

8. Role of profit

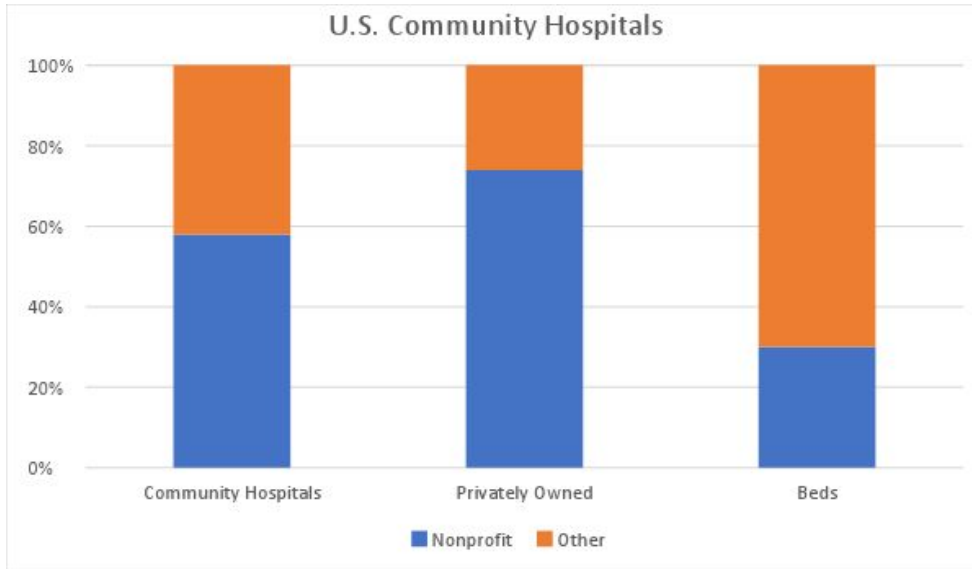
Is Profit a Problem?

Overview: Does profit have a place in healthcare? Is it a positive, negative, or neutral force? An Institute of Medicine consensus [report](#) tackled this issue as far back as 1986. Supporters claim that for-profit (FP) or investor-owned models offer new capital, greater innovation, stronger incentives to excel, and better management approaches. Critics argue that the profit motive is inimical to the key values of patient care, and that FP organizations prioritize money over lives and add cost to the healthcare system. And some observers say that it's a non-issue because FP and not-for-profit (NFP) healthcare organizations differ little in their behavior and outcomes.

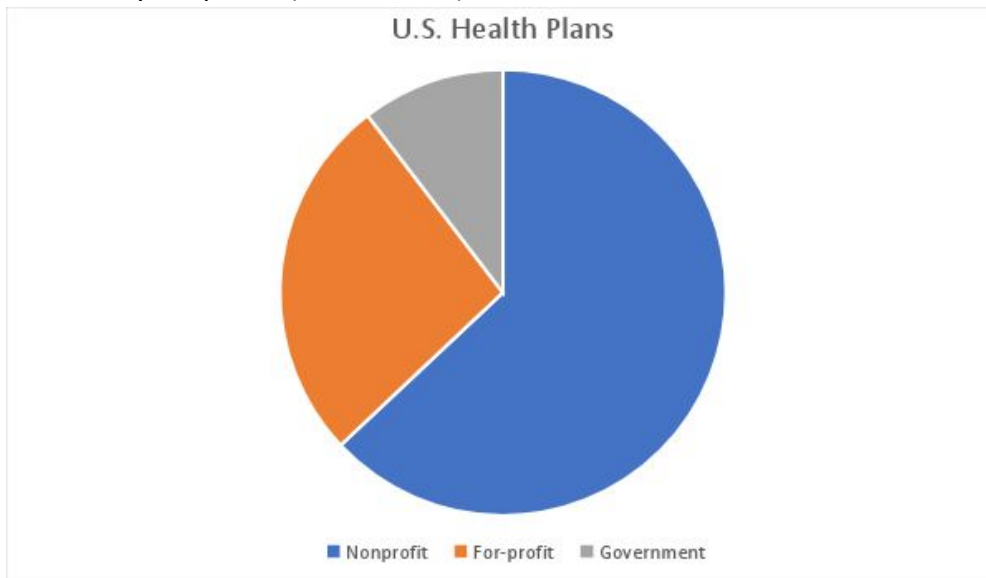
In America's market-based economy, profit-seeking organizations dominate most industries. By contrast, US healthcare has a mix of FP, not-for-profit (NFP), and government entities providing and financing care. What are the facts regarding the role and impact of profit in US healthcare?

How Much of the US Healthcare System is For-Profit?

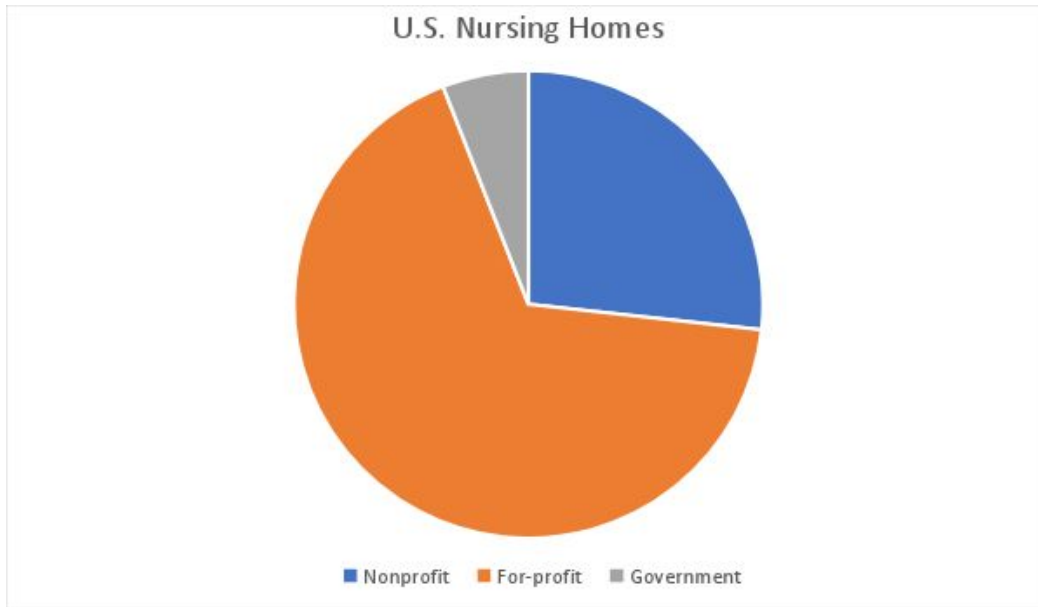
The nonprofit health care sector accounts for 58% of community hospitals (and 69% of community hospital beds), 45% of private health plans (and 50% of private plan enrollment), and between 50-92% of hospices, home care providers and nursing homes in about half of the states.



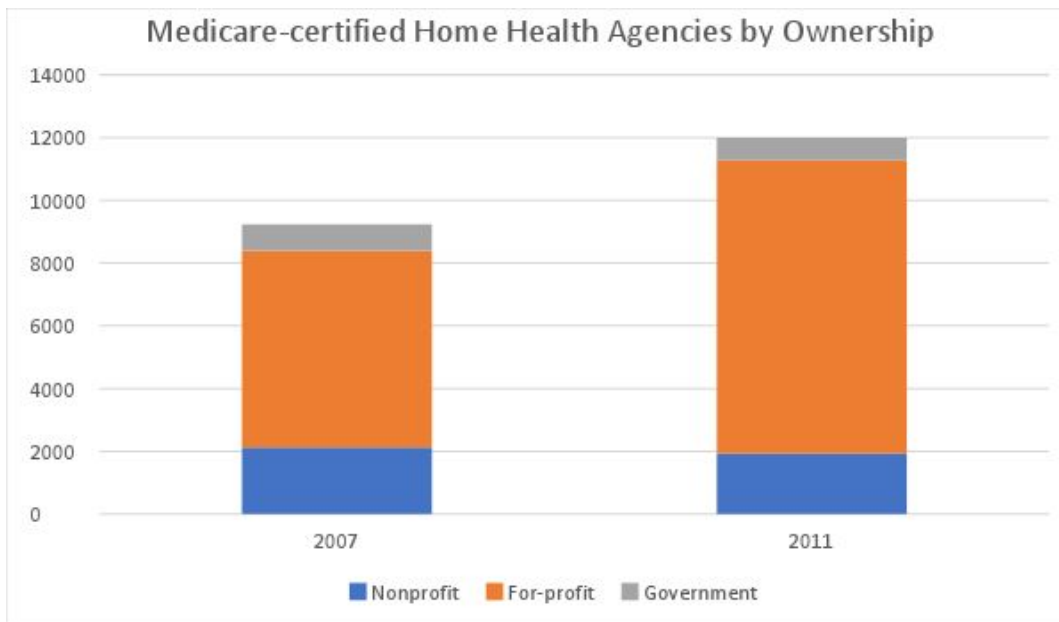
Non-profit hospitals: There are 2,904 nonprofit community hospitals in the U.S., representing 58% percent of the total number of community hospitals and about 74% of all privately owned community hospitals. (30% of beds)



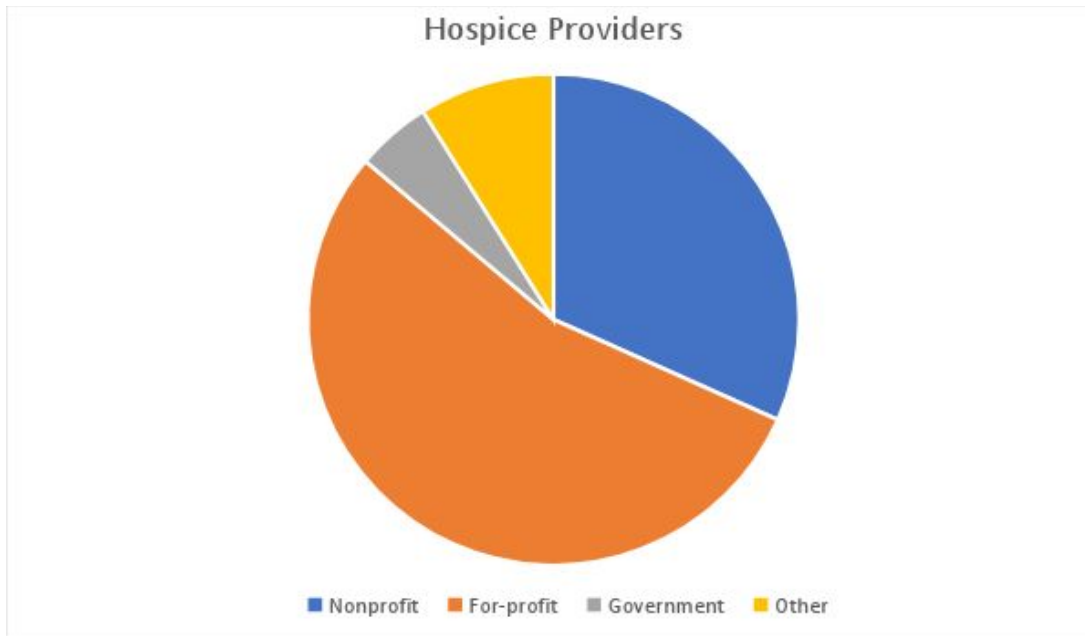
Health plans: Of the 154 health plans in the United States with at least 100,000 enrollees, 97 (or 63%) are nonprofit, 41 are for-profit (27%), and 16 (10%) are government.



[Nursing homes](#): There are 4,226 nonprofit nursing homes in the U.S., representing about 27% of the 15,884 nursing homes in the U.S. About 6% are government-owned and the remaining 68% are for-profit.



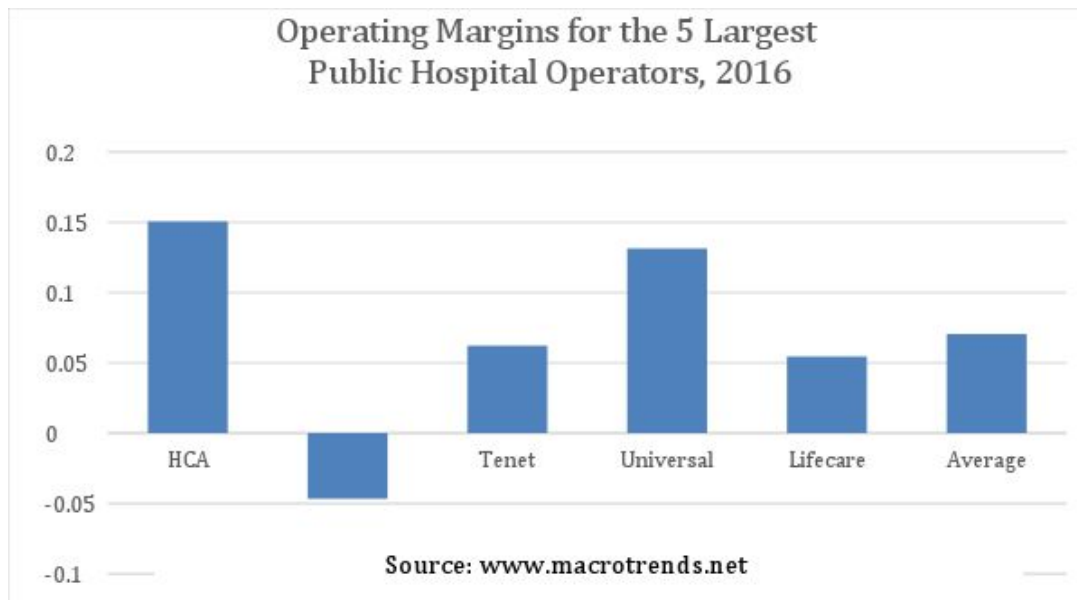
[Home health services](#): There are about 12,000 Medicare-certified home health agencies in the United States, up about 30% since 2007. Sixteen percent (16%) of these agencies are nonprofit (down seven percentage points since 2007), 6% are government (down three percentage points since 2007), and 78% are for-profit (up ten percentage points since 2007).



[Hospice](#): A slight majority of hospice providers (55%) are for-profit, while 32% are nonprofit, 5% are government, and 9% fall into an “other” category.

How do non-profit versus for-profit entities behave differently from one another?

A Moody’s report pegged median NFP hospital operating margins at 2.7% in 2016. Operating margins at the 5 largest publicly held FP hospital chains that year averaged 7.0%. The largest chain, Hospital Corporation of America (which accounted for about half of all hospitals in the group) earned a 15.1% operating margin in 2016. FP profit margins are usually higher than NFPs, though Community Health Systems, the second largest FP chain, saw a 4.1% operating loss in 2016.



NFP hospitals pay no income taxes, but in return are expected to serve community needs. For hospitals, a major part of this is delivering uncompensated care. A 2017 Modern Healthcare [analysis](#) that compared the nation’s 20 largest NFP hospitals and hospital systems by revenue in 2015 and 2016 that coverage for charity care varied widely. As a percentage of net operating expenses, charity care ranged from 0.46% to 16.69%. Mayo Clinic’s charity care accounted for nearly 6% of operating expenses in 2016. Analysts pointed out that demands for charity care differ in various hospitals.

As a recent *Health Affairs* [study](#) highlights, the ACA had encouraged tax-exempt hospitals to make more of an investment in community health benefits, but 4 years after the ACA’s enactment, spending for these benefits had increased very little, by just 0.5 percentage points.

There is some controversy over whether NFP hospitals provide more uncompensated care than do FPs. Several studies found little or no difference. A [2010](#) study of about 188,000 patients at more than 1,000 hospitals determined that FPs and NFPs offered comparable amounts of uncompensated care in patients hospitalized for childbirth, heart attack or coronary artery bypass grafting. Critics of FPs claim that most studies showing no difference in uncompensated care are based on single-state or regional data sets, and combine charity care and bad debt. As part of the ACA, CMS collected data from 2011 through 2014 from all hospitals and did find a difference: In 2014, charity care by FPs equaled 1.07% of patient revenue, compared with 2.20% for NFPs. That’s double the percentage, but some observers question whether the 1.13% difference justifies the tax break that NFPs receive.

A team of researchers did an [analysis](#) of U.S. hospitals, categorizing them into four groups: privately-owned NFP hospitals, government-owned public hospitals, FP hospitals that were part of the HCA large hospital chain, and all other FP hospitals. Quality was assessed using the following metrics: patient experience, adherence to evidence-based guidelines, mortality

and readmission rates, and Hospital Safety Score. Researchers found that public hospitals did the worst and HCA hospitals did the best, scoring well on patient experience, adherence to quality guidelines, and on mortality and readmissions. They did particularly well with the Leapfrog safety score. In comparison, FP hospitals outside of the HCA scored lower on patient experience and mortality and readmission rates, although they did better on processes measures. The study's author who blogged about the report's findings concluded that a hospital's FP versus NFP status is less important than the individual hospital's leadership and dedication to improvement and focus on quality.

Health Plans:

The health insurers' trade association, America's Health Insurance Plans (AHIP), released a study in 2017 analyzing insurance company costs and profits. The target group of 22 NFP plans and 5 FP insurers had average net profits of 2.7%. While this figure wasn't broken down along FP/NFP lines, that same year the 4 largest FP plans averaged 5.0% margins. This suggests that FP insurers routinely earn higher margins than NFPs. However, it's worth noting that the largest NFP plan, Kaiser Permanente, earned a 5.5% margin in 2014. This raises the possibility that size is more important than profit status to profit margin. However, many other factors may impact margin, including product mix, regional economics, provider concentration, and management competence. Few studies have examined the differences in profit margins of FP vs. NFP plans.

Most observers seem to feel that there's little meaningful difference in the behavior of FP and NFP health plans. The Blues plans, often categorized as NFPs, aren't seen as very different from UnitedHealthCare or Kaiser.

In 2014, California's Franchise Tax Board revoked Blue Shield of California's tax-exempt status, casting [renewed scrutiny](#) in other tax-exempt sectors of healthcare, as the Blues plan sought to challenge the state's decision. Some critics suggest that the company should convert to for-profit status, which would return billions of dollars to the public immediately and provide ongoing tax revenue. Several other Blues plans have done this previously, including Blue Cross of California, which converted to for-profit status in 1996 to form Anthem.

A 2001 Health Affairs [study](#) of FP and NFP health plans in Medicaid found few differences in management style, although FP plans were more likely to use aggressive utilization review and had slightly less developed quality management systems. This blogger [comments](#) that NFPs hold a competitive advantage over FP plans in that they don't have to pay taxes and may seem more honest to consumers who find the idea of a plan making money distasteful. FP plans, however, have access to capital and have better buying capabilities to acquire companies.

Nursing Homes:

This [report](#) from the Center for Medicare Advocacy asserts that there is a difference in quality of care between FP and NFP nursing home facilities. For profits ranked much lower than not-for-profits in terms of having more serious deficiencies, poorer quality of care and lower staffing levels. Another [report](#) from Marshall University had similar results. "Based on the findings of this review, it was suggested that NFP nursing homes have achieved higher quality of

care due to a more effective balance of business aspects, as well as prioritizing resident well-being, and care quality over profit maximization in NFP homes,” the authors summarized.

Does salary matter?

Not-for-profit healthcare businesses typically pay their executives very well. Several [analyses](#) reveal that the salaries of not-for-profit (NFP) CEOs are quite significant and on the rise. An [analysis](#) in JAMA of more than 1,800 hospital CEOs at 2,681 private NFP hospitals found that these executives on average were getting paid nearly \$600K annually. Factors such as the number of beds, teaching status, location and hospital performance affected earnings. Supporters point out that these salaries make sense, considering that some of these NFP CEOs are in charge of more than 150,000 employees. A CEO at a FP facility would likely get three times as much.

In 2017, an Axios [analysis](#) of 113 CEOs representing 70 of the largest publicly traded healthcare companies (FP only) found that since passage of the Affordable Care Act (ACA) in 2010, these executives have earned a cumulative \$9.8 billion. The Axios analysis concluded that generous pay packages of CEOs, much of which comes from invested stock, reduce incentives to rein in healthcare spending.

Executive compensation in total is a tiny fraction of overall healthcare costs. While 7-figure salaries garner headlines, and CEOs with FP companies typically earn more than their NFP counterparts (particularly from stock options when corporate growth is strong), cutting executive pay is unlikely to have a material impact on healthcare expenditures. More interesting is the issue of whether the way executives are compensated – especially though not exclusively at for-profit companies – leads to higher healthcare costs.

How does the FP vs. NFP debate relate to single payer?

Some experts argue that private healthcare organizations – whether FP or NFP – will always seek to maximize their revenue and thus act to raise healthcare costs. Under this line of thinking, only a fixed national healthcare budget would eliminate the incentive to continually increase utilization and income. Some claim that a single payer system with tight reimbursement controls would at last force healthcare companies to focus on efficiency rather than growth. However, even under a single payer scenario the key question about FP healthcare would remain: Does the profit motive lead to better outcomes and better service at lower cost compared with NFP organizations, or does it prioritize money over patient care?

8.1 Role of profit: discussion questions

- Is there a meaningful difference in the outcomes or behavior of FP vs. NFP provider organizations? Of health plans? Other healthcare organizations?
- Is there a difference between a FP company’s desire for profit margin and an NFP’s drive for surplus?
- Given that doctors historically operated their own for-profit businesses, is there anything about an FP model that is inherently in conflict with good patient care?

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- Should it matter if FP companies earn higher margins and pay higher salaries vs. NFPs if they are more efficient and save the system cost overall?
- Is there a reasonable profit margin for a healthcare organization? Does that figure differ for a FP vs. NFP organization, given that NFPs are tax-exempt?
- Does the difference in charity care or other community service provided by NFP vs. FP hospitals justify their tax-exempt status?
- Conversely, should government require specific benefits from NFP providers in order for them to maintain their tax-exempt status?
- Should compensation for healthcare CEOs be limited? Does the answer differ for CEOs of FP vs. NFP companies? Should executive compensation in healthcare be treated differently from compensation in other industries?
- If all FPs converted to NFPs, to what extent would the prior profits no longer being earned be saved by the healthcare system?
- Does executive compensation at FP companies drive up healthcare costs? At NFP companies?
- Should NFP health plans that build up substantial reserves be forced to convert to FP status?
- How does the FP vs. NFP debate apply to physician behavior?
- How would the FP vs. NFP discussion differ under a single payer system?
- While many Americans would like to get profits out of healthcare coverage and delivery, few make the same claim for pharmaceutical companies for fear of reducing innovation. To what extent is the same rationale applicable to providers and insurers?