014 study explained, “Hospitals that converted to for-profit status were more often small or medium in size, located in the south, in an urban or suburban location, and were less often teaching institutions.”⁴⁴

Behind the average for each ownership type is a broad range of scores, indicating that ownership type, by itself, is not always predictive of quality.

Figure 8. Average Hospital Compare Rating vs. Percentage For-Profit Ownership, by State



Source: CMS Hospital Compare

Outstripping the difference between for-profit and not-for-profit hospitals nationally is the performance gap between hospitals in New York versus the country as a whole.

The average score among for-profits nationwide (2.86) was four-tenths higher than that of New York’s not-for-profits (2.44), and almost one-and-a-half points better than the average for New York’s government-owned hospitals (1.39).⁴⁵

Nineteen percent of for-profit hospitals received four stars or better, compared to 9 percent among all hospitals in New York, where for-profits are absent.

New York’s unusual situation is illustrated in Figure 8, a scatter plot juxtaposing the percentage of for-profit hospitals in each state against that state’s average score. The chart shows that the two metrics are negatively correlated – i.e., states with a higher percentage of for-profit hospitals tend to have a lower average quality score.

Among the outliers to this pattern is New York, which sits at the low end of both axes – and thus adds to the evidence that ownership type, by itself, is not enough to predict quality.

What is the cost of tax exemptions granted to not-for-profit hospitals? Do those hospitals provide community benefits commensurate with the value of their tax exemptions? The tax exemptions of New York’s not-for-profit hospitals cost approximately \$2 billion a year. The level of community benefits provided by not-for-profit hospitals varies widely, with no minimum standards imposed.

The tax exemptions of not-for-profit hospitals – which are some of the biggest employers in the state – represent a loss of government revenue that otherwise would be collected. Not-for-profit hospitals are exempt from paying both federal and state corporate taxes, along with state and local sales taxes and property taxes. The bonds issued on their behalf to finance capital projects are also often tax-exempt, and the donations they receive are tax-deductible.

As of 2011, the combined value of all not-for-profit hospital tax exemptions nationwide was an estimated \$24.6 billion, according to a study in *Health Affairs*. About half of that amount was federal exemptions, and the rest was divided between state and local exemptions.⁵³

The value of the exemptions in New York, with its relatively high taxes, was estimated at \$10 million per hospital, which ranked among the top 10 among the 50 states.⁵⁴ That translates to almost \$2 billion in lost revenue – half for the federal government, and half for state and local governments.

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What the Research Says

1997

A study of financial data for 6,227 hospitals in 1990 and 1994 found that for-profit hospitals had both higher administrative costs and higher costs per discharge than either not-for-profit or public hospitals.⁴⁶

2000

An analysis of Medicare data from 3,991 hospitals from 1984 through 1994 found mortality rates among elderly heart-disease patients were between 0.3 and 1 percentage points higher in for-profit hospitals than not-for-profit hospitals. However, the authors attributed much of the disparity to differences in location. “When we compare hospital quality within specific markets, for-profit ownership appears, if anything, to be associated with better quality care.”⁴⁷

2002

In a meta-analysis of 15 observational studies involving 36 million patients treated between 1982 and 1995, 11 studies showed mortality rates were lower at not-for-profit hospitals, three found that mortality rates were lower at for-profit hospitals and one study found no difference. Combining results, the authors estimated that overall risk of death was 2 percent higher at the for-profit hospitals.⁴⁸

2003

A meta-analysis of 149 comparative studies on quality of care, cost-efficiency and charity care found that 59 percent showed not-for-profits to be superior, 12 percent favored for-profits, and 29 percent saw no difference or mixed results.⁴⁹

2010

An analysis of data from 10 states found that not-for-profit and for-profit hospitals “appear to provide a similar amount of uncompensated care while government hospitals provide significantly more.”⁵⁰

2013

A study of federal emergency department performance data from 2,927 hospitals from 2008 to 2010 found that for-profit hospitals achieved a median score of 50, compared to 35 for not-for-profit hospitals and 30 for non-federal government-owned hospitals.⁵¹

2014

A study found that hospitals converting from not-for-profit or government-owned to for-profit status improved their financial condition without significantly affecting quality of care, mortality rates or the proportions of poor and minority patients served. The study compared 237 converting hospitals to a control group of 631 not-for-profit and government-owned hospitals from 2003 to 2010.⁵²

In their federal cost reports for 2015, New York's not-for-profit hospitals reported owning \$29.5 billion in land and buildings that would otherwise be subject to property taxes. Tax rates vary widely from place to place, but the state Department of Taxation and Finance calculated the average full-value rate for 2015 at \$28 per \$1,000.⁵⁵ Using that figure as a rough benchmark, hospitals collectively saved about \$826 million in unpaid municipal, county and school property taxes.

The impact on individual communities can be significant. The assessment roll of the city of Albany for 2017 put the combined value of property owned by the city's two hospital systems—Albany Medical Center and St. Peter's—at \$797 million.⁵⁶ As for-profit businesses, they would owe about \$35 million in city, county and school taxes.⁵⁷

The approximate school tax they avoid, at about \$22 million, is the equivalent of 19 percent of the city's school district's tax levy—meaning that if the hospitals were fully taxable, the burden on other Albany property owners would be 19 percent less.⁵⁸ For a home assessed at \$200,000, that would translate to an annual tax savings of more than \$800.

In 2016, Albany Medical Center announced it would voluntarily make a \$500,000 payment in lieu of local taxes—a gesture welcomed by city officials, but a fraction of what it would owe as a profit-making business.⁵⁹

In return for tax protection, hospitals and other charitable enterprises are expected to generate a corresponding benefit to the community. In the past, not-for-profit hospitals could satisfy that expectation simply by providing health care, which was seen as inherently beneficial to society.

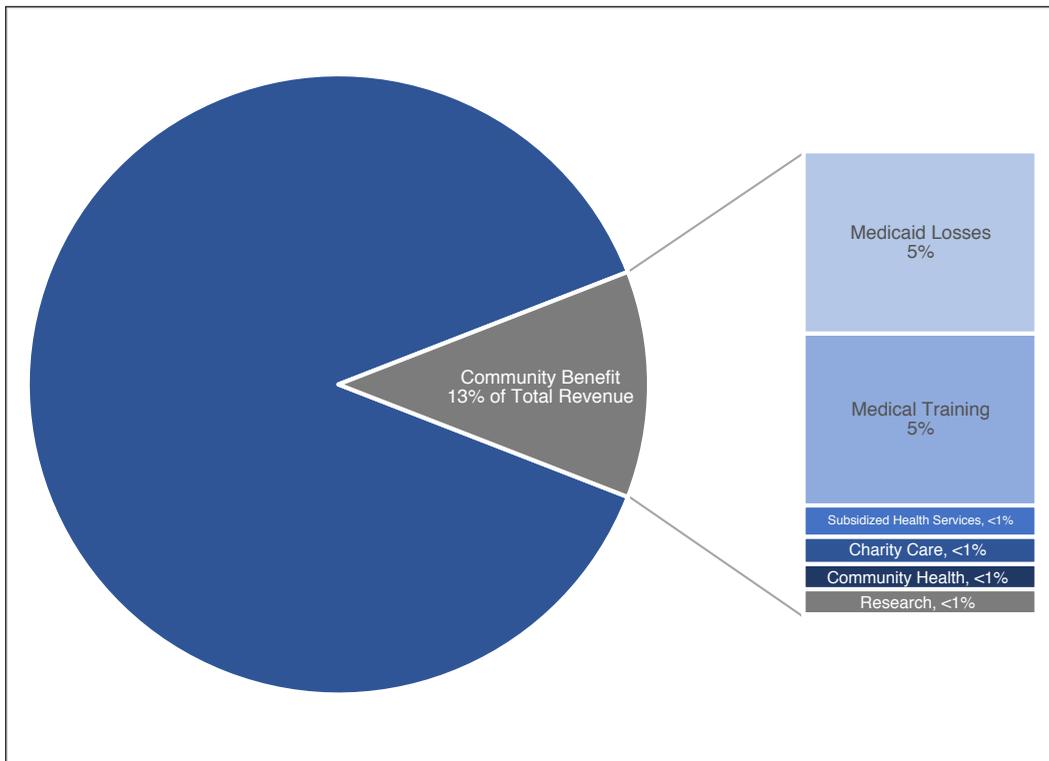
In more recent years, as health care delivery has become more businesslike and lucrative, hospitals have come under increasing pressure to document their charitable activities—and there have been calls for establishing minimum community-benefit standards that hospitals would have to meet in order to retain not-for-profit status.

Hospitals are obliged to document their community benefit activities in a special section of their annual filings with the IRS, known as Form 990s.

A review of those forms for the state's 20 largest hospitals shows that they collectively reported \$4.1 billion in community benefits, or 13 percent of their aggregate revenue.⁶⁰ (See *Figure 9*.)

More than one-third of that amount, or about 5 percent of revenues, was the reported cost of “graduate medical education”—i.e., training for young physicians who have finished medical school but not yet been licensed. Some critics question whether this expense should count as community benefit, since GME is otherwise subsidized by Medicare, physicians in training are a source of low-cost labor for teaching hospitals and many doctors leave the state after completing their training.

**Figure 9. ‘Community Benefit’ Spending
By New York’s 20 Largest Hospitals**



Source: IRS Form 990s, 2016

The next largest share of the 20 hospitals’ community benefits (or 5 percent of their revenues) were losses incurred treating patients on Medicaid and other means-tested government programs, which typically pay less than private insurance. For-profit hospitals sustain similar losses when they treat patients in these programs.

The remainder of reported community benefits, each amounting to less than 1 percent of revenues, was divided among charity care, research, contributions to charities, “subsidized health services” and “community health improvement.”

Even after accounting for the cost of community benefits, the 20 hospitals’ revenue exceeded expenses by \$1.1 billion, or 3.4 percent.

For-profit hospitals do not file Form 990s and are not required to disclose community benefits. As discussed above, however, for-profit hospitals on average provide as much or more Medicaid and charity care as New York’s not-for-profits do, even as they pay full taxes.

How would allowing for-profit ownership affect capital investment in hospitals? Changing ownership laws would open the door to an infusion of private investment in New York’s hospitals, potentially mitigating a growing expense for the state.

Like other businesses, hospitals need regular infusions of capital funds to expand or modernize facilities and purchase major equipment.

Hospitals of all ownership types raise capital by setting aside a portion of annual profits and by borrowing money through loans and bond issues. Not-for-profit hospitals can also solicit charitable donations toward capital projects.

In New York, state government has made available billions in capital grants for hospitals and other health care institutions (discussed further below).

Unlike not-for-profit and government-owned facilities, for-profit hospitals have the additional option of raising capital from private investors, either by selling ownership stakes in a private company or issuing shares of stock to the public.

As a result, for-profit hospitals as a group carry far less debt. In financial statements for 2015, for-profit hospitals reported aggregate liabilities equal to 11 percent of their assets, compared to 45 percent for not-for-profit hospitals.

For-profit hospitals also realized higher profits in 2015—averaging 11 percent, compared to 5 percent for not-for-profits nationwide—which further enabled higher levels of capital investment.

Some of New York’s hospitals maintain consistently positive operating margins and have relatively little trouble raising capital through borrowing and contributions. Others frequently lose money and already carry heavy debt loads. Often these are the hospitals most in need of investment to improve their facilities.

As a group, New York’s hospitals face more capital challenges than their not-for-profit counterparts in other states.

The overall liabilities-to-asset ratio for New York hospitals in 2015 was 72 percent, the highest of any state. Among not-for-profits alone, it was 66 percent, compared to a national average of 45 percent.

New York’s not-for-profits also realized aggregate margins of just 1.8 percent in 2015, barely one-third the national average for not-for-profits of 5.2 percent—leaving them relatively little money to allocate for capital.

One symptom of a chronic shortage of capital funds is that New York’s hospitals have some of the oldest facilities in the country, with an average age-of-plant of 15.9 years, 22 percent higher than the national norm.⁶¹

Chart 2. Taxpayer Funded Capital Grants for Health Care

Program	Fiscal Year	Amount
Capital Restructuring Financing Program	2015	\$1.2 billion
Health Care Facility Transformation Program: Kings County	2016	\$700 million
Health Care Facility Transformation Program: Oneida County	2016	\$300 million
Essential Health Care Provider Support Program	2016	\$355 million
Health Care Facility Transformation Program: Statewide	2017	\$200 million
Health Care Facility Transformation Program: Statewide II	2018	\$500 million
Health Care Facility Transformation Program: Statewide III	2019	\$525 million
	Five-year total	\$3.78 billion

Sources: NYS budget documents

Given these conditions, New York’s hospitals have increasingly looked to state government for capital support. In March 2016, for example, the Healthcare Association of New York State (HANYS), a trade group for hospitals and nursing homes, included the “urgent need for capital funding” on its list of budget requests from the state Legislature.

“New York’s average statewide hospital operating margin is the second worst in the country and far below the national average—and our health care facilities are the sixth oldest in the nation,” the HANYS statement said.⁶²

The state has traditionally supported the capital needs of hospitals by providing low-interest, tax-exempt loans through bonds issued by the Dormitory Authority. More recently, the state has also provided outright grants.

The HEAL-NY program (short for Healthcare Efficiency and Affordability Law for New Yorkers), launched under Governor George Pataki in 2005, has distributed \$2.5 billion to hospitals over the past 12 years.⁶³

More recently, Governor Andrew Cuomo and the Legislature have allocated capital funds for health care in each of the last five budgets, from fiscal years 2015 through 2019, for a total commitment of \$3.8 billion.⁶⁴ That equates to additional government debt of about \$190 per state resident. (*See Chart 2.*)

In January, Cuomo announced that \$700 million in capital funding allocated for Brooklyn in fiscal year 2016 would be used to finance the consolidation of Brookdale, Interfaith and Kingsbrook Jewish hospitals into a new entity called One Brooklyn Health.⁶⁵

Not all of the state’s capital grants have gone to hospitals, and not all of them have been distributed according to need.

In March 2016, for example, the Cuomo administration announced the awards of \$1.6 billion in health care grants to 162 recipients.⁶⁶ Of that amount, about a quarter, or \$386 million, went to hospitals on the Health Department's "watch list" of fiscally distressed institutions. Eleven of 32 hospitals on the watch list received no funding in that round of grants.

Other grants included a total of \$25 million to Crystal Run Healthcare, a rapidly growing for-profit multi-specialty physician group in Orange County, which used the money to finance a pair of medical office buildings. A \$7.9 million grant went to New York-Presbyterian Hospital in Manhattan, the state's largest hospital, which reported a \$270 million surplus of revenues over expenses for 2015.

Whether the state can continue offering capital funds on this scale is unclear. Under the Debt Reform Act of 2000, state borrowing may not exceed 4 percent of personal income. Despite a recent windfall of billions in financial settlements, Comptroller Thomas DiNapoli reported in December 2017 that the state is on track to hit the statutory borrowing cap in the early 2020s.⁶⁷

PROPOSALS FOR CHANGE

In response to the distressed financial condition of many New York hospitals, Albany lawmakers have recently contemplated rolling back the state's restrictions on private investment, albeit in limited fashion.

A bill sponsored by Senate Health Chairman Kemp Hannon (R-Nassau County) from 2013 through 2016 called for a pilot project that would authorize business corporations to acquire as many as 10 hospitals.⁶⁸ These corporations could not be publicly traded, but their owners would be exempt from other requirements, including the "natural person" rule, character and competence reviews and prior approval of sales and transfers.

Such acquisitions would be subject to approval by the Public Health and Health Planning Council. Would-be hospital buyers would have to commit to maintaining existing service levels and quality of care, retaining staff and creating a foundation to benefit the public health, among other conditions.

A similar pilot project was included in Governor Cuomo's executive budget proposals for fiscal years 2014 through 2016.⁶⁹ The governor's proposals were more restrictive than the Senate's. The 2014 version authorized no more than two for-profit hospitals (one of which had to be located in Brooklyn), and the later versions authorized no more than five. However, the governor omitted some of the other conditions in Hannon's bill.

Cuomo's proposals never made it into law. Hannon's bill passed the Senate in 2015, but was never taken up by the Assembly.

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The Dialysis Precedent

The most recent major change to state's health care ownership policies came in 2007, when lawmakers waived some requirement of Article 28 for dialysis clinics.⁷⁰ That change holds potential lessons for policymaking on hospital ownership.

At the time, the dialysis industry in New York, as limited by Article 28, consisted mostly of small, independent operators that struggled to afford up-to-date technology—causing both their finances and patient services to suffer. The industry in the rest of the country was increasingly dominated by for-profit chains which, due to economies of scale, had more money to invest in modern equipment that improved quality and saved money.

Some of the state's clinics had begun affiliating with national chains, both for-profit and not-for-profit, through “representative governance,” under which a clinic's titular owners signed contracts that gave effective control to larger corporations. The Health Department approved these arrangements, but the process was cumbersome for both operators and regulators.⁷¹

The Legislature's response was a bill that rolled back key parts of Article 28, allowing national chains, including publicly traded corporations, to directly operate in the state. The legislation modified or waived the rules requiring owners to be “natural persons,” to undergo background checks and to seek state approval of stock sales.

“Many New York dialysis care providers have operated on very thin profit margins and have limited access to capital,” said a memorandum accompanying the bill. “This, in turn, has hampered their ability to invest in new technology.

“In contrast, some companies that have been providing dialysis care in other states have had far greater access to capital and have developed efficient ways to provide goods and services, as well as quality protocols, policies and procedures that combine to improve clinical outcomes.”⁷²

The bill was cosponsored by the Legislature's two longtime Health Committee chairmen, Assemblyman Richard Gottfried (D-Manhattan) and Senator Kemp Hannon (R-Nassau County). It passed with broad bipartisan support and was signed by then-Governor Eliot Spitzer.

In the decade since, the ownership of the state's dialysis clinics has shifted significantly. Two-thirds are now for-profit, up from 49 percent in 2007.

Over that same period, the state's performance on dialysis quality measures tracked by the federal government has improved.

Each year, for example, CMS scores the patient survival rate at each clinic in one of three categories: “better than expected,” “as expected” or “worse than expected.”

As of 2007, only 3.7 percent of New York's clinics were rated as better than expected for patient survival, while 8.4 percent were worse. In the most recent ratings (based on performance in 2013 through 2015), 19.7 percent of New York's clinics were better than expected, and only 7.6 percent were worse.⁷³ (See Figure 10.)

Another benchmark tracked by CMS is the share of patients with a urea removal rate of 65 percent or greater, a measure of how effectively their blood was filtered. In 2007, the state's clinics were meeting that standard for an average of 94.7 percent of their

patients. By 2014, the average rate was up to 98.2 percent.

Despite signs of improvement, New York clinics continue to lag the national average. On Dialysis Facility Compare—a five-star rating system combining multiple quality measures, similar to Hospital Compare—the New York’s average rating of 3.2 stars is 45th highest among the states.

Both the signs of improvement among New York clinics and their continued below-average ratings could be explained by one factor: the growing but still limited role of chain-owned clinics in the state’s dialysis industry.

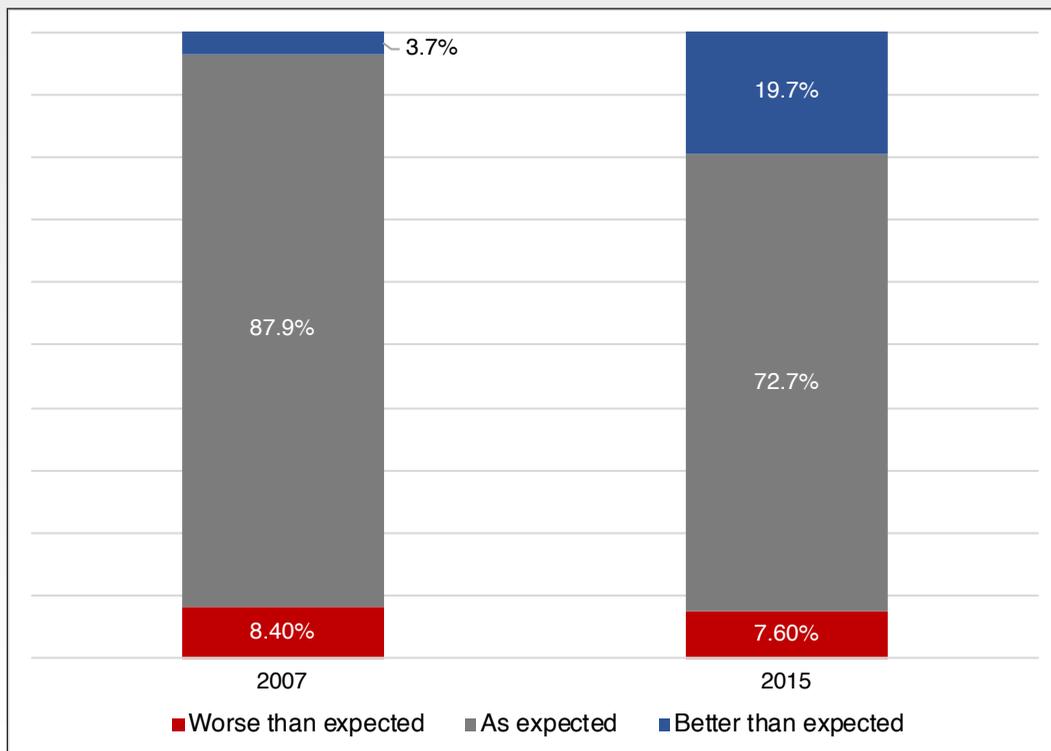
As lawmakers noted in passing the 2007 law, the higher volume and greater resources of chain-owned clinics appear to result in greater efficiency and higher quality. On Dialysis Facility Compare, chain facilities score an average of 3.4 stars, while the

average for independent clinics is 3.1. This is a bigger difference than the gap between the not-for-profits, which average 3.4, and for-profits, which average 3.3. For-profit chains, at 3.4, also outscore not-for-profit independents, at 3.3.

These patterns are further evidence that ownership type can be less predictive of quality than other factors, such as membership in a chain—which undermines the justification for a policy focused on ownership type.

Clinics dedicated to the single service of providing dialysis are of course smaller in scale and less complex than hospitals, so caution is warranted in applying lessons from one industry to the other. However, the state’s experience with dialysis clinics over the past decade suggests that broadening for-profit ownership of health care facilities can be associated with improvements in quality of care.

Figure 10. Mortality in New York Dialysis Clinics After Change in Ownership Laws



Source: CMS Dialysis Facility Compare

DISCUSSION

New York's longstanding restrictions on for-profit hospital ownership are an unusual and consequential intervention in the state's health care industry.

These laws have not merely limited the presence of for-profit general hospitals in the state but eliminated them completely.

Based on the evidence presented in this report, there is little indication that excluding for-profit hospitals has resulted in a public health advantage for New York. As discussed previously, the average quality ratings of the state's hospitals rank at or near the bottom of national report cards; the state's per capita spending on hospital care is higher than the norm, and its not-for-profit institutions provide lower-than-average levels of uncompensated care to the indigent, among other negative indicators.

Longstanding ownership restrictions did not necessarily cause these shortcomings, but the restrictions do not appear to have ameliorated them, either.

Also weighing against the status quo are financial factors, such as the loss of tax revenue that for-profit hospitals would otherwise pay and the loss of capital investment that for-profit hospital companies might otherwise make in New York's health care system.

It could be argued that lack of effectiveness alone is reason enough to reverse a restrictive policy that applies to no other major sector of New York's economy.

As a practical matter, however, any proposal to change the policy must address concerns that introducing for-profit hospitals into New York would have a further negative effect on quality, cost and access.

Evidence presented in this paper indicates that some of these concerns are exaggerated or misplaced. Financial data, for example, show that for-profit hospitals, in the aggregate, provide roughly the same levels of Medicaid care and uncompensated care as not-for-profit hospitals.

Meanwhile, data show that for-profit hospitals maintain larger profit margins, more cash reserves and lower debt levels than not-for-profit hospitals, meaning they are less dependent on government for subsidies, loans and capital infusions.

On quality, the evidence is harder to parse.

On one hand, the comparative research summarized above, coupled with scores for Hospital Compare and other report cards, indicate that for-profit hospitals tend to be of lower quality, on average, than not-for-profit and government-owned

hospitals at the national level. That gap appears to be narrowing with the advent of improved quality measurement and value-based financial incentives, but has not disappeared.

On the other hand, New York—where for-profit hospitals are effectively banned—has some of the lowest quality scores of any state.

A possible explanation for New York's quality gap is that hospital performance is being dragged down by underlying features of the state's operating environment—such as demographics, economics or regulatory structure. Those features would presumably diminish the quality of for-profit hospitals as well. If so, a change in ownership laws by itself would have little impact.

Another possible explanation is that the absence of for-profit owners has contributed to the performance gap by insulating the state's hospital industry from competition and limiting its access to innovative managers and their successful practices. If so, the state would stand to gain from a change in ownership policy.

In weighing this mix of evidence, it's important to remember that a change in ownership laws would not authorize any particular for-profit company to operate in New York. Rather, it would give such a company the right to apply for an ownership license, in some cases in competition with other bidders.

For-profit bidders would be subject to the multiple layers of review that any change in hospital ownership would necessarily undergo. This process could be used to screen out lower-quality options.

The most likely avenue for a for-profit company to enter New York is not opening a new facility in a crowded market, but converting one that already exists. To start, such a conversion would need support from the institution's board of directors. As volunteers with a demonstrated concern for both the hospital in question and its community, and with no prospect of financial gain, hospital directors could be expected to vet would-be buyers and reject those with poor track records.

The next layer would be the state Health Department and its Public Health and Health Planning Council. Even if the restrictions on for-profit ownership were loosened, these regulators would retain authority to review the history of the acquiring company and its management—and check the background of major owners involved in operations. They could be specifically empowered to reject would-be buyers who have operated low-rated hospitals in other states.

The reorganized company would also have a legal obligation to compensate the public for the loss of a charitable asset, which often means endowing a health-oriented foundation or simply making payments to the state. That process would need approval from both New York's attorney general and a court, both of which would be duty-bound to reject deals that work to the disadvantage of the public.

How much interest for-profit hospital companies and other investors would have in acquiring New York facilities is difficult to gauge. There was little public campaigning in favor of the reform proposals floated over the past several years, possibly because the state's hospitals have been effectively closed to private investment for so long.

Some industry officials anticipate that the big chains would be discouraged by New York's environment of relatively tight regulations and slim financial margins. Others see the state's market as too big and lucrative to go untapped forever.

One prominent hospital system CEO, Michael Dowling of Long Island's Northwell Health, has said the entry of for-profit operators into New York's market is "inevitable."⁷⁴

A change in New York's hospital ownership laws would not mandate the conversion of any hospital to for-profit status. Rather, it would provide hospital managers with an additional option for managing the financial futures of their institutions.

For-profit conversions would be voluntary, require both a willing seller and a willing buyer, and be subject to multiple layers of regulation. Current laws effectively veto all such deals in advance. A changed policy would allow each to be weighed on the merits.

Conversion would hold relatively less appeal for big-name academic medical centers and other high-quality, financially strong institutions that have thrived as not-for-profits. The more likely candidates would be lower-quality, financially weaker institutions – of which there are many scattered across the state. For them, buy-outs might represent a lifeline, the chance for increased stability rather than continuing decline and bankruptcy.

Small shareholders with no role in running a hospital, and their routine sales of stock, would no longer be subject to background checks – a procedure that is, at best, an indirect form of oversight. The Health Department would still have full licensing authority over the company and its management, as well as all of the doctors, nurses and other medical professionals on its staff.

Through its "certificate of need" law, the state would continue to control which types of care – such as delivering babies or performing heart surgery – hospitals can add or subtract from their menu of services. This would limit the risk that a for-profit company would aggressively "poach" lucrative patients from not-for-profit rivals.

Not-for-profit hospitals would also continue to enjoy the significant competitive advantage of exemption from taxes and access to government-backed low-interest bonds. For-profits, meanwhile, would pay full corporate income, sales and property taxes, becoming a potentially significant source of revenue, especially for local government.

A 2014 study in the *Journal of the American Medical Association*, referenced earlier, offers perhaps the most pertinent lessons for New York's situation.

The study analyzed the outcome of 237 for-profit hospital conversions, comparing their financial status, quality performance and patient mix to a control group of 631 hospitals that remained not-for-profit or government-owned. The analysis used Medicare data from 1.8 million patients from 2002 to 2010—a more recent period than most other studies.

The authors found that converting hospitals improved their operating margins by an average of 2.2 percentage points—shifting from modest losses to modest gains—compared to 0.4 points for non-converting hospitals.

At the same time, they found that mortality rates and other quality metrics generally improved at all hospitals, with no statistically significant difference between those that converted to for-profit and those that retained their former status.

The authors further found that converting hospitals as a group treated more patients who were African-American, Hispanic and recipients of Medicaid than the control group—and that there was no significant change in their collective patient mix after conversion.

Ownership reform that produced similar results for New York—an improvement in the financial status of converting hospitals without any harm to quality or access—would be a positive for the state.

RECOMMENDATIONS

The proposals from Governor Cuomo and Senator Hannon both took the form of demonstration projects that would open the door to for-profit ownership, but for a limited number hospitals and subject to special conditions.

This cautious approach would be one way to assuage concern about the effect of changing a long-standing policy and make it easier for state regulators to manage and monitor the transition.

Policymakers should also be aware of pitfalls. Capping the number of for-profit hospitals to be authorized, and imposing restrictions on stock ownership and sales, might have a chilling effect on potential investors. These provisions might discourage long-term investments by more risk-averse companies while opening the door to smaller, less experienced groups focused on short-term returns.

Also potentially counterproductive are provisions that would forbid corporate owners from paring back unprofitable services or cutting staff at hospitals they acquire. In some circumstances, those steps could be necessary for a successful turnaround.

To maximize the benefits of private investment, the state could set guidelines giving preference to conversion proposals aimed at hospitals with low quality or weak finances. The state could be especially welcoming to companies that would invest in hospitals on the Health Department’s fiscal “watch list” or those in underserved communities, including lower-income neighborhoods of New York City and rural areas of upstate.

To minimize segregation in the hospital system, the state should consider setting stronger uncompensated care standards for all hospitals—and fixing its dysfunctional system for reimbursing charity care, which currently tends to overpay hospitals that treat few indigent patients while underpaying the safety-net institutions.⁷⁵

To assure that the public gets adequate value in return for tax exemptions, lawmakers should consider setting minimum standards for the “community benefits” that not-for-profit hospitals must provide and tightening the definition of what qualifies as benefit.

Finally, lawmakers should take note of the significant shortcomings in hospital performance documented in this report, which ownership reform alone would be unlikely to resolve. Whether those shortcomings are the result of management practices, money issues, demographics or regulatory environment, they demand deeper examination and broader policy responses.

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- 5 Federal data for 2015 show at least one for-profit hospital in each state except Hawaii, Maine and Vermont. The single for-profit hospital shown for Connecticut converted to not-for-profit ownership in 2017. A handful of for-profit psychiatric hospitals operate in New York. That specialized category was omitted from both the state and national analyses in this report.
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- 9 Karen E. Joynt et al., "Association Between Hospital Conversions to For-Profit Status and Clinical and Economic Outcomes," *Journal of the American Medical Association* 312, no. 16 (2014), <https://jamanetwork.com/journals/jama/full-article/1917437>.
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- 11 CMS Nursing Home Compare data downloaded from <https://data.medicare.gov/data/nursing-home-compare>.
- 12 CMS Dialysis Facility Compare data downloaded from <https://data.medicare.gov/data/dialysis-facility-compare>.
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