Bill as Introduced

HB 470 – AS AMENDED BY THE HOUSE

25mar03... 0728h

2003 SESSION

03-0750
01/09

HOUSE BILL ***470***

AN ACT relative to health insurance providers.

SPONSORS: Rep. Gilman, Graf 9; Rep. Buhlman, Hills 66; Rep. Sorg, Graf 11; Sen. Martel, Dist 18

COMMITTEE: Commerce

AMENDED ANALYSIS

The bill requires health insurers to keep a provider's personal information confidential.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 470 – AS AMENDED BY THE HOUSE

25mar03... 0728h

03-0750
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Three

AN ACT relative to health insurance providers.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Section; Health Insurers; Providers. Amend RSA 400-A by inserting after section 15-a the following new section:

400-A:15-b Confidentiality of Provider's Personal Information.

I. Health insurers and other third party payors shall not display a medical provider's home address, date of birth, or social security number on documents provided to subscribers for the purpose of claim payment unless the provider has provided that information for the purposes of claim payment.

II. The provisions of this section shall apply to group hospital and medical expense policies subject to RSA 415, group health service plan contracts issued pursuant to RSA 420-A, and to health maintenance organization policies and plans issued pursuant to RSA 420-B.

2 Effective Date. This act shall take effect January 1, 2004.

Amendments

Senate Insurance
May 27, 2003
2003-1829s
09/01

Amendment to HB 470

Amend the title of the bill by replacing it with the following:

AN ACT relative to health insurance providers and establishing a committee to study current insurance market trends and insurance carrier non-payment discrimination.

Amend the bill by replacing all after section 1 with the following:

2 Nondiscrimination Among Health Care Providers. Amend RSA 420-J:4, VI to read as follows:

VI.*(a)* Nothing in this section shall be construed to require a health carrier to select a health care professional as a participating provider solely because the health care professional meets the health carrier's credentialing verification standards, or to prevent a health carrier from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts.

(b) The fact that a health carrier does not include in its network any hospital with which a health care professional holds privileges shall not be grounds to refuse to select a health care professional as a participating provider.

3 Committee Established. There is established a committee to study current insurance market trends and insurance carrier non-payment discrimination.

4 Membership and Compensation.

I. The members of the committee shall be as follows:

(a) Three members of the senate, appointed by the president of the senate.

(b) Three members of the house of representatives, appointed by the speaker of the house.

II. Members of the committee shall receive mileage at the legislative rate when attending to the duties of the committee.

5 Duties. The committee shall study current insurance market trends and insurance carrier non-payment discrimination. The committee shall study issues related to:

(a) The effect of lack of competition in the New Hampshire small group health insurance market.

(b) New Hampshire health insurance price trends relative to other states.

(c) Fairness in physician contracting, including whether statewide payment schedules utilized by major insurance companies are affecting access to specialty providers and access to health care in rural areas of the state.

(d) Profitability of major insurers in New Hampshire.

(e) The effect of insurance carrier non-payment discrimination and the impact of legislation eliminating non-payment discrimination.

(f) Any other issues relating to willing provider policies.

6 Chairperson; Quorum. The members of the study committee shall elect a chairperson from among the members. The first meeting of the committee shall be called by the first-named senate member. The first meeting of the committee shall be held within 45 days of the effective date of this section. Four members of the committee shall constitute a quorum.

7 Report. The committee shall report its findings and any recommendations for proposed legislation to the senate president, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before November 1, 2003.

8 Effective Date.

I. Section 1 of this act shall take effect January 1, 2004.

II. The remainder of this act shall take effect upon its passage.

2003-1829s

AMENDED ANALYSIS

The bill requires health insurers to keep a provider's personal information confidential.

This bill states that the fact that a health carrier does not include in its network a hospital with which a health care professional holds privileges is not grounds to refuse to select such health care professional as a participating provider.

The bill also establishes a committee to study current insurance market trends and insurance carrier non-payment discrimination.

Committee Minutes

COPY

Date: 4/15/03
Time: 9:10 AM
Room: 101, LOB

The Senate Committee on Insurance held a hearing on the following:

HB 470 relative to health insurance providers.

Members of Committee present: Senator Flanders
Senator Prescott
Senator Cohen
Senator Martel
Senator Roberge

The Chair, Senator Robert B. Flanders, opened the hearing.

Senator Robert B. Flanders, D. 7: I will open the hearing on House Bill 470 and call upon Representative Gilman.

Representative G. Michael Gilman: For the record I am Representative Mike Gilman, I represent District 9-Grafton, Littlton and Lyman, and I am here to represent House Bill 470, relative to health insurance providers. This is an amended bill. It's actual a component of a large bill and I am glad thankful that this survived. This bill requires health insurers to keep providers personal information confidential. The reason for this bill is that there actual is a problem with some insurance companies sending benefit statements with personal information of a provider.

I speak from almost personal experience, my wife is a doctor of clinical psychology, and she is a clinical director for a private non-profit that deals with sex offenders and batteries. The last thing you want is personal information from a provider being in the hands of those people. Over the last eight years there have been several instances where there have been threatening situations and twice we actually had the ____inaudible_____ and this is easy accessed information. Not all-insurance companies do that; they

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are only handfuls that do that. I know that Anthem doesn't, in fact, they were very helpful in putting this amendment together. I think it is self-explanatory, it requires that health insurers and other third-party payers shall not display medical providers home address, date of birth, or social security number. What some insurance companies had been doing was using social security numbers instead of BIN's, employees identification numbers.

Senator Robert B. Flanders, D. 7: Any questions of this witness? I only have one. Is this based upon what I have been hearing the last day, the federal government has done, is this necessary?

Representative Gilman: Is the federal government dealing with the patient information?

Senator Robert B. Flanders, D. 7: I don't understand it, I've heard a lot about it and read a lot about it. Any other questions?
If not, thank you for your testimony. Do you wish to testify?

Attorney Chris Gallagher, Lakes Region General Hospital: For the record my name is Chris Gallagher, I representing today Lakes Region General Hospital and I have an amendment propose to House Bill 470.

We are at present becoming more and more aware of a new structure for health insurance in New Hampshire. The senate has been working their Senate Bill 119 and 110. Everyone is very much aware that there needs to be some change. Another issue that has become extremely well through all of this is the fact that our safety net carrier Blue Cross/Blue Shield has been taken over by Anthem, which is the natural process, and there is nothing wrong with that. They clearly have a different mission then Blue Cross/ Blue Shield did. It's becoming obvious that they intend to protect themselves from cost shifts and they intend to use tactics in doing so, which are quite hardballs in nature.

The change that is bringing us about is I believe, is the cut backs that are promised at the federal level and the state level for providers for Medicare and for Medicaid. You are all familiar with them and you are going to have to wrestle with this problem later this month in terms of just how much chaos you can cause by pulling back provider payments for Medicaid care. A good deal of the problems we face in the health care industry, are I believe tied to these government under payments because there is a cost shift that falls from it. While the government maybe saving money they are creating chaos in a lot of other ways.

I believe that Anthem looks at this situation nationwide and says okay, if the government is going to do that it is not going to be cost shifted onto us. So they take an aggressive stance to keep that from happening in their bargaining negotiations with they providers.

All of this is understandable and all of this is the way that business runs, but in this case, we are now in a position where this Anthem has reached a size in market power with market pricing power where it is appropriate to look at. The infrastructure of rules of the game if it is a good way to describe it. To see whether or not in order to have commerce run properly and in order to protect the public, government needs to change the balance of power. This amendment is designed to take a step in that direction, that is to change the balance of power that presently exists between the healthcare carriers and the providers physicians and hospitals and all other providers who might be covered. It" appropriate to act now because the problem is happening now. The landscape is changing because of the government cutbacks, which are all but certain.

The safety net provider that was once with a charitable mission now has a different mission. It is indicating in the context of its dispute with Lakes Region General Hospital that it intends to use the public in order to obtain the objectives that it seeks. Specifically in a dispute about the rate of payment for the hospitals they have announced that they will be cutting off the doctors from their provision and their contracts as well; unless they are affiliated with a different hospital. This secondary pressure activity maybe legitimate under antitrust law or it may not, but the fact of the matter is its appropriate for you to take a look at this and to try and change it. If indeed there is a misuse of market power under these circumstances and a tilting of the playing field that winds up injuring the public.

Whether it enables Anthem and others who have that size market power to do, is to select where and who they are going to treat, when and where they plan to do it. They can move by their negotiating power by refusing to pay the same prices for hospital A and hospital B. They can move patients to hospital A. they may have good reasons for wanting to do so. They may feel that quality is better in hospital A. they may feel that quantity reached quality in these cases, as I see in many cases it does. They couldn't be able to use the public as human shields in this kind of aggressive activity, and that is what is happening here.

This bill was prompted, if you will, by the fight at Lakes Region, but because of the factors that I have discussed I think it has much broader impact, much broader importance. Two weeks ago, less than two weeks ago, the U.S. Supreme Court upheld a state, the state of Kentucky's EMI Willing Provider

Law. In so doing has rekindled this issue of your power as a state legislator. To say to these carriers if someone is willing to meet the terms under which you pay to people with whom you have a contract then they ought to be able to be paid.

Most importantly, it provides patients with a choice of doctors. The ability to move out a network and have their physician or their hospital paid. I don't think there is a more pressing issue with the consumer these days then choice in the provision of healthcare. I don't say that we should just give them choice and not allow the carriers to have some balance. I am simply saying that because of these recent events the playing field has titled and it needs to be righted again.

So this amendment which amends RSA 420-J, which is the insurance section of the law which applies to HMO's. It has in it a section, Section VI-a. It says nothing in this section shall be construed to require a health carrier to select a health care professional as a participating provider solely because the healthcare professional meets the health care's credentialing and verifications standards, or to prevent a health carrier from utilizing separate or additional criteria. In short, just because someone wants to go along with the provisions of the health care carrier's contract. The health care carrier doesn't have to accept that position or facility into its network.

This says is, but, and that's the dark print, if the provider is willing to meet the terms and conditions that are part of the contract then the healthcare carrier has to pay this. Then you come to the print.pay them what... In the case of physicians it provides that it would pay them 100% of the fee schedule that it applicable for that procedure to physicians. In this case to the nearest physicians who are doing that procedure. Some physicians may actually be getting $110% or 115% that's fine, it doesn't attempt to go there, and it's just the 100%.

With respect to facilities it would apply to any facility that is comparable for a comparable rate and the fee schedule shall be whatever is provided for, for facilities within a thirty-mile radius of the facility in question. So if Lakes Region does the procedure even though they are not in the Anthem network and there's a comparable rate and procedure at Concord Hospital, that is the rate that would apply to Lakes Region because it is within thirty miles. If there were more than one hospital within that thirty-mile radius then the higher one would apply.

So this won't result in one statewide single rate because it would be geographic as it probably should be. It will keep Anthem from using its weight to steer patients around from using its marketing power. To threaten

patients at execrating the conflict in circumstances where there is a bargaining impasse. I think based on the changes that going on right now today particularly in healthcare in New Hampshire its time to make this adjustment.

So with that I thank you, and would be happy to answer any questions?

Senator Robert B. Flanders, D. 7: Any questions of this witness? I thank you for your testimony. Yes, you want to speak?

Leslie Ludtke: I would like to make a response to Attorney Gallagher's comments. I haven't had an opportunity to read the amendment. I don't want to address that, but I do want to address some issues that he raised relative to the contract dispute between Lakes Region and Anthem. Plus Anthem's use of the public as human shields.

The law requires that a provider be affiliated or have privileges at a network hospital. That's the requirement so that when you go see your physician and you need to go to a hospital that your physician has privileges at a network based hospital so that you can get treatment. That is the basis for the problem with the providers in the Lakes Region, given the dispute between Lakes Region and Anthem. That provision has been in a law for sometime and I think it is an essential provision of the law that consumers or patients when they do see a physician expect that the physician will have privileges at a network based hospital for treatment.

Anthem has advised the insurance department that it will make all efforts possible to insure that the providers in the lakes region area obtain privileges at another hospital. Or affiliate with a provider who has privileges because the law says if a provider is affiliated with another provider that has privileges at a network based hospital that that provider can be in the network.

I think the characterization of Anthem's strategy as using provider's as human shields is not an accurate characterization and I don't want to get into any more details concerning negotiations, but I do want the committee to understand that this is a provision that is in the law and that Anthem at this point is making every conceivable effort that it can to address the problem, and actually characterize the problem as in its view, not a substantial issue because it felt confident that it would be able to make arrangements with the providers in the area to either admitted at a another network based hospital or affiliate with a provider who was.

Any questions I would be happy to answer them.

Senator Robert B. Flanders, D. 7: If not, thank you for your testimony. I see no one else wishing to testify on House Bill 470, I will close the hearing.

The hearing on House Bill 470 closed at 9:50 AM.

Respectfully submitted,

Livia Acdan

Livia Acdan
Senate Secretary

Attachment "A"

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AMENDMENT TO HB 470

Amend the bill by replacing all after section 1 with the following.

2 Nondiscrimination Against Providers. Amend RSA 420-J:4, VI. to read as follows:

VI. *(a)* Nothing in this section shall be construed to require a health carrier to select a health care professional as a participating provider solely because the health care professional meets the health carrier's credentialing verification standards, or to prevent a health carrier from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts*[-]*; ***provided that with respect to health care services provided by a health care provider to a covered person, including services provided pursuant to the New Hampshire state Medicaid program and Medicaid partnerships, a health carrier shall not refuse to pay any claim for such services by any such health care provider who is willing to meet such applicable terms, conditions, provisions and requirements for participation, as are established by contract or otherwise, by or with such health care carrier for the provision of such health care services and are applicable and effective within a thirty mile radius of the delivery of such service at a rate for health care professionals of no less than 100 percent of such fee schedule, provided that whenever there is more than one such fee schedule in effect within such radius, the fee schedule applicable hereunder shall be whichever such schedule applies the highest fee for such health care services, and for health care facilities at a rate comparable to the rate paid for such services when provided by the nearest facility under contract for same with such health carrier.***

***

(b) The fact that a health carrier does not include in its network any hospital with which a health care professional holds privileges shall not be grounds to refuse to pay a claim pursuant to this section.

3 Effective Dates.

Section 1 of this act shall take effect January 1, 2004.

Section 2 of this act shall take effect July 1, 2003.

HB 470 Proposed Amendment

"ANY WILLING PROVIDER"

Executive Summary

Any Willing Provider (AWP) legislation in N.H. has not been well received in past years. But it is now needed because provider networks used once to hold down costs are now being used to leverage profits in a new health insurance business model pursued by nationwide carriers bent on financial recovery from losses incurred during the earlier era of cost containment. A more level playing field provided by AWP legislation will adjust the balance at the bargaining table between providers and carriers and discourage abuse of the network concept.

Thus, in New Hampshire:

1. Anthem has acquired the huge (state-supported) market of the old BC/BS. If competition can be deterred from entering N.H., the program works even better (i.e., opposition to SB 110).

2. Using it to pursue a different mission, it is operating in a new "Broker" paradigm that maximizes return to the carrier rather than cost containment. This business model uses the network that was created to hold down costs to the public in order to increase profits to the carrier.

3. Nationwide, state and federal governments are dealing with deficits by cutting back on reimbursements to providers – expecting, no doubt, that the providers will "pass on " the costs of these cutbacks by raising rates charged to others. The new "Broker" carriers will not willingly play this game because it cuts into the widened spreads they are creating to increase earnings per share.

4. As these developments were unfolding nationwide, LRGH/Franklin Hospitals happened to reach the end of their financial rope, and requested from Anthem reimbursement parity with other hospital providers.

5. Playing "hardball," Anthem has responded harshly. By dragging into the dispute the physician providers and their patients, cutting off payments to them unless they are staff at a network hospital now under contract Anthem has introduced new and disruptive tactics (see attached Foster's article). This unusual and unwarranted escalation has not only harmed the public, it has shown how hard Anthem and others with network leverage will play to protect their new profits. They will do whatever it takes to avoid pass-through of the new government "cuts."

In former years when carrier-managed care provider networks were used to hold down costs, AWP legislation was not advisable. With the new "Broker" paradigm where the network clout is used to widen the gap between patient demand (the buy side) and provider supply (the sell side) in order to build profit (commission), the carrier's network is used to benefit the carrier's bottom line rather than to obtain cost savings for the public. The power of the network is thus, likely to be abused. By weakening the leverage of the network in this new environment, AWP legislation can work to provide more arms-length negotiation between providers and carriers. In this period of increasing governmental underpayment of Medicaid and Medicare reimbursement, pressures on all will increase. A more level bargaining table is now clearly in the public's best interest.

Issues

AWP legislation provides that if a professional or an institutional health care provider is willing to meet the terms and conditions of an insurance carrier's area contract with networked providers, the carrier must pay the provider an equivalent amount for the services, even though that provider is not in the carrier's provider network. In past years, AWP legislation has had little success in New Hampshire. Here's why.

At a time when the strength of the carrier network was needed to force providers to hold down or swallow costs rather than passing them on, it is easy to see why AWP legislation was deemed inconsistent with the policy behind managed care cost containment. But because of public indignation over their own loss of choice, the insurance industry has backed away from aggressive cost management, stating that it will concentrate on what it does best; evaluating and risk then spreading its impact through premiums paid by underwriting their covered lives. But while sounding their "retreat" from aggressive costs management and announcing their return to the traditional insurance business model many large carriers have in fact "advanced" in another direction. They have embraced a new business paradigm, referred to by many as the "Broker" model.

The "Broker" business model is based upon pulling commission (read profit) from the spread between what is paid on behalf of patients for services and what is collected from them in premiums. Steering access by patients through provider networks, the carrier controls the patient's "buy side" of the health transaction. The provider's "sell side" is then held low by low reimbursement contracts with providers negotiated by using the bargaining clout of the network. The game is to keep widening the "spread" between the buy and sell sides. In the case of health care, this game is easily "won" by controlling both sides of the transaction. Expanding the spread builds the "commission," i.e., increasing financial return to the for-profit carrier. These returns have increased along with share prices and executive salaries.

In this new paradigm, once a desirable "price" is nailed down by the contract (sell side), control over the "buy side" is then maintained with the clout of the networks, which both control and limit access by channeling patients to agreeable providers. The larger and more comprehensive the network, the better. By controlling both the buy and sell sides and widening the "spread," United Health Care, PacifiCare and Anthem , et al., have been able to increase profits, raise share price and pump up executive compensation. (See announcements of this past week, attached.) The policy problem is that these diverted funds now pushed into the expanded spread to build profit might be better spent

on nursing or research, etc., or by offsetting the unreimbursed costs of hospital operations such as ERs and primary care physicians.

Providers (reeling from losses incurred when they swallowed "capitation" by absorbing the "risk" that the carriers transferred in contracts negotiated in the old managed care era) were once only too happy to sign unfavorable new contracts. Even if their reimbursement was not profitable, at least it assured volumes needed to survive and carry out their mission at a time when financial operations were strained. But now with more government cut-backs, increased operational expenses and continuing poor returns on endowment, these contracts terms must be renegotiated. AWP sets a legislative context within which such negotiations can be productive for both sides, and thus for the public.

New Hampshire

The old BC/BS system was a pure "insurance-type" operation. It paid for claims and their administration, while leaving a small operating margin for the carrier's own administrative costs. Because of its nonprofit and provider servicing mission, it was supported statewide and developed a broad market. Anthem "bought" this broad-based constituency, set up a trust, and publicly announced a changed mission. The mission is now very much for-profit. It is doing very well, (See attached press clipping) a conclusion easily confirmed at Anthem's [ATH] own website.

But Anthem's aggressive negotiating attitude confirms that it is utilizing the new Broker paradigm to the fullest, leveraging its broad network to aggregate, channel, and control "demand" while leaning hard on the "supply" of providers to hold their prices low. Working under current regulation with the Department of Insurance it keeps the public pressure on our hospitals, and physician providers. Its opposition to SB 110 has demonstrated its tenacity in protecting its turf from the return of competition. Its negotiating clout, backed by the broad network of the old BC/BS, is now used to leverage their profits up rather than the public's costs down.

Recent Government Deficits

At present, both providers and this new "broker" paradigm are threatened by accelerating underpayment of Medicare and Medicaid by state and federal governments, a trend that appears to have no end in sight. Broker payors, focused on the compressed operating margins of the hospitals, are dismayed to see government playing the same game. State and federal governments have upset their apple cart by lowering their payments to providers through unilateral reductions, and through reductions in Medicare and Medicaid reimbursements. These reductions to providers attack the payors' new model in two ways. They channel whatever is left of provider margins away from the payors to the government, and they force the providers to push back on the payors either by cost shifting or by refusing to accept any longer the payors' deeply discounted reimbursement contracts. Indeed, providers may need even greater reimbursement to make up for the losses inflicted by the government and our economy. Tough negotiations are thus in the offing. AWP legislation is designed to properly balance the negotiating table between the payors and the providers in order to protect the public and to provide a context for employers and others to hold down costs while increasing quality.

Anthem's negotiating behavior can be expected now from other "broker"-insurers. Indeed, from this point forward, it is a predictable consequence whenever the government reduces payments for entitlements below the cost of providing them and providers try to share the resulting financial pain. N.H. hospital providers, already reeling from their own financial difficulties, are caught between the government and these new "broker"-payors. What is happening at LRGH/Franklin demonstrates that Anthem will do whatever it takes to maintain its profitable spread – even to the point of escalating the impasse to include physicians and their patients.

Because we are now contending with "broker"-insurers and the prospect of continuing government cutbacks, coupled with the demonstrated aggressiveness by our own state's largest health insurance carrier it is not only time to enact AWP legislation, it is necessary to do so, so that as other contracts are renegotiated, what is happening to the

public in the Lakes Region and Franklin will not so easily repeat itself throughout the state.

The notion that AWP legislation may not have made sense five years ago in a different managed care paradigm has no bearing on the need today for AWP legislation. This is a classic situation in which the legislatively designed "rules of the game" must be altered in order to deal with this new "broker" insurance model and the stress caused by "broker"-payors as they contest with government over the shrinking margins of financially stressed hospital providers. AWP legislation can not cure all of these problems, but by weakening capacity to misuse the power of "network," which once was needed and now has become available for abusive bargaining practices, it will lower the "broker"-insurer's unfair advantage within the system, while still allowing the system to operate. Hard bargaining is in the public's interest. It should be encouraged by laws designed to help it work in the public's interest. AWP legislation will help level the playing field between providers and payors. More important, it will help prevent future upsetting and unfair manipulation of the public as our nation's continuing health care crisis plays itself out in N.H.

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New Hampshire's Online News Leader
From the La

Sunday, April 20, 2003

E-mail This Article

Patient's coverage at risk in hospital, insurer squabble

By RAY CARBONE

Lakes Region Bureau Editor

Doctors and medical officials are concerned about a tactic the state's largest insurance company has taken in its dispute with LRGHealthcare, a maneuver they say uses doctors as bargaining chips in a high stakes negotiating process and leaves patients uninsured with their primary physician.

If the dispute is not resolved, come Sept. 1, as many as 10,000 people in central New Hampshire would not be reimbursed by Anthem Blue Cross Blue Shield when they see their local doctor, both at the hospital and the doctor's office.

On April 1, Anthem announced that negotiations over a new contract with LRGHealthcare — which operates Lakes Region General Hospital in Laconia and Franklin Regional Hospital — had broken down over the amount of reimbursement for services.

The local medical community was caught off guard when Anthem subsequently announced that it was canceling a second contract, which covers as many as 88 local doctors who use the two hospitals. That means that someone with Anthem insurance will not be covered when they visit those doctors — even if the visit is in the doctor's office.

Neither would they be covered for expenses incurred at the two hospitals.

The doctors affected include those employed directly by the hospitals and those who are not employed by the hospitals but provide services within those health facilities.

Anthem, which took over the not-for-profit Blue Cross Blue Shield in 1999, is the largest insurance company in the state with somewhere between 555,000 and 660,000 subscribers. In addition, Anthem took over the contract that insures state employees for the first time this year.

Anthem is a for-profit corporation based in Indianapolis, Ind.

The insurer says it had no choice but to cancel the Lakes Region doctors' contract, effective Aug. 31, because the physicians will not be associated with a hospital that is part of its network.

According to Karen rown, director of corporate communications for the

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According to Karen Brown, director of corporate communications for the company, since primary care physicians oversee all aspects of their patients' care — including care that takes place in a hospital setting — they need to be associated with hospitals that are in the Anthem network. Without an agreement at LRGH and FRH, the local doctors are in violation of their contract, she said.

But Christopher Boothby, director of development and community affairs for LRGHealthcare, says there is nothing in state law or insurance regulations that requires Anthem to terminate its agreement with doctors who use the local facilities, even if they're not part of its network.

"This is a decision that has been made by Anthem," Boothby said. "And it's caused tremendous unrest in our community.

"I have received on average 15 or 16 calls a day since this story broke, and I have not received one of which the person who called was not concerned about losing their primary care physician," he added. "That's the number one impasse in our community."

Around the region and around the country, others share Boothby's concern.

Dr. Bill Monnig of Kentucky, who is chairman of the organized medical staff section of the American Medical Association, says patients should not be penalized because their doctors work at a certain hospital.

Monnig says there's no reason to tie an insurance company's reimbursement relationship with a hospital to charges incurred by doctors who use that hospital.

"I think it's an inappropriate move on the part of the insurance carrier," he said.

Monnig said he's heard of other large insurance companies using a similar tactic in disputes with hospitals.

"I think they use it as a levering point, so that the doctors start complaining to the hospitals that they have to find better arrangements to contract with them (Anthem)," he said.

"And doctors are not allowed to join together to lobby (the company directly) because that would be considered unfair restraint of trade."

Rick Wade, senior vice president for the American Hospital Association, said he's never heard of an insurance company moving against a hospital's doctors before.

"I've heard it be threatened, but I don't think I've ever seen it taken before," he said.

Larry Akey, a spokesman for the Health Insurance Association of America, said the tactic was also new to him, although it's not entirely shocking given the current relationship between hospitals and insurance companies.

"As a result of changes in managed health care and the consolidation of hospitals, negotiations between HMO-style health plans and hospitals have gotten very hardball in the last 18 months," Akey said. "I've not heard of this tactic before, but it doesn't surprise me. It's one more point of leverage" for the insurance company.

Dawn Touzin was the lead counsel for the Citizens Alliance of New Hampshire

when the consumer advocate group was involved in the process of evaluating Anthem when the Indiana-based company was buying Blue Cross Blue Shield of New Hampshire. She was in Washington recently for Federal Trade Commission hearings into medical insurance problems where she heard about many disputes between companies and health care providers.

But there were none where an insurance carrier refused to sign a contract with doctors, she said.

"It does seem retaliatory," said Touzin, who now works with Community Catalyst, a Boston-based group consumer health care advocacy group.

Touzin agreed that the maneuver seems to be trying to exert pressure on the hospital from the local doctors.

"It's interesting to see this particular effort at getting the docs personally involved," Touzin said. "It's a new and very powerful approach, if it works," she added.

Brown says that requiring doctors to use network hospitals is standard in the HMO industry.

"When LRGHealthcare terminated its contract, it triggered a clause in the contract that it had signed on behalf of its own doctors, and a clause in the contract signed with (other) physicians that said you must have admitting privileges to a network hospital," she said. "It's a contractual clause, it's a contractual issue."

But Monnig doesn't buy the insurance company's rationale. Anthem argues that by choosing which hospitals — and doctors — are in its network, it ensures a certain level of medical care to its policyholders, he said.

"But most of the care that doctors render isn't in the hospital, it's in the office," Monnig said. "So it's really depriving their policyholders of their ability to keep their primary-care doctors.

Health-care providers across the region are watching the situation in the Lakes Region with great interest.

"We've been in similar difficult situations when negotiating with insurers over the past five or six years — Tuft, Blue Cross and CIGNA," said Leslie Pope, vice president of marketing and public affairs for Portsmouth Regional Hospital. "It's unfortunate, and I feel very badly for the hospital and the people in the community who are put in this situation."

"I think everybody is going to be looking at this very, very closely," said Ned Helms, director of the Institute for Health Care Policy and Practice at the University of New Hampshire. "Laconia has one of the most innovative sets of hospital administrators in the state... Hopefully, this thing will resolve itself."

Since LRGHealthcare sent a letter notifying Anthem of its intention to terminate their pact March 31, the sides have not been in direct communications.

However New Hampshire Insurance Commissioner Paula Rogers said her office is talking to both sides, and hopes to have them sitting down together soon.

"I'm cautiously optimistic that we can get the parties to the table," she said.

Rogers said there have been four or five similar — although somewhat less public — disputes between insurers and health-care providers in recent years and that all have been resolved.

If the situation is not resolved, the commissioner's office has the authority to take punitive action against Anthem if it judges that the company's network is too limited. Penalties could include a fine, or an order that the company alter its network so local policyholders have easier access to health-care practitioners, Rogers said.

"We've never had to do that before," she added.

Meanwhile, Monnig argues that it's not right for the company to cancel the doctor's contract as a result of a dispute with the hospitals.

"If you look at the human side of this, to disadvantage patients such that they have to drive long distances to receive care, it's just inappropriate," he said. "If they're used to getting their medical care in that community, they ought to be able to do it.

"These tactics, if not illegal, are certainly unfair," he concluded.

Ray Carbone can be reached at 524-3800, ext. 5941, or by e-mail at rcarbone@citizen.com

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CNBC

REUTERS

UPDATE 1-Anthem boosts outlook on lower medical costs

April 17, 2003 4:39:00 PM ET

(Recasts first sentence, adds analyst comments, closing share prices)

By Kim Dixon

CHICAGO, April 17 (Reuters) - Anthem Inc. (ATH) on Thursday became the second U.S. health insurer this week to raise its earnings forecast, fueling hopes on Wall Street that HMOs are getting a firm grip on runaway medical costs.

The move followed PacifiCare Health Systems Inc.'s (PHSY) doubling of first-quarter profit projections late Wednesday, sending its shares up 27 percent on Thursday.

Anthem, PacifiCare, and UnitedHealth Group Inc. (UNH) all said this week they set aside more cash than needed to pay for doctors, prescription drugs and hospital stays. As medical costs climb at break-neck pace, analysts are seeking hints of a peak.

"It's really good news for the system if there is a leveling off, and also for the profitability of insurers," said Paul Ginsberg, president of the Center for Studying Health System Change in Washington.

Anthem shares rose 3.4 percent on Thursday, and shares of UnitedHealth edged up 2 percent on the New York Stock Exchange.

Anthem, the fifth-biggest publicly traded health insurer, now expects first-quarter earnings, excluding one-time gains, of $1.18 per share, compared with a prior view of $1.00 to $1.05 per share.

The Blue Cross and Blue Shield plan with 11 million members said it expects net profit of $1.36 per share, up 43 percent from a year ago.

In addition to lower-than-expected medical costs, Anthem said it was helped by gains in membership.

MIXED SIGNALS

Investors and analysts differ on when soaring health care costs will plateau.

"I'm one of these people who think we are not finished with this cost increase cycle," said Stuart Altman, economist at Brandeis University. He said any abatement will prove fleeting.

Health insurance prices soared 12.7 percent in 2002, the biggest spike in a decade. Experts see 2003 as the third straight year of double-digit jumps in costs.

Most managed health-care companies failed to predict costs accurately during the mid-1990s and suffered from falling profit margins.

"The key issue is, can they go through a period of deceleration of prices without getting into a margin squeeze?" Hewitt said.

Investors are clearly confused. On Wednesday, after health giant UnitedHealth posted a 37 percent jump in profit, the stock skidded nearly 4 percent.

Investors questioned the underlying strength of the earnings, which included a boost from excess reserves for medical claims.

At the same time, UnitedHealth Chief Executive William McGuire said overall medical costs would likely come in lower than expected this year, citing patent expiration of pricey prescription drugs like the popular allergy drug Claritin.

The Morgan Stanley Health Payor index closed up nearly 4 percent on Thursday.

ANTHEM, PACIFICARE YEAR FORECASTS UP

Anthem also revised its full-year outlook to reflect the strength in the first quarter. The full-year 2003 adjusted earnings outlook was raised to $5.00 to $5.05 per share, excluding items. The company had previously forecast adjusted earnings of $4.75 to $4.85 per share.

Analysts had expected the company to earn $1.05 cents a share for the first quarter and $4.85 per share for the year, according to research firm Thomson First Call.

PacifiCare, a Cypress, California-based HMO, on Wednesday said it expects to earn $1.90 a share in the quarter, compared with its prior guidance of 85 cents to 95 cents a share. The company sharply raised its 2003 outlook to $6.00 to $6.10 per share, from a range of $4.25 to $4.35. PacifiCare shares jumped $6.10 or nearly 27 percent to $29.11 on the Nasdaq. REUTERS

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Speakers

SENATE INSURANCE COMMITTEE

Date 04/15/03 Time 9:10 AM Public Hearing on **Bill # HB 470**

relative to health insurance providers.

Please check box(es) that apply.

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING
☑	☑	☐	Representative G. Michael Gilman	Prime Sponsor
☑	☑	☐	Chris Gallagher	CRG Gale (Mason
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Testimony

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AMENDMENT TO HB 470

Amend the bill by replacing all after section 1 with the following.

2 Nondiscrimination Against Providers. Amend RSA 420-J:4, VI. to read as follows:

VI. *(a)* Nothing in this section shall be construed to require a health carrier to select a health care professional as a participating provider solely because the health care professional meets the health carrier's credentialing verification standards, or to prevent a health carrier from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts*[.]*; ***provided that with respect to health care services provided by a health care provider to a covered person, including services provided pursuant to the New Hampshire state Medicaid program and Medicaid partnerships, a health carrier shall not refuse to pay any claim for such services by any such health care provider who is willing to meet such applicable terms, conditions, provisions and requirements for participation, as are established by contract or otherwise, by or with such health care carrier for the provision of such health care services and are applicable and effective within a thirty mile radius of the delivery of such service at a rate for health care professionals of no less than 100 percent of such fee schedule, provided that whenever there is more than one such fee schedule in effect within such radius, the fee schedule applicable hereunder shall be whichever such schedule applies the highest fee for such health care services, and for health care facilities at a rate comparable to the rate paid for such services when provided by the nearest facility under contract for same with such health carrier.***

***

(b) The fact that a health carrier does not include in its network any hospital with which a health care professional holds privileges shall not be grounds to refuse to pay a claim pursuant to this section.

3 Effective Dates.

Section 1 of this act shall take effect January 1, 2004.

Section 2 of this act shall take effect July 1, 2003.

State of New Hampshire

HOUSE OF REPRESENTATIVES

CONCORD

MEMORANDUM

DATE: **October 30, 2003**

TO: **Honorable Craig Benson, Governor**
Honorable Gene G. Chandler, Speaker of the House
Honorable Thomas R. Eaton, President of the Senate
Honorable Karen O. Wadsworth, House Clerk
Honorable Steven J. Winter, Senate Clerk
Michael York, State Librarian

FROM: **Rep. Paul D. Spiess, Chairman**
9 Roberts Road, Amherst NH 03031-2608
(603) 673-6770

SUBJECT: **Final Report on HB 470, relative to the contracting process between managed care insurers and health care providers**

Pursuant to Chapter 284:4, Laws of 2003, enclosed please find the Final Report of the committee charged with studying the contracting process between managed care insurers and health care providers.

If you have any questions or comments regarding this report, please do not hesitate to contact me.

PDS:co

cc: Study Committee Members
Pam Smarling, Committee Researcher

FINAL REPORT

RE: HB 470 (Chapter 284:4, Laws of 2003) relative to the contracting process between managed care insurers and health care providers

This committee was established as a result of passage of HB 470 relative to health insurance providers. Among other provisions, the bill created a committee to "study the contracting process between managed care insurers and health care providers in the state".

The committee was organized to be composed of three members from the House of Representatives and three members of the Senate. Selected to represent the House were:

Rep. Stephen DeStefano
Rep. George Liebl
Rep. Paul Spiess.

Representatives of the Senate were:

Sen. Iris Estabrook
Sen. Robert Flanders
Sen. Andre Martel.

The committee held an organizational meeting on Wednesday, October 1, 2003. At that time, Rep. Spiess was selected to chair the committee. The members discussed various ways to proceed with the task, and decided upon three primary areas of interest to be examined: cost shifting from Medicaid/Medicare insurers to private pay insurance plans; the concept of "any willing provider; and the contracting process between managed care insurers and health care providers. It was determined that a separate meeting for each topic was appropriate.

Cost Shifting:

A meeting was held on Thursday, October 9, 2003 to examine the impact and consequences of the concept of shifting costs between governmental insurance programs (i.e., Medicaid and Medicare) and private insurance programs. Of significant help to the committee was a report prepared by the New Hampshire Center for Public Policy entitled *"Cost-Shifting in New Hampshire Hospitals"*, presented by Douglas Hall (see *Attachment "A"*). This issue is deemed relevant by the committee because the impact of cost shifting between government and private pay plans is causing financial stress and economic tension between insurers and providers. The Center's report provides an in-depth look at the

concept of cost shifting and measures the impact upon private plan insurers and hospital providers.

Subsequent testimony indicated that cost shifting has a greater or lesser impact upon hospitals based upon their size, the mix of their patients, source of insurance payments, and their geographic location. It was evident from a chart presented by the New Hampshire Hospital Association and supported by testimony that smaller hospitals, located in rural and semi-rural areas which serve an older or more indigent customer base, are most severely impacted by cost shifting.

The committee also received three articles from the publication, *"Health Affairs"*, which provided further insight into the causes and effects of the problem.

Any Willing Provider:

The committee held a hearing on Wednesday, October 15, 2003, to hear testimony concerning the concept of "any willing provider". One of the driving forces behind the concept of managed care plans was the desire to drive down the cost of health care through negotiated agreements between insurers and providers. Insurers wanted to be able to choose which providers would be in the plan and to negotiate reimbursement agreements based upon a number of factors. One of the practical results of this process is that not all providers are accepted into the various plans. This can result in patients being required to change providers (i.e., physicians) or receive services at less accessible locations. The plans also tend to consolidate services to a select group of providers, weakening the economic viability of providers outside the plan.

The committee heard testimony from representatives of the insurers that opening the plans to any providers willing to accept the terms and conditions of the plan could increase administrative costs up to 15%. It would also weaken the value of the negotiated contract to providers within the plan. Providers excluded from the plans felt the practice was discriminatory, and could possibly be an anti-trust violation by artificially restricting the supply of providers.

The committee recognized that the health insurance market is highly consolidated in New Hampshire, with CIGNA and Anthem representing 80% of the premiums received. It was felt that a further examination of the monopoly/anti-trust issues might be necessary to assure a competitive provider market. The following materials were provided to the committee:

- The Managed Care Handbook (pp. 1334-1335)
- The Challenge of Managed Care Regulation
- Kentucky's "Any Willing Provider" Law and ERISA
- Council of State Governments: Any Willing Provider Laws: Managed Care or Restraint of Choice?

Contracting Process:

The committee held a hearing on Thursday, October 23, 2003 to hear testimony relative to the process that insurers and providers utilize to negotiate service contracts. The committee heard a description of the contracting process from the perspective of the insurers (see written testimony of Doug Wenners, in file) and from the perspective of hospitals (see written testimony of Christopher Gallagher and Walter Maroney, in file).

The recent contract negotiation between Anthem and Lakes Region Hospital was used as an example of how the process can reach impasse. The committee was particularly concerned about the impact upon consumers if insurers and providers cannot reach agreement. The Insurance Department gave testimony concerning its "unofficial" capacity to mediate disputes. At present, there is no statutory role for the State in the contracting process.

The committee believes that it may be in the public interest to give the State a statutory capacity to act as a mediator if an impasse occurs.

There was considerable discussion about whether there is equal bargaining power between insurers and hospitals. The committee recognizes that insurance premiums/policies are highly concentrated (80%) within two insurance companies – Anthem and CIGNA. This creates a defecto "duopoly" which makes it difficult for providers to obtain competitive proposals. Conversely, hospitals often tend to virtually monopolize local geographic areas which gives them considerable bargaining power when insurers must provide adequate access to services. It is also recognized that larger, full-service hospitals located in densely populated areas possess more resources and bargaining leverage than smaller/rural hospitals. The committee raised the question of whether small hospitals' bargaining positions would be enhanced if they were allowed to bargain collectively.

Time did not permit the committee to hear all the relevant testimony. The subject was carried over to the next meeting.

Conclusion, Summary and Recommendation:

The committee held its final meeting on Tuesday, October 28, 2003. At that time, testimony resumed on the contracting process.

Upon completion of the testimony and discussion, the committee felt that significant progress had been made in understanding the contracting process

and the many forces and issues that affect the parties to the process. It was agreed that future legislation may be necessary to:

1. Correct economic imbalances in the payment system.

2. Assure that monopolistic practices do not emerge to distort the contracting process.

3. Assure access to necessary information to monitor predatory practices.

4. Provide for a statutory role for the State in the negotiating process.

The committee felt that more time and work was needed before bringing forward recommendations for specific action. A motion was made by Sen. Flanders and seconded by Sen. Estabrook to request a continuation of the study committee through November 1, 2004. The motion was approved on a 5-0 vote.

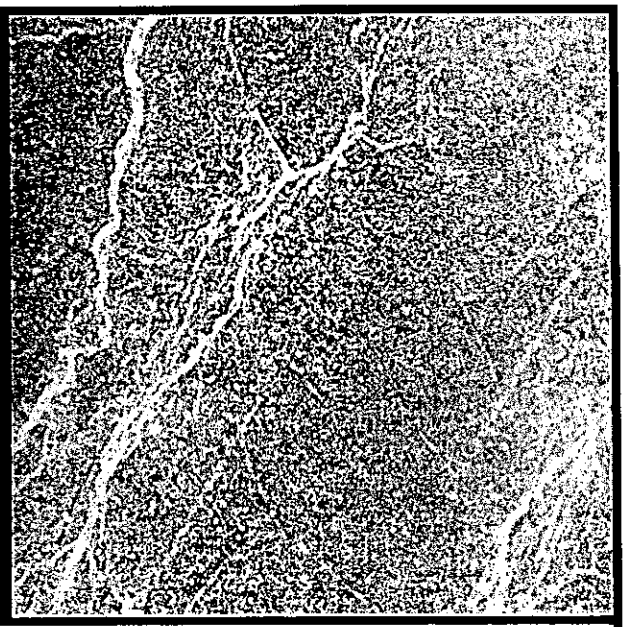
The committee authorized Rep. Spiess to compose a report and request an appropriate extension.

Respectfully submitted,

Rep. Paul D. Spiess, Chairman
On Behalf of the Committee

PDS:co

Attachment: *Attachment "A"*, Copy of "Cost-Shifting in New Hampshire Hospitals"



New Hampshire Center for
PUBLIC POLICY Studies

www.nhpolicy.org

Cost-Shifting in New Hampshire Hospitals

Author
Douglas E. Hall
Co-Executive Director

October 2003

Executive Summary

New Hampshire's hospitals generally lose money every time they care for an elderly person whose charges are paid by Medicare. The same is true for low-income patients whose charges are paid by Medicaid. Those public programs don't reimburse hospitals enough for the hospitals to cover their costs, let alone generate enough income to invest in new equipment or other services. Those hospitals with disproportionately high percentages of elderly or poor patients are generally in worse financial condition than those that treat more patients with conventional health insurance. That's because those patients—and the companies that employ them and provide their insurance—are making up much of the revenue the hospitals need to stay in business.

The Center estimates that in 2001—the last year for which all data are available—New Hampshire's employers and individuals with private health insurance paid what amounts to a hidden tax of 17 percent on that portion of their insurance bills that pays for hospital care. That tax helps hospitals offset underpayments elsewhere. Private payers—including health insurance carriers, self-insured businesses, and individuals—paid $197 million to hospitals in excess of what might be considered the real cost of their services.

The total amount of "cost-shifting" in 2001 was even larger, however. Hospitals themselves "contributed" some $39 million in reduced operating margins. In total, the Center estimates, New Hampshire's 26 hospitals shifted $237 million in costs from Medicare, Medicaid, and patients unable to pay.

The extent of cost-shifting has not been apparent to employers, insurance providers, patients, voters and the elected and appointed people who set Medicare and Medicaid reimbursement rates. The lack of easily available public information about hospital charges and payments has weakened the cost signals that could help foster more market competition in health care. More clarity would also help the legislature and Congress make more rational decisions about health care policy and finance. The Center calls on hospitals and insurance carriers to make relevant data public.

1. Introduction: The Business of Hospitals

New Hampshire has 26 acute-care hospitals, two of which are for-profit enterprises. The financial well-being of all of these institutions is important to the communities they serve and to the state as a whole. Whether it is a non-profit organization or is part of a profit-making corporation, each hospital attempts to balance its revenue and its expenditures and still leave a positive net margin. The hospitals' annual reports typically announce how successful their boards and managers have been in this business enterprise.

Those financial reports show operating costs and revenues, and the amount of "charity care" and bad debt absorbed by the hospital. But the reports do not reveal much about the kind of costs each hospital confronts nor about how much it charges various types of patients to cover those costs and generate an operating margin. This paper does that for the first time in New Hampshire. The paper defines "cost-shifting" in hospitals and quantifies its magnitude across

the 26 hospitals combined and in four particular hospitals. Using a series of graphs, the paper displays how cost-shifting is affecting these hospitals and, in turn, the state's health care system.

Understanding cost-shifting will help voters, health-care consumers, and policy makers understand the impact of their decisions. The paper shows, for example, that federally set Medicare reimbursement rates are too low, in New Hampshire at least, and are thus raising costs to those employers providing health insurance to their workforce. Raising reimbursement rates—and the payroll taxes that fund Medicare—would spread those costs among a much broader workforce. This paper raises policy choices that it cannot yet answer; it is an introduction to the topic, not the last word.

2. Cost-Shifting Defined

Cost-shifting is in part a function of a hospital's "patient mix" and "funding mix."

Most hospital care is paid for by commercial health insurance, by the federal Medicare program for seniors, the state Medicaid program for low-income and disabled individuals, and directly by patients who have received care. Hospitals also provide charity care for which they receive no payment. A hospital may be paid very different amounts for the same service by different payers. When the payment received is inadequate to cover the actual costs, hospitals must find the financial support for services from some other source or they will soon become financially impaired. A common term for this is "cost-shifting." One definition of cost-shifting is, "the allocation of unpaid costs of care delivered to one patient population through above-cost revenue collected from other patient populations."[1] Other terms that are used to describe the same facts are "price shifting," "margin shifting," "price discrimination," and "reimbursement shifting." This cost-shifting in health care is often described qualitatively, but rarely quantified.[2]

Hospital "patient mix" refers to the relative proportion of patients whose medical care is paid for by different payer types. Some are Medicare patients, some are self-pay, some have their services paid for by third-party insurers, some by Medicaid. The patient mix differs by type of service. Figures 1 and 2 display the mix of patient types served in aggregate by New Hampshire's 26 acute care hospitals in 2001.[3]

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

[2] Participants at the meeting noted in footnote 1 included foundation managers, consulting firms, health finance experts from academia, health care policy analysts, and government officials. None was able to cite any quantitative studies of cost-shifting.

[3] Patients counts are for the calendar year 2001. Source: Foundation for Healthy Communities, derived from Uniform Hospital Discharge Data Set.

Figure 1

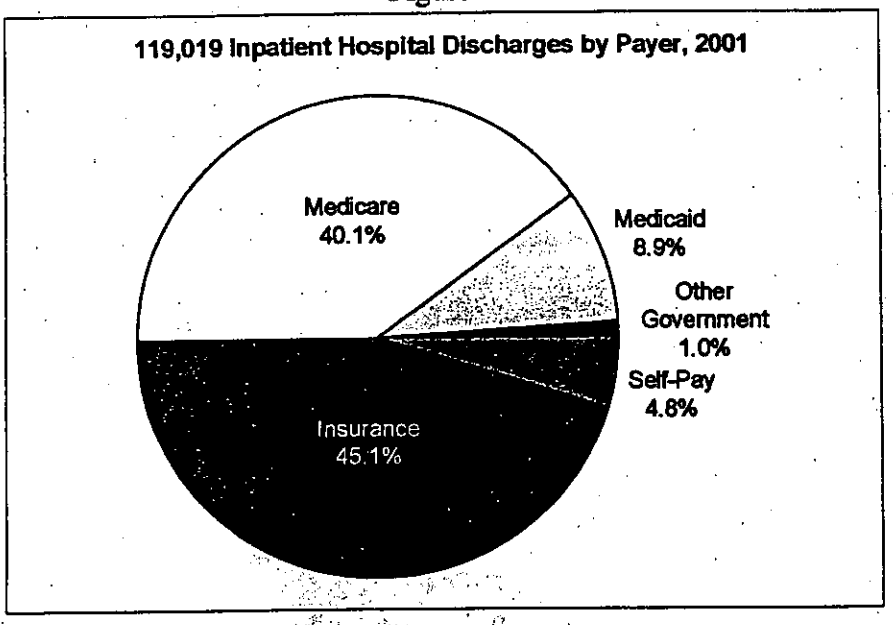
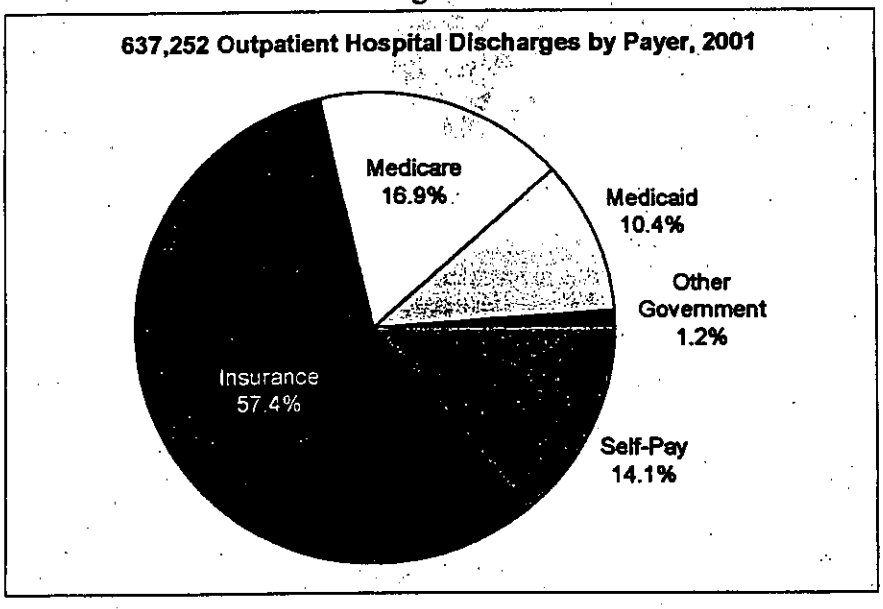


Figure 2

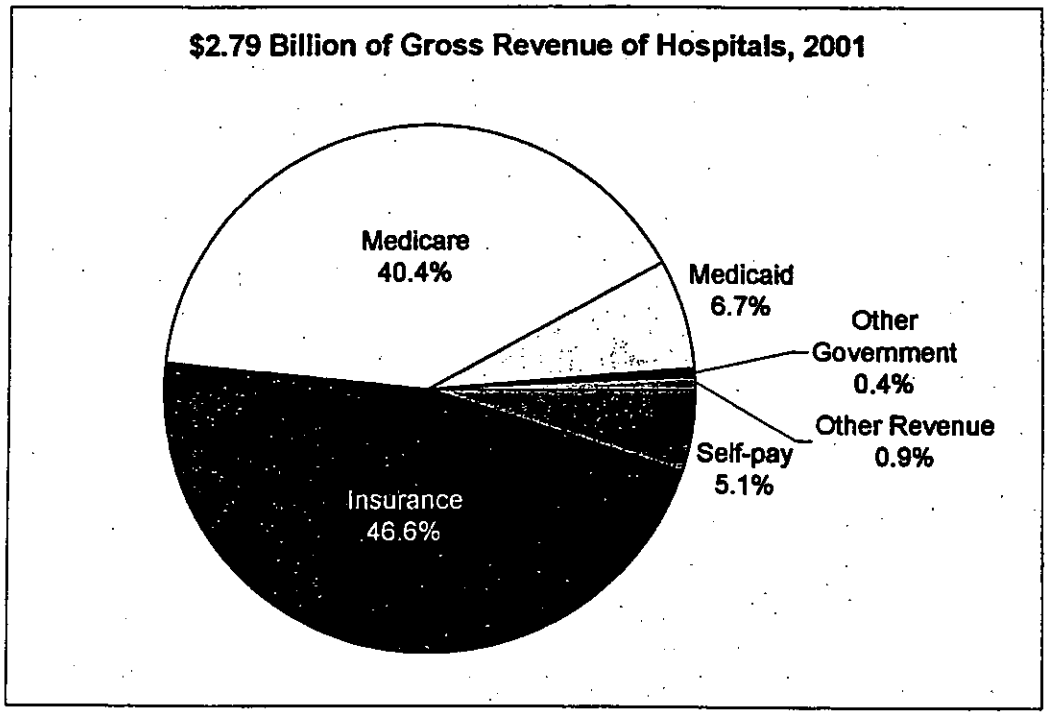


Almost exactly 50 percent of the 119,019 patients who received inpatient services had their services paid for by government programs. Among patients who received outpatient care (not admitted for overnight stay), however, only 28 percent had their services paid for by government programs.

Medicare was the responsible payer for 40 percent of the inpatient discharges but only 17 percent of the ambulatory discharges. Patients who were responsible to pay for the hospital's services out of their own pocket were slightly less than 5 percent of inpatients, but nearly triple that percentage among outpatients.

Based on rates they establish internally, hospitals bill for each service they provide. In 2001 the 26 acute care hospitals billed a total of $2,789,731,668 for the services they provided.[4] Figure 3 displays the percentage of those charges that were attributable to different payer types.

Figure 3



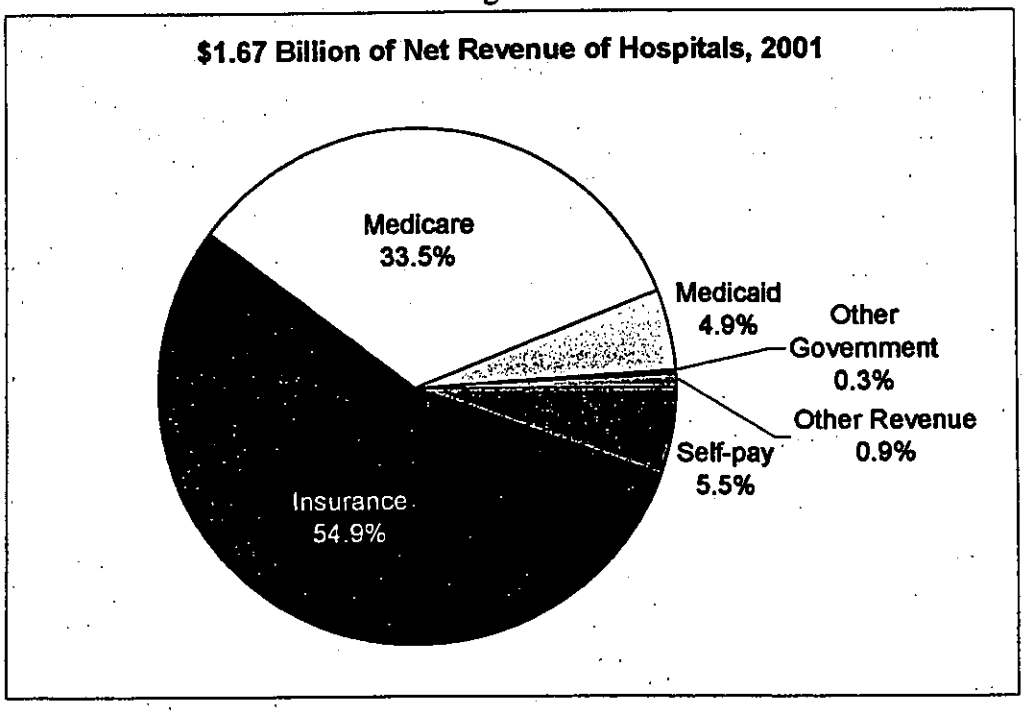
Patients whose bills were paid by private insurance companies accounted for about 47 percent of all charges. Medicare patients accounted for about 40 percent. The pie chart shows that there is nearly an even split between billings to government programs (Medicare, Medicaid, and other government) and to private sector payers (insurance and self-pay). When one considers that some of the patients whose charges are billed to their insurance are public sector employees (teachers, state and local government employees), it is clear that more than half of the gross charges are ultimately public responsibility.

Gross charges, however, considerably exceed the amount hospitals actually receive as revenue. Commercial insurers have negotiated discounts to the standard billed rates; Medicare and Medicaid establish their own payment scales; some individuals do not pay their bill in full, seeking charity care or defaulting on payment.

The revenue actually received for patient care in 2001 was $1,669,813,570. This was only 60 percent of the gross charges. Figure 4 displays the percentage of realized revenue from different payers.

[4] Revenue data from American Hospital Association survey spreadsheet tables prepared by the NH Hospital Association. This is an aggregate of reported 2001 fiscal year data; all hospitals do not use the same fiscal year.

Figure 4



Public programs only paid 39 percent of the revenue the hospitals actually received although they constituted about 47 percent of the gross charges. Insurance companies, however, paid 55 percent of the revenue while their patients represented only 47 percent of the gross charges.

3. Charges Are Not Costs

As noted above, gross charges for all patient services in the 26 hospitals in 2001 were $2,789,731,668. Actual operating expenses for 2001 were $1,723,705,402. If all gross charges had been paid in full, the hospitals in aggregate would have had a markup ratio of 62 percent and net operating income of over $1 billion.

The hospitals did not intend or expect to generate such a huge net income. Gross charges had been set high so that "discounts" could be negotiated with major payers and still result in a modest income.

In considering the issue of hospital cost-shifting, it is important not to assume that anyone underpaying gross charges is failing to pay a "fair share" of costs. Charges are not costs.

4. Marginal Costs and Average Costs

The marginal cost of providing a single additional service in a hospital may be small. At the unit of service level, nearly all costs, including staffing, equipment, maintenance, contracted services, and debt service would have to be considered fixed costs. Certain supplies and medications might be the only marginal costs actually incurred in treating one additional injury in an emergency room, for example.

While some economists have argued theoretically that cost-shifting occurs only when payment for services is below marginal costs, this is not a practical way of viewing hospital finance (or other health system finance). If all payers were expected to pay only for their marginal costs, that would leave no source of revenue to pay the hospitals' fixed costs.

We take the position that cost-shifting occurs whenever certain payers pay less than average cost while others pay more than average cost for any service.

5. The Cost-Plus Basis

If hospital charges were set so that gross revenue exactly equaled expenses, hospitals would not be able to generate a net income and increase their fund balances. Under such conditions, the state's two for-profit hospitals would not generate any profit. Even the 24 non-profit hospitals need to generate a small positive income in order to provide funds for investment in new equipment or hold as reserves against the possibility of unexpected losses in subsequent years. A net operating margin of 62 percent is implausibly high and a net operating margin of 0 percent is too low.

The aggregate net revenue of all hospitals in 2001 was $70,872,799 on net operating revenue of $1,723,705,402; this was an average margin of 4.1 percent. Table 1 contains the aggregate margin of the acute care hospitals for each year from 1992 to 2002.[5]

Table 1

Year	Net Operating Income	Total Operating Expenses	Operating Margin
1992	$43,410,545	$974,671,211	4.5%
1993	$29,989,583	$1,039,670,165	2.9%
1994	$63,196,739	$1,058,967,177	6.0%
1995	$56,671,474	$1,146,625,066	4.9%
1996	$52,444,145	$1,200,793,556	4.4%
1997	$70,902,929	$1,258,418,306	5.6%
1998	$42,478,391	$1,325,787,093	3.2%
1999	$41,640,425	$1,417,449,304	2.9%
2000	$46,592,048	$1,548,480,634	3.0%
2001	$70,872,799	$1,723,705,402	4.1%
2002	$84,520,774	$1,905,109,946	4.4%

We take the position that an average operating margin of 5 percent would be reasonable to ensure sufficient funds for future investment.[6]

[5] Source: spreadsheets from NH Hospital Association containing data from audited financial statements of the hospitals for these years. These data differ in small ways from the AHA data for the same time periods. The reasons for the differences are not known, but they are small and do not affect the general presentation or conclusions.

[6] A hospital's overall margin will differ from its operating margin. Hospitals may obtain revenue and have expenses unrelated to operations (e.g., interest income and capital gains and losses from investments). These other activities will result in a total margin that is greater than or less than the net operating margin.

Thus if all payers paid for actual costs plus a 5 percent margin, then hospitals would generate a 5 percent net income from patient services at the end of a year.

6. Charity Care, Self-Pay, and Bad Debt

A relatively small number of people are billed directly for their hospital care because they have no private insurance and are not eligible for a public program. Others are insured but must pay directly for certain services up to a deductible amount before their insurance will begin to pay.

Some individuals may not be able to actually pay the charges for their care.

"Charity care" is care that a hospital agrees in advance to provide for free. Based on an application by an individual for assistance, the hospital agrees not to bill for the care. For accounting reasons, because no billing is done, the charges are not included as revenue in a hospital's income statement. Gross charges for charity care that were not billed in 2001 were $45,736,960.[7]

Gross "Self-pay" charges are the billed amounts that hospitals expect patients to pay directly. These amounts are included in gross income. Some patients pay these charges in full. Others, however, never pay the full amount. Like any other business, a hospital must occasionally write-off its bad debts. For accounting purposes, the hospital records a "bad debt" expense equal in value to the billed charges that are being written off. As a result, the gross charges for the services it provided are included in both revenue and expense in the hospital's income statements.

Table 2

Payer	Gross Charges	% of Charges
Insurance	$1,298,801,314	45.8%
Medicare	$1,125,742,085	39.7%
Medicaid	$185,786,720	6.6%
Charity care	$45,736,960	1.6%
Bad debt	$96,243,326	3.4%
Self-pay received	$46,183,348	1.6%
Other government & other	$36,974,875	1.3%
Total	$2,835,468,628	100.0%

Table 2 reports the total of gross charges, including charity care. The rightmost column displays the percent of gross charges attributable to each payer type when the charity care is included. The amount that individuals should have paid directly consists of the three categories: charity care, bad debt, and self-pay received.

2001 operating expense as reported on the hospitals' income statements was $1,723,705,402. However, this amount includes $96,243,326 of bad debt write off. These write-offs must be subtracted from the stated expenses to determine the real cost of services. "Real cost" of services in 2001 was $1,627,462,076.

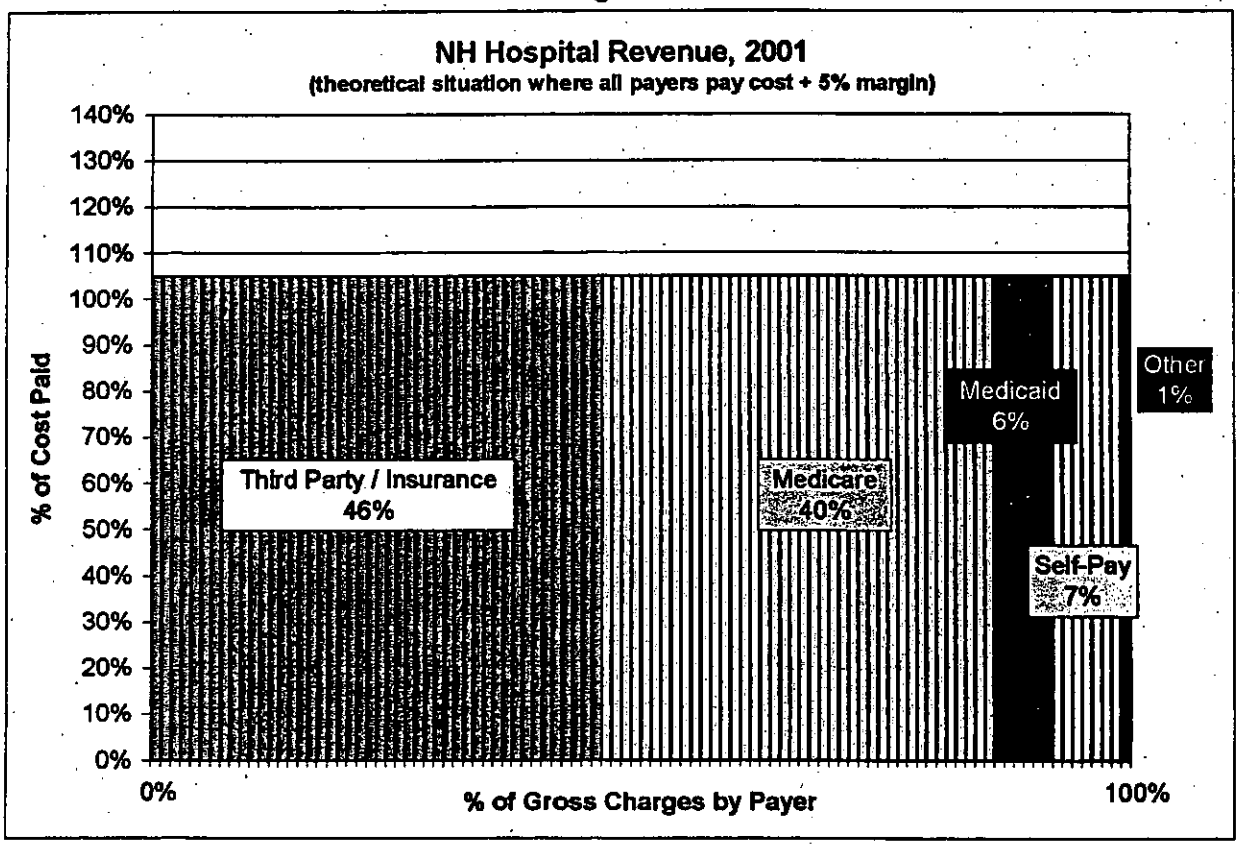
[7] This is obtained from the financial reports hospitals submitted to the NH Hospital Association.

7. The Base Case and the 'Hydraulics' Diagram

As noted above, major payers do not pay full charges, but benefit from some discount to charges. If all payers (including charity care cases now receiving care at no charge and persons responsible for the bad debt that is being written off) actually paid 105 percent of the real cost, hospitals would have an operating margin of 5 percent.

Figure 5, a "hydraulics" diagram[8], displays such a theoretical payment environment for New Hampshire's hospitals. The horizontal axis represents the percent of gross charges by payer. There are 100 narrow vertical bars on the chart. Each 1 percent of gross charges is represented by one vertical bar; for example, the left-most 46 bars represent the payments that hospitals receive from third-party insurance. The 6 percent of gross charges attributable to Medicaid patients are represented by 6 vertical bars farther to the right on the chart. This chart shows each payer paying exactly 105 percent of cost for all patients.

Figure 5



Under this scenario, the hospitals would have generated $1,708,835,180 in patient revenue in 2001 to cover their $1,627,462,076 real operating costs and also provide $81,373,104 of margin. In this situation, no cost-shifting would be occurring: each and every payer would be paying its share of costs plus margin.

[8] The design of the hydraulics diagram, as well as its name, were first brought to the author's attention by Al Dobson of The Lewin Group, in "Cost Shifting: An Integral Aspect of U.S. Health Care Finance," November 13, 2002.

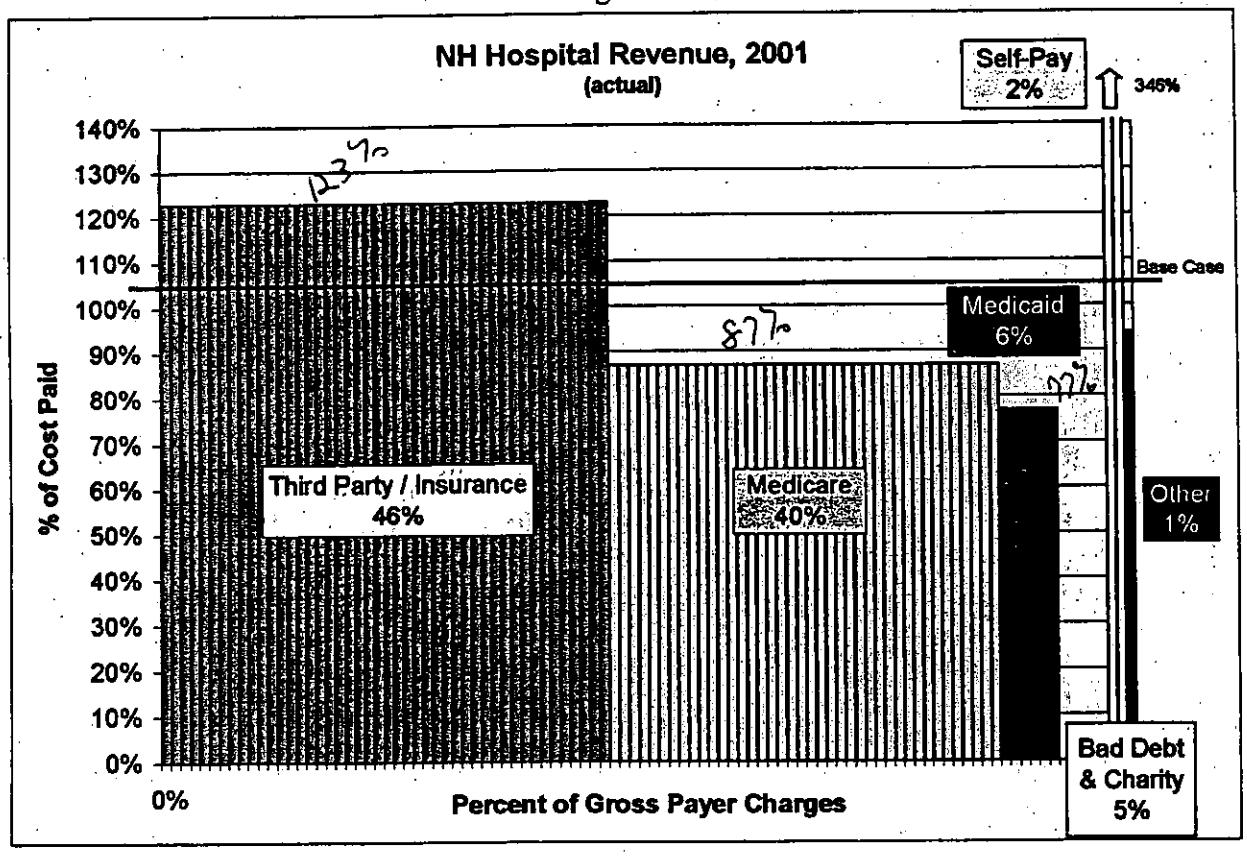
8. The Actual Situation in 2001

The actual situation was quite different as shown in Table 3 and Figure 6.

Table 3

Payment Source	% of Gross Charges	Net revenue received	Allocation of real operating expenses on basis of gross charges	Allocation of real operating expenses + 5% margin	Net revenue as % of expense share
Third Party	45.8%	$916,840,046	$745,467,561	$782,740,939	123.0%
Medicare	39.7%	$559,189,410	$646,137,479	$678,444,353	86.5%
Medicaid	6.6%	$82,259,512	$106,635,227	$111,966,988	77.1%
Charity Care	1.6%	$0	$26,251,452	$27,564,024	0.0%
Bad debt	3.4%	$0	$55,240,380	$58,002,399	0.0%
Self-pay	1.6%	$91,660,528	$26,507,663	$27,833,046	345.8%
Other Government + Other	1.3%	$19,864,074	$21,222,314	$22,283,430	93.6%
TOTAL	100.0%	$1,669,813,570	$1,627,462,076	$1,708,835,180	102.6%

Figure 6

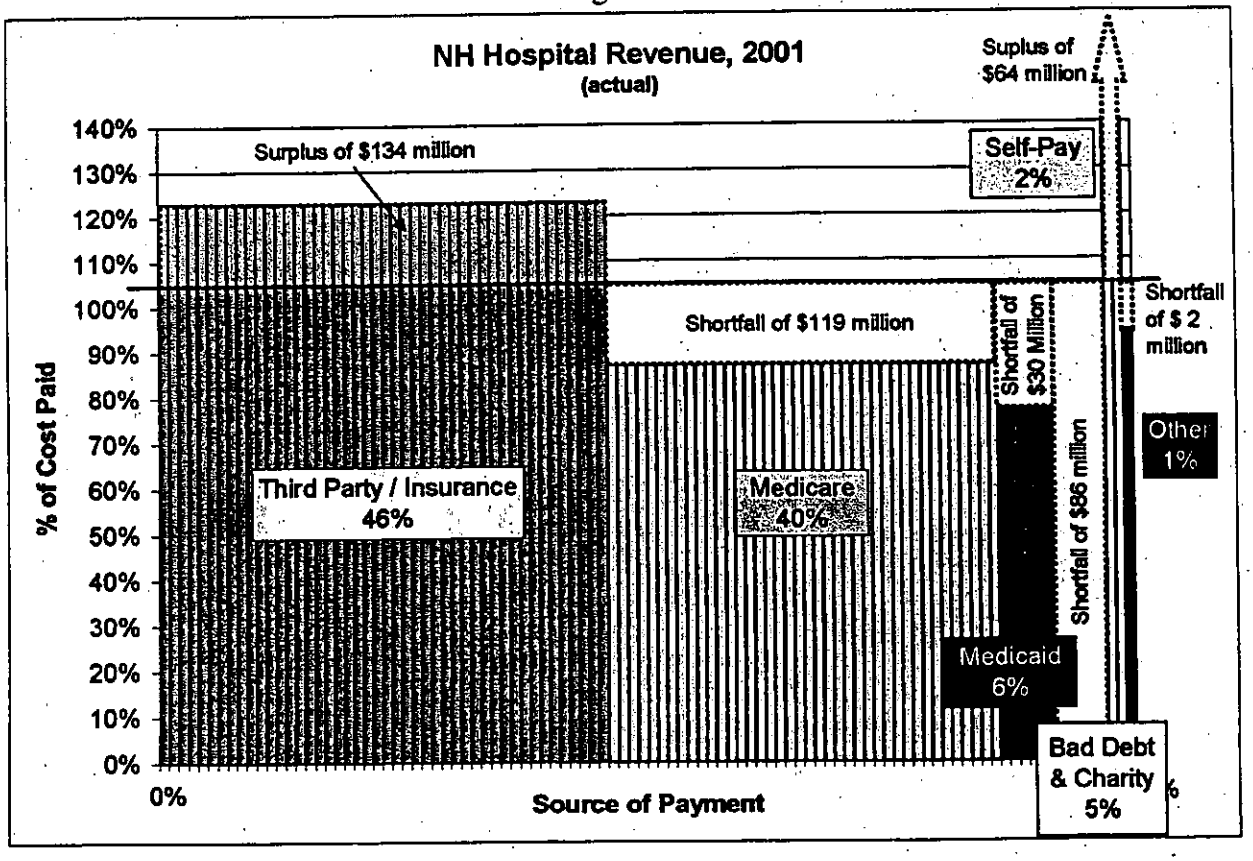


On average, third-party/insurance payers paid 123 percent of their share of actual expenses while Medicare paid 87 percent and Medicaid paid only 77 percent.[9] This means that insurance payments were 18 percent above what would be expected if they were to pay their share of expenses plus margin. One can think of this as an indirect and hidden "tax" or subsidy.

The figure and table show "self-pay" covering 346 percent of costs, a proportion that may be somewhat misleading. Payments directly from individuals is a more complicated. The hospitals received no revenue for the charges represented by bad debt and charity care. They did receive $91 million in payments from individuals. Some charges for services were partially paid and partially written off. Unfortunately, there are no data regarding what portion of a given individual's charges was actually paid. Thus, in Figure 6, one could consider that some of the self-pay amount should actually fill in some of the empty space above the bad debt and charity portion. However, we do not know how much should be so represented from the data available.

The size of the rectangles above or below the base cost line in Figure 6 are proportional to the cost shift from one payer type to another. Excess payments by one set of payers are used to offset the shortfalls caused by other payers. This is shown more clearly in Figure 7 where the $ volume of each rectangle is included.

Figure 7



[9] For year 2000 the American Hospital Association reported aggregate payment-to-cost ratio of New Hampshire hospitals to be 0.91 for Medicare, 0.682 for Medicaid, and 1.267 for all private-payers. Thus, our results are fairly close to those calculated by the AHA for the prior year.

Bad debt and charity cases fell short of their ideal share by $86 million. Medicaid fell short by $30 million. Medicare paid a higher percentage of its share but because it covered so many more services for so many more people, it fell short of its share by $119 million. A small $2 million shortfall occurred in the "Other" category. These shortfalls are shown in Table 4 and total $237 million.

Table 4

Payer	Actual Revenue	Revenue Needed to Meet Expenses Plus 5% Margin	Excess or (Shortfall)
Shortfalls			
Medicare	$559,189,410	$678,444,353	($119,254,943)
Medicaid	$82,259,512	$111,966,988	($29,707,476)
Bad Debt/Charity Care	$0	$85,566,423	($85,566,423)
Other	$19,864,074	$22,283,430	($2,419,356)
		Total	**($236,948,198)**
Surpluses			
Insurance	$916,840,046	$782,740,939	$134,099,107
Self-Pay	$91,660,528	$27,833,046	$63,827,482
		Total	**$197,926,588**
		Remaining shortfall	**($39,021,610)**
Operating margin			
Theoretical operating margin		5.0%	$81,373,104
Actual margin		2.6%	$42,351,494
Reduced margin			**$39,021,610**

Third-party insurers paid $134 million in excess of their 105 percent while self-pay generated a surplus of $64 million. The remaining $39 million was made up by the hospitals themselves through a reduced operating margin. They did not achieve our theoretical margin of 5 percent.[10]

A non-profit hospital can operate on less than a 5 percent margin and the community it serves may see little difference, especially in the short run. However, if continued for many years, lower margins may prevent the hospital from making investments in new facilities or technology. Some hospitals may make up lost margin through fund-raising, profits from ancillary non-medical services, or special grants. Hospitals owned by profit-making corporations need to generate a somewhat greater margin as they must pay federal and state business taxes on net income and still return profit to investors. If the return on investment is insufficient, hospital corporations will not be attractive investments.

[10] The observant reader will note a difference between the cited 2.6 percent operating margin in Table 4 and the 4.1 percent margin cited in Table 1. Table 4 is based on the data in the American Hospital Association survey, while Table 1 is based on data submitted by the hospitals to the NH Hospital Association. We cannot fully explain the difference.

In 2001 New Hampshire's 26 hospitals shifted costs among their patient groups and payers totaling some $237 million. To cover that amount third-party insurance paid $134 million above its share of cost plus margin, individuals paying directly for their care covered an additional $64 million, and the hospitals "ate" the remaining $39 million by operating with margins below 5 percent.

Medicare is the largest contributor to cost-shifting in New Hampshire's hospitals and contributes in aggregate four times the amount to the total cost shift as Medicaid.

While insurers negotiate discounts from standard charges from the hospitals, the resulting insurance payments for claims includes $134 million to cover cost-shifting. This is essentially a hidden tax of 17 percent. This hidden tax on hospital claims is passed on to employers and employees through the premiums they pay for health insurance.

9. Individual Hospitals

The calculations above represent the aggregate of all 26 community acute-care hospitals. The relative amount of cost-shifting at any given hospital may be more or less. Hospitals with higher percentages of Medicare and Medicaid patients, for example, are engaged in more cost-shifting and typically have lower operating margins. Some hospitals operated at a loss in 2001.

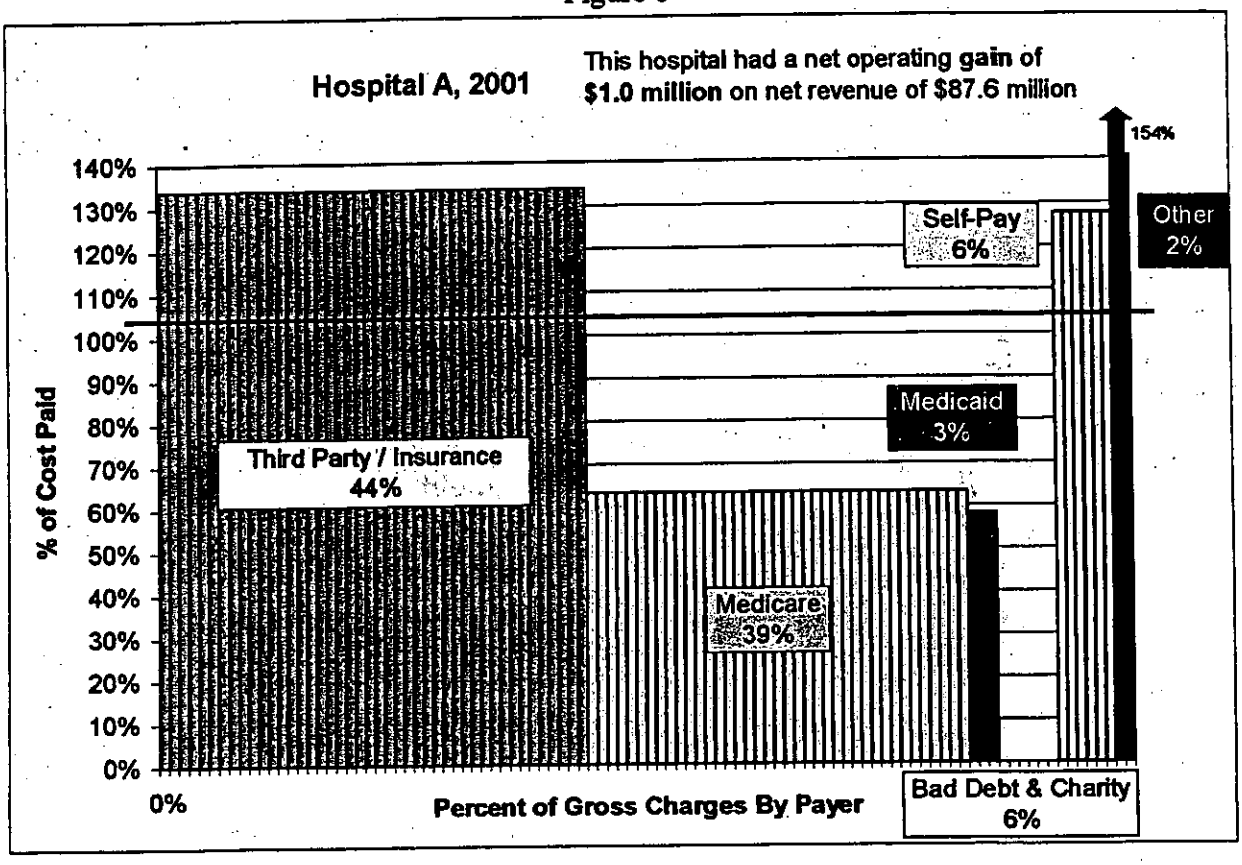
This section graphs the situation of four actual New Hampshire hospitals, using their own financial data for 2001. The four are illustrative of the variations across hospitals in patient mix and overall financial well-being. Because the examples are included to illustrate the general points of this paper, we identify them only as Hospitals A through D.

Hospital A

This hospital was operating very close to "break-even" in 2001. It had a net operating margin of only 1.1 percent. Figure 8 displays the data for this hospital.

The percentage of gross charges that are made to insurance companies are about the same as for the average hospital shown in Figure 6 (44 percent for Hospital A and 46 percent for the average). Medicare, too, represents about the same proportion of gross charges as it does for the average hospital. Note that Medicaid, however, represents a smaller percentage of gross charges (3 percent compared to 6 percent for the average hospital) while self-pay represents a greater percentage (6 percent versus 2 percent).

Figure 8



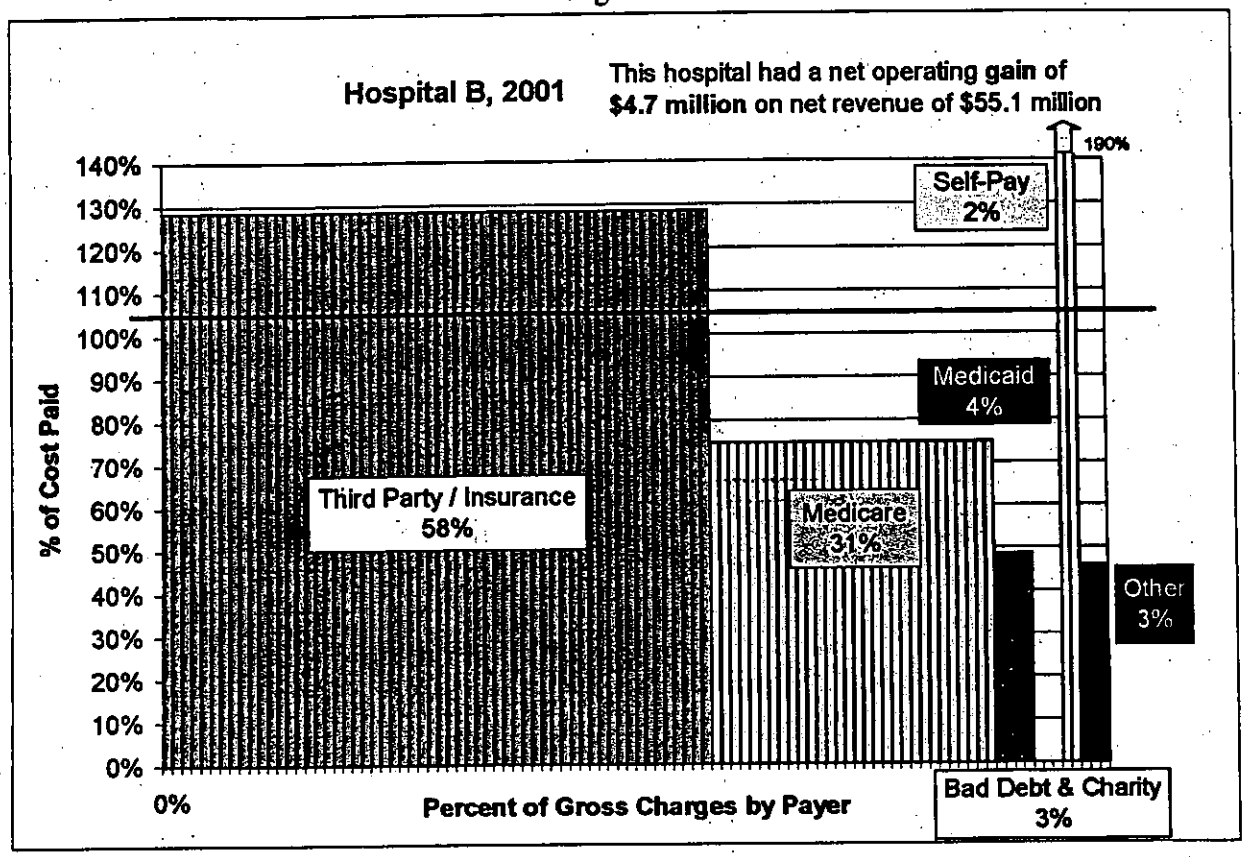
For this hospital, Medicare is only making payments that represent 62 percent of cost (for the average hospital it is 86 percent), thus resulting in a larger amount of deficit that must be filled by excess revenue from others. Insurance payments do fill much of that, representing 134 percent of cost in comparison to 123 percent for the average hospital.

Visually, one can see that the amounts in excess of 105 percent just about balance the amounts of shortfall from other payment sources.

Hospital B

This hospital had a solid operating gain in 2001. Its margin was 9.1 percent. Figure 9 shows how that margin of revenue over expense was achieved. Medicare represented only 31 percent of the gross charges for this hospital. Medicaid, charity care, and bad debt together represented only 7 percent of gross charges while they represented 11 percent of the average hospital's gross charges.

Figure 9



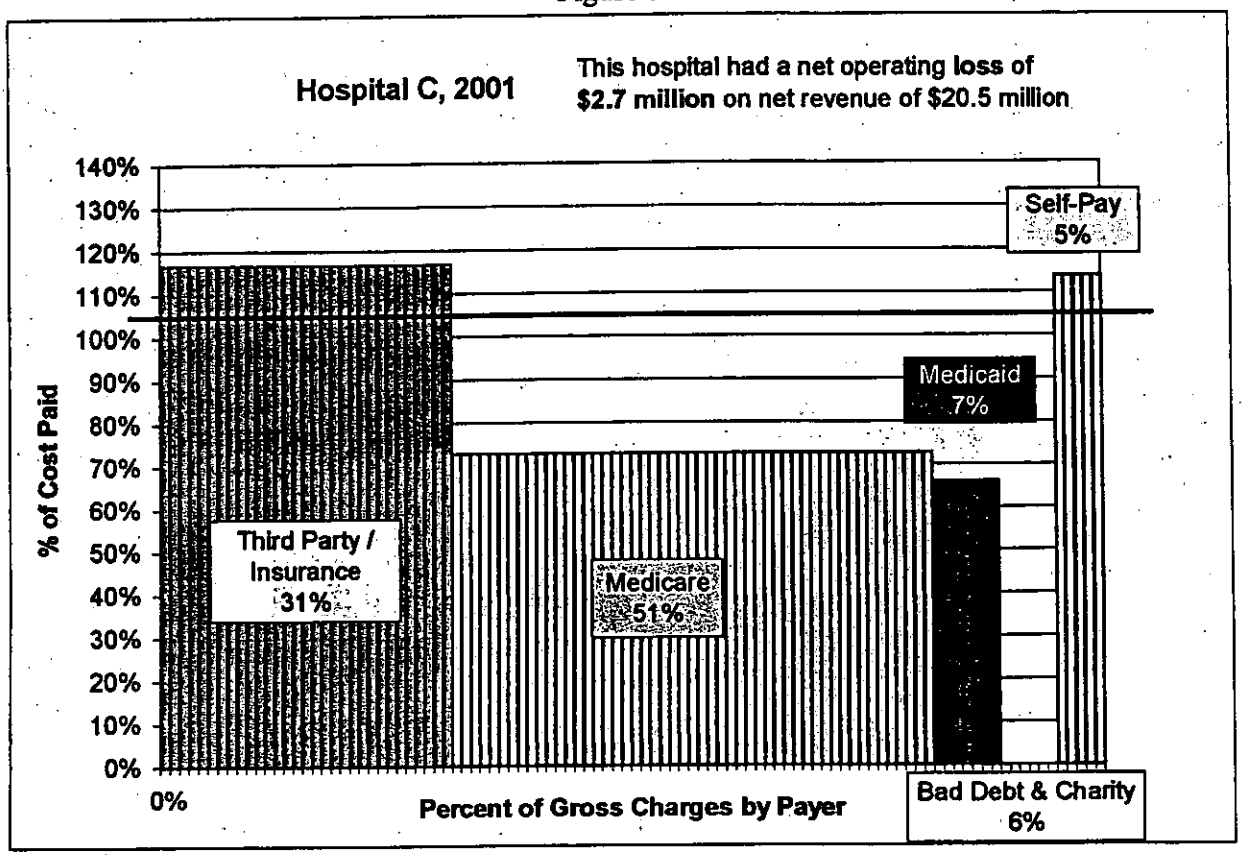
Insurance payers paid 128 percent of cost, slightly more than the state average. Because they constituted a larger percentage of charges as well, they contributed considerably more excess revenue toward the hospital's shortfalls from other payment sources.

Hospital C

This hospital was operating in the red in 2001. Its operating revenue was inadequate to cover its operating costs. Not only did it not achieve our theoretical operating margin of 5 percent, it had an operating margin of –11.7 percent. Its revenue was far short of what was needed to support its expenses.

Figure 10 shows why this was the case. Medicare represented 51 percent of gross charges while charges billed to insurance companies represented only 31 percent. The amount of excess revenue obtained from insurance companies and self-pay sources were grossly inadequate to cover the losses from Medicare, Medicaid, bad debt, and charity care.

Figure 10



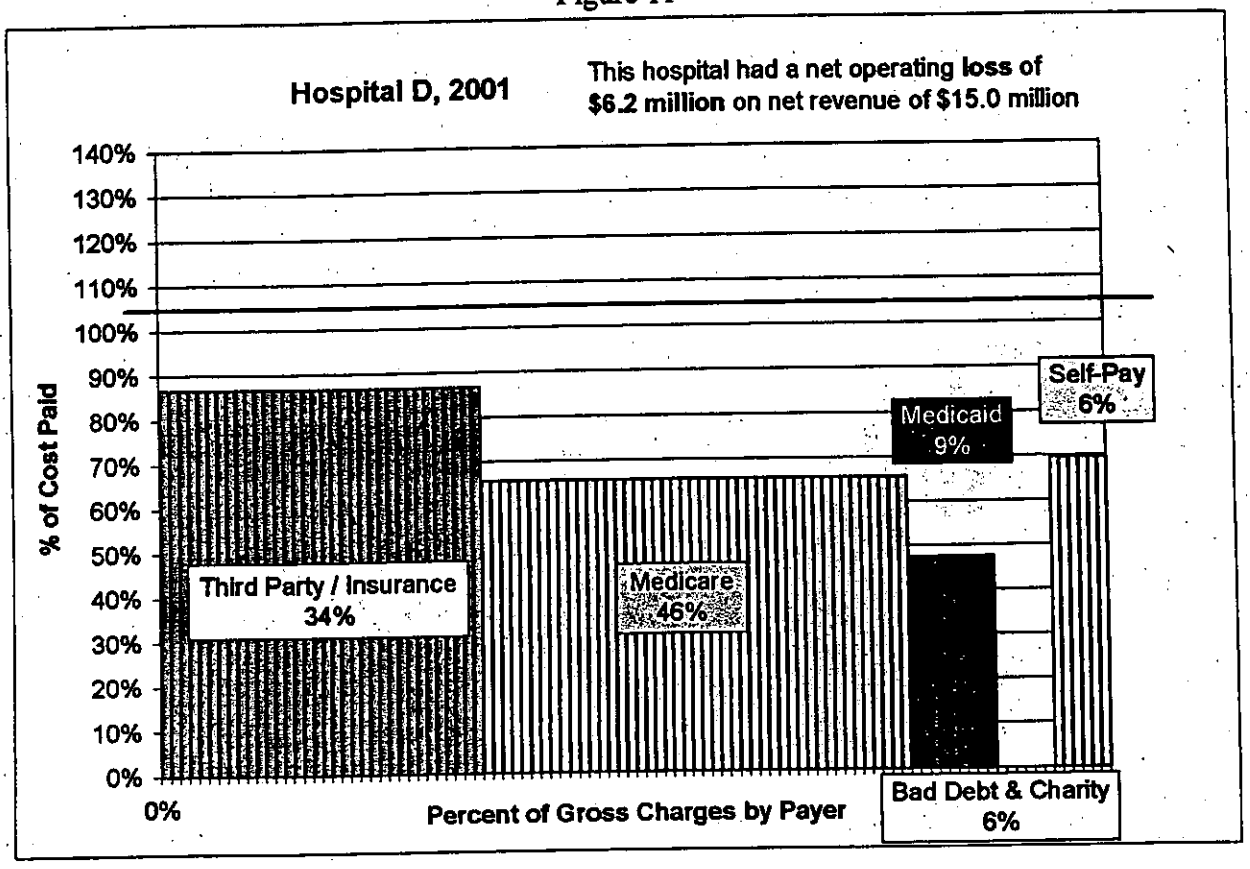
Comparing Hospital C with Hospital B indicates that the difference in patient mix (as represented by percent of gross charges billed to different sources) is largely responsible for the fact that Hospital C was operating at a large loss while Hospital B was able to operate with a healthy margin.

Hospital D

A quick glance at Figure 11 tells the story for this hospital. Not one source of payment for services was covering its costs. Every payer category was contributing to loss. There was no source of revenue to cover the cost-shifting caused by Medicare, Medicaid, bad debt, and charity care. In 2001 this hospital had an operating margin of –29.3 percent.

Obviously the operation of this hospital under these financial conditions could not continue for long.

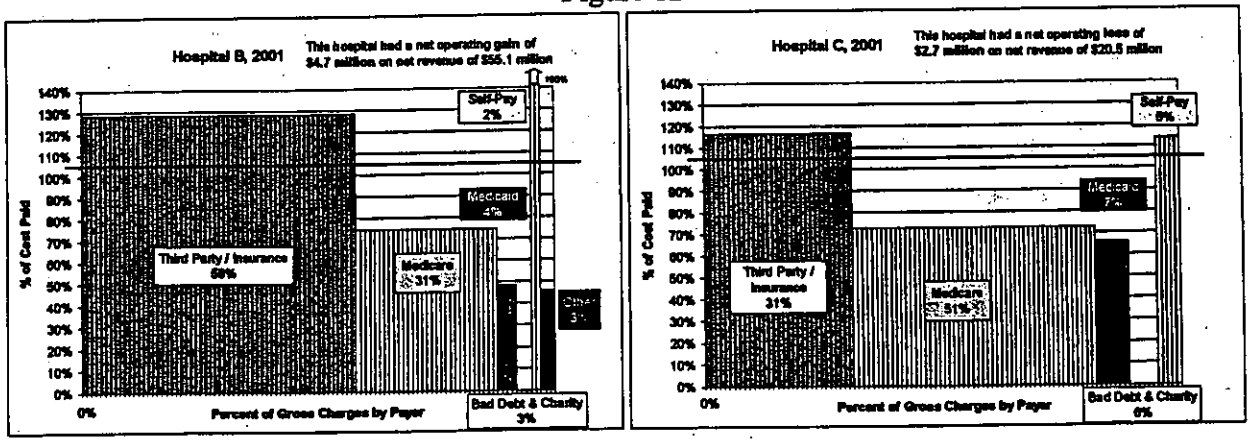
Figure 11



10. A Problem in Making Comparisons

While the hydraulics diagram of each hospital is a striking visual that fairly presents the status of finance in *that* hospital, it is not appropriate to compare two charts side by side. Such a possible comparison is shown in Figure 12. The problem lies in the vertical axis.

Figure 12



The vertical axis in these two charts is "% of Cost Paid." Because each hospital's cost structure is different, 100 percent of cost on the left hand chart does not necessarily represent the same

whether the differences are because one hospital's cost structure is higher or because the amount it receives in payment for services is lower.

We are currently unable to make a comparison using a vertical axis stated in absolute terms so that hospitals can be compared. The reason we cannot do so is that the information needed to calculate and display the data is not available to us.

11. More Data Required for Better Understanding

Further important analysis could be done on hospital finance.

How much cost-shifting is caused by higher than average cost structures?
How much cost-shifting is caused by lower than average payments?
How do charges and payments relate to average cost for different procedures?
What portions of gross charges are derived from which procedures and services?
Which services and procedures generate the most excess revenues?
Which services are "loss leaders?"

Answers to these questions and others would inform discussion of the kinds of policies needed to ensure continued support for workforce health insurance and adequate public programs that ensure access to services for those who are uninsured.

In regard to hospital finance, three types of data are needed for each hospital:

- The hospital's master list of charges;
- A count of the number of charges made for each charge type over each 12 month period;
- The amounts actually received as payment for each charge type from larger payment sources for which some amount less than charge is accepted as payment.

These data are available to each hospital. Without them, a hospital could not bill for the treatments and services it provides, nor could it credit income received against billed revenue. Currently hospitals assert that these data are private and proprietary and that disclosure might adversely affect competitive situations or violate anti-trust laws. Also, some of these data are protected by non-disclosure clauses in agreements negotiated between hospitals and insurers.

If health care is to function as a market-driven system – as some argue it should – it must provide price signals that inform and potentially impact behavior: behavior of consumers of health care, competitive behavior of providers, and payment behavior of third-parties, including public programs and commercial insurers. Currently the necessary price and cost information is not easily available to the public.

We urge release of the types of data identified here. While there is currently no legal requirement that such information be publicly available, employers (who ultimately fund much of health care through the premiums they pay for insurance for their employees) could request that this type of information be made available to them by their insurers and by the health care institutions that serve their communities.

In addition, we also urge hospitals to serve their communities – and health care policy generally – by summarizing and disclosing their cost-shifting information regularly and in an easily understandable format. In its annual report, each hospital should present a table similar to Table 4 and a "hydraulics diagram" like the ones presented in this report. These could be prepared or reviewed by the hospitals' auditing firms.[11]

12. Data Sources

The NH Hospital Association provided financial data on all hospitals for 2001 and earlier years. They loaned copies of the audited financial reports of the hospitals to the Center and also provided copies of NHHA Excel spreadsheets containing annual financial data.[12]

Additional data were obtained from unpublished tables and analysis prepared by The Lewin Group based on the American Hospital Association's Year 2000 Annual Survey of community hospitals.

Useful insights and background material can be found in "The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis," Office of Planning and Research, NH Department of Health and Human Services, December 13, 2000. The most relevant paper for this project that is contained in that report is "Analysis of Health Care Charitable Trusts in the State of New Hampshire: The Hospital Sector" by Nancy M. Kane.

[11] In 2001, eight auditing firms were employed by 24 acute care hospitals: Baker, Newman & Noyes; Berry, Dunn, McNeil &Parker; Dana S. Beane & Co.; Ernst & Young; KPMG; Price Waterhouse Coopers; Robin R. Grill; Tyler, Simms, & St. Saveur. As component parts of national profit-making firms, two of the hospitals do not have separately reported finances, but could still voluntarily disclose such information.

[12] Hospitals do not all share the same fiscal year. Some end on June 30, some on September 30, and some on December 31. The fiscal year totals across all hospitals are not, therefore, equal to figures reported by Medicare or Medicaid which use federal fiscal years (October-September) or state fiscal years (July-June). Some hospitals are part of a larger corporate entity that may include other functions such as home nursing or community health education. In those cases, the data used represents only the hospital's finances.

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Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: May 28, 2003

THE COMMITTEE ON Insurance

to which was referred House Bill 470

AN ACT relative to health insurance providers.

VOTE: 5-0

2003-1829s

Having considered the same, report the same with the following amendment and recommend that the bill: **AS AMENDED OUGHT TO PASS.**

Senator Robert B. Flanders
For the Committee

HB470 Docket

Next|Prev|Results List|Main|Bill Status

Bill Title: relative to health insurance providers.

Date	Body	Description
1/9/2003	H	Introduced and ref to Commerce; HJ 12, p197
1/28/2003	H	Hearing Feb 5 2:30 RM302,LOB
2/24/2003	H	Subcom Work Session Mar 10 9:15 RM302,LOB
2/24/2003	H	(Subcom: Reps Liebl, Brady and Kopka)
3/13/2003	H	Subcom Work Session Mar 18 8:45 RM302,LOB
3/18/2003	H	Maj Report OTP/AM for Mar 25 (Vote 18-0;CC)
3/18/2003	H	Prop Comm Am{0728}; HC26, p705
3/25/2003	H	Passed with Am; HJ29-pt 1, p823 + pt 2, p965
4/3/2003	S	Introduced and Ref. Insurance; SJ 11, Pg.272
4/11/2003	S	Hearing; April 15, 2003, Room 101, LOB, 9:10 a.m.; SC18
5/28/2003	S	Committee Report; Ought to Pass with Amendment{1829},(New Title), [06/05/03]; SC25, Pg.26-27
6/5/2003	S	Committee Amendment{1829},(New Title), AA, VV; SJ 19, Pg.626-628
6/5/2003	S	Ought to Pass with Amendment{1829},(New Title), MA, VV; OT3rdg; SJ 19, Pg.628
6/5/2003	S	Passed by 3rd Reading Resolution; SJ 19, Pg.663
6/5/2003	H	House Nonconc with Sen Am req Conf Comm, Rep Whalley MA; HJ 51, p1597
6/5/2003	H	(Spkr appts Reps: Hunt, Fraser, Liebl & Kathleen Taylor)
6/5/2003	S	Sen. Flanders Accede to House Request For Committee of Conference, MA, VV; SJ 19, Pg.671
6/5/2003	S	President Appoints; Senators Flanders, Martel, Cohen; SJ 19, Pg.671
6/12/2003	H	Conf Comm Meeting June 17 10:00 RM302,LOB
6/19/2003	S	Committee of Conference Report; New Am.{2224}, Filed;
6/24/2003	S	Conference Committee Report{2224}, Adopted, VV; SJ 20, Pg.782-783
6/24/2003	H	Conf Comm Report Adopted VV;
6/30/2003	H	Enrolled
6/30/2003	S	Enrolled;
7/21/2003	H	Signed by the Governor 7/18/03 Eff: 7/18/03* Chap 0284
7/21/2003	H	*Multiple Effective Dates Sec 2,3,9 eff: 7/01/03. Sec 1 eff 1/01/04 . Remainder eff: 7/18/03

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Docket Abbreviations