Nonprofit Hospitals Face Structural as Well as Financial Challenges: Lessons from Massachusetts

Eric W. Hayden

Abstract. Like most nonprofit hospitals, those of Massachusetts are facing serious financial challenges. Although the immediate issue is the shortfall between revenues and expenses, the author finds that the real problems are systemic, evidenced by at least three structural impediments: uncompensated care, overuse of teaching hospitals, and an increasingly unattractive environment for the practice of medicine. Other states whose nonprofit hospitals face persistent financial difficulties may find it useful to consider whether (similar or different) structural impediments are also undermining the operating performance of their own hospitals.

Key words: operating performance, structural impediments

The rating agencies remind us that the outlook for the nation's nonprofit hospitals is at best problematic (Fitch Ratings 2004; Moody's Investor Service 2004). The culprits include the following: weak patient volume; declining governmental and nongovernmental reimbursements; mounting expenses, especially labor and growing bad debt costs (the latter reflecting the push toward consumer-driven care); increases in the uninsured population; and competition from physician-owned diagnostic and treatment centers. This portends increasingly difficult access to credit markets at a time of significant capital needs (Unland and Ponton 2003).

In this article, I examine one portion of the nonprofit hospital universe, that of Massachusetts. Despite its long-held reputation as a medical mecca, the state's predominantly nonprofit healthcare system faces what one observer calls a perpet-ual "cycle of fiscal convulsions" (Grossman 2000). As I explore in greater detail in the paragraphs that follow, the financial performance of its acute hospitals has been marginal at best for many years, as one- third of them have closed over the past 25 years. One survey reports that nearly 60% of the responding hospitals having delayed capital investment in order to first address operating shortfalls (Massachusetts Hospital Association 2004). Furthermore, an analysis of hospital access to capital ranks Massachusetts fifth worst out of the 50 states (Healthcare Financial Management Association 2003).

The ongoing financial challenges facing the state's hospitals prompted the former head of one of Boston's teaching hospitals to predict that "there are elements both formed and gathering that will create the 'perfect storm' that will devastate Massachusetts hospitals" (O'Donnell 2003). I undertook the study described here to test the veracity of that prediction. As the research evolved, it became increasingly clear that, although the immediate challenge of the typical Massachusetts hospital is the classic mismatch between revenue and expenses, the real problems are structural in nature. The broader question for other state hospital systems is whether the operating performance of their nonprofit hospitals is also being undermined by (similar or different) structural impediments.

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The Massachusetts Healthcare Setting

The condition of Massachusetts hospitals is an outgrowth of the state's unique healthcare setting. This includes its overwhelming bias against for-profit healthcare, a bias stemming from a widely held view that, as a consumer entitlement, healthcare can be easily compromised in a for-profit setting focused on net income rather than quality of care for everyone, including the uninsured. Reflecting this strong nonprofit bias, 97% of the state's hospitals are nonprofit (compared with 85% nationwide), and nonprofit HMOs account for well over 90% of all managed care enrollments (vs. 35% nationwide).

Another feature of Massachusetts healthcare dates from 1991, when the long-standing hospital rate-setting system (guaranteeing fixed payments regardless of cost) was abolished. The objective was to force hospitals to negotiate separately with each private payer, presumably helping to contain healthcare costs. Hospitals were henceforth expected to compete on the basis of pricing, which would in turn depend on each institution's respective costs and reimbursement arrangements.

There were two significant outcomes of the new Darwinian environment. The first was the dramatic drop in excess hospital capacity that had accumulated during the nearly two decades (prior to 1991) of state-mandated hospital fees. Accordingly, in the decade that followed (i.e., 1991–2001), the number of hospitals fell 20.8% (vs. the national average of 8.1%); beds decreased by 23.8% (vs. 10.6%); inpatient days dropped 24.1% (vs. 12.9 %); and outpatient visits increased 76.4% (vs. 67.2%; see Mechanic 2003).

The second outcome was that competition also led to consolidation in the payer market, as cost-conscious employers turned to managed care payers to contain rising healthcare premiums. In the increasingly cutthroat quest among HMOs for market share, only four major health plans ultimately prevailed; all are local (as opposed to national) and currently control some 85% of the state's private health insurance market. The dominance of these plans within the state reflects the particular nature of the Massachusetts HMO market, where providers contract with multiple HMOs, all of which generously accommodate enrollee and physician preferences in the selection of hospitals, specialists, procedures, and tests.

As the local HMO market matured in the 1990s, competition for market share among the state's HMOs produced aggressive underpricing of member premiums. The other component of the HMOs' strategy was to contain provider reimbursements by pitting hospital against hospital, curtailing the use of more expensive inpatient care, and keeping payment-to-cost ratios well below hospital break-even levels. The rising popularity of HMOs among employers compelled hospitals to accept reimbursement discounts or lose patients to more accommodating competitors. As discussed later, the HMO oligopoly also significantly restricted physician reimbursement.

Until the late 1990s, hospitals managed to offset low Medicaid and HMO reimbursements with generous Medicare payments, often running at rates of at least 15% above treatment cost. However, this windfall ended with passage of the federal Balanced Budget Act (BBA) of 1997, which drastically reduced Medicare payments to acute care hospitals, home healthcare providers, and nursing homes across the nation. The impact was especially severe in Massachusetts, where Medicare accounts for one third of all hospital reimbursements.

Besides losing money to Medicare, the state's hospitals have also historically been underpaid by both Medicaid (accounting for about one-tenth of total hospital revenues) and managed care providers (one-third of revenues). The pernicious impact of Medicaid will be discussed later. In a bold effort to break the stranglehold that managed care has had on hospital revenues, the state's dominant hospital system, Partners HealthCare, told each of its three major private payers in 2001 that, without "full-cost pricing," its hospitals were prepared to withdraw from recalcitrant provider networks. Partners HealthCare was emboldened by the market power it had acquired through the dramatic shrinkage of hospital capacity occurring over more than a decade of managed care underpayments and statewide hospital closures. The outcome of its "do-not-blink" strategy was that Partners successfully negotiated major hikes in its HMO reimbursements. Other hospitals have followed suit, but, lacking Partners' leverage, they have typically met with less success.

Hospital Financial Performance

For more than 50 years, Massachusetts hospital total margins have consistently lagged behind the national average (Sager 2002). In the 1970s and

1980s, Massachusetts hospitals' low margins were mainly due to the hospital rate-setting environment noted earlier. In the 1990s, the cause was the tight-fisted reimbursement rates of governmental and nongovernmental payers. Improved managed care payments since 2001 have allowed some hospitals occasionally to break out of their loss modes and report bounces in earnings. Nevertheless, these blips are relatively rare and are typically followed by a reversion to red ink.

Tables 1 and 2 document the persistent underperformance of Massachusetts acute care hospitals vis-à-vis their national peers. Although data for fiscal year 2004 are an improvement against historic numbers (reflecting marginally higher private payer reimbursements), the overall trend remains troubling for a variety of reasons, including these: the operating margin of half of the state's hospitals is lower than the minimally positive 0.8% median; 42% of hospitals reported negative operating margins in fiscal year 2004, with over one-third reporting worse results than the prior year; and 25% of hospitals reported negative total margins, with one-third experiencing a deterioration from the year before. In short, the 7-year average (1.17%) is not only well below the national average (3.33%) but also well below the 3% margin generally required for long-term viability (Massachusetts Hospital Association 2005).

Clearly, the financial quagmire in which the state's hospitals find themselves is not a one-time phenomenon. The question, then, is this: Do these consistently poor financial results stem from factors other than the obvious gap between revenues and expenses? In the remainder of this article I argue that least three structural factors underlie the ongoing financial problems of the state's hospitals.

Uncompensated Care

Medicaid, the federal healthcare program for the low-income and disabled population that is administered at the state level, has been a generous provider of healthcare benefits to Massachusetts residents. Enrollment has grown to 1 million (up from 700,000 in 1997) out of a total population of 6 million. However, Medicaid has never been popular with the state's hospitals, because it reimburses them an average of 70 cents for each dollar's worth of inpatient and outpatient care; this is one of the lowest Medicaid reimbursement rates in the nation.

Even more problematic for the hospitals, however, is the significant increase within Massachusetts of the number of people without healthcare insurance (from 365,000 four years ago to an estimated 600,000 in 2004), reflecting a combination of rising unemployment, reduced small business healthcare coverage, and Medicaid eligibility cutbacks. The burden of caring for this growing uninsured population has fallen primarily on the hospitals through the Uncompensated Care Pool (UCP), which was created in 1985.

Prior to the UCP, most hospitals passed the cost of treating uninsured patients onto privately insured patients. However, inner-city hospitals, the major providers of uncompensated care, were at a relative disadvantage, given their smaller volumes of privately insured patients compared with those of the typical suburban hospital. The UCP was thus aimed at reimbursing hospitals and freestanding community health centers for both uncompensated care to low-income state residents and urgent care to nonresidents.

What began as a sound theoretical concept based on social equity has become a major source of divisiveness within the state's hospital universe. At the outset, fearing a dramatic increase in uncompensated care costs, the private payers negotiated a cap for which they would be responsible each year. Costs above that cap have been funded by annual contributions from the government and the hospital industry. All hospitals contribute to

TABLE 1. Massachusetts Hospital Median Margins: 1998–2004

Margin (%)	1998	1999	2000	2001	2002	2003	2004
Operating	–1.2	–1.1	–1.0	–0.6	0.1	0.1	0.8
Total	2.0	1.2	1.0	0.8	0.4	1.0	1.8

Source. Massachusetts Hospital Association (MHA), "Report on Acute Care Hospital Performance," February 11, 2005. Data derived from 1998–2003 hospital-submitted Schedule 23, Form 403 cost reports, collected by the Massachusetts Division of Health Care and Finance Policy; and the MHA Survey for fiscal year 2004.

TABLE 2. U.S. Hospital Median Total Margins: 1998–2003

1998 %	1999 %	2000 %	2001 %	2002 %	2003 %
3.8	3.4	3.0	3.1	4.0	2.7

Source. Massachusetts Hospital Association (MHA), "Report on Acute Care Hospital Performance," February 11, 2005. Data derived from CHIPS/Ingenix (2003 results are preliminary).

the pool, with those treating the highest percentage of privately insured patients paying the most. Provider hospitals are paid from the pool, with those treating the largest number of poor patients receiving the most. To minimize abuses, audits were officially mandated to ensure that hospitals serving the uninsured were not writing off as "bad debt" or "free care" those accounts that could in fact be reasonably collected from insured patients.

Two decades later, with annual payments from the UCP running in the $500 million range, the pool has grown into an unwieldy system with little accountability and considerable inconsistency with regard to coverage and payment. For example, the UCP covers emergency services in some places but elsewhere acts like a comprehensive health program, providing primary and routine care. There is similar disparity in terms of reimbursement, as some institutions are paid for as much as 95% of free care cost (vs. 70% under Medicaid) whereas others receive less than 50% of their costs. A major problem has been that there are different payments to different providers for the same procedure.

Because the largest proportion of uninsured people live in urban areas, the urban hospitals—including the teaching hospitals—are the major UCP recipients. The two major "safety net" hospitals (Boston Medical Center and Cambridge Health Alliance) receive the bulk of pool dollars. Because allowable uncompensated care costs typically exceed available pool funds each year, all other hospitals effectively fund any shortfall by paying higher yearly assessments into the UCP. The net effect is that more than half (some $250 million) of all uncompensated care in the state is paid for by hospitals. As the size of the uninsured community grows, the financial burden on the hospitals is further exacerbated.

Although few would dispute the UCP's vital role in funding care to the uninsured, the real issue is who should be underwriting that care—the state or the local hospitals that are being forced to redirect millions of healthcare dollars annually from their primary missions of providing healthcare to their neighboring communities. Especially disadvantaged are community hospitals, not only because they are reimbursed at below cost but also, and more significantly, because they have ended up paying most of the hospital component of UCP funding. For example, one typical 150-bed community hospital, with annual revenues of $200 million, pays between $3 and 4 million as its contribution to the pool, effectively eroding its entire operating surplus (and, in the process, most of its capital budget).

Overuse of Teaching Hospitals

An ongoing debate within the state's healthcare community is the relative quality and cost of care provided by teaching versus community hospitals. A recent study of data from hospitals in six states, including Massachusetts, finds that (a) inpatient cost per case is 19% greater at teaching hospitals than at community hospitals; and (b) the quality of care provided by community hospitals is comparable with that at teaching hospitals (Kane, Needleman, and Rudell 2004).

These findings notwithstanding, Massachusetts residents have a strong bias in favor of using teaching hospitals for even the most common procedures. The result is that healthcare costs in the state are immeasurably increased by the overuse of the high-cost providers. This, in turn, has distorted hospital use and produced severe capacity constraints. A report (Massachusetts Division of Health Care Finance and Policy 2003, 1) on healthcare outcomes notes the following:

> National data show that Massachusetts residents are hospitalized in teaching hospitals three times more often per 1,000 population than residents of other states who rely more heavily on community hospitals. Care for comparable conditions is typically more expensive at teaching hospitals than at community hospitals due to overhead expenses inherent in teaching and research functions, and the availability of advanced technology and equipment. In addition, dependence on teaching hospitals in Massachusetts is increasing, and younger patients are migrating to teaching hospitals more rapidly than older patients.

Illustrating the point by citing statewide maternity outcomes, the report notes that over a recent 2-year period, two-thirds of the women delivering

children in Boston's six (of the state's eight) teaching hospitals resided in zip codes outside the city's limits. Another study notes that the state's teaching hospitals operate at bed-occupancy rates ranging from 85–100%, compared with 60% among the state's community hospitals (Center for Studying Health System Change 2003). The net effect has been the serious erosion of community hospital revenues. Not surprisingly, of the 29 hospitals forced to close since 1980, all were community hospitals.

The latest hospital in Massachusetts to close was the century-old, 200-bed Waltham Hospital, whose serving area included 10 communities. Its shutdown in May 2003, following losses in 9 out of 10 years, is illustrative of the teaching versus community hospital quagmire. Located within 10 miles of downtown Boston, Waltham had a problem that was fundamental to most community hospitals in the greater Boston metropolitan area: failure to attract sufficient patients to generate adequate revenue to keep the facility open. The numbers speak for themselves. When residents of Waltham (population 58,000) needed to be admitted to a hospital, less than 40% of them chose the local community hospital. The majority did what most Massachusetts suburban residents do—they went to a teaching hospital, usually one in downtown Boston (Sweeney 2003).

The second-class status of the state's community hospitals is not only evidenced by lower patient volumes. They also lack the teaching hospitals' collective access to capital (by means of fund-raising and capital market access) as well as endowment income, their clout to negotiate higher private payer reimbursement rates (made possible by consolidations and affiliations that have concentrated patient volumes in a smaller number of providers), their access to federal research dollars, and their financial resources to compete in the crucial labor markets (e.g., nursing, pharmacists, lab technicians).

An Increasingly Unattractive Place to Practice Medicine

Over each of the past 3 years, the Massachusetts Medical Society has conducted a comprehensive survey of physician practice conditions and physician attitudes toward their profession. The surveys poignantly demonstrate a third structural factor affecting the state's troubled healthcare system, namely the growing perception among physicians that the state is a financially and administratively difficult place in which to practice medicine (Massachusetts Medical Society 2002, 2003a, 2004). The findings of the three surveys support one another and, as the most recent one observes (Massachusetts Medical Society 2004, 13), the physician labor market in Massachusetts:

> . . . continues to be under extreme stress, and the forces that pushed these markets into this unenviable state are numerous and not likely to be easily reversed . . . The most significant characteristic of the . . . [s]urveys was the extraordinarily high frequency of negative responses to all questions relating to the current availability of physicians to fill positions, as well as the degree of difficulty in recruiting and retaining physicians. In all three years, the mean response . . . indicat[es] that there are persistent structural problems in the functioning of physician labor markets [within the state].

More than half of the most recent respondents are dissatisfied with the current practice environment and a similar number say they are not sure whether they would choose medicine as a profession again. Three-fourths call their incomes "uncompetitive," and one-fourth are contemplating a career change because of the state's practice environment. Nearly one-third of the respondents have either decided to move out of the state to practice medicine or would consider doing so if the environment does not change.

The major factors contributing to this image as an increasingly inhospitable environment for physician practice are all structural and largely unique to Massachusetts: high living costs, high practice costs, and low reimbursements. Illustratively, metropolitan Boston's cost of living is more than 35% above the metropolitan national average (American Chamber of Commerce Researchers Association, 2005). Besides high rents and salary costs for maintaining office space, the major item impacting the second factor (higher practice costs) is soaring malpractice insurance. Although this is not unique to Massachusetts, it is nevertheless an especially virulent problem within the state, where the average premium charged by the largest commercial malpractice insurer jumped 77.8% on a compound basis from 1998–2003 (Massachusetts Medical Society 2003b). Finally, the third factor (low reimbursement rates) is exacerbated by the HMO oligopoly, blamed by physicians as having disproportionate power to limit reimbursements and, thus, constrain physician salaries at levels considered to be among the lowest in the nation (Holler 2004).

In response to rising dissatisfaction with their work environment and compensation, those physicians continuing to practice within the state are becoming increasingly entrepreneurial—buying diagnostic equipment to offer patients tests, ranging from magnetic resonance imaging to nuclear radiology to stress testing, that were previously done at hospitals; opening ambulatory surgery and orthopedic centers; and consolidating practices in order to reduce overhead and maximize the efficient use of equipment and centers. Although they may have been, until recently, less aggressive than their colleagues nationally in adopting these types of money-making activities (Kowalczyk 2004), the outcome will certainly be harmful to the financial health of the state's hospitals.

Conclusion

Massachusetts hospitals face the same mismatch between revenues and expenses that is affecting the financial viability of nonprofit hospitals across the nation. However, my research has also found that the state faces its own unique structural issues impacting hospital performance: an uncompensated healthcare system that forces hospitals to assume the charity role of the state; community hospitals that are losing market share and financial resources to the state's renowned teaching hospitals; and a work environment that undermines physician loyalty to the state and its hospitals and fosters entrepreneurial activities that further undermine the financial practicability of those hospitals. The result of these structural fissures is a hospital system whose financial performance ranks well below national averages and that, if allowed to continue, jeopardizes the state's long-held position as a medical mecca.

Other states whose nonprofit hospitals face persistent financial difficulties might find it helpful to consider whether structural impediments—rather than more traditional accounting measures such as revenues and expenses—may also be undermining the operating performance of their own institutions.

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