Financially Distressed Hospitals – Impact of Commercial Payers

Abstract

Correlation between commercial reimbursement rates and hospitals' financial condition

According to Chartis Center for Rural Health's February 2024 report[i], *Unrelenting Pressure Pushes Rural Safety Net Crisis into Unchartered Territory*, 89% of Kansas' rural hospitals operate in the red and 38% are vulnerable to closure. Chartis evaluated 16 indicators and found that 9 to be statistically significant in predicting hospital closures. Of those 9 indicators, Chartis determined those most likely to reduce the risk of closure are case mix index, government control status, Medicaid expansion, and average daily census for swing beds/skilled nursing facility.

One indicator Chartis did not include in its vulnerability index is commercial reimbursement rates, most likely because this data is not readily available. Failure to evaluate the impact of these rates, however, results in an incomplete – and possibly misleading – analysis of the causes of the rural health crisis. This, in turn, may result in policymakers pursuing solutions which may have limited impact.

To evaluate the potential impact of commercial reimbursement rates on hospitals' financial condition – and, in turn, those hospitals' continuing ability to serve their local communities – PYA developed a methodology to compare the relative financial strength of Kansas hospitals to those in neighboring states (specifically, Nebraska and Oklahoma) and commercial reimbursement rates by state for key "payers".

Assuming a correlation is identified, we anticipate "payers" will push back by claiming they cannot afford to increase hospital rates. Thus, PYA compiled and analyzed publicly available information regarding those Kansas, Nebraska, and Oklahoma "payers" with significant market share to understand the relative financial strength and profitability of these organizations as compared to community hospitals.

Hospital Assessment – Setting the Stage

1) **Hospital Configuration -** Kansas hospitals face financial challenges due to high fixed costs and low patient volumes. Appreciating this conundrum, federal and state healthcare programs operate special payment programs for rural providers. Some of those programs include:
   - cost-based reimbursement for critical access hospitals
   - provider-based rural health clinics
   - programs for rural PPS hospitals:
     - *sole community hospital*
     - *low volume hospital*
     - *Medicare dependent hospital*
     - *rural referral center*

   Commercial payers, however, generally do not operate similar programs.

Some hospitals also receive non-operating revenue which fills the gap (in whole or in part) between expenses and reimbursement. Examples include:

- local tax support
- investment income
- grant monies (including COVID-19-related payments)

2) **COVID-19 -** COVID-19's impact on hospital operations was significant and the post COVID-19 reality includes:
   - higher labor
   - higher pharmaceutical and supply costs to deliver services

3) **Hospital closures -** From 2010 to present, eight hospitals in Kansas have either closed or converted to a model that excludes inpatient care (not including REH conversions). This is compared to only 6 hospitals in Oklahoma and 2 hospitals in Nebraska[ii].

Phase I – Assessing Hospitals' Financial Health

1) **Risk Score** - PYA evaluated financial metrics of CAHs and PPS hospitals in Kansas, Nebraska, and Oklahoma to assess the financial health of each state's hospitals. Specifically, we performed the following work steps:
   - Obtained financial statement data from Medicare Cost Reports 2019 through 2022
   - For each hospital, evaluated the following financial metrics to assign a risk classification: operating margin, equity financing, and equity financing trend
   - Assigned a weight to each metric's risk score
   - Based on its overall risk score, each hospital was assigned to one of four risk classifications: limited short-term risk, low risk, medium risk, and high risk

Each financial metric assigned a risk score based on (1) the median metric results in each state, and (2) PYA's professional judgment.

Metric	Period Evaluated	Metric Weight
Operating Margin[1]	FY19 - FY21 Average (weighted 65%) + FY22 (or terminal year) (weighted at 35%)	**30%**
Equity Financing[2]	FY22 (or terminal year)	**60%**
Equity Financing Trend[3]	FY19 - FY22 (or terminal year)	**10%**

1 Operating Margin = (Net Patient Revenue - Total Expenses) / Net Patient Revenue

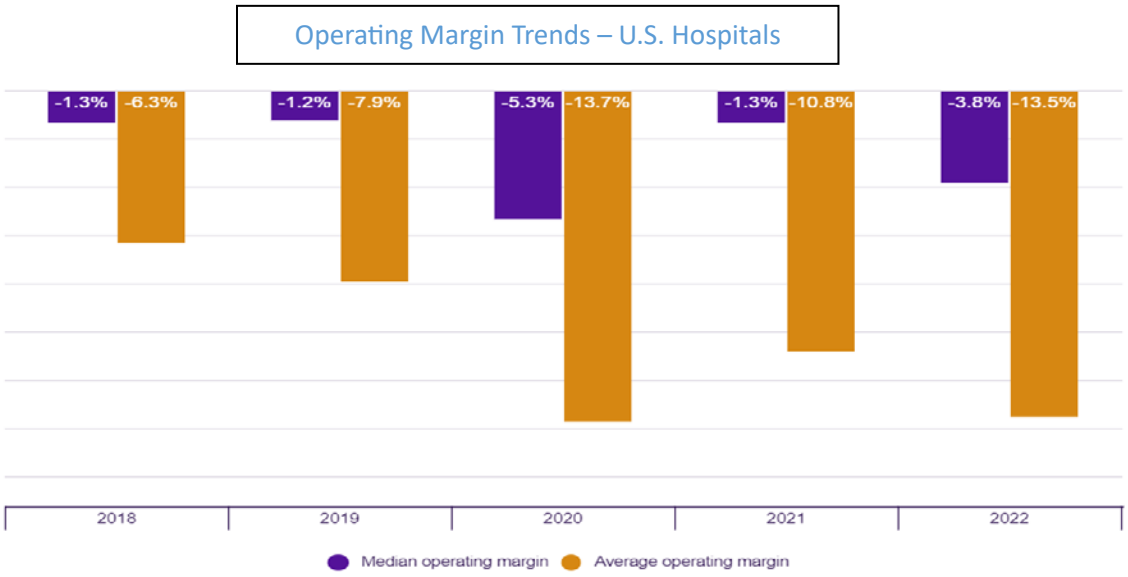
2 Equity Financing = (Total Assets – Total Liabilities) / Total Assets

3 Equity Financing Trend = FY19 to FY22 (or terminal year)

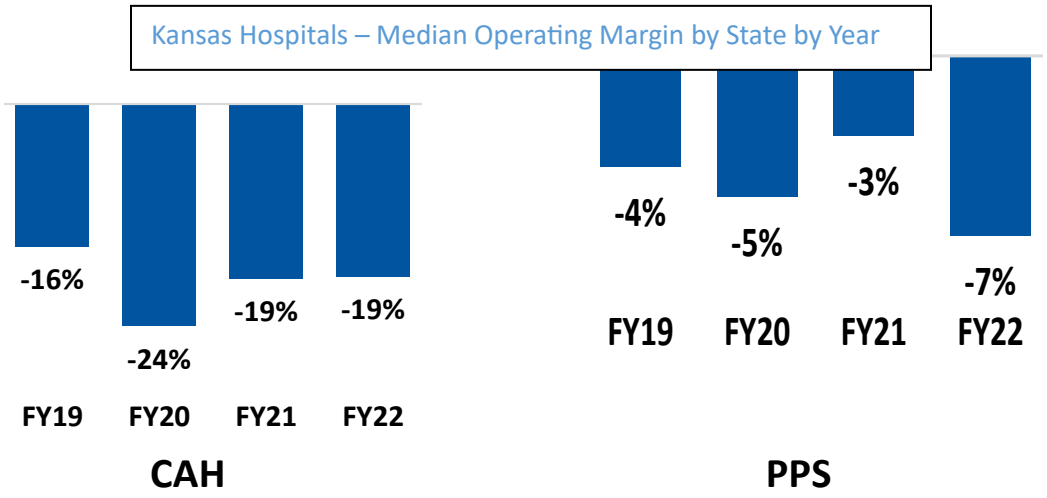
Then, each hospital was assigned to one of 4 risk classifications based on its cumulative score

Hospital Risk Classification
Limited Risk
Lower Risk
Medium Risk
Higher Risk

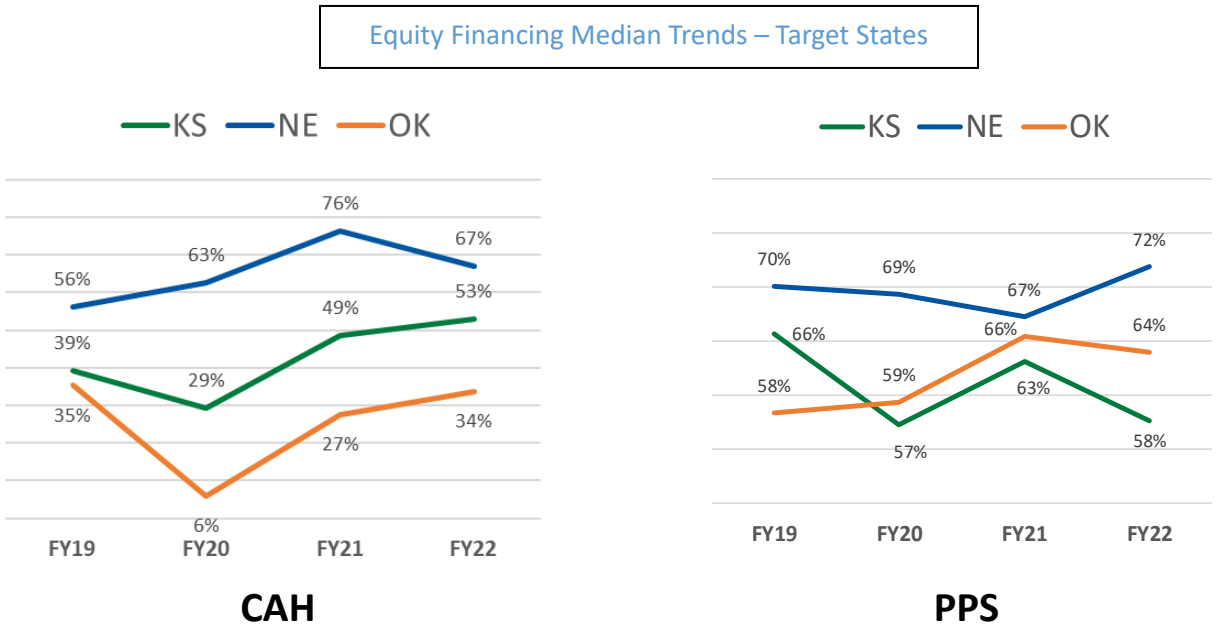
2) **U.S. Operating Margin -** In FY22, U.S. hospitals' **median** operating margin was **negative 3.8%. T**he **average** operating margin was **negative 13.5%**[iii]**.** To remain financially viable, the average hospital must rely on non-operating income to close the gap between revenue and expenses.



3) **Kansas Operating Margin** - In FY22, Kansas hospitals' **median** operating margin was **negative 12.7**%. This can be broken down into Critical Access Hospitals at **negative 19%** and PPS hospitals at **negative 7%**[iv]**.**



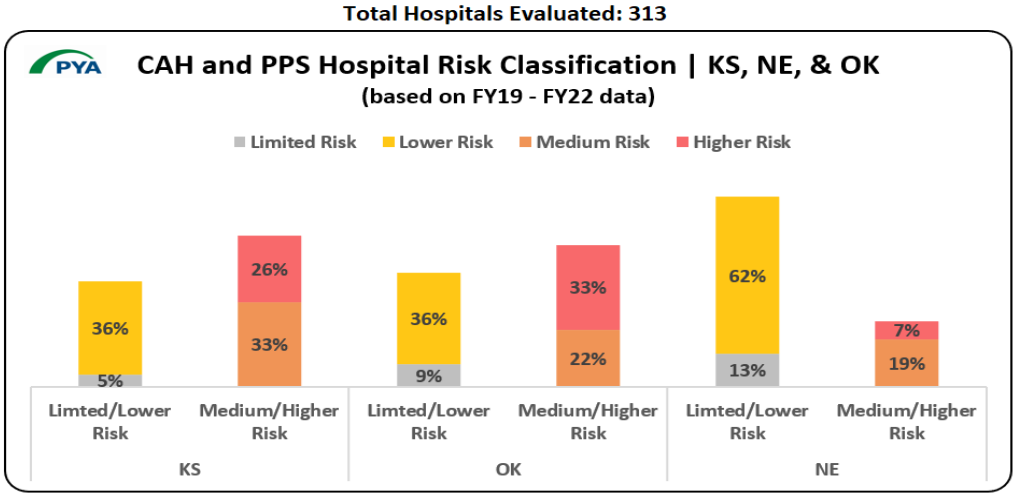
4) **Kansas Equity Financing** - In FY22, Kansas hospitals' **median** equity financing ratio was **53%** for CAHs and **58%** for PPS hospitals.[v]



5) **Risk Classifications** - Risk Classifications for CAHs and PPS Hospitals were evaluated for 313 hospitals in Kansas, Nebraska and Oklahoma. The Percentage of Medium/Higher Risk hospitals for each state were:

- **KS – 59%**
- OK – 55%
- NE – 26%

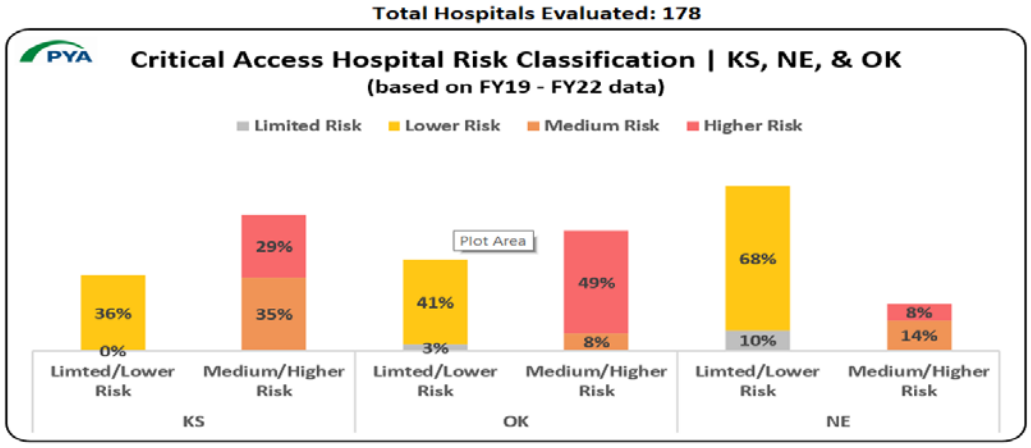
Nebraska has the highest percentage (75%) of Limited/ Lower Risk hospitals while Kansas has only 41% of hospitals at Limited/Lower Risk.



CAHs - When you break that down by looking at CAHs only, the percentage of CAHs with Medium/Higher Risk for each state were:

- **KS – 64%**
- OK – 57%
- NE – 22%

When evaluating CAHs only, Nebraska has the highest percentage (78%) of Limited/Lower Risk hospitals while approximately one-half of Oklahoma's CAHs are Limited/Lower Risk. Kansas only has 36% of their CAHs at Limited/Lower Risk.

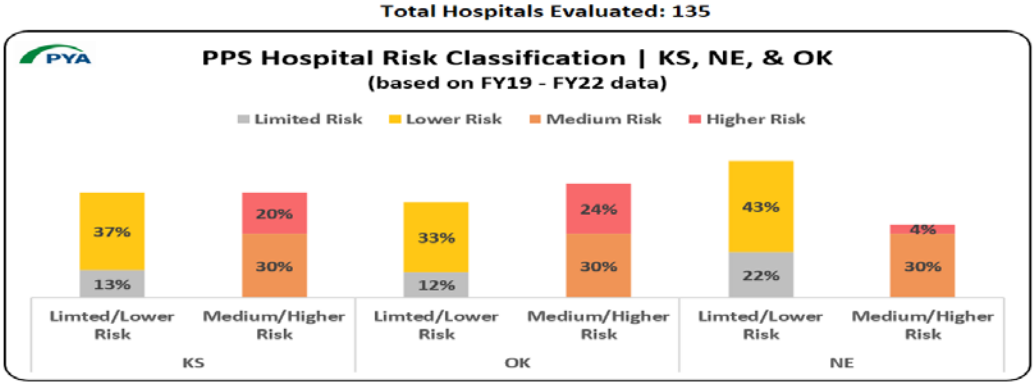


CAHs	78	37	63

PPS - When you break that down by looking at PPS' only, the percentage of PPS' with Medium/Higher Risk for each state were:

- **KS – 50%**
- OK – 54%
- NE – 34%

Nebraska has the highest percentage (65%) of Limited/Lower Risk PPS hospitals while approximately half of the Kansas PPS hospitals are at higher risk.



PPS	46	66	23

6) **High BCBS-KS IP/OP Volume Hospitals** - After resolving that Nebraska hospitals were at a much lower risk when compared to Kansas hospitals, PYA made the decision to compare commercial payers within the States. Using hospitals' posted price transparency negotiated rates, PYA compared Kansas commercial reimbursement rates to those in Oklahoma and Nebraska for a limited number of services. PYA identified 23 Kansas hospitals with a greater than 25% Blue Cross Blue Shield of Kansas (BCBSKS) IP/OP patient volume in 2022 and were classified as medium/higher risk. This will move us into Phase II where we look deeper into commercial payers.

Phase I Summary

PYA's analysis of operating margin and equity financing metrics offers valuable insights into the financial health of Kansas CAHs and PPS hospitals, compared to their counterparts in Oklahoma and Nebraska.
Our review of publicly posted price transparency data suggests a link between low commercial reimbursement rates and heightened financial distress. However, further analysis is necessary to substantiate the strength of this correlation.

Key Findings:

- Loss of Patient Services – In FY 2022, the median operating margin for Kansas Hospitals was negative 12.7%, with most hospitals losing money on patient services. PYA also evaluated hospitals in neighboring states, that showed Kansas had the lowest median operating margin compared to Nebraska and Oklahoma
- Low Financial Reserves – The hospitals at greatest financial risk are burdened with more debt than net assets (equity). In FY2022, more than one-third of Kansas hospitals were in this position.
- Peer Comparison – Kansas had a higher percentage (59%) of hospitals classified as medium to high risk than Nebraska and Oklahoma. Nebraska has the best percentage with 75% of Nebraska hospitals falling in limited/lower risk hospitals.

While commercial rates are a significant factor in hospital financial stability, they are not the only consideration. In Phase II, PYA selected a subset of hospitals from Phase I for a more detailed examination of:

- The financial impact of services they provide to their communities
- The implication of commercial reimbursement rates on their overall financial position

Phase II – Correlation between commercial reimbursement rates and hospitals' financial condition

Phase IIa - Specific Hospital Assessment

The objective of the first part of phase II was to assess the level of commercial reimbursement rates necessary for hospitals to sustainably provide care to their communities.

1) **Hospital Selection -** PYA initially identified 23 Kansas hospitals based on the following criteria:
   - Over 25% BCBS KS inpatient/outpatient commercial patient volume in 2022
   - Classified as Medium or Higher Risk

   From this group, PYA selected 3 hospitals for in-depth financial evaluation
   - 1-Prospective Payment System (PPS) Hospital
   - 2-Critical Access Hospitals

   The following key data sources were gathered from the three hospitals selected for the more comprehensive assessment:
   - **Billing and Collections Data**– to analyze reimbursement differences among major payers, including value-based arrangement incentives
   - **Audited Financial Statements** – to assess the overall financial strength of each facility fiscal 2022 and 2023 as available by each hospital
   - **Medicare Cost Reports** – to evaluate Medicare reimbursement rates as a percent of billed charges by type of service from the most recent time period available

   For the period analyzed, all three facilities analyzed were operating at a financial loss, a situation that is not viable long-term. Continuing down this path could compromise their ability to provide quality care to the community, invest in necessary infrastructure, ensure adequate clinical and support staff, and meet other operational costs such as pharmaceuticals and supplies. Without intervention, these financial challenges could lead to reduced services, staff cuts, or even closure, highlighting the urgent need for strategic changes to achieve financial stability.

	PPS 1	CAH 1	CAH 2
Net Patient Revenue	$215.1M	$18.7M	$22.7M
Other Operating Income	$6.3M	$0.7M	$2.4M
Operating Revenue	$221.4M	$19.4M	$25.2M
Operating Expenses	-$237.5M	-$22.2M	-$26.6M
Operating Margin	-$16.1M	-$2.8M	-$1.5M
Other Income	$10.5M	$1.0M	$0.2M
Total Margin before capital grants	-$5.6M	-$1.8M	-$1.2M

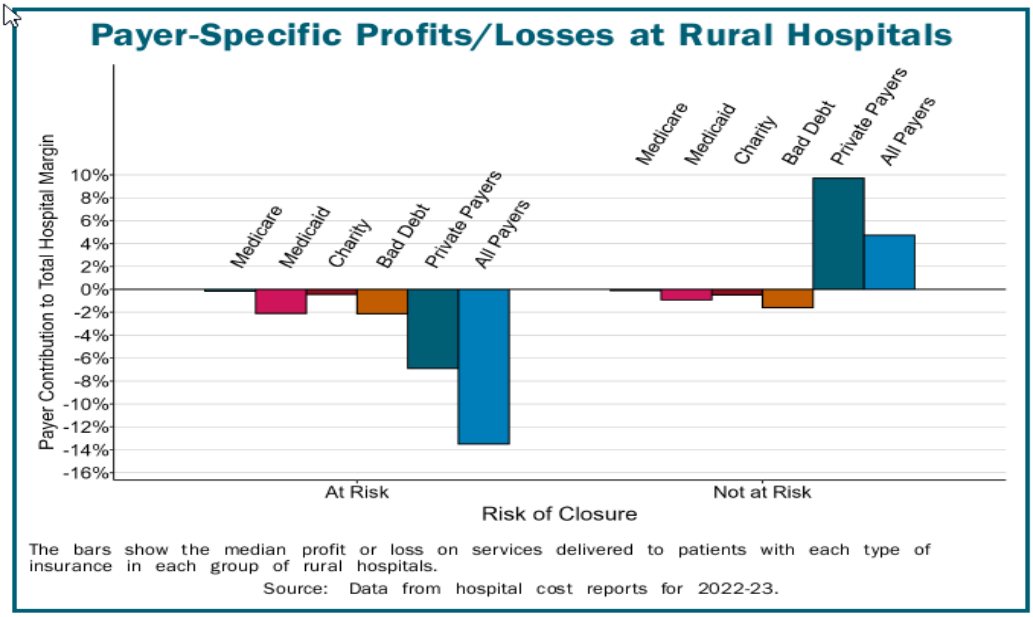
Operating Margin %	**-7.3%**	**-14.5%**	**-5.8%**
Total Margin %	**-2.6%**	**-9.8%**	**-5.4%**

2) **Inadequate Payments from Private Health Plans -** The Center for Healthcare Quality & Payment Reform recently published a document addressing the state of rural health care in the U.S. Key learnings from the study included the following:

*Rural hospitals at risk of closing face **underpayment from private insurance plans**, which fail to cover the cost of patient services. While these hospitals also lose money on uninsured and Medicaid patients, losses from privately insured patients contribute most to their overall financial struggles.*

*In contrast, **successful rural hospitals profit from patient services due to adequate payments from private health plans**. These payments cover costs for privately insured patients and offset losses from uninsured and Medicaid patients.*

The level of private plan payments, rather than Medicare or Medicaid reimbursements, typically determines a rural hospital's financial viability.[vi]



3) **Key Factors Impacting Operating Margin -** PYA conducted an analysis of key factors impacting operating margin, including clinic operations, hospice/home health and other items. We also identified the estimated financial effects of commercial payers and Medicare/Medicaid Advantage paying below the cost of providing services.

Key services and variables impacting operating margin (in millions)

		PPS 1	CAH 1	CAH 2
Services	Professional Services, Clinic, and Other Operations	-16.1	-1.3	-0.3
	Home Health/Hospice Operations	0.0	-0.1	-0.7
	Geriatric Psychiatry	0.0	0.6	0.0
Payer reimbursement	Estimated Medicaid Loss	-2.0	-1.4	-0.2
	Medicare reimbursement compared to cost	-9.8	0.0	0.0
	Estimated Medicare Advantage compared to Medicare reimbursement	-2.2	-0.5	-0.7
	Commercial payers other than Blue Cross compared to Medicare reimbursement	8.9	0.1	0.1
	Blue Cross compared to Medicare reimbursement	9.7	-0.9	0.5
Other	340B contract pharmacy	0.0	0.3	0.8
	Other Revenue	0.0	0.3	0.0
	Unreimbursed and uncompensated care	-4.6	-1.0	-0.8
	Other	0.0	0.5	-0.2
	Government appropriations (per cost report)	0.0	0.5	0.0
	Operating Margin $	**($16.1)**	**($2.8)**	**($1.5)**
	Operating Margin %	**-7.3%**	**-14.5%**	**-5.8%**

4) **Modeling Commercial Reimbursement Rates -** PYA next calculated the additional reimbursement needed from commercial payers to help hospitals achieve a sustainable operating margin. The assessment assumes these rates would be realized rates, after considering estimated reductions due to payer policies and the challenges associated with collecting patient payments under high-deductible health plans.

Leveraging hospital billing and collections data, PYA modeled proposed commercial reimbursement rates using various multiples of Medicare reimbursement.

Multiples of Medicare to model proposed commercial reimbursement rates

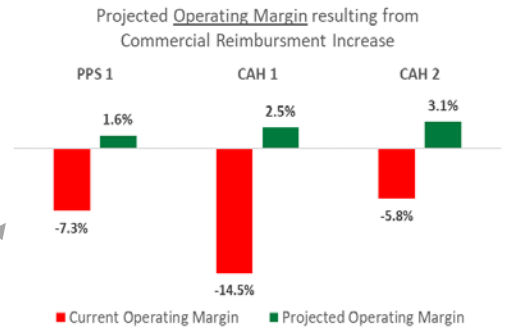
	PPS	CAH
Hospital (IP and OP)	220%	130%
Professional	200%	200%

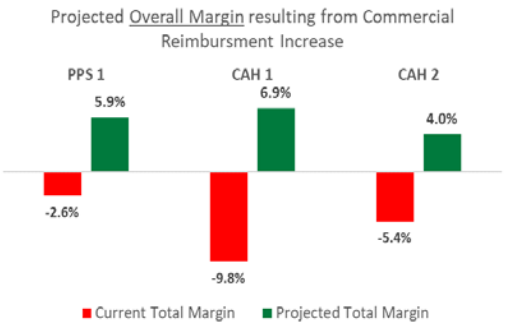
% increase in commercial rates compared to current

	PPS 1	CAH 1	CAH 2
Hospital (IP and OP)	23%	57%	15%
Professional	9%	96%	76%
Overall	**20%**	**60%**	**28%**

The proposed increase in commercial reimbursement rates shifted all three hospitals from financial losses to achieving positive operating and overall margins.

	PPS 1	CAH 1	CAH 2
Net Patient Revenue	$215.1M	$18.7M	$22.7M
Other Operating Income	$6.3M	$0.7M	$2.4M
Operating Revenue	$221.4M	$19.4M	$25.2M
Additional Commercial Reimbursement	$19.8M	$3.4M	$2.3M
Modeled: Operating Revenue	$241.2M	$22.8M	$27.5M
Operating Expenses	-$237.5M	-$22.2M	-$26.6M
Operating Margin	$3.7M	$0.6M	$0.9M
Other Income	$10.5M	$1.0M	$0.2M
Total Margin	$14.2M	$1.6M	$1.1M
Operating Margin %	**1.6%**	**2.5%**	**3.1%**
Total Margin %	**5.9%**	**6.9%**	**4.0%**





Phase IIb – Processor Assessment

*PYA has defined 'processor' as the health insurance payer for this study.

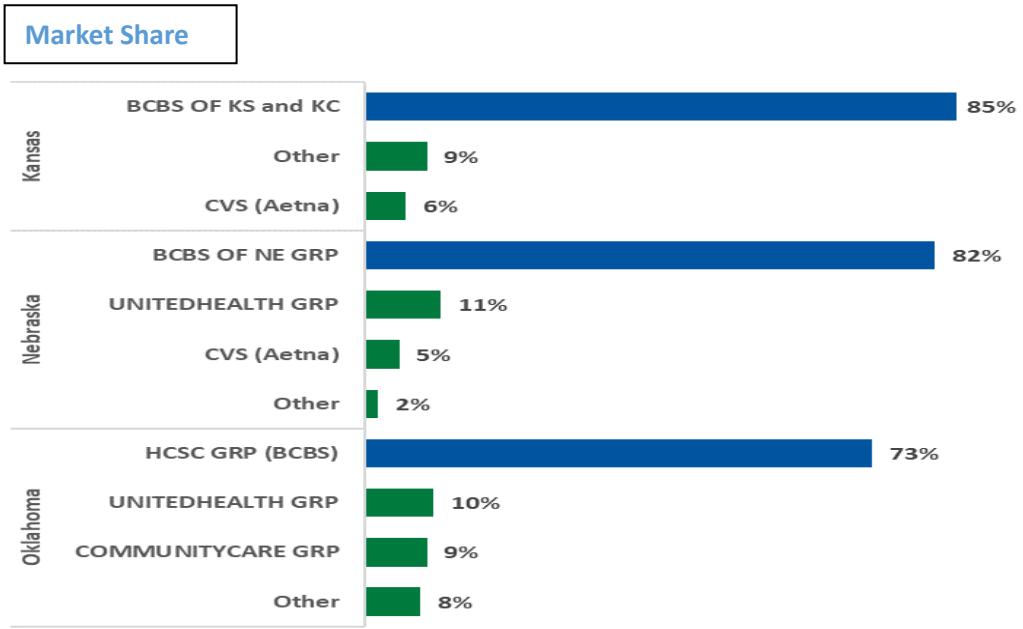
The objective of the second part of phase II was to understand the relative financial strength of Kansas' major processors.

1) **Financial Strength of Major Processors -** PYA analyzed publicly available information from the National Association of Insurance Commissioners (NAIC) to gain a high-level understanding of processors-
    - Organizational profitability
    - Financial strength over time
    - Insured member volumes

    Note our analysis is limited by incomplete and/or inconsistent reporting of data. We have attempted to interpret the available data in an objective manner, but we cannot be certain our analysis provides a wholly accurate picture of the "payers'" financial positions.

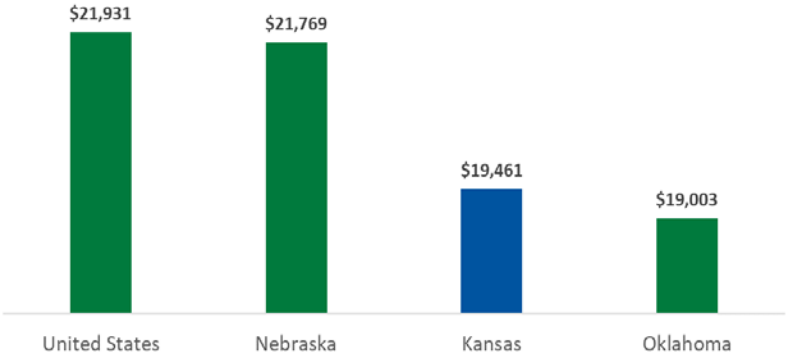
    PYA evaluated the following processors:
    - Blue Cross Blue Shield of Kansas
    - Blue Cross Blue Shield of Kansas City
    - Blue Cross Blue Shield of Nebraska
    - Health Care Service Corporation (BCBS of Oklahoma)
    - Aetna Better Health of Kansas, Inc.
    - United Health Care Group

    Blue Cross Blue Shield holds a dominant market share in the 3 states evaluated
    - **Kansas – 85%**
    - Nebraska – 82%
    - Oklahoma – 73%[vii]



Kansas ranks 49th in the nation for having one of the lowest average annual family premiums per enrolled employee (for employer-based health insurance in 2022)[viii]; however, the Kansas Hospital Association payer scorecard shows patients in Kansas pay more out-of-pocket on patient bills than most other states. Kansas ranks the second worst on patient responsibility dollars. Patients are responsible for paying 18% of the health care bill in Kansas. Particularly, when looking at out-of-pocket patient cost of BCBSKS patients, 25% of the patient bills are paid by the patient. When comparing to Nebraska BCBSNE, patients pay only 11% of the patient bill[ix].

Average Annual Family Premium per Enrolled Employee For Employer-Based Health Insurance (2022)



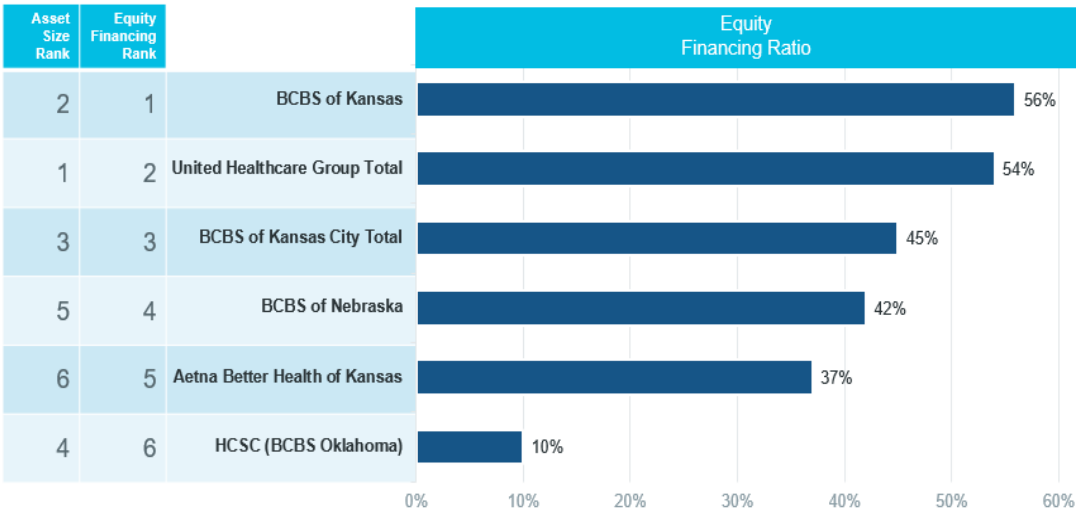
Rank by State	25	49	50

2) **Equity Finance Ratio comparison** - Since the level of equity compared to assets demonstrates the overall financial strength of each organization, we felt it important to report this statistic along with the operating results of each entity. While most "payers" reported operating losses in 2022, other changes in equity (e.g., changes in various reserves, investment returns, sales of assets) materially impacted their equity financing ratios.

When looking at the Blue Cross Blue Shield Affiliates, based on the 2022 financial reports submitted from these insurers, from a financial strength position, BCBS-KS had the highest equity financing ratio of all entities evaluated at 56%, followed by BCBS-KC at 45% and BCBS-NE at 42%. HCSC (the BCBS affiliate operating in Oklahoma, along with other states) had the lowest ratio at 10%.

Other processors such as UnitedHealthcare and Aetna Kansas had more limited data available. UnitedHealthcare is many times larger than any of the Blue Cross Blue Shield affiliates and has a financing ratio of 54% (large and strong). Aetna Better Health of Kansas, Inc. is smaller than the other processors we analyzed, and its 2022 equity financing ratio was 37%

Processor Snapshot



When looking at Blue Cross Blue Shield of Kansas particularly, their equity financing ratio remained strong and stable from 2018 through 2022 (56% at the end of 2022). Four of the five years reviewed reflected a positive change in equity. In 2022, BCBSKS had $2.1 billion in assets. While in comparison, BCBSKS and BCBSNE have similar dominant market shares, BCBSKS has more than double the assets of BCBSNE. In 2022, BCBSNE had $951 million in assets.

Phase II Summary

PYA identified key factors impacting operating margins, including service offerings, reimbursement rates, and other considerations. Additionally, PYA estimated the financial impact of commercial payers and Medicare/Medicare Advantage programs reimbursing below the estimated cost of providing services.

Key Findings:

- Blue Cross Blue Shield holds a dominant market share in the 3 states evaluated (Kansas – 85%, Nebraska – 82%, Oklahoma – 73%)
- Blue Cross Blue Shield of Kansas reported the most favorable financial position of the six insurers in our analysis with an equity financing ratio of 56% on an asset base of over $2.1B which was the highest asset base of the regional insurers analyzed.
- Blue Cross Blue Shield of Nebraska reported an equity financing ratio of 42% on a smaller asset base of just under $1B.
- HCSC (Blue Cross Blue Shield of Oklahoma) reported the lowest equity financing ratio of 10%.
- While Kansas employer premiums are low compared to other states, more patient co-share dollars are being passed onto the patient than other states.

Historically, reimbursement from commercial payers has offset losses from services provided to Medicaid and other underfunded/uninsured patients. With over half of Kansas hospitals operating at a loss, the question

arises: where will the additional funds come from to keep these hospitals running? PYA evaluated the impact of increased commercial reimbursements in the following section to understand what types of reimbursement increases would be required to balance the budget for these sample hospitals for fiscal 2022 (the year of data analyzed).

PYA modeled the necessary reimbursement increases from commercial payers to help hospitals achieve a sustainable operating margin. The analysis used hospital billing and collections data to propose reimbursement rates as a percentage of Medicare reimbursement, aiming for an operating margin between 1.5% and 3.0%. These operating margin levels are intended to cover operational costs, allow for necessary capital improvements, and enable hospitals to continue fulfilling their mission within the community. *The rates as expressed below are rates that would actually be realized or received by the hospitals, not just contracted rates which may likely be reduced due to claim denials, downcoding of services, or unpaid patient obligations*.

The proposed rates that generated a small positive operating margin for the sample hospitals included the following:

- 220% of Medicare for PPS hospital services
- 130% for CAH services
- 200% for professional services across both PPS and CAH hospitals

These proposed rates ranged from rate increases of 20% to 60% across the three hospitals. These proposed increases successfully shifted all three from financial losses to positive operating margins.

Conclusion

PYA's analysis underscores the severe financial challenges facing rural hospitals, particularly in Kansas. With over 30% of rural hospitals nationwide at risk of closure, and more than half of Kansas's hospitals threatened, urgent action is needed. Without additional funding, these hospitals will continue to operate at a loss, threatening their ability to provide essential healthcare services, maintain infrastructure, and support necessary staffing levels. By aligning funding more closely with the actual costs of care, whether through commercial reimbursement or other sources, these hospitals can move from financial distress to sustainability, ensuring they continue to serve their communities.

Appendix

BCBS- KS

Balance Sheet	2018	2019	2020	2021	2022
Equity	$ 892,533,599	$ 976,614,052	$ 898,583,364	$ 1,085,767,412	$ 1,186,968,418
Assets	$ 1,765,783,546	$ 1,929,372,844	$ 2,209,672,609	$ 2,276,993,251	$ 2,109,570,463
Equity Financing Ratio	**51%**	**51%**	**41%**	**48%**	**56%**
Change in Equity Financing Ratio		0%	-10%	7%	9%

Income Statement	2018	2019	2020	2021	2022
Net Income (loss)	105,090,688	65,480,056	32,825,270	77,916,205	(130,296,746)
Other changes in equity	(4,116,208)	18,600,397	(110,855,958)	109,267,843	231,497,752
Total change in equity	100,974,480	84,080,453	(78,030,688)	187,184,048	101,201,006

Other changes in equity include changes in asset valuation reserve, investments etc.

Overall Statistics	2018	2019	2020	2021	2022
Total Members	Not Reported	519,774	512,016	503,658	484,157
Calculated total margin	-5.6%	2.3%	1.1%	0.2%	-5.6%

Includes all members, not just group and individual

Detailed Statistics 2022	Individual Plans		Group Plans		MLR (Individual)	MLR (Group)
	Total	Per Member	Total	Per Member	(estimate)	(estimate)
Members	29,384		122,017			
Premiums & other revenue	351,236,756	11,953	1,265,220,503	10,369		
Medical expense (benefit payments/reserve adj.	349,711,540	11,901	1,128,452,900	9,248	100%	89%
Administrative and other expense	50,033,954	1,703	175,748,820	1,440		
Total expenses net of adjustments	399,745,494	13,604	1,304,201,720	10,689		
Net income (loss) from operations	(48,508,738)	(1,651)	(38,981,217)	(319)		
Margin	-13.8%		-3.1%			

BCBS-KC (total organization)

Balance Sheet	2021	2022
Equity	$ 742,431,000	$ 719,696,000
Assets	$ 1,649,922,000	$ 1,608,655,000
Equity Financing Ratio	**45%**	**45%**
Change in Equity Financing Ratio		0%

Values in thousands ('000(s))

Income Statement	2021	2022
Net income (loss)	(124,932,000)	(149,888,000)
Other changes in equity	ISD	127,153,000
Total change in equity	ISD	(22,735,000)

Other changes in equity include changes in asset valuation reserve, investments etc.

Overall Statistics	2021	2022
Total Members	ISD	ISD
Calculated operating margin	-5.4%	-3.6%

Includes all members, not just group and individual

BCBS-NE

Balance Sheet	2018	2019	2020	2021	2022
Equity	$ 387,725,884	$ 401,725,410	$ 413,957,393	$ 454,437,085	$ 401,008,245
Assets	$ 912,251,871	$ 908,933,074	$ 943,169,477	$ 974,606,908	$ 951,064,603
Ratio	**43%**	**44%**	**44%**	**47%**	**42%**
Change in Equity Financing Ratio		2%	0%	3%	-4%

Income Statement	2018	2019	2020	2021	2022
Net income (loss)	6,321,761	916,124	22,805,302	(5,263,624)	(74,852,925)
Other changes in equity	(25,071,818)	13,083,403	(10,573,320)	45,743,316	21,424,085
Total change in equity	(18,750,057)	13,999,527	12,231,982	40,479,692	(53,428,840)

Other changes in equity include changes in asset valuation reserve, investments etc.

Statistics	2018	2019	2020	2021	2022
Members	327,925	310,528	294,825	288,678	283,836
Calculated total margin per member	0.4%	0.1%	1.4%	-0.3%	-4.5%

Includes all member months, not just group and individual

Detailed Statistics 2022	Comprehensive Plans		MLR (Individual)
	Total	Per Member	(estimate)
Members	not reported		
Premiums & other revenue	1,096,247,619		
Medical expense (benefit payments/reserve adj.)	1,050,700,329		96%
Administrative and other expense	69,868,239		
Total expenses net of adjustments	1,120,568,568		
Net income (loss) from operations	(24,320,949)		
Margin	-2.2%		

HCSC (Blue Cross Blue Shield Affiliate Serving Oklahoma)

Balance Sheet	2018	2019	2020	2021	2022
Equity	$ 247,811,799	$ 236,352,448	$ 185,341,347	$ 172,519,696	$ 105,223,030
Assets	$ 1,043,871,963	$ 897,871,669	$ 904,886,791	$ 994,601,182	$ 1,077,551,884
Ratio	**24%**	**26%**	**20%**	**17%**	**10%**
Change in Equity Financing Ratio		3%	-6%	-3%	-8%

Income Statement	2018	2019	2020	2021	2022
Net income (loss)	(156,280,285)	(101,170,660)	(88,311,033)	(41,687,704)	(102,916,215)
Other changes in equity	144,612,973	89,711,309	37,299,932	28,866,053	35,619,549
Total change in equity	(11,667,312)	(11,459,351)	(51,011,101)	(12,821,651)	(67,296,666)

Other changes in equity include changes in asset valuation reserve, investments etc.

Statistics	2018	2019	2020	2021	2022
Members	529,103	544,545	531,742	535,244	549,379
Calculated total margin per member	-0.9%	-1.8%	-1.2%	-0.7%	-1.2%

Values are for total, not reported as individual business lines

Detailed Statistics 2022	Other Health Plans		MLR
	Total	Per Member	(estimate)
Members and end of year	not reported		
Premiums & other revenue	207,864,884		
Medical expense (benefit payments/reserve adj.)	230,401,481		111%
Administrative and other expense	33,870,410		
Total expenses net of adjustments	264,271,891		
Net income (loss) from operations	(56,407,007)		
Margin	-27.1%		

Aetna Better Health of Kansas, Inc.

Balance Sheet	2022
Equity	$ 157,346,566
Assets	$ 430,919,288
Equity Financing Ratio	**37%**

Income Statement	2022
Net income (loss)	47,963,566
Other changes in equity	(30,632,382)
Total change in equity	17,331,184

Other changes in equity include changes in asset valuation reserve, investments etc.

Overall Statistics	2022
Total Members	156,411
Calculated total margin	3.3%

Includes all members, not just group and individual

Detailed Statistics 2022	Comprehensive (Hospital + Medical)		MLR
	Total	Per Member	(estimate)
Members and end of year	not reported		
Premiums & other revenue	33,022,437		
Medical expense (benefit payments/reserve adj.)	26,721,839		81%
Administrative and other expense	4,094,496		
Total expenses net of adjustments	30,816,335		
Net income (loss) from operations	2,206,102		
Margin	6.7%		

UnitedHealthcare

Balance Sheet (in millions)	2021	2022
Assets	125,289,000,000	144,286,000,000
Liabilities	53,529,000,000	66,514,000,000
Equity	71,760,000,000	77,772,000,000
Total liabilities and equity	125,289,000,000	144,286,000,000
Equity to Assets Ratio	57%	54%
		-3%

[i] Chartis' report available at https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf

[ii] Source: https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

[iii] Source: https://www.definitivehc.com/resources/healthcare-insights/hospital-operating-margins-united-states

[iv] Medicare Cost Reports (FY19 & FY22)

[v] Source: Medicare Cost Reports (FY19 – FY22) - https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports/cost-reports-fiscal-year

[vi] *Source: Center for Healthcare Quality & Payment Reform*

[vii] Source: 2021 KFF analysis of MLR data from [Health Coverage Portal TM](https://www.markfarrah.com/products/health-coverage-portal/), a market database maintained by Mark Farrah Associates, which includes information from the National Association of Insurance Commissioners. Mini-med companies with a medical focus were included.

[viii] Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey Insurance Component. Data tool can be found [here.](https://datatools.ahrq.gov/meps-ic)

[ix] Kansas Hospital Association All-Payers Scorecard Data