An Overview of New Hampshire Hospital Financial Measures

Prepared by the New Hampshire Institute for Health Policy and Practice for the New Hampshire Department of Insurance

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1. Introduction

This report has been prepared by the New Hampshire Institute of Health Policy and Practice (NHIHPP) for the New Hampshire Insurance Department's (NHDOI) Advisory Group. The Advisory Group has been asked to focus on several areas:

1. market pricing of healthcare services that resulted in the development of the HealthCost web site (www.nhhealthcost.org)
2. uninsured/underinsured/self-pay category of patients seeking services, which is the focus of this report.

This report was developed to paint a financial portrait of New Hampshire's hospitals, and to lay the groundwork for additional modifications to the NH Health Cost web site (www.nhhealthcost.org).

This report provides information regarding hospital revenues, overall discounts, levels of charity care, levels of bad debt, gross total margins, and the ratio of selling and administrative expenses to health care services for New Hampshire's non-profit hospitals.

2. Discussion of Data Sources and Methodologies

Multiple data sets were examined for this report. The following list contains the data sets, a description of what was examined, and the order in which they were examined:

1. 2002 and 2003 IRS 990 tax returns. For 2002 and 2003, 23 and 16 hospital returns were examined, respectively. Data was captured regarding: revenues, expenses, bad debt, charity care, and other financial measures. Not all returns were available for all years/hospitals, and the data had many inconsistencies due to different methods of reporting by the hospitals.
2. 2002, 2003, and 2004 State of New Hampshire Charitable Trust Division Community Benefit Annual Reports. A total of 53 reports were examined for 21 hospitals across the three years. There were eight reports attached to the tax returns, although they are not required as part of the 990 submissions. The remaining 45 reports were reviewed in the office of the New Hampshire Attorney General. Key data points from each report were captured into a spreadsheet. Not all reports were available for all hospitals, and inconsistencies in hospital reporting made valid comparisons across hospitals difficult.
3. 2002 and 2003 inpatient and outpatient hospital claims discharge data sets. Data sets were provided by NH DHHS. The data sets were specifically used to examine the percent of charges by payer type[1], and to calculate the number of unique patients treated by the hospitals in 2002 and 2003.
4. 2003 and 2004 audited hospital financials. Audited financials for 2003 and 2004 were reviewed for 23 hospitals. Data for 2002 was found in the 2003 financials. For Memorial Hospital the 2003 financials were for the hospital only and the 2004 financials for the hospital and subsidiaries. The 2003 financials for St. Joseph Hospital's parent company were replaced in 2004 with the consolidated financials for Covenant Health Systems, Inc. financials, thus not all 2004 numbers were available. Covenant is a conglomeration of hospitals and healthcare entities. For Wentworth-Douglass Hospital consolidated versus hospital-only financials were examined.

After analysis of each of the data sets, it was determined that only the claims discharge data sets and the audited hospital financials would be used for the final report analysis. The available data sets do not provide paid claims data from which to calculate the actual hospital discounts by payer and by payer type. From experience, it is known that hospitals in New Hampshire have varying financial contractual arrangements with the primary insurance carriers. These contractual arrangements include per diem, capitation, fee schedules, and discount from charges (retail) arrangements[2]. The hospital discharge data sets provide charges (retail), and the audited financials provide the overall discount amount, not generally separated by payer type.

Appendix C contains all of the methodologies used for all of the calculations in this report.

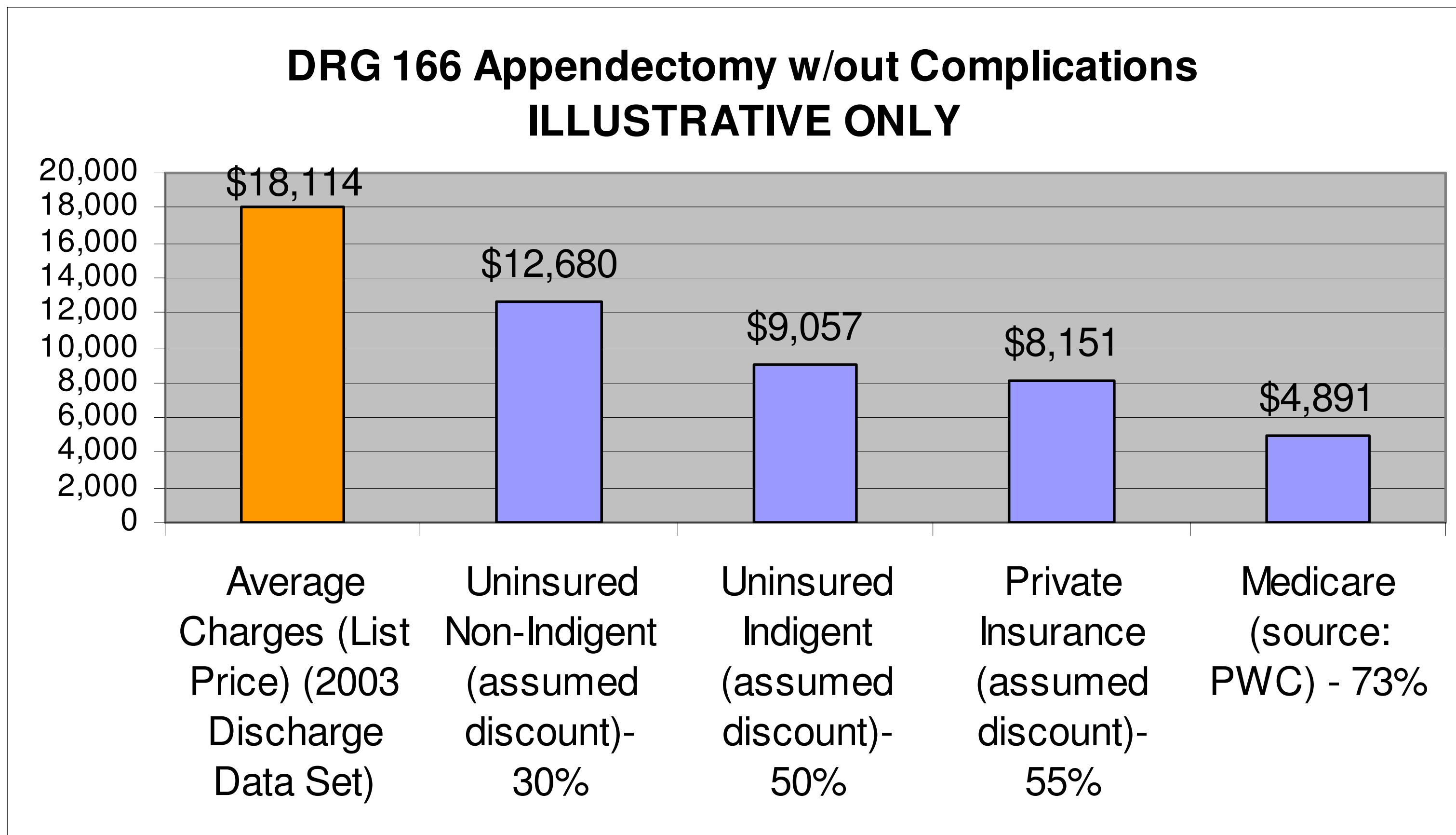
[1] Payer Type = the different types of payments a hospital may receive. Typically includes: Government programs (Medicare, Medicaid, etc.), private insurance (HMOs, indemnity, etc.), the uninsured or self-pay, and workers compensation.

[2] Per Diem = a fixed *daily* rate for a specific procedure or set of procedures; Capitation = a fixed fee per patient paid to a hospital by an insurance carrier regardless of the amount of services rendered – it is a risk taking arrangement; Fee Schedules = a fixed rate for a specific procedure or set of procedures; Discount from Charges = a discount amount from the retail charge rate.

3. Setting the Stage

In 2005, PricewaterhouseCoopers' (PWC) Health Research Institute authored a report entitled "*Acts of charity; Charity care strategies for hospitals in a changing landscape*". Their data illustrated the plight that many uninsured, non-indigent patients face. It is not uncommon for the uninsured to pay more for services than privately insured patients and Medicare patients.

The chart below was created for illustrative purposes to demonstrate the assumed pricing structure in New Hampshire. It shows that while the average charges for an appendectomy are $18,114, that with either a 30% or 50% discount from charges the uninsured would pay more ($12,680) for this service than do privately insured patients ($8,151) or Medicare patients ($4,891).



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New Hampshire specific data regarding actual hospital discount prices are not yet available. This is because paid claim information[3] is not available as part of the hospital claims discharge data sets.[4] The discharge data sets contain hospital charge amounts only. In the spring of 2006, New Hampshire paid claims data will become available from the Maine Health Information Center. With paid claims data it will be possible to determine actual discounts provided to insurers, and the above illustrative chart can be re-calculated by procedure, average carrier cost, and hospital.

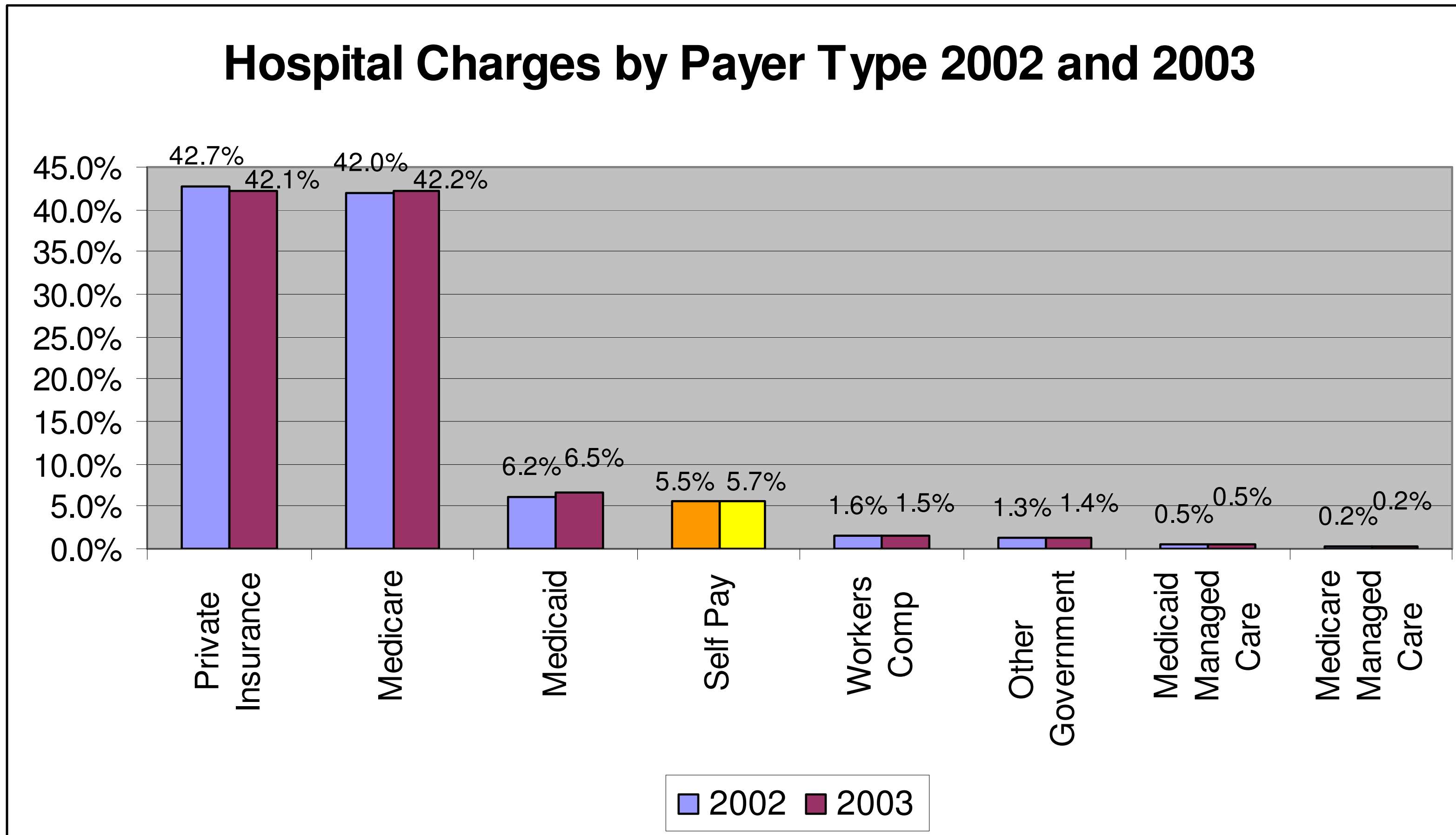
Nationally, there is a move towards requiring hospitals to provide discounts to the uninsured, regardless of income. These findings are detailed in Appendix A of this report. The discounts are generally calculated as a percentage of the applicable Medicare rate (i.e., 125% of Medicare). These legislative policies have been developed in response to both legal challenges (specifically a class-action law suit against the Tenet Healthcare hospital chain) and advocates for the uninsured.

In New Hampshire, the Hospital Association has developed the Health Access Network and Medication Bridges programs to qualify patients for hospital specific discounts based upon income guidelines set by each provider. All of the hospitals in the state participate in these discount programs. In Appendix B of this report, there is an article from the November 27, 2005, *Union Leader* detailing an upcoming across-the-board discount program being put into effect for January 1, 2006, by Dartmouth Hitchcock Medical Center. The program is a discount from charges versus a rate tied to the Medicare fee schedule.

[3] Paid Claims Amount = the amount of money the hospital collects from an insurer or a government payer. Typically, it is less than what the hospital charges for their services.
[4] Hospital discharge data sets are managed by the Department of Health and Human Services.

4. Self Pay Payer Type

The following bar graph depicts the percentage of total hospital[5] charges (retail charges) by payer type, and it is derived from the inpatient and outpatient data sets. The self-pay payer type accounted for 5.5% of the total charges in 2002 (orange bar) and 5.7% in 2003 (yellow bar). For the purposes of this report, the self-pay payer type is equivalent to the uninsured population.

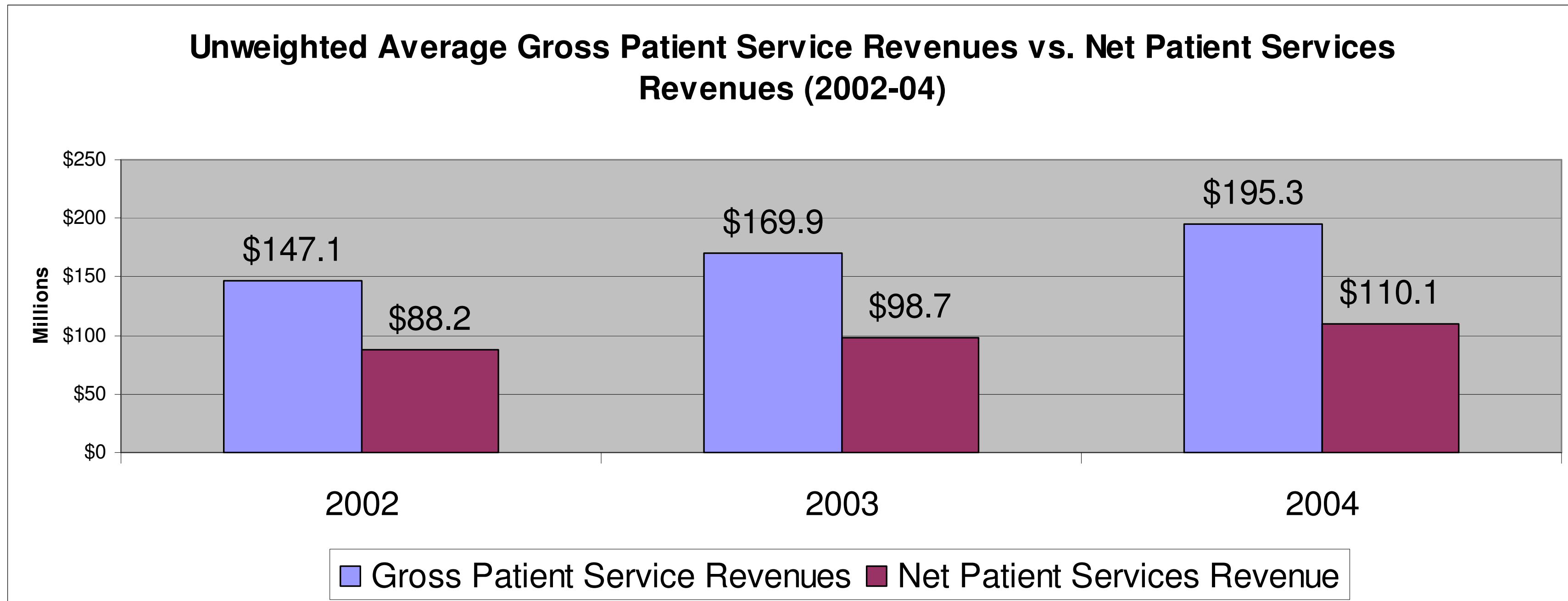


[5] Includes all hospitals in New Hampshire, including Parkland Medical Center and Portsmouth Regional Hospital (two, for-profit hospitals). These two hospitals are not included in the remainder of the analyses in this document.

5. Hospital Revenues

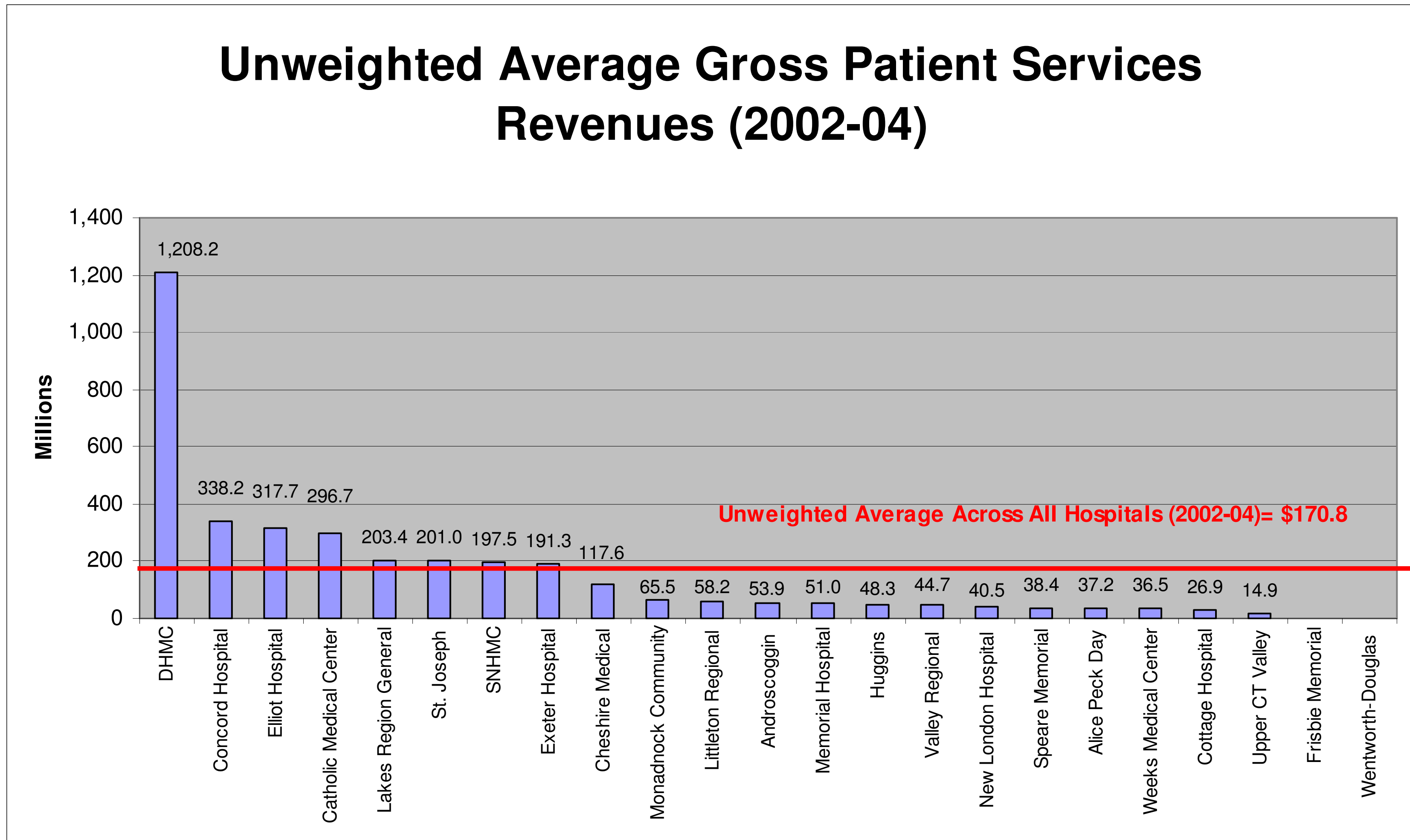
Total gross patient services revenues[6] (retail charges) for New Hampshire hospitals[7] for 2002, 2003, and 2004, were $3.1, $3.6, and $3.9 billion, respectively. For the same years, the total net patient services revenues[8] equaled $1.9, $2.1, and $2.2 billion, respectively.

The chart below compares the unweighted average gross patient service revenues to the unweighted average net patient services revenues for all three years. There is a consistent upward trend for both.

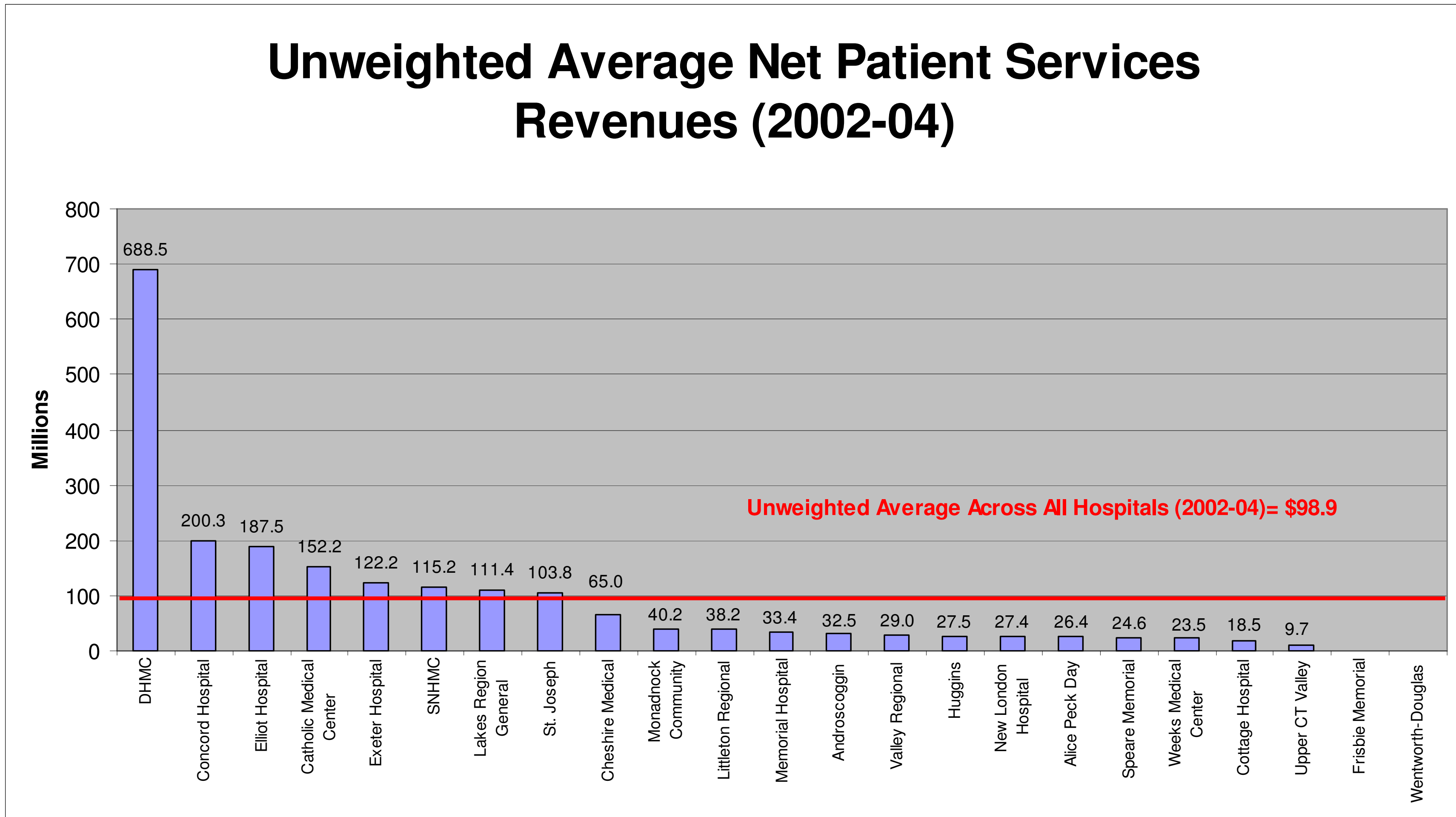


[6] Gross Patient Services Revenues = Hospital retail charges for services rendered.
[7] Excludes Frisbie and Wentworth-Douglas Hospitals as they did not report their gross and operating revenues.
[8] Net Patient Services Revenues = Gross Patient Services Revenues minus Contractual Allowances minus Provision for Charity Care

The chart below details by hospital their unweighted average gross patient services revenues (retail charges) for all three years. Frisbie Memorial and Wentworth-Douglas Hospitals did not report gross patient services revenues. Upper Connecticut Valley had the least revenues and Dartmouth Hitchcock the most.

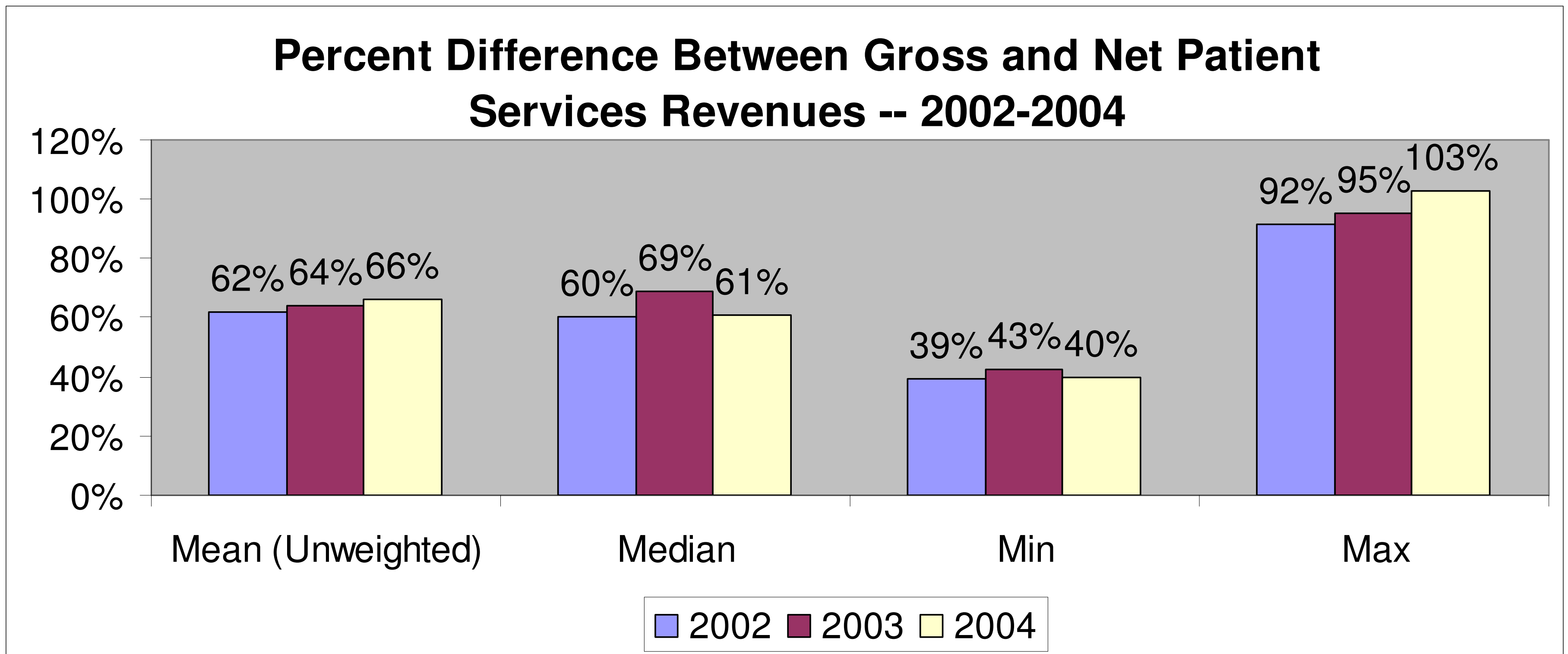


The chart below details by hospital their unweighted average net revenues for all three years. Frisbie Memorial and Wentworth-Douglas Hospitals did not report gross patient services revenues. There are some differences in the descending order of the hospitals from the prior chart. These are attributed to the hospitals marking up their charges by differing amounts. The next section of the report details hospital markup in more detail.



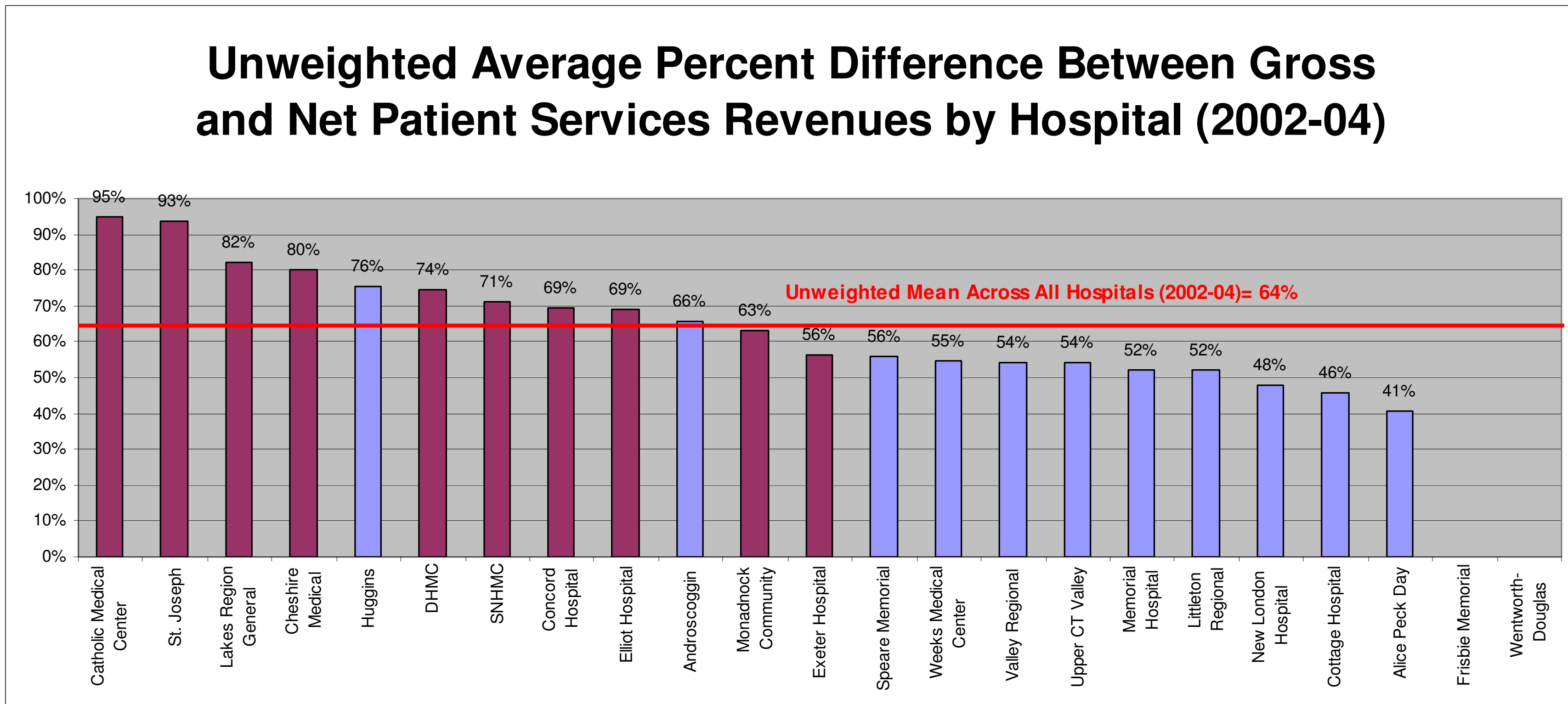
6. Hospital Retail Charges vs. Collected Revenues

As seen in the chart on page 7, New Hampshire's non-profit hospitals report two separate types of revenue. Both are increasing from year to year. The gross patient services revenues are retail charges and net patient services revenues are what the hospital ultimately receives as payment. As seen in the chart below, using an unweighted average, the percent difference between gross and net patient services revenues were 62%, 64%, and 66% in 2002, 2003, and 2004 respectively. All hospitals except Frisbie Memorial and Wentworth-Douglas are included in this chart.



The chart below depicts the unweighted average percent difference between gross and net patient services revenues across the three years by hospital. The highest unweighted average percent difference was Catholic Medical Center at 95% and the lowest was Alice Peck Day at 41%. Neither Frisbie Memorial nor Wentworth-Douglas provided data for the calculations.

The hospitals indicated with maroon bars are those with the ten highest revenue amounts for both gross patient services revenue and net patient services revenue (taken from the charts on pages 8 and 9). The hospitals with the highest revenues also tend to have higher markups.



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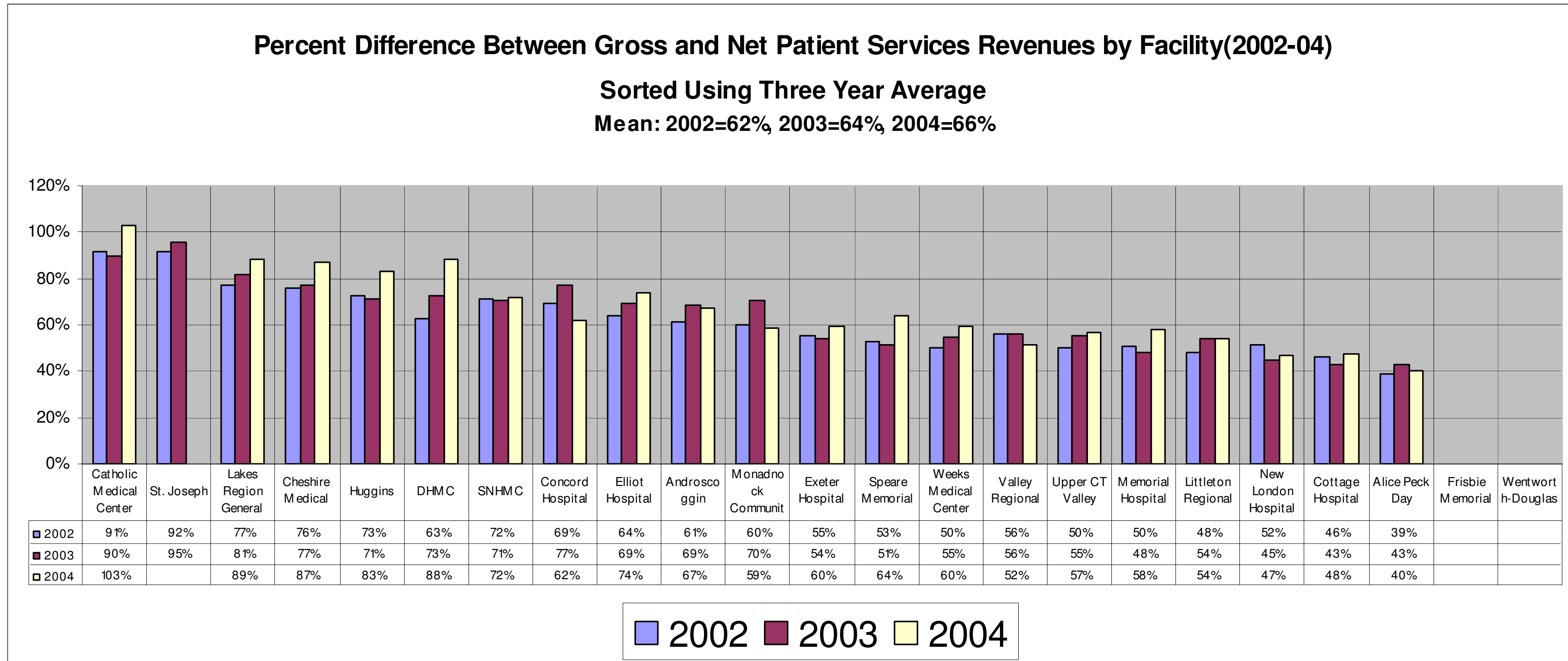
To provide more detail from the prior page, the chart below details the percent difference between gross and net patient services revenues for each hospital for each of the three years. It is sorted using the three year average found on the prior page. St. Joseph did not report 2004 data. Frisbie Memorial and Wentworth-Douglas did not report data for all three years.

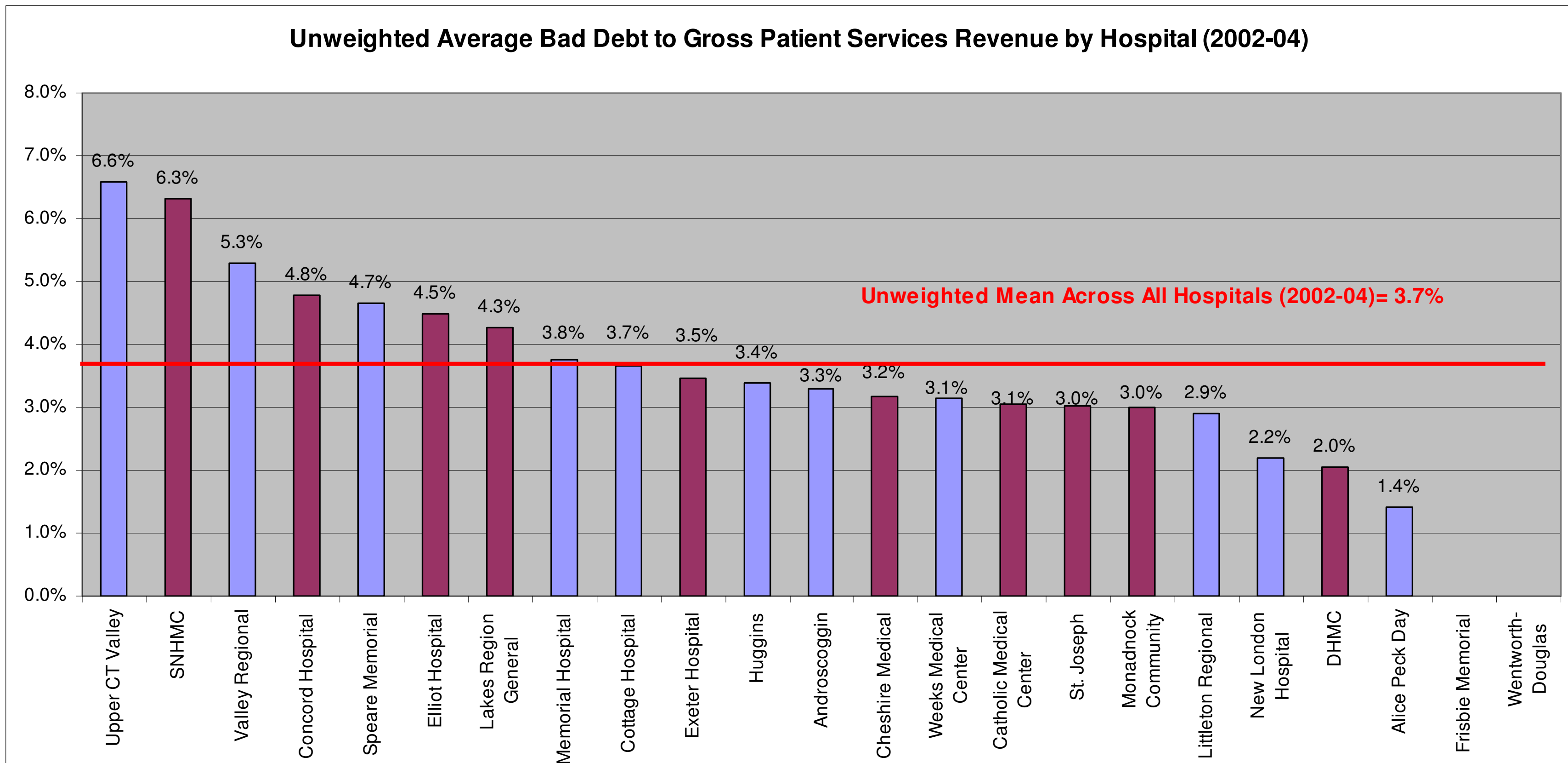


	Catholic Medical Center	St. Joseph	Lakes Region General	Cheshire Medical	Huggins	DHMC	SNHMC	Concord Hospital	Elliot Hospital	Androsco ggin	Monadno ck Communit	Exeter Hospital	Speare Memorial	Weeks Medical Center	Valley Regional	Upper CT Valley	Memorial Hospital	Littleton Regional	New London Hospital	Cottage Hospital	Alice Peck Day	Frisbie Memorial	Wentwort h-Douglas
2002	91%	92%	77%	76%	73%	63%	72%	69%	64%	61%	60%	55%	53%	50%	56%	50%	50%	48%	52%	46%	39%		
2003	90%	95%	81%	77%	71%	73%	71%	77%	69%	69%	70%	54%	51%	55%	56%	55%	48%	54%	45%	43%	43%		
2004	103%		89%	87%	83%	88%	72%	62%	74%	67%	59%	60%	64%	60%	52%	57%	58%	54%	47%	48%	40%		

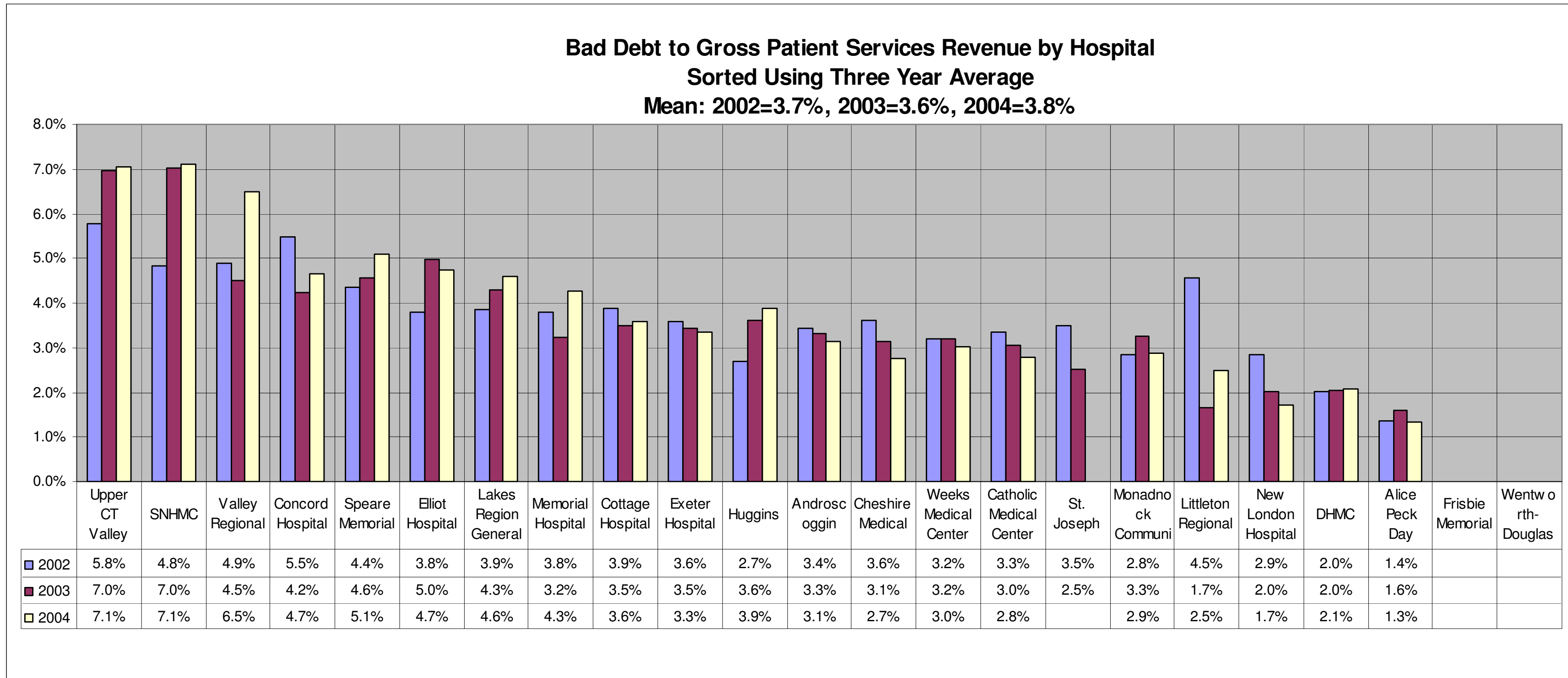
7. Bad Debt

The chart below shows the unweighted average percentage of bad debt to gross patient services revenues for each hospital for all three years combined. Neither Frisbie Memorial nor Wentworth-Douglas provided gross patient services revenue data for the calculations.

The hospitals indicated with maroon bars are those with the ten highest revenue amounts for both gross patient services revenue and net patient services revenue (taken from the charts on pages 8 and 9).

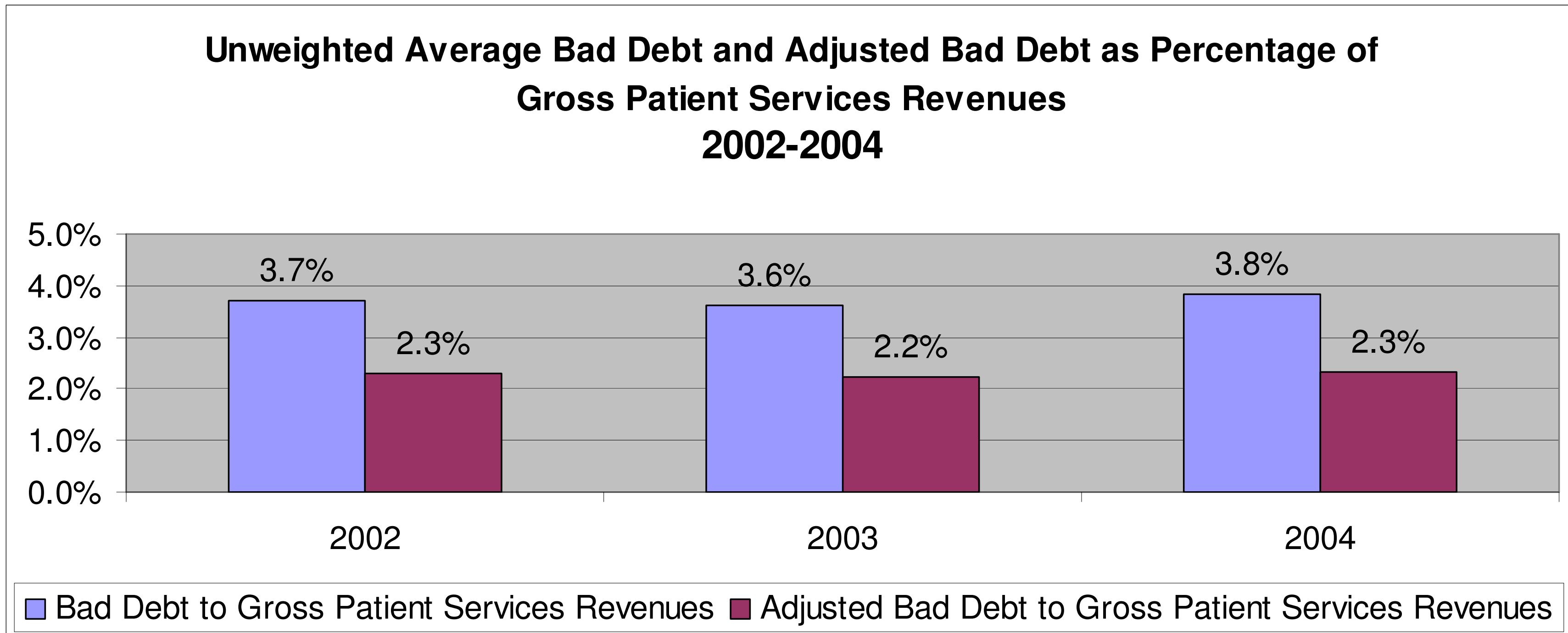


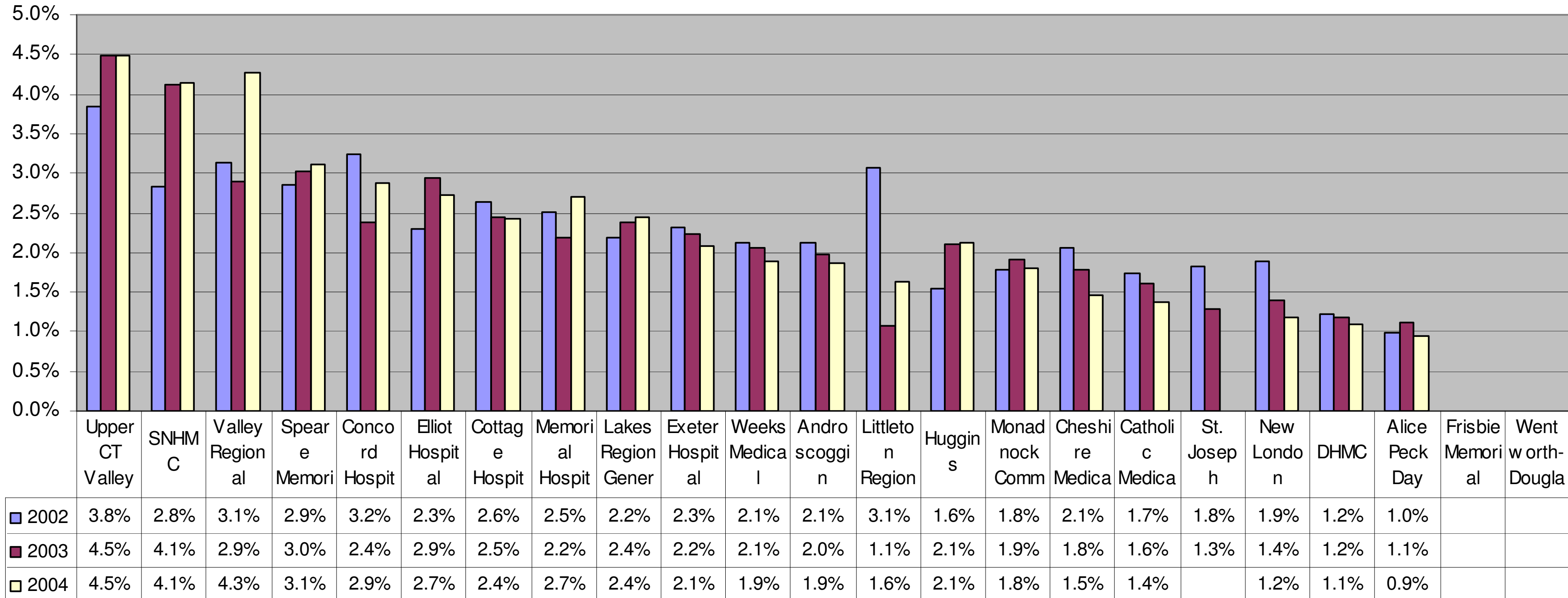
To provide more detail from the prior page, the following chart shows the percentage of bad debt to gross patient services revenue by hospital for each of the three years. It is sorted using the three year average found on the prior page.



	Upper CT Valley	SNHMC	Valley Regional	Concord Hospital	Speare Memorial	Elliot Hospital	Lakes Region General	Memorial Hospital	Cottage Hospital	Exeter Hospital	Huggins	Androscoggin	Cheshire Medical	Weeks Medical Center	Catholic Medical Center	St. Joseph	Monadnock Communi	Littleton Regional	New London Hospital	DHMC	Alice Peck Day	Frisbie Memorial	Wentworth-Douglas
2002	5.8%	4.8%	4.9%	5.5%	4.4%	3.8%	3.9%	3.8%	3.9%	3.6%	2.7%	3.4%	3.6%	3.2%	3.3%	3.5%	2.8%	4.5%	2.9%	2.0%	1.4%		
2003	7.0%	7.0%	4.5%	4.2%	4.6%	5.0%	4.3%	3.2%	3.5%	3.5%	3.6%	3.3%	3.1%	3.2%	3.0%	2.5%	3.3%	1.7%	2.0%	2.0%	1.6%		
2004	7.1%	7.1%	6.5%	4.7%	5.1%	4.7%	4.6%	4.3%	3.6%	3.3%	3.9%	3.1%	2.7%	3.0%	2.8%		2.9%	2.5%	1.7%	2.1%	1.3%		

The bad debt figures in the hospital financials are reported in terms of charges versus actual costs associated with bad debt. Due to this, it was necessary to adjust the data in order to provide a truer picture of the percentage of bad debt services delivered. To adjust the data, the net patient services revenues were divided by the gross patient services revenues. This ratio was then multiplied by the bad debt charges reported by the hospital. As shown in the below chart, the adjusted data of the unweighted average ratio of bad debt to gross patient services is less than the unadjusted data.

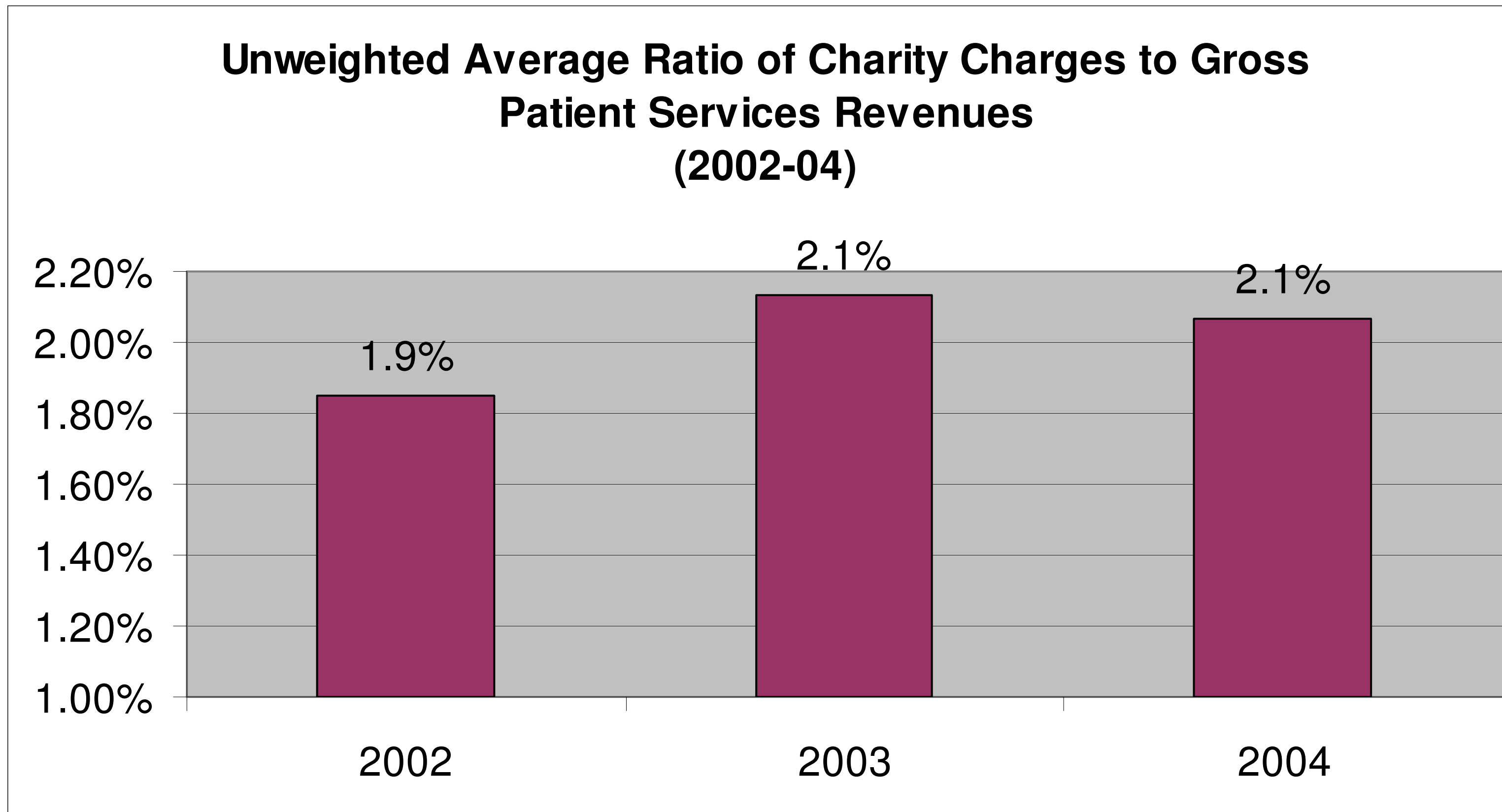




	Upper CT Valley	SNHMC	Valley Regional	Speare Memori	Concord Hospit	Elliot Hospital	Cottage Hospit	Memorial Hospit	Lakes Region Gener	Exeter Hospital	Weeks Medical	Androscoggin	Littleton Region	Huggins	Monadnock Comm	Cheshire Medica	Catholic Medica	St. Joseph	New London	DHMC	Alice Peck Day	Frisbie Memorial	Wentworth-Dougla
2002	3.8%	2.8%	3.1%	2.9%	3.2%	2.3%	2.6%	2.5%	2.2%	2.3%	2.1%	2.1%	3.1%	1.6%	1.8%	2.1%	1.7%	1.8%	1.9%	1.2%	1.0%		
2003	4.5%	4.1%	2.9%	3.0%	2.4%	2.9%	2.5%	2.2%	2.4%	2.2%	2.1%	2.0%	1.1%	2.1%	1.9%	1.8%	1.6%	1.3%	1.4%	1.2%	1.1%		
2004	4.5%	4.1%	4.3%	3.1%	2.9%	2.7%	2.4%	2.7%	2.4%	2.1%	1.9%	1.9%	1.6%	2.1%	1.8%	1.5%	1.4%		1.2%	1.1%	0.9%		

8. Charity Care[9]

All of the hospitals examined reported the amount of charity care[10] provided in terms of charges to render services versus cost[11]. The chart below depicts the unweighted average ratio of charity care charges to gross patient services revenues (retail charges).

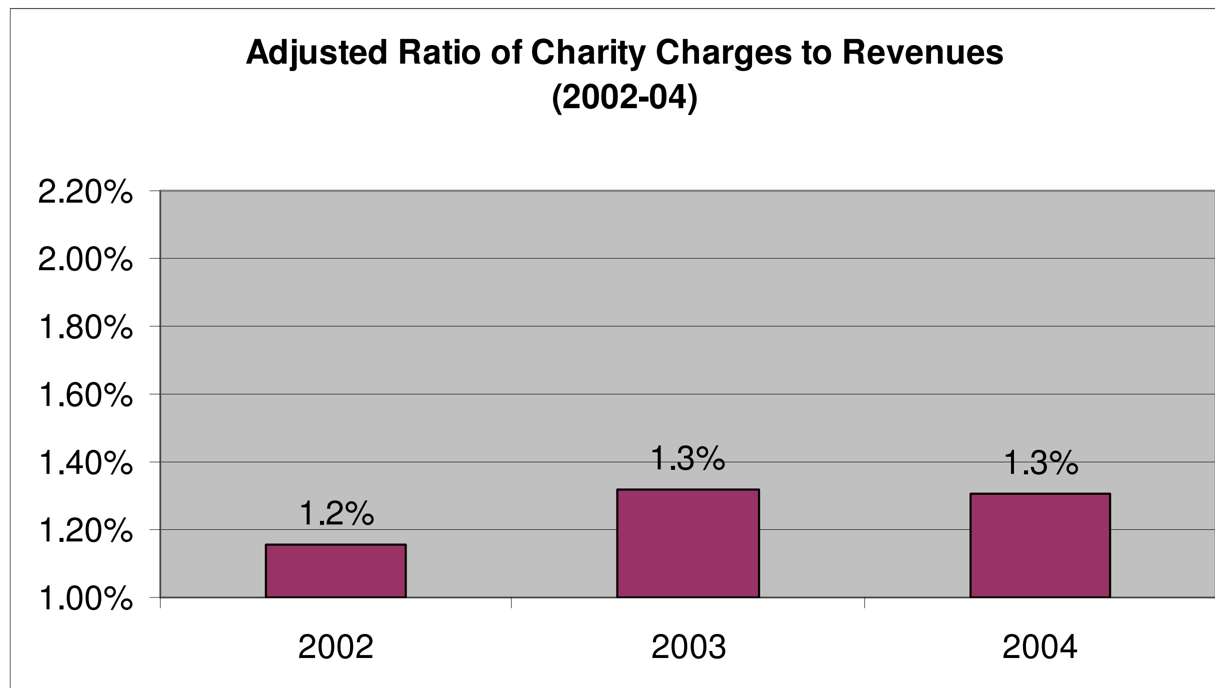


[9] Community benefits reporting is different from charity care. Several of the audited financial statements reviewed provided high level community benefits information.
[10] Charity Care = Services for which hospitals neither expected to receive nor did receive payment for services rendered.
[11] St. Josephs Hospital charity care charges data for 2004 was not reported.

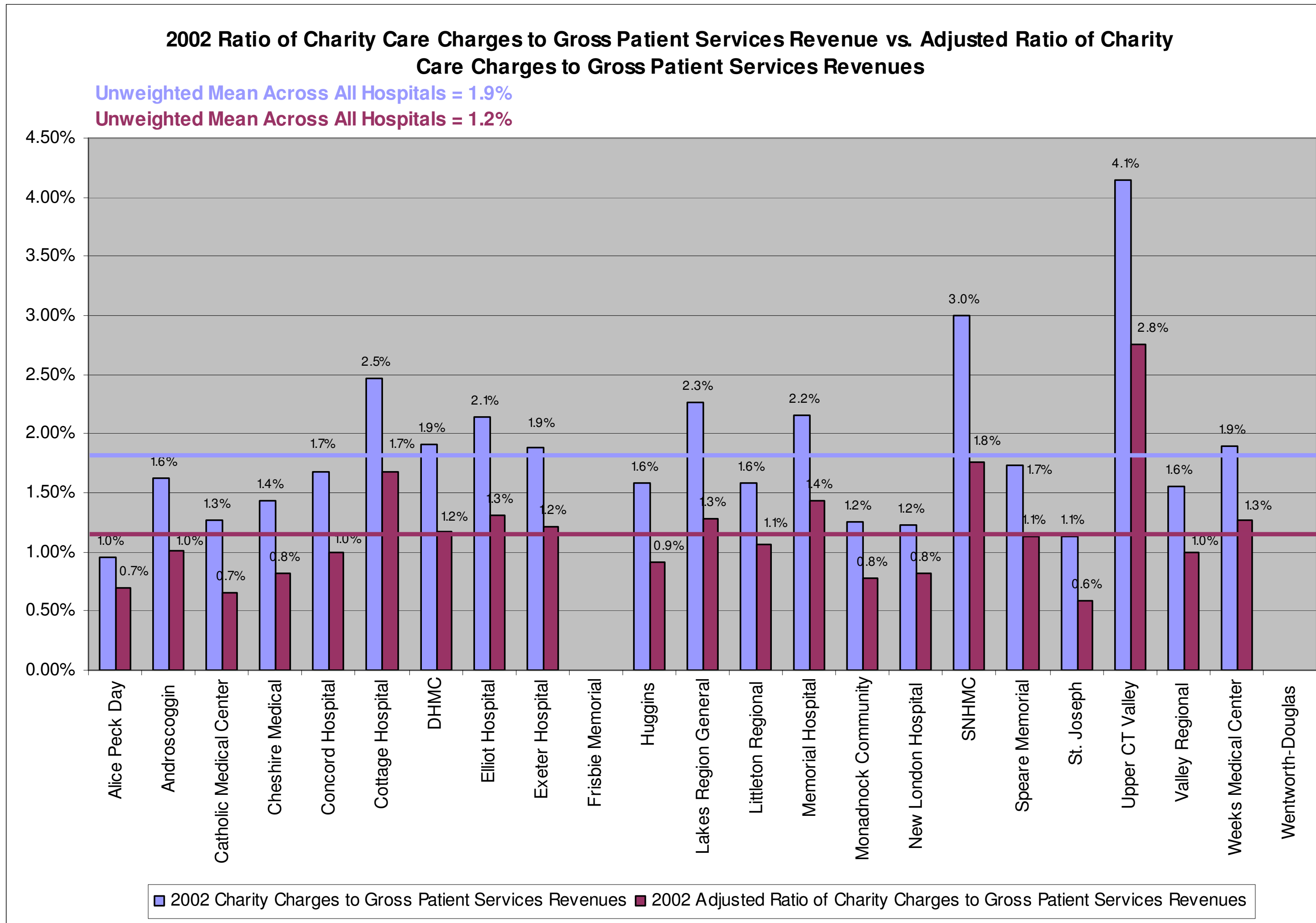
All 23 of the hospitals in this report stated their total charity **charges** for each of the three years, with the exception of St. Joseph Hospital that did not report 2004 charity care charges. In contrast, traditional charity care **costs** were reported by 13 of the 23 hospitals (57%). The following 10 hospitals did not report charity care costs: Catholic Medical Center, Cheshire, Concord, Elliot, Exeter, LRGH, Memorial Hospital, Southern New Hampshire Medical Center, St. Joseph Hospital, and Wentworth-Douglas Hospital.

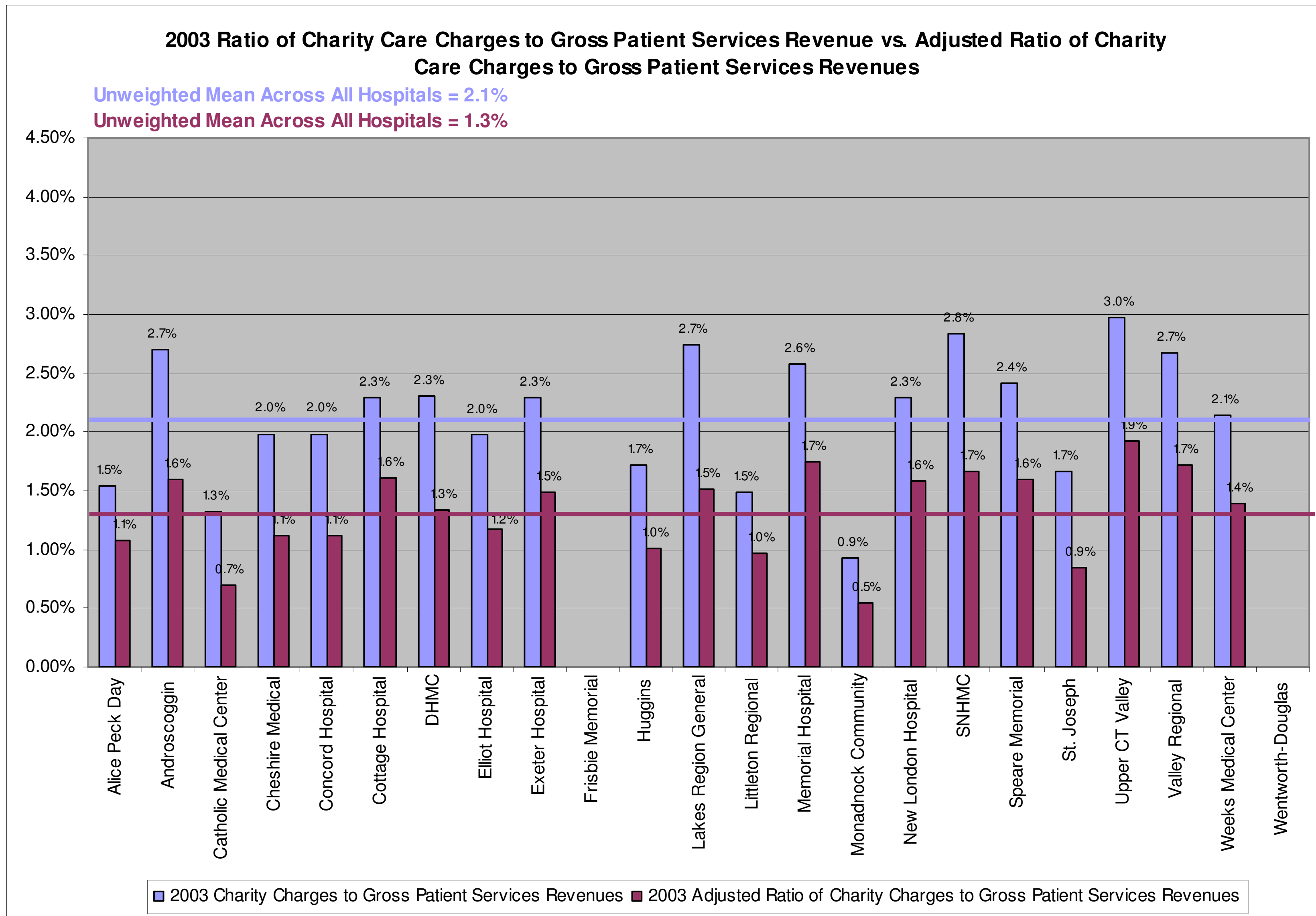
Because only 13 of the hospitals reported charity care costs in addition to charity care charges, and because hospital patient services revenues are retail charges that individual hospitals may set, the following chart was developed as a way to adjust the data so that the highly variable, individually-set hospital charge amounts had less impact on the percentage of charity care actually delivered.

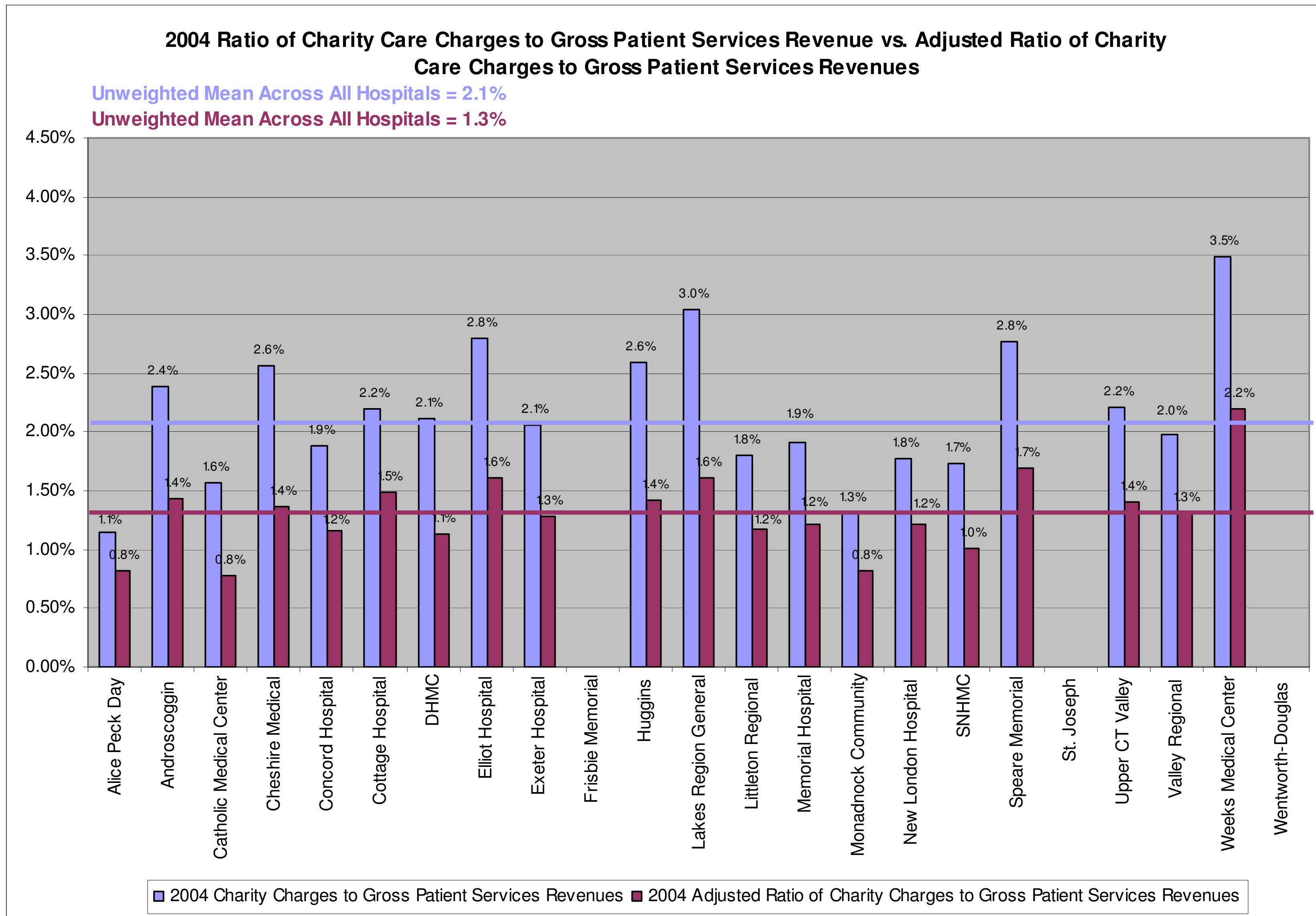
To adjust the data, the net patient services revenues were divided by the gross patient services revenues. This ratio was then multiplied by the total charity care charges reported by the hospital. As shown in the below chart, the adjusted data of the unweighted average ratio of charity charges to gross patient services is less than the unadjusted data shown on page 17.



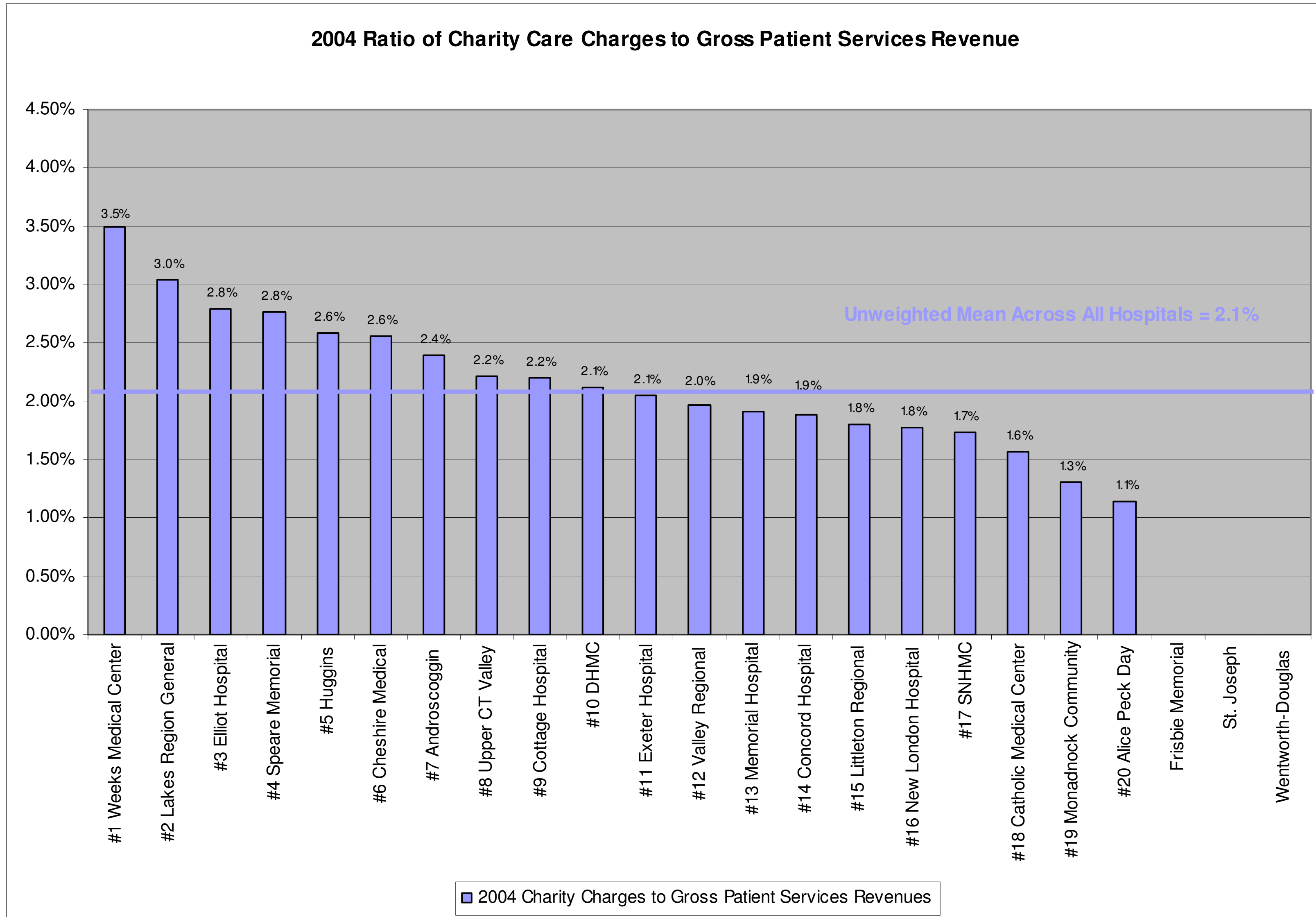
The following three charts provide 2002, 2003, and 2004 hospital-specific ratios comparing charity care charges to gross patient services revenues with the adjusted charity care charges to gross patient services revenues. The charts show that the specific relationship to the main may change when the revenue is adjusted. For example, Speare Memorial is at the mean for adjusted revenues, while it is below the mean when the revenues are not adjusted. Both Frisbie Memorial and Wentworth-Douglass Hospital did not report gross patient services revenues for the calculation.



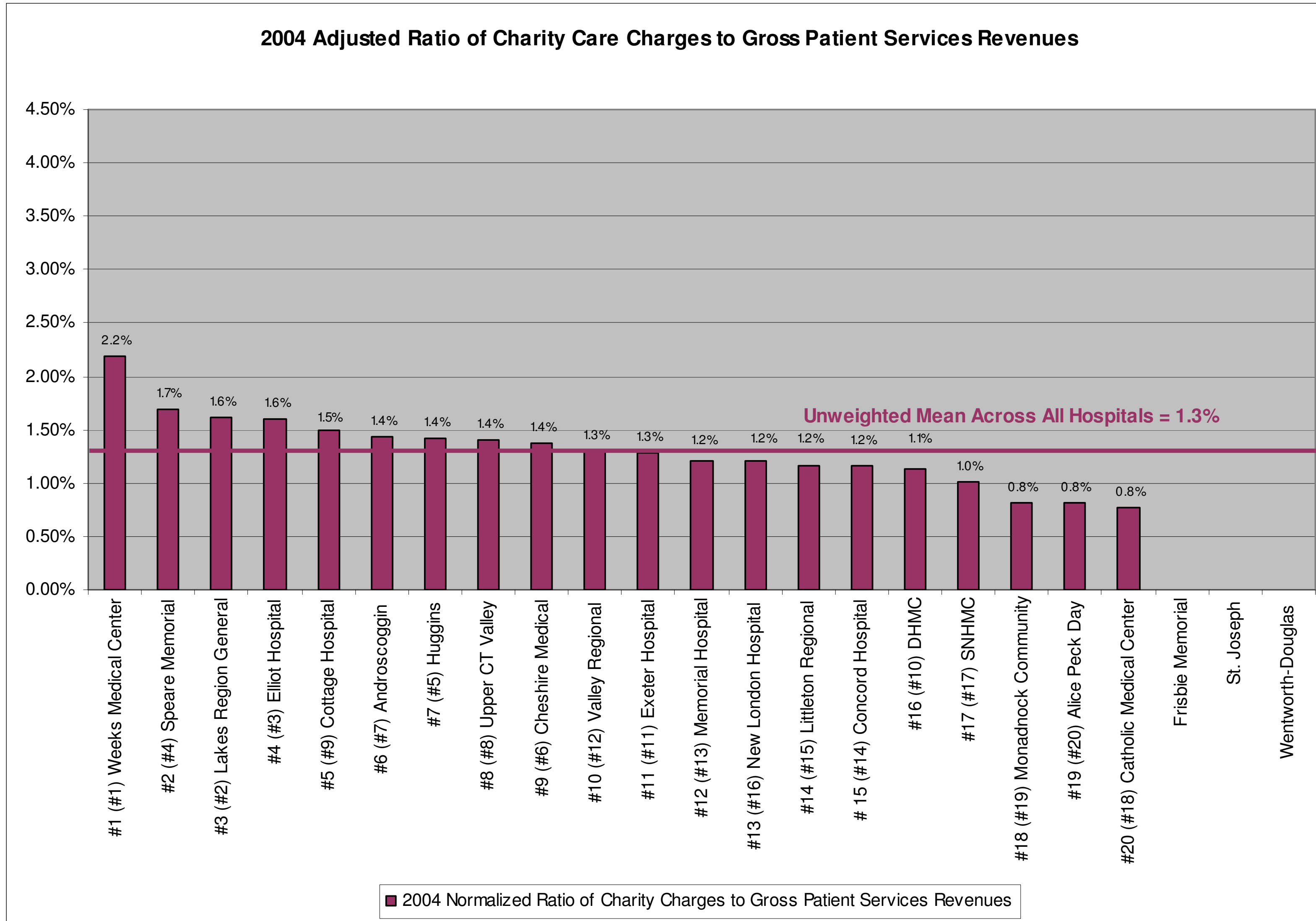

2003 Ratio of Charity Care Charges to Gross Patient Services Revenue vs. Adjusted Ratio of Charity Care Charges to Gross Patient Services Revenues
Unweighted Mean Across All Hospitals = 2.1%
Unweighted Mean Across All Hospitals = 1.3%
4.50%
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
Alice Peck Day 1.5% 1.1%
Androscoggin 2.7% 1.6%
Catholic Medical Center 1.3% 0.7%
Cheshire Medical 2.0% 1.1%
Concord Hospital 2.0% 1.1%
Cottage Hospital 2.3% 1.6%
DHMC 2.3% 1.3%
Elliot Hospital 2.0% 1.2%
Exeter Hospital 2.3% 1.5%
Frisbie Memorial
Huggins 1.7% 1.0%
Lakes Region General 2.7% 1.5%
Littleton Regional 1.5% 1.0%
Memorial Hospital 2.6% 1.7%
Monadnock Community 0.9% 0.5%
New London Hospital 2.3% 1.6%
SNHMC 2.8% 1.7%
Speare Memorial 2.4% 1.6%
St. Joseph 1.7% 0.9%
Upper CT Valley 3.0% 1.9%
Valley Regional 2.7% 1.7%
Weeks Medical Center 2.1% 1.4%
Wentworth-Douglas
2003 Charity Charges to Gross Patient Services Revenues
2003 Adjusted Ratio of Charity Charges to Gross Patient Services Revenues


2004 Ratio of Charity Care Charges to Gross Patient Services Revenue vs. Adjusted Ratio of Charity Care Charges to Gross Patient Services Revenues
Unweighted Mean Across All Hospitals = 2.1%
Unweighted Mean Across All Hospitals = 1.3%
4.50%
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
Alice Peck Day 1.1% 0.8%
Androscoggin 2.4% 1.4%
Catholic Medical Center 1.6% 0.8%
Cheshire Medical 2.6% 1.4%
Concord Hospital 1.9% 1.2%
Cottage Hospital 2.2% 1.5%
DHMC 2.1% 1.1%
Elliot Hospital 2.8% 1.6%
Exeter Hospital 2.1% 1.3%
Frisbie Memorial
Huggins 2.6% 1.4%
Lakes Region General 3.0% 1.6%
Littleton Regional 1.8% 1.2%
Memorial Hospital 1.9% 1.2%
Monadnock Community 1.3% 0.8%
New London Hospital 1.8% 1.2%
SNHMC 1.7% 1.0%
Speare Memorial 2.8% 1.7%
St. Joseph
Upper CT Valley 2.2% 1.4%
Valley Regional 2.0% 1.3%
Weeks Medical Center 3.5% 2.2%
Wentworth-Douglas
2004 Charity Charges to Gross Patient Services Revenues
2004 Adjusted Ratio of Charity Charges to Gross Patient Services Revenues

The graph below contains the unadjusted data only (blue bar) from the graph on page 21, however, it is sorted in descending rank order versus alphabetically.

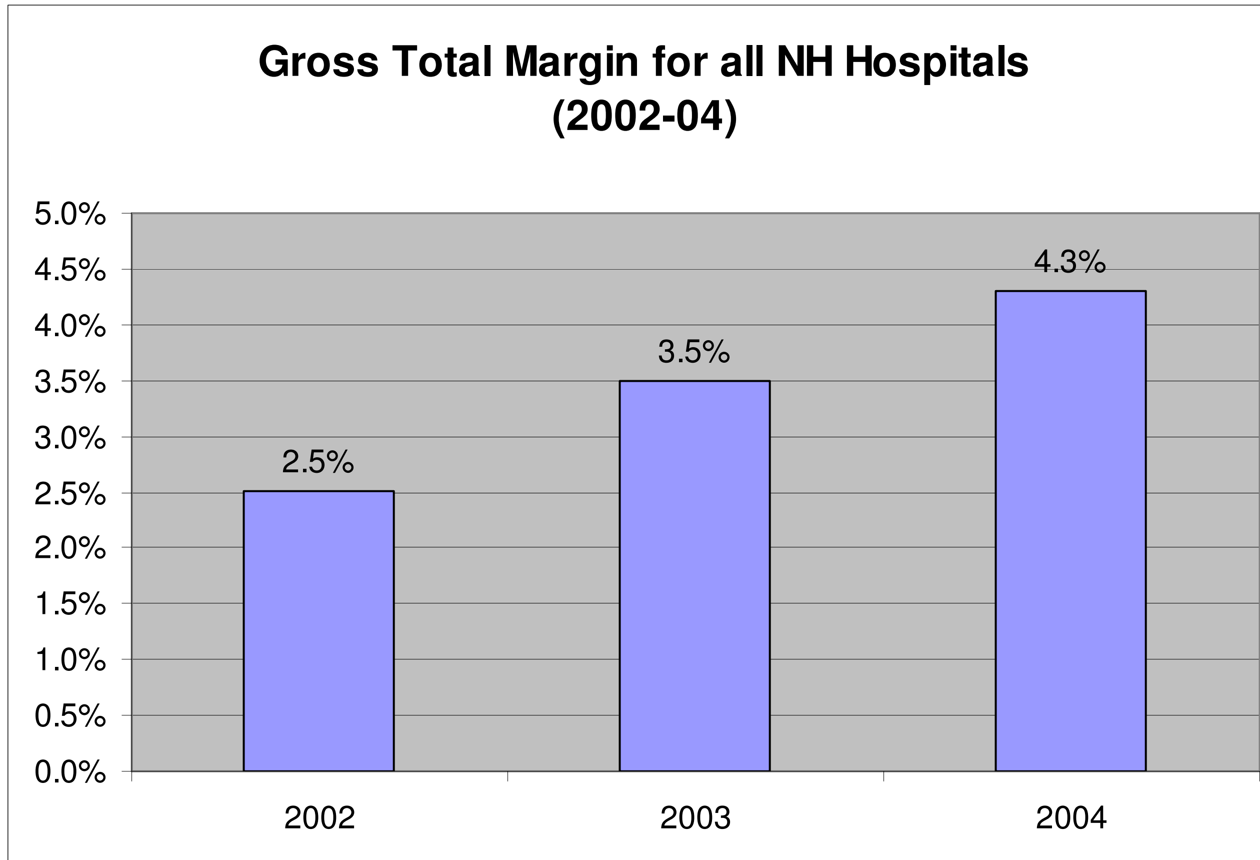


The graph below contains the adjusted data only (maroon bar) from the graph on page 21, however, it is sorted in descending rank order versus alphabetically. The rank in ( ) is the rank from the prior page for comparison purposes. There are some changes in the ranking from the prior page.



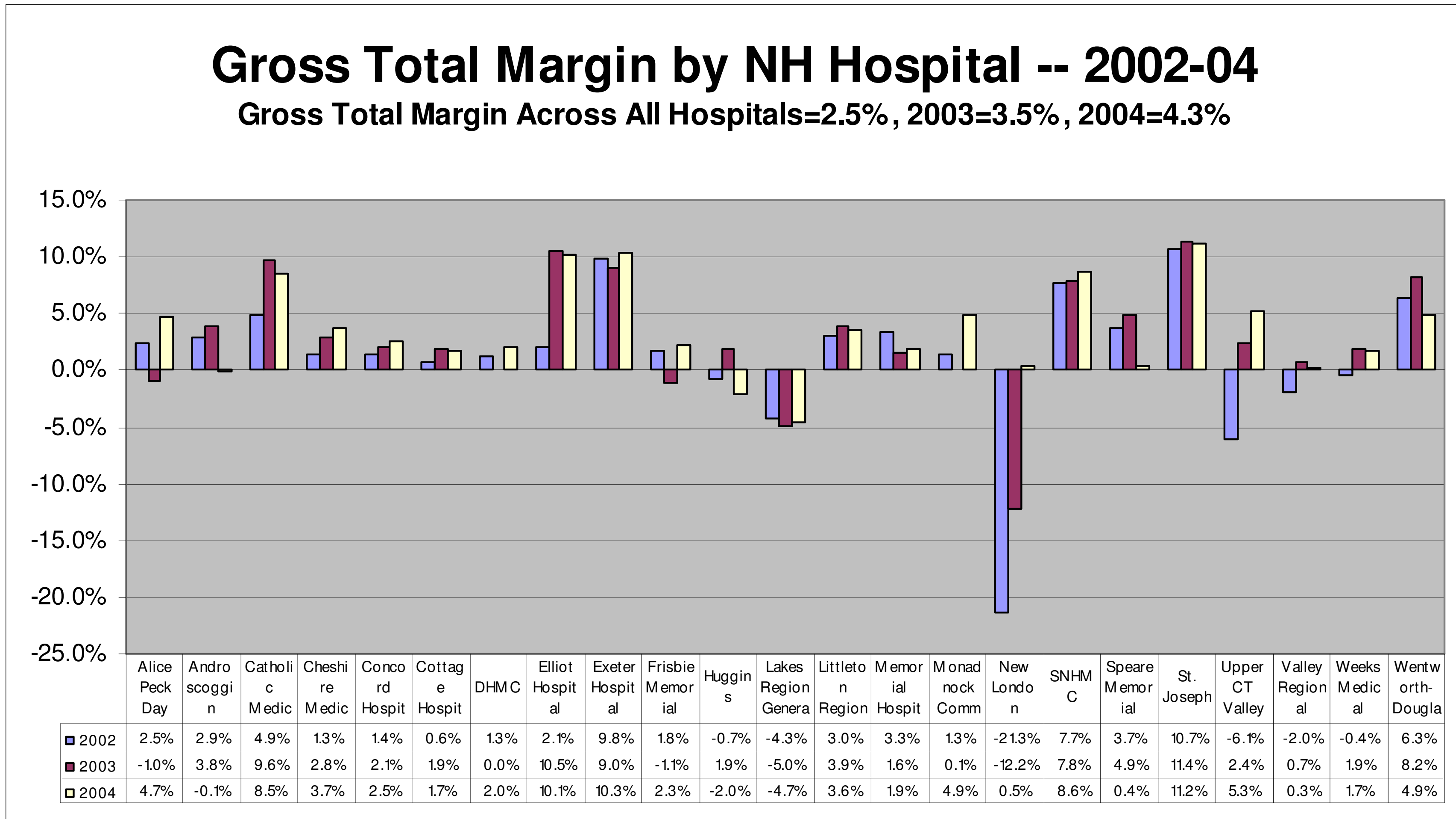
9. Gross Total Margin

The following chart shows the unweighed gross total margin[12] calculated across all New Hampshire hospitals for 2002-2004[13].



[12] Hospital Gross Total Margin calculated as: (Gross Revenues less Gross Expenses) / Gross Revenues
[13] The NH Hospital Association calculates Operating Margin on their trending reports posted quarterly to http://www.nhha.org/nhha/healthcare_data/index.php#Trend. The Operating Margin calculated by NHHA was 4.6%, 6.1%, and 5.6% for 2002, 2003, and 2004, respectively.

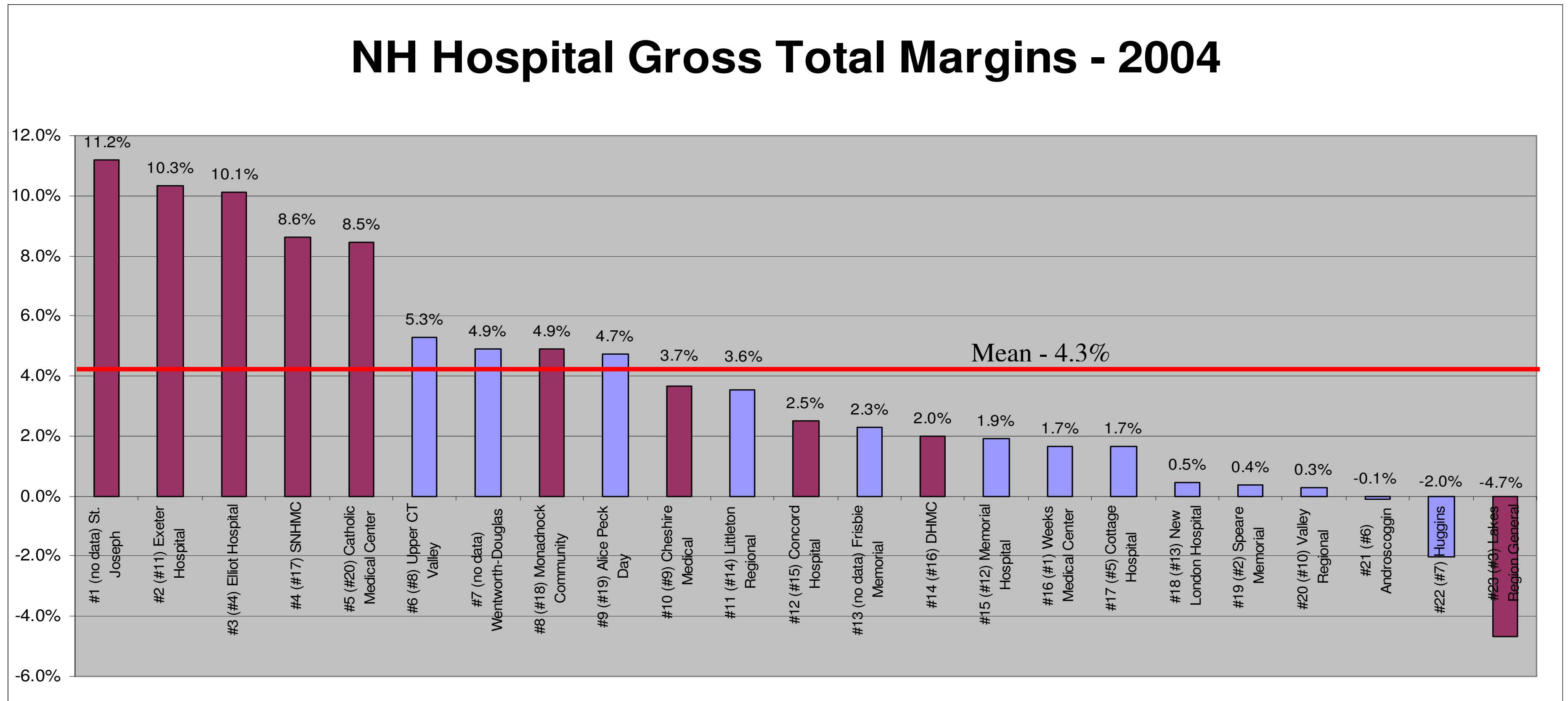
The following chart shows that the unweighted gross total margins for New Hampshire hospitals for years 2002, 2003, and 2004. The majority of the hospitals demonstrate increasing total margins from year to year. Lakes Region consistently demonstrates a loss.



	Alice Peck Day	Androscoggin	Catholic Medic	Cheshire Medic	Concord Hospit	Cottage Hospit	DHMC	Elliot Hospital	Exeter Hospital	Frisbie Memorial	Huggins	Lakes Region Genera
2002	2.5%	2.9%	4.9%	1.3%	1.4%	0.6%	1.3%	2.1%	9.8%	1.8%	-0.7%	-4.3%
2003	-1.0%	3.8%	9.6%	2.8%	2.1%	1.9%	0.0%	10.5%	9.0%	-1.1%	1.9%	-5.0%
2004	4.7%	-0.1%	8.5%	3.7%	2.5%	1.7%	2.0%	10.1%	10.3%	2.3%	-2.0%	-4.7%

	Littleton Region	Memorial Hospit	Monadnock Comm	New London	SNHMC	Speare Memorial	St. Joseph	Upper CT Valley	Valley Regional	Weeks Medical	Wentworth-Dougla
2002	3.0%	3.3%	1.3%	-21.3%	7.7%	3.7%	10.7%	-6.1%	-2.0%	-0.4%	6.3%
2003	3.9%	1.6%	0.1%	-12.2%	7.8%	4.9%	11.4%	2.4%	0.7%	1.9%	8.2%
2004	3.6%	1.9%	4.9%	0.5%	8.6%	0.4%	11.2%	5.3%	0.3%	1.7%	4.9%

The following chart describes the unweighted gross total margins by hospital for 2004, sorted in descending order. The number format "#x (#x)" proceeding the name of the hospital is for comparative purposes. The first "#" is the ranking gross total margin. The second "(#)" is the ranking of the Adjusted Ratio of Charity Care Charges to Gross Patient Services Revenues. Frisbie Memorial, St. Josephs and Wentworth-Douglas Hospital do not have a ranking due to unreported data.



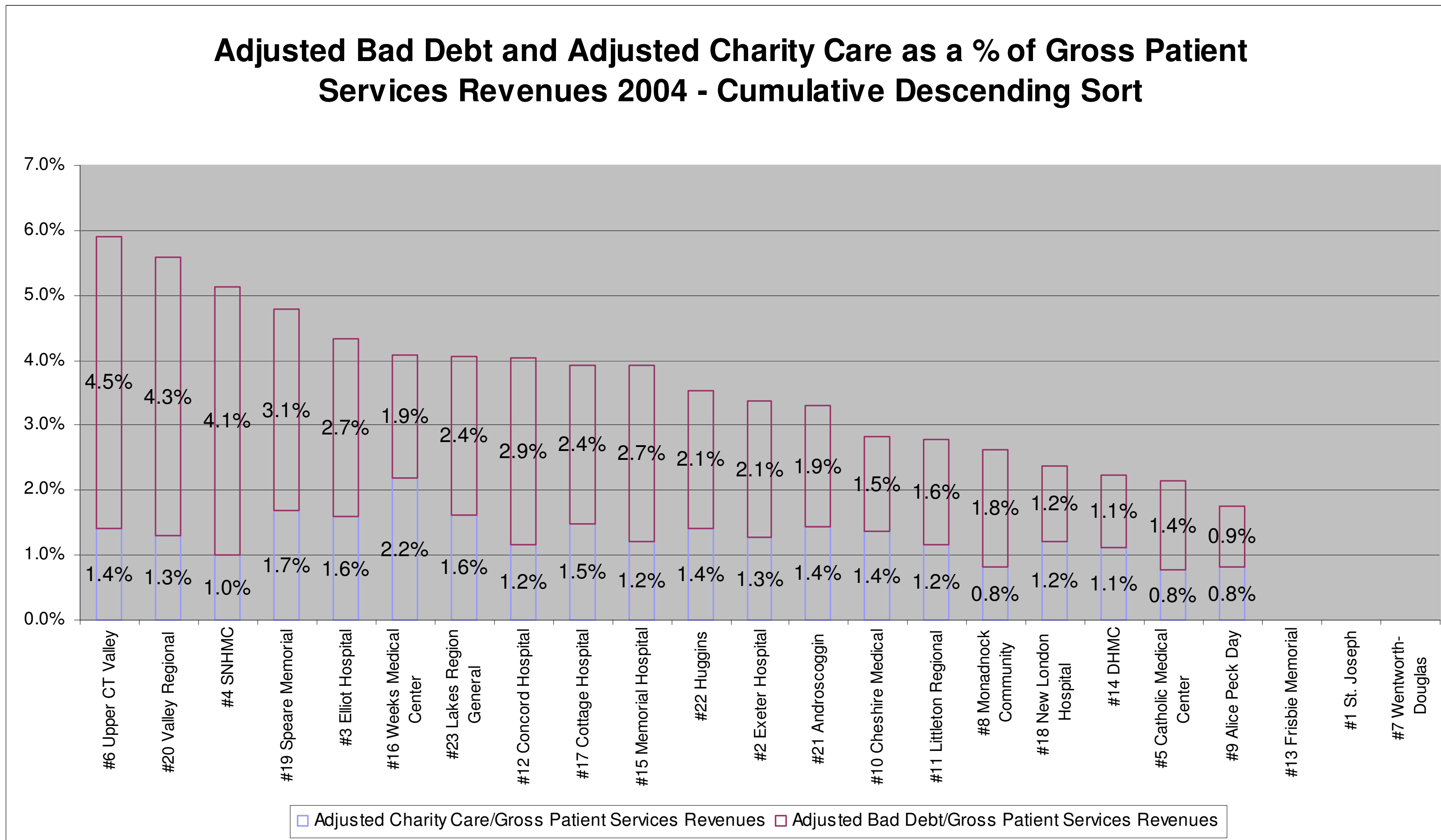
An Overview of New Hampshire Hospital Financial Measures

The following table is the same data as the ranking information shown on the prior graph, but in a tabular format. The hospitals in red have the ten highest revenue amounts for both gross patient and net services revenues.

2004	Gross Total Margin Ranking (p.24)	Adjusted Charity Care Charges to Gross Patient Services Revenues Ranking (p.21)
St. Joseph	1	No data reported
Exeter Hospital	2	11
Elliot Hospital	3	4
SNHMC	4	17
Catholic Medical Center	5	20
Upper CT Valley	6	8
Wentworth-Douglas	7	No data reported
Monadnock Community	8	18
Alice Peck Day	9	19
Cheshire Medical	10	9
Littleton Regional	11	14
Concord Hospital	12	15
Frisbie Memorial	13	No data reported
DHMC	14	16
Memorial Hospital	15	12
Weeks Medical Center	16	1
Cottage Hospital	17	5
New London Hospital	18	13
Speare Memorial	19	2
Valley Regional	20	10
Androscoggin	21	6
Huggins	22	7
Lakes Region General	23	3

This final chart displays summary data for adjusted bad debt, adjusted charity care, and ranking of gross total margin. The chart below shows the cumulative amount of adjusted bad debt and adjusted charity care as percentages of gross patient services revenues for 2004 data. It is sorted in cumulative descending order.

The "# x" next to each hospital name represents the ranking for that hospital in terms of gross total margin. For example, Upper Connecticut Valley has the highest bad debt and charity care percentages, but was #6 in terms of gross total margin.



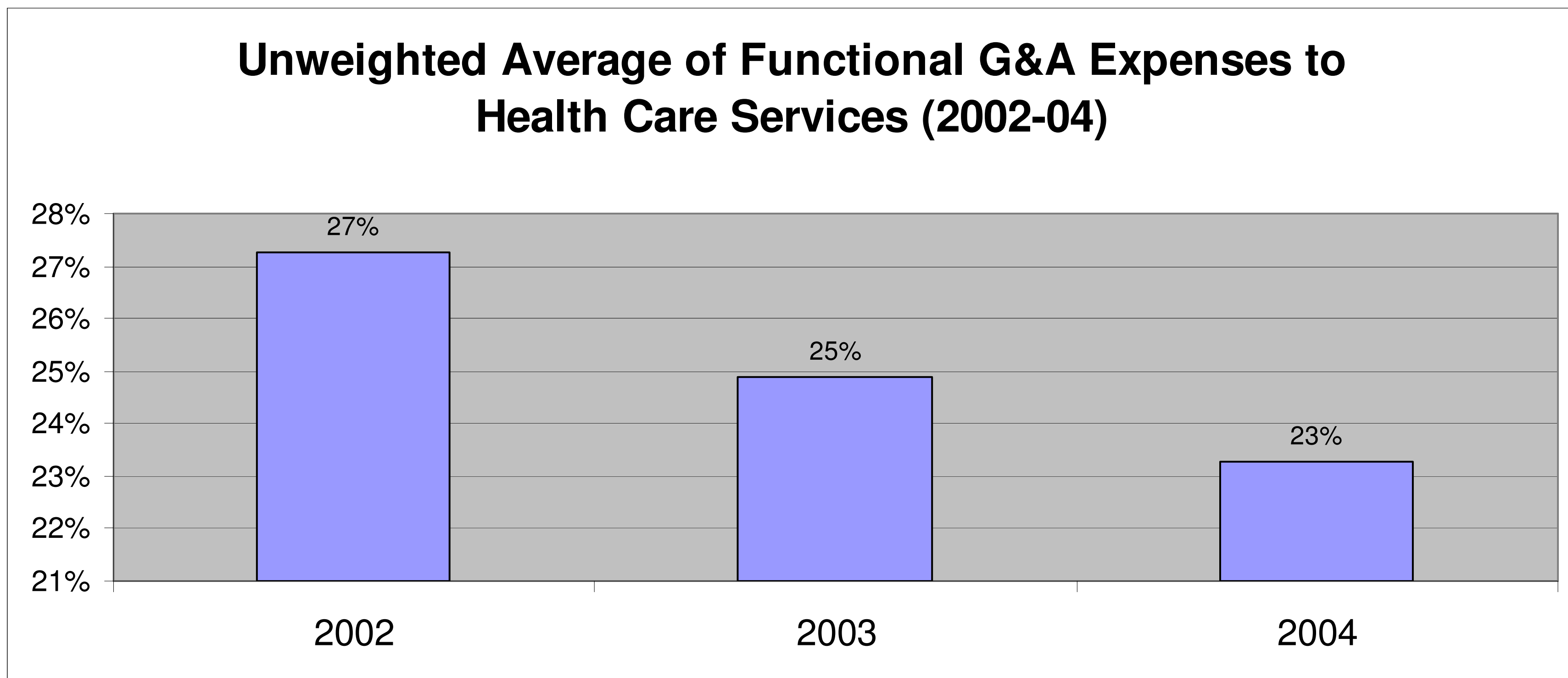
An Overview of New Hampshire Hospital Financial Measures

The following table is the same data as the ranking information shown on the prior graph, but in a tabular format. The hospitals in red have the ten highest revenue amounts for both gross patient and net services revenues.

2004	Gross Total Margin Ranking (p.24)	Bad Debt and Adjusted Charity Care as a % of Gross Patient Services Revenues Cumulative Ranking (p.26)
St. Joseph	1	Not reported
Exeter Hospital	2	12
Elliot Hospital	3	5
SNHMC	4	2
Catholic Medical Center	5	17
Upper CT Valley	6	1
Wentworth-Douglas	7	Not reported
Monadnock Community	8	15
Alice Peck Day	9	20
Cheshire Medical	10	14
Littleton Regional	11	16
Concord Hospital	12	7
Frisbie Memorial	13	Not reported
DHMC	14	18
Memorial Hospital	15	8
Weeks Medical Center	16	10
Cottage Hospital	17	11
New London Hospital	18	19
Speare Memorial	19	4
Valley Regional	20	3
Androscoggin	21	13
Huggins	22	9
Lakes Region General	23	6

10. General & Administrative Expenses

The average ratio of functional selling and general expenses (G&A) to functional healthcare expenses was 27%, 25%, and 23% for 2002, 2003, and 2004 respectively. Dartmouth Hitchcock Medical Center did not report selling and general expenses. Catholic Medical Center's total functional expenses reported for 2003 differed between the 2003 and 2004 financial statements. The 2004 Catholic Medical Center statement figures were used for this report. Overall, selling and general expenses are decreasing, which suggests that they are becoming more administratively efficient.



11. Appendices

Appendix A: Research Summary of State and Federal Actions re: Uninsured Discounts - Updated August 15, 2005

A brief review of legislative efforts in other states and at the federal level was conducted in order to determine if other states were requiring hospital providers to provide discounts to their uninsured patients. There does appear to be movement in this direction in several states. Additionally, both HCA and Tenet Healthcare, two of the nation's largest for-profit hospital chains, both have discount programs for the uninsured. Tenet Healthcare's discount was announced in March of 2005 as part of a settlement that guarantees uninsured patients discounts to those equal of managed care providers *regardless of the patient's income*. The NH Health Access and NH Medication Bridge programs both have income restrictions. HCA announced on their website in 2005 a "managed care like discount" for the uninsured.

The following synopsis includes the web links to the core articles and references:

1. The NH Health Access Network and the NH Medication Bridge programs provide assistance to NH residents seeking medical care and pharmaceuticals. These programs are restricted to residents under certain income guidelines. http://www.healthynh.com/fhc/initiatives/access/NHHAN.php and http://www.healthynh.com/fhc/initiatives/access/medicationbridge.php
2. February 2004, CMS' Tommy Thompson issues letter to American Hospital Association blasting AHA and setting the record straight that hospitals can discount to uninsured. Source: http://www.hhs.gov/news/press/2004pres/20040219.html
3. CMS issues guidelines on uninsured and clarifies in Question 5 that discounting to uninsured is no different than other payer discounts. Source: http://www.cms.hhs.gov/FAQ_Uninsured.pdf
4. March 2004, Advocates from Council of United Latinos (a CA group) in Florida argue that the uninsured should receive discounts of "about 135 percent of Medicare's required reimbursement rates." The CUL accuses Florida hospitals of "economic racism."[14] Source: http://www.cahi.org/article.asp?id=136
5. April 2004: 108th Congress introduces HB 4092. Title: To amend title XIX of the Social Security Act to require fair billing for hospital services provided to uninsured patients as a condition of Medicaid funding for a hospital. Would place a cap of 125% of payment amount on uninsured bills. Referred to House Subcommittee on Health. Source: http://www.theorator.com/bills108/hr4092.html
6. 2005: HCA announces a new, four part, charity policy including a "managed care like discount" for the uninsured. Source: www.hcahealthcare.com/cpm/Uninsured%20web%20document.doc

[14] Group is also in Wall Street Journal article "Activist for Uninsured Needles Hospitals -- And Draws Blood" **June 19, 2003.**

7. March 2005: Tenet Healthcare announces that under a court settlement: "uninsured patients would be guaranteed discounts equal to those of managed care providers, regardless of the patient's income". Source: http://www.medicalnewstoday.com/medicalnews.php?newsid=21105
8. In 2005, TN SB 1903 passed senate to house; limits hospitals to charging 120 percent of Medicare for certain self-pay patients. Full copy of bill text cannot be found. Am unclear if signed into law. Source: http://www.ncsl.org/programs/health/uninsleg.htm -- National Conference of State Legislatures
9. May 2005, Congress examines nonprofit hospital status in wake of record earnings. Source: http://www.political-news.org/breaking/11221/congress-examines-nonprofit-hospitals.html
10. Maine's Dirigo Health reimburses providers the same rates paid by private insurers. Goal of covering uninsured is to "reduce bad debt and charity care costs." Source: http://www.umaine.edu/mcsc/MPR/Vol12No3/Treat/Treat.htm

Appendix B: Union Leader Article November 27, 2005

Some hospitals have already made changes

Lebanon - Beginning Jan. 1, Dartmouth-Hitchcock Medical Center will offer a 30 percent discount for uninsured patients.

The discounts will apply to services provided by both the Lebanon hospital and physicians affiliated with Dartmouth-Hitchcock Clinic around the state.

"We are doing this because we believe it's the right thing to do for our patients," said Mary Kay Boudewyns, vice president for revenue management at Dartmouth-Hitchcock. "It's really a fairness issue. Why should the uninsured have to pay more for their service than what most patients under insurance plans have to pay?"

Boudewyns said the change was triggered by a recognition of the growing number of uninsured individuals who don't qualify for financial assistance.

She said one study found that households making $50,000 and more a year account for 90 percent of the increase in the numbers of uninsured over the past 10 years. "There's a shift in who the uninsured are, and in response to that, we need to think differently about how we help people be able to pay their bills for the care they need."

As the state's insurance market has consolidated, Boudewyns noted, the companies that remain have been able to negotiate ever-deeper discounts. She said the 30 percent rate represents the average discount for the insurers that contract with the hospital and clinic doctors.

Boudewyns said the change also comes from a recognition that uninsured patients are less likely to seek medical care. "By offering a discount, it makes it more affordable for them, and hopefully they can get the care they need to keep them in a good state of health."

Concord Hospital also changed its billing policy for uninsured patients this past summer, according to Michael Green, the chief executive officer.

"We recognized it was time to change," Green said.

While the hospitals' financial counselors have previously negotiated "unique arrangements" with many individual patients who did not have health insurance, he said, "We decided to put into formal policy a lot of what we were doing informally, so more people would more easily qualify."

There are several components to the comprehensive new program, including a catastrophic assistance program that gives up to a 50 percent discount for uninsured individuals who make up to 500 percent of the federal poverty level (FPL), based on the amount of the hospital bill. "It's scaled so that the lower you happen to be in comparison to the federal poverty guidelines, the greater your discount is on larger bills," Green explained.

For a family of five, 500 percent of the FPL would be about $113,000 in annual income, he noted. For a single person, it would be $47,850.

Concord Hospital also offers a 20 percent discount for uninsured patients who pay within 30 days of when they receive their bills. And there's a 10 percent discount for those who pay within 60 days.

"Concord Hospital has been very well supported by this community and we feel a very strong sense of obligation to give back to this community, and give back to those people who need us the most," Green said.

Appendix C: Analysis Methodology

The methodology used for the analysis in this report is outlined in this section. All calculations are transparent. This section is divided into each major section of the report. The source data is identified and the calculation is explained.

Report Section	Calculation Description	Source Data	Calculation Explanation
3. Setting the Stage	3.1 Appendectomy average charges of $18,114.	2002 and 2002 inpatient and outpatient data sets supplied by NHDHHS.	All claims data for DRG 166 was selected. This data set was grouped by unique patient identifier to provide total charges per patient identifier. The average charge was then calculated.
	3.2 Values assigned to each of the payer types (blue bars).	Created for the report.	The $18,114 average charge amount was multiplied by each of the assumed discounts. This number was subtracted from the $18,114 figure for each of the payer types.
4. Self Pay Payer Type	4.1 Percentage of hospital charges by payer type.	2002 and 2002 inpatient and outpatient data sets supplied by NHDHHS.	All claims data were selected. The data were grouped by payer type field and total charges were summed for each payer type. The percent total by payer type for each year was then calculated. Note: payer type of “Other” had approximately $250,000 in charges, but equated to zero percent of the total amounts (in excess of $2 billion in total charges).
5. Hospital Revenues	5.1 Unweighted average gross patient services revenues by year	2002, 2003, and 2004 audited hospital financials	All gross patient services revenues for each hospital were added separately by year and the unweighted averages for each year were calculated.
	5.2 Unweighted average net patient services revenues by year	2002, 2003, and 2004 audited hospital financials	All gross net patient services revenues for each hospital were added by year and the unweighted averages for each year were calculated. The net patient services revenues are the result of subtracting contractual allowances and provision for charity care from gross patient services revenues.
	5.3 Unweighted average	2002, 2003, and 2004	All gross patient services revenues for each hospital

Report Section	Calculation Description	Source Data	Calculation Explanation
	gross patient services revenues for 2002-2004 combined.	audited hospital financials	were added separately by year. An unweighted average for all three years was calculated by hospital.
	5.4 Unweighted average net patient services revenues for 2002-2004 combined.	2002, 2003, and 2004 audited hospital financials	All gross net patient services revenues for each hospital were added separately by year. An unweighted average for all three years was calculated by hospital. The net patient services revenues are the result of subtracting contractual allowances and provision for charity care from gross patient services revenues.
6. Hospital Retail Charges vs. Collected Revenues	6.1 Mean (unweighted), median minimum, and maximum percent difference between gross and net patient services reveneues for each year 2002-2004.	2002, 2003, and 2004 audited hospital financials	This is calculated as the percent difference between gross patient services revenue (A) and net patient services revenue (B) as shown in the formula (A-B)/B. The calculation was performed for each hospital for each year and then mean, median, min, and max were calculated for each year.
	6.2 Unweighted average percent difference between gross and net patient services reveneues by hospital for 2002-2004 combined.	2002, 2003, and 2004 audited hospital financials	This is calculated as the percent difference between gross patient services revenue (A) and net patient services revenue (B) as shown in the formula (A-B)/B. The calculation was performed for each hospital for each year. The unweighted average was then calculated for the three years for each hospital and then displayed.
	6.3 Percent difference between gross and net patient services reveneues by facility for each year 2002-2004.	2002, 2003, and 2004 audited hospital financials	This is calculated as the percent difference between gross patient services revenue (A) and net patient services revenue (B) as shown in the formula (A-B)/B. The calculation was performed for each hospital for each year and then displayed.
7. Bad Debt	7.1 Unweighted average	2002, 2003, and 2004	The bad debt amount was divided by the gross

Report Section	Calculation Description	Source Data	Calculation Explanation
	percent bad debt to gross patient services revenues by hospital across all three years 2002-2004.	audited hospital financials	patient services revenues for each year for each hospital. The individual hospital unweighted averages were calculated across all three years and displayed.
	7.2 Unweighted average percent bad debt to gross patient services revenues by hospital for each of the three years 2002-2004.	2002, 2003, and 2004 audited hospital financials	The bad debt amount was divided by the gross patient services revenues for each year for each hospital. The individual hospital ratios were then displayed. They are sorted in descending order using the calculations from 7.1 above.
	7.3 Adjusted data of the unweighted average ratio of bad debt to gross patient services	2002, 2003, and 2004 audited hospital financials	The patient services revenues were divided by the gross patient services revenues for each hospital for each year. This ratio was then multiplied by the total bad debt charges for each hospital for each year. The unweighted average was then calculated for all hospitals by year and displayed.
	7.4 Adjusted bad debt to gross patient services revenues by hospital for each of the three years 2002-2004.	2002, 2003, and 2004 audited hospital financials	The patient services revenues were divided by the gross patient services revenues for each hospital for each year. This ratio was then multiplied by the total bad debt charges for each hospital for each year. The unweighted average was then calculated for each hospital by year and displayed. Sorted in descending order.
8. Charity Care	8.1 Unweighted average ratio of charity care charges to gross patient services revenues for each year 2002-2004.	2002, 2003, and 2004 audited hospital financials	The charity care charges were divided by the gross patient services revenues for each hospital for each of the three years 2002-2004. The unweighted average was then calculated for each year across all hospitals and displayed for each year.
	8.2 Adjusted ratio of charity charges to revenues for each year 2002-2004.	2002, 2003, and 2004 audited hospital financials	The patient services revenues were divided by the gross patient services revenues for each hospital for each year. This ratio was then multiplied by the total charity care charges for each hospital for each year.

Report Section	Calculation Description	Source Data	Calculation Explanation
			The unweighted average was then calculated for all hospitals by year and displayed.
	8.3, 8.4, 8.5	2002, 2003, and 2004 audited hospital financials	Comparison of 8.1 and 8.2 was displayed for each year and for each hospital.
9. Gross Total Margin	9.1 Gross Total Margin for all NH hospitals	2002, 2003, and 2004 audited hospital financials –statement of operations	The gross revenues and expenses for all hospitals were summed. Then the following formula was calculated (Gross Revenues less Gross Expenses) / Gross Revenues.
	9.2 Gross Total Margin by NH Hospital	2002, 2003, and 2004 audited hospital financials –statement of operations	The following formula was calculated for each individual hospital (Gross Revenues less Gross Expenses) / Gross Revenues.
	9.3 NH Hospital Gross Total Margin by Hospital for 2004	2002, 2003, and 2004 audited hospital financials –statement of operations	The following formula was calculated for each individual hospital (Gross Revenues less Gross Expenses) / Gross Revenues. The hospitals were then sorted in descending order.
	9.4 Adjusted Bad Debt and Adjusted Charity Care as a % of Gross Patient Services Revenues 2004	2002, 2003, and 2004 audited hospital financials	Data from Section 7 and Section 8 was represented in a stacked bar format.
10. General and Administrative Expenses	10.1 Unweighted average of functional G&A expenses to health care services	2002, 2003, and 2004 audited hospital financials	The functional general and administrative expenses were divided by the functional health care services for each hospital for each year. The unweighted average was then calculated for all hospitals by year and then displayed.

Appendix D: List of Hospital Financials Reviewed

The following table contains the list of the audited financials used for the report.

Hospital Name	2003 Financials Title	Hospital Only?	2004 Financials Title	Hospital Only?
Alice Peck Day	Alice Peck Day Health Systems Corporation and Subsidiaries Consolidated Financial Statements	No	Alice Peck Day Health Systems Corporation and Subsidiaries Consolidated Financial Statements	No
Androscoggin	Androscoggin Valley Hospital, Inc. Financial Statements	Yes	Androscoggin Valley Hospital, Inc. Financial Statements	Yes
Catholic Medical Center	Catholic Medical Center Financial Statements	Yes	Catholic Medical Center Financial Statements	Yes
Cheshire Medical	The Cheshire Medical Center Financial Statements	Yes	The Cheshire Medical Center Financial Statements	Yes
Concord Hospital	Concord Hospital, Inc. and Subsidiaries Consolidated Financial Statements and Additional Information	No	Concord Hospital, Inc. and Subsidiaries Consolidated Financial Statements and Additional Information	No
Cottage Hospital	Cottage Hospital Financial Statements	Yes	Cottage Hospital Financial Statements	Yes
DHMC	Dartmouth-Hitchcock and Subsidiaries Consolidated Financial Statements	No	Dartmouth-Hitchcock and Subsidiaries Consolidated Financial Statements	No
Elliot Hospital	Elliot Hospital Financial Statements	Yes	Elliot Hospital Financial Statements	Yes
Exeter Hospital	Exeter Hospital, Inc.	Yes	Exeter Hospital, Inc.	Yes

Hospital Name	2003 Financials Title	Hospital Only?	2004 Financials Title	Hospital Only?
	Financial Statements		Financial Statements	
Frisbie Memorial	Frisbie Memorial Hospital and Subsidiaries Consolidated Financial Statements	No	Frisbie Memorial Hospital and Subsidiaries Consolidated Financial Statements	No
Huggins	Huggins Hospital and Subsidiary Financial Statements and Additional Information	No	Huggins Hospital and Subsidiary Financial Statements and Additional Information	No
Lakes Region General (including Franklin)	LRGHealthcare Audit Report	No	LRGHealthcare Audit Report	Yes
Littleton Regional	Littleton Regional Hospital Financial Statements	Yes	Littleton Regional Hospital and Affiliate Financial Statements	Yes
Memorial Hospital	The Memorial Hospital at North Conway, NH Financial Statements	No	The Memorial Hospital at North Conway, NH and Subsidiaries Consolidated Financial Statements	No
Monadnock Community	Monadnock Community Hospital Consolidated Financial Statements	No	Monadnock Community Hospital Consolidated Financial Statements	No
New London Hospital	New London Hospital Association, Inc. and Subsidiaries Consolidated Financial Statements	No	New London Hospital Association, Inc. and Subsidiaries Consolidated Financial Statements	No
SNHMC	Southern New Hampshire Medical Center Financial	Yes	Southern New Hampshire Medical	Yes

Hospital Name	2003 Financials Title	Hospital Only?	2004 Financials Title	Hospital Only?
	Statements		Center Financial Statements	
Speare Memorial	Speare Memorial Hospital Association, Inc. and Subsidiaries Financial Statements	No	Speare Memorial Hospital Association, Inc. and Subsidiaries Financial Statements	No
St. Joseph	St. Joseph Hospital Financial Statements	No	Covenant Health Systems, Inc. Consolidated Financial Statements and Supplemental Consolidating Financial Statements	No
Upper CT Valley	Upper Connecticut Valley Hospital Association Financial Statements	Yes	Upper Connecticut Valley Hospital Association Financial Statements	Yes
Valley Regional	Valley Regional Hospital Financial Statements	Yes	Valley Regional Hospital Financial Statements	Yes
Weeks Medical Center	Weeks Medical Center Financial Statements	Yes	Weeks Medical Center Financial Statements	Yes
Wentworth-Douglas	Wentworth-Douglas Hospital and Subsidiaries Audited Consolidate Financial Statements	Yes	Wentworth-Douglas Hospital and Subsidiaries Audited Consolidate Financial Statements	Yes

Appendix E: Study Authors

Patrick Miller, MPH is a Principal with the Pero Consulting Group, LLC. He has both a management and technical background, having served in a variety of senior positions, including Chief Information Officer for Choicelinx Corporation and Director of Research and Process Design for CIGNA. He founded Pero Consulting Group in 1999. Patrick's background includes product development, information management and analysis, health plan operations, business planning, and project management.

Amy Philbrick, MPH is a Senior Policy Analyst with the New Hampshire Institute for Health Policy and Practice at the University of New Hampshire. Prior to joining the Institute, she was the Vice President of Provider Network Management for the Neighborhood Health Plan, a Medicaid HMO in Boston, Massachusetts. In addition, she held executive level positions at Regence Blue Shield in Seattle, Washington and has experience and expertise in contracting, rate negotiation, cost containment, pricing, and health care financing.