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Driving Health Care Premiums: Cost-Shifting in New Hampshire

September 2008

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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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Driving Health Care Premiums: Cost-shifting in New Hampshire

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Executive Summary

The phenomenon of hospital cost-shifting in New Hampshire has been well documented by the Center. 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 allocation of unrecovered costs of one patient population to above-cost revenue collected from other patient populations – largely the privately insured. This phenomenon is called ‘cost-shifting.’ Hospitals also generate positive operating margins. Operating margins are the share of revenues for patient care services that exceed expenses for providing that care.

The major findings of this analysis are:

- 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 127 percent from \$179 million in 2001 to \$406 million in 2007, or an average of 15% per year.
- Medicare services are the single largest driver of the need to cost-shift in New Hampshire hospitals, accounting for 42% of the total deficits in hospital services. The aging of the population – and increasing enrollment in Medicare – ensures that the cost-shift will continue to increase.
- Hospital operating margins have also been growing since 2001. In 2001, the hospital industry experienced net operating income of \$60 million. Between 2001 and 2007, net operating income grew by 225% or an average of 22% per year.
- 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 margins of 3% while non-critical access designated hospitals experienced margins of 7%.

The financial burden of cost-shifting and the generation of operating margins are borne directly by New Hampshire businesses and consumers. In 2007, over \$600 million in below cost reimbursement from the public sector, charitable care and operating margins were shifted onto the privately insured. By extension, in the aggregate health care premiums in New Hampshire may have been as much as \$600 million dollars higher than they otherwise would have been in the absence of this ‘cost-shifting’ phenomenon. Put another way, healthcare premiums in New Hampshire could have been as much as 25% lower than they were if there was no cost-shifting and no operating margins.

Given the role that cost-shifting to fund deficits in public programs and uncompensated care plays in health insurance premium levels, what can policy makers do to limit this cost shift? There are three different possible policy responses. The first is to find ways to encourage the health care system to lower the cost of the services it is providing so that existing reimbursement levels are adequate. The second is to expand health insurance coverage so that charitable care is financed by a source other than cost-shifting. The third is to focus on reimbursement levels in the public system, encouraging both the state Medicaid program and the federal Medicare program to increase its reimbursements. Any of these changes could significantly reduce the cost-shifting phenomenon – and theoretically reduce premiums. However, the costs of these policy options – specifically expansions in coverage and increases in reimbursement levels – would have to be borne by either the state or federal government.

Regardless of the policy approach, given the primary role that Medicare plays in generating the need to cost-shift, the state, its policy-makers, and New Hampshire businesses may want to turn their focus towards Washington, DC and the federal government. As the single largest payer in the United States, the federal government (through Medicare and Medicaid) remains the market-maker in healthcare.

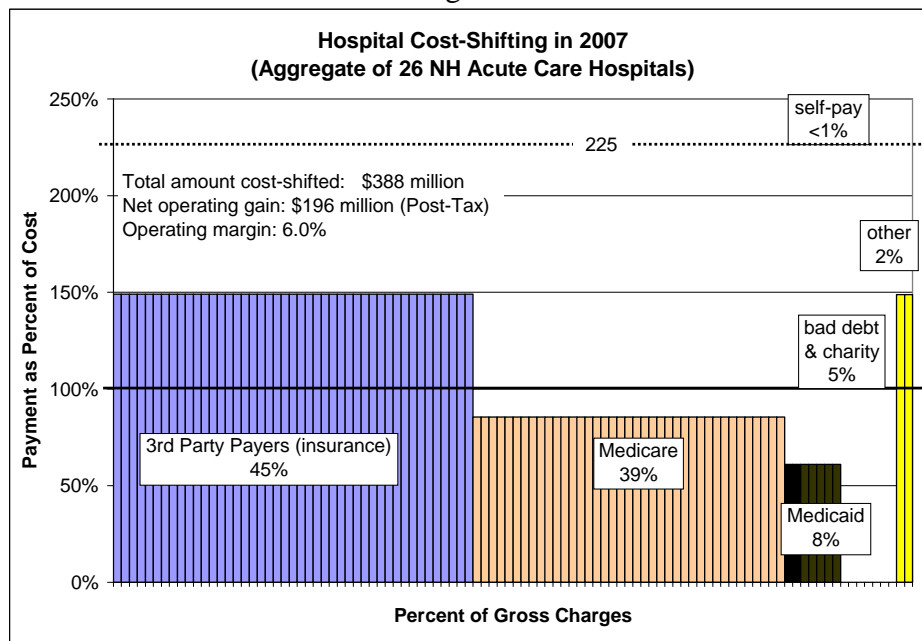
Cost-shifting

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 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.”¹ Figure 1 is a hydraulics diagram that exhibits the aggregate of revenues and cost-shifting of New Hampshire’s 26 acute care hospitals in 2007.²

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.³ Another 39 percent of charges were billed to Medicare and 8 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. Two percent were billed to “other.”⁴ Less than one percent of charges were fully paid by uninsured persons.

The vertical axis of Figure 1 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 225 percent of cost, the average charge amount. The vertical bar representing a payer that actually pays full charges would rise to this level.

Figure 1



¹ In November 2004 the Center published “A Framework for Thinking About Cost-Shifting in Health Care.” That report describes the concept of cost-shifting.

² 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.

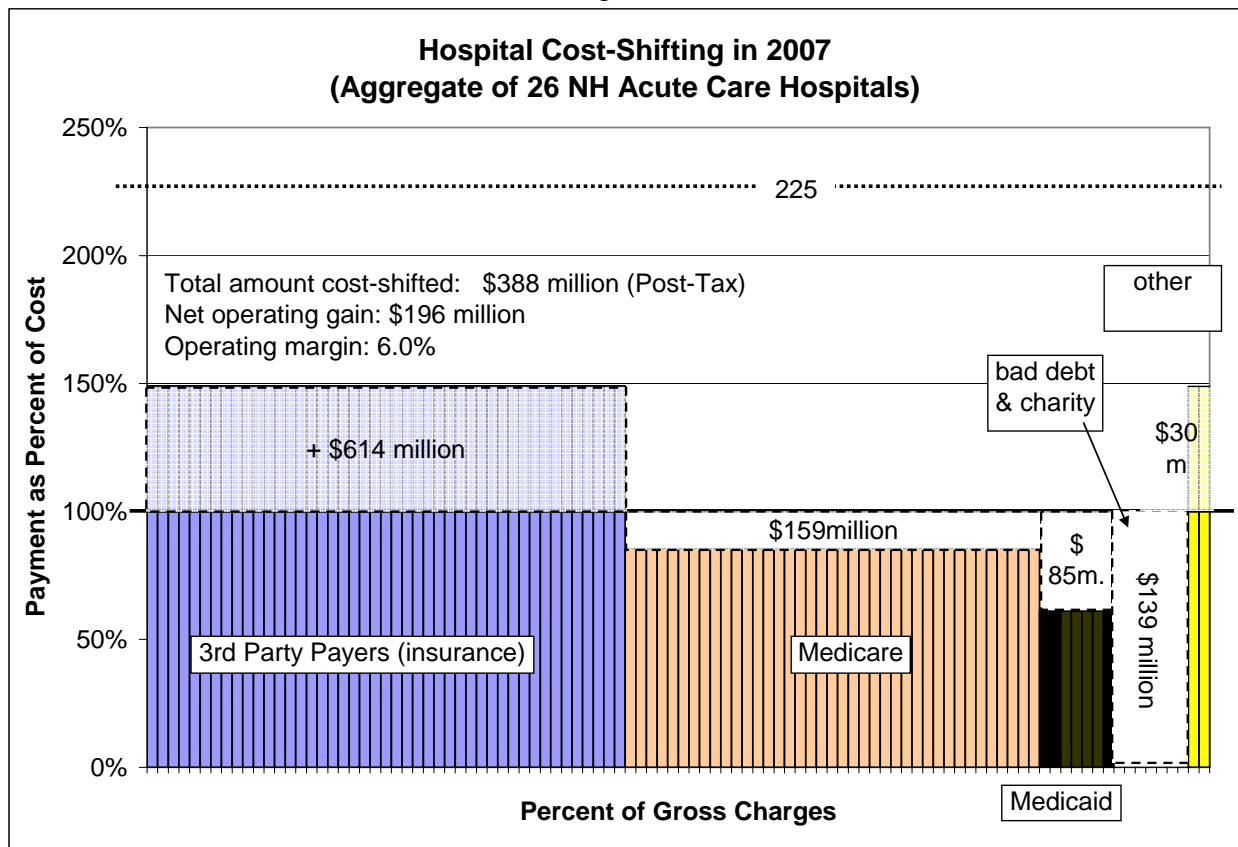
³ A certain portion of the 3rd party payer amounts in these figures (and all subsequent hydraulics diagrams) is uncompensated care that is incompletely identified by the hospitals. See our discussion of uncompensated care in NHCPP, “Cost-shifting in New Hampshire Hospitals, 2004.” February, 2006.

⁴ The “other” category is larger than it should be. Some hospitals– including Memorial in North Conway – did not differentiate between insurance categories in the financial data they submitted to New Hampshire Hospital Association (NHHA). We suspect that a significant share of this category is actually for charges billed to insurance companies.

How high the vertical bars rise indicates what percent of cost that payer type actually paid. On average in 2007, insurers paid 149 percent of cost. That is considerably below the amount of charges. The difference between charges at 225 percent of cost and payment at 149 percent of cost represents the average “discount” to health insurers. On average, Medicare paid only 86 percent of cost. Medicaid paid even less on average, only 61 percent of cost. “Other” payers paid 149 percent of cost.

Figure 2 shows the surplus or deficit relative to the costs of providing services by each payer. Medicare payments were \$159 million short of paying for the cost of services to Medicare patients. Medicaid payments were \$85 million short of paying for cost, while uncompensated care was \$139 million short. Altogether, hospitals were \$388 million short of recovering their costs for these patient populations. 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.

Figure 2



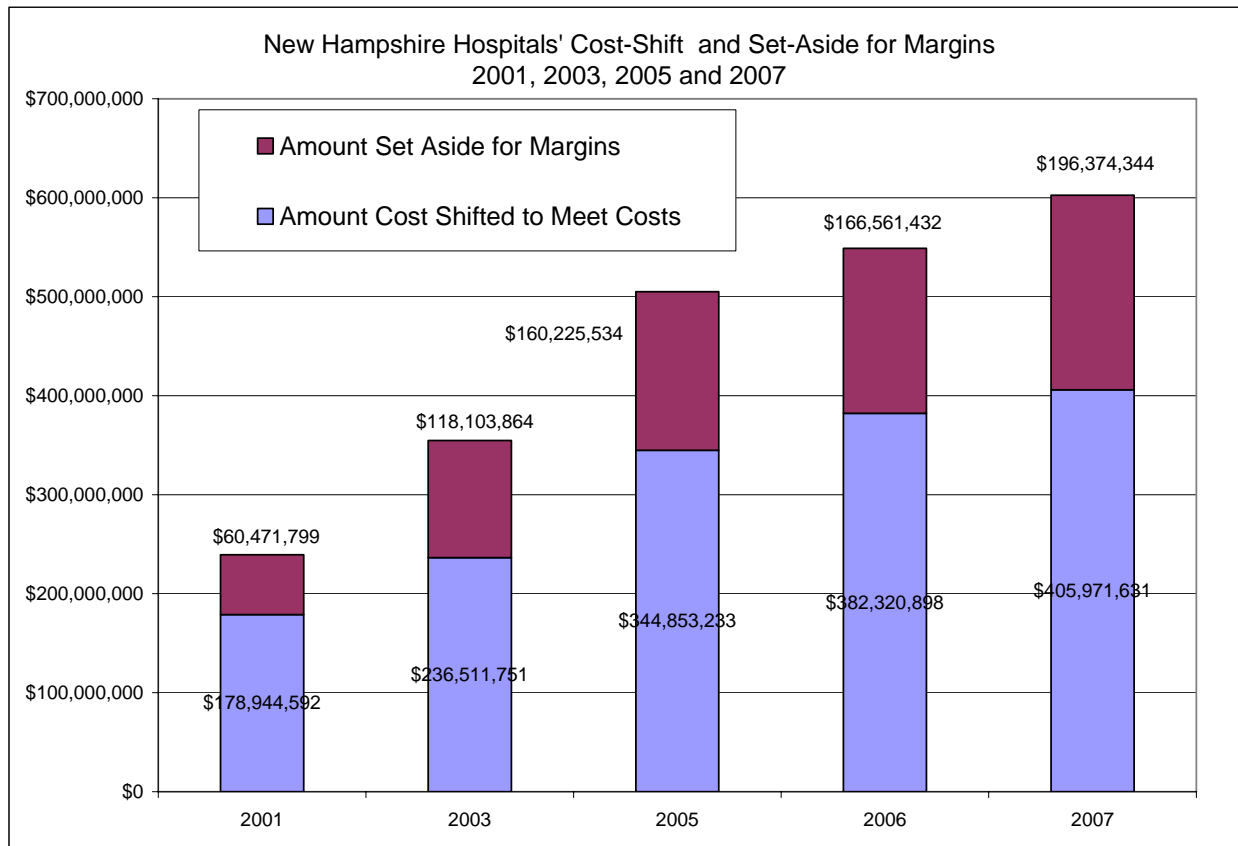
In addition to shifting sufficient revenues to meet their patient services costs, hospitals have also generated surpluses in the form of positive operating margins. The hospitals were able to cost-shift the \$388 million they were short, and they were also able to set aside \$196 million after taxes above breakeven, enough to result in an overall operating margin of 6.0 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.

A Growing Burden on Consumers and Businesses

The cost-shifting phenomenon has grown considerably since the Center began conducting its work on cost-shifting in 2001. As Figure 3 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 \$60 million.

By 2007, the magnitude of the cost shift had grown considerably, as had net income. The amount set aside for margins grew at 22% per year between 2001 and 2007. The amount cost-shifted grew by approximately 15% per year.

Figure 3



At this aggregate level, it is hard to understand the impact that this has on those who pay for health care. As the amount cost-shifted increases and as margins increase, health care premiums paid by businesses and individuals have to increase to compensate, as these deficits are borne by the private sector. To put this in perspective, Table 1 analyzes the share of total health care premiums that were attributable to the hospital cost shift and the generation of hospital operating margins. Because the number of people covered by health insurance changes over time, we normalize all figures by the number of lives covered by insurance policies in New Hampshire. This provides us with a basic assessment of how premiums have changed and the role that growth in cost-shifting and the generation of operating margins plays in that growth. We use 2006 data instead of 2007 data because data on premiums and covered lives from the Insurance Department are not available for 2007.

As Table 1 illustrates, total premiums per covered lives increased by 10.7% per year on average, increasing from approximately \$2,344 in 2001 to \$3,893 in 2006. Many factors affect premiums including the underlying rate of service utilization, changes in enrollment, and health plan margins, among others. In this analysis, we attempt to isolate changes in premiums that are attributable only to those factors analyzed here: cost-shifting from public payers, charitable care, and hospital operating margins.

A significant portion of this growth was attributable to changes in operating margins, cost-shifting and the provision of uncompensated care. These calculations suggest that in 2006, 24% of premiums were associated with these factors: 10% to cost-shifting for public payers, 6% for uncompensated care; and 7% for operating margins. Put another way, healthcare premiums in New Hampshire could have been as much as 25% lower than they were if there was no cost-shifting and no operating margins. And the share of premiums that are attributable to these factors has increased since 2001. In 2001, roughly 20% of the total premium dollar was attributable to these factors, increasing to 24% by 2006.

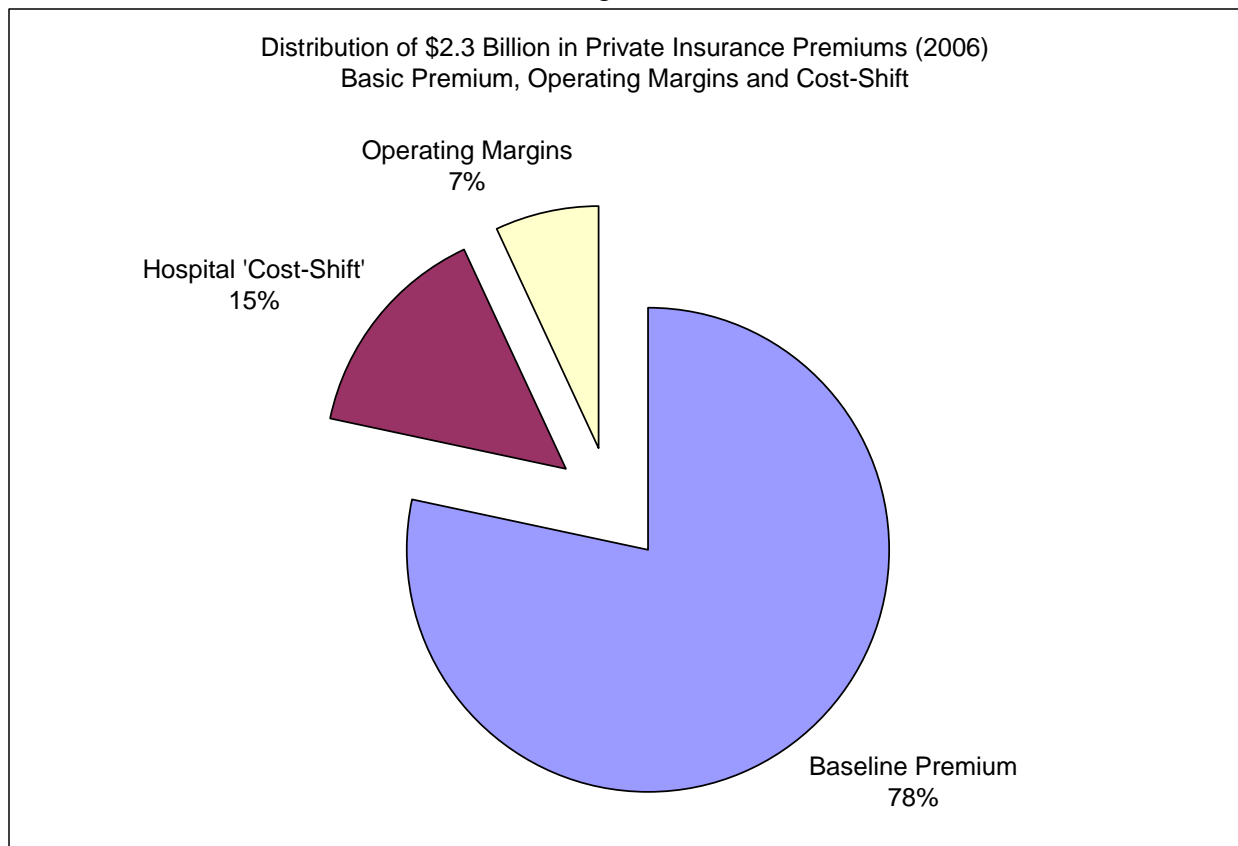
Table 1
Premiums, Cost-Shift and Operating Margins Per Covered Life

	2001		2006		Annual Compound Increase (2001-2006)
	Amount	% of Total	Amount	% of Total	
Basic Premium Per Covered Life	\$1,883	80%	\$2,974	76%	9.6%
Operating Margin Per Covered Life	\$116	5%	\$279	7%	19.1%
Cost-Shift Per Covered Life	\$180	8%	\$395	10%	17.1%
Uncompensated Care Per Covered Life	\$165	7%	\$245	6%	8.2%
Total Premium Per Covered Life	\$2,344	100%	\$3,893	100%	10.7%

Source: Data on total premiums and covered lives are included in the Department of Insurance Supplemental Data Report for 2001, 2003 and 2006.

The impact of this on consumers and businesses in New Hampshire is large. Figure 4 shows the share of total private insurance premium dollars in New Hampshire in 2006 that were accounted for by the hospital cost-shift and the generation of hospital operating margins. For 2006, the hospital cost-shift accounted for 15% of the total premium dollars in New Hampshire. Operating margins accounted for approximately 7%. Together, the hospital cost-shift and the operating margins increased premiums by as much as 22% over what they would otherwise have been.

Figure 4



While it is impossible to estimate just how much of this is borne by New Hampshire businesses and state and municipal governments (which pay, on average, 75% of the health care premiums for their employees), it is safe to assume that much of this was paid for by New Hampshire businesses.

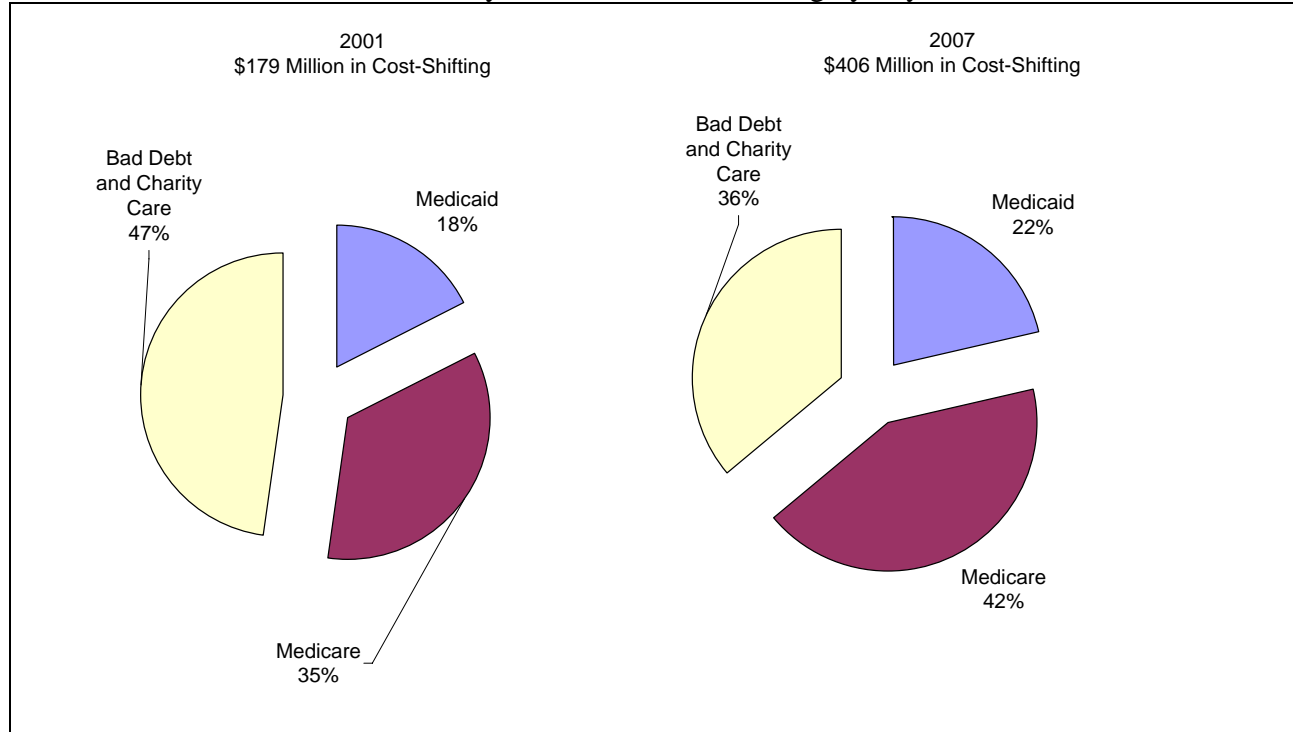
Primary Driver of Increases in the Need to Cost Shift

Figure 2 showed the surplus or deficit relative to the costs of providing services by each payer. The largest share of the deficits was created within the Medicare population, where payments were \$159 million short of paying for the cost of services to patients. Over time, the deficit in the Medicare program has come to play an even larger role in the cost-shifting phenomenon.

Figure 5 shows the distribution of the amount cost shifted by payer in 2001 and 2007. These charts highlight the critical role that Medicare plays in this issue of cost-shifting. In 2001, the total amount of cost shift was \$179 million. Charity care and bad debt accounted for almost half of the cost shift. Medicare accounted for 35% and Medicaid 18%. By 2007, the total amount to be cost-shifted was \$388 million, of which 42% was related to Medicare deficits, 36% to bad-

debt and charity care and 22% to Medicaid. An increasingly large share of the amount of cost-shift is being driven by the Medicare program.

Figure 5
The Primary Sources of Cost-Shifting by Payer.



As the population ages, a larger and larger share of the population will be enrolled in Medicare. The implication of this demographic shift, along with the fact that Medicare reimburses below expenses, means that the amount of cost-shifting required by the system will grow, and likely accelerate. The further implication is that private premiums will have to grow more quickly to account for those deficits. To counter this process, either providers have to lower their costs or Medicare has to increase reimbursements.

Charity Care

The share of the total cost shift associated with charity care – uncompensated care and bad debt – has declined over time from 47% of the total volume of cost-shifting in 2001 to 36% in 2007. As Table 2 shows, between 2001 and 2007, the amount of charity care provided almost doubled from \$85 million to \$158 million.⁵ Despite this significant increase in aggregate amounts, the share of patient care resources devoted to charity care has increased only slightly since 2001. As Table 2 shows, charity care as a share of patient services was 5.0 percent of patient services revenue in 2001 and increased slightly to 5.2 percent in 2007.

Table 2

Charity Care in NH Hospitals		
	Total Charity Care Costs	Charity Care Costs as Percent of Patient Services Expenditures
2001	\$85,641,569	5.0%
2002	\$98,446,383	5.1%
2003	\$108,051,360	5.1%
2004	\$125,655,080	5.4%
2005	\$136,499,675	5.3%
2006	\$153,014,262	5.4%
2007	\$158,366,721	5.2%

⁵ 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. These data on uncompensated care do 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.

Hospital Operating Margins

In 2007, the hospitals in New Hampshire experienced a 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. Almost one third of aggregate operating margins occurred in the two for-profit hospitals in the state – Portsmouth Regional and Parkland Medical. Another 40% occurred in the other major hospitals in the Southern part of the state – Exeter, Southern New Hampshire Regional, Saint Josephs, Elliot and Concord Hospitals. Clearly hospitals in the southern part of the state continue to experience positive financial position.

Not all hospitals are fairing well however. Five hospitals – Weeks Memorial, Monadnock, Cottage, Alice Peck Day and New London – experienced negative operating margins. Contrast this to 2005, when only 1 hospital experienced a negative operating margin. Hospitals in rural parts of the state – largely in the North Country – appear to have experienced a slight decline in their financial position.

Table 3
NH Post-Tax Operating Margins (2007)

Hospital	Ownership	Critical Access Designation?	Operating Margin After Tax	Aggregate Operating Margins	Percent of Aggregate Operating Margins
Portsmouth Regional	For Profit		25.2%	\$46,783,263	23.8%
Parkland Medical	For Profit		17.2%	\$16,548,152	8.4%
Wentworth-Douglass	Not-For-Profit		11.1%	\$21,274,077	10.8%
Exeter	Not-For-Profit		10.4%	\$18,388,462	9.4%
So. NH Regional	Not-For-Profit		10.4%	\$18,555,808	9.4%
St. Joseph	Not-For-Profit		8.1%	\$12,589,403	6.4%
Huggins	Not-For-Profit	Yes	6.5%	\$2,601,750	1.3%
Cheshire	Not-For-Profit		6.5%	\$8,558,821	4.4%
Elliot	Not-For-Profit		6.0%	\$15,469,066	7.9%
Concord	Not-For-Profit		4.2%	\$12,398,727	6.3%
Littleton	Not-For-Profit	Yes	3.9%	\$1,945,254	1.0%
Speare Memorial	Not-For-Profit	Yes	3.7%	\$1,384,229	0.7%
Frisbie Memorial	Not-For-Profit		3.1%	\$3,448,590	1.8%
Androscoggin	Not-For-Profit	Yes	2.6%	\$1,184,253	0.6%
Lakes Region	Not-For-Profit		2.5%	\$3,434,737	1.7%
Valley Regional	Not-For-Profit	Yes	2.3%	\$925,944	0.5%
Catholic Med Ctr	Not-For-Profit		2.0%	\$4,007,285	2.0%
Mary Hitchcock	Not-For-Profit		1.8%	\$11,373,000	5.8%
Franklin Regional	Not-For-Profit	Yes	1.7%	\$601,033	0.3%
Memorial	Not-For-Profit	Yes	1.4%	\$736,505	0.4%
Upper Conn Valley	Not-For-Profit	Yes	1.2%	\$179,787	0.1%
Weeks Memorial	Not-For-Profit	Yes	-1.1%	(\$384,552)	NA
Monadnock	Not-For-Profit	Yes	-1.5%	(\$888,314)	NA
Cottage	Not-For-Profit	Yes	-2.8%	(\$674,440)	NA
Alice Peck Day	Not-For-Profit	Yes	-2.8%	(\$986,182)	NA
New London	Not-For-Profit	Yes	-7.6%	(\$3,080,315)	NA
Total			6.0%	\$196,374,344	

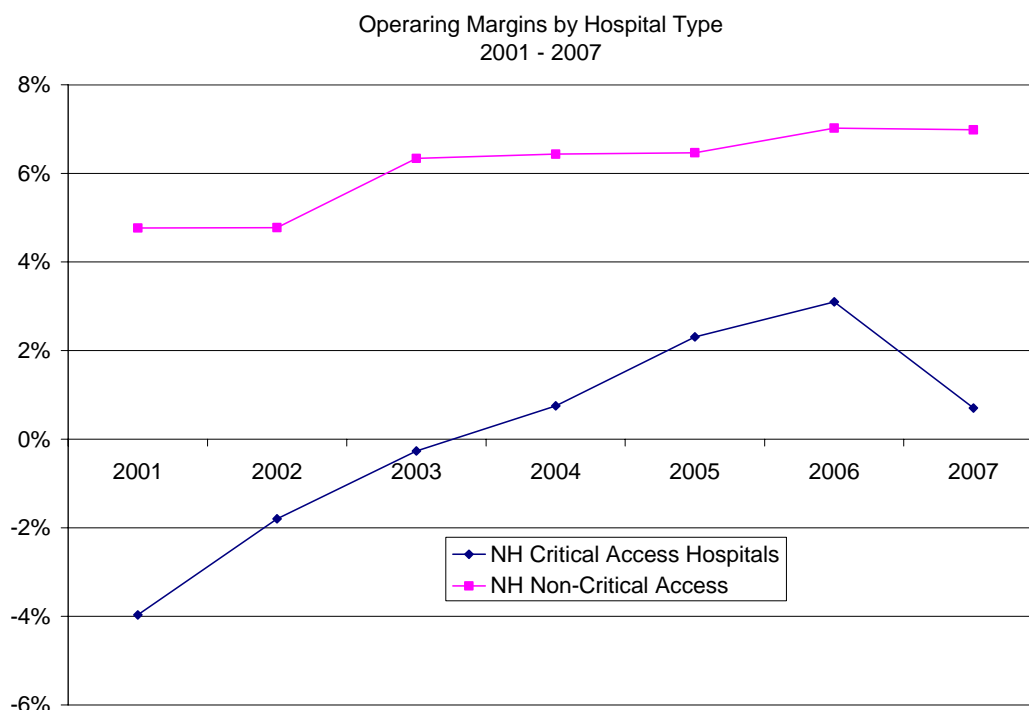
On average hospital operating margins, while fluctuating over the last 6 years, have shown increases since the year 2001. Table 4 shows net income (pre and post tax) as well as the average hospital margin in the state since 2001. In 2001, New Hampshire hospitals generated \$60 million in net income which represented 3.4 percent of operating revenue. In 2007, New Hampshire hospitals generated \$196 million in net income which represented 6.0 percent of operating revenue.

Table 4

Net Operating Margins in NH Hospitals				
Year		Net Operating Income	Net Operating Income - Income Tax	Operating Margin (After Tax)
2001		\$70,872,799	\$60,471,799	3.4%
2002		\$83,304,446	\$73,620,700	3.7%
2003		\$131,646,929	\$118,103,864	5.3%
2004		\$153,376,544	\$137,111,380	5.5%
2005		\$182,980,608	\$160,225,534	5.8%
2006		\$195,178,809	\$166,561,432	5.5%
2007		\$230,153,956	\$196,374,344	6.0%

These aggregate statistics mask significant differences across the state in the income generated by New Hampshire hospitals. Figure 6 shows the average margin for two different groups of New Hampshire hospitals: Critical access hospitals in the rural areas of the state and non-critical access hospitals.⁶ Figure 6 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 2001 and 2003 critical access hospitals experience negative margins on average, though there has been a general increase in the financial well-being of critical-access hospitals in the state since then.

Figure 6

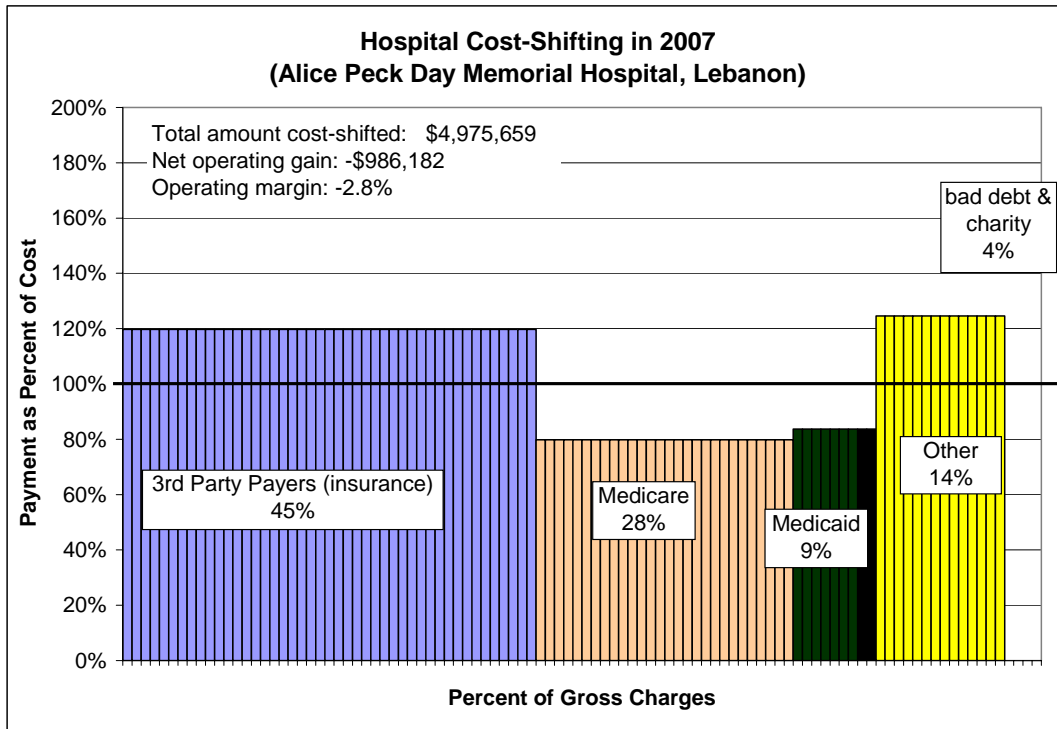


⁶ As of January 2006, thirteen of the state’s 26 hospitals have been designated “Critical Access” hospitals. This designation is a recognition on the part of Medicare (and now the State’s Medicaid) of the need to target additional funds to these rural entities based on their historical financial situation. Appendix B includes a list of the critical access hospitals and when they converted to critical access status.

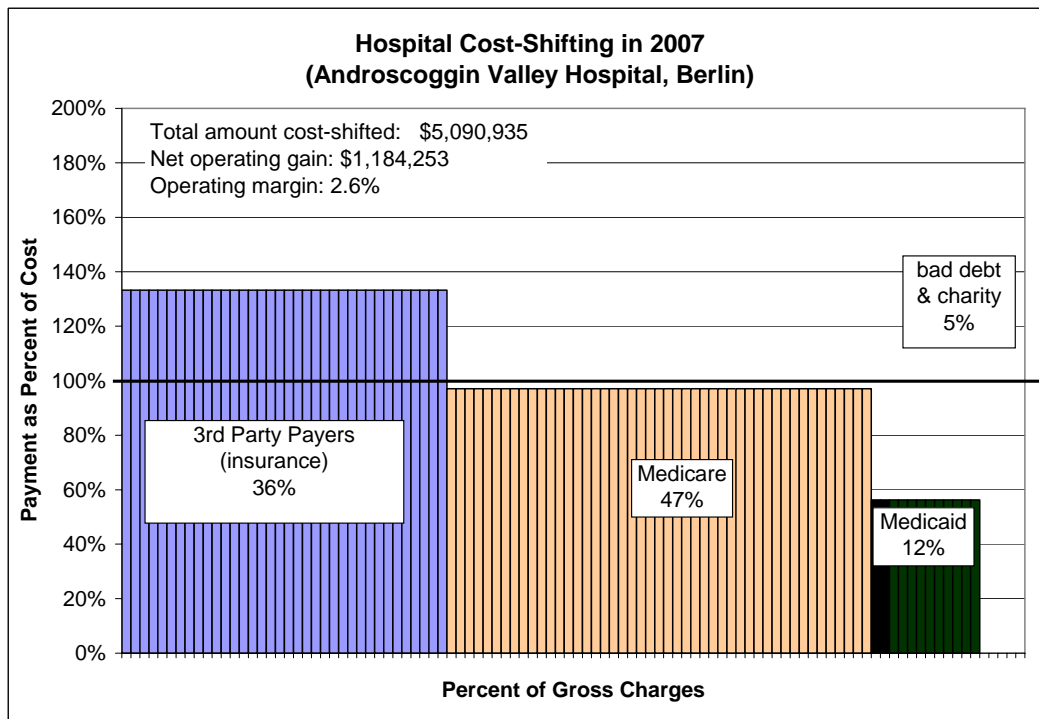
While it is clear that a significant share of the variation in operating margins is explained by for-profit status and geography, there are other possible explanations for this variation in margins. Hospitals have various long-term needs which require investment – including the development of information technology and upgrades to physical plant. Moreover, hospitals provide community benefits in a variety of different forms. How positive operating margins are allocated to these various activities is not clear from the data used by the Center in the analysis. Moreover, an unknown amount of the variation in hospital operating margins is due to the fact that the structure of the hospital systems – and what health care activities are included in the financial data – varies. Operating margins could vary based on whether or not hospitals include other health care activities, including hospital owned physician practices and nursing home beds in their financial data. While the Center requests hospital data only, some hospitals indicated that the data includes other hospital-owned activities.

Appendix A: 2007 Hydraulics Charts for 26 Hospitals

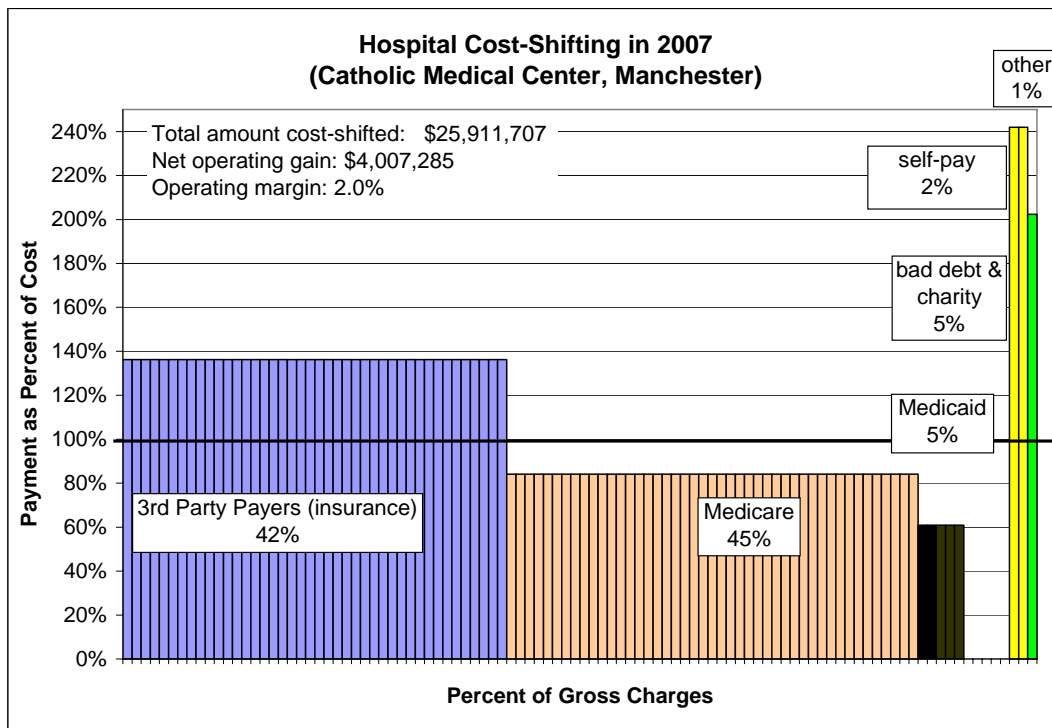
Alice Peck Day Memorial Hospital, Lebanon



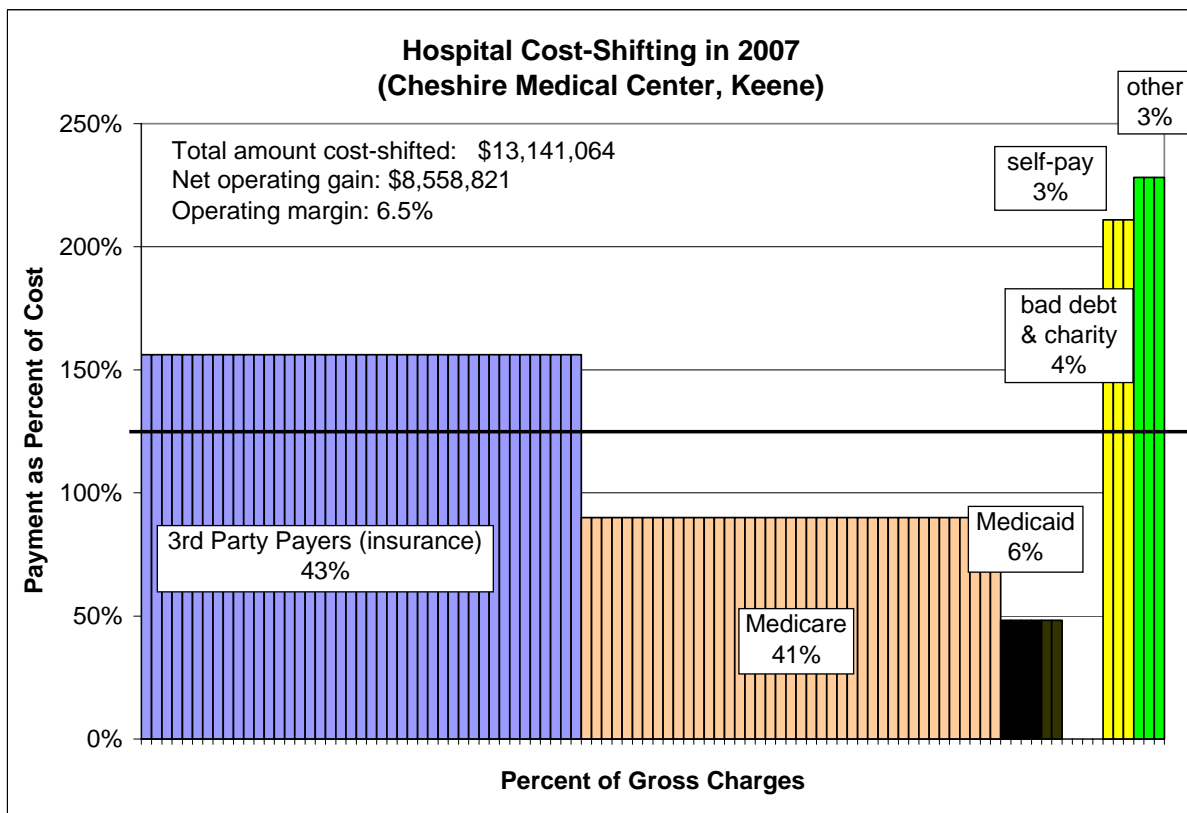
Androscoggin Valley Hospital, Berlin



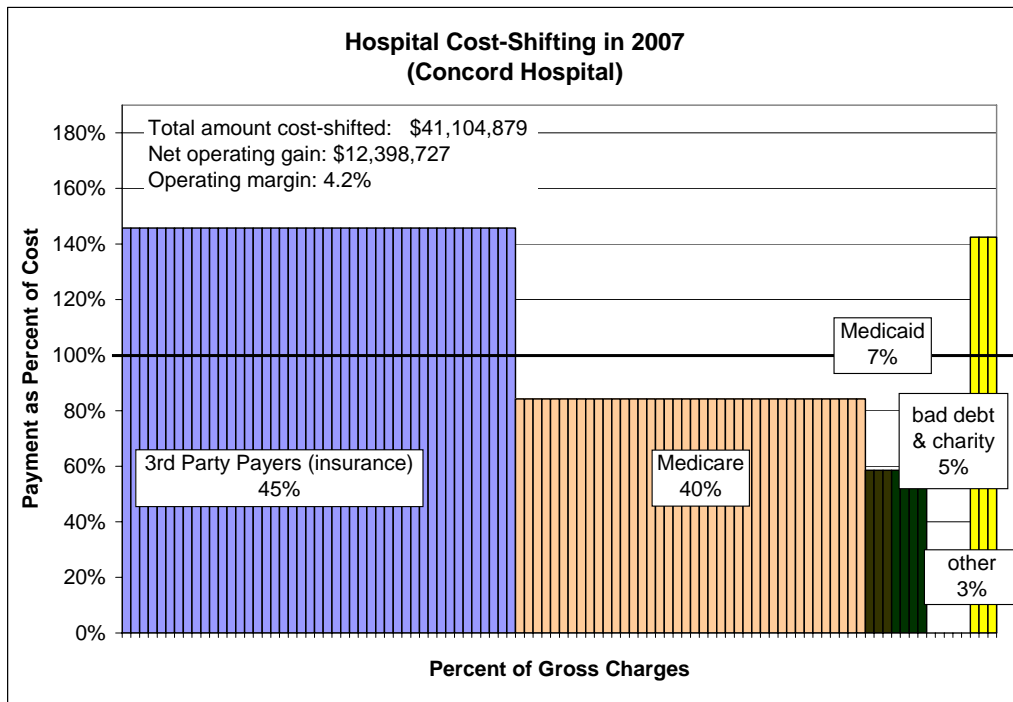
Catholic Medical Center, Manchester



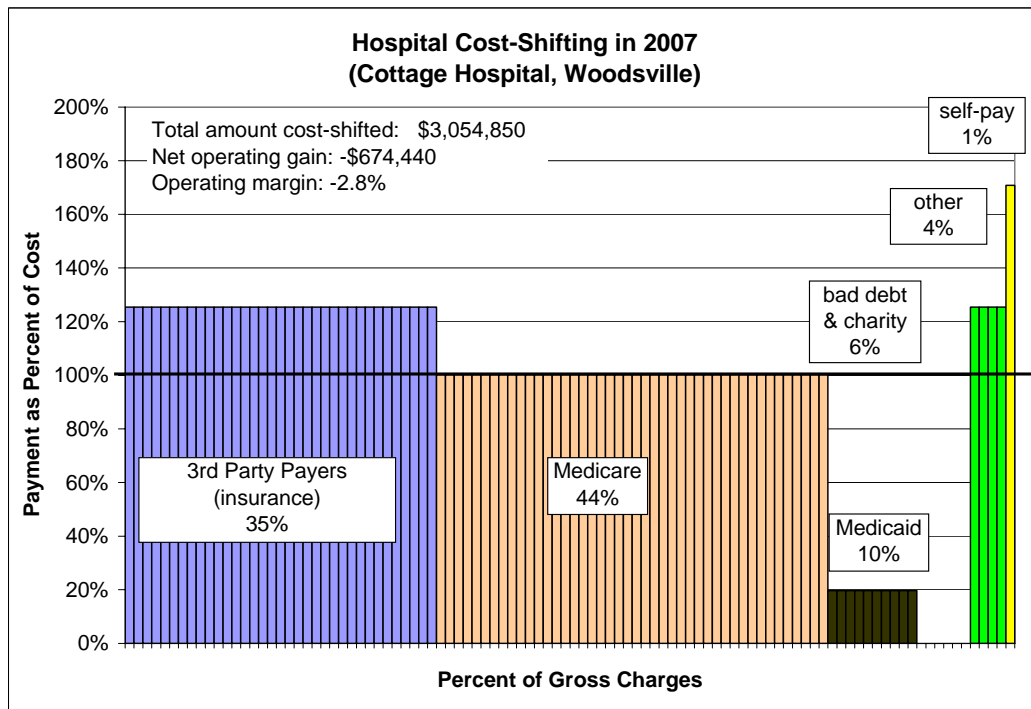
Cheshire Medical Center, Keene



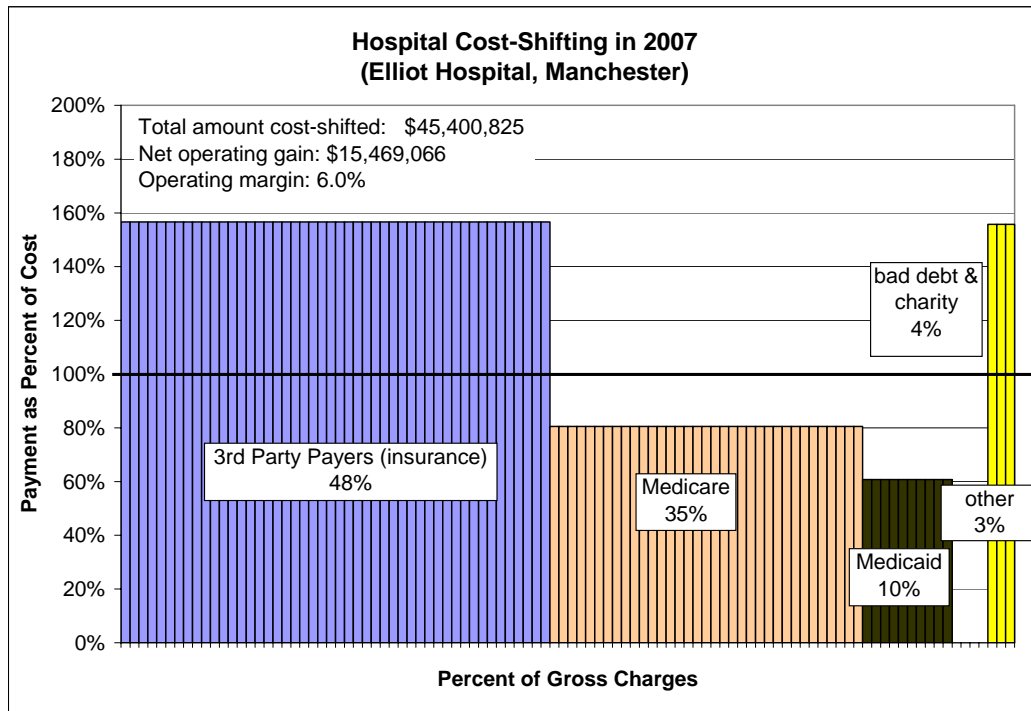
Concord Hospital



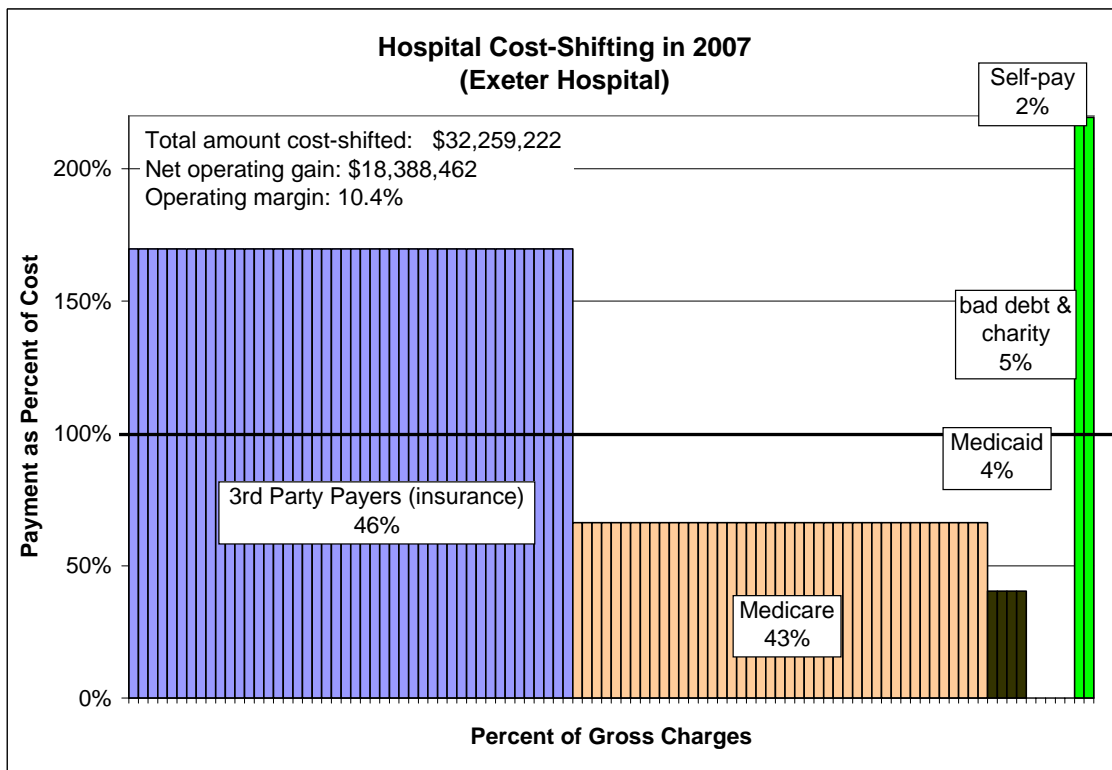
Cottage Hospital, Woodsville



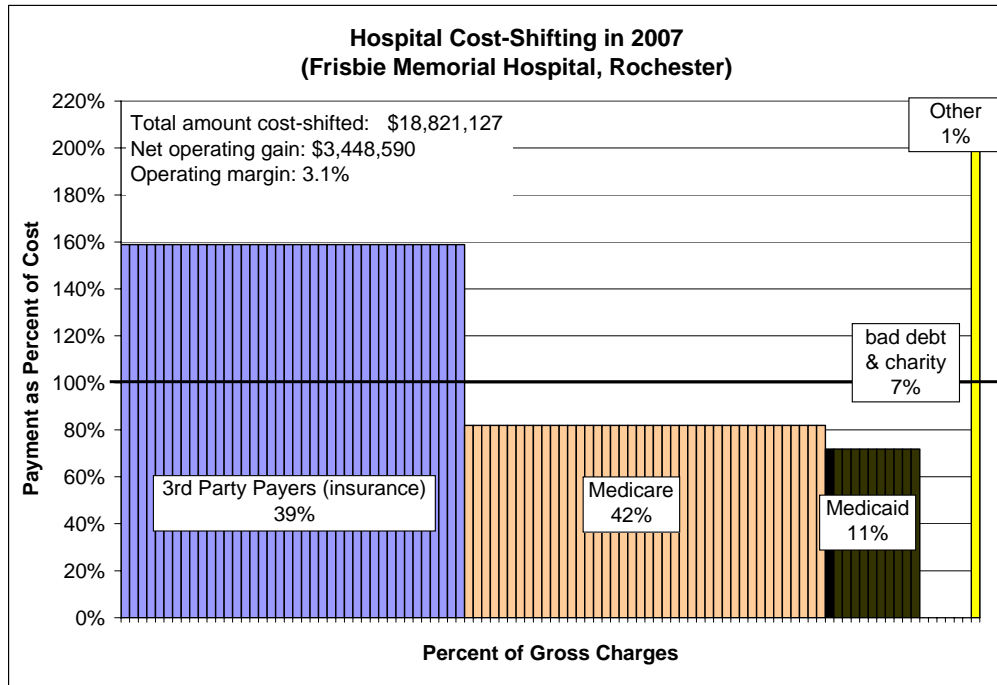
Elliot Hospital, Manchester



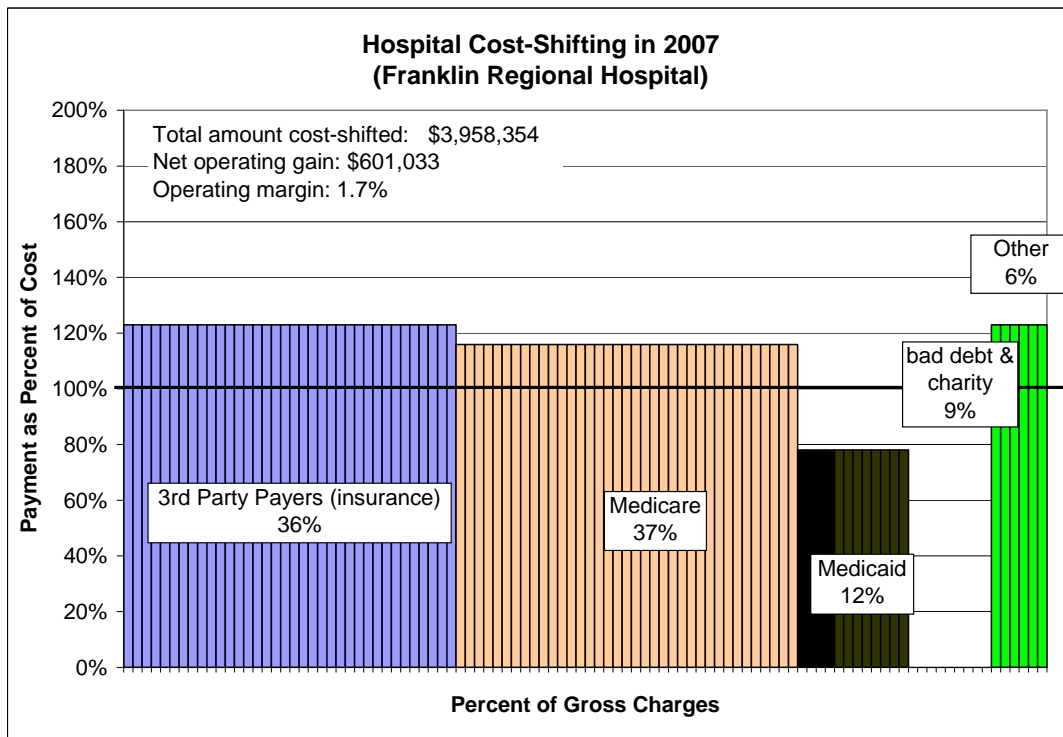
Exeter Hospital, Exeter



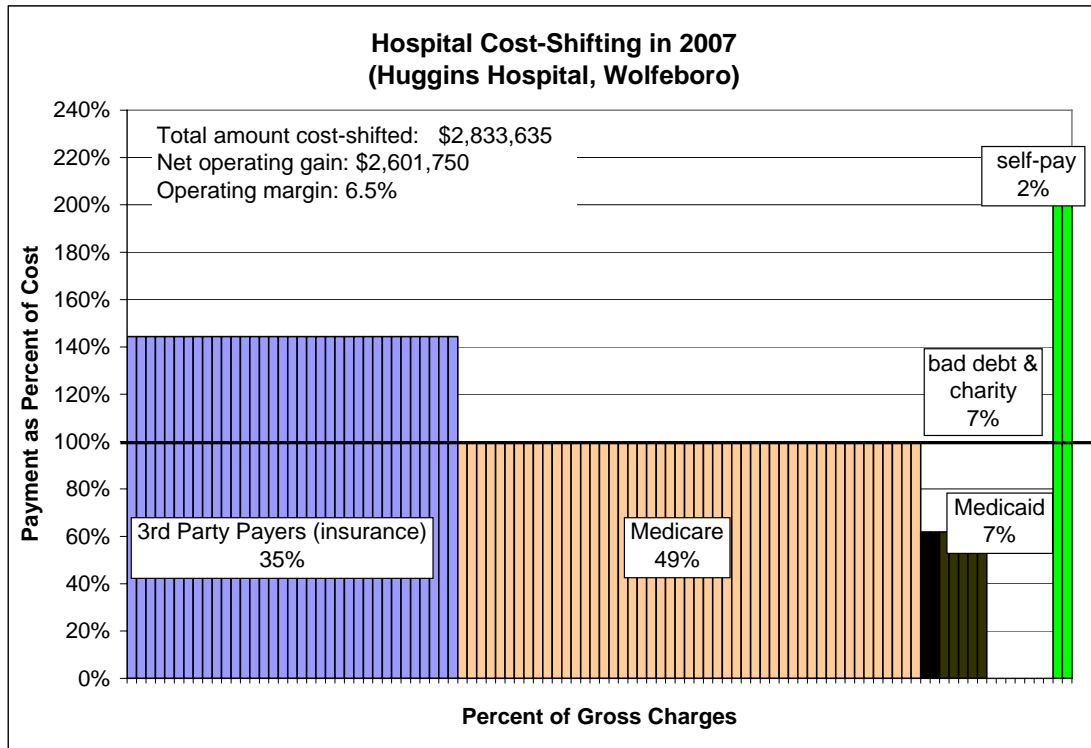
Frisbie Memorial Hospital, Rochester



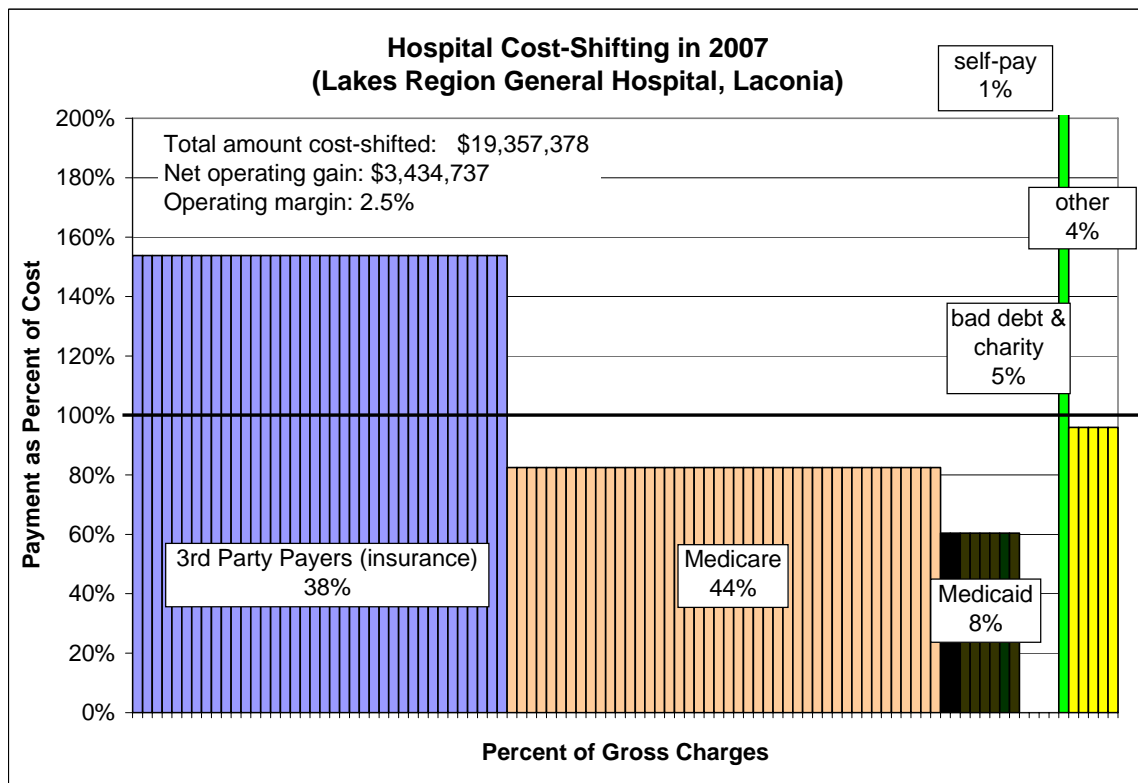
Franklin Regional Hospital



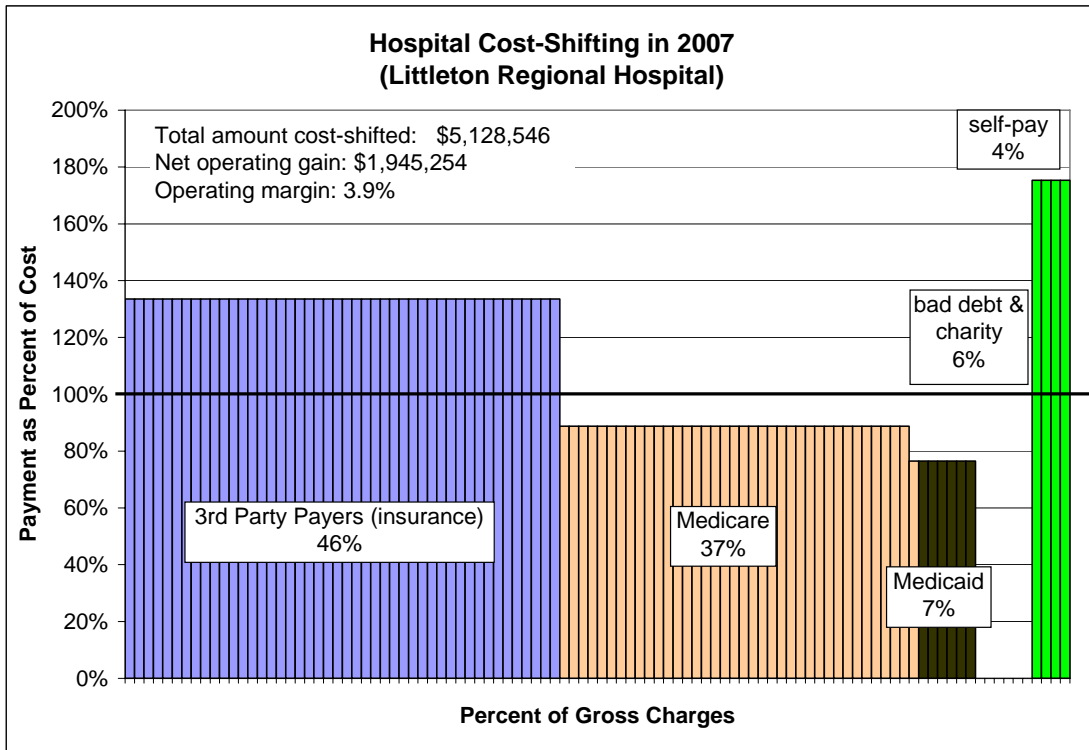
Huggins Hospital, Wolfeboro



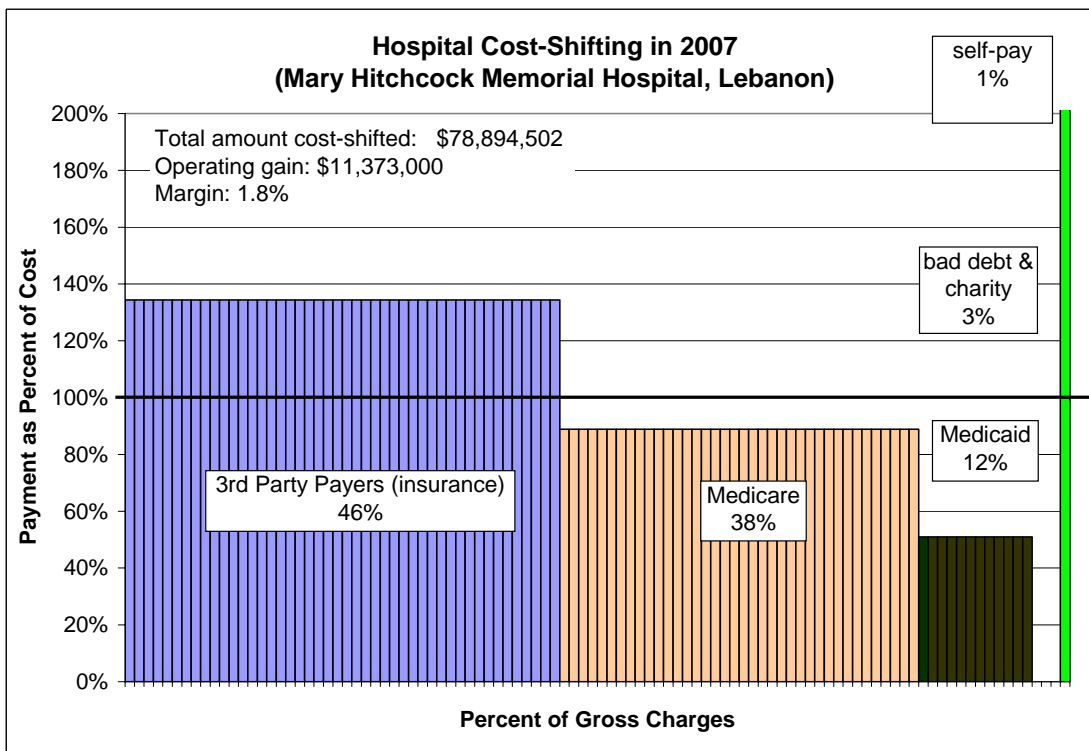
Lakes Region General Hospital, Laconia



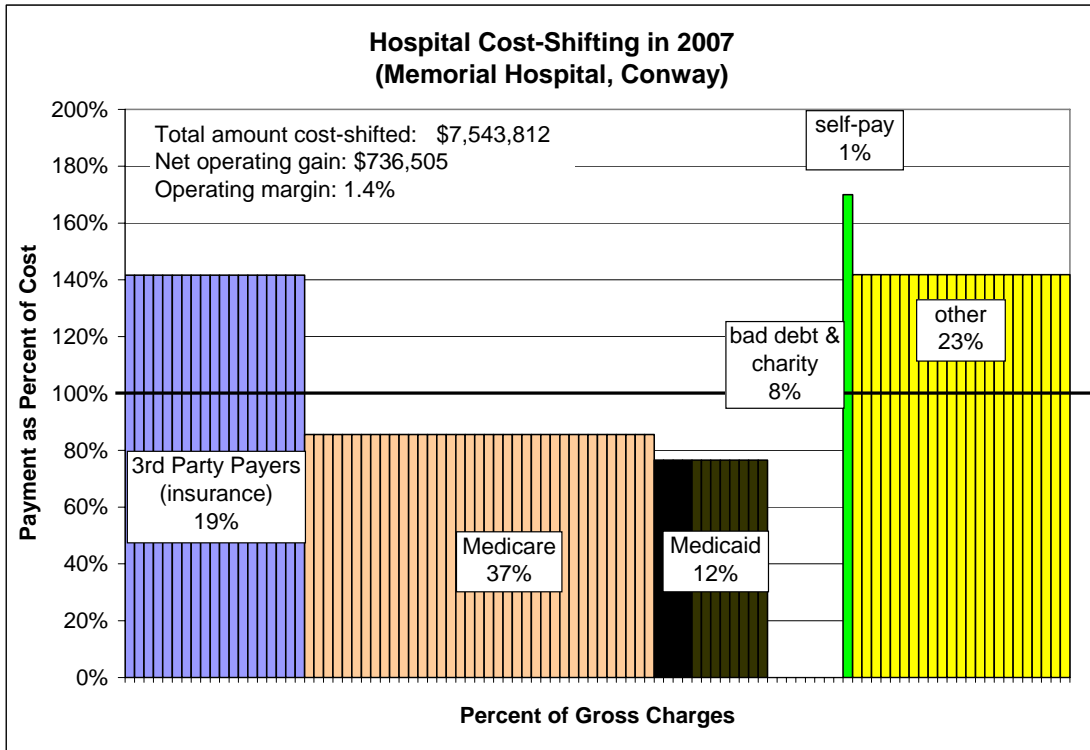
Littleton Regional Hospital



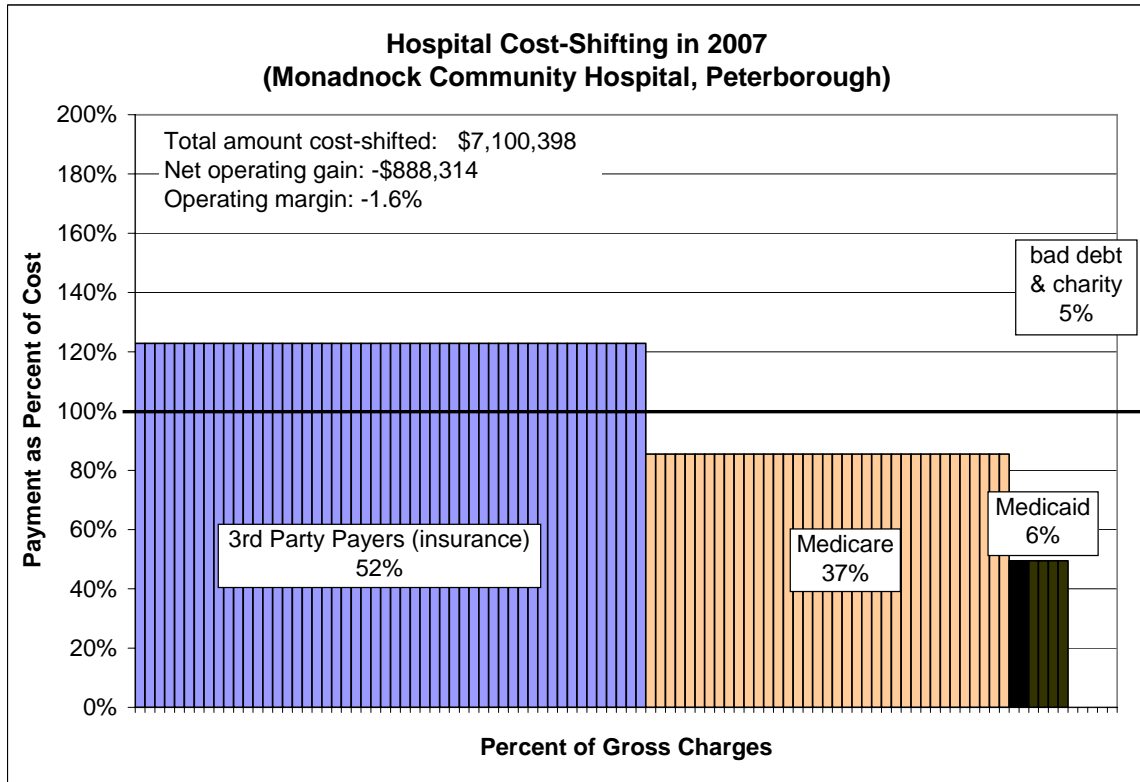
Mary Hitchcock Memorial Hospital, Lebanon



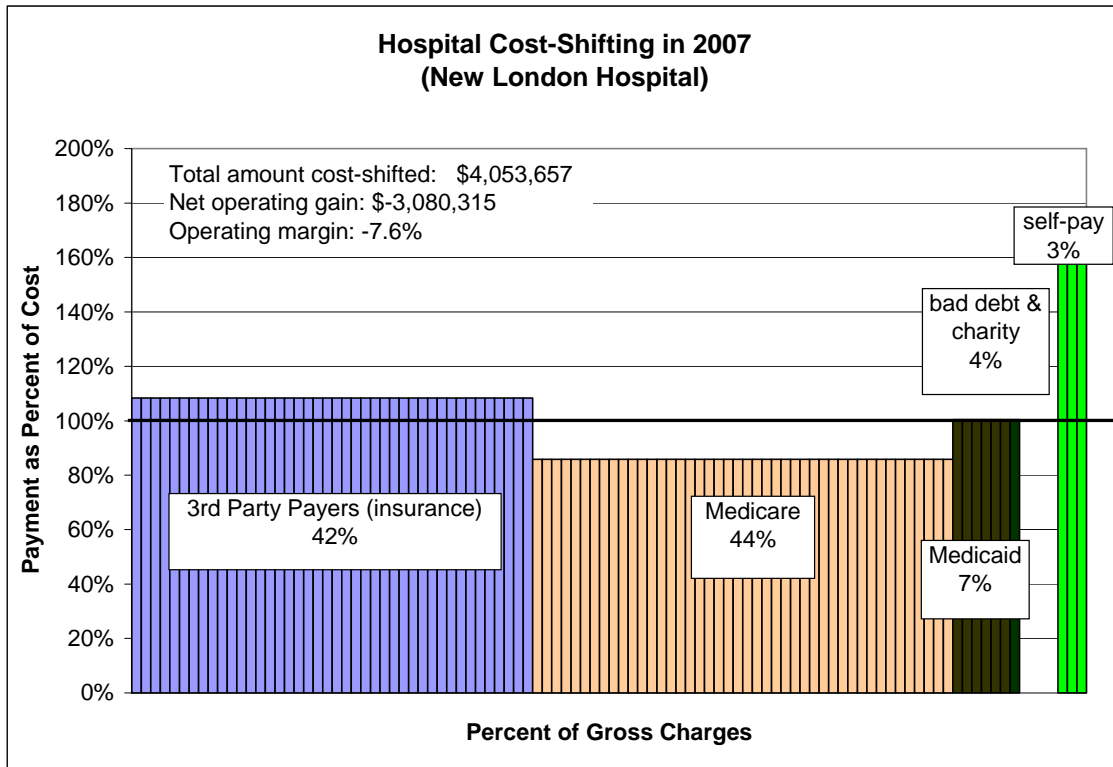
Memorial Hospital, Conway



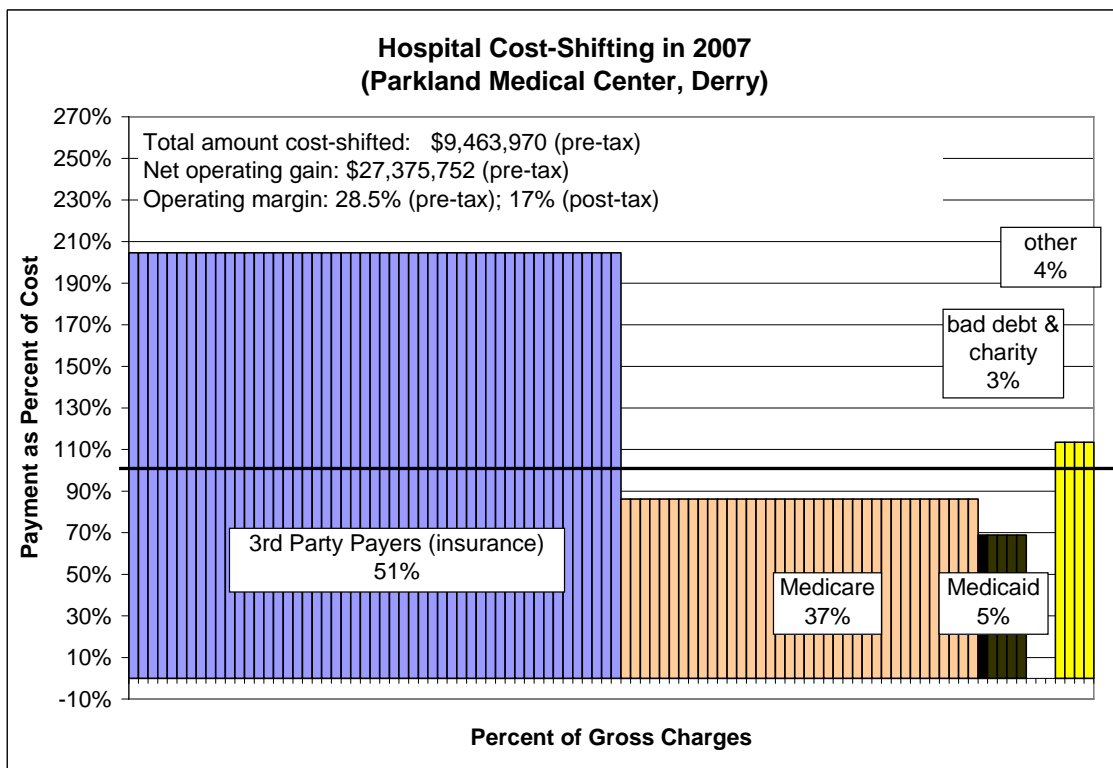
Monadnock Community Hospital, Peterborough



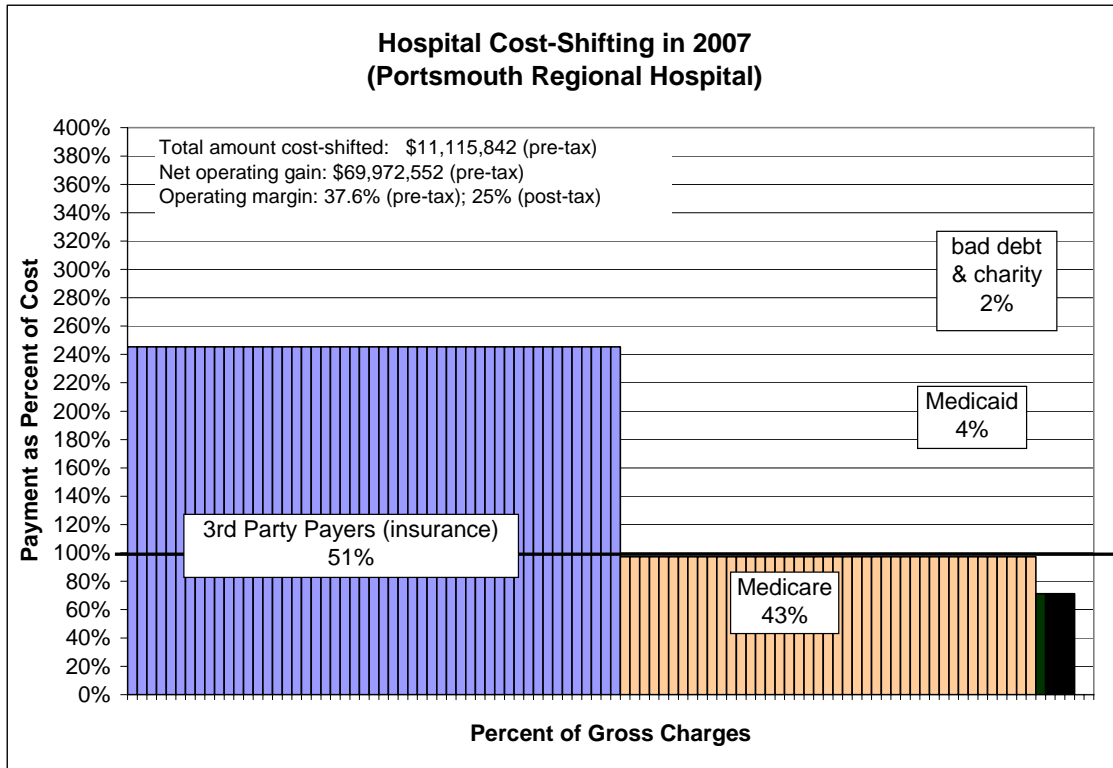
New London Hospital



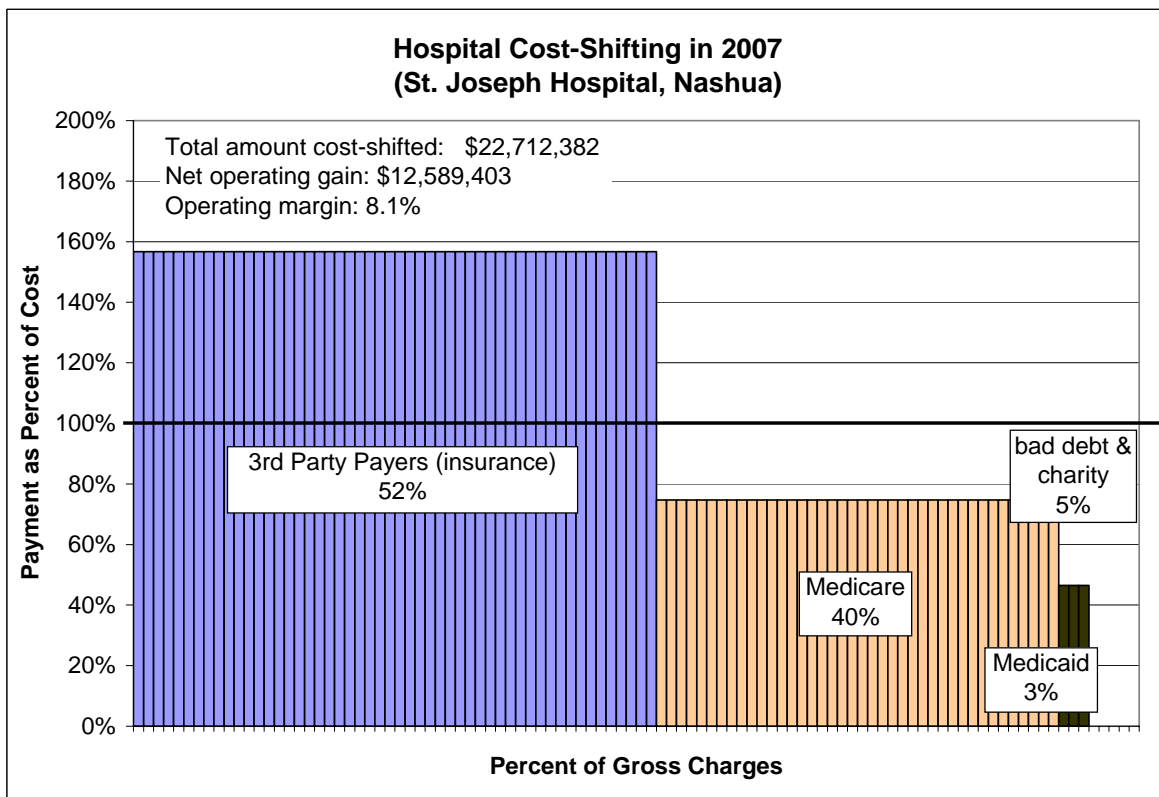
Parkland Medical Center, Derry



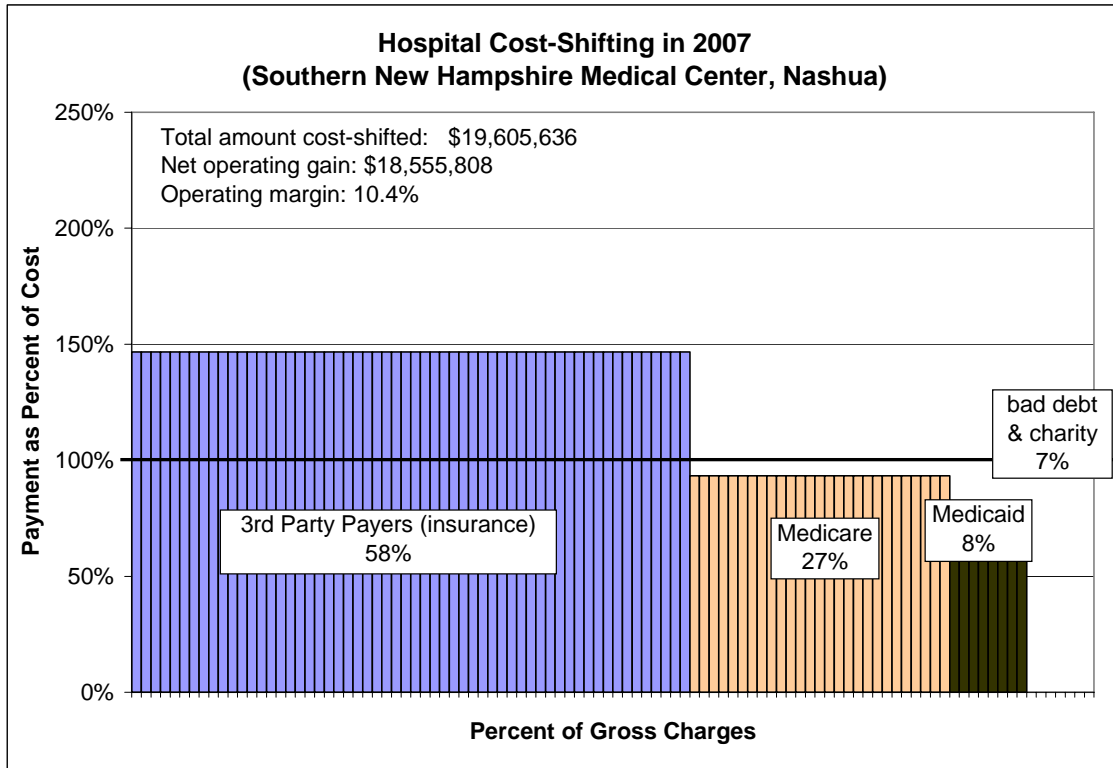
Portsmouth Regional Hospital, Portsmouth



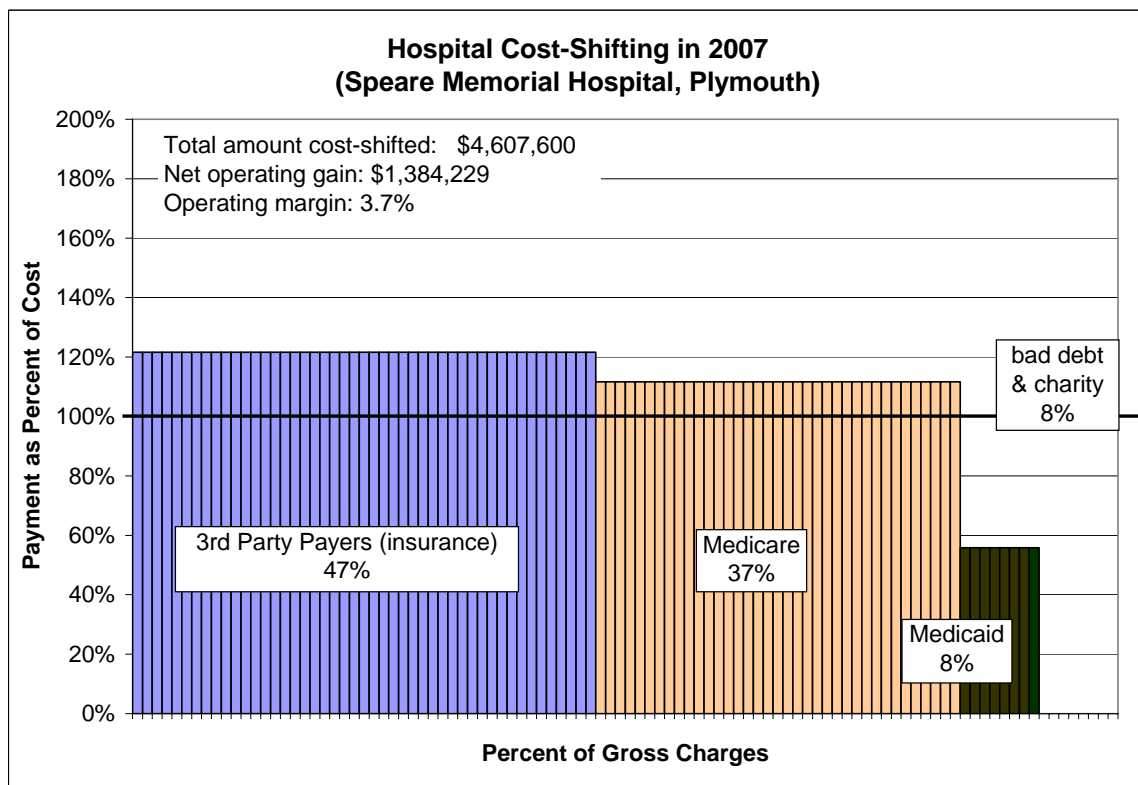
St. Joseph Hospital, Nashua



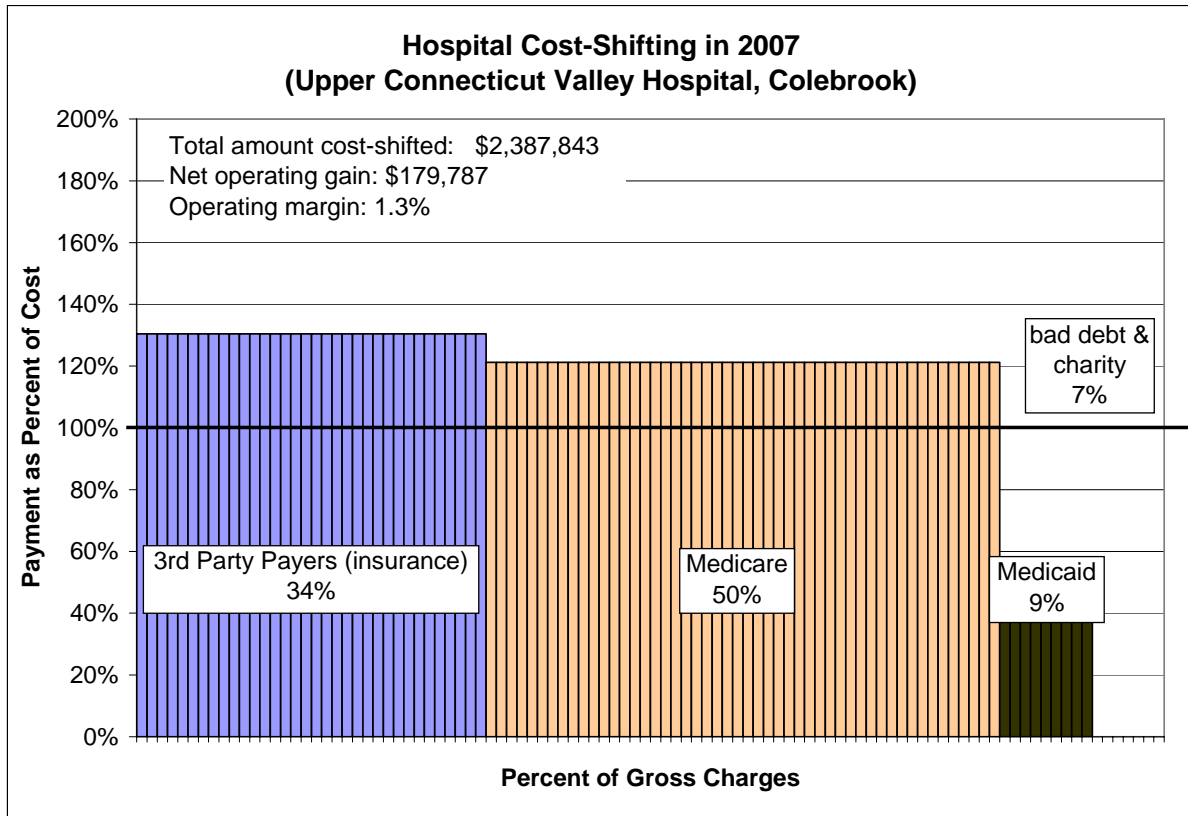
Southern New Hampshire Medical Center, Nashua



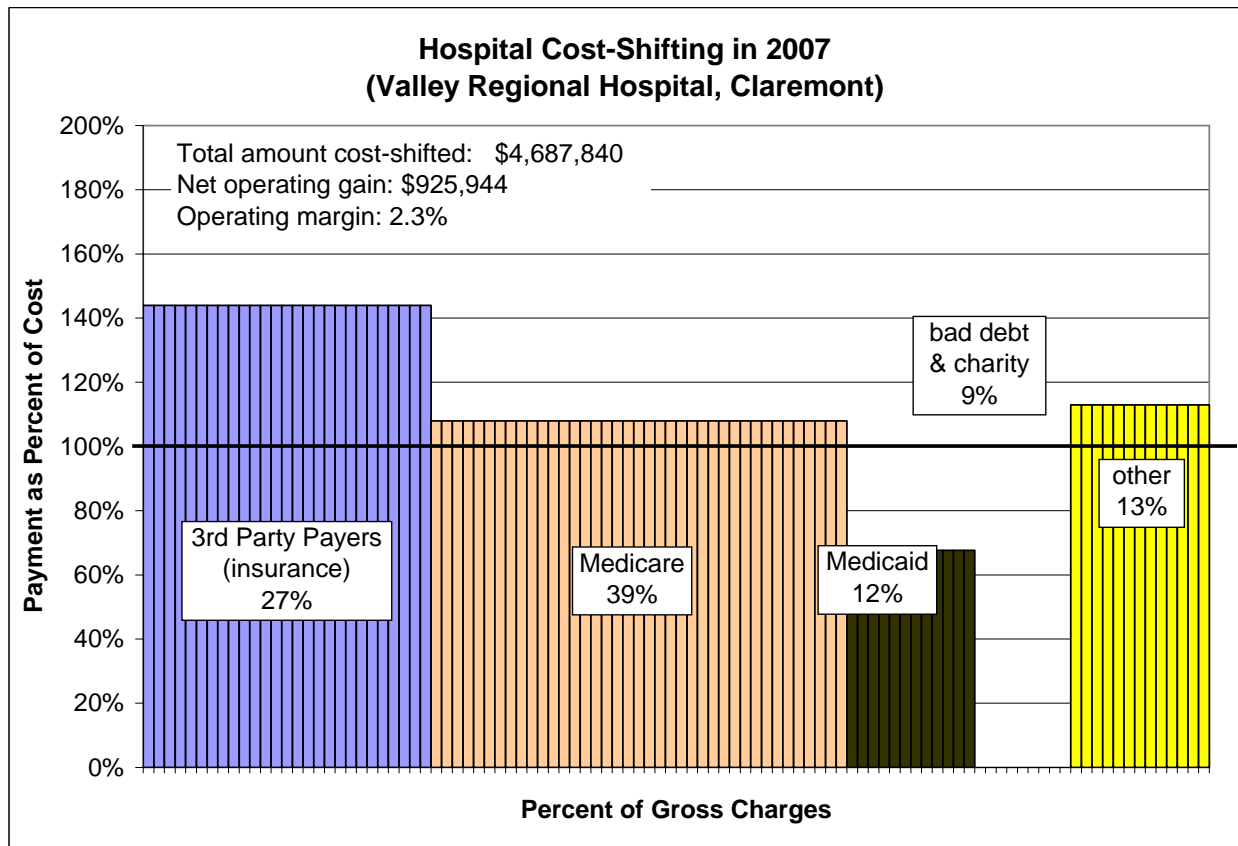
Spere Memorial Hospital, Plymouth



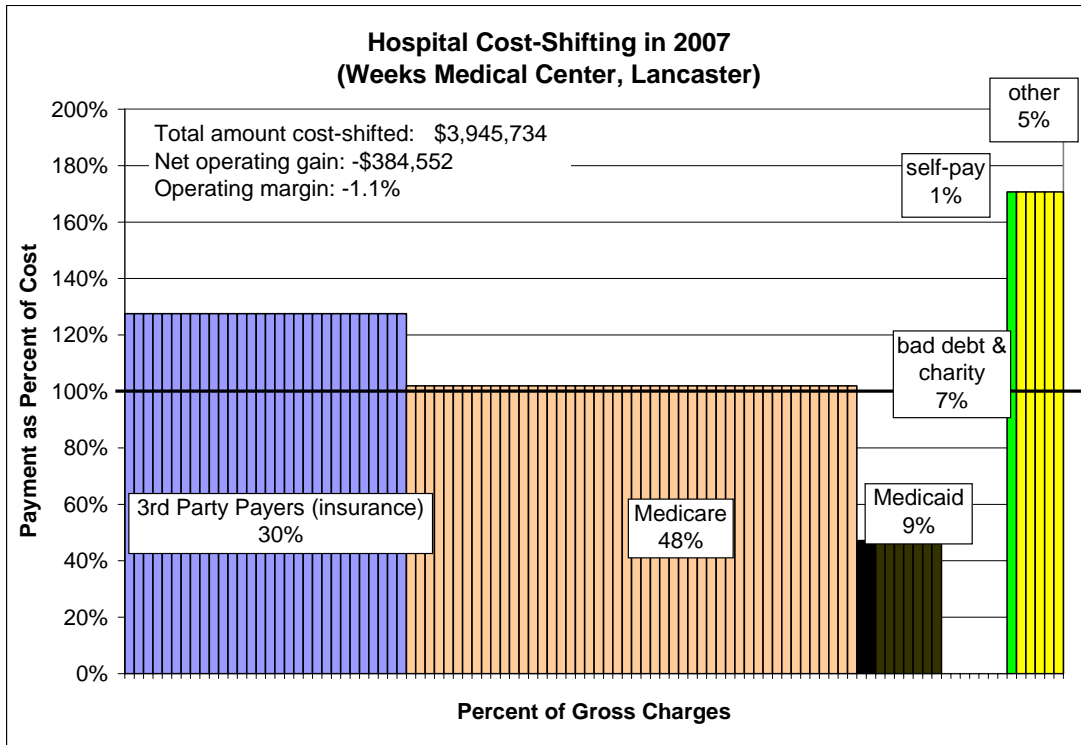
Upper Connecticut Valley Hospital, Colebrook



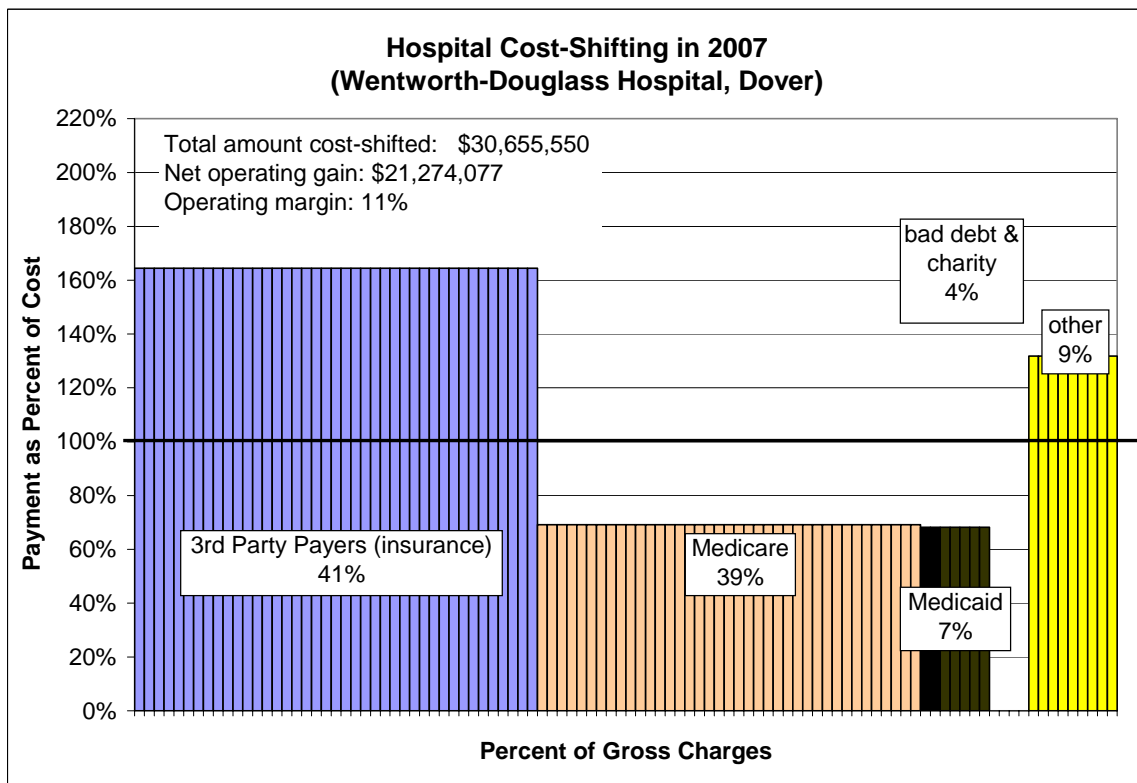
Valley Regional Hospital, Claremont



Weeks Medical Center, Lancaster



Wentworth-Douglass Hospital, Dover



Appendix B: Critical Access Hospitals and Conversion Date

<u>Hospital</u>	<u>Location</u>	<u>Date of Conversion</u>
Upper Connecticut Valley Hospital	Colebrook	04/01/01
Cottage Hospital	Woodsville	06/01/01
Littleton Regional Hospital	Littleton	09/01/01
Weeks Medical Center	Lancaster	08/01/01
New London Hospital	New London	04/01/03
Alice Peck Day Memorial Hospital	Lebanon	08/01/03
Franklin Regional Hospital	Franklin	07/01/04
The Memorial Hospital	North Conway	10/18/04
Valley Regional Hospital	Claremont	10/01/04
Monadnock Community Hospital	Peterborough	12/27/04
Androscoggin Valley Hospital	Berlin	12/31/04
Speare Memorial Hospital	Plymouth	05/05/05
Huggins Hospital	Wolfeboro	04/01/05

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