THE HEALTH OF NEW HAMPSHIRE'S COMMUNITY HOSPITAL SYSTEM

Issue Briefing - December 2000

A Financial and Economic Analysis[1,2]

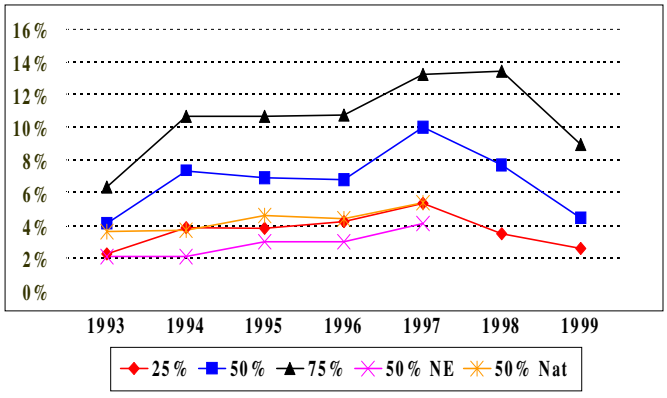
New Hampshire's community and teaching hospitals are fulfilling their historic mission.

Hospitals deliver essential services to all who seek care regardless of ability to pay or insurance status. They work with other community members and providers to improve the quality of life for the residents in their service areas and represent the largest concentration of provider resources and capital within the health care system. In 1998, an estimated 35% of all New Hampshire health care dollars went to hospitals.

▪ **Between 1993-1999, the majority of New Hampshire's 24 non-profit hospitals exhibited strong financial performance.**

Between 1993 and 1999, median total margins and operating margins for New Hampshire hospitals exceeded those of the New England and United States hospitals for all but one year. In 1998, operating margins decreased for half of the hospitals and in 1999 for all of them. The median operating margin in 1999 was 1% and the median total margin was 4.4% .

Total Margin



Total margin measures the hospital's ability to cover expenses from all sources.

▪ **New Hampshire hospitals are stronger than their New England and national counterparts in terms of two important measures of liquidity.**

Liquidity measures the extent to which hospitals have ready access to relatively liquid resources (cash, short-term investments, accounts receivable, inventory) to meet their current obligations and their operating expenses. New Hampshire hospitals are stronger than New England and the United States in terms of current ratio (current assets/ current liability) and days cash on hand (the number of days the hospital could continue to operate without collecting additional cash).

In 1997, New England and national hospitals had on average 100 days of cash on hand. New Hampshire hospitals had 240 days of cash on hand. By 1998, half of New Hampshire hospitals had 300 or more days of cash on hand; in 1999, days cash on hand decreased slightly. While the 1999 cash flow is still one of strategic flexibility, some strains are beginning to show.

▪ **New Hampshire hospitals are less reliant on debt and more capable of paying off their debt from their cash flow than other hospitals in New England and the nation.**

This has not been achieved at the expense of investment in property, plant and equipment as the median age of property, plant and equipment is well below national and regional medians.

▪ **There appears to be a natural spacing of hospitals throughout the state.**

New Hampshire does not appear to have a lot of duplication in the supply of medical services. There also appears to be a natural efficient segmentation of services between a few high-end tertiary care hospitals and larger numbers of smaller more dispersed primary and secondary care providers.

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[1] *Analysis of Health Care Charitable Trusts in the State of New Hampshire: The Hospital Sector*, Nancy M. Kane, DBA, Harvard School of Public Health, December 2000.

[2] *Assessing the Competitiveness of New Hampshire's Health Care Markets: A Focus on Hospitals*, Center for Health Economics Research, December 2000.

▪ New Hampshire hospitals are cost efficient. The average cost per inpatient discharge and the net revenue per discharge is lower in New Hampshire than the national and New England average.

Low cost is a proxy for efficiency. In 1998, the average cost per inpatient discharge in New Hampshire hospitals was lower than the national average, the New England average and each of the five other New England states. Low net revenue per discharge is a proxy for price and consumer expense. In 1998, the net revenue per discharge in New Hampshire hospitals was lower than the national average, the New England average and four of the New England states.

Regional Comparison of Hospital Financial Performance, 1998

State	Net Revenue/ Discharge	Cost/ Discharge
New Hampshire	$ 6,372	$ 6,404
Rhode Island	6,255	6,509
Vermont	6,777	7,052
Connecticut	6,736	7,055
Maine	7,624	7,507
Massachusetts	6,501	7,833
New England Average	6,711	7,060
United States Average	6,509	6,702

AHA Hospital Statistics, 2000 and AHA Annual Survey of Hospitals, 1998

▪ If New Hampshire's hospitals are – in general — financially healthy and low cost, might the State then have the best of all possible worlds? Four additional considerations, however, complicate the analysis.

1. In New Hampshire most hospitals control their markets and have very few competitors.

This high degree of market concentration is not necessarily bad. There is an important difference between having monopoly power and behaving like a monopoly (charging very high prices, lowering output, constructing barriers to entry). As noted above, the costs and net revenues per discharge in New Hampshire are among the lowest in New England. Nonetheless, as "natural monopolies," hospitals have considerable control over the reimbursement rates that will be paid for hospital care in their communities. This is demonstrated by the private pay rates and the cash accumulated by New Hampshire hospitals.

2. The revenue and margins generated by different payers varies significantly.

In 1998, New Hampshire hospitals exhibited losses on their Medicare and Medicaid patient revenues of approximately two percent each. They also posted losses totaling slightly over five percent on bad debt and charity care. These losses on publicly insured patients, bad debt and charity care were offset by positive margins on privately insured patients and by income from accumulated savings which in 1998 totaled half a billion in cash and marketable securities. Hospital margins from private payers were 9.7 percent in 1998, compared with 6.1 percent regionally and 5.5 percent nationally.

3. During this period of prosperity and accumulated cash, the amount of charity or free care provided by hospitals has decreased.

Between 1994 and 1999, charity care (as a percentage of gross patient service revenue) decreased from slightly more than 2% to less than 1.5%.

4. Averages mask the fact that some hospitals essential to the well being of the State's residents are not faring well.

The federally designated Critical Access Hospitals will protect some rural hospitals that are at financial risk by increasing their level of reimbursement for Medicare patients. However, not all essential hospitals will meet the federal criteria or choose to become a Critical Access Hospital.

In response to these findings, the Department of Health and Human Services has joined with the Department of Insurance and the Attorney General's Office to recommend the following actions:

1. The State should work with small rural hospitals that are financially at risk, communities and the federal government to designate them as "Critical Access Hospitals."

2. The State should routinely examine the Medicaid reimbursement rate structure to hospitals.

3. Hospital administrators and trustees should review their charitable spending (free care) policies and programs relative to their financial performance each year and also continue efforts to quantify the value of their community benefit programs.

4. Hospitals should participate in and invest in community-based partnerships to: identify preventable threats to the public's health; determine the health needs of their service area; and to develop community benefit plans to address these needs.

5. The State, hospitals, providers, businesses, foundations and communities should partner to enroll all eligible patients in Medicaid and the State Children's Health Insurance Program and to expand health insurance coverage to people who cannot afford insurance coverage.

6. Community hospitals, providers, hospital systems, businesses, foundations and other organizations should partner to provide community-based, coordinated care management programs to people without medical or dental insurance.

7. The State, with market participants, should continue to monitor the impact of market forces on the structure, capacity and financial stability of the State's community hospitals. It should also expand research and monitoring efforts to other sectors of the State's health care system: the insurance, physician, and nursing home markets.