

**PRESENT AND FUTURE CHALLENGES
AFFECTING NEW HAMPSHIRE HOSPITALS**

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New Hampshire Hospital Association

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PRESENT AND FUTURE CHALLENGES AFFECTING NEW HAMPSHIRE HOSPITALS

Hospitals in New Hampshire have a proud history of meeting patient care needs and improving the health and well-being of their communities. In recent years, hospitals have been faced with unprecedented challenges, including ever-changing governmental health policies, multiple and complex reimbursement systems, the need for a highly skilled workforce and public demand for sophisticated technologies. As the healthcare environment continues its rapid evolution, hospitals have continued to support their core mission – to provide healthcare to residents of their communities. The ability of hospitals to continue to carry out their mission is based on a strong commitment of hospital leaders to form community partnerships, continuously monitor community needs and ensure the financial health of their hospitals.

The key factors affecting hospitals discussed in this report are:

- *The Role of Hospitals in Their Communities*
- *Demographics – An Aging Population*
- *Care for the Uninsured*
- *Medical Technology and Consumer Expectations*
- *Changing Care Settings*
- *Workforce*
- *Federal Policy*
- *State Policy*
- *Revenues and Expenses*
- *The Future*

THE ROLE OF HOSPITALS IN THEIR COMMUNITIES

Hospitals play a critical role in the life of the communities they serve. Hospitals provide essential access to health care in a variety of settings. The uninsured have historically relied on hospital emergency departments that provide care 24 hours a day, seven days a week, 365 days a year and are available to everyone in the community, regardless of ability to pay. Hospitals continue to serve as a safety net for people who cannot afford the care they need, and do not qualify for private or public assistance. In 1999, New Hampshire hospitals delivered \$34.7 million worth of free care to people unable to pay.

In addition, hospitals wrote off \$76.7 million ¹ in care for patients who could not pay in full, or cover their deductibles or co-payments, or simply did not pay at all.

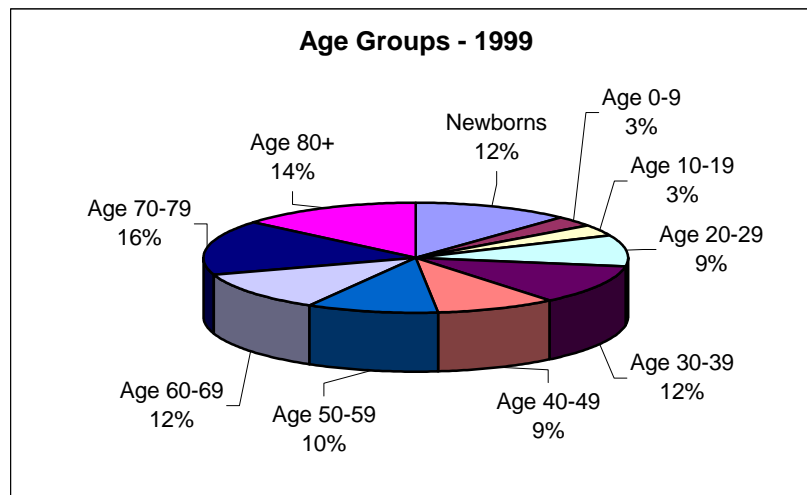
The amount of services provided by New Hampshire hospitals is staggering. Based on 1998 statistics reported to the American Hospital Association², New Hampshire hospitals provided:

- Over 475,000 emergency room visits
- Care for 108,900 patients who stayed overnight (inpatients)
- 1.85 million outpatient visits
- 31,000 inpatient surgeries and 61,000 outpatient surgeries

Below are the top five reasons why patients stay overnight in a New Hampshire hospital³:

- Normal Newborns
- Vaginal Deliveries
- Psychoses (mental disorder)
- Pneumonia
- Heart Failure and Shock

New Hampshire hospitals care for people throughout their life span. For example, newborns account for 12% of all inpatients, and the frail, elderly population (age 80 and above) accounts for 14%. The range of inpatient age groups is shown below ⁴:



Hospitals have taken on an increasingly greater role in responding to community needs for primary and preventive care. In addition to providing conventional inpatient and outpatient hospital care, hospitals are reaching beyond their traditional boundaries to

¹ New Hampshire Hospital Association, 1999 Hospital Audited Financial Statements.

² American Hospital Association, *Hospital Statistics*, 2000.

³ Foundation for Healthy Communities, Uniform Hospital Discharge Data Set, January – December 1999.

⁴ Foundation for Healthy Communities, Uniform Hospital Discharge Data Set, January – December 1999.

substantially improve the health of the communities they serve. Hospitals are engaged in a broad range of activities that include the creation of provider networks offering care to the uninsured, medication assistance programs, transportation services, free dental clinics, free cancer screening, community health education, tobacco prevention, teen pregnancy prevention, training for advanced care planning, and more. This broader social role of hospitals contributes to the community's overall well-being. Hospitals provide support through partnerships with diverse groups including schools, social service agencies, local governments, community health centers, home health agencies, and nursing homes, all of which are working together to build healthier communities.

Hospitals are keeping pace with continual breakthroughs in sophisticated medical technologies. Unprecedented medical advances have fueled increasing consumer demands for medical care – at the same time that public and private payors are implementing extensive cost cutting measures. New technologies require a skilled professional workforce that is properly trained in these new advanced interventions. Hospitals in New Hampshire are struggling to compete with bordering urban markets in the recruitment and retention of qualified health care workers.

New Hampshire hospitals pride themselves in adhering to the very highest standards of quality and in their commitment to improving their communities' health. A recent study conducted by the Health Care Financing Administration and published in the *Journal of the American Medical Association* ranks New Hampshire #1 in the nation on quality of care for seniors.⁵ The study used 1997 and 1998 data to look at how Medicare beneficiaries were treated for six conditions and ranked states by their adherence to quality indicators associated with these conditions. Hospitals in New Hampshire are successfully meeting patients' needs and continue to strive toward maintaining the high level of care their patients deserve. Additionally, another recently published study ranks New Hampshire #1 as the healthiest state in the nation. Of the seventeen measures studied, New Hampshire ranked #1 on several measures, including adequacy of prenatal care, support for public health care and lowest infant mortality.⁶

Hospitals, whether located in rural or urban areas, play an essential social and economic role in their communities. In smaller communities, hospitals often are the economic engine that drives the local economy by providing jobs and contributing to the economic viability of the community. In those communities in which the hospital is the largest employer, citizens rely heavily on the economic stability the hospital brings to their area. In many communities, businesses rely on the existence of a hospital to attract and retain members of their own workforce.

Together with the state's community health centers, hospitals serve as a guaranteed source of health care. People who lack health insurance coverage often turn to the hospital emergency department for their care.

⁵ Jencks, Stephen, *Quality of Medical Care Delivered to Medicare Beneficiaries*, Journal of the American Medical Association, 2000;284:1670-1676.

⁶ UnitedHealth Group, *State Health Ranking – 2000 Edition*, November 2000.

In order to sustain their capacities to support communities' health care needs, hospitals strive to be financially viable within the context of a constantly changing environment of regulations, demographics and financial constraints. Many of New Hampshire's hospitals are financially healthy and are therefore well positioned to continue to meet community need, as well as to respond to complex regulatory demands. Those hospitals are better equipped to deal with the many risks and uncertainties in today's health care environment that are threatening the viability of less well-positioned hospitals. A hospital must be financially healthy in order to ride out difficult times even while it continues to invest in patient care and community benefit. Hospitals that are not doing well financially are more often located in areas with greater needs associated with poverty, poor health status and lack of health insurance. These are the hospitals that are least able to meet the demand for services.

The following discussion presents some of the major challenges facing hospitals today. The state's health care delivery system is an extraordinarily complex patchwork of providers, government regulators, third party payors, businesses and patients. Without necessary resources, hospitals will not be able to meet their patients' increasing needs and expectations. The greatest challenge to hospitals today is to continue meeting communities' health care needs with available resources.

DEMOGRAPHICS – AN AGING POPULATION

Issue: New Hampshire's elderly population will nearly double in the next 25 years. Based on a recent White House report, New Hampshire's over 65 population will grow from 12% of the state's current population to 19% in the year 2025.⁷

Impact: Hospitals must prepare to provide services for the growing elderly population to help keep them healthy and care for them when they become ill. Hospitals will be expected to meet the challenges of a larger geriatric population presenting:

- an increased number of Medicare patients resulting in a changing hospital payor mix;
- a preponderance of chronic diseases that will intensify as life expectancies increase; and
- changing attitudes toward death and dying that will require better advanced care planning.

CARE FOR THE UNINSURED

Issue: The New Hampshire Department of Health and Human Services reports that approximately 9% of New Hampshire citizens (96,000) had no health insurance in 1999. A significantly higher percentage of uninsured residents reside in rural areas. For example, approximately 14% of Northern New Hampshire is uninsured. The

⁷ *America's Seniors and Medicare: Challenges for Today and Tomorrow*, The White House, February 29, 2000.

national rate is 17%.⁸ New Hampshire hospitals provide care to all patients, regardless of insurance status or ability to pay. Hospitals account for patients who cannot pay in two ways – by providing direct charity care allowances or by writing off all or part of a patient’s bill if the hospital could not collect payment (called bad debt). Taken together, charity care and bad debt are referred to as uncompensated care.

Impact: Despite a low uninsured rate and a booming local economy, New Hampshire hospitals are providing an increasing amount of uncompensated care. According to hospital audited financial statements, hospitals in New Hampshire provided \$111.5 million in uncompensated care in 1999, up from \$95.4 million in 1995. On average, this represents 5.3% of gross patient revenue, with individual hospital rates ranging from a low of 3.0% to a high of 10.6% (see Appendix A for individual hospital rates). The national average is 5.9%.⁹

All New Hampshire hospitals have charity care policies that set guidelines for providing charity care to patients in need of financial assistance. The policies, approved by hospital boards of trustees, generally focus on the patient’s current assets and expenses and use the Federal Poverty Guidelines, which, for a family of four in 1999 was \$16,799.¹⁰ Hospitals routinely grant assistance to patients with incomes well above this level.

Bad debt is the cost of services provided that is neither paid for nor classified as charity care. Although there is a clear distinction between charity care and bad debt in accounting terms, the distinction blurs in real life situations. Bills may remain unpaid because a patient is unable to pay but has not applied for charity care or is unwilling to pay. Portions of hospital bills may also remain unpaid by insured patients who don’t qualify for charity care but yet cannot afford to pay the co-payment or deductible. This situation is known as underinsurance. Therefore, the combination of both bad debt and charity care is an accurate measure of a hospital’s level of uncompensated care rather than focusing on charity care in isolation.

In addition to providing direct dollar support to indigent patients, hospitals are helping people gain access to care and insurance coverage. For example, hospitals identify and enroll children who qualify for the New Hampshire Healthy Kids Program (subsidized health insurance) and have been innovators in providing care through programs such as free dental clinics, cancer screenings and prescription drug assistance.

MEDICAL TECHNOLOGY AND CONSUMER EXPECTATIONS

Issue: Medical breakthroughs are continually changing the manner in which care is delivered. Hospitals are expected to keep pace with new research and new

⁸ *Health Insurance Coverage and the Uninsured in New Hampshire*, Department of Health and Human Services, November 1999.

⁹ American Hospital Association, unpublished AHA Annual Survey 1998 data.

¹⁰ *Federal Register*, Vol. 64, No.52, March 18, 1999, pp. 13428-13430.

technologies in medical interventions and treatments. Health care consumers are more actively involved in making decisions about the care they receive. They expect more choices, control, customer service and interaction with their health care providers.¹¹

Impact: New equipment, highly trained specialists and physical changes to facilities will be necessary to incorporate these new advanced technologies. This requires significant investment in capital, staff and resources. The public's demand for high tech care closer to home has brought highly sophisticated services to more regions around the state.

Hospitals must respond to the demands of better-educated consumers. For example, consumers are demanding access to non-traditional medicine which then creates challenges such as adding new services and establishing credentialing standards for new types of providers.

The impact of the Internet on healthcare utilization is unprecedented. Never before have people had such immediate access to the latest clinical research data or to medical scientific journals. According to a recent national study, 40.9 million U.S. adults, or 54% of people using the Internet, are using it for healthcare purposes. In addition, while only 3.7 million have e-mailed their doctors, 33.6 million are interested in doing so.¹²

CHANGING CARE SETTINGS

Issue: Over the last decade, advances in medical and pharmaceutical technologies have allowed services that were traditionally only provided in the hospital to be performed in outpatient settings, such as hospital-based ambulatory surgery suites, free-standing ambulatory surgery centers and physician offices. These technological changes have increased competition in healthcare and created shifts in the delivery of care from the inpatient to the outpatient setting.

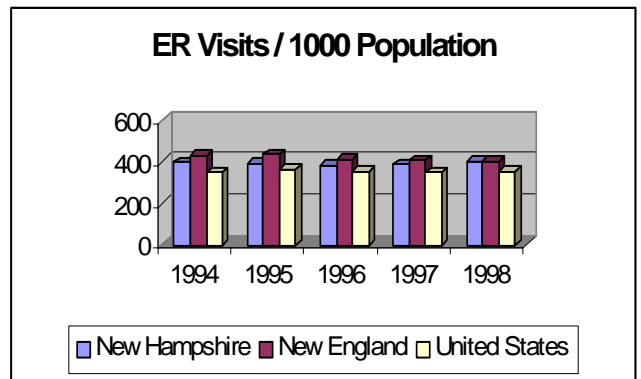
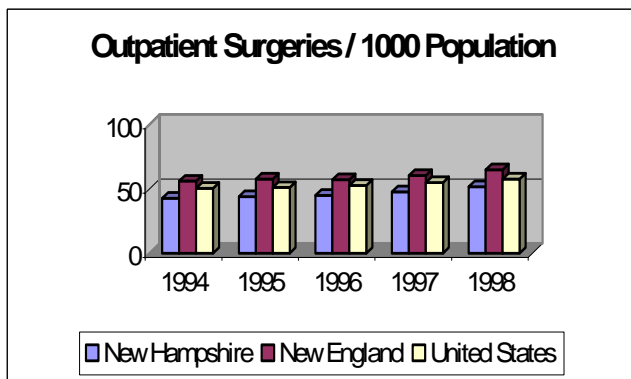
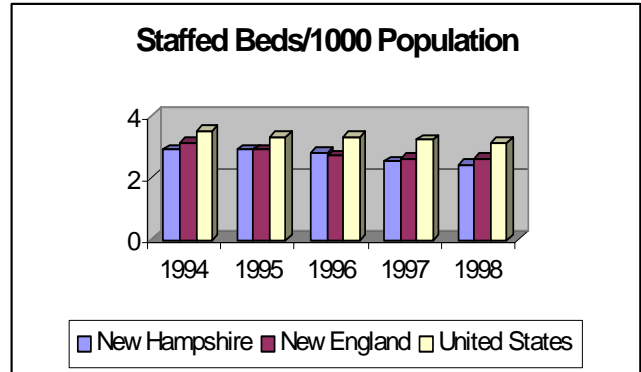
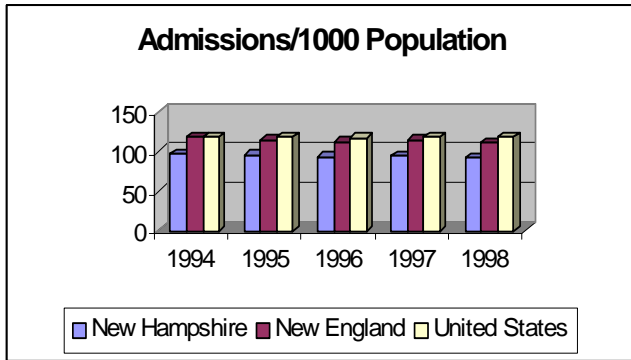
Impact: This shift from the inpatient to the outpatient setting has been evident for some time, especially in New Hampshire. New Hampshire hospitals have been ahead of the curve in adapting to these changes. New Hampshire hospitals' inpatient utilization rates have been below New England and national averages. New Hampshire hospitals have also had a consistently lower number of staffed beds than in New England or nationwide. In addition, New Hampshire hospitals have maintained lower per 1000 population rates of outpatient surgery and emergency room visits than New England and the nation, despite the actual number of outpatient services increasing.¹³ The ability of hospitals to cross-subsidize lower margin services with more profitable services is continually diminishing. The migration of profitable services from the hospital setting to other

¹¹ *The Future of the Internet in Health Care*, Robert Mittman and Mary Cain, Institute for the Future, January 1999.

¹² CyberDialogue.com, press release, "CyberDialogue Releases Cybercitizen Health 2000", August 22, 2000.

¹³ American Hospital Association, *Hospital Statistics*, 2000.

providers leaves hospitals with a portfolio of lower margin or negative margin services, thus weakening their financial position and their ability to support community needs.



WORKFORCE

Staffing

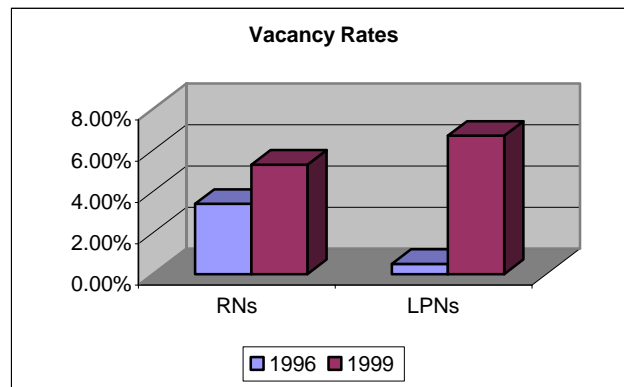
Issue: New Hampshire's unemployment rate is 2.7%, well below the national rate of 4.1%¹⁴. The New Hampshire Department of Employment Security reports that 11.7% of Granite Staters enter the workforce with a bachelor's degree, while 4.5% enter the workforce with an associate's degree.¹⁵ As a result, hospitals face steep competition in a tight labor market, especially for highly skilled professional and technical workers. At the same time, while the demand for health care personnel is growing, the supply of healthcare workers is declining.

¹⁴ NH Dept of Employment Security, Figures as of August 2000, seasonally unadjusted.

¹⁵ NH Dept of Employment Security, *New Hampshire Employment Projections by Industry and Occupation, 1996 to 2006*.

Impact: The implications of New Hampshire's current labor market are twofold: as the shortage of healthcare workers grows more acute, hospitals will have to increase resources to recruit employees and increase salaries and benefits to fill positions and retain employees. Hospitals are very labor intensive - in 1999, more than 50% of a hospital's expenses represented salaries and benefits.¹⁶

Based on a study conducted by the New Hampshire Hospital Association¹⁷, vacancies for nursing positions are on the rise. In 1996, 3.4% of the total number of RN positions in hospitals went unfilled. As of November 1999, that figure had risen to 5.3%. LPN positions are far worse. In 1996, the vacancy rate for LPNs was 0.5% and in November 1999, vacancies grew to 6.7%. Specialized areas, such as intensive care units and emergency departments, are facing an even harder time recruiting qualified candidates. Many hospitals in New Hampshire must rely on temporary nurses under contract to fill vacant positions. This is a very costly means of providing staffing and is expected to continue as the nursing shortage grows.



The ability to attract healthcare professionals presents an even greater challenge in rural areas. Small and rural hospitals have less flexibility to manage staffing shortages and cannot compete, in most instances, with salaries and benefit packages available at larger institutions. Hospitals are trying to increase the interest of young people to enter the healthcare profession and are working with universities and colleges to create curriculum that will support the future demands of healthcare needs.

Staff Development

Issue: As hospitals adapt to the many challenges of providing high quality healthcare, hospital staff members must adapt as well. Hospitals require a technically advanced and flexible workforce that can:

- **promote a transition from inpatient settings to ambulatory and home based settings;**

¹⁶ New Hampshire Hospital Association, 1999 Hospital Audited Financial Statements,

¹⁷ New Hampshire Hospital Association, *Health Professional Supply Report*, November 1999.

- **handle increasingly intensive services in the inpatient setting; and**
- **master evolving and complex medical information and equipment.**

Impact: Hospitals must provide ongoing training and education to meet changes in technology and medicine which require substantial investments of time and money. Hospitals must balance time spent on necessary education with time needed to care directly for patients.

Worker Safety

Issue: Healthcare workers can be exposed to infectious agents and other hazards in the course of their work.

Impact: A top priority for hospitals is to maintain a safe work environment. New technologies are available to provide for a safe environment and are considered part of the cost of providing care. Hospitals must also remain aware of advances in the availability of safe medical devices, particularly sharp-edged devices such as needles and scalpels. The use of these safe medical devices, as well as gloves, masks, protective glasses and clothing, minimizes the risks of exposure at a substantial cost to the hospital.

STATE POLICY

Community Benefit

Issue: In 1999, the New Hampshire Legislature passed the state's first community benefit reporting statute. Beginning in 2000, all healthcare charitable trusts (including not-for-profit hospitals, nursing homes and home health agencies) must report on their community benefits. The community is defined as the service area or patient population of the organization. Healthcare charitable trusts are required to conduct and update a community needs assessment every three years, file an annual community benefits plan and report on the actual unreimbursed cost of each activity undertaken in the preceding year to the Attorney General's Office of Charitable Trusts.

Impact: Not-for-profit hospitals are accountable to the communities they serve to ensure their activities are consistent with their charitable mission and community needs. Many hospitals presently comply with the requirement of *planning* community benefits, however *measuring* and *reporting* benefits is a new undertaking. This process will provide hospitals and communities with a new tool for working together to meet the healthcare needs of the people they serve.

Hospitals develop community benefits to meet identified community health needs. Hospitals offer a variety of services and programs that impact the well-being of their communities such as health screenings, health promotion education, dental care, school

nurses, tobacco prevention, transportation, bicycle helmets, car seats and many, many more.

Certificate of Need

Issue: The Health Services Planning and Review Board performs extensive reviews prior to granting permission for new or expanded health services in New Hampshire in which costs exceed a legislatively set threshold. This process, called Certificate of Need, works to assure the public that limited financial resources will only be invested in services that can be supported by a region's population, thus preventing unnecessary duplication. CON evaluates the economic viability of existing providers as well as the needs of the community.

Impact: The CON process requires hospitals and other healthcare providers to demonstrate that proposed services are needed in the community. The CON process provides for public scrutiny and oversight of healthcare capital expenditures for certain services that meet certain cost thresholds. However, as the costs of certain technologies go down, more profitable services may be shifted away from hospitals without the scrutiny of CON review. This shift diminishes the hospital's ability to support essential money-losing services, such as emergency rooms and labor and delivery units, particularly for low-income and uninsured patients.

FEDERAL POLICY

Balanced Budget Act of 1997 - Medicare

Issue: In 1997, Congress passed the Balanced Budget Act (BBA), balancing the federal budget at a tremendous cost to hospitals and other healthcare providers. Nearly half of the savings relative to Medicare came from reduced Medicare payments to hospitals. Implementation of the BBA requires the proliferation of regulations with which hospitals must comply.

Impact: In New Hampshire, the BBA has been projected to reduce Federal Medicare payments to all hospitals by \$379 million from 1998 to 2004.¹⁸ These reductions include lowered payments in the amount of \$215 million for inpatient services; \$57 million for outpatient hospital services and \$22 million for hospital-based home health care. More than 75% of BBA inpatient cuts fall on hospitals between 2000 and 2002. For New Hampshire's rural hospitals, Medicare payments will be at least \$32 million less than expected between 1998 and 2002. In addition to reduced payments, hospitals must expend additional resources to comply with new regulations implementing BBA payment changes. For example, the new outpatient payment system regulations and associated

¹⁸ The Lewin Group, *The Impact of the Medicare Balanced Budget Refinement Act on Medicare Payments to Hospitals*, February 1, 2000.

non-regulatory requirements imposed by Medicare have posed a substantial burden on all hospitals.

In 1998, Medicare margins (an indicator of how well Medicare reimburses hospitals) in New Hampshire were *negative* 6.5% compared to the U.S. average of *positive* 2.5%.¹⁹ In other words, Medicare paid hospitals less than the cost of providing services to Medicare patients. In New Hampshire, 36% of all admissions are covered by Medicare.

Small and rural hospitals serve a higher percentage of Medicare patients and thus are more adversely affected by the BBA reductions and increased administrative requirements. In New Hampshire, small and rural hospitals serve an average of 43% Medicare patients, compared to the urban average of 37% Medicare. For example, Franklin Regional Hospital, a small, rural hospital, sees the highest percentage of Medicare patients in the state, representing over 57% of the hospital's patients.²⁰

While some relief has been received, including enhanced payments to vulnerable rural hospitals, additional relief from BBA cuts is still needed for all hospitals. The BBA provided much needed relief to the very smallest rural hospitals (15 to 25 beds) under the Medicare Rural Flexibility Critical Access Hospital program. Only five of the New Hampshire's rural hospitals could potentially qualify. For these hospitals, the Critical Access Hospital program may provide the economic stability they need to remain as essential providers of healthcare services.

Health Insurance Portability and Accountability Act (HIPAA)

Issue: The Health Insurance Portability and Accountability Act of 1996 mandated regulations that govern privacy, security and administrative simplification standards for health care information. HIPAA regulations are expected to be finalized by the end of 2000. These regulations will require major changes in how hospitals handle all facets of information management, including patient records, reimbursement, coding and security.

Impact: While patient privacy protection is of top importance for hospitals, HIPAA requires investment in new or revised software, staff education, and appointment of staff to serve as privacy and security officers. These requirements generate additional costs to hospital operations. The costs for complying with the proposed HIPAA standards are predicted to far exceed the cost of preparing for Y2K, which was estimated to have cost \$24 million in New Hampshire.²¹ While estimates for New Hampshire are not yet available, the federal government estimates that the cost of the administrative simplification provisions of HIPAA will be about \$3.5 billion for providers, accruing over the first three years of implementation. Hospitals alone are expected to spend about

¹⁹ HCIA Sachs, Ernst & Young, LLP, *The Financial State of Hospitals: Post-BBA and Post-BBRA*, May 2000

²⁰ Foundation for Healthy Communities, Uniform Hospital Discharge Data Set, January – December 1999

²¹ American Hospital Association, special Year 2000 survey, 1999.

\$1.4 billion in implementation costs over this period. New Hampshire hospitals are concerned that the immediate investment will be burdensome. However, hospitals recognize the value in protecting patient privacy and will take the necessary steps to be in compliance with the HIPAA standards by October 2002.

REVENUES AND EXPENSES

Payor Mix

Issue: Hospitals bill their services to many payors, including Medicare, Medicaid, health plans, commercial insurers and patients. Payment varies depending on who pays the bill.

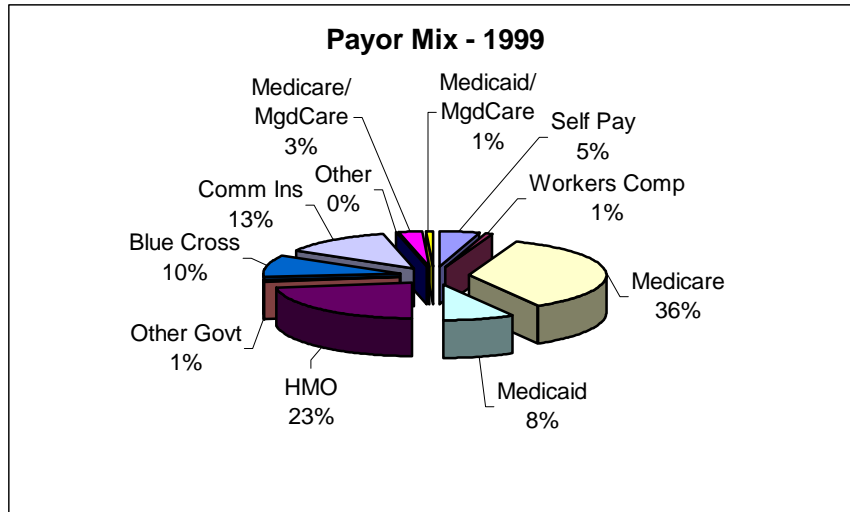
Impact: Payor mix is one of the most important factors in determining a hospital's viability. Hospitals are bound by federal and state laws governing reimbursement levels for Medicare and Medicaid. Patients covered by these two programs represent more than 44% of total hospital admissions in New Hampshire, and these programs do not pay the full cost of their care. In 1998, New Hampshire hospitals received, on average, 94 cents for every dollar spent on Medicare patients and only 77 cents for every dollar spent on Medicaid patients. Nationally, hospitals were paid an average of \$1.02 for Medicare and 97 cents for Medicaid.²²

Private insurers represent 50% of total payor mix for hospitals in New Hampshire. Most private insurers negotiate contracts with hospitals for specific rates for services rendered to their members. In 1998, New Hampshire hospitals received an average of \$1.23 for every dollar spent on privately insured patients. Nationally, hospitals were reimbursed an average of \$1.16. The New Hampshire private insurer market is currently undergoing unprecedented restructuring, making future payment rates uncertain.

Each hospital has its own unique payor mix. Some hospitals benefit from a more "favorable" payor mix, whereas others are hindered by their payor mix. For example, if a hospital has a high percentage of Medicare and Medicaid patients, it will lose more money per patient than hospitals with a higher percentage of private insurers. Shown on the next page is the breakdown of payors for all New Hampshire hospital admissions.²³ These percentages vary among hospitals. See Appendix B for individual hospital payor mix.

²² The Lewin Group analysis of the American Hospital Association (AHA) Annual Survey data, 1998.

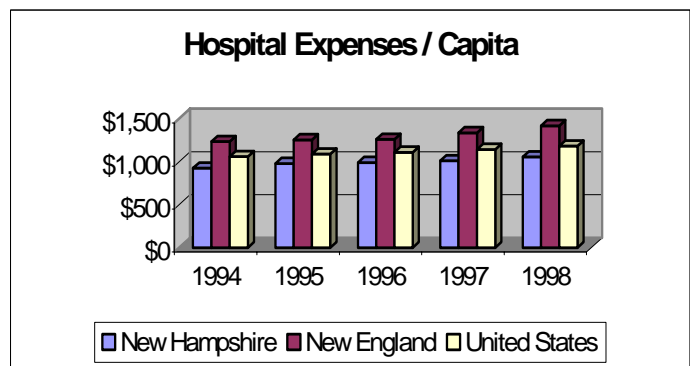
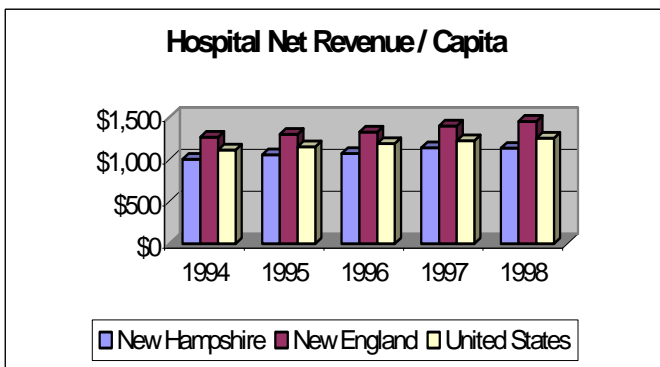
²³ Foundation for Healthy Communities, Uniform Hospital Discharge Data Set, January – December 1999.



Issue: New Hampshire hospitals manage a wide variety of payors with diverse and sometimes conflicting rules, regulations or contractual arrangements.

Impact: Despite these challenges, New Hampshire hospitals continue to deliver high quality care while managing costs. On a per capita basis, New Hampshire's net revenue rate is consistently below the per capita rates of New England and United States hospitals. In 1998, New Hampshire's rate was \$1,134, New England's rate was \$1,450 and the national rate was \$1,252.²⁴

Likewise hospital expenditure per capita rates are below New England and United States hospitals. In 1998, New Hampshire's rate was \$1,055, the region's rate was \$1,415, and the national rate was \$1,180.



Private Insurance

Issue: In 1998, there were six health plans operating in New Hampshire: Aetna/US Healthcare, BlueCross BlueShield of New Hampshire, Healthsource/CIGNA, Harvard Pilgrim Health Care, Matthew Thornton Health Plan and Tufts Health

²⁴ American Hospital Association, *Hospital Statistics*, 2000.

Plan. Managed care penetration (the percent of New Hampshire's population covered by managed care) was 36%, compared to 24% in Maine and Vermont. Managed care membership grew by almost 13% between 1997 and 1998.²⁵

The private insurance market has changed dramatically. In 1996, Matthew Thornton Health Plan, New Hampshire's oldest not-for-profit health plan, was acquired by BlueCross Blue Shield of New Hampshire (also a not-for-profit organization). In 1999, BlueCross BlueShield of New Hampshire was acquired by Anthem and became a for-profit mutual holding company. Also in 1999, Tufts Health Plan filed for bankruptcy and later was liquidated, leaving New Hampshire hospitals with unpaid Tufts claims of more than \$12.5 million. Additionally, Harvard Pilgrim Health Plan was placed under temporary receivership by the Massachusetts Insurance Commissioner due to financial instability.

Impact: New Hampshire hospitals were not paid for a portion of the costs of caring for Tufts members, which was an unprecedented event in our state. Additionally, hospitals must now work exclusively with health plans that are headquartered out-of-state. New and evolving business relationships add to the uncertainty of future payments. In this climate, hospitals place more emphasis on building larger cash reserves to withstand increasing payment risks.

Margins

Issue: Hospital operating margins and total margins are key indicators of the financial health of a hospital. New Hampshire hospitals' operating margins are declining. In 1995, all New Hampshire hospitals had positive operating margins. By 1999, eight out of 26 hospitals had negative margins (see Appendix C). Statewide, the operating margin was 2.3%, compared to 3.1% nationally.^{26,27} Margins vary widely from hospital to hospital. Margins for an individual hospital can also vary widely from year to year.

Impact: Hospitals with negative operating margins depend on investment income and income from non-patient care to sustain their operations on a temporary basis. Negative operating margins cannot be sustained over a lengthy period of time. Some hospitals are in a strong position relative to reserves, whereas some have low reserves to rely on. Without adequate operating margins hospitals will be less able to:

- attract and maintain high quality medical and professional staff;
- keep medical equipment and technologies current and operational;
- maintain and fund community health and outreach programs;
- access capital for growth and improvement;
- pay off debts;

²⁵ Foundation for Healthy Communities, *Managed Care Market Analysis*, 1999.

²⁶ New Hampshire Hospital Association, 1999 hospital audited financial statements.

²⁷ American Hospital Association, unpublished AHA Annual Survey 1998 data.

- adapt to changes in care settings; and
- allow for uncertainties and contingencies (volatile payor market, fluctuations in volume, staffing crises, etc.)

THE FUTURE

How will hospitals in New Hampshire continue to meet the need for essential healthcare and safety net services? Hospitals are working with community partners to better position themselves to meet community needs. The confluence of governmental, private payor and consumer demands is making it increasingly difficult, particularly for less well-positioned hospitals.

Hospitals serve people and communities, 24 hours a day, seven days a week, 365 days a year. Their ability to do so hinges on their ability to remain financially healthy. Hospitals are the backbone of the local health care system – they are but one of many providers of the community’s healthcare. Hospitals collaborate with other community providers to strengthen their community’s health care delivery system and improve patients’ ability to navigate through the system to get the care they need.

Residents throughout the state rely on the many programs and services offered by hospitals. Hospitals provide a broad range of services including inpatient, outpatient, physician services, home care, rehabilitation services, behavioral health, long term care, health education and many more along the continuum of care. Appropriate financial resources are needed to sustain these services. Remaining strong requires investments in technology and physical plant, knowledge to keep pace with medical advances, strong management, a highly trained workforce, and sophisticated information systems to support clinical, financial and general operations.

NEW HAMPSHIRE ACUTE CARE HOSPITALS

APPENDIX A

AMOUNT OF UNCOMPENSATED CARE - 1999

Hospital	Location	Bad Debt	Charity	Gross Revenue	Percent Uncompensated
Alice Peck Day Memorial Hospital	Lebanon	\$605,800	\$106,619	\$23,514,830	3.03%
Androscoggin Valley Hospital	Berlin	\$1,109,731	\$361,868	\$35,129,539	4.19%
Catholic Medical Center	Manchester	\$6,386,595	\$2,308,736	\$202,430,352	4.30%
Cheshire Medical Center	Keene	\$2,482,245	\$1,060,544	\$75,702,964	4.68%
Concord Hospital	Concord	\$8,034,000	\$3,142,000	\$185,925,000	6.01%
Cottage Hospital	Woodsville	\$345,481	\$342,648	\$17,827,314	3.86%
Elliot Hospital	Manchester	\$8,454,056	\$2,273,584	\$172,015,696	6.24%
Exeter Hospital	Exeter	\$4,505,787	\$1,312,092	\$108,365,815	5.37%
Franklin Regional Hospital	Franklin	\$943,385	\$412,724	\$25,324,422	5.35%
Frisbie Memorial Hospital	Rochester	\$3,541,823	\$1,573,156	\$65,958,650	7.75%
Huggins Hospital	Wolfeboro	\$1,220,659	\$276,026	\$29,796,392	5.02%
Lakes Region General Hospital	Laconia	\$3,381,479	\$2,268,147	\$100,032,423	5.65%
Littleton Hospital	Littleton	\$2,205,154	\$854,279	\$32,060,915	9.54%
Mary Hitchcock Memorial Hospital	Lebanon	\$7,858,000	\$7,366,000	\$353,947,000	4.30%
Memorial Hospital	No. Conway	\$1,412,727	\$705,253	\$31,528,295	6.72%
Monadnock Community Hospital	Peterborough	\$817,736	\$111,476	\$27,534,575	3.37%
New London Hospital	New London	\$769,993	\$207,872	\$26,481,532	3.69%
Parkland Medical Center	Derry	\$2,686,136	\$513,964	\$80,938,172	3.95%
Portsmouth Regional Hospital	Portsmouth	\$1,597,824	\$3,568,601	\$157,386,824	3.28%
So. NH Regional Medical Center	Nashua	\$7,906,245	\$2,812,003	\$129,990,272	8.25%
Speare Memorial Hospital	Plymouth	\$931,805	\$455,737	\$19,227,834	7.22%
St. Joseph Hospital	Nashua	\$2,769,233	\$1,180,387	\$114,741,421	3.44%
Upper Connecticut Valley Hospital	Colebrook	\$769,254	\$90,081	\$8,119,301	10.58%
Valley Regional Hospital	Claremont	\$1,567,029	\$466,619	\$34,734,868	5.85%
Weeks Memorial Hospital	Lancaster	\$481,765	\$282,024	\$20,267,195	3.77%
Wentworth-Douglass Hospital	Dover	\$3,984,779	\$700,862	\$94,364,800	4.97%
All New Hampshire hospitals:		\$76,768,721	\$34,753,302	\$2,114,702,032	5.27%

NOTE: Uncompensated Care is defined as Bad Debt and Charity Care.

Source: Audited Financial Statements; Totals Compiled by New Hampshire Hospital Association
Cheshire and St. Joseph numbers have been adjusted to reflect 12 months. Both changed fiscal year ends in 1999.

NEW HAMPSHIRE ACUTE CARE HOSPITALS

APPENDIX B

**PAYOR MIX - 1999
PERCENT OF DISCHARGES**

Hospital	Total	Workers	Other	Blue	Comm	Medicare	Medicaid	HMO	Other	Blue	Comm	Medicare	Medicaid
	Disch												
Total Discharges:	113,602	5,282	933	41,142	9,486	25,866	762	11,585	14,422	47	3,013	1,064	
Percent Discharges:		4.7	0.8	36.2	8.4	22.8	0.7	10.2	12.7	0.0	2.7	0.9	
Alice Peck Day Memorial Hospital	977	1.7	1.2	21.6	6.2	22.0	0.0	28.6	16.5	0.0	0.0	2.2	
Androscoggin Valley Hospital	2,111	6.7	0.4	53.8	14.9	12.9	0.5	5.8	5.0	0.0	0.1	0.0	
Catholic Medical Center	7,500	4.8	0.5	52.1	4.8	14.5	0.4	8.1	4.6	0.1	10.0	0.0	
Cheshire Medical Center	5,353	3.9	0.3	46.4	10.6	17.9	0.5	6.8	13.6	0.0	0.0	0.0	
Concord Hospital	10,957	4.2	1.4	33.5	7.2	26.4	0.7	13.9	8.2	0.0	4.0	0.4	
Cottage Hospital	851	5.4	0.6	55.5	6.2	12.5	0.7	7.3	8.0	0.0	0.1	3.8	
Elliot Hospital	12,936	3.9	1.5	23.4	9.8	36.2	0.3	12.5	7.0	0.1	3.9	1.6	
Exeter Hospital	4,965	4.9	0.4	31.9	8.1	16.6	0.3	11.3	26.6	0.0	0.0	0.0	
Franklin Regional Hospital	1,596	4.6	0.3	57.1	12.9	14.6	0.3	7.0	3.1	0.0	0.0	0.0	
Frisbie Memorial Hospital	3,499	4.9	0.3	44.3	14.0	20.2	0.4	5.4	10.5	0.0	0.0	0.0	
Huggins Hospital	1,475	4.3	0.4	54.3	9.9	13.4	1.6	6.1	9.7	0.0	0.3	0.0	
Lakes Region General Hospital	4,836	4.2	1.1	44.7	10.6	17.9	0.3	12.7	8.4	0.1	0.0	0.0	
Littleton Hospital	1,513	5.7	1.6	35.4	12.6	15.3	0.5	14.3	14.3	0.4	0.0	0.0	
Mary Hitchcock Memorial Hospital	16,330	4.5	1.0	36.7	6.8	20.2	0.3	10.3	15.9	0.0	0.2	4.1	
MHMH Psych	861	9.8	0.5	37.1	9.5	16.0	0.7	8.6	12.0	0.0	0.1	5.8	
Memorial Hospital	1,706	6.7	1.1	36.4	13.8	13.8	0.5	11.3	16.1	0.0	0.4	0.0	
Monadnock Community Hospital	2,006	3.8	0.2	33.2	6.3	22.5	0.5	7.7	18.5	0.0	7.3	0.1	
New London Hospital	1,240	2.6	0.2	55.7	7.1	12.4	0.3	9.5	11.2	1.0	0.0	0.0	
Parkland Medical Center	3,467	3.0	0.4	27.8	7.4	38.8	1.1	2.8	13.6	0.0	4.1	1.0	
Portsmouth Regional Hospital	6,430	3.1	0.8	35.8	5.4	25.2	3.5	10.8	13.1	0.0	2.2	0.0	
So. NH Medical Center	8,522	7.8	0.3	19.4	9.1	26.6	0.4	11.1	22.3	0.0	2.9	0.0	
Speare Memorial Hospital	878	3.6	0.3	41.2	12.2	19.4	0.5	15.2	7.5	0.0	0.1	0.0	
St. Joseph Hospital	5,861	5.0	0.8	30.4	3.0	27.3	1.4	5.9	16.8	0.0	9.5	0.0	
Upper Connecticut Valley Hospital	509	8.5	0.2	48.5	9.6	9.4	1.2	9.0	12.0	0.0	0.4	1.2	
Valley Regional Hospital	1,856	6.2	0.7	40.8	15.5	5.6	0.2	11.1	18.3	0.2	1.5	0.1	
Weeks Memorial Hospital	889	1.5	1.0	54.7	11.6	16.1	0.5	7.1	7.4	0.0	0.0	0.2	
Wentworth-Douglass Hospital	4,478	4.3	0.7	41.4	8.5	22.7	0.4	10.8	11.3	0.0	0.0	0.0	

Payor categories:

Self Pay: patient does not have insurance or pays the bill themselves

Workers Comp: worker's compensation insurance

Medicare: federal Medicare program

Medicaid: in and out-of-state Medicaid

HMO: Health Maintenance Organization

Other Government: other types of government subsidized programs such as CHAMPUS and Federal Employee Program

Blue Cross: in and out-of-state Blue Cross insurance (includes all BC products, such as Blue Choice)

Commercial Insurance: commercial insurance includes companies such as John Hancock, Prudential and also includes self insured employers

Other

Medicare Managed Care: any managed care health plan that provides coverage to Medicare-eligible patients

Medicaid Managed Care: any managed care health plan that provides coverage to Medicaid-eligible patients

Source: Foundation for Healthy Communities, Uniform Hospital Discharge Data Set, January - December 1999

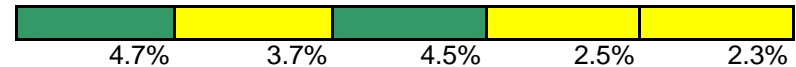
NEW HAMPSHIRE ACUTE CARE HOSPITALS

APPENDIX C

OPERATING MARGINS

Hospital	Location	1995	1996	1997	1998	1999
Alice Peck Day Memorial Hospital	Lebanon	Green	Green	Green	Red	Green
Androscoggin Valley Hospital	Berlin	Green	Green	Green	Green	Green
Catholic Medical Center	Manchester	Green	Green	Green	Red	Red
Cheshire Medical Center	Keene	Green	Green	Green	Green	Green
Concord Hospital	Concord	Green	Green	Green	Green	Green
Cottage Hospital	Woodsville	Green	Green	Green	Green	Green
Elliot Hospital	Manchester	Green	Green	Green	Red	Green
Exeter Hospital	Exeter	Green	Green	Green	Green	Green
Franklin Regional Hospital	Franklin	Green	Red	Green	Red	Red
Frisbie Memorial Hospital	Rochester	Green	Green	Green	Green	Green
Huggins Hospital	Wolfeboro	Green	Green	Green	Green	Green
Lakes Region General Hospital	Laconia	Green	Green	Red	Green	Red
Littleton Hospital	Littleton	Green	Green	Green	Green	Red
Mary Hitchcock Memorial Hospital	Lebanon	Green	Green	Green	Green	Green
Memorial Hospital	No. Conway	Green	Green	Green	Green	Green
Monadnock Community Hospital	Peterborough	Green	Green	Red	Green	Red
New London Hospital	New London	Green	Green	Green	Green	Red
Parkland Medical Center	Derry	Green	Green	Green	Green	Green
Portsmouth Regional Hospital	Portsmouth	Green	Green	Green	Green	Green
So. NH Medical Center	Nashua	Green	Green	Green	Green	Green
Speare Memorial Hospital	Plymouth	Green	Green	Green	Green	Green
St. Joseph Hospital	Nashua	Green	Green	Green	Green	Green
Upper Connecticut Valley Hospital	Colebrook	Green	Green	Green	Green	Red
Valley Regional Hospital	Claremont	Green	Red	Green	Red	Green
Weeks Memorial Hospital	Lancaster	Green	Green	Green	Green	Red
Wentworth-Douglass Hospital	Dover	Green	Green	Green	Green	Green

All New Hampshire hospitals:



Color Code:

- Operating Margins < 0
- Operating Margins 0-3.9%
- Operating Margins 4%+

Source:
 Hospital Audited Financial Statements
 Compiled by New Hampshire Hospital Association

NOTE: Parkland and Portsmouth total expenses include taxes.
 1999-St Joseph numbers represent 10 months and Cheshire Medical Center numbers represent 15 months due to changes in fiscal year ends.