BEFORE IT'S TOO LATE:
Why Additional For-profit Hospitals and HMOs Should Be Outlawed in Massachusetts

Alan Sager, Ph.D. and Deborah Socolar, M.P.H.
Access and Affordability Monitoring Project

Boston University School of Public Health
80 East Concord Street
Boston, Massachusetts 02118
(617) 638-5042

Joint Committee on Health Care
Tuesday 11 March 1997

Thank you for the opportunity to appear before you this afternoon. As always, we speak only for ourselves and not for either Boston University, its School of Public Health, or our funders. We will offer only brief oral testimony today and ask you to accept more detailed testimony in writing.

We would like to speak in support of three bills:

H. 2102 – To Prohibit Licensing Additional For-profit Hospitals
H. 2103 – To Prohibit Licensing Additional For-profit HMOs.
Senate Docket 1697 – for a moratorium on Hospital Conversions

Our main themes:

1. The benefits that free markets could offer are not available in health care because it is not possible to attain a free market in health care (except for eyeglasses).

2. Price competition among hospitals and HMOs already provides a huge financial inducement to limit care. Adding loot-seeking enterprises to that competitive mix is dangerously explosive. It will destabilize much that remains good and decent in Massachusetts health care.

3. Competition will be short-lived. Geographic monopolies will emerge, leaving us with perhaps 10-15 hospitals (down from 80-some today) and perhaps 4,000 beds (down from over 20,000 today). That will mean less care at higher prices.

4. For-profits can't be trusted, because this phony market can't be

trusted. Although for-profit hospitals and HMOs may attain certain efficiencies, they also cut care that may be needed. Evidence of poorer quality care includes the lower quality ratings given to for-profit HMOs in several evaluations, compared with non-profits, and their higher disenrollment rates.

5. Compared to non-profits, for-profit HMOs and hospitals use far more of their revenues for administration and profit, diverting it from care. For-profit U.S. hospitals devote much less of their spending to paying employees (under 40 percent in the chains now in this state) than non-profits do (55 percent). That means fewer people to provide care. If all Massachusetts acute hospitals were for-profits extracting the 20 percent return on revenue that Columbia/HCA demands, $1.5 billion more would be diverted from care here this year.

6. State action to protect patients here is vital, before it is too late. People in Massachusetts have been buffered from many of the sad health care realities unfolding in other states as for-profit HMOs and hospitals and counterfeit competition undermine appropriateness and quality of care. Although many non-profit hospitals in Massachusetts have been bloated and wasteful, the solution isn't to jump to the other extreme and starve our caregiving organizations.

* * *

Most bills before you today recognize that for-profits raise new problems, but we think they do not grapple with the heart of the matter. Although recent conversions have lacked sufficient public scrutiny, and although for-profit hospitals tend to provide insufficient free care, the biggest issue in conversions is that the health care organizations' guiding principles change, and that has potentially devastating effects on the quality of care.

The first duty of for-profit HMOs and hospitals is to financially reward their shareholders. That is incompatible with putting patients first. With incentives to limit care and related dangers already growing under intensified price competition and managed care, adding Wall Street's demands will make an explosive mix, destabilizing much that is good in Massachusetts health care.

Two months ago, many in Massachusetts felt that we had dodged a bullet when New England Medical Center decided not to sell out to a for-profit chain. But with several local hospital networks in talks with for-profits, the next sudden announcements are not likely to be good news.

We are here to say— act before it is too late. This may be your last chance to do what is needed to preserve the high quality of care that

We are here to say— act before it is too late. This may be your last chance to do what is needed to preserve the high quality of care that Massachusetts has been known for and that our citizens have been able to trust.

It is clear from many years of wasteful fee-for-service care that money talks in health care. It is very hard to regulate effectively against the power of financial motives in health care. Because financial interests of for-profit HMOs and hospitals fundamentally conflict with their ability to focus on their patients' needs, they do not seem susceptible to reform.

COMPETITION WILL BE SHORT-LIVED

For-profits dramatically boost the trend toward oligopoly and monopoly. Let's look down the road, and if we don't like what we see ahead, let's not travel down that road. The entry of for-profits give a turbo boost to price competition's V-8-powered drive toward fewer and bigger hospitals and HMOs. We are moving toward oligopoly and monopoly in health care. This will mean less care for fewer people at greater cost. Competition needs competitors. All the mergers, closings, and alliances forming in health care, as hospitals and HMOs hope to grow big enough to win market power, signal an end to competition. This is just one symptom of how phony is the rhetoric of price competition in health care.

Protections are needed. We have no objection to free-market competition, if it could be attained. But many traits make free markets impossible in health care. These include steep barriers to entry and the dependence of patients (nominal buyers) on caregivers (the sellers) to determine what care is needed. Deep pockets also aid some health care organizations in riding out competitive storms, dropping prices just until their poorer competitors are driven out of business. Absent the conditions for genuine free markets, competition does not remain free and therefore advances only private interests, not the public good.

Columbia/HCA , in particular, has a record of buying up, cannibalizing, and shutting down competitors. The result is to

- restrict the availability of vital services
- restore a seller's market, raising hospital prices.

But when that happens, communities can do little to protect themselves. The decision-making power is held by (probably out-of-state) business executives whose first obligation is to stockholders.

If this state adds more for-profits to the growing pressures of price competition, we will face drastic destabilization of much that is good in Massachusetts health care.

Hospitals and HMOs alike will respond to intensified price competition with further consolidation— but mergers need not increase efficiency. In fact, market power is the goal. Geographic monopolies are likely, and that means higher prices, less care, and less responsive care.

What could we see in a decade? From 80-some hospitals in the state today (142 in 1970), we could find just 10 or 15 surviving hospitals and emergency rooms. All survivors would be tied in to a few chains, mostly run for-profit. Several HMOs would survive, mostly run for-profit. Most hospitals and HMOs would enjoy oligopoly or regional monopoly power.

Recent evidence shows how many hospital beds would be lost in Massachusetts just by applying the actual rates of hospital bed use that already prevail elsewhere. (See attached chart.) While the actual use rate here in 1994 demanded roughly 20,000 beds, the average use rate for California HMOs in 1995 would mean a demand here for less than 8,000 beds. The use rates deemed by the Advisory Board Company the "best practice" in California HMOs would demand just 4,330 beds.

But there is little reason to think much money would be freed for primary care, or for covering uninsured people. (Most savings probably would go to higher HMO administrative spending and profits, as discussed shortly. And note that the uninsured share of the California population has risen steadily under price competition. It is now about double ours.)

Even more crucial— there is no evidence that these changes are safe. We should stop them at the border until we find evidence that they are safe. The medical injunction is to first, do no harm. Make sure. Test. Evaluate. We must stop and think before we let the nose of for-profit health care any further under our state's tent. Soon, it will be too late.

FOR-PROFITS DIVERT MONEY FROM CARE

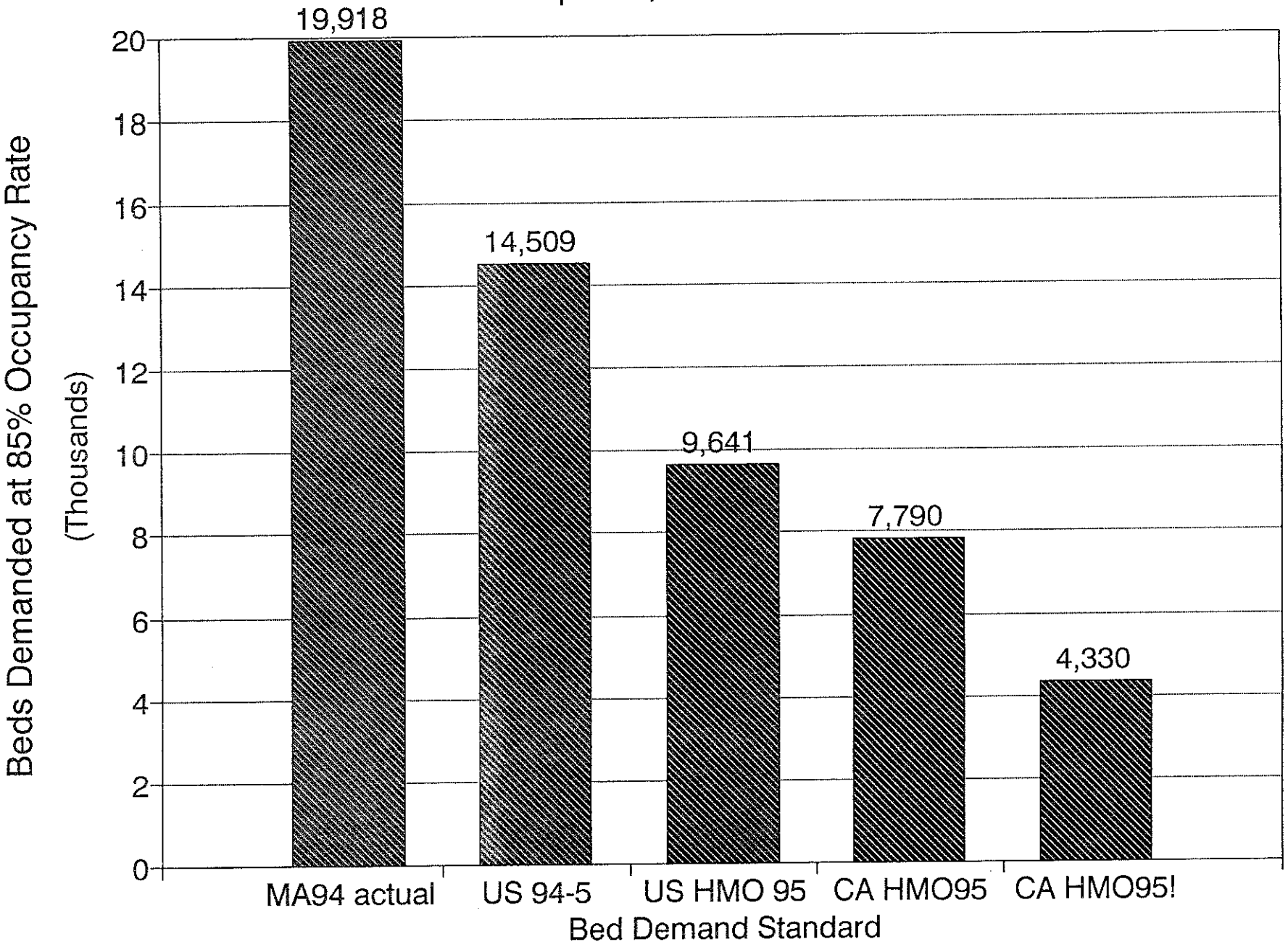
Both for-profit HMOs and hospitals appear likely to divert health care dollars from vitally-needed care to non-care.

- This is partly because their main goal is to maximize returns for investors.

- But for-profit HMOs also tend, for example, to spend more on

DEMAND FOR MASSACHUSETTS HOSPITAL BEDS

Acute Hospitals, Various Use Rates



marketing and advertising. A 1993 report by New York City's Commissioner of Consumer Affairs found that for-profit HMOs there spent over five times as much on marketing, per member, as non-profits did.[1]

- The entry of for-profit HMOs into a health care market also raises the level of such spending by non-profits, because competitive pressures again force them to imitate the for-profits.

- Despite such imitation, substantial disparities in spending on care are clear in California, where most HMOs (67 percent in 1993) operate for-profit.[2] Using data on California's largest HMOs, we documented last year[3] that the average share of revenue spent on medical care was 13.7 percentage points higher in non-profits than in for-profits. Comparing the five largest California HMOs of each type in 1994-95 revealed these average care shares, weighted by enrollment:

  - ◊ 92.7 percent of revenue spent on care in non-profits, but just
  - ◊ 79.0 percent in California for-profits.

  A very similar gap appeared between non-profit and for-profit HMOs in a survey of 37 plans nationwide by *Consumer Reports*.[4]

  Total HMO revenues in Massachusetts were over $5 billion in 1995.[5] If Massachusetts HMOs behaved like the for-profits in California, spending 13.7 percent less of their revenue on care, that would have meant $685 million less to benefit patients. And the sums diverted from care would grow as HMOs do. In a few years, when HMO revenues reach $10 billion, the lower for-profit care share would divert $1.37 billion from serving patients.

- Diversions from care are growing nationally. *Consumer Reports* found that the care share fell between 1992 and 1994 in many large HMOs, sometimes sharply and especially in for-profits.[6] *Business & Health* observed that care shares "in the 70 percent range [are] increasingly common among for-profit HMOs."[7]

- All who use and pay for hospital care should be similarly concerned about what proportion of hospital revenues are devoted to care. Price competition apparently has already prompted higher non-care spending for marketing, advertising, consultants, decor, and hotel-like services.[8] The recent arrival of for-profit acute hospitals in Massachusetts may accelerate this trend. Like for-profit HMOs, they will divert health care dollars to shareholder dividends.

- One sign of the diversion from care is that for-profit hospitals devote much less of their expenses to paying employees, and that means fewer people to provide care. For 1995, as shown on the attached graph, hospitals reported that the following shares of their expenses were for employees:

  - ◊ for non-profit hospitals nationally, about 55 percent
  - ◊ in for-profits overall, only about 47 percent
  - ◊ at Columbia/HCA and OrNda, just below 40 percent
  - ◊ at Tenet, only 37.4 percent.

  This probably reflects the for-profits taking more out of the business not only for shareholders but also to acquire more hospitals, and for property and income taxes (though these return to the public, they are removed from health care).

  So for-profits may have fewer employees, or a lower skill mix, or simply pay their staff less. But all of those suggest risk of lower quality care. The result is that, for example, as reported on *60 Minutes*, the Indianapolis Board of Health was compelled last summer to fine a for-profit hospital for severe understaffing in its neonatal ICU.

  We also have been hearing grave concerns about understaffing and deskilling, and patients thus being endangered, in Massachusetts hospital networks that may be positioning themselves to be acquired by for-profits. Clearly, the presence of any for-profits starts to undermine quality even in health care organizations that are still non-profit.

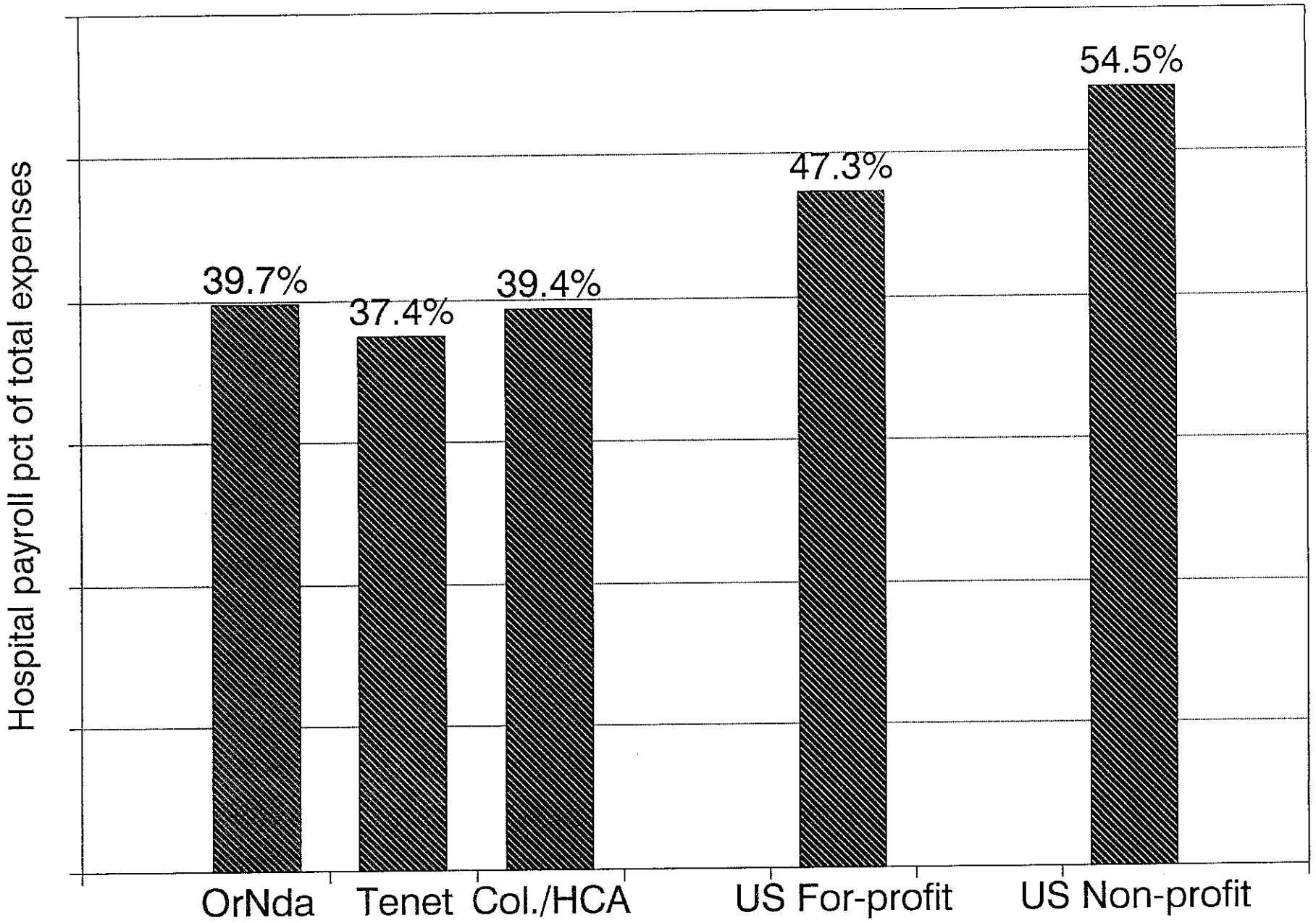
- If all Massachusetts acute hospitals were for-profits, and they extracted the 20 percent return on revenue which Columbia/HCA demands as a minimum,[9] that would mean diverting $1.5 billion more from care to cupidity here this year.[10]

  The surpluses extracted by national for-profit chains also are often siphoned out of the community and the state to finance new acquisitions.

- Further, for-profit hospital chains and HMOs often boost their profits by purchasing non-profit health care organizations at prices far below market value– thus plundering the community assets accumulated over decades of tax-exempt financing and charitable contributions. The *Boston Globe* report last November on Worcester's St. Vincent Hospital gave good reason to fear that the hospital was seriously

HOSPITAL PAYROLL PCT OF TOTAL EXPENSES

Hospital Fiscal Year 1995



undervalued in its sale. Strikingly, more was spent on lawyers to arrange the deal than is going into the foundation that is intended to compensate the community.[11]

EVIDENCE OF QUALITY PROBLEMS IN FOR-PROFITS

- Briefly, regarding hospitals, we have already heard of physician concerns about quality of care and staff demoralization at one of the recently converted Massachusetts hospitals.

- Regarding HMOs, we and others – including *Consumer Reports* and benefit managers for Massachusetts-based GTE[12] – have found that quality and satisfaction ratings of for-profits tend to be lower than those of non-profits. The *Boston Globe* had headlines last fall when New England HMOs managed care plans did better than HMOs nationally on several preventive care measures.[13] But HMOs here may do better precisely because most HMOs here are non-profits, but most nationwide operate for profit. Indeed, we calculated that among the Massachusetts HMOs reported on in that *Globe* story, the non-profits as a group did better than the for-profits, for each of the three measures included. And differences on two measures were at least as great as between HMOs in New England and nationally.[14]

- Also, data from the HMO industry association show that the percentage of people who disenrolled from for-profit HMOs was higher (17.5 percent) than from non-profits (15.8 percent).[15] This disparity suggests two things:

  - first, that patients are more dissatisfied with for-profit HMOs

  - second, that as a result, for-profit health maintenance organizations have even less financial reason to invest in maintaining patients' health than non-profit HMOs do, because people don't stay enrolled long enough for the investment to pay off.

    High patient turnover already gives Massachusetts HMOs little reason to focus on long-term health, even though most HMOs here are still non-profit. As we testified to the Insurance Committee last summer, using the disenrollment rate here from a recent quarter, we calculate that a majority of people in this state's HMOs disenroll in less than four years.[16]

We also see a pattern of substituting financial for quality measures. Attention to quality of care is being lost as the focus on money prevails.

- Managed care organizations today appear to emphasize economic profiling of their physicians— seeking those whose patients use few resources— rather than emphasizing assessment of quality.

- Columbia/HCA publicizes widely the appearance of many of its hospitals among "The Top 100 Hospitals in America" in a rating by Mercer Consulting and HCIA, Inc. But those ratings include six measures of hospital cost and finances, and just two measures that reflect the quality of care.

STATE ACTION IS VITAL

Our Project certainly recognizes the need for greater efficiency in health care. For example, we have led in highlighting the waste in bloated Massachusetts non-profit hospitals. But the solution isn't to withhold resources from caregiving until this state's hospitals and patients starve to death. There must be something in between. Do you really want to trade the problems of an over-fed first-world health care system for a starvation diet of financial famine?

To protect Massachusetts patients, and to preserve much of the good in Massachusetts health care, we urge you to prohibit the licensing of any additional for-profit hospitals and HMOs in this state.

If you believe that more focused debate is needed, we urge you at least to adopt the proposed moratorium on further conversions.

Either a prohibition or a moratorium must be enacted quickly. Once the horses are out of the barn, it is too late.

If just a few more of this state's hospitals convert to for-profits— and more planned conversions could be announced at any time— it will likely be impossible to prevent a race to the bottom that will devastate the quality of care that Massachusetts residents have long relied on. And once private interests plunder the resources accumulated over decades in Massachusetts health care, the damage will be irreversible.

With so much at stake for citizens of the Commonwealth, if you fail to prohibit more conversions or at least to establish a moratorium, you will violate your obligation to first, do no harm.

NOTES

[1] *Vital Signs: What The HMOs Don't Tell You That You Need To Know*, New York: City of New York Department of Consumer Affairs, April 1993, p. 5.

[2] *Managed Care Digest*, 1994 HMO Edition, Kansas City, MO: Marion Merrill Dow, 1994.

[3] A. Sager and D. Socolar, "Why Additional For-profit Hospitals and HMOs Should be Outlawed in Massachusetts," testimony to the Health Care Committee on H. 5902, H. 5908, H. 5910, and H. 5911, 3 April 1996. Analysis is of data from tables 1-3, from California Medical Association, *Knox-Keene Health Plan Expenditures Summary, FY 1994-95*, Sacramento: The Association, February 1996.

[4] "Can HMOs help solve the health care crisis?" *Consumer Reports*, October 1996, p. 33.

[5] Total 1995 revenue for 15 HMOs with Massachusetts members, reported in *Boston Business Journal*, 26 July 1996.

[6] "Can HMOs help solve the health care crisis?" *Consumer Reports*, October 1996, p. 33.

[7] S. Findlay, "Will big HMOs stamp out competition?" *Business & Health*, October 1995, p. 60.

[8] See, for example, Robert M. Kahn, "The Ritziest Hospitals in Town," *Boston Magazine*, February 1996. See also Deborah Socolar, Alan Sager, and Peter Hiam, "Competing to Death: California's High Risk System," *Journal of American Health Policy*, March-April 1992, pp. 45-50. There is little reason to think that a greater HMO presence forces hospitals to reduce their administrative costs. For example, despite our high HMO penetration, hospital administrative costs as a percentage of total hospital costs in this state were slightly above the national average in an analysis by Steffie Woolhandler and others, "Administrative Costs in U.S. Hospitals," *New England Journal of Medicine,* vol. 329, no. 6, 5 August 1993, pp. 400-403.

[9] Robert Kuttner, "Columbia/HCA and the Resurgence of the For-Profit Hospital Business," New England Journal of Medicine, vol. 335, no. 5, 1 August 1996, pp. 362-367.

[10] Starting with the $9.083 billion in Massachusetts acute hospital revenues reported for 1995 (American Hospital Association, *Hospital Statistics*), assume a five percent increase in each of the next two years, yielding 1997 total hospital revenues of $10.014 billion. Assume generously that non-profits are retaining five percent of their revenues after expenses. In that case, using Columbia/HCA's minimum standard, for-profits would be extracting an additional 15 percent as profit, or $1.5 billion.

[11] Spotlight team, "Profit motives doom Worcester hospital," *Boston Globe,* 17 November 1996.

[12] *Consumer Reports* subscriber survey results reported August 1996, p. 40; data on health plans used by GTE reported in Maggie Mahar, "Time for a Checkup," *Barron's*, 4 March 1996.

[13]National Committee for Quality Assurance data reported in Alex Pham, "N.E. HMOs top national `report cards,'" *Boston Globe*, August 22, 1996.

[14] Access and Affordability Monitoring Project, "Quality Scores of Non-Profit and For-Profit HMOs," 30 August 1996.

[15] Data for 1993, the most recent available from American Association of Health Plans, *HMO & PPO Industry Profile*, 1995-1996 edition, Table 3-9.

[16] Alan Sager and Deborah Socolar, "Testimony on H.6144, An Act Prohibiting Financial Incentives to Health Care Providers for Limiting Health Care Services," 9 July 1996.