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(603) 226-2500
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(603) 226-2500
ddelay@nhpolicy.org

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rjtappin@nhpolicy.org

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(603) 226-2500
doughall@nhpolicy.org

Financing New Hampshire Hospitals: Cost-Shifting in 2005

March 2007

Author

Steve Norton
Executive Director

About this paper

We thank the New Hampshire Hospital Association (NHHA) for sharing with us the audited financial statements and standard financial spreadsheets that they collect from the hospitals in the state and for their assistance in clarifying a number of issues with the data. The analysis and opinions expressed in this paper, however, are those of the Center alone.

This paper is one of a series published by the NH Center for Public Policy Studies on the broad topic of health-care finance and insuring the New Hampshire workforce. The Concord-based Endowment for Health has sponsored this work.

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Financing New Hampshire Hospitals: Costing Shifting in 2005

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Executive Summary

Hospitals play a critical role in the health care system in New Hampshire. Total health expenditure in New Hampshire will total \$9.65 billion in 2006. Hospital care accounted for the largest share of personal health care spending in 2006 and will also account for the largest share of growth over the next five years.¹ Understanding hospital finances is critical to understanding the broader health care market and the future of the health care safety net, as the hospital sector is an important asset for the state and for the communities in which the hospitals reside.²

Critical to the financial well-being of New Hampshire hospitals is their ability to cover, and in some cases, recover the costs of providing services. In an environment in which the public payers – which account for almost 50 percent of health care expenditures – pay less than the costs of services and some of the uninsured are provided services through hospital-based charitable care, the hospital industry has to find ways to support patient care services. One way of financing these deficits has been through the allocation of unpaid costs to one patient population – in this case, the publicly funded and uninsured – through above cost revenue collected from other patient populations – largely the privately insured. This phenomenon is called ‘cost-shifting.’ This analysis updates previous work the Center has conducted on cost shifting.

The major findings of this analysis are:

- In 2005, hospitals shifted approximately \$345 million for deficits in charity care, Medicaid and Medicare onto private insurance.
- Over time, the aggregate amount of cost shift has been increasing. The total volume of losses associated with the public payers and charitable care increased by 93 percent from \$179 million in 2001 to \$345 million in 2005.
- In addition to covering their costs, New Hampshire hospitals have been able to achieve operating surpluses. Hospitals in New Hampshire generated \$160 million in net income in 2005 and only Alice Peck Day experienced a negative operating margin.
- Hospital operating margins have also been growing since 2001. In 2001, the hospital industry experienced net operating income of \$48 million. In 2005, net operating income was almost \$160 million, representing a 230 percent increase over 2001.
- Not all hospitals in New Hampshire have fared well historically. Critical access hospitals – a federal designation allowing for enhanced Medicare reimbursement for the rural hospitals in the state – experienced negative margins between 2000 and 2003.
- Cost-shifting results in significant increase in private insurer payments above and beyond the existing cost of services. In 2005, this implicit hospital surcharge amounted to 45 percent of the costs of a given service.

¹ New Hampshire Center for Public Policy Studies. “16 Cents of Every Dollar: Health Care Costs in New Hampshire (2004-2005),” February 2007

² The hospital industry accounts for a significant share of the state’s non-profit activity. In 2004 according to the National Center for Charitable Statistics, New Hampshire hospitals accounted for 22 percent of the state’s charitable assets, second only to secondary education. Moreover, the hospitals provide community benefit (and are required to report on those activities by state law) in a variety of different forms including providing charitable care and supporting other safety net organizations like community health centers.

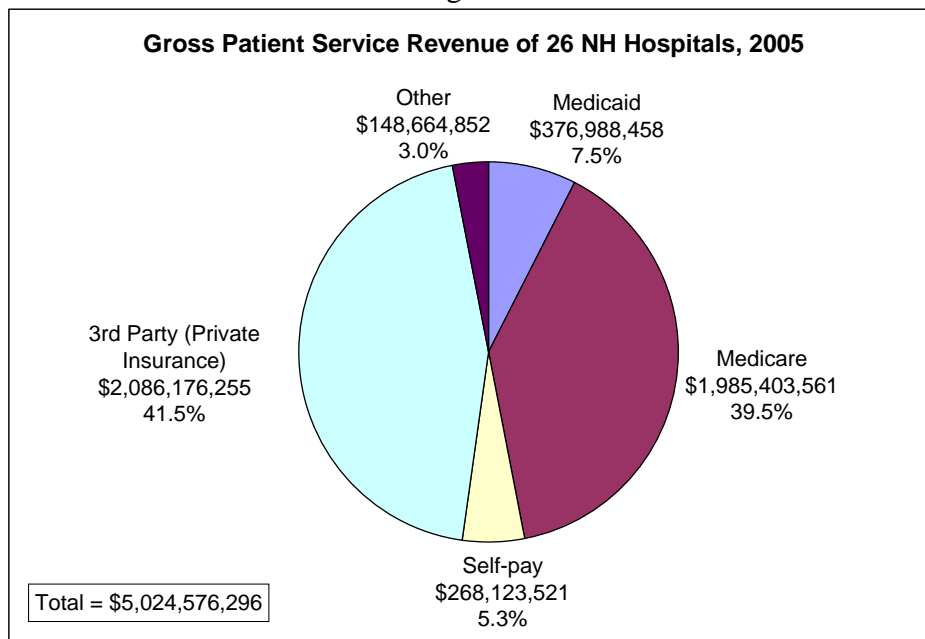
Hospital Charges and Revenues

Hospital care is billed to and then paid for by commercial health insurance, by the federal Medicare program for seniors, by the state Medicaid program for low-income and disabled individuals, and directly by patients who received care. Charges or bills – what NH hospitals call gross patient service revenue – represent the “list price” for a hospital’s services. In 2005, the total amount billed by hospitals was \$5.0 billion. Figure 1 displays the amount and percentage of gross patient service revenue – what was billed – to each major payer. While private insurance payments remain the largest share of total billings, Medicare was a close second.

Payment – patient service revenue – is the amount of revenue actually received based on the fixed fees of government programs, contractual discounts with insurers, and debt written off. The amount of revenue generated from these hospital charges – \$2.7 billion – was much less than charges for a variety of reasons. Hospitals provide discounts to insurers, Medicare and Medicaid programs pay less than the amount billed, and charity care and bad debt³ had to be written off. Each of these results in a reduction in the amount received from the various payers. The amount and sources of this net resulting patient service revenue are shown in Figure 2.

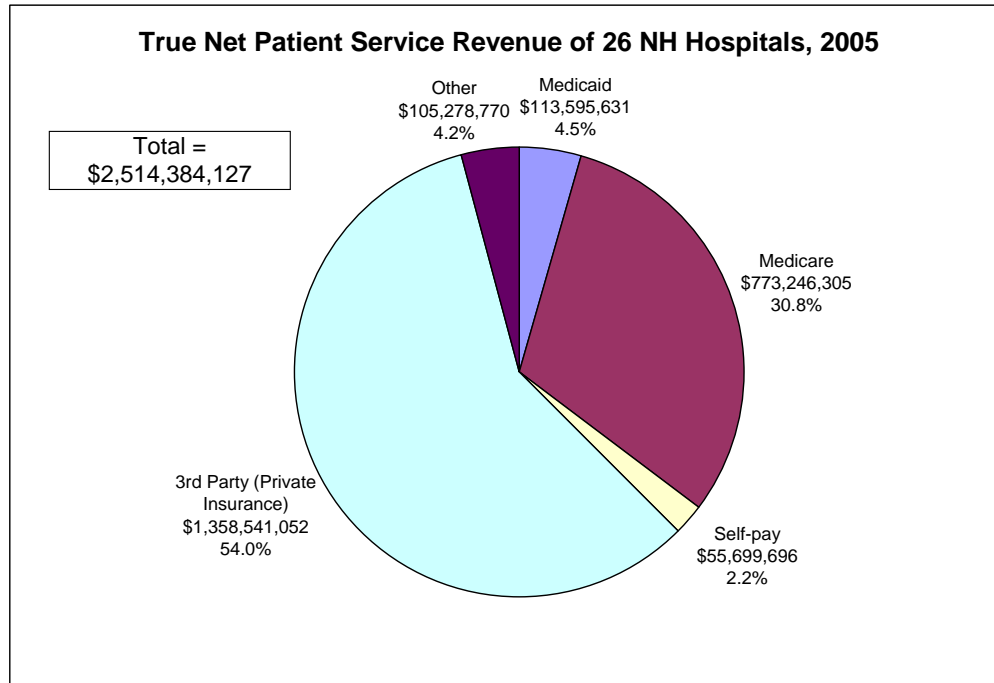
Taken together, these figures clearly suggest that hospitals receive a significantly higher share of their billed charges from private payers than for the other large payers. While charges to Medicare were 39.5 percent of total charges, Medicare payments constituted only 30.8 percent of the revenue hospitals actually received. In comparison, private insurance payments accounted for 41.5 percent of total charges and 54 percent of actual revenues.

Figure 1



³ Based on a survey of the hospitals conducted by the NH Hospital Association fielded in 2005, 74 percent of bad debt in 2004 was attributed to self-pay patients while 26 percent was attributed to insured patients.

Figure 2



Cost Shifting

When payment received for services from any payer is inadequate to cover costs – the true expenses of operating the hospital and providing patient services, including wages, equipment, medical supplies, heat, light, among other inputs – a hospital must find the financial support for those services from some other source, or the hospital will soon become financially impaired. A common term for this is “cost-shifting.” One definition of cost-shifting is “the allocation of unpaid costs of care delivered to one patient population through above-cost revenue collected from other patient populations.”⁴ Other terms that are used to describe the same facts are “price shifting,” “margin shifting,” “price discrimination,” and “reimbursement shifting.” In November 2004 the Center published “A Framework for Thinking About Cost-Shifting in Health Care.” That report describes the concept of cost-shifting, provides a framework for developing estimates of the shift in costs that occur, and more completely describes the hydraulics diagrams used to explain cost shifting below. Figure 3 is a hydraulics diagram that exhibits the aggregate of revenues and cost-shifting of New Hampshire’s 26 acute care hospitals in 2005.⁵

The horizontal axis of this diagram is divided into 100 sections, each representing one percent of gross charges. It shows that 45 percent of the gross charges were billed to insurance companies on behalf of insured individuals.⁶ Another 40 percent of charges were billed to Medicare and 7

⁴ “Cost Shifting: An Integral Aspect of U.S. Health Care Finance,” Al Dobson, The Lewin Group, November 13, 2002, at an invitational meeting “When Public Payment Declines Does Cost-Shifting Occur? Hospital and Physician Responses,” sponsored by The Robert Wood Johnson Foundation and conducted by AcademyHealth in Washington D.C., November 13, 2002.

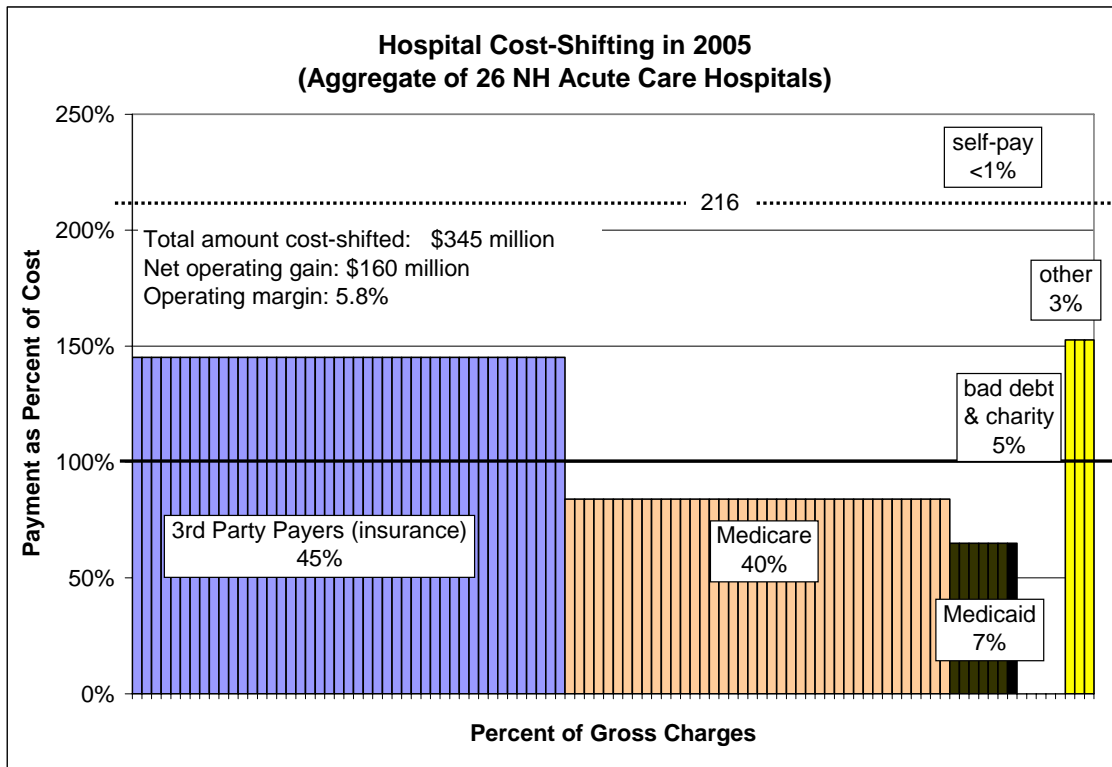
⁵ For a step-by-step review of how these aggregate numbers were calculated, see “Cost Shifting in New Hampshire Hospitals, 2004” New Hampshire Center for Public Policy Studies, February 2006.

⁶ A certain portion of the 3rd party payer amounts in these figures (and all subsequent hydraulics diagrams) is uncompensated care that is incompletely identified by the hospitals. We have recommended that hospital financial reporting in future years clearly distinguish between uncompensated care to insured and uninsured persons, though

percent were billed to the state Medicaid program. Five percent of charges were never paid; they were written off, either as free charity care or as bad debt. Three percent were billed to “other.”⁷ Less than one percent of charges were fully paid by uninsured persons.

The vertical axis of Figure 3 displays percentage of cost. A thick black horizontal line marks 100 percent of cost. A payer whose payments exactly equaled costs would be represented by vertical bars that rise exactly to this 100 percent level. A dotted horizontal line marks 216 percent of cost, the average charge amount. The vertical bar representing a payer that actually pays full charges would rise to this level.

Figure 3



How high the vertical bars rise indicates what percent of cost that payer type actually paid. On average in 2005, insurers paid 144 percent of cost. That is considerably below the amount of charges. The difference between charges at 216 percent of cost and payment at 144 percent of cost represents the average “discount” below charges enjoyed by health insurers. On average, Medicare paid only 83 percent of cost. Medicaid paid even less on average, only 65 percent of cost. “Other” payers paid 151 percent of cost.

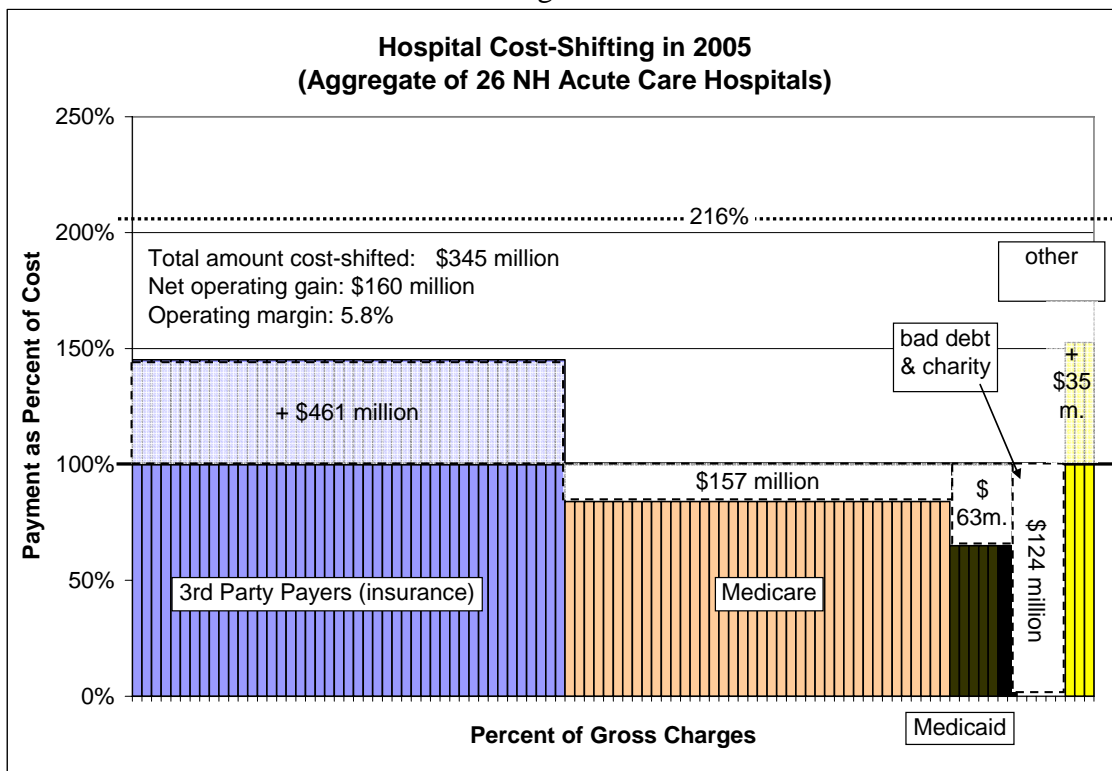
to date the hospitals have not adopted these recommendations. See our discussion of uncompensated care in NHCPP, “Cost Shifting in New Hampshire Hospitals, 2004.” February, 2006.

⁷ The “other” category is larger than it should be. A number of hospitals – including Memorial in North Conway – did not differentiate between self-pay and 3rd-party pay in the financial data they submitted to NHHA and submitted the total as “other.” Because we cannot separate revenue from these sources if the hospitals do not do so, our “other” category reflects their representation. We suspect that a significant share of this category is actually for charges billed to insurance companies.

Figure 4 shows the surplus or deficit relative to the costs of providing services by each payer. Medicare payments were \$157 million short of paying for the cost of services to Medicare patients. Medicaid payments were \$63 million short of paying for cost. And uncompensated care was \$124 million short. Taken together, for these three payers, hospitals were \$345 million short of paying for their costs.

To make up the difference, the hospitals had to receive more than the cost from other payers – primarily third party private insurers – for patient services. Payments on behalf of insured persons, mostly from their insurance companies, were \$461 million higher than cost. Payments from self-insured persons who paid for their entire hospital care and payments from “Other” payers were \$35 million above cost.

Figure 4

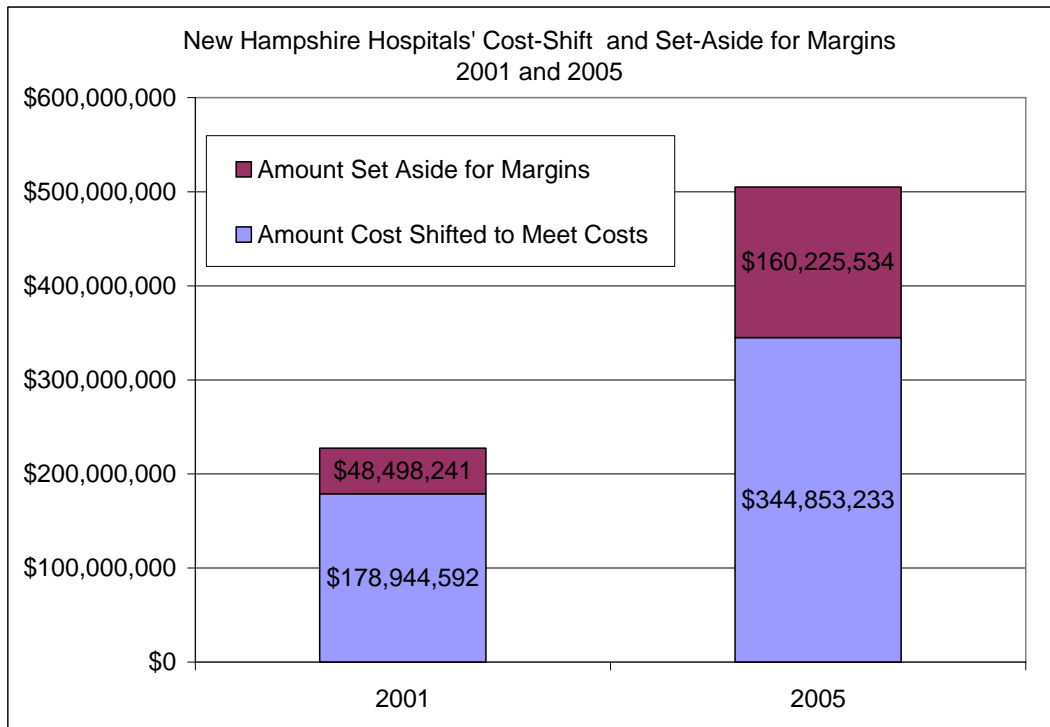


In addition to shifting sufficient revenues to meet their patient services costs, hospitals have also generated surpluses in the form of positive operating margins. The hospitals were able to cost-shift the \$333 million they were short, and they were also able to set aside \$183 million above breakeven, enough to result in an overall operating margin of 5.8 percent. Appendix A contains a cost-shift hydraulics chart for each hospital individually. As has been noted in the Center’s previous work, these charts should be viewed with caution given the variability in size, scope and reporting of New Hampshire hospitals which makes comparisons across hospitals difficult. We urge readers to use caution in making comparisons between any two hospitals.

The cost shifting phenomenon has grown considerably since the Center began conducting its work on cost shifting in 2001. As Figure 5 illustrates, our analysis of the 2001 finances of the same 26 hospitals showed that the hospitals had to shift approximately \$179 million to meet operating costs and, in addition, create operating margins of almost \$49 million. In 2005, the

magnitude of the cost shift had grown considerably as had net income creating operating margins.

Figure 5



The Hospital Surcharge to Private Insurance

Using the data from the previous analysis, it is possible to describe the surcharge or surtax for this cost-shift an individual makes to a hospital that is beyond the actual cost of services being provided. Table 1 provides an example. Assume that the average hospital billed or charged an insurance company \$10,000 for services to an insured person. As noted above, on average, this was 216 percent of the actual *cost* of services. The cost of the services to the hospital was actually \$4,640. Private insurers, however, paid \$7,082. When the payment of \$7,082 was received by the hospital, it covered the \$4,640 cost for services to the insured person, \$1,576 that was cost-shifted to cover services to others, and \$886 that was set aside as operating margin for future use. Thus, in 2005, the surtax for cost-shifting was 30 percent and the additional surcharge for net margin was 16 percent. This surtax has increased relative to 2004 and the portion set aside for an operating margin has increased from 11 percent to 16 percent.

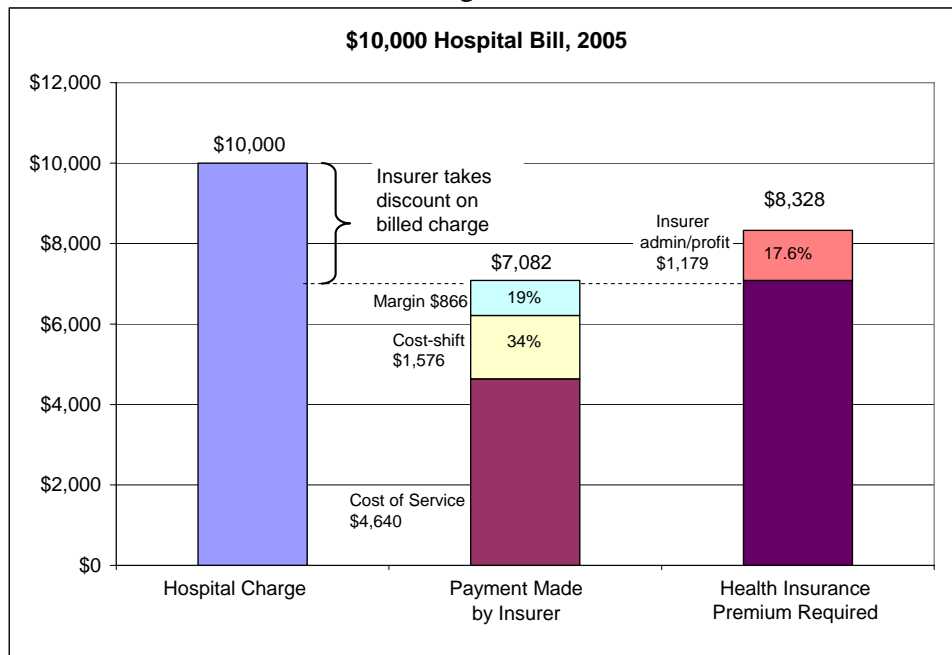
Displaying and describing in this manner how hospitals use the payments they receive from insurers illustrates one important reason why it is possible for some free-standing private health providers to offer certain kinds of equivalent services at lower cost. To the extent these providers do not have an internal 27 percent surtax to provide uncompensated care to other persons, they will be able to offer identical services at a lower price even if the actual costs for the service actually delivered to the insured person are the same.

Table 1

Insurance Premium to Pay for Hospital Service (2004 and 2005)				
	2004		2005	
	Hospital	Total	Hospital	Total
Hospital Charge	\$10,000		\$10,000	
Actual Cost of Service	\$4,854		\$4,640	
Cost-shift surcharge	\$1,284		\$1,576	
For operating margin	\$561		\$866	
Claim to be paid	\$6,699		\$7,082	
Claim to pay		\$6,699		\$7,082
Insurer admin/profit (17.6%)		\$1,179		\$1,246
Premium required		\$7,878		\$8,328
Premium as % of cost of service		162%		179%

Health insurers, in turn, must obtain the money they use to pay claims from the premiums they charge to employers and individuals. On average, in 2004, health insurance companies used 85 percent of premiums to pay claims and 15 percent for claims processing, administration, and their own profit.⁸ On average, the premium that an insurer had to obtain to pay a \$7,082 claim was 117.6 percent of the payment or \$8,328. Therefore, the health insurance premium was 179 percent of the actual cost of delivering the hospital service to the insured individual. This is portrayed graphically for 2005 in Figure 6.

Figure 6



⁸ New Hampshire Center for Public Policy Studies. "Basic Facts on Health Insurers in NH, 2001-2004." October 2005.

Hospitals' Need to Cost-Shift by Payer

Hospitals need to shift costs stems from the fact that public payers – Medicaid and Medicare – pay less than cost and that hospitals provide uncompensated care – both bad debt and charity care – to uninsured and under-insured New Hampshire residents. In what follows, we assess how the need to shift costs has changed.

Medicaid

In 2005, the hospitals provided services to Medicaid patients for which the charges were \$377 million. The actual cost of these services was \$177 million. The state Medicaid program, however, paid only \$114 million toward those costs. This resulted in the need for the hospitals to cost-shift \$63 million onto other payers. Lacking the state funds to increase funding (through payment rates), the full \$63 million was shifted, primarily onto health insurers and, therefore, onto the health care premiums paid by employers and individuals.

Between 2001 and 2005, the amount of cost shifting resulting from the Medicaid program increased considerably. In 2001, the hospitals provided services to Medicaid patients that cost \$99 million and the state paid \$67 million.⁹ This resulted in the need for the hospitals to cost-shift \$32 million that year. Between 2001 and 2005, the amount of premiums paid by employers and individuals increased considerably as a result of the hospital cost shift of below cost Medicaid payments.

Medicare

In 2005, the hospitals provided services to Medicare patients for which the charges were approximately \$2 billion. The actual cost of these services was \$930 million. The federal Medicare program, however, paid only \$773 million toward those costs. This resulted in the need for the hospitals to cost-shift \$157 million onto other payers.

Between 2001 and 2005, the amount of cost shifting resulting from the Medicare program increased considerably. In 2001, the hospitals provided services to Medicare patients that cost \$687 million and the federal government paid \$625 million. This resulted in the need for the hospitals to cost-shift \$62 million that year. Between 2001 and 2005, the amount of premiums paid by employers and individuals increased as a result of the hospital cost shift of below cost Medicare payments.

Uncompensated Care

In the aggregate, uncompensated care provided by New Hampshire hospitals has grown considerably since 1993. Uncompensated care includes both charity care – care which is provided free of charge – and bad debt – care generally for the insured that was not ultimately paid for by either the insurance company or the individuals themselves. As Table 2 shows, between 1993 and 2005, the amount of uncompensated care provided more than doubled from \$65 million to \$137 million.¹⁰ This represents the amount hospitals had to cost shift as a result of uncompensated care.¹¹

⁹ New Hampshire Center for Public Policy Studies. “Cost Shifting in New Hampshire Hospitals.” October, 2003. The report and data for 2001 can be found at <http://www.nhpolicy.org/health/costshift2001.pdf/>.

¹⁰ These are actual uncompensated care costs. They are calculated by summing the gross charity care and bad debt charges and multiplying that figure by the cost to charge ratio.

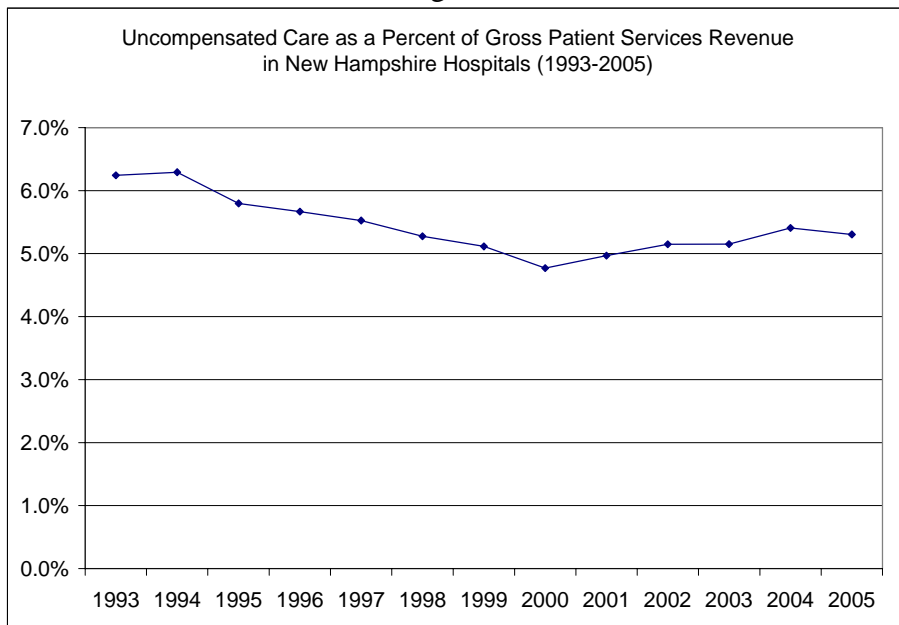
¹¹ This data on uncompensated care does not net out self-pay revenue as it was not available prior to 2001. Therefore the uncompensated care value is slightly higher than the bad-debt charity care measures used in the remainder of the paper.

Table 2

Uncompensated Care in NH Hospitals	
	Total Costs
1993	\$64,901,988
1994	\$66,621,905
1995	\$66,450,596
1996	\$68,018,986
1997	\$69,518,145
1998	\$69,952,658
1999	\$72,494,510
2000	\$73,849,546
2001	\$85,641,569
2002	\$98,446,383
2003	\$108,051,360
2004	\$125,655,080
2005	\$136,499,675

Generally speaking, the share of patient care resources devoted to uncompensated care has declined since 1993. As Figure 7 shows, uncompensated care as a share of patient services was slightly higher than 6 percent of patient services revenue in 1993 and declined slightly to 5.3 percent in 2005.

Figure 7



Hospital Operating Margins

It is clear that the financial well-being of hospitals is at least in part a function of their ability to shift the un-reimbursed costs of charity care and the public payers to the private market and, in the same fashion, set aside resources for operating margins which can be for a variety of

purposes including investing in the hospital's future. In what follows, we provide data on hospital operating margins since 1993. Hospital operating margins are only one measure of the financial well-being of hospitals and exclude income such as returns on investment.

In 2005, the hospitals in New Hampshire experienced a 5.6 percent operating margin on average. Table 3 provides operating margins after taking into account tax payments made by the two for-profit hospitals in the state. Table 3 shows significant variation across the state, and all but one hospital – Alice Peck Day – generated a positive operating margin. Contrast this to 2004, when three hospitals experienced negative operating margins: Lakes Region (-1.1 percent), Franklin Regional Hospital (-18.8 percent), and Androscoggin Valley (-2.6 percent).¹²

Table 3
NH Post-Tax Operating Margins (2005)

Hospital	Ownership	Critical Access Designation?	Operating Margin After Tax
Parkland Medical	For Profit		11.9%
Portsmouth Regional	For Profit		10.4%
Exeter	Not-For-Profit		10.3%
So. NH Regional	Not-For-Profit		10.0%
Elliot	Not-For-Profit		8.8%
Memorial	Not-For-Profit	Yes	8.7%
Catholic Med Ctr	Not-For-Profit		7.3%
Wentworth-Douglass	Not-For-Profit		7.0%
Littleton	Not-For-Profit	Yes	6.8%
Frisbie Memorial	Not-For-Profit		6.6%
Lakes Region	Not-For-Profit		5.8%
St. Joseph	Not-For-Profit		5.4%
Concord	Not-For-Profit		3.9%
Cheshire	Not-For-Profit		3.3%
Upper Conn Valley	Not-For-Profit	Yes	3.3%
Mary Hitchcock	Not-For-Profit		3.2%
Speare Memorial	Not-For-Profit	Yes	3.2%
Androscoggin	Not-For-Profit	Yes	2.7%
Valley Regional	Not-For-Profit	Yes	1.7%
Weeks Memorial	Not-For-Profit	Yes	1.4%
Huggins	Not-For-Profit	Yes	1.0%
New London	Not-For-Profit	Yes	0.5%
Franklin Regional	Not-For-Profit	Yes	0.3%
Monadnock	Not-For-Profit	Yes	0.3%
Cottage	Not-For-Profit	Yes	0.2%
Alice Peck Day	Not-For-Profit	Yes	-2.1%
Total			6.6%

Hospital operating margins, while fluctuating over the last 13 years, have shown increases since the year 2000. Table 4 shows net income (pre and post tax) as well as the average hospital margin in the state since 1993. In 1993, New Hampshire hospitals generated \$30 million in net income which represented 2.51 percent of operating revenue. In 2005, New Hampshire hospitals generated \$160 million in net income which represented 5.8 percent of operating revenue.

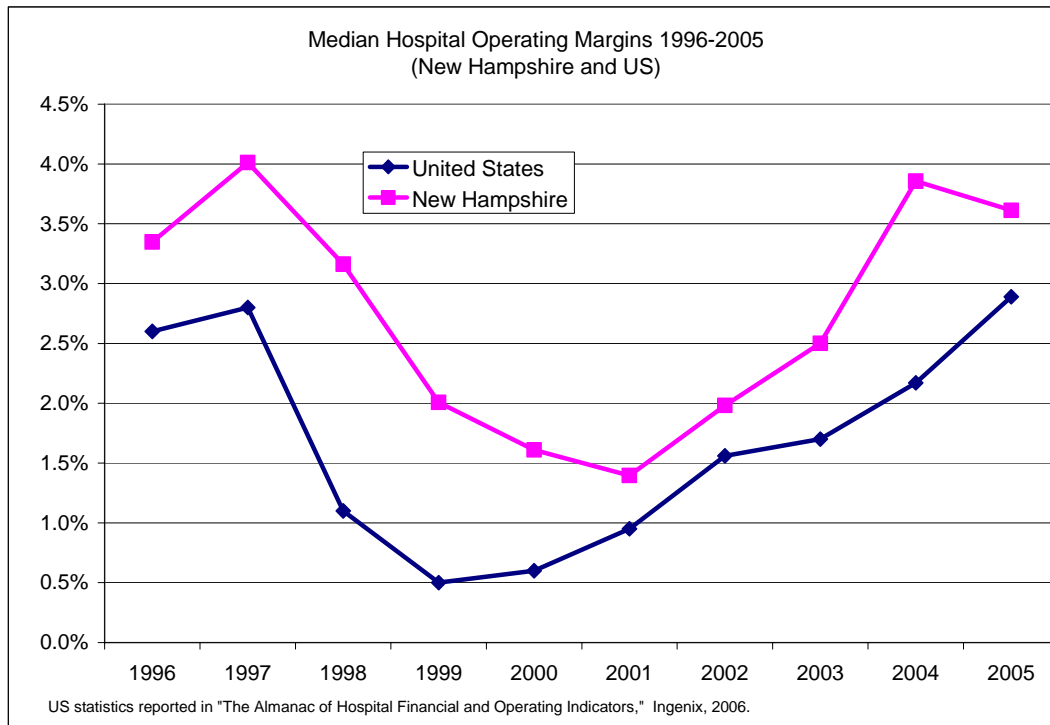
¹² New Hampshire Center for Public Policy Studies, "Cost-Shifting in New Hampshire Hospitals, 2004." February 2006. This report can be downloaded at <http://www.nhpolicy.org/health/costshift2004.pdf>.

Table 4

Net Operating Margins in NH Hospitals			
Year	Net Operating Income	Net Operating Income - Income Tax	Operating Margin (After Tax)
1993	\$29,989,583	\$26,887,270	2.51%
1994	\$63,196,739	\$58,705,238	5.23%
1995	\$56,671,474	\$52,604,289	4.37%
1996	\$52,444,145	\$46,331,464	3.70%
1997	\$70,902,929	\$61,061,734	4.59%
1998	\$42,478,391	\$34,468,365	2.52%
1999	\$41,640,425	\$33,481,033	2.29%
2000	\$46,592,048	\$37,581,389	2.36%
2001	\$70,872,799	\$60,471,799	3.37%
2002	\$83,304,446	\$73,620,700	3.69%
2003	\$131,646,929	\$118,103,864	5.30%
2004	\$153,376,544	\$137,111,380	5.53%
2005	\$182,980,608	\$160,225,534	5.81%

Operating margins in the New Hampshire hospital sector have remained consistently higher than the rest of the nation. Figure 8 compares the median operating margin in New Hampshire hospitals from 1996 through 2005. While the trends over time are similar – changes in operating margins in NH mirrored those in the national generally – the New Hampshire hospital sector has experienced net margins which are almost twice as high as the experience nationally.

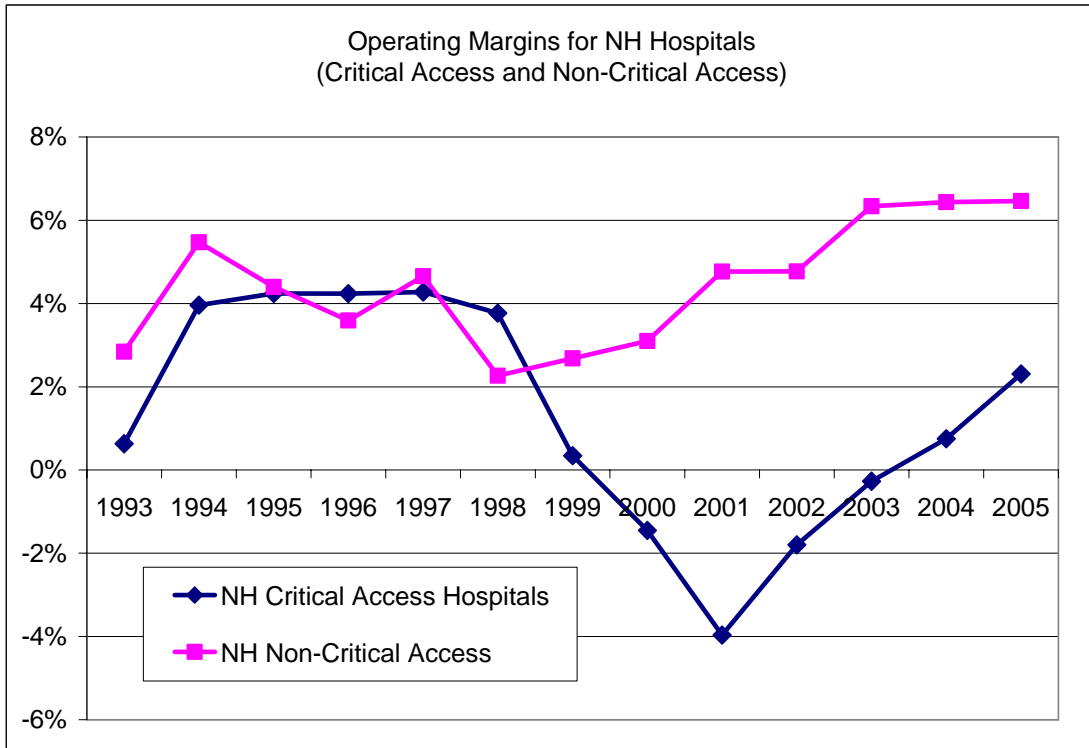
Figure 8



Such aggregate statistics mask significant differences across the state in the income generated by New Hampshire hospitals. Figure 9 shows the average margin for two different groups of NH hospitals: Critical access hospitals in the rural areas of the state and non-critical access

hospitals.¹³ Figure 9 demonstrates that not all hospitals in the state have fared equally well. Critical access hospitals have generally fared worse than non-critical access hospitals. Between 2000 and 2003, critical access hospitals experience negative margins on average.

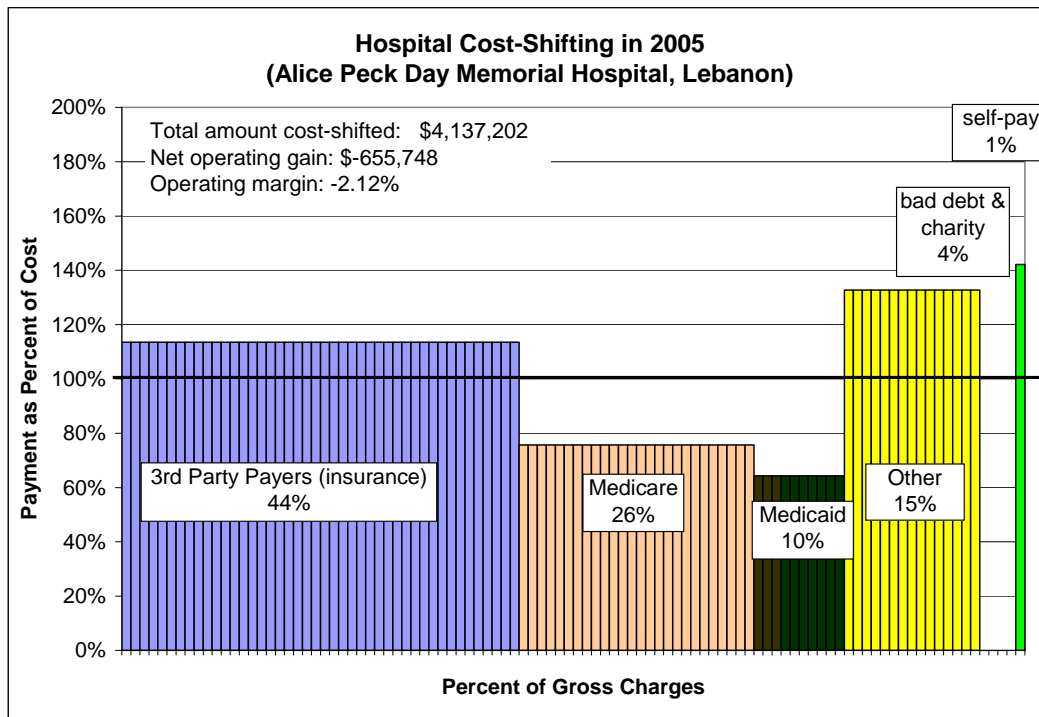
Figure 9



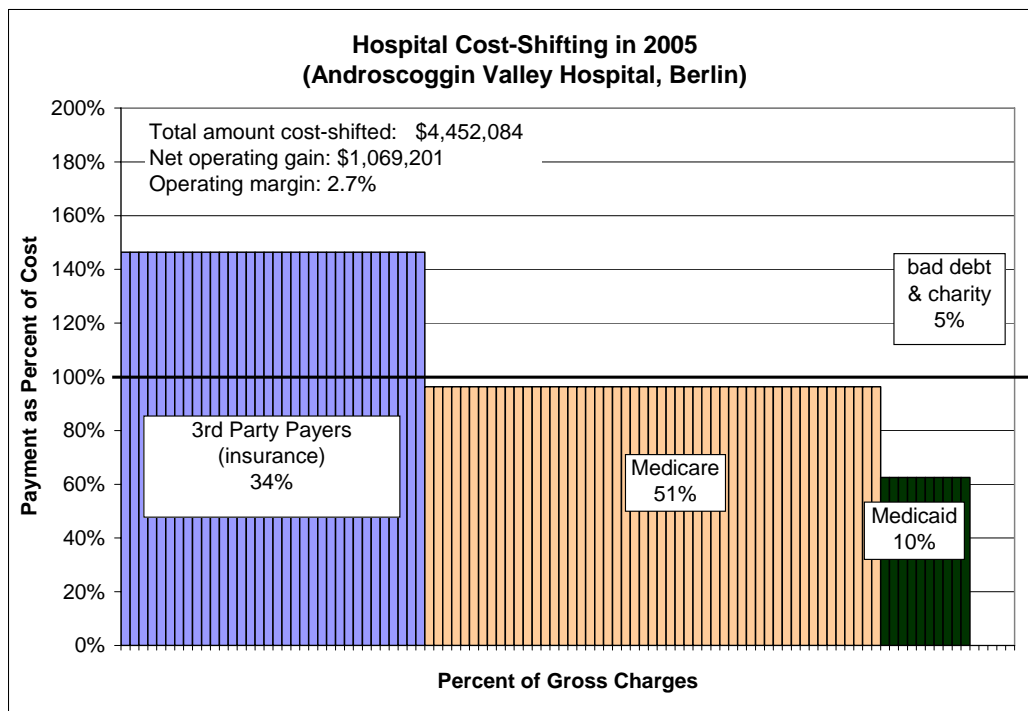
¹³ As of January 2006, thirteen of the state’s 26 hospitals have been designated “Critical Access” hospitals. This designation is a recognition on the part of Medicare (and now the State’s Medicaid) of the need to target additional funds to these rural entities based on their historical financial situation.

Appendix A: 2005 Hydraulics Charts for 26 Hospitals

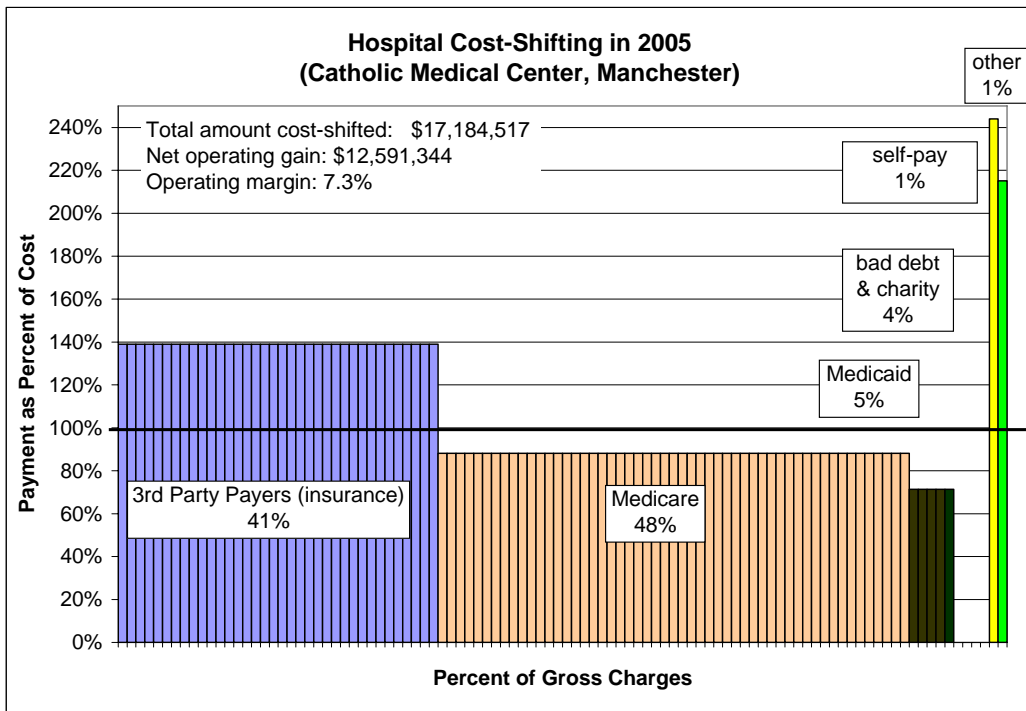
Alice Peck Day Memorial Hospital, Lebanon



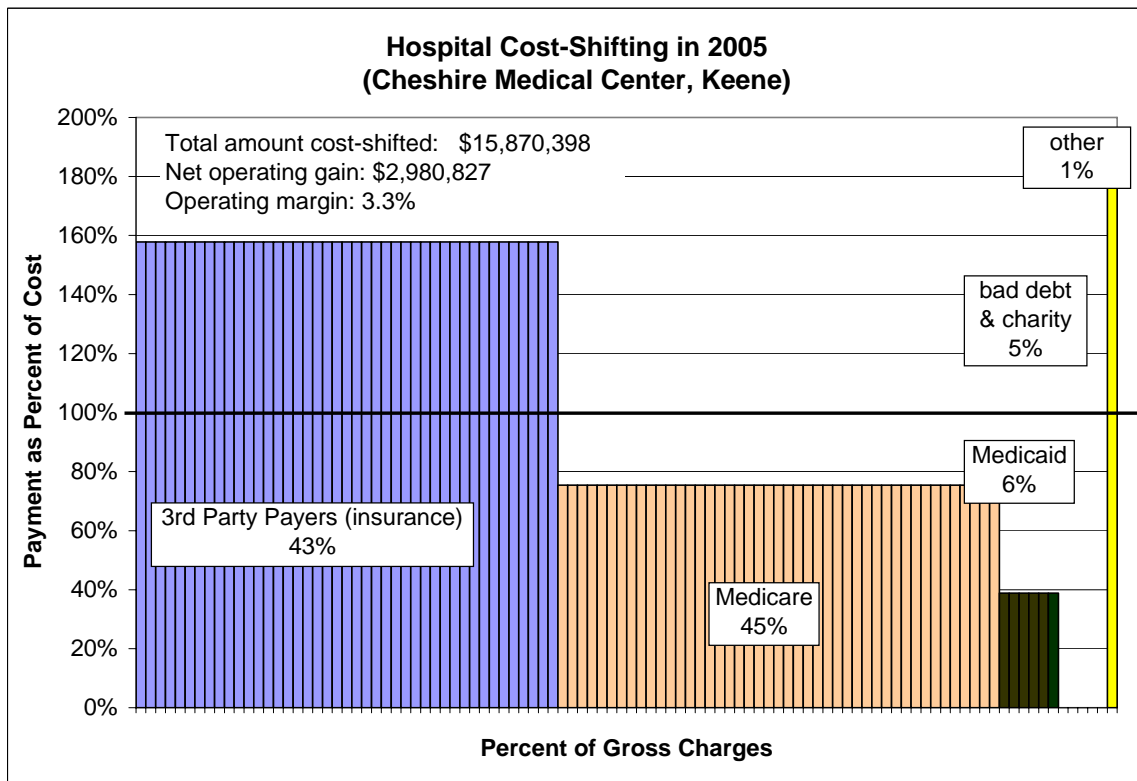
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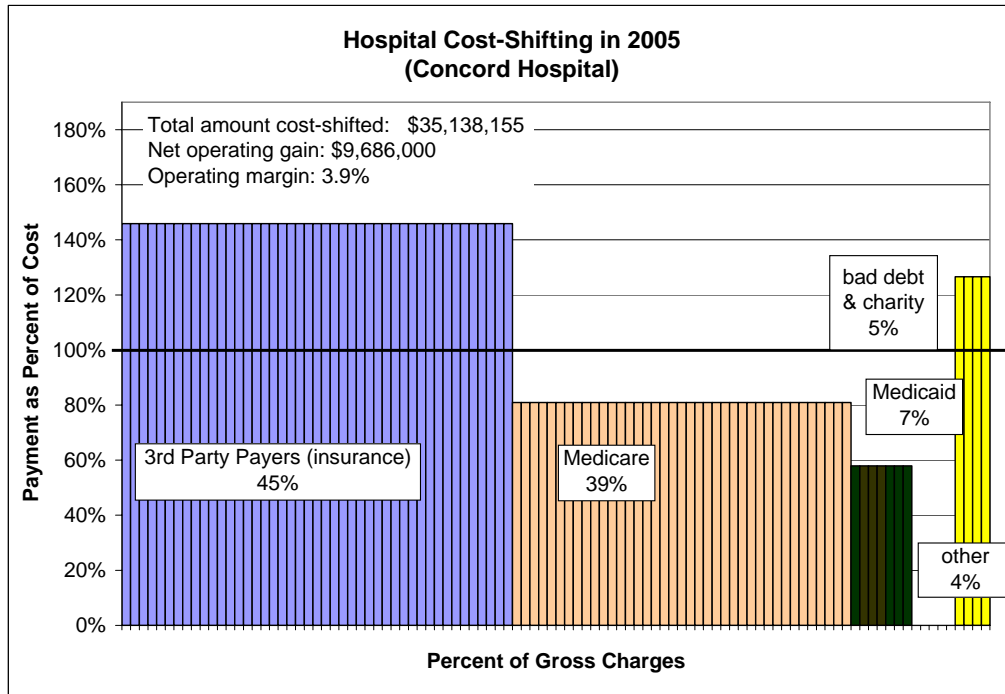
Catholic Medical Center, Manchester



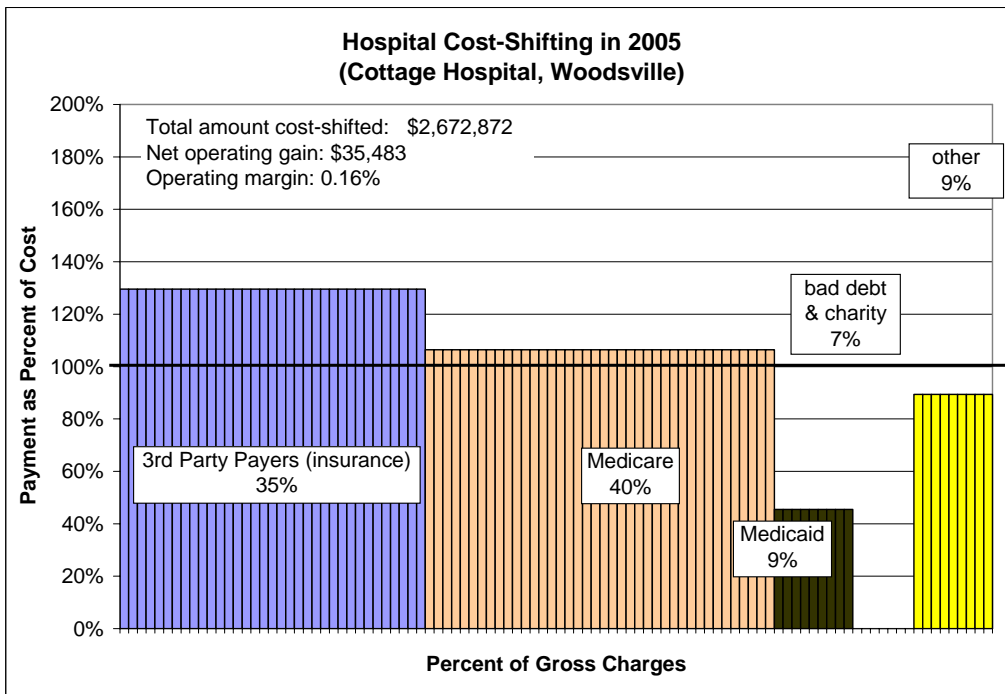
Cheshire Medical Center, Keene



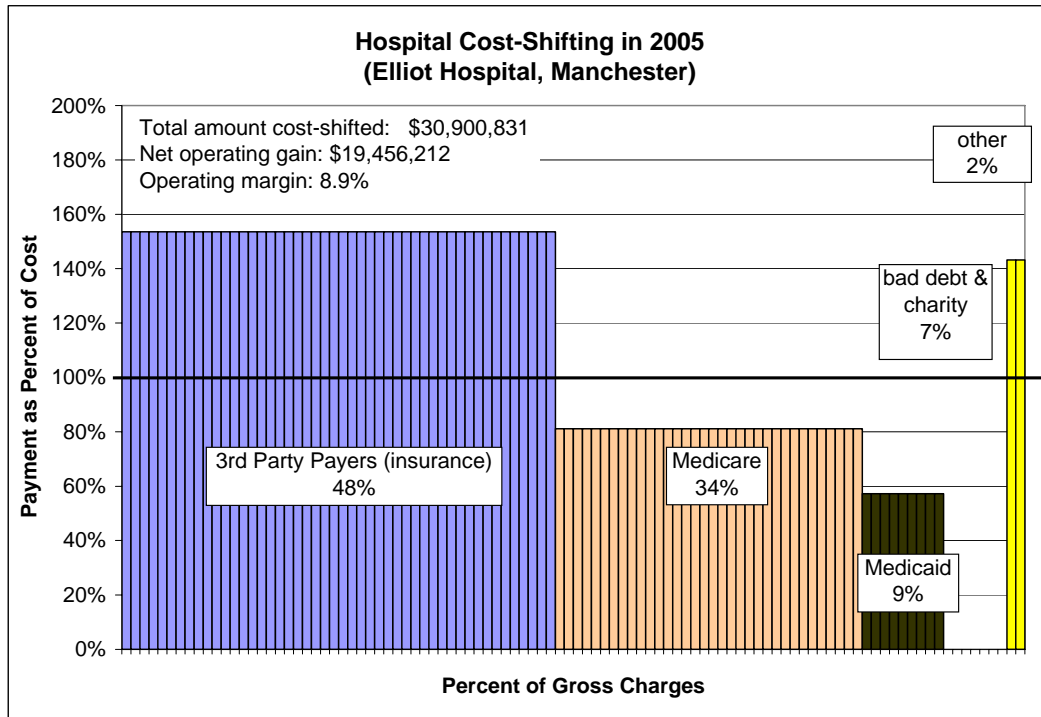
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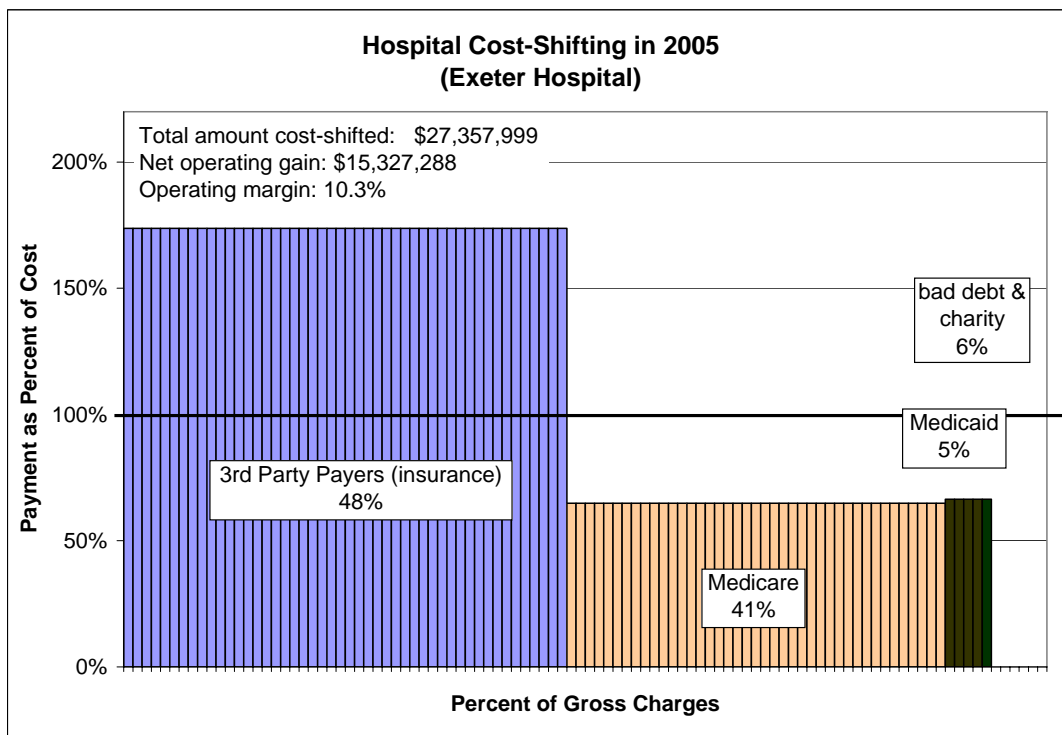
Cottage Hospital, Woodsville



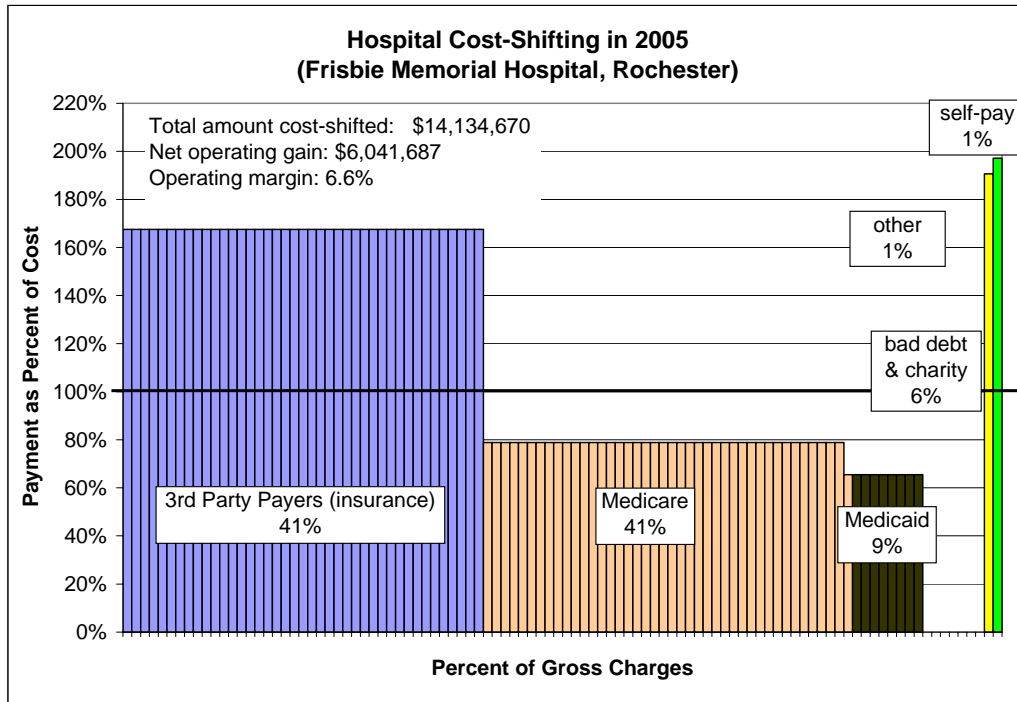
Elliot Hospital, Manchester



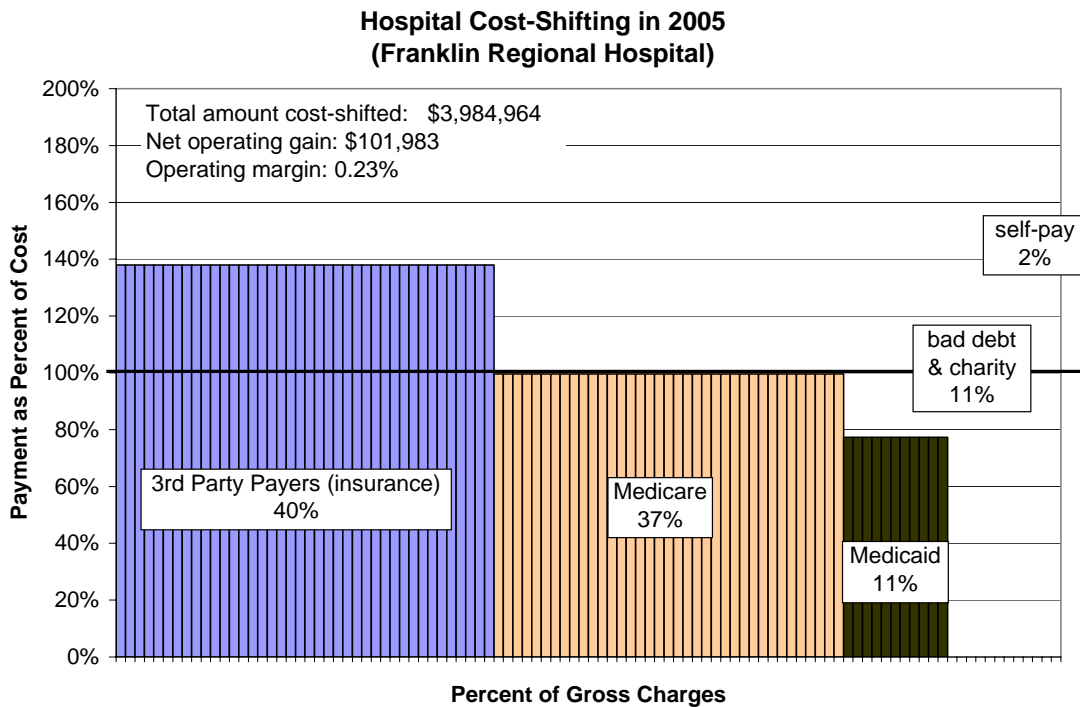
Exeter Hospital, Exeter



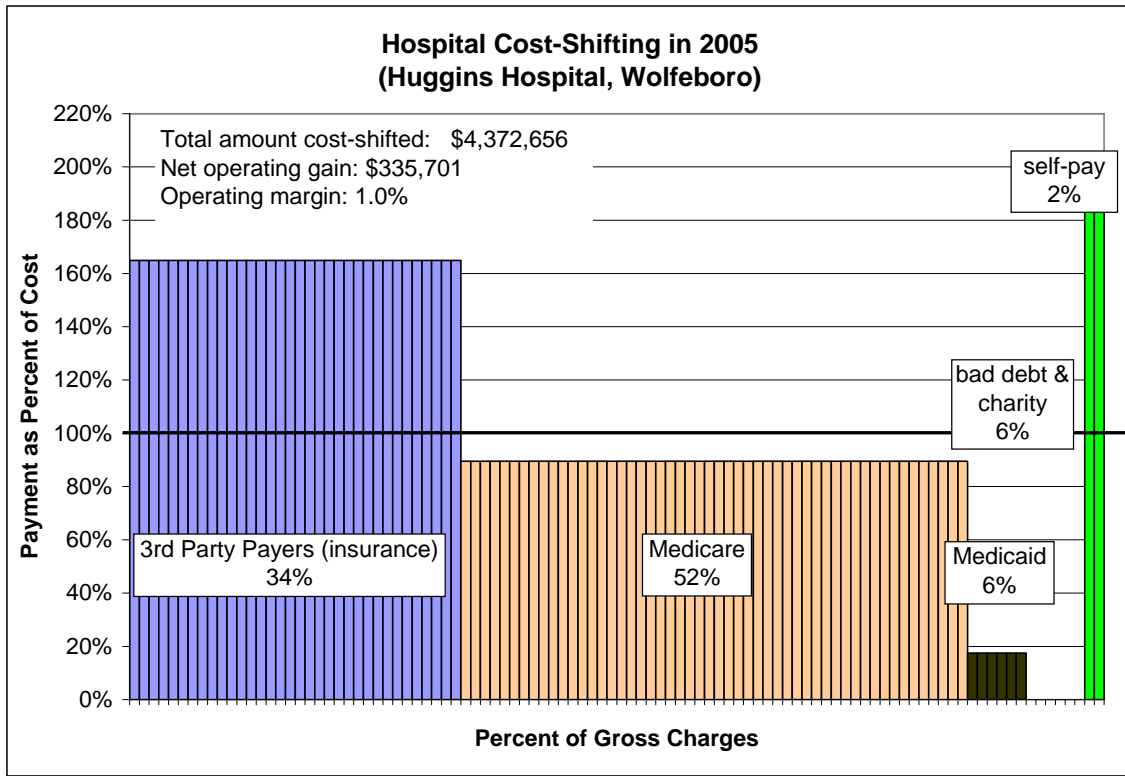
Frisbie Memorial Hospital, Rochester



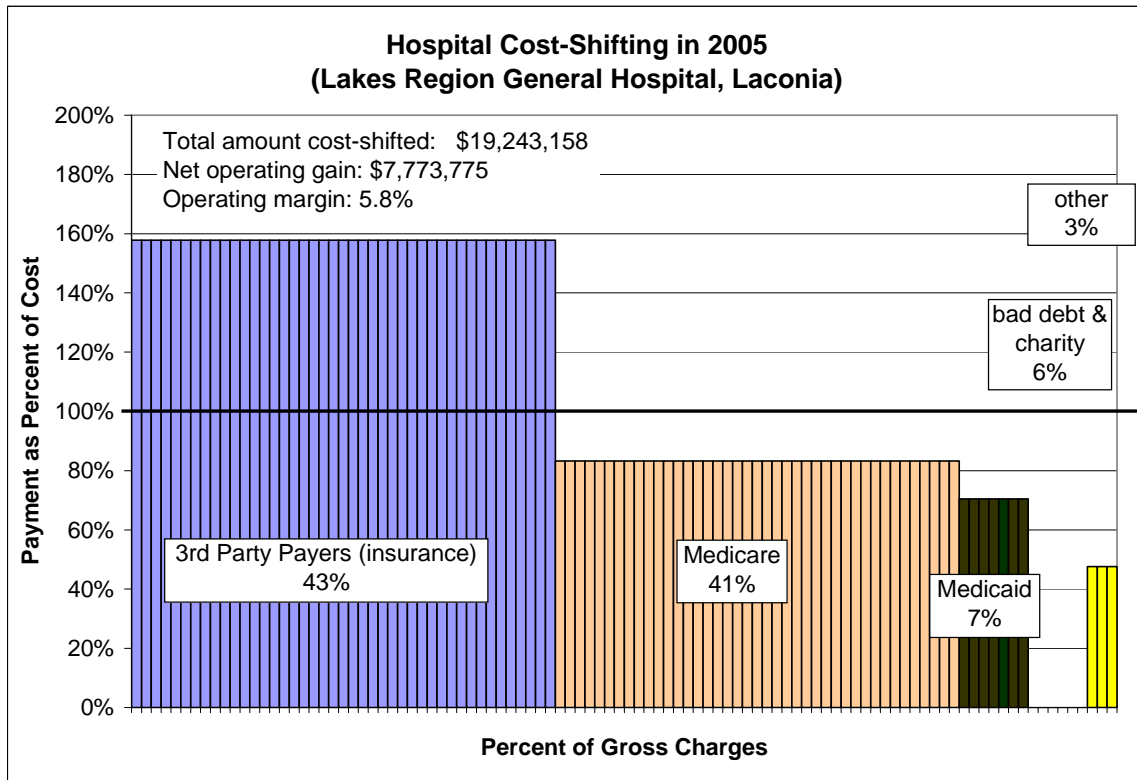
Franklin Regional Hospital



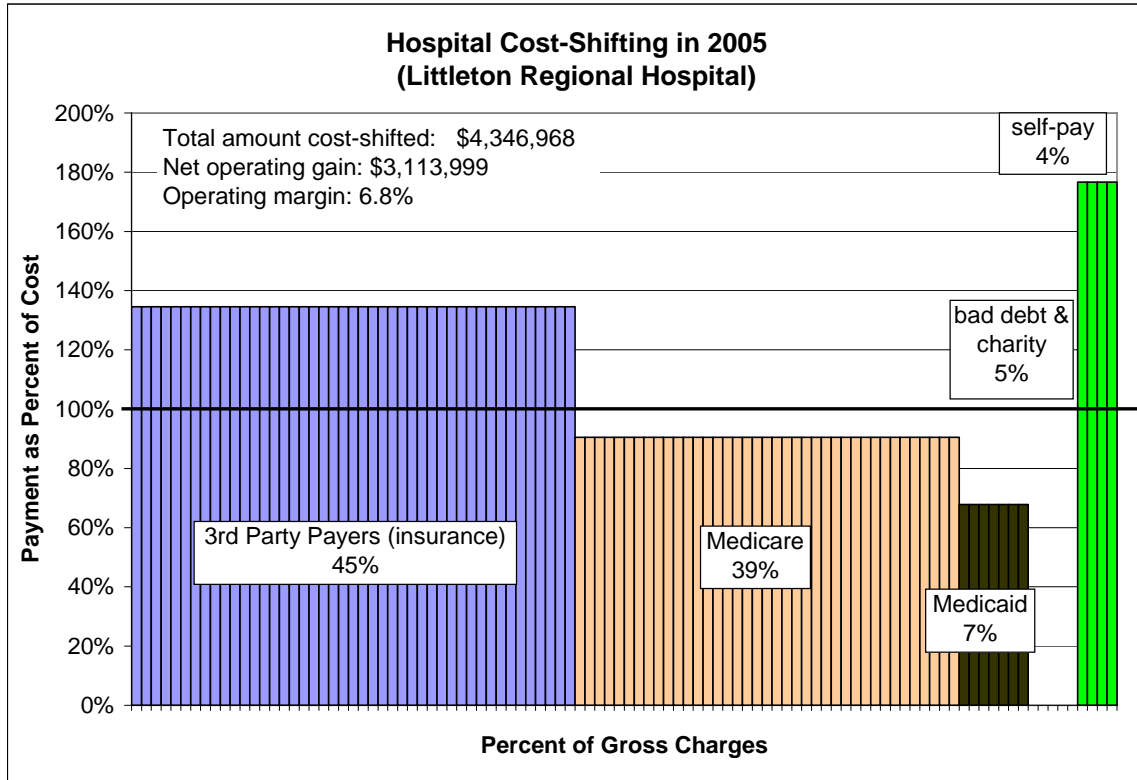
Huggins Hospital, Wolfeboro



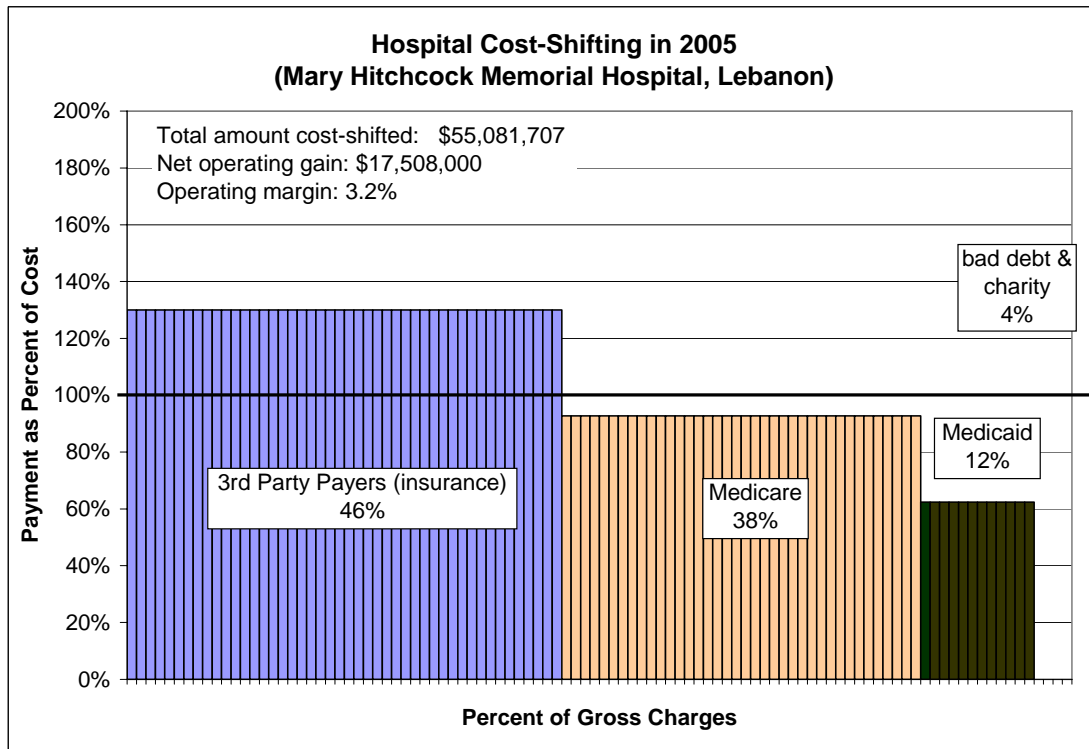
Lakes Region General Hospital, Laconia



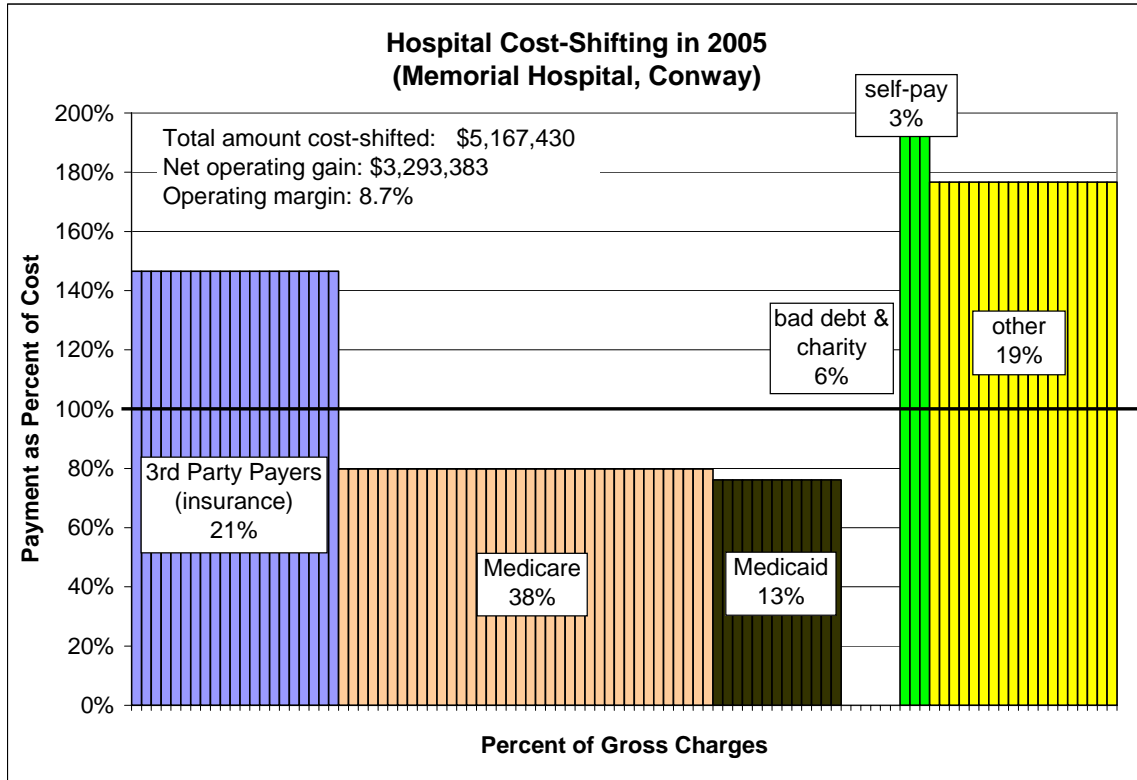
Littleton Regional Hospital



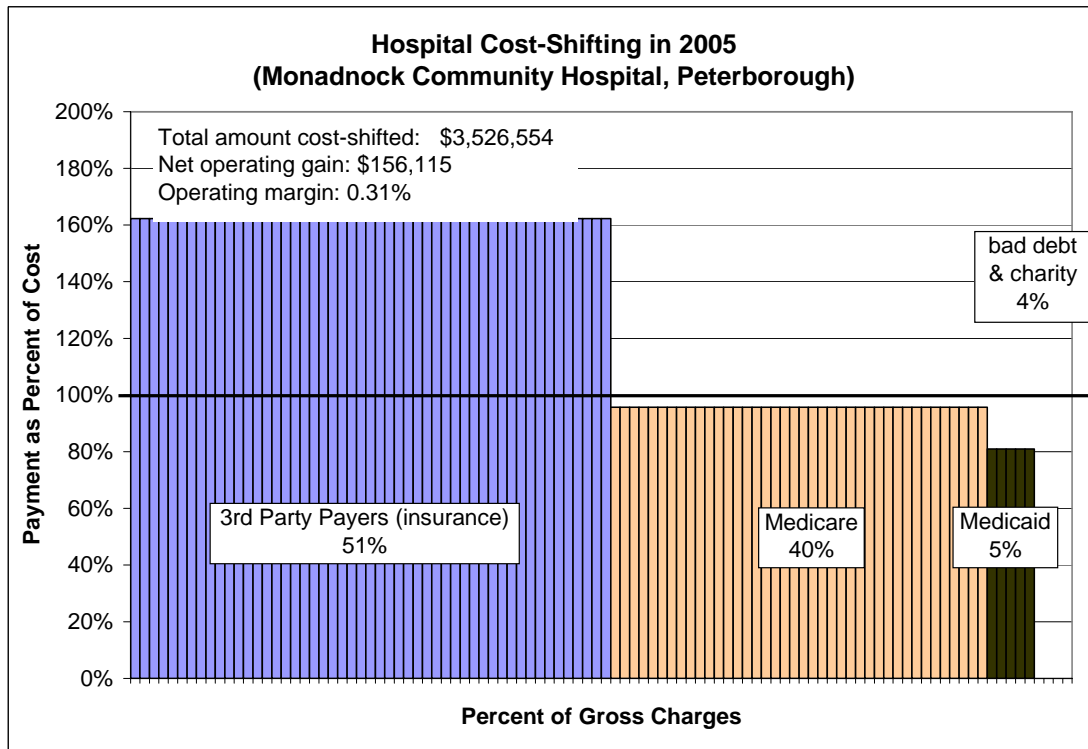
Mary Hitchcock Memorial Hospital, Lebanon



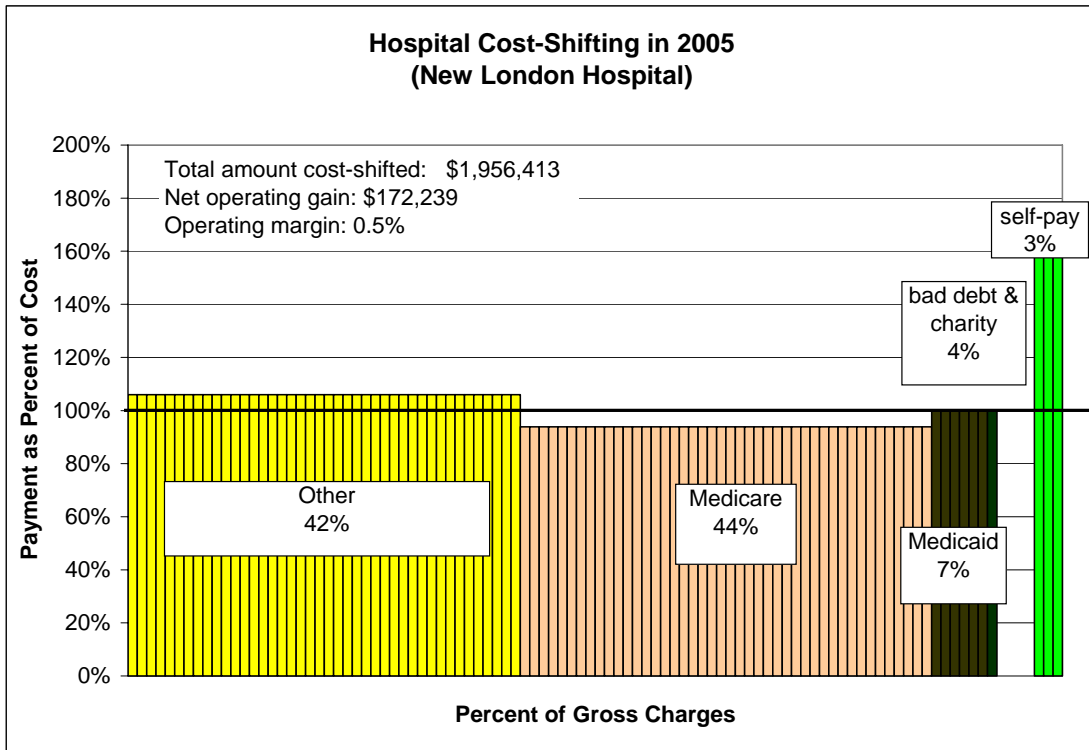
Memorial Hospital, Conway



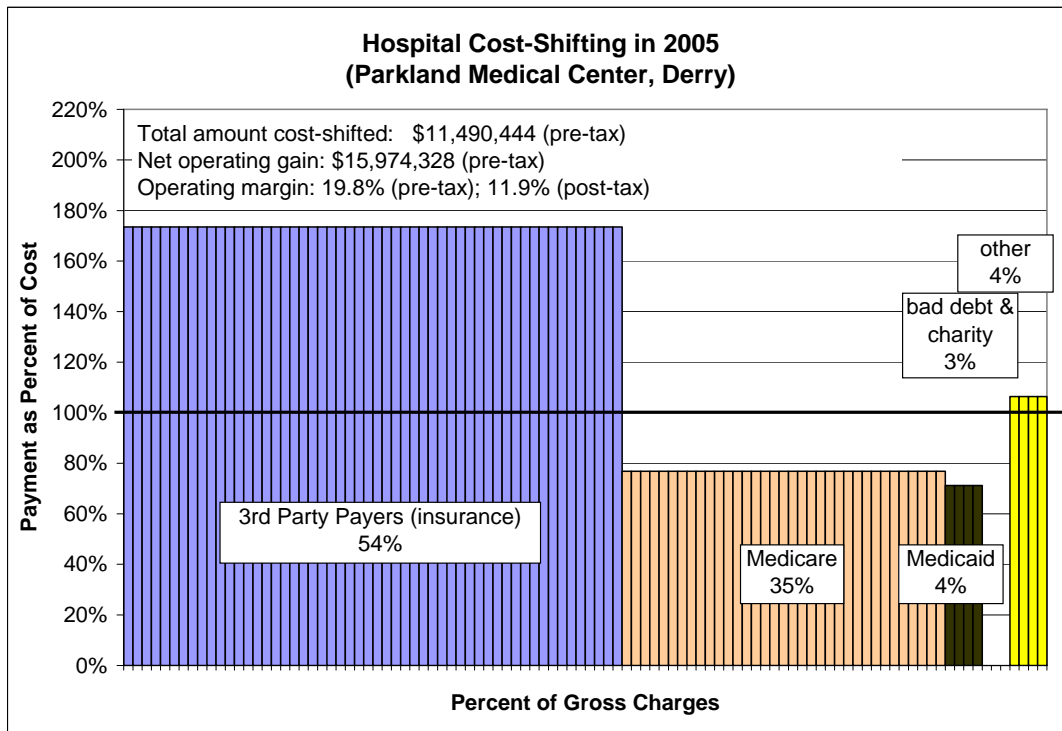
Monadnock Community Hospital, Peterborough



New London Hospital¹⁴

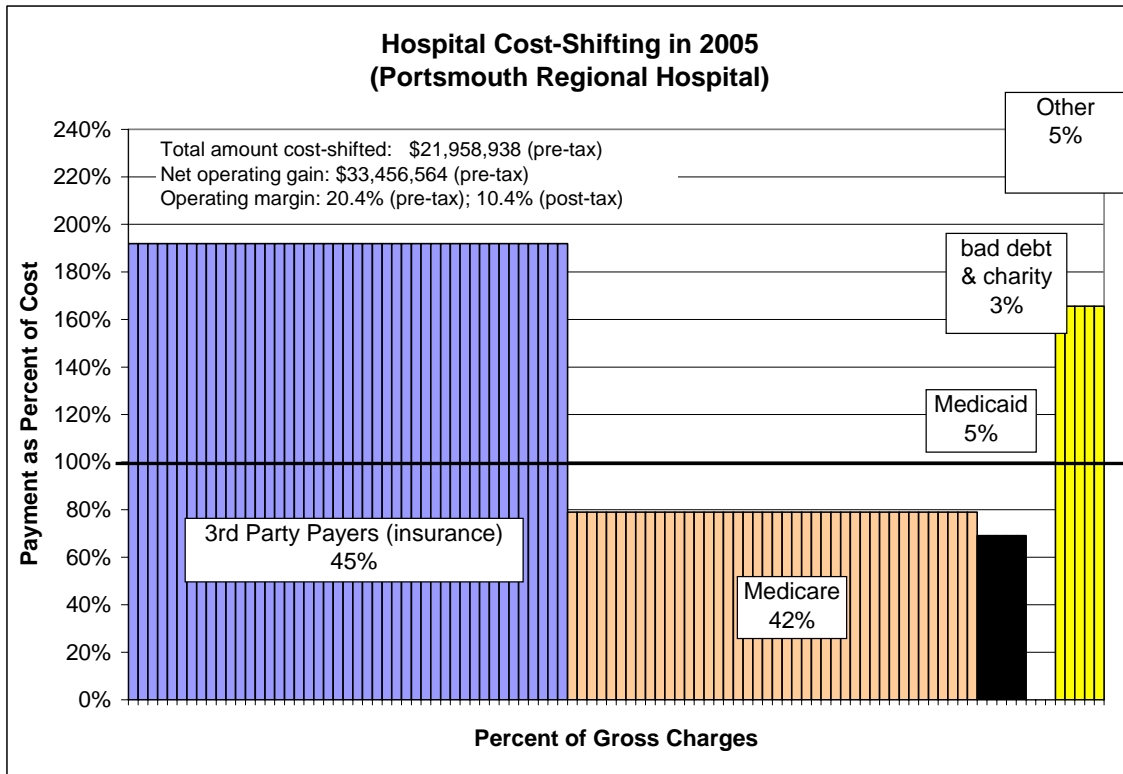


Parkland Medical Center, Derry

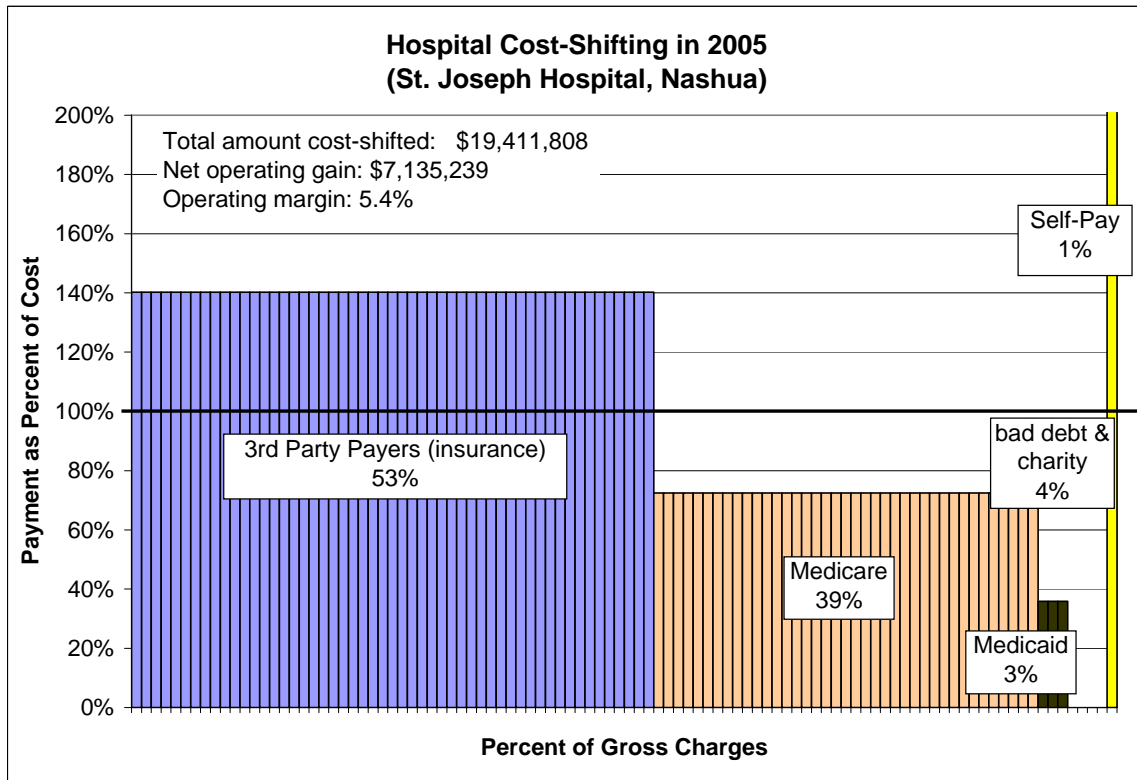


¹⁴ Subsequent to release of the report, New London hospital noted that the 'Other' charges had been misclassified and were actually third-party (insurance) charges.

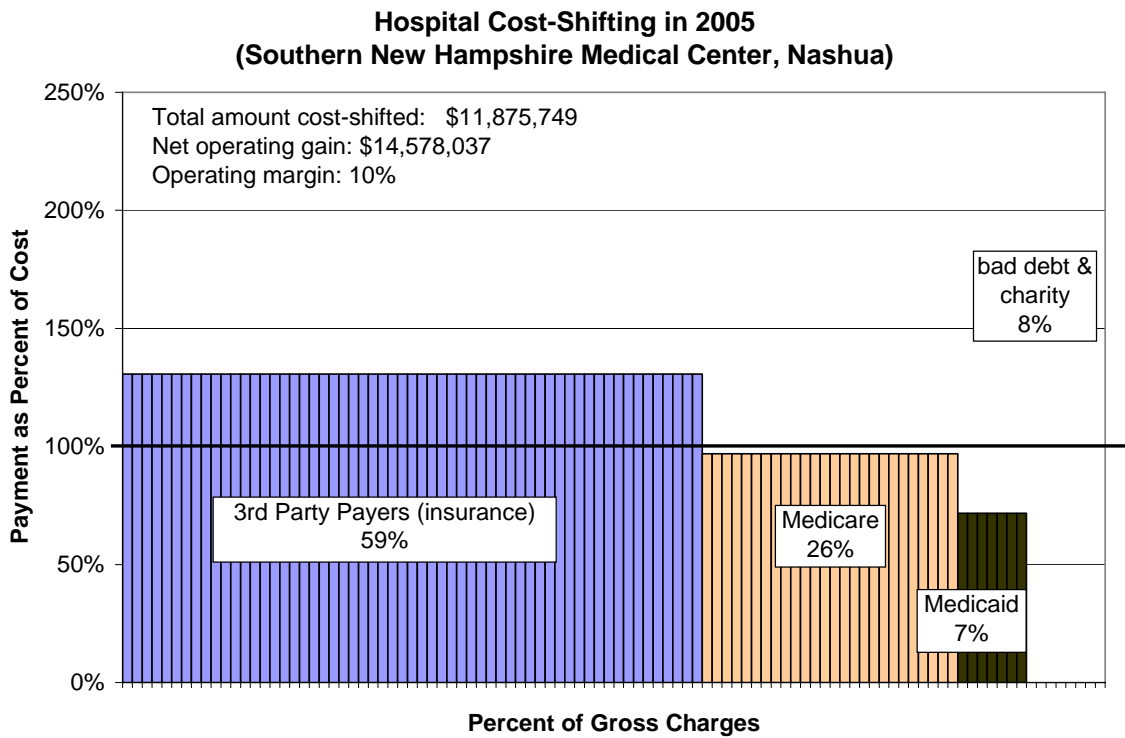
Portsmouth Regional Hospital, Portsmouth



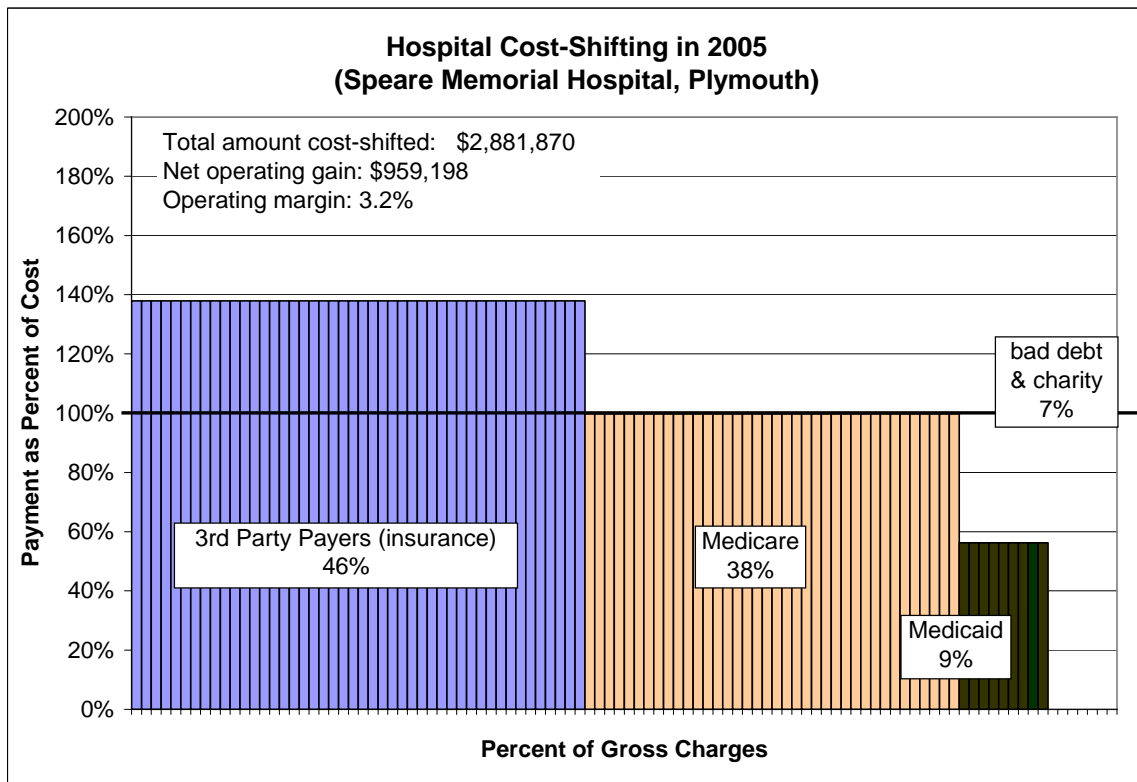
St. Joseph Hospital, Nashua



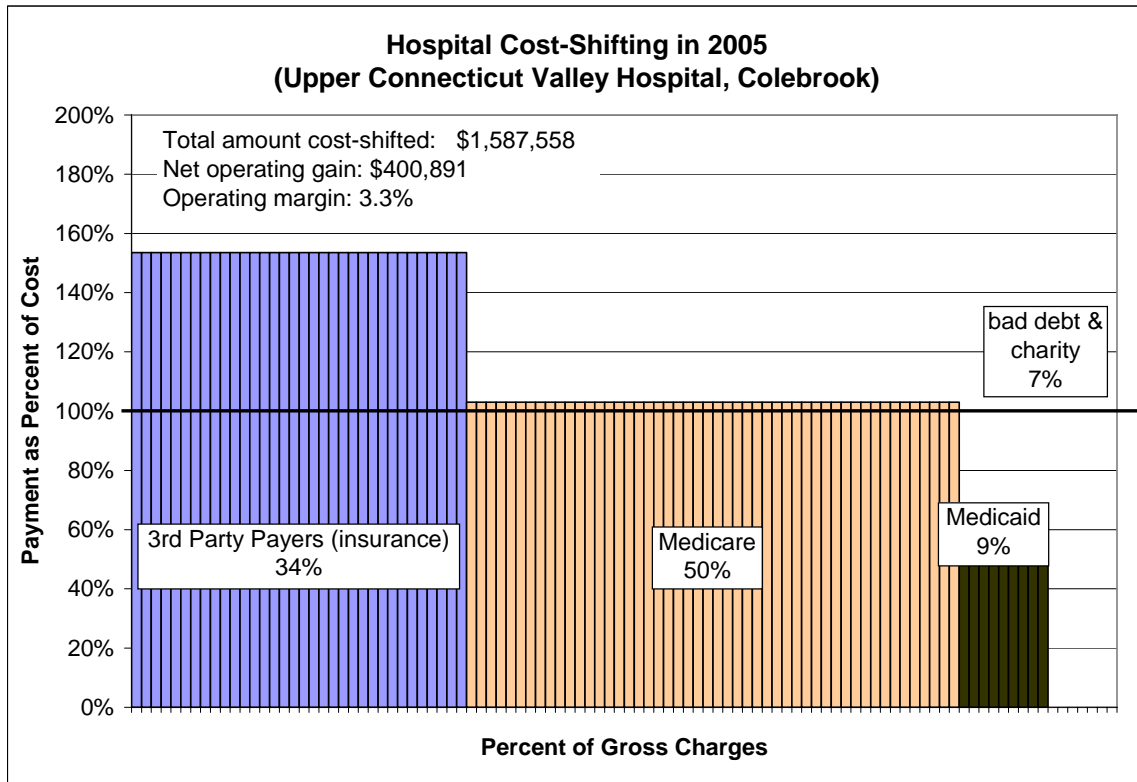
Southern New Hampshire Medical Center, Nashua



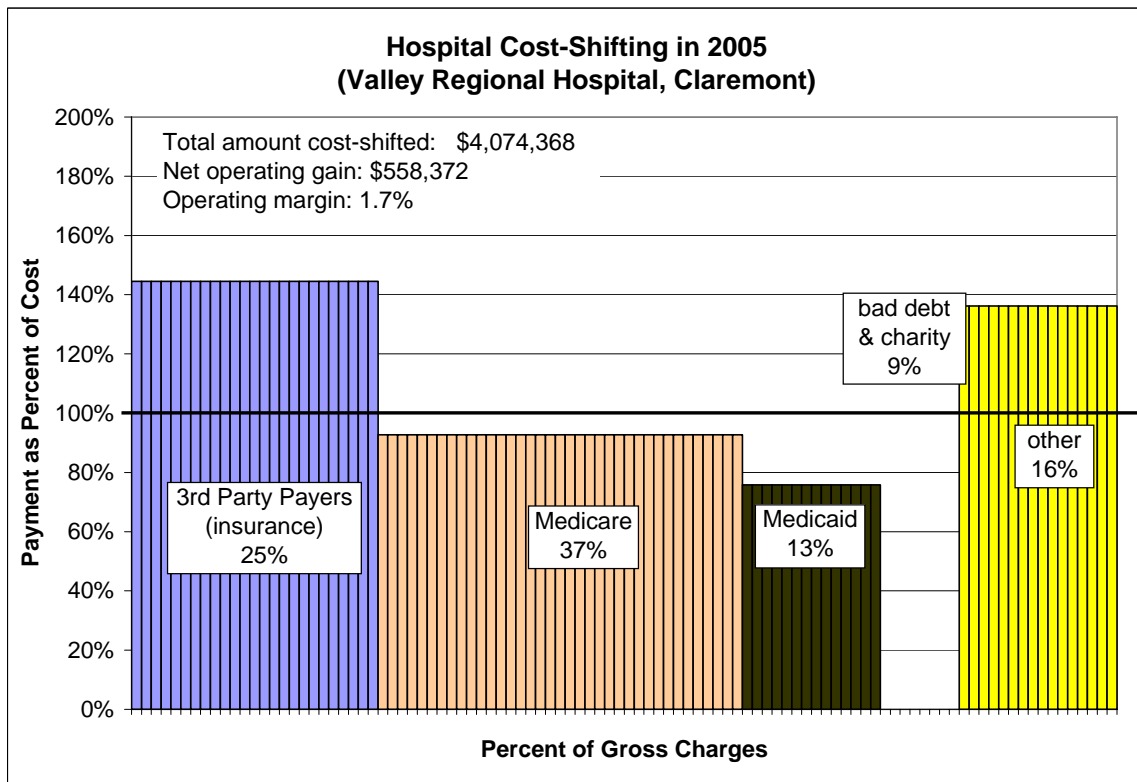
Spere Memorial Hospital, Plymouth



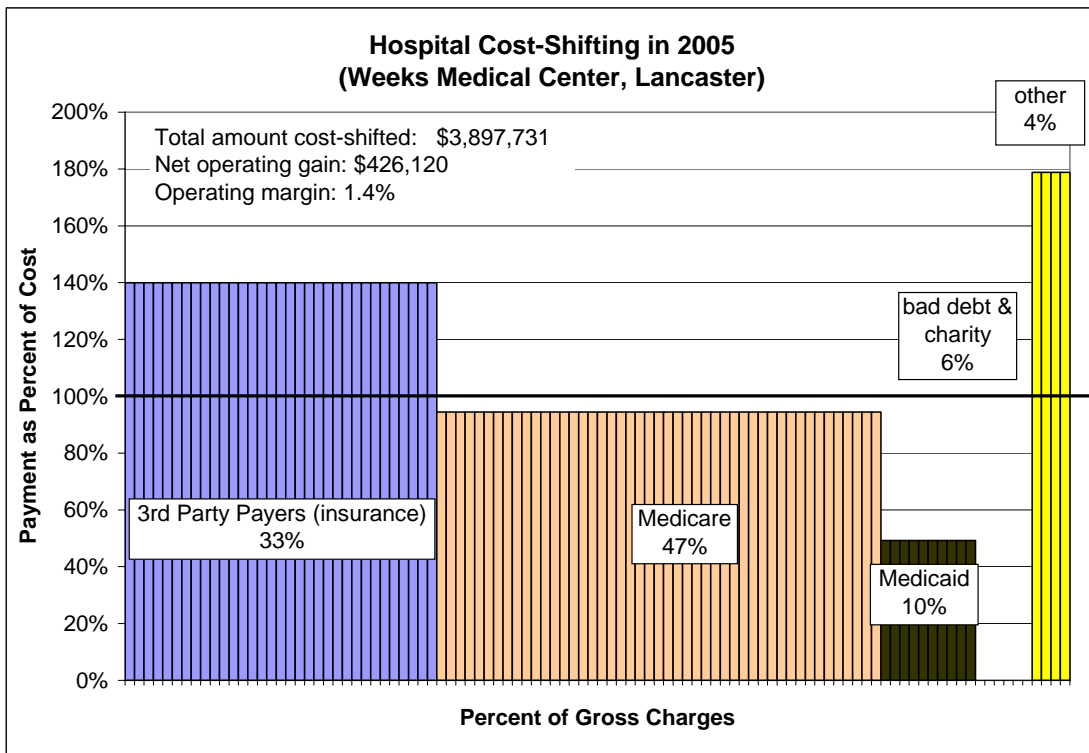
Upper Connecticut Valley Hospital, Colebrook



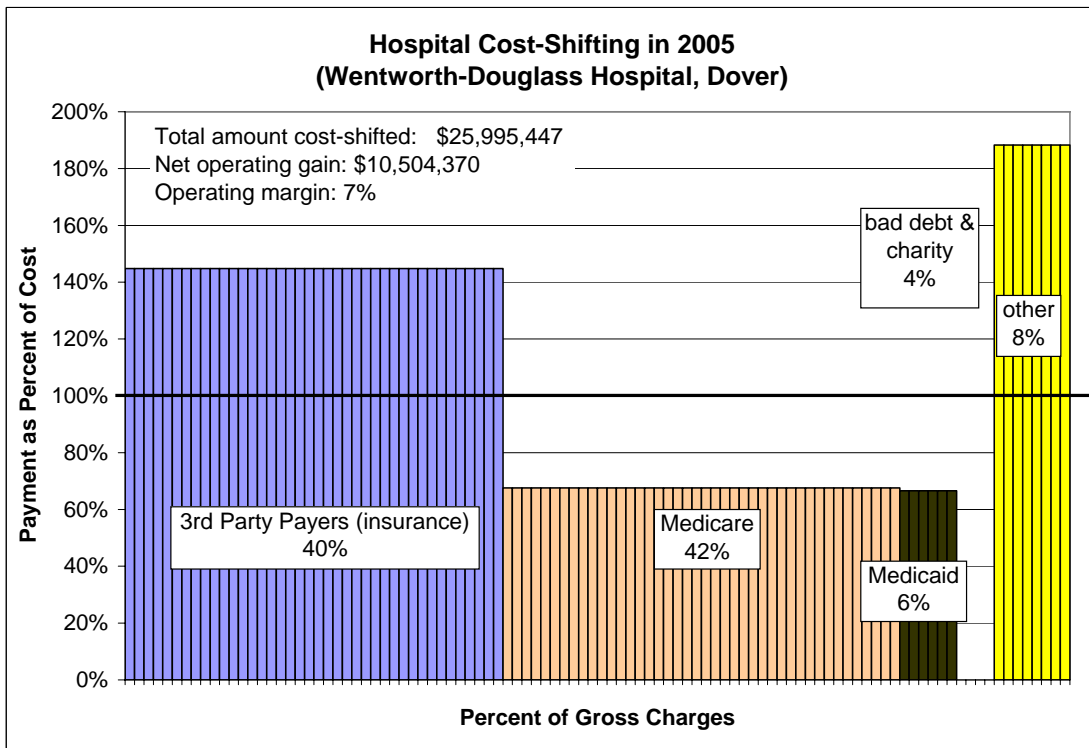
Valley Regional Hospital, Claremont



Weeks Medical Center, Lancaster



Wentworth-Douglass Hospital, Dover



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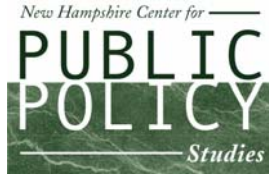
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