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Public vs. private provision of charity care? Evidence from the expiration of Hill–Burton requirements in Florida

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ABSTRACT

This paper explores the consequences of the expiration of charity care requirements imposed on private hospitals by the Hill–Burton Act. We examine delivery care and the health of newborns using the universe of Florida births from 1989 to 2003 combined with hospital data from the American Hospital Association. We find that charity care requirements were binding on hospitals, but that private hospitals under obligation "cream skimmed" the least risky maternity patients. Conditional on patient characteristics, they provided less intensive maternity services but without compromising patient health. When obligations expired, private hospitals quickly reduced their charity caseloads, shifting maternity patients to public hospitals. The results in this paper suggest, perhaps surprisingly, that requiring private providers to serve the underinsured can be effective.

1. Introduction

The provision of charity care, medical care for those who lack insurance and cannot afford to pay for it, is a central issue in the current debate over health care reform in the U.S. This is not surprising given that the number of U.S. residents without health insurance is projected to increase to 52 million or 19% of the population this year (Gilmer and Kronick, 2009). At the same time, the proportion of U.S. physicians providing charity care dropped 8 percentage points in the last decade, falling to 68% of physicians in 2004–2005. Among physicians who practice in a hospital setting, the drop is even larger—from 66% in 1996–1997 to 54% in 2004–2005 (Cunningham and May, 2006).

Historically, different solutions to the charity care problem have been implemented for specific groups. For example, the elderly all receive public health insurance under the Medicare program. Most children are now eligible for insurance coverage under a mix of private and public insurance plans, where the coverage of the public insurance plan (Medicaid) is sometimes substantially better or worse than that of most private plans. And many indigent patients receive charity care, often at public hospitals. Private non-profit hospitals receive substantial tax subsidies in return for an implicit agreement that the hospitals provide public services including the provision of charity care.

One proposal that was discussed in the context of health care reform is to place explicit requirements to provide charity care on these hospitals. Pear (2009) describes a bipartisan proposal sponsored by Senators Baucus and Grassley to require an explicit amount of charity care in return for getting or keeping tax exempt status. This provision has been vigorously opposed by organizations representing hospitals on the grounds that the current system of tax subsidies already successfully encourages hospitals to provide charity care so that quotas would increase the burden on hospital administrators without creating any social benefit.

This paper studies the expiration of historical requirements that private hospitals provide a fixed percentage of charity care, so as to "pay back" construction subsidies. The Hospital Survey and Construction Act of 1946 was intended to improve hospital infrastructure in underserved areas. It is often referred to as the Hill–Burton Act after its two senate sponsors. The Act provided

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grants and low-interest loans for hospital construction, and specified that recipients would be obligated to provide charity care for 20 years after the initial funds had been disbursed (see Almond et al., 2007 for further discussion). An important point is that over our sample period, Hill–Burton requirements took the form of explicit quotas from operating costs that were spent on charity care.

We examine hospitals' responses to the expiration of these requirements using a unique data set of all births in hospitals in Florida between 1989 and 2003. An important feature of these data is that we can track the same mothers over time, and hence we can control for the selection of mothers into different types of hospitals by estimating models with mother fixed effects. We investigate the effects of contract expirations on the services offered by the facilities, the mix of mothers served, procedures, and health outcomes. Furthermore, Florida is a state with an especially large number of uninsured persons. In 2006, 25.3% of the non-elderly population did not have health insurance coverage compared to 18.1% nationally.[1]

We find that private hospitals under obligation were indeed constrained by the charity care provisions. However, they selected low risk patients and offered less aggressive (and therefore less expensive) maternity services. When their obligations expired, private hospitals quickly adjusted the mix of services and their caseloads and reduced the amount of charity care provided. Hence, the tax subsidy for non-profit hospitals, which remained in place, was not enough to encourage hospitals to maintain previous levels of charity care.

Private hospitals whose obligations expired reduced the provision of maternity care, and shifted mothers to public hospitals. Perhaps surprisingly, mothers in public hospitals received additional services, but did not benefit from any measurable improvements in outcomes. Thus, the public hospitals provided maternity services to the marginal patient less efficiently than private hospitals that were constrained to serve charity patients. These results provide additional support for solutions to the charity care problem that integrate the uninsured into the mainstream of health care delivery. Another reading of our results is that private hospitals are quick to adjust practices and caseloads in response to financial incentives, so that appropriate incentives are essential to control health care costs.

The rest of the paper is laid out as follows. The next section provides important background information and a discussion of hospital incentives. Section 3 describes the data and Section 4 describes our methods. Results are shown in Section 5, with some extensions in Section 6. Section 7 concludes.

2. Background on the Hill–Burton Program and hospital incentives

The Hill–Burton Act authorized Federal grants, loans, and loan guarantees to assist states and communities in constructing hospitals and public health centers. By 2000 the Hill–Burton Act had dispensed more than $4.6 billion in grants as well as $1.5 billion in loans to nearly 6800 healthcare facilities in over 4000 communities (Hill and Hill, 2004). To be eligible for Hill–Burton funds, the hospital could be either a public or not for profit entity. Facilities were initially obliged for a period of 20 years to make a "reasonable volume" of free services available to persons unable to pay. In 1979, "reasonable volume" was defined to be "not less than the lesser of (i) three percent of its operating costs for the most recent fiscal year for which an audited financial statement is available or (ii) ten percent of all Federal assistance provided to or on behalf of the facility, adjusted by a percentage equal to the percentage change in the national Consumer Price Index for medical care between the year in which the facility received assistance or 1979, whichever is later, and the most recent year for which a published index is available."[2]

The obligation begins when construction of any facility built with Hill–Burton funds is completed. If a facility does not provide the required volume of uncompensated care in any year, then it must make up the difference even if that extends the total number of years under obligation, then it must make up the difference even if that takes more than 20 years (Department of Health, 1992). Over the period under consideration, many hospitals converted from non-profit to for-profit status. Nevertheless, these hospitals continued to be obligated by their Hill–Burton requirements.[3]

Although some public hospitals also received funding under Hill–Burton, we focus on the responses of private hospitals. Previous studies have suggested little difference in the behavior of non-profit and for-profit private hospitals (Duggan, 2000; Needleman et al., 1999; Norton and Staiger, 1994; Pauly, 1987); both are constrained by market forces. On the other hand, public hospitals are paid for by the state, city or county, and have an obligation to serve the indigent. Hill–Burton requirements were unlikely to be binding on many public hospitals. For example, Jackson Memorial hospital in Miami-Dade county reported that charity care as a percent of operating revenue was 23% in 1999 (Jackson et al., 2002).

We can think of private hospitals (hereafter "hospitals") as having a target level of charity care. Frank and Salkever (1991) and Frank et al. (1990) point out that this level can be greater than zero, if for example, providing charity care improves relationships with regulatory agencies, or increases donations to the hospital. If the optimal level of charity care is greater than the Hill–Burton requirement, then the obligation's expiration should have no effect. Alternatively, if it is binding then hospitals will reduce charity care when the obligations expire.

Our analysis indicates that the obligations were binding. Data on hospitals' financial performance for the period 1979–2003 were obtained from the Agency for Health Care and Administration for the state of Florida. These data include the amounts spent by hospitals every year to meet their Hill Burton requirements and other funds donated or devoted to charity. Fig. 1 shows the fraction of total patient revenue devoted to Hill–Burton care by participating hospitals before and after their obligations expired.[4] The figure shows that hospitals spent close to the expected level of 3% of operating costs on Hill–Burton patients in each fiscal year. Since the

[1] Authors' calculations based on the Current Population Survey.

[2] CFR (1979).

[3] The Hill-Burton regulations' provision in such cases is that either the hospital continued to comply with the initial obligations stipulated by the contact signed with the non-profit entity or the federal loan is returned in full to the federal government. The same rule applied to hospital mergers in which one of the entities is under obligation at the time of the merger. The Health Resources and Services Administration assured us that there were no cases in Florida in which the for-profit (or merged) hospital opted to return the grant money rather than take on the obligations. The updated list of Hill-Burton facilities and expiration dates was cross-checked with the list of hospital mergers and hospitals that changed to for-profit status to confirm this statement. No discrepancies were found.

[4] Hospitals that have not finished all of their obligations by the year of the expiration are expected to continue providing Hill-Burton care until those full obligations are met, which accounts for non-zero contributions in the years immediately following expiration. It may also account for the fact that contributions fall in the year prior to expiration on average. That is, if the hospital owes only 1.5% of revenues in their last year of obligation, then that is the amount of charity care they supply, not 3%. See 42 C.F.R §124.503 compliance levels: (b) Deficits. If in any fiscal year a facility fails to meet its annual compliance level, it shall provide uncompensated services in an amount sufficient to make up that deficit in subsequent years, and its period of obligation shall be extended until the deficit is made up.