# The State of New Hampshire
# Insurance Department

21 South Fruit Street, Suite 14
Concord, NH 03301
(603) 271-2261 Fax (603) 271-1406
TDD Access: Relay NH 1-800-735-2964

**Roger A. Sevigny**
**Commissioner**

**Alexander K. Feldvebel**
**Deputy Commissioner**


April 13, 2012

Governor John Lynch
Senate President Peter Bragdon
House Speaker William O'Brien
State House
Concord, NH 03301

## The Commissioner's First Annual Health Insurance Rate Report

The New Hampshire Insurance Department is required under RSA 420-G:14-a to hold an annual public hearing concerning premium rates in the health insurance market and to identify the factors, including health care costs and cost trends, that have contributed to rate increases during the prior year. On October 28, 2011 the Department held its first public hearing. Representatives of New Hampshire's major health insurance carriers, including Anthem Health Plans of New Hampshire, Harvard Pilgrim Health Care, Cigna, New Hampshire Health Plan, and MVP Health Plan of New Hampshire testified at the hearing. The Department also heard testimony from the New Hampshire Hospital Association, the New Hampshire Medical Society, Bi-State Primary Care and New Hampshire Voices for Health. The Department contracted with Compass Health Analytics, Inc. to assist in evaluating the testimony and other information received as part of the hearing process.

The first annual health insurance rate report being issued today is one step toward better identifying the cost drivers leading to health insurance premium increases and toward improving the transparency of the health insurance premium review process. The focus of this report is to break down the premium cost growth measured between 2009 and 2010 to determine which components of cost contributed most to that growth. The analysis considered claims costs, administrative loads, and health carrier profits. However, there are more fundamental, underlying factors, such as new medical technologies and other systemic developments, that are also part of the health insurance and health care cost equation. In future reports, the Department will further explore some of these issues, such as the correlation between health care prices and the extent to which premium rates in the commercial insurance sector may be affected by lower payments to health care providers from Medicare, Medicaid, and the uninsured.

Key findings discussed in today's report include the following:

1. **When comparing costs for a fixed benefit package, premiums grew 14% between 2009 and 2010.**

   This overall estimated increase breaks into large employer, small employer and individual (non-group) premium growth rates of 6%, 15% and 39% respectively.

2. **Premium increases were driven by several years of rapid claims cost growth leading up to 2010, especially for hospital outpatient services.**

   Services cited by carriers as being particularly expansive and responsible for this cost growth include outpatient surgery, outpatient laboratory, and IV infusion therapy. Actual claims costs for 2010 were far lower than carriers expected.

3. **The average level of benefit coverage dropped 10% between 2009 and 2010.**

   The price of coverage went up by 14% on average, but actual premium revenue collected by carriers grew by only 2.6% because buyers chose coverage packages with reduced benefit levels. Benefit buy-downs generally lower premiums , but increase cost sharing for patients.

4. **Per-person service use in this period declined by 2.2%**

   Provider prices increased by 5.4%, but growth in overall payments to providers dropped dramatically in comparison to prior years, going from 9% growth in 2009 to 3% growth in 2010.

5. **Carrier profits in New Hampshire averaged 1.8% of premium revenue.**

   Anthem, with 45% of the market, had an underwriting gain of 6.6%. This is more than twice the national average of 3.1%. The other three carriers lost money.

The analysis contained in this report continues the Department's effort to better understand and explain health insurance premium growth and to provide information that will help New Hampshire's policymakers develop strategies for increasing the efficiency of New Hampshire's health care financing and delivery system.

# Report to the
# State of New Hampshire Insurance Department

## 2010 Cost Drivers
## 2010-RRG-01

April 13, 2012

Submitted by


Compass Health Analytics, Inc.

254 Commercial St. 2nd floor, Portland, Maine 04101
(p) 207.541.4900 (f) 207.523.8686
www.compass-inc.com
Contact: James Highland, PhD, jh@compass-inc.com


# Report to the State of New Hampshire Insurance Department on 2010 Cost Drivers

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# Report to the State of New Hampshire Insurance Department on 2010 Cost Drivers

## Executive Summary

"An Act requiring public hearings concerning health insurance cost increases in health care services" (RSA 420-G:14-a) directs the New Hampshire Insurance Commissioner as follows:

> "The commissioner shall hold an annual public hearing concerning premium rates in the health insurance market and the factors, including health care costs and cost trends, that have contributed to rate increases during the prior year. The commissioner shall evaluate claims costs, administrative loads, and health carrier profits. The commissioner shall identify the factors that contribute to cost increases affecting health insurance premiums and health care services in New Hampshire."

The bill goes on to direct the commissioner to:

- Prepare an annual report addressing the market factors for premium increases in the prior year
- Include identification and quantification of health care spending trends and the underlying factors that contributed to increases in health insurance premiums.

This report represents the New Hampshire Insurance Department's (The Department) compliance with this statutory requirement, and the key findings are contained in this executive summary. The following findings describe results from an analysis of New Hampshire's fully insured market, and rely on data obtained from the following data filed with the Department of Insurance:

- Carrier Annual Statements (financial statements) from 2006-2010,
- Carrier Supplemental Report data submitted in 2009 and 2010,
- A questionnaire of carriers formulated for the purposes of this study which collected additional data for 2009 and 2010, and
- The New Hampshire Comprehensive Health Information System database.

In addition, data from the National Association of Insurance Commissioners was used for purposes of regional and national comparisons.

The findings are summarized in five areas of findings below, focusing on premium levels (insurance prices for fully insured products), drivers of premium levels, and the actual healthcare utilization and cost experience in 2010.

**Finding #1: For a fixed benefit package, per-person premiums grew 14% between 2009 and 2010**

Premiums are the prices charged by carriers for fully insured products. The amount of coverage in the average policy sold has been declining over time owing to increased patient cost sharing. When the coverage level declines, the change in premium understates the true price increase. Premiums were adjusted for the change in coverage level using data provided by the carriers, to approximate the price change for a fixed benefit package.

- *The per-person premium cost at a given coverage level increased an estimated 14.3% between 2009 and 2010.* Premium levels in 2010 grew by approximately 14.3% relative to 2009 at a given coverage level, though coverage levels dropped significantly.
- *Individual policies at a given coverage level increased by much more, and large group policies by less.* On an identical-policy-basis (that is, adjusted to a constant coverage level), the overall estimated increase of 14.3% breaks into large group, small group, and individual (non-group) policy growth rates of 6%, 15% and 39% respectively.

**Finding #2: Premium increases were driven by several years of rapid claims cost growth, especially hospital outpatient services**

Premium levels for 2010 were set by carriers in late 2009 after evaluating historical rates of growth in medical spending, expected future changes in provider contracts, financial performance in previous years, and other factors.

- *Rapid medical claims cost growth in the years leading up to 2010 was the biggest driver of carrier cost projections and premium levels for 2010.* Claims cost growth in 2007-2009 averaged over 10% per year over that period.

- *Outpatient facility costs were the biggest driver of claims costs and premium levels.* Of the historical claims costs, outpatient facility services were the fastest growing in the prior periods, with the 2008-2009 growth rate nearly twice as large (12.8%) as other service categories (inpatient, physician, pharmacy), which grew between 5.5% and 7.5%, and so were the biggest drivers of claims costs. Services cited by carriers as being particularly expensive and responsible for this cost growth include outpatient surgery, outpatient laboratory, and IV infusion therapy. Actual costs in 2010, after premium levels were set in late 2009, were far lower than expected for outpatient hospital and all other services.

- *Carrier administrative cost component of premium grew at the same rate as premiums, but actual spending grew faster than premiums, led by wages, salaries, and benefits.* Carrier administrative loads as a percentage of premium revenue were flat over the historical periods and carriers did not build a cost increase (on a percentage basis) into their premiums. However, actual administrative spending as a percentage of actual premium revenue grew one percentage point, to 10.9%, and actual administrative expenses per

member (not including taxes and assessments) grew by 12.5%, from $37.26 to $41.92 per member per month.

**Finding #3: Carrier profits are consistently above the national average for one carrier and consistently negative for other carriers**

Of the market for fully insured business in New Hampshire in 2010, approximately 93% was sold by four carriers. Of those, Anthem BlueCross and BlueShield had 45% of the market, Harvard Pilgrim 31%, and Cigna and MVP each with just under 9%.

- *Carrier profits were at a level within national benchmarks overall.* Based on carrier annual statement data, carrier profits averaged 1.8% of premium revenue in 2010, compared to a national average of 3.1%.
- *Carrier profit for Anthem BlueCross BlueShield was over twice the national average.* Anthem's underwriting gain was 6.6%, compared to the national average of 3.1%.
- *The other three carriers composing the bulk of the market lost money.* The carriers with second, third, and fourth ranked market share lost money.

This pattern of large positive margins for Anthem and losses for the other three large carriers occurred in four of the five years from 2006-2010.

**Finding #4: Reduced insurance coverage levels were purchased in 2010, reducing the increase in average premium revenue received by carriers and shifting cost to patients**

After premium levels are set for the year, decisions are made by businesses and individuals about the level of coverage to purchase, including deductible, copayments, and coinsurance levels. The change in actual premium revenue collected per insured person reflects both the change in the price of insurance coverage (generally increasing) and the change in the coverage level (generally decreasing, that is, higher member cost sharing).

- *The average level of benefit coverage in policies sold dropped approximately 10% between 2009 and 2010.* There was a 10% decrease in the "actuarial value," that is, the ratio of a given benefit level to a standard plan design, in health insurance policies sold in 2010 compared to those sold in 2009. The decrease in actuarial value indicates a greater cost-sharing by the insured.
- *Per-person premium revenue grew slowly as a result*. Per-person carrier premium revenue grew by only 2.6% owing to the decline in coverage levels, which offset the 14.3% increase in the cost of a fixed benefit package cited above under Finding #1.

**Finding #5: Provider prices increased faster than claims costs and per-person service use experienced a negative growth rate**

Growth in per person claims costs was deconstructed into changes in the price levels paid to providers, and the change in the amount of services provided to patients. The change in the amount of services is composed of both service volume and service mix/intensity (this study did not attempt to deconstruct the components of service changes into these factors).

- *The rate of growth in claim payments per member to providers for covered services delivered dropped dramatically, compared to prior years, growing approximately 3 percent.* As measured by the allowed charge trend, the rate of growth of payments received by providers from both insurers and patients for services used decreased significantly, from just under 9% in 2009 to approximately 3% in 2010. It is likely that at least some of this reduction is related to the response by patients to the higher cost sharing, though identifying a definitive cause of the reduced trend is not possible.
- *Provider prices increased approximately 5.4%, at a rate faster than payments, implying a decrease in services used by patients of approximately 2.2%.* Given the carrier-provided information on provider price increases in 2010 of approximately 5.4%, service use (including service mix or intensity) declined by an estimated 2.2%. The largest decline was in pharmacy, which was aided by the expiration of patents on popular drugs.

**Report to the State of New Hampshire Insurance Department on 2010 Cost Drivers**

## Introduction

"An Act requiring public hearings concerning health insurance cost increases in health care services" (RSA 420-G:14-a) directs the New Hampshire Insurance Commissioner as follows:

> "The commissioner shall hold an annual public hearing concerning premium rates in the health insurance market and the factors, including health care costs and cost trends, that have contributed to rate increases during the prior year. The commissioner shall evaluate claims costs, administrative loads, and health carrier profits. The commissioner shall identify the factors that contribute to cost increases affecting health insurance premiums and health care services in New Hampshire."

The bill goes on to direct the commissioner to:

- Prepare an annual report addressing the market factors for premium increases in the prior year
- Include identification and quantification of health care spending trends and the underlying factors that contributed to increases in health insurance premiums.

This report represents the New Hampshire Insurance Department's (The Department) compliance with this statutory requirement.

The primary focus of this report is on drivers of health insurance premiums in the fully insured state-regulated market. Since the primary focus is on cost growth and the drivers of that growth, and not on cost levels, it is the change between years that must be measured, and as such it is critical that the data between years be reported on a consistent basis so as not to distort the measured change.

Available data sources were incomplete and inconsistent for a number of reasons. First, carriers without New Hampshire-specific insurance licenses have their data reported across states in their annual statements, without a breakout of New Hampshire data. Second, the Supplemental Health Care Exhibit (SHCE), which provides New Hampshire-specific information for all carriers licensed in New Hampshire, first became available in 2010. Since 2009 data are not available, no change over time can be calculated.[1] The Department's Supplemental Report (SR) data is a good source of additional information on the carriers. However, the SR data may not correspond exactly with the primary data sources, as the approval of rate increases for some of the policies about which SR

[1] Further, there are issues with the information reported in the 2010 SHCE. These issues range from the general (ambiguities in the instructions) to the specific (some carriers' SHCEs examined for this project appear to be inconsistent with the carriers' associated Annual Statements (AS)).

information is submitted may occur outside New Hampshire. Information in the SR data to exclude these persons is available but may have reliability issues.

Since existing sources could not measure changes from 2009 to 2010 accurately, and since there are additional information items useful to the purpose of this study, a carrier questionnaire (CQ) was issued to the four largest carriers to obtain a consistent measurement over the two years for approximately 85%-90% of the insured market.

## Definition of Cost Drivers

The statute compelling this report directs the State to investigate claims costs, administrative costs, and carrier profits and to "identify the factors that contribute to cost increases affecting health insurance premiums and health care services in New Hampshire."

The focus of this report is to deconstruct the cost growth measured between 2009 and 2010 to determine which components of cost, based on their relative size and relative growth rates, contributed most to that growth. The largest contributors to cost will be termed "cost drivers." However, before undertaking the discussion of this cost growth deconstruction, we will briefly address what research tells us are more fundamental underlying factors in health care cost growth that are not specific to New Hampshire or to 2009-2010.

Health economists addressing the issue of health care cost growth will confirm in the minds of those searching for a way to reduce health care cost growth Carlyle's nickname for economics as the "dismal science." Hartwig (2008) notes that despite differences in the level of health care spending between countries, "The share of health care expenditure in GDP rises rapidly in virtually all OECD [developed] countries." He poses and empirically confirms a model which attributes this cost growth to health care's labor-intensive nature and the degree to which it necessarily has lower productivity increases than industries in which automation accelerates productivity growth. The only possible result is that more labor-intensive industries like healthcare will increase their share of GDP relative to industries with technologically-driven productivity increases.

Technology not only does not help healthcare keep pace with other industries in productivity growth, technology is generally agreed to be the primary driver of health care costs. In healthcare, technology generally increases the number of conditions that can be addressed with medical spending, or the degree to which a condition can be ameliorated. A Congressional Budget Office study (2008) reviewed the literature and concluded that technology manifested in "the capabilities of medicine" has been the largest single driver of healthcare costs, and is responsible for the majority of cost growth. Fuchs (2005) points out that while factors such as higher physician incomes, more amenities, lower utilization of expense fixed equipment, and other factors explain differences in the level of health care spending between the U.S. and other countries, "…the rate of growth of expenditures over time in the United States and in other countries is driven primarily by new technology and new applications of old technology."

As to what can be done about health care cost growth, Chernew et. al. (2004) conclude that "Policy debates and budgetary discussions must recognize that health care cost growth in excess of GDP growth is likely inevitable in the foreseeable future." Similarly, Pauly (2003) is skeptical that we have the means to reduce cost growth in a manner that people find satisfactory (as witnessed by the managed care backlash of the 1990s). In fact, health care technology innovation has provided tremendous benefits to the population, benefits that are highly valued in many cases. Ultimately, Pauly points out, the standard for additional health care spending is whether marginal benefits of care exceed marginal costs, and evaluating potential policy actions involves trade-offs rather than silver bullets.

Recognizing that there are large systemic forces at work in cost growth does not mean that any specific situation's cost growth does not have the potential for improvement. At a minimum, understanding the actual components of cost growth provides the right context for any policy interventions that might be made. So, we can evaluate the actual growth between 2009 and 2010, as required by statute, breaking the growth down into per person costs for:

- Claims, which can be further broken into service categories, utilization rates, and unit costs,
- Administrative costs, which can be sub-divided into categories of administrative cost, and
- Profit

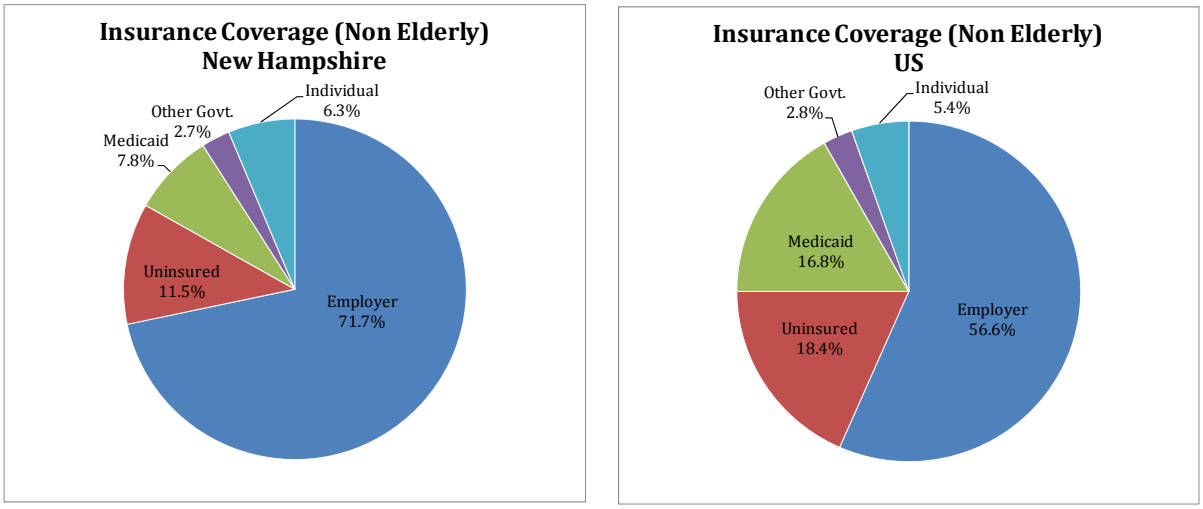
Those items growing at a rate faster than the overall cost growth rate between 2009-2010 can, for purposes of this study, be deemed cost drivers.

## Overview of the New Hampshire Private Insurance Market

New Hampshire's private insurance market is a large component of the state's health care system. Exhibit 1 illustrates that with below-national-average levels of Medicaid-covered and uninsured individuals, in 2008 the private market in New Hampshire covered 80% of the non-elderly, as compared to 62% nationally[2].

[2] The Kaiser Family Foundation data used here do not agree exactly with the carrier data received and presented in this report. In particular, the individual market is slightly larger as measured by Kaiser.

**Exhibit 1**




Source: CMS Annual Statistical Compendium, Kaiser Family Foundation State Health Facts

In Exhibit 2, we see that based on the 2010 New Hampshire SR, just under 300,000, or 46.6%, of the privately insured are in fully-insured products, and 53.4% are covered by self-insured employers. The fully insured market is dominated by Anthem and Harvard Pilgrim, with 45% and 31% market share, respectively, followed by Cigna and MVP with 9% each.

**Exhibit 2**

**New Hampshire Membership and Market Share by Coverage Type - 2010 Private Coverage**

| | Fully-Insured Members | Percent of Fully Insured | Self-Insured Members | Percent of Self-Insured | Total Members | Percent of Total |
|---|---|---|---|---|---|---|
| Anthem NH | 134,242 | 45.0% | 143,704 | 42.2% | 277,946 | 43.5% |
| Harvard Pilgrim | 92,306 | 30.9% | 60,078 | 17.6% | 152,384 | 23.8% |
| MVP | 25,948 | 8.7% | 0 | 0.0% | 25,948 | 4.1% |
| CIGNA_CGLC_GW | 25,732 | 8.6% | 111,541 | 32.7% | 137,273 | 21.5% |
| HealthMarkets | 7,087 | 2.4% | 0 | 0.0% | 7,087 | 1.1% |
| UnitedHealth | 4,949 | 1.7% | 0 | 0.0% | 4,949 | 0.8% |
| Assurant | 4,791 | 1.6% | 0 | 0.0% | 4,791 | 0.7% |
| Celtic Insurance Co | 1,552 | 0.5% | 0 | 0.0% | 1,552 | 0.2% |
| Aetna | 821 | 0.3% | 20,427 | 6.0% | 21,248 | 3.3% |
| American_Republic | 504 | 0.2% | 0 | 0.0% | 504 | 0.1% |
| Golden Rule | 237 | 0.1% | 0 | 0.0% | 237 | 0.0% |
| The Guardian Life | 83 | 0.0% | 0 | 0.0% | 83 | 0.0% |
| Usable Mutual | 0 | 0.0% | 5,088 | 1.5% | 5,088 | 0.8% |
| **Total** | **298,250** | | **340,838** | | **639,088** | |

Source: New Hampshire 2010 Supplemental Report

Exhibit 3 displays data on the market segment break down of the fully insured market, with 50% of members in large groups, 40% in small groups, and 11% in individual (non-group) coverage[3]. HMO coverage dominates, with just over half of all covered lives. PPO coverage is second most popular, particularly with large groups. PPO is the most popular plan in non-group coverage, and EPO is more popular in the small group market than in other markets.

**Exhibit 3**

**New Hampshire Fully Insured by Market Segment and Product Type**
**2009, 2010, and Change**

| 2009 | Large Group | Small Group | Non-Group | Total |
|---|---|---|---|---|
| HMO | 80,593 | 63,233 | 388 | 144,215 |
| POS | 7,131 | 2,858 | - | 9,989 |
| PPO | 47,262 | 26,041 | 26,688 | 99,991 |
| EPO | 4,786 | 14,203 | 25 | 19,014 |
| Indemnity | 1,140 | 238 | 2,546 | 3,924 |
| **Total** | **140,912** | **106,575** | **29,647** | **277,133** |
| Exclusions | 52,602 | 22,702 | 209 | 75,512 |
| Total Reported | 193,514 | 129,277 | 29,856 | 352,645 |
| | | | | |
| **2010** | | | | |
| HMO | 65,980 | 64,024 | 203 | 130,207 |
| POS | 4,498 | 5,717 | - | 10,215 |
| PPO | 54,207 | 18,675 | 25,980 | 98,863 |
| EPO | 6,583 | 16,882 | 71 | 23,536 |
| Indemnity | 31 | 101 | 2,175 | 2,307 |
| **Total** | **131,299** | **105,400** | **28,429** | **265,128** |
| Exclusions | 9,621 | 6,451 | 17,051 | 33,122 |
| Total Reported | 140,920 | 111,851 | 45,480 | 298,250 |
| | | | | |
| **Change 2009-2010** | | | | |
| HMO | (14,613) | 791 | (186) | (14,008) |
| POS | (2,633) | 2,859 | - | 226 |
| PPO | 6,945 | (7,366) | (708) | (1,128) |
| EPO | 1,797 | 2,679 | 46 | 4,522 |
| Indemnity | (1,109) | (138) | (371) | (1,617) |
| **Total** | **(9,612)** | **(1,175)** | **(1,218)** | **(12,005)** |

Source: New Hampshire 2009 and 2010 Supplemental Reports

## Premium Trends

Premium trends can be evaluated in three different ways. The first measurement of premium draws on the filed rates provided by carriers to the Department. These rates are average premium

[3] Note that the Supplemental Report data in Exhibit 3 has been adjusted to make it comparable between years. More specifically, the Healthy Kids program has been excluded from both years, and member data for legal entities were only included in Exhibit 3 if available for both 2009 and 2010.

rates that draw on assumptions about enrollment in benefit plan and product mix before enrollment actually takes place, and so produce average premium levels at assumed (usually historical) mixes of enrollment. This average premium is a measure of price, but it is an average price affected by and reflecting an average product mix that may not occur after enrollment. Exhibit 4 shows that overall the 2010 rates filed by the four largest carriers increased 8.4% over their 2009 filed levels. Increases in individual (non-group) products were far lower, at 1.6%.

**Exhibit 4**

**Aggregate Rate Filing Assumptions by Market Segment, PMPM**
**Four Largest Carriers, Weighted Average by Member Months**

| | 2009 | 2010 | % Change |
|---|---|---|---|
| Fully Insured | | | |
| Non-Group | $302.17 | $307.05 | 1.6% |
| Small Group | $449.69 | $496.05 | 10.3% |
| Large Group | $432.04 | $466.28 | 7.9% |
| **Total Fully Insured** | **$428.12** | **$464.00** | **8.4%** |

Source: 2011 NHID Carrier Questionnaire

The second measurement of premium price change uses actual premium revenue based on the actual enrollment into benefit plans and products. The change in PMPMs of actual premium revenue between 2009 and 2010 is displayed in Exhibit 5.

**Exhibit 5**

**Aggregate Actual Premium Revenue by Market Segment, PMPM**
**Four Largest Carriers, Weighted Average by Member Months**

| | 2009 | 2010 | % Change |
|---|---|---|---|
| Fully Insured | | | |
| Non-Group | $270.92 | $295.45 | 9.1% |
| Small Group | $384.63 | $403.61 | 4.9% |
| Large Group | $388.39 | $388.76 | 0.1% |
| **Total Fully Insured** | **$376.48** | **$386.35** | **2.6%** |

Source: 2011 NHID Carrier Questionnaire

To the extent that "buy down" (i.e., selection of lower than historical average benefit levels by customers) occurs, the average premium revenue will be lower than the premium assumption in the filed rates. The actual premium revenue increased at a much higher rate than the filed rates (9.1% vs. 1.6%) for individual products, and increased at a much lower rate than filed rates (0.1% vs. 8.4%) for large group insurance. Potential sources of difference between filed rates and actual premiums include the difference between the carriers' assumed mix of benefit plans and contract types (single, family, etc.) in the filed rates, and their actual mix of benefit plans and contract types in coverage sold. We do not have data on the assumed mixes the carriers used to calculate aggregate premiums PMPM in the rate filing, and so we cannot assess the specific contribution of

the difference in benefit plan and contract type mix to the rate of increase in filed rates versus the rate of increase in actual premium.

For large groups, there was a significant shift from fully insured plans to self-insured plans (note the drop in fully insured large groups in Exhibit 3), which may have left the mix of benefit plans in fully-insured less rich (data discussed further below supports a significant decrease in the average benefit plan); this could contribute to a difference between the filed benefit plan mix and the actual mix. Large groups also negotiate their increases; the average negotiated discount would also contribute to a smaller increase in average actual rates than in filed rates.

For non- group, the larger actual average change in rates compared to the filing would be consistent with a lower benefit mix in the filings, which would occur, for example, if the carriers over-estimated the degree of benefit buy down that would occur. However, without access to the benefit mix carriers assumed in their rate filing calculations it is difficult to know. It is worth pointing out that the standard actuarial values required in the ACA's insurance exchanges would reduce this uncertainty about pricing. In any case, requiring information on the assumed benefit mix in rate filings would help to determine the source of the differences between filed and actual rates.

The third measurement of rate of change in premiums adjusts the premiums for the relative "actuarial value" of the benefit packages, attempting to hold the coverage level constant when comparing premium levels. The comparison made is the 2009 average premium to the 2010 average premium, where both have been adjusted to represent a standard benefit package. Changes in the levels of both filed rates (prospective average premiums) and premium revenue (retrospective, actual average premiums paid) reflect both changes in the cost of delivering a given benefit package, and changes in the average benefit level over time. The generally decreasing level of average benefits (e.g., increasing deductibles) then depresses the rate of change in premiums below the rate of the rate of change in the price of delivering a fixed benefit package. In other words, since the degree of insurance coverage is shrinking over time, the change in premiums is smaller than the change in the cost of a given level of coverage. In the tables above, the overall increase between 2009 and 2010 of actual premium revenue was 2.6%. This could indicate that the degree of buy down in coverage was larger than assumed in the rate filings, which showed an average increase of 8.4%. As noted, some of the difference is also attributable to the much lower rate of increase than projected in large group insurance. We can attempt to adjust for the different benefit levels between the years to isolate the pure price change in premium levels, though the accuracy of the actuarial values submitted in the Supplemental Report is difficult to verify and is likely anomalous in some cases[4].

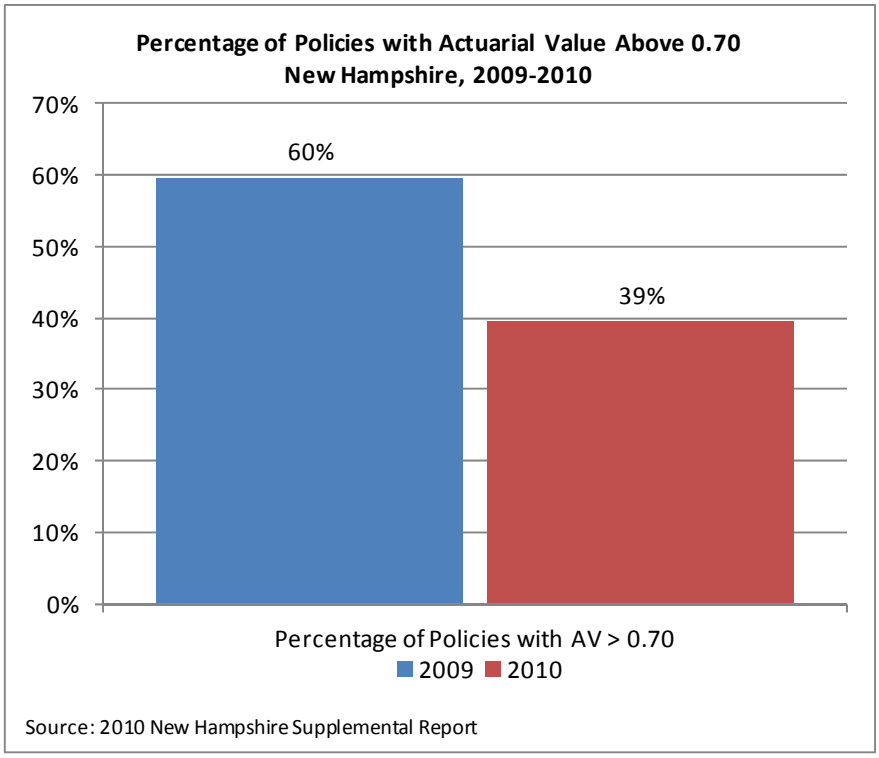
The actuarial value represents the ratio of a given benefit level to a standard plan design. The standard plan designs used represent benefit levels close to full coverage. For example, in the standard plans, HMO, POS, and PPO have no deductible and no coinsurance if care is in-network; co-pays for professional services are $10, Rx is $5/$10/$25, and ER is $50. Over time, one would

[4] Supplemental Report of the 2010 Health Insurance Market in New Hampshire, State of New Hampshire Insurance Department, April 10, 2011

expect the actuarial value for a given benefit level to increase due to the impact of leveraging. As total medical expenses grow with trend, the portion of the expenses covered by member cost-sharing (e.g. deductibles, copayments, coinsurance) becomes smaller while the portion of expenses covered by the carrier gets larger; thus, the actuarial value of the benefit level increases. When looking at a block of business, if health care costs increased while all other factors remained constant from one year to the next, the overall average actuarial value for the block of business would be expected to increase for the reason described.

Despite this natural tendency to increase, in the New Hampshire fully insured market the overall actuarial value has decreased from 0.63 in 2009 to 0.56 in 2010. One likely reason for this significant decrease is the movement of members from richer benefit levels in 2009 to less rich (higher member cost-sharing) benefit levels in 2010. In 2009, 60% of members had benefit levels with an actuarial value greater than 0.70 while in 2010, 39% of members had benefit levels with an actuarial value greater than 0.70, as shown in Exhibit 6.

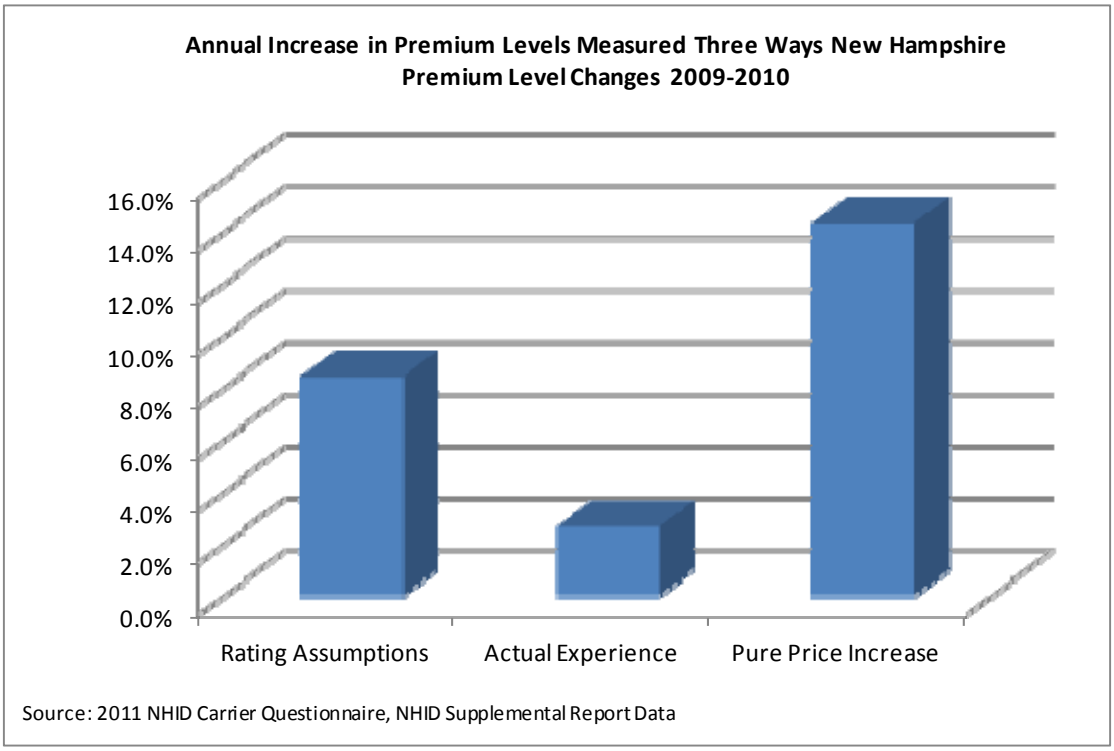
**Exhibit 6**




The "pure price increase" adjusts the premiums for the actuarial value, and shows an increase from 2009 to 2010 of 14.3%, shown in Exhibit 7. While the actuarial value adjustments depend on the accuracy of the actuarial value data submitted by the carriers in the Supplemental Report, these results suggest that the low increase in premium revenue of 2.6% is masking a large decrease in the

coverage value of the policies purchased, and that the average price increase of these policies with coverage levels held constant is many times larger than the nominal price increase[5].

**Exhibit 7**




How does the change in actual revenue between 2009 and 2010 compare to historical increases? Using publicly available Annual Statement data for the largest carriers with New Hampshire-specific licenses, we can see that the 2010 premium revenue shows the lowest annual increase of the last four years[6].

[5] In response to a question from Commissioner Sevigny during the Hearing, one carrier testified that the typical policy had an increase in deductible over this period from $1,500 to $2,000.

[6] As noted, the Annual Statement data presented excludes carriers with annual statements containing operations in multiple states, thus excluding some of the operating entities of the four largest carriers. The data include all of Anthem and MVP, but exclude two of the three Cigna operating units and two of the three HPHC operating units. Results from the carrier questionnaire include these entities missing from the annual statement data, i.e., the NH operations of carriers with multi-state licenses. As a result, the rate of change for 2010 in Exhibit 8 is similar to but somewhat different from the carrier questionnaire data in Exhibit 5.

**Exhibit 8**

**Comprehensive Major Medical Revenue Growth Rate**

| | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|
| Anthem (Consolidated) | 4.4% | 7.5% | 6.8% | 4.1% |
| *Anthem Hlth Plans of NH* | *0.3%* | *3.1%* | *8.7%* | *7.5%* |
| *Matthew Thorton Hlth Plan Inc* | *8.0%* | *11.4%* | *5.5%* | *1.3%* |
| Harvard Pilgrim Health Care New Eng | 10.5% | 9.2% | 9.0% | 9.5% |
| MVP (Consolidated) | -5.4% | 6.4% | 8.9% | -2.0% |
| *MVP Hlth Ins Co of NH Inc* | | | *8.5%* | *-2.2%* |
| *MVP Hlth Plan of NH Inc* | *-5.4%* | *2.1%* | *15.9%* | *93.6%* |
| Cigna Hlthcare NH Inc | 6.0% | 8.3% | 15.7% | 10.6% |
| **Overall** | **6.2%** | **7.1%** | **7.3%** | **3.9%** |

Source: Annual Statements filed with NHID, 2007-2010.

We do not have actuarial value data available for the prior years in Exhibit 8 to isolate the pure price increase effect from reductions in average benefit levels over time[7].

What is driving these increases over time? As we discuss at length in the next section, the most important part of what drives changes in premium levels is the growth in medical claims costs in time periods 2-4 years before the period to which the rates are applicable.

More detailed comparisons of rating assumptions, actuarial experience, and actuarial-value adjusted premiums are contained in the Appendices to the report.

## Claim Trends

Carriers submit rate filings approximately one quarter before the rates become effective, which means the analysis for the filing is being conducted from 4-6 months prior to the beginning of the rating period, in year "R-1". At that point in time, some estimated information on trend in R-1 is available, but complete data is available only for the prior year, that is, two years before the rating period in year "R-2". Trend rates will typically be evaluated then, for years R-4 through R-2, with some preliminary data for R-1. A key driver then of the levels of the premium rates in a given year are these trends from earlier periods, with consideration of known changes that are expected to impact future trend. The largest groups are most likely to be trended using their own group-specific experience, which will be evaluated in light of more broadly-based trends. Small group and individual insurance is trended in blocks, which in a smaller state like New Hampshire might combine the small group and large group experience, and/or draw on regional or national data. The exact methods used are based on the judgment of the carriers' actuaries.

[7] Note that Comprehensive Major Medical Insurance refers to Group and Non-Group Health lines of business. It does not include Medicare Supplement, Dental only, Vision only, FEHBP, Medicare, Medicaid, Other Health, and Other Non-Health lines of business, as defined in the NAIC Annual Statement.

Using the annual statement data for the four largest carriers (which, as noted, does not include all the entities regulated by the Department) allows an examination of trends for the years leading up to 2010, as shown below in Exhibit 9.

**Exhibit 9**

**Comprehensive Major Medical Medical Expense Growth Rate**

| | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|
| Anthem (Consolidated) | 6.0% | 12.6% | 8.9% | -0.7% |
| *Anthem Hlth Plans of NH* | *-1.5%* | *10.6%* | *5.9%* | *2.7%* |
| *Matthew Thorton Hlth Plan Inc* | *11.7%* | *15.2%* | *10.5%* | *-3.7%* |
| Harvard Pilgrim Health Care New Eng | 13.0% | 14.7% | 11.5% | 5.1% |
| MVP (Consolidated) | -15.0% | 33.0% | 26.5% | -6.5% |
| *MVP Hlth Ins Co of NH Inc* | | | *28.7%* | *-6.6%* |
| *MVP Hlth Plan of NH Inc* | *-15.0%* | *57.4%* | *-27.2%* | *28.0%* |
| Cigna Hlthcare NH Inc | 11.2% | 4.3% | 12.0% | 24.1% |
| **Overall** | **8.3%** | **11.2%** | **11.1%** | **-0.7%** |

Source: Annual Statements filed with NHID, 2007-2010.

While the actual trend rate in claims for 2010 was negative, this was not known in 2009 when the rate filings were prepared – in fact, as they were prepared the carriers were in the second consecutive year of 11+% trend. So, it would appear that the 8.6% assumption for claims growth in the 2010 rate filings and reflected in the 2010 premium growth rates was based on the history of high trend in claims in 2007-2009. Whether or how much the large reduction in actuarial value of the average policy sold for 2010 could have been or was anticipated is not clear, but it seems clear that the trend rates used for the rate filings reflected less utilization impact due to buy-down than actually occurred.

How would the large actual reduction in actuarial value have affected the trend rates? In evaluating the trend rates displayed in the data, it is important to consider this change in the average actuarial value of policies and the impact on the interpretation of those trends. Benefit "buy down," that is, purchase of policies with higher cost sharing, reduces cost trends in two ways:

1.) The higher cost sharing influences covered individuals to utilize fewer and/or less-expensive services, decreasing utilization and/or utilization growth
2.) For services utilized and covered by benefits, the proportion of allowed amounts covered and paid by the carrier is lower

Actuarial value and paid trend rates are affected by both of these factors. We would expect a large drop in actuarial value to depress paid trend rates significantly. Allowed amounts and allowed trend rates are affected by the utilization reduction (#1 above) but not by the reduced proportion of covered benefits (#2 above). We may expect the allowed charge trend to be similar to the paid trend adjusted for the decrease in actuarial value. However, significant decreases in utilization could help explain why the adjusted trend is higher than the allowed trend.

However, if we examine the growth in claims for 2010 after adjusting for the actuarial values of the policies using the values provided in the supplemental reporting data, the -0.7% actual paid claim trend on an adjusted basis becomes 10.7%[8]. It would appear that the underlying rate of growth in service costs did not drop to the degree suggested by the actual rate of growth in claims, but the thinner coverage provided in 2010 (reflected by the large drop in the 2010 actuarial value compared to 2009) resulted in claims expense to the carriers that was actually lower on a PMPM basis than in 2009. As will be discussed further in the "Profit" section below, this helped contribute to a significant increase in profit levels for the group of the four largest carriers (though actually increasing profits for only two of the four and resulting in positive profits for only one of the four).

The paid claim trend contained in the rate filing assumptions provided by the Top 4 carriers in the carrier questionnaire (displayed in Exhibit 10) averaged 8.6% overall, with similar levels for all but the non-group segment, which was projected to increase by only 1.2%.

**Exhibit 10**

**Claim Trend by Market Segment Used in Rating Assumptions, PMPM**
**Top Four Carriers, Change 2009 to 2010**

| | 2009 | 2010 | % Change |
|---|---|---|---|
| Non-Group | $222.35 | $224.92 | 1.2% |
| Small Group | $375.20 | $411.92 | 9.8% |
| Large Group | $362.37 | $394.18 | 8.8% |
| **Overall** | **$355.51** | **$386.01** | **8.6%** |

Source: 2011 NHID Carrier Questionnaire

Actual paid claim trend among the Top 4 (displayed in Exhibit 11) was far lower at -0.6% overall in 2010 (-0.7% in the 5-year annual statement data presented above), and was also slightly negative for the large group and small group segments. Non-group had trend at a positive level of 7.6%.

**Exhibit 11**

**Claim Trend by Market Segment, PMPM, Actual**
**Top Four Carriers, Change 2009 to 2010**

| | 2009 | 2010 | % Change |
|---|---|---|---|
| Non-Group | $171.54 | $184.54 | 7.6% |
| Small Group | $353.16 | $352.02 | -0.3% |
| Large Group | $345.09 | $339.12 | -1.7% |
| **Overall** | **$332.79** | **$330.77** | **-0.6%** |

Source: 2011 NHID Carrier Questionnaire

The average actuarial value for the Top 4 carriers was 0.66 in 2009, dropping to 0.60 in 2010. This could explain the low level of actual paid claim trend in 2010.

[8] Actuarial value would more properly be used to adjust only premium levels, but this calculation provides an approximation of the claim trend rate that would be implied without the change in AV.

The only available source of allowed charge data to calculate trends is the NHCHIS data. Coverage type (fully insured vs. self-insured) was not populated in 2009 in CHIS, so the analysis of allowed charges was performed on the entire claims data set, which includes both coverage types. The overall market allowed charge trend between 2009 and 2010 was 2.6%, down from 8.8% in 2009. The high trend in facility outpatient services cited by several carriers is evident in 2009, but has dropped dramatically in 2010 on both a paid and allowed basis[9].

**Exhibit 12**

**Paid and Allowed Trend 2009-2010**
**Top Four Carriers, Fully Insured and Self Insured**

| | 2009 Paid Trend | 2010 Paid Trend | 2009 Allowed Trend | 2010 Allowed Trend |
|---|---|---|---|---|
| Professional | 6.3% | -0.1% | 7.3% | 1.6% |
| Facility Outpatient | 12.8% | 2.8% | 13.1% | 4.2% |
| Facility Inpatient | 7.6% | 2.3% | 7.6% | 3.0% |
| Rx | 5.6% | 1.1% | 3.8% | 0.6% |
| Combined | 8.8% | 1.5% | 8.9% | 2.6% |

Source: 2011 NHID Carrier Questionnaire and the NHCHIS database

A similar pattern is evident for other services. In general, the claim trend data for 2010 shows what appears to be a large reduction in utilization trend, some of which may be attributable to benefit buy down. This is explored further in the next section.

The carrier questionnaire (fully insured and self-insured combined for comparability) contains paid claim trend data by service category between 2009 and 2010, which can be compared to the NHCHIS data. The trend rates as measured in the questionnaire are 1.1% for professional, 4.6% for outpatient, 1.4% for inpatient, and -3.2% for pharmacy.

## Cost vs. Utilization

Medical expense trends can be further deconstructed by analyzing the growth due to changes in the amounts paid to providers for services (cost) versus changes in the number and types of services used (utilization). This type of analysis requires looking at the allowed charges trend, which is different from the medical expense trend, or paid claim trend, discussed up to this point. The paid claim trend is the rate of growth of the claim amounts paid by the carrier. The allowed charges trend is the rate of growth of the total claim amount, which consists of the claims paid by the carrier and the member cost-sharing (e.g. deductible, copayments, and coinsurance). The allowed charges represent the amount that is actually paid to the providers, no matter the source of the payment.

At this time, the only source of allowed charge claim data available for use is in the NHCHIS. Changes in the submission requirements for the NHCHIS between 2009 and 2010 and carrier-

[9] Some of the trend data testimony at the hearing contained information for 2009 and earlier periods, rather than the requested period 2010, which explains the high trend rates cited.

specific idiosyncrasies required that the analysis of the dataset for the specific change from 2009 to 2010 be conducted to take those issues into account. To conduct this analysis, ratios of allowed charges to paid claims by service type were calculated from the NHCHIS database. These ratios were then applied to the paid claims provided by the carriers[10] in the NHID Carrier Questionnaire to estimate the allowed charges and calculate allowed charge trends. Both fully insured and self-insured members were included. The 2011 NHID Carrier Questionnaire included information on cost increases by claim type for 2009-2010 for the top four carriers. Using the calculated allowed charge trend described above and relying on the validity of the cost trend from the NHID Carrier Questionnaire, utilization trend can be estimated. The results can be seen in Exhibit 13.

Overall, although cost increases were greater than 5%, decreases in utilization brought the estimated allowed charges trend down to 3.1%. Trends by service type vary, but most exhibit a pattern of positive cost trend and negative utilization trend. Only hospital outpatient is showing a positive utilization/mix change. As noted in the preceding section, a shift to generics and the likely reductions in pharmacy benefits reduced pharmacy spending significantly. The unit cost trend provided by the carriers for pharmacy implies a larger utilization and service mix reduction for pharmacy.

The results would appear to be consistent with research findings which show that three quarters of health care cost increases derive from cost per case, with only one quarter caused by increases in treated prevalence (Roehrig and Rousseau, 2011). New technologies and cost shifting from government payers to the commercial sector are also consistent with these estimates.

**Exhibit 13**

**2009-2010 Allowed Trend by Claim Type**
**with Cost Trend and Utilization/Service Mix Trend**
**Top Four Carriers, Fully Insured and Self-Insured**

| | Allowed Charges | Cost | Util/Mix |
|---|---|---|---|
| Hospital Inpatient | 2.0% | 6.5% | -4.2% |
| Hospital Outpatient | 6.2% | 5.2% | 1.0% |
| Physician/Other | 2.6% | 4.0% | -1.3% |
| Pharmacy | -3.4% | 8.3% | -10.8% |
| **Overall** | **3.1%** | **5.4%** | **-2.2%** |

Source: New Hampshire CHIS (allowed charge assumptions) and 2011 NHID Carrier Questionnaire (paid claims, unit cost growth)

[10] Two carriers did not provide all SI claims by service type so an assumed distribution was used to allocate the claims to service categories. Claims identified as "Other" by one carrier were allocated to service type using the SI claims reported by service type. Another carrier's SI claims were allocated to service type using the distribution of their FI claims by service type. To the extent that actual claim experience was different from this assumption, the resulting trend rates could vary.

## Loss Ratios

Medical loss ratios can be a useful metric to understand the efficiency with which the insurance system is providing coverage. The loss ratio is simply the medical claims paid by the carrier divided by the total premium, though details of what expenses are categorized into medical expense can be more complicated than one would expect. If we look at the remainder of the premium, it is composed of administrative expenses and profit. So the loss ratio tells us how much of the premium was spent on medical services, and correspondingly, how much went to administrative overhead (including taxes and assessments) and carrier profit. Higher loss ratios can be thought of as a positive thing in that "more of the premium is going to care." However, high loss ratios could also be associated with medical costs that are too high, or with administrative expenses that are too low to adequately manage and ensure quality care. In any case, with appropriately careful interpretation, understanding how loss ratios have changed over time, and evaluating why, is an important part of performance measurement in an insurance system.

Exhibit 14 below shows the loss ratios used in 2009 and 2010 in the rating assumptions provided by the four largest carriers. Overall, the loss ratio was projected to increase slightly, with large group expected to increase and small group and individual projected to decrease slightly. The actual results shown in Exhibit 15 make clear that actual loss ratios declined by 2.8% overall, with the largest drop of 4% occurring in the small group market segment. Exhibit 16, with annual statement data, shows the multi-year trend of loss ratios, which have generally increased over time since 2006, though have dropped back down significantly in 2010 to 84.4% from 2009's five-year high level of 88.3% owing to the issues discussed above related to the drop in the claim trend in 2010[11]. The drop in the loss ratio can be further clarified by examining the changes in administrative expenses and in profits, which are addressed in the next sections.

**Exhibit 14**

**Medical Loss Ratios by Market Segment in Rating Assumptions**
**Top Four Carriers, Change 2009 to 2010**

| | 2009 | 2010 | % Change |
|---|---|---|---|
| Non-Group | 73.6% | 73.3% | -0.3% |
| Small Group | 83.4% | 83.0% | -0.4% |
| Large Group | 83.9% | 84.5% | 0.7% |
| **Overall** | **83.0%** | **83.2%** | **0.2%** |

Source: 2011 NHID Carrier Questionnaire

[11] Again, the Annual Statement data do not tie exactly to the carrier questionnaire data because the Annual Statement only includes information for carriers with New Hampshire-specific licenses, and not data for carrier entities operating in New Hampshire with multi-state licenses.

**Exhibit 15**

**Medical Loss Ratios by Market Segment, Actual**
**Top Four Carriers, Change 2009 to 2010**

| | 2009 | 2010 | % Change |
|---|---|---|---|
| Non-Group | 63.3% | 62.5% | -0.9% |
| Small Group | 91.5% | 87.5% | -4.0% |
| Large Group | 88.9% | 87.2% | -1.6% |
| **Overall** | **88.4%** | **85.6%** | **-2.8%** |

Source: 2011 NHID Carrier Questionnaire

**Exhibit 16**

**Comprehensive Major Medical Medical Loss Ratio**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | 77.8% | 79.0% | 82.7% | 84.4% | 80.4% |
| *Anthem Hlth Plans of NH* | *78.1%* | *76.7%* | *82.2%* | *80.1%* | *76.6%* |
| *Matthew Thorton Hlth Plan Inc* | *77.7%* | *80.3%* | *83.0%* | *87.0%* | *82.7%* |
| Harvard Pilgrim Health Care New Eng | 82.8% | 84.7% | 88.9% | 90.9% | 87.3% |
| MVP (Consolidated) | 79.8% | 71.7% | 89.6% | 104.1% | 99.3% |
| *MVP Hlth Ins Co of NH Inc* | | | *87.9%* | *104.2%* | *99.5%* |
| *MVP Hlth Plan of NH Inc* | *79.8%* | *71.7%* | *110.5%* | *69.3%* | *45.8%* |
| Cigna Hlthcare NH Inc | 90.2% | 94.7% | 91.2% | 88.2% | 99.0% |
| **Overall** | **80.5%** | **82.1%** | **85.3%** | **88.3%** | **84.4%** |

Source: Annual Statements filed with NHID, 2007-2010.

## Administrative Loads

Carrier rates did not contain an increase in administrative expenses as a percentage of premium overall, with decreases projected in individual and large group rates, and a small increase small group rates administrative expenses. The changes by market segment are shown in Exhibit 17.

**Exhibit 17**

**Administrative Ratios by Market Segment in Rating Assumptions**
**Top Four Carriers, Change 2009 to 2010**

| | 2009 | 2010 | % Change |
|---|---|---|---|
| Non-Group | 18.1% | 16.2% | -1.9% |
| Small Group | 9.8% | 10.3% | 0.5% |
| Large Group | 9.4% | 9.2% | -0.2% |
| **Overall** | **10.1%** | **10.1%** | **0.0%** |

Source: 2011 NHID Carrier Questionnaire

The increases in actual administrative expenses as a percentage were approximately 1% overall and in each of the market segments, as shown in Exhibit 18.

**Exhibit 18**

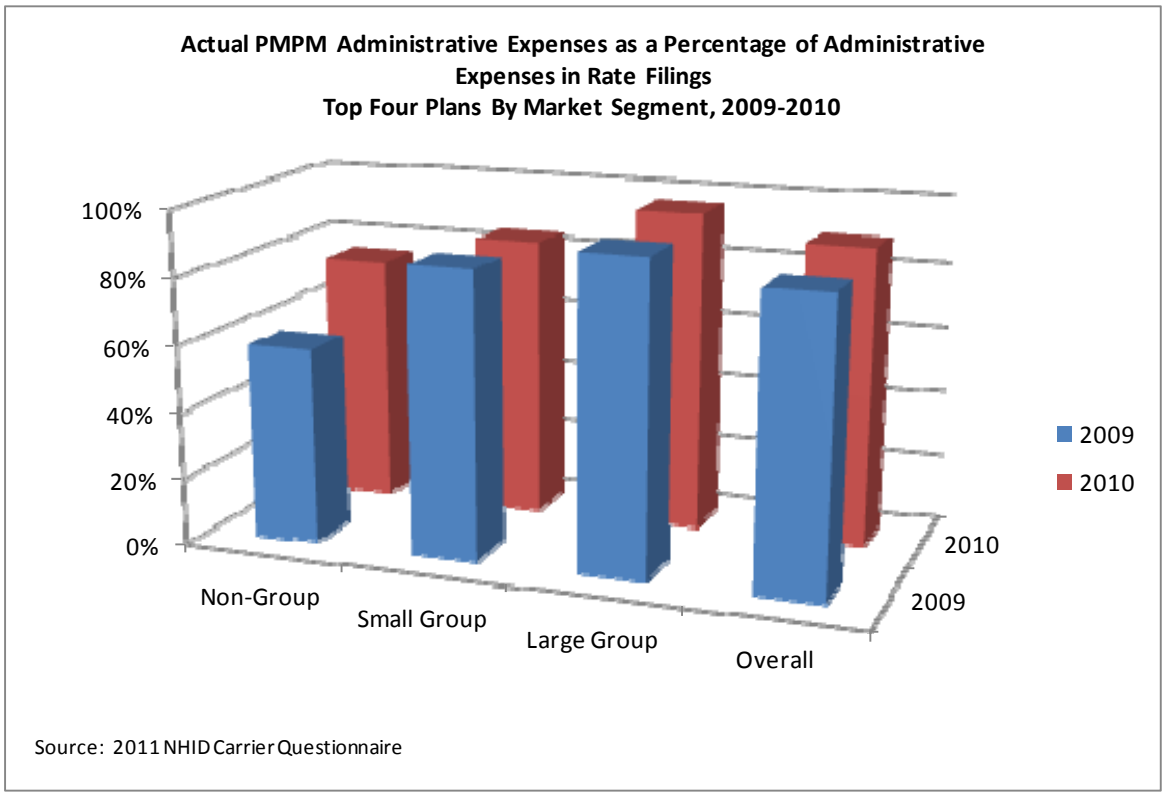
**Administrative Ratios by Market Segment, Actual**
**Top Four Carriers, Change 2009 to 2010**

| | 2009 | 2010 | % Change |
|---|---|---|---|
| Non-Group | 11.8% | 12.6% | 0.9% |
| Small Group | 9.8% | 10.7% | 0.9% |
| Large Group | 9.7% | 10.6% | 1.0% |
| **Overall** | **9.9%** | **10.9%** | **1.0%** |

Source: 2011 NHID Carrier Questionnaire

Overall, the administrative expenses for the top 4 plans were projected to be $47.07 PMPM in 2010, but were actually $41.92. A similar difference occurred in 2009 ($43.34 projected and $37.26 actual). So while the rates included provision for significantly more administrative expense than was actually required, actual administrative expenses across all market segments grew by 12.5%, from $37.26 to $41.92. This information is summarized in Exhibit 19.

**Exhibit 19**




It is not clear from these data whether more administrative expenses would have been required if premium revenue had been at the levels anticipated in the rate filings. At a market segment level,

the difference between projected and actual expense occurred for the large group, small group, and non-group segments, with the ratio of actual to projected expense PMPMs at 0.96, 0.84, and 0.76 respectively in 2010. It may be worthwhile to understand more about these differences between segments. With actual premium revenue being lower than projected, costs may also be lower. Certainly some administrative costs vary with average premium levels, particularly when they are associated with higher or lower claim activity. However, an increase in the average deductible level, for example, would not have an impact on cost as dramatic as the differences measured. The significant influence on 2010 premiums of buy down is discussed further below.

We can use the annual statement data to look at the change in administrative expenses over time. The annual statements do not include non-New Hampshire-based entities for Cigna and Harvard Pilgrim, and contain taxes and assessments in the administrative data. As a basis for comparison with the carrier questionnaire data, we repeat the tables above with taxes and assessments added to administrative expenses, totaling to expense load. Expense load increased slightly as a percentage of premium in the rating assumptions at 0.1% in Exhibit 20, but more significantly in actual expenses at 1.2% in Exhibit 21.

**Exhibit 20**

**Expense Load by Market Segment in Rating Assumptions**
**Top Four Carriers, Change 2009 to 2010**

| | 2009 | 2010 | % Change |
|---|---|---|---|
| Non-Group | 20.1% | 18.2% | -1.9% |
| Small Group | 12.5% | 13.1% | 0.6% |
| Large Group | 12.2% | 12.1% | -0.2% |
| **Overall** | **12.8%** | **12.9%** | **0.1%** |

Source: 2011 NHID Carrier Questionnaire

**Exhibit 21**

**Expense Load by Market Segment, Actual**
**Top Four Carriers, Change 2009 to 2010**

| | 2009 | 2010 | % Change |
|---|---|---|---|
| Non-Group | 14.5% | 15.8% | 1.3% |
| Small Group | 12.0% | 13.2% | 1.2% |
| Large Group | 12.2% | 13.3% | 1.1% |
| **Overall** | **12.3%** | **13.5%** | **1.2%** |

Source: 2011 NHID Carrier Questionnaire

The five year trend from the annual statement data in Exhibit 22 for the top four plans show that the administrative expense as a percent of premium is at a five year high and has increased each of the past three years. While premium levels and claim costs trended at slightly negative levels, administrative costs increased at an annual rate of 12.5% in 2010, and by 13.3% when taxes are

included, increasing the percentage of premium going to administrative expenses. The growth of components of expense over time can be seen in Exhibit 23 below. Salaries, wages, and benefits grew at the highest rate of any of the expense components in 2010, perhaps related to bonuses driven by the larger profits earned in 2010, a topic we turn to next.

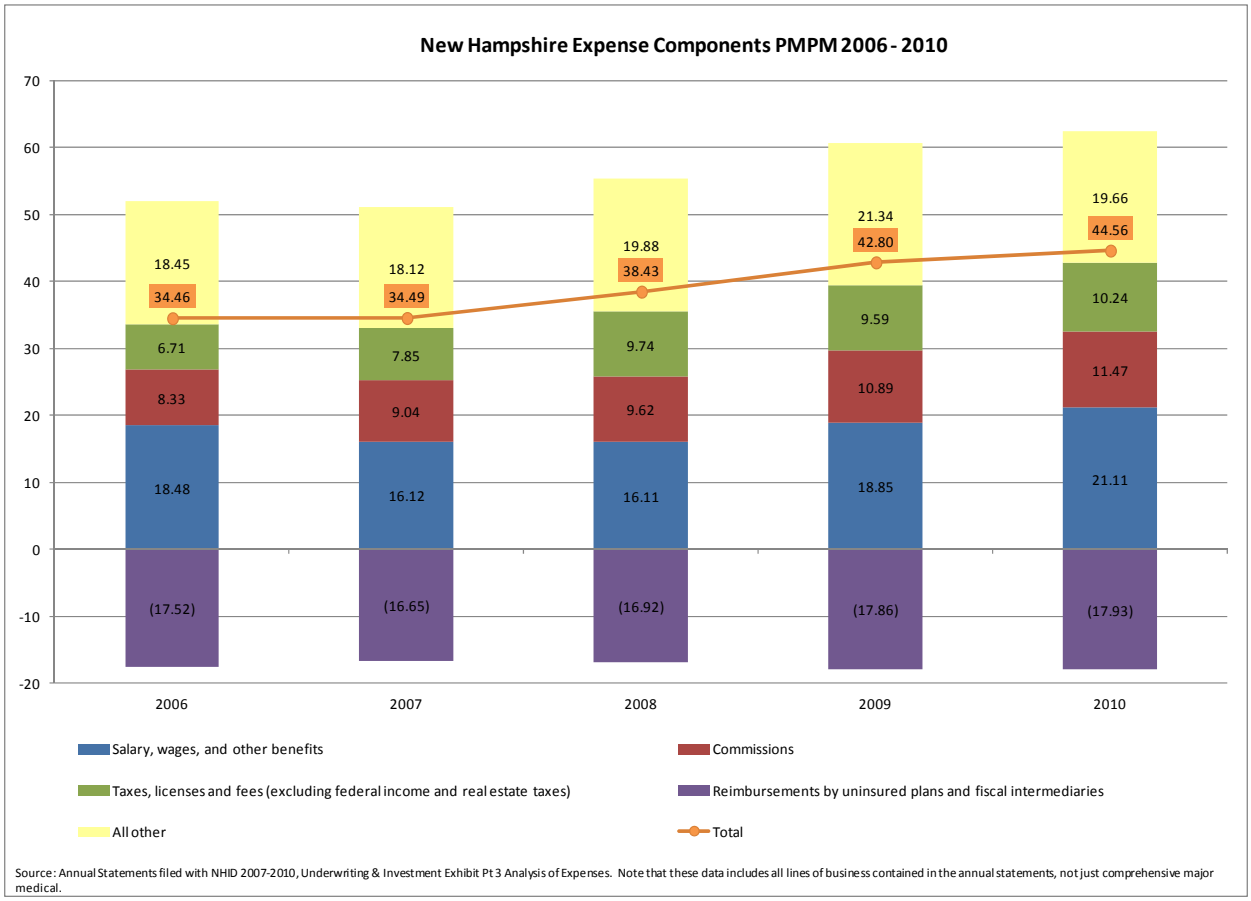
**Exhibit 22**

**Comprehensive Major Medical Total Expense Ratio**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | 11.4% | 11.2% | 11.1% | 11.9% | 12.5% |
| *Anthem Hlth Plans of NH* | *12.6%* | *11.9%* | *11.7%* | *12.8%* | *13.9%* |
| *Matthew Thorton Hlth Plan Inc* | *10.8%* | *10.8%* | *10.6%* | *11.3%* | *11.8%* |
| Harvard Pilgrim Health Care New Eng | 17.4% | 14.2% | 13.6% | 12.7% | 12.8% |
| MVP (Consolidated) | 128.5% | 38.1% | 21.9% | 18.6% | 18.9% |
| *MVP Hlth Ins Co of NH Inc* | | | *20.6%* | *17.7%* | *18.6%* |
| *MVP Hlth Plan of NH Inc* | *128.5%* | *38.1%* | *37.3%* | *206.0%* | *114.9%* |
| Cigna Hlthcare NH Inc | 14.2% | 14.7% | 16.4% | 14.8% | 22.5% |
| **Overall** | **13.2%** | **12.6%** | **12.6%** | **12.8%** | **13.3%** |

Source: Annual Statements filed with NHID, 2007-2010.

**Exhibit 23**




Source: Annual Statements filed with NHID 2007-2010, Underwriting & Investment Exhibit Pt 3 Analysis of Expenses. Note that these data includes all lines of business contained in the annual statements, not just comprehensive major medical.

## Profits

The NHID Carrier Questionnaire results on rating assumptions about profits in 2009 and 2010 are displayed below in Exhibit 24. On average, carriers planned for underwriting gains (equal to premium revenue less claims and administrative expenses) for small group and large group business at approximately 4%, with an expected gain on non-group insurance of approximately 8% in 2009 and 6% in 2010. As noted in testimony at the Hearing, these assumptions vary significantly by carrier, with Anthem testifying to a 6% target and Harvard Pilgrim a 1%-2% target[12].

Actual margins (underwriting gains), displayed in Exhibit 25, were lower in both years than targeted overall and by segment, with the exception of the non-group business, which had over 20% margins in both years. It is worth understanding more about why the margins on the non-group (individual) business are so extraordinarily large.

[12] Transcript of Public Hearing on Premium Rates in the Health Insurance Market Pursuant to RSA 420-G:14-a V, October 28, 2011.

**Exhibit 24**

**Underwriting Gain by Market Segment in Rating Assumptions**
**Top Four Carriers, Change 2009 to 2010**

| | 2009 | 2010 | % Change |
|---|---|---|---|
| Non-Group | 6.3% | 8.5% | 2.2% |
| Small Group | 4.1% | 3.9% | -0.2% |
| Large Group | 3.9% | 3.4% | -0.5% |
| **Overall** | **4.1%** | **3.9%** | **-0.2%** |

Source: 2011 NHID Carrier Questionnaire

**Exhibit 25**

**Underwriting Gain by Market Segment, Actual**
**Top Four Carriers, Change 2009 to 2010**

| | 2009 | 2010 | % Change |
|---|---|---|---|
| Non-Group | 22.2% | 21.7% | -0.5% |
| Small Group | -3.5% | -0.7% | 2.8% |
| Large Group | -1.0% | -0.5% | 0.5% |
| **Overall** | **-0.7%** | **0.9%** | **1.6%** |

Source: 2011 NHID Carrier Questionnaire

Profit levels increased significantly, but on aggregate for these carriers went from negative in 2009 (-0.7%) to positive in 2010 (0.9%). While the increasing profit levels would be a component of the increase in costs between 2009 and 2010, the negative level of profits in 2009 and the modest level in 2010 do not stand out as an issue in explaining cost growth. However, if we use publicly available annual statement data to examine the data at the carrier level, we can see that the average profit levels described above mask a very stark division in the New Hampshire insurance market.

The annual statement numbers contain information over time, and include increases in reserves, which the carrier questionnaire does not, and again the annual statement does not include all entities in the questionnaire. The annual statement includes only one of three entities operating in New Hampshire for both Harvard Pilgrim Healthcare (Harvard Pilgrim Healthcare New England) and Cigna (Cigna Healthcare New Hampshire, Inc.). Consequently, the profit levels shown in the five year annual statement table are slightly different than the carrier questionnaire results for 2009 and 2010, however, the five year annual statement are measured consistently over time and display the time pattern of profits for fully insured business.

Underwriting gain as a PMPM, as a percentage of revenue, and as total dollars is displayed in Exhibits 26, 27, and 28 below. From this information we see that Anthem New Hampshire's underwriting gains have a averaged 7.5% per year over the five years 2006-2010 while the other three carriers in the Top 4 have averaged -7.3% over the same period. Anthem's worst year during this stretch earned $23.5 million in 2009 (its best was $75 million in 2006), while the best year of the other three carriers combined was a loss of $9.7 million in 2006 (the worst was a loss of $38

million in 2009). This time pattern is illustrated in Exhibit 29. With the exception of Harvard Pilgrim in 2007, each of these other three carriers has suffered an underwriting loss every year over this five year period.

Overall profits have come down over the period, but this has reduced profits for all the carriers, leaving the contrast between Anthem and the other carriers.

**Exhibit 26**

**Comprehensive Major Medical Underwriting Gain PMPM**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | $33.70 | $31.83 | $21.74 | $13.95 | $25.50 |
| Anthem Hlth Plans of NH | $27.23 | $33.69 | $18.42 | $23.43 | $29.31 |
| Matthew Thorton Hlth Plan Inc | $36.74 | $30.59 | $24.31 | $6.78 | $22.96 |
| Harvard Pilgrim Health Care New Eng | ($0.41) | $3.82 | ($9.68) | ($15.25) | ($0.70) |
| MVP (Consolidated) | ($352.04) | ($30.20) | ($37.71) | ($90.55) | ($68.91) |
| MVP Hlth Ins Co of NH Inc | | | ($27.92) | ($88.07) | ($68.21) |
| MVP Hlth Plan of NH Inc | ($352.04) | ($30.20) | ($150.29) | ($638.84) | ($428.53) |
| Cigna Hlthcare NH Inc | ($18.15) | ($35.01) | ($19.44) | ($11.17) | ($128.18) |
| **Overall** | **$19.35** | **$17.39** | **$8.10** | **($5.23)** | **$7.35** |

Source: Annual Statements filed with NHID, 2007-2010

**Exhibit 27**

**Comprehensive Major Medical Underwriting Gain as a % of Revenue**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | 10.8% | 9.8% | 6.2% | 3.7% | 6.6% |
| Anthem Hlth Plans of NH | 9.3% | 11.4% | 6.1% | 7.1% | 8.2% |
| Matthew Thorton Hlth Plan Inc | 11.5% | 8.9% | 6.3% | 1.7% | 5.6% |
| Harvard Pilgrim Health Care New Eng | -0.1% | 1.1% | -2.5% | -3.7% | -0.2% |
| MVP (Consolidated) | -108.2% | -9.8% | -11.5% | -25.4% | -19.7% |
| MVP Hlth Ins Co of NH Inc | | | -8.5% | -24.7% | -19.5% |
| MVP Hlth Plan of NH Inc | -108.2% | -9.8% | -47.8% | -175.3% | -60.7% |
| Cigna Hlthcare NH Inc | -5.4% | -9.8% | -5.0% | -2.5% | -26.0% |
| **Overall** | **6.1%** | **5.2%** | **2.3%** | **-1.4%** | **1.8%** |

Source: Annual Statements filed with NHID, 2007-2010

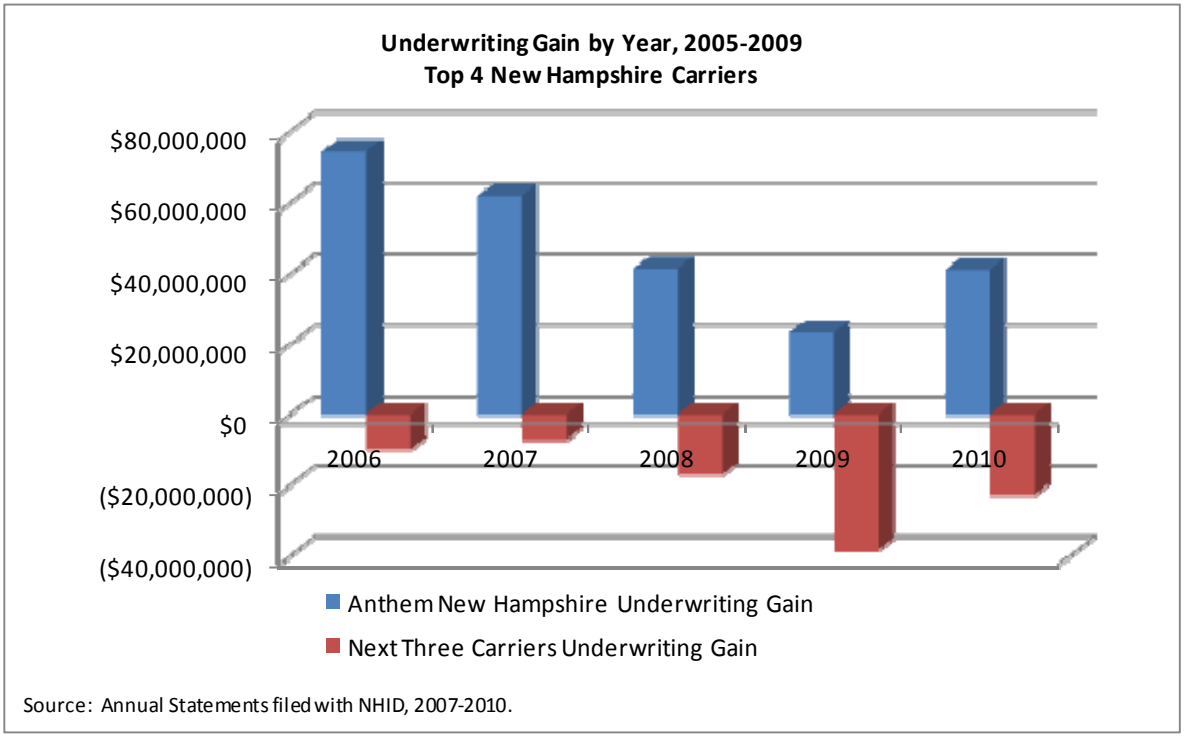
**Exhibit 28**

**Comprehensive Major Medical Underwriting Gain**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | $74,728,116 | $62,082,819 | $41,543,872 | $23,504,114 | $41,229,782 |
| Anthem Hlth Plans of NH | $19,304,334 | $26,232,095 | $15,361,862 | $16,992,193 | $18,967,839 |
| Matthew Thorton Hlth Plan Inc | $55,423,782 | $35,850,724 | $26,182,010 | $6,511,921 | $22,261,943 |
| Harvard Pilgrim Health Care New Eng | ($300,318) | $3,500,173 | ($7,989,145) | ($12,275,232) | ($421,611) |
| MVP (Consolidated) | ($1,841,512) | ($586,064) | ($6,317,025) | ($25,534,691) | ($21,474,683) |
| MVP Hlth Ins Co of NH Inc | | | ($4,301,676) | ($24,721,450) | ($21,218,425) |
| MVP Hlth Plan of NH Inc | ($1,841,512) | ($586,064) | ($2,015,349) | ($813,241) | ($256,258) |
| Cigna Hlthcare NH Inc | ($7,496,736) | ($9,875,752) | ($2,628,139) | ($347,107) | ($700,867) |
| **Overall** | **$65,089,550** | **$55,121,176** | **$24,609,563** | **($14,652,916)** | **$18,632,621** |

Source: Annual Statements filed with NHID, 2007-2010

**Exhibit 29**




Source: Annual Statements filed with NHID, 2007-2010.

## More Detailed Findings

More detailed results of the carrier survey and the 5 year analysis of annual statement data is contained in the Appendices to this report. Appendix A contains summary tables from the 2010 Carrier Questionnaire, and Appendix B contains an analysis of five years of annual statement data. Both reflect the four largest carriers.

## Carrier Hearing

On October 28, 2011 the Department held a hearing pursuant to RSA 420-G:14-a V with carriers, providers, and other interested parties. Points made by the carriers included the following:

- Different carriers target different profit margins in their rating assumptions. Harvard Pilgrim targets 1% to 2% profit in its rates; Anthem targets 6% profit.
- Costs are driven by three factors, unit cost, increases in utilization, and increases in the service mix or intensity, which include new services like PET scans and Remicade (a monoclonal antibody used to treat Crohn's disease and rheumatoid arthritis).
- Outpatient hospital services is the fastest growing segment of services, growing about twice as fast as other services over the past five years, and include outpatient radiology, outpatient lab, and IV infusion therapy.
- Government requirements including ICD-10 and mandates increase costs.
- Cost-shifting from government payers to private payers increases private prices, Anthem citing an 18% increase in one year.
- Hospital construction and renovation projects have been widespread in New Hampshire.
- Carriers incurring losses cited the need to "catch up" rates to avoid future losses.
- Offsetting cost increases are an increase in blockbuster drugs going off patent and the utilization decline associated with the cessation of marketing by the patent holder.
- There was significant discussion about the difficulty of entering the New Hampshire market, as with any market, when contracted provider rates are at a competitive disadvantage. This raises rates, making the increased market share necessary to improve leverage with providers difficult to attain. The small size of the commercial fully insured risk pool exacerbates this problem.
- One carrier testified to the importance of moving away from a fee-for-service system in which volume is rewarded.
- Carriers touched on various strategies employed to control costs, including medical management, tiered products, and provider models such as medical home and ACO.
- Cigna pointed out (as supported by the data discussed in the previous sections) that trend was significantly lower than expected in 2010.

Providers testified also, several focusing on their role as employers buying insurance, rather than on their role as providers of care contributing to insurance costs. The New Hampshire Hospital Association addressed the role of government underfunding of public programs and the consequent cost shift onto commercial insurance, and described declining financial health for New Hampshire's

hospitals. Testimony described a drop in the ratio of payment to cost for Medicaid from 54% to below 50% between 2009 and 2010. In a discussion of payment reform and accountable care models, the NHHA described carrier strategies that are not aligned with pursuit of an ACO model, with a focus on short term cost reduction. Testimony on behalf of consumers and small businesses cited the issues that high premiums present to both, and the need to pursue the transparency goals of the ACA.

A full transcript of the hearing can be found in Appendix C.

## Benchmarks

Benchmarks can provide a useful means of exploring the efficiency of a system. Proper care must be taken to ensure that the source of benchmark data is well understood, and that its applicability is a comparator for data is appropriate. Some simple benchmarks using national data from the NAIC are illuminating.

Exhibit 30 shows New Hampshire 2009 and 2010 premium data vs. comparable data from New England and national premium levels.

**Exhibit 30**

**Comparison of New Hampshire to Regional and National Benchmarks**

All data from NAIC Statistical Compilation of Annual Statement Information for Health Insurance Companies
New England includes CT, MA, ME, NH, RI, and VT

Comprehensive Major Medical only
Premium = "Health premiums earned" from Line 15 of Exhibit for Premiums, Enrollment and Utilization
Claims = "Amount Incurred for Provision of Health Care Services" from Line 18 of Exhibit for Premiums, Enrollment and Utilization
Medical Loss Ratio = Claims / Premium

| | NATIONAL | NEW ENGLAND | NH |
|---|---|---|---|
| 2010 Premium PMPM | $299.32 | $395.54 | $389.21 |
| 2010 Claims PMPM | $252.50 | $344.41 | $333.42 |
| 2010 Medical Loss Ratio | 84.4% | 87.1% | 85.7% |
| 2009 Premium PMPM | $286.02 | $378.19 | $378.63 |
| 2009 Claims PMPM | $248.69 | $337.45 | $336.10 |
| 2009 Medical Loss Ratio | 86.9% | 89.2% | 88.8% |
| $ Change in Premium PMPM | $13.30 | $17.34 | $10.58 |
| % Change in Premium PMPM | 4.7% | 4.6% | 2.8% |
| $ Change in Claims PMPM | $3.81 | $6.96 | ($2.68) |
| % Change in Claims PMPM | 1.5% | 2.1% | -0.8% |

Note: the PMPM's on this exhibit do not tie to information on the other exhibits due to a different data source

The dramatic decrease in New Hampshire trend occurred regionally and nationally, but not to the extent seen in New Hampshire. These data are not adjusted for actuarial value, so it may be that New Hampshire's large drop in actuarial value was larger than that seen regionally or nationally.

Exhibits 31 and 32 show the 2010 and 2009 benchmarks to the national numbers for more detailed components of the carrier financial results[13]. New Hampshire's loss ratio is one to two percentage points above the national average, and its administrative expense ratio is within less than half a point of the national number. Underwriting gain is below the national average, however, as discussed in Part 1 of this report, the New Hampshire average numbers reflect large gains for the Anthem and large losses for the other three top carriers.

**Exhibit 31**

**Comparison of 2010 PMPM's to National Benchmarks**

National from NAIC Statistical Compilation of Annual Statement Information for Health Insurance Companies in 2010
NH AS from compilation of data in Annual Statutory Financial Statements for NH Health companies
NH CQ from data received from carriers (listed below) in response to NH Carrier Questionnaire

| Comprehensive Major Medical | NH AS | NH CQ | National |
|---|---|---|---|
| Revenue | $400.31 | $386.35 | $290.46 |
| Medical Expense | $337.70 | $330.77 | $243.34 |
| Administrative Expenses | $53.39 | $51.98 | $38.06 |
| Increase in Reserves | $1.87 | n/a | $0.18 |
| Underwriting Gain (Loss) * | $7.35 | $3.60 | $8.88 |
| | | | |
| Medical Loss Ratio ** | 84.4% | 85.6% | 83.8% |
| Administrative Expense Ratio | 13.3% | 13.5% | 13.1% |
| UW Gain as % of Revenue | 1.8% | 0.9% | 3.1% |

* Calculated as Revenue less Medical Expense less Administrative Expenses for NH CQ since Increase in Reserves is not available
** Calculated as Medical Expense / Revenue

The change between 2009 and 2010 is shown in Exhibit 33. It shows that New Hampshire's administrative costs are growing somewhat faster than the national average. The odd and large percent changes in underwriting gain both in New Hampshire and nationally are a reflection of the negative underwriting gains in 2009.

[13] This level of detail was not available at the state level for purposes of constructing a New England benchmark.

## Exhibit 32

**Comparison of 2009 PMPM's to National Benchmarks**

National from NAIC Statistical Compilation of Annual Statement Information for Health Insurance Companies in 2009
NH AS from compilation of data in Annual Statutory Financial Statements for NH Health companies
NH CQ from data received from carriers (listed below) in response to NH Carrier Questionnaire

| Comprehensive Major Medical | NH AS | NH CQ | National |
|---|---|---|---|
| Revenue | $385.11 | $376.48 | $276.86 |
| Medical Expense | $340.03 | $332.79 | $239.44 |
| Administrative Expenses | $49.35 | $46.16 | $35.58 |
| Increase in Reserves | $0.96 | n/a | $0.18 |
| Underwriting Gain (Loss) * | ($5.23) | ($2.47) | $1.67 |
| | | | |
| Medical Loss Ratio ** | 88.3% | 88.4% | 86.5% |
| Administrative Expense Ratio | 12.8% | 12.3% | 12.9% |
| UW Gain as % of Revenue | -1.4% | -0.7% | 0.6% |

* Calculated as Revenue less Medical Expense less Administrative Expenses for NH CQ since Increase in Reserves is not available
** Calculated as Medical Expense / Revenue

## Exhibit 33

**Change from 2009 to 2010**

| $ Change in PMPM | NH AS | NH CQ | National |
|---|---|---|---|
| Revenue | $15.21 | $9.87 | $13.60 |
| Medical Expense | ($2.32) | ($2.02) | $3.90 |
| Administrative Expenses | $4.04 | $5.82 | $2.48 |
| Increase in Reserves | $0.91 | n/a | $0.01 |
| Underwriting Gain (Loss) | $12.58 | $6.07 | $7.21 |

| % Change in PMPM | NH AS | NH CQ | National |
|---|---|---|---|
| Revenue | 3.9% | 2.6% | 4.9% |
| Medical Expense | -0.7% | -0.6% | 1.6% |
| Administrative Expenses | 8.2% | 12.6% | 7.0% |
| Increase in Reserves | 95.1% | n/a | 3.5% |
| Underwriting Gain (Loss) | 240.6% * | 246.0% * | 432.2% |

** Absolute Value*

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# Appendices

## Appendix A: NHID Carrier Questionnaire Data

**Exhibit A.1: Aggregated Responses from 2011 NHID Carrier Questionnaire**
**Actual Claims, Revenue, Expenses by Market Segment**
**Fully Insured**

| Non-Group | 2010 | 2009 | % Change |
|---|---|---|---|
| Revenue | $295.45 | $270.92 | 9.1% |
| Claims | $184.54 | $171.54 | 7.6% |
| Expenses | $37.29 | $31.89 | 16.9% |
| Assessments/Taxes | $9.44 | $7.37 | 28.2% |
| UW Gain | $64.18 | $60.13 | 6.7% |
| | | | |
| Medical Loss Ratio | 62.5% | 63.3% | |
| Expense Ratio (w/ Assessments/Taxes) | 15.8% | 14.5% | |
| UW Gain as a % of Revenue | 21.7% | 22.2% | |

| Small Group | 2010 | 2009 | % Change |
|---|---|---|---|
| Revenue | $403.61 | $384.63 | 4.9% |
| Claims | $353.16 | $352.02 | 0.3% |
| Expenses | $43.17 | $37.78 | 14.3% |
| Assessments/Taxes | $10.28 | $8.49 | 21.2% |
| UW Gain | -$3.01 | -$13.65 | -77.9% |
| | | | |
| Medical Loss Ratio | 87.5% | 91.5% | |
| Expense Ratio (w/ Assessments/Taxes) | 13.2% | 12.0% | |
| UW Gain as a % of Revenue | -0.7% | -3.5% | |

| Large Group | 2010 | 2009 | % Change |
|---|---|---|---|
| Revenue | $388.76 | $388.39 | 0.1% |
| Claims | $339.12 | $345.09 | -1.7% |
| Expenses | $41.34 | $37.51 | 10.2% |
| Assessments/Taxes | $10.37 | $9.81 | 5.8% |
| UW Gain | -$2.08 | -$4.02 | -48.1% |
| | | | |
| Medical Loss Ratio | 87.2% | 88.9% | |
| Expense Ratio (w/ Assessments/Taxes) | 13.3% | 12.2% | |
| UW Gain as a % of Revenue | -0.5% | -1.0% | |

| Overall | 2010 | 2009 | % Change |
|---|---|---|---|
| Revenue | $386.35 | $376.48 | 2.6% |
| Claims | $330.77 | $332.79 | -0.6% |
| Expenses | $41.92 | $37.26 | 12.5% |
| Assessments/Taxes | $10.06 | $8.90 | 13.0% |
| UW Gain | $3.60 | -$2.47 | -246.0% |
| | | | |
| Medical Loss Ratio | 85.6% | 88.4% | |
| Expense Ratio (w/ Assessments/Taxes) | 13.5% | 12.3% | |
| UW Gain as a % of Revenue | 0.9% | -0.7% | |

**Exhibit A-2: Aggregated Responses from 2011 NHID Carrier Questionnaire**
**Rate Filing Assumptions by Market Segment**
**Weighted Average by Member Months**

| Non-Group | 2010 | 2009 | % change |
|---|---|---|---|
| Claims | $224.92 | $222.35 | 1.2% |
| Expenses | $49.73 | $54.80 | -9.2% |
| Profit | $26.17 | $18.96 | 38.0% |
| Assessments/Taxes | $6.23 | $6.06 | 2.9% |
| Total Rate | $307.05 | $302.17 | 1.6% |
| | | | |
| Medical Loss Ratio | 73.3% | 73.6% | |
| Expense Load (w/ Assessments/Taxes) | 18.2% | 20.1% | |
| Profit as a % of Premium | 8.5% | 6.3% | |

| Small Group | 2010 | 2009 | % change |
|---|---|---|---|
| Claims | $411.92 | $375.20 | 9.8% |
| Expenses | $51.32 | $44.20 | 16.1% |
| Profit | $19.16 | $18.43 | 4.0% |
| Assessments/Taxes | $13.66 | $11.86 | 15.2% |
| Total Rate | $496.05 | $449.69 | 10.3% |
| | | | |
| Medical Loss Ratio | 83.0% | 83.4% | |
| Expense Load (w/ Assessments/Taxes) | 13.1% | 12.5% | |
| Profit as a % of Premium | 3.9% | 4.1% | |

| Large Group | 2010 | 2009 | % Change |
|---|---|---|---|
| Claims | $394.18 | $362.37 | 8.8% |
| Expenses | $43.03 | $40.53 | 6.2% |
| Profit | $15.73 | $16.79 | -6.3% |
| Assessments/Taxes | $13.34 | $12.36 | 7.9% |
| Total Rate | $466.28 | $432.04 | 7.9% |
| | | | |
| Medical Loss Ratio | 84.5% | 83.9% | |
| Expense Load (w/ Assessments/Taxes) | 12.1% | 12.2% | |
| Profit as a % of Premium | 3.4% | 3.9% | |

| Overall | 2010 | 2009 | % Change |
|---|---|---|---|
| Claims | $386.01 | $355.51 | 8.6% |
| Expenses | $47.07 | $43.34 | 8.6% |
| Profit | $18.10 | $17.67 | 2.4% |
| Assessments/Taxes | $12.82 | $11.59 | 10.6% |
| Total Rate | $464.00 | $428.12 | 8.4% |
| | | | |
| Medical Loss Ratio | 83.2% | 83.0% | |
| Expense Load (w/ Assessments/Taxes) | 12.9% | 12.8% | |
| Profit as a % of Premium | 3.9% | 4.1% | |

**Exhibit A-3: Aggregated Responses from 2011 NHID Carrier Questionnaire**
**Actual Enrollment by Coverage Type and Market Segment**

| | 2010 | 2009 | % Change |
|---|---|---|---|
| **Self Insured** | **356,761** | **341,730** | **4.4%** |
| Fully Insured | | | |
| Individual | 23,308 | 23,659 | -1.5% |
| Small Group | 105,177 | 114,201 | -7.9% |
| Large Group | 126,020 | 131,548 | -4.2% |
| **Total Fully Insured** | **254,505** | **269,408** | **-5.5%** |
| **Grand Total** | **611,267** | **611,137** | **0.0%** |

**Exhibit A-4: Financial Summary - Top Four Carriers, Fully Insured - 2010 versus 2009 Per Member Per Month**

| | 2009 PMPM | | | | 2010 PMPM | | | |
|---|---|---|---|---|---|---|---|---|
| | Rating Assumptions | Actual Experience | Adjusted Actual*** | Actuarial Value | Rating Assumptions | Actual Experience | Adjusted Actual*** | Actuarial Value |
| **Claims** | $ 355.51 | $ 332.79 | | | $ 386.01 | $ 330.77 | | |
| **Admin** | $ 54.93 | $ 46.16 | | | $ 59.89 | $ 51.98 | | |
| **Profit *** | $ 17.67 | $ (2.47) | | | $ 18.10 | $ 3.60 | | |
| **Total Revenue** | $ 428.12 | $ 376.48 | $ 566.34 | 0.66 | $ 464.00 | $ 386.35 | $ 648.67 | 0.60 |
| **Members** | | 269,408 | | | | 254,505 | | |

| | PMPM Change | | | % Change PMPM** | | |
|---|---|---|---|---|---|---|
| | Rating Assumptions | Actual Experience | Adjusted Actual*** | Rating Assumptions | Actual Experience | Adjusted Actual*** |
| **Claims** | $ 30.50 | $ (2.02) | | 8.6% | -0.6% | |
| **Admin** | $ 4.96 | $ 5.82 | | 9.0% | 12.6% | |
| **Profit *** | $ 0.43 | $ 6.07 | | 2.4% | 246.0% | |
| **Total Revenue** | $ 35.89 | $ 9.87 | $ 82.33 | 8.4% | 2.6% | 14.5% |

** Profit on Actual Experience is Revenue less Claims less Admin; other items may affect actual profit levels*

*** % Change equals PMPM Change/Absolute Value of 2009 PMPM*

**** Actual divided by average actuarial value (from 2009 and 2010 Supplemental Report Data); application to all components assumes components of the rate as percentages remain constant with benefit changes*

# Appendix B: Data from Annual Statements Filed with the NHID

**Exhibit B-1: Comprehensive Major Medical Member Months**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | 2,217,497 | 1,950,371 | 1,911,123 | 1,685,253 | 1,616,558 |
| *Anthem Hlth Plans of NH* | *709,047* | *778,556* | *833,972* | *725,217* | *647,168* |
| *Matthew Thorton Hlth Plan Inc* | *1,508,450* | *1,171,815* | *1,077,151* | *960,036* | *969,390* |
| Harvard Pilgrim Health Care New Eng | 727,517 | 917,202 | 825,146 | 804,735 | 600,638 |
| MVP (Consolidated) | 5,231 | 19,405 | 167,501 | 281,991 | 311,654 |
| *MVP Hlth Ins Co of NH Inc* | *0* | *0* | *154,091* | *280,718* | *311,056* |
| *MVP Hlth Plan of NH Inc* | *5,231* | *19,405* | *13,410* | *1,273* | *598* |
| Cigna Hlthcare NH Inc | 412,955 | 282,054 | 135,220 | 31,077 | 5,468 |
| **Overall** | **3,363,200** | **3,169,032** | **3,038,990** | **2,803,056** | **2,534,318** |

**Exhibit B-2: Comprehensive Major Medical Membership Growth Rate**

| | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|
| Anthem (Consolidated) | -12.0% | -2.0% | -11.8% | -4.1% |
| *Anthem Hlth Plans of NH* | *9.8%* | *7.1%* | *-13.0%* | *-10.8%* |
| *Matthew Thorton Hlth Plan Inc* | *-22.3%* | *-8.1%* | *-10.9%* | *1.0%* |
| Harvard Pilgrim Health Care New Eng | 26.1% | -10.0% | -2.5% | -25.4% |
| MVP (Consolidated) | 271.0% | 763.2% | 68.4% | 10.5% |
| *MVP Hlth Ins Co of NH Inc* | | | *82.2%* | *10.8%* |
| *MVP Hlth Plan of NH Inc* | *271.0%* | *-30.9%* | *-90.5%* | *-53.0%* |
| Cigna Hlthcare NH Inc | -31.7% | -52.1% | -77.0% | -82.4% |
| **Overall** | **-5.8%** | **-4.1%** | **-7.8%** | **-9.6%** |

**Exhibit B-3: Comprehensive Major Medical Revenue PMPM**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | $311.30 | $325.01 | $349.39 | $373.27 | $388.65 |
| *Anthem Hlth Plans of NH* | *$294.18* | *$295.00* | *$304.29* | *$330.80* | *$355.57* |
| *Matthew Thorton Hlth Plan Inc* | *$319.35* | *$344.95* | *$384.31* | *$405.36* | *$410.73* |
| Harvard Pilgrim Health Care New Eng | $317.34 | $350.63 | $382.97 | $417.53 | $457.18 |
| MVP (Consolidated) | $325.25 | $307.75 | $327.47 | $356.63 | $349.61 |
| *MVP Hlth Ins Co of NH Inc* | | | *$328.62* | *$356.60* | *$348.92* |
| *MVP Hlth Plan of NH Inc* | *$325.25* | *$307.75* | *$314.36* | *$364.44* | *$705.69* |
| Cigna Hlthcare NH Inc | $335.62 | $355.80 | $385.18 | $445.75 | $492.80 |
| **Overall** | **$315.62** | **$335.06** | **$358.89** | **$385.11** | **$400.31** |

**Exhibit B-4: Comprehensive Major Medical Revenue Growth Rate**

| | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|
| Anthem (Consolidated) | 4.4% | 7.5% | 6.8% | 4.1% |
| *Anthem Hlth Plans of NH* | *0.3%* | *3.1%* | *8.7%* | *7.5%* |
| *Matthew Thorton Hlth Plan Inc* | *8.0%* | *11.4%* | *5.5%* | *1.3%* |
| Harvard Pilgrim Health Care New Eng | 10.5% | 9.2% | 9.0% | 9.5% |
| MVP (Consolidated) | -5.4% | 6.4% | 8.9% | -2.0% |
| *MVP Hlth Ins Co of NH Inc* | | | *8.5%* | *-2.2%* |
| *MVP Hlth Plan of NH Inc* | *-5.4%* | *2.1%* | *15.9%* | *93.6%* |
| Cigna Hlthcare NH Inc | 6.0% | 8.3% | 15.7% | 10.6% |
| **Overall** | **6.2%** | **7.1%** | **7.3%** | **3.9%** |

**Exhibit B-5: Comprehensive Major Medical Medical Expense PMPM**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | $242.18 | $256.70 | $289.04 | $314.90 | $312.54 |
| *Anthem Hlth Plans of NH* | *$229.81* | *$226.25* | *$250.24* | *$264.99* | *$272.20* |
| *Matthew Thorton Hlth Plan Inc* | *$248.00* | *$276.93* | *$319.09* | *$352.60* | *$339.47* |
| Harvard Pilgrim Health Care New Eng | $262.67 | $296.90 | $340.50 | $379.70 | $399.23 |
| MVP (Consolidated) | $259.39 | $220.59 | $293.45 | $371.13 | $347.01 |
| *MVP Hlth Ins Co of NH Inc* | | | *$288.77* | *$371.66* | *$347.06* |
| *MVP Hlth Plan of NH Inc* | *$259.39* | *$220.59* | *$347.30* | *$252.69* | *$323.49* |
| Cigna Hlthcare NH Inc | $302.88 | $336.87 | $351.22 | $393.20 | $487.78 |
| **Overall** | **$254.09** | **$275.25** | **$306.03** | **$340.03** | **$337.70** |

**Exhibit B-6: Comprehensive Major Medical Medical Expense Growth Rate**

| | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|
| Anthem (Consolidated) | 6.0% | 12.6% | 8.9% | -0.7% |
| *Anthem Hlth Plans of NH* | *-1.5%* | *10.6%* | *5.9%* | *2.7%* |
| *Matthew Thorton Hlth Plan Inc* | *11.7%* | *15.2%* | *10.5%* | *-3.7%* |
| Harvard Pilgrim Health Care New Eng | 13.0% | 14.7% | 11.5% | 5.1% |
| MVP (Consolidated) | -15.0% | 33.0% | 26.5% | -6.5% |
| *MVP Hlth Ins Co of NH Inc* | | | *28.7%* | *-6.6%* |
| *MVP Hlth Plan of NH Inc* | *-15.0%* | *57.4%* | *-27.2%* | *28.0%* |
| Cigna Hlthcare NH Inc | 11.2% | 4.3% | 12.0% | 24.1% |
| **Overall** | **8.3%** | **11.2%** | **11.1%** | **-0.7%** |

**Exhibit B-7: Comprehensive Major Medical Medical Loss Ratio**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | 77.8% | 79.0% | 82.7% | 84.4% | 80.4% |
| *Anthem Hlth Plans of NH* | *78.1%* | *76.7%* | *82.2%* | *80.1%* | *76.6%* |
| *Matthew Thorton Hlth Plan Inc* | *77.7%* | *80.3%* | *83.0%* | *87.0%* | *82.7%* |
| Harvard Pilgrim Health Care New Eng | 82.8% | 84.7% | 88.9% | 90.9% | 87.3% |
| MVP (Consolidated) | 79.8% | 71.7% | 89.6% | 104.1% | 99.3% |
| *MVP Hlth Ins Co of NH Inc* | | | *87.9%* | *104.2%* | *99.5%* |
| *MVP Hlth Plan of NH Inc* | *79.8%* | *71.7%* | *110.5%* | *69.3%* | *45.8%* |
| Cigna Hlthcare NH Inc | 90.2% | 94.7% | 91.2% | 88.2% | 99.0% |
| **Overall** | **80.5%** | **82.1%** | **85.3%** | **88.3%** | **84.4%** |

**Exhibit B-8: Comprehensive Major Medical Claim Adjustment Expenses PMPM**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | $9.86 | $9.57 | $13.12 | $8.10 | $12.20 |
| *Anthem Hlth Plans of NH* | *$15.34* | *$6.46* | *$12.51* | *$8.08* | *$12.37* |
| *Matthew Thorton Hlth Plan Inc* | *$7.28* | *$11.64* | *$13.60* | *$8.11* | *$12.08* |
| Harvard Pilgrim Health Care New Eng | $11.99 | $12.88 | $14.11 | $14.51 | $8.20 |
| MVP (Consolidated) | $81.22 | $18.72 | $14.96 | $7.92 | $9.67 |
| *MVP Hlth Ins Co of NH Inc* | | | *$14.75* | *$8.00* | *$9.61* |
| *MVP Hlth Plan of NH Inc* | *$81.22* | *$18.72* | *$17.31* | *($9.38)* | *$39.48* |
| Cigna Hlthcare NH Inc | $8.02 | $9.45 | $7.52 | $8.10 | $13.09 |
| **Overall** | **$10.21** | **$10.58** | **$13.24** | **$9.92** | **$10.94** |

**Exhibit B-9: Comprehensive Major Medical Claim Adjustment Expenses Growth Rate**

| | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|
| Anthem (Consolidated) | -2.9% | 37.1% | -38.3% | 50.6% |
| *Anthem Hlth Plans of NH* | *-57.9%* | *93.7%* | *-35.4%* | *53.0%* |
| *Matthew Thorton Hlth Plan Inc* | *59.9%* | *16.8%* | *-40.3%* | *48.9%* |
| Harvard Pilgrim Health Care New Eng | 7.4% | 9.6% | 2.8% | -43.4% |
| MVP (Consolidated) | -76.9% | -20.1% | -47.0% | 22.0% |
| *MVP Hlth Ins Co of NH Inc* | | | *-45.8%* | *20.1%* |
| *MVP Hlth Plan of NH Inc* | *-76.9%* | *-7.5%* | *-154.2%* | *-520.8%* |
| Cigna Hlthcare NH Inc | 17.9% | -20.4% | 7.7% | 61.6% |
| **Overall** | **3.6%** | **25.2%** | **-25.1%** | **10.3%** |

**Exhibit B-10: Comprehensive Major Medical General Administrative Expenses PMPM**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | $25.56 | $26.91 | $25.49 | $36.33 | $36.57 |
| *Anthem Hlth Plans of NH* | *$21.80* | *$28.62* | *$23.13* | *$34.30* | *$37.15* |
| *Matthew Thorton Hlth Plan Inc* | *$27.33* | *$25.78* | *$27.32* | *$37.86* | *$36.19* |
| Harvard Pilgrim Health Care New Eng | $43.09 | $37.03 | $38.04 | $38.57 | $50.45 |
| MVP (Consolidated) | $336.68 | $98.63 | $56.78 | $58.40 | $56.56 |
| *MVP Hlth Ins Co of NH Inc* | | | *$53.02* | *$55.22* | *$55.19* |
| *MVP Hlth Plan of NH Inc* | *$336.68* | *$98.63* | *$100.03* | *$759.98* | *$771.25* |
| Cigna Hlthcare NH Inc | $39.73 | $42.71 | $55.48 | $57.84 | $98.00 |
| **Overall** | **$31.58** | **$31.69** | **$31.96** | **$39.43** | **$42.45** |

**Exhibit B-12: Comprehensive Major Medical General Administrative Expenses Growth Rate**

| | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|
| Anthem (Consolidated) | 5.3% | -5.3% | 42.5% | 0.7% |
| *Anthem Hlth Plans of NH* | *31.3%* | *-19.2%* | *48.3%* | *8.3%* |
| *Matthew Thorton Hlth Plan Inc* | *-5.7%* | *6.0%* | *38.6%* | *-4.4%* |
| Harvard Pilgrim Health Care New Eng | -14.1% | 2.7% | 1.4% | 30.8% |
| MVP (Consolidated) | -70.7% | -42.4% | 2.9% | -3.1% |
| *MVP Hlth Ins Co of NH Inc* | | | *4.2%* | *-0.1%* |
| *MVP Hlth Plan of NH Inc* | *-70.7%* | *1.4%* | *659.7%* | *1.5%* |
| Cigna Hlthcare NH Inc | 7.5% | 29.9% | 4.2% | 69.4% |
| **Overall** | **0.3%** | **0.9%** | **23.4%** | **7.7%** |

**Exhibit B-13: Comprehensive Major Medical Total Expenses PMPM**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | $35.42 | $36.49 | $38.61 | $44.43 | $48.77 |
| *Anthem Hlth Plans of NH* | *$37.14* | *$35.07* | *$35.64* | *$42.38* | *$49.51* |
| *Matthew Thorton Hlth Plan Inc* | *$34.62* | *$37.43* | *$40.92* | *$45.97* | *$48.27* |
| Harvard Pilgrim Health Care New Eng | $55.08 | $49.91 | $52.15 | $53.08 | $58.65 |
| MVP (Consolidated) | $417.90 | $117.36 | $71.74 | $66.32 | $66.23 |
| *MVP Hlth Ins Co of NH Inc* | | | *$67.77* | *$63.22* | *$64.80* |
| *MVP Hlth Plan of NH Inc* | *$417.90* | *$117.36* | *$117.35* | *$750.59* | *$810.73* |
| Cigna Hlthcare NH Inc | $47.75 | $52.17 | $63.01 | $65.94 | $111.10 |
| **Overall** | **$41.78** | **$42.26** | **$45.20** | **$49.35** | **$53.39** |

**Exhibit B-14: Comprehensive Major Medical Total Expenses Growth Rate**

| | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|
| Anthem (Consolidated) | 3.0% | 5.8% | 15.1% | 9.8% |
| *Anthem Hlth Plans of NH* | *-5.6%* | *1.6%* | *18.9%* | *16.8%* |
| *Matthew Thorton Hlth Plan Inc* | *8.1%* | *9.3%* | *12.4%* | *5.0%* |
| Harvard Pilgrim Health Care New Eng | -9.4% | 4.5% | 1.8% | 10.5% |
| MVP (Consolidated) | -71.9% | -38.9% | -7.5% | -0.1% |
| *MVP Hlth Ins Co of NH Inc* | | | *-6.7%* | *2.5%* |
| *MVP Hlth Plan of NH Inc* | *-71.9%* | *0.0%* | *539.6%* | *8.0%* |
| Cigna Hlthcare NH Inc | 9.3% | 20.8% | 4.7% | 68.5% |
| **Overall** | **1.1%** | **7.0%** | **9.2%** | **8.2%** |

**Exhibit B-15: Comprehensive Major Medical Total Expense Ratio**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | 11.4% | 11.2% | 11.1% | 11.9% | 12.5% |
| *Anthem Hlth Plans of NH* | *12.6%* | *11.9%* | *11.7%* | *12.8%* | *13.9%* |
| *Matthew Thorton Hlth Plan Inc* | *10.8%* | *10.8%* | *10.6%* | *11.3%* | *11.8%* |
| Harvard Pilgrim Health Care New Eng | 17.4% | 14.2% | 13.6% | 12.7% | 12.8% |
| MVP (Consolidated) | 128.5% | 38.1% | 21.9% | 18.6% | 18.9% |
| *MVP Hlth Ins Co of NH Inc* | | | *20.6%* | *17.7%* | *18.6%* |
| *MVP Hlth Plan of NH Inc* | *128.5%* | *38.1%* | *37.3%* | *206.0%* | *114.9%* |
| Cigna Hlthcare NH Inc | 14.2% | 14.7% | 16.4% | 14.8% | 22.5% |
| **Overall** | **13.2%** | **12.6%** | **12.6%** | **12.8%** | **13.3%** |

**Exhibit B-16: Comprehensive Major Medical Increase in Reserve PMPM**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | $0.00 | ($0.00) | ($0.01) | $0.00 | $1.83 |
| *Anthem Hlth Plans of NH* | *$0.00* | *($0.01)* | *($0.01)* | *$0.00* | *$4.55* |
| *Matthew Thorton Hlth Plan Inc* | *$0.00* | *$0.00* | *($0.00)* | *$0.00* | *$0.02* |
| Harvard Pilgrim Health Care New Eng | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| MVP (Consolidated) | $0.00 | $0.00 | $0.00 | $9.73 | $5.27 |
| *MVP Hlth Ins Co of NH Inc* | | | *$0.00* | *$9.78* | *$5.28* |
| *MVP Hlth Plan of NH Inc* | *$0.00* | *$0.00* | *$0.00* | *$0.00* | *$0.00* |
| Cigna Hlthcare NH Inc | $3.15 | $1.77 | ($9.61) | ($2.22) | $22.09 |
| **Overall** | **$0.39** | **$0.16** | **($0.43)** | **$0.96** | **$1.87** |

**Exhibit B-17: Comprehensive Major Medical Underwriting Gain PMPM**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | $33.70 | $31.83 | $21.74 | $13.95 | $25.50 |
| *Anthem Hlth Plans of NH* | *$27.23* | *$33.69* | *$18.42* | *$23.43* | *$29.31* |
| *Matthew Thorton Hlth Plan Inc* | *$36.74* | *$30.59* | *$24.31* | *$6.78* | *$22.96* |
| Harvard Pilgrim Health Care New Eng | ($0.41) | $3.82 | ($9.68) | ($15.25) | ($0.70) |
| MVP (Consolidated) | ($352.04) | ($30.20) | ($37.71) | ($90.55) | ($68.91) |
| *MVP Hlth Ins Co of NH Inc* | | | *($27.92)* | *($88.07)* | *($68.21)* |
| *MVP Hlth Plan of NH Inc* | *($352.04)* | *($30.20)* | *($150.29)* | *($638.84)* | *($428.53)* |
| Cigna Hlthcare NH Inc | ($18.15) | ($35.01) | ($19.44) | ($11.17) | ($128.18) |
| **Overall** | **$19.35** | **$17.39** | **$8.10** | **($5.23)** | **$7.35** |

**Exhibit B-18: Comprehensive Major Medical Underwriting Gain as a % of Revenue**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Anthem (Consolidated) | 10.8% | 9.8% | 6.2% | 3.7% | 6.6% |
| *Anthem Hlth Plans of NH* | *9.3%* | *11.4%* | *6.1%* | *7.1%* | *8.2%* |
| *Matthew Thorton Hlth Plan Inc* | *11.5%* | *8.9%* | *6.3%* | *1.7%* | *5.6%* |
| Harvard Pilgrim Health Care New Eng | -0.1% | 1.1% | -2.5% | -3.7% | -0.2% |
| MVP (Consolidated) | -108.2% | -9.8% | -11.5% | -25.4% | -19.7% |
| *MVP Hlth Ins Co of NH Inc* | | | *-8.5%* | *-24.7%* | *-19.5%* |
| *MVP Hlth Plan of NH Inc* | *-108.2%* | *-9.8%* | *-47.8%* | *-175.3%* | *-60.7%* |
| Cigna Hlthcare NH Inc | -5.4% | -9.8% | -5.0% | -2.5% | -26.0% |
| **Overall** | **6.1%** | **5.2%** | **2.3%** | **-1.4%** | **1.8%** |

**Exhibit B-19: Analysis of Change from 2009 to 2010 - NH Companies**

| | 2009 | 2010 | Difference % | Difference $ | % of Total |
|---|---|---|---|---|---|
| Revenue | $385.11 | $400.31 | 3.9% | $15.21 | |
| Medical Expense | $340.03 | $337.70 | -0.7% | ($2.32) | -15.3% |
| Claim Adjustment Expenses | $9.92 | $10.94 | 10.3% | $1.02 | 6.7% |
| General Administrative Expenses | $39.43 | $42.45 | 7.7% | $3.02 | 19.9% |
| Increase in Reserves | $0.96 | $1.87 | 95.1% | $0.91 | 6.0% |
| Underwriting Gain (Loss) | ($5.23) | $7.35 | -240.6% | $12.58 | 82.7% |
| | | | | | |
| Medical Loss Ratio | 88.3% | 84.4% | -3.9% | | |
| Total Expense Ratio | 12.8% | 13.3% | 0.5% | | |
| UW Gain as % of Revenue | -1.4% | 1.8% | 3.2% | | |

**Exhibit B-20: Analysis of Change from 2009 to 2010 - National Benchmarks**
***National from NAIC Statistical Compilation of Annual Statement Information for Health Insurance Companies in 2009 and 2010***

| | 2009 | 2010 | Difference % | Difference $ | % of Total |
|---|---|---|---|---|---|
| Revenue | $276.86 | $290.46 | 4.9% | $13.60 | |
| Medical Expense | $239.44 | $243.34 | 1.6% | $3.90 | 28.7% |
| Claim Adjustment Expenses | $10.00 | $10.20 | 2.0% | $0.20 | 1.5% |
| General Administrative Expenses | $25.58 | $27.85 | 8.9% | $2.27 | 16.7% |
| Increase in Reserves | $0.18 | $0.18 | 3.5% | $0.01 | 0.0% |
| Underwriting Gain (Loss) | $1.67 | $8.88 | 432.2% | $7.21 | 53.0% |
| | | | | | |
| Medical Loss Ratio | 86.5% | 83.8% | -2.7% | | |
| Total Expense Ratio | 12.9% | 13.1% | 0.3% | | |
| UW Gain as % of Revenue | 0.6% | 3.1% | 2.5% | | |

**Exhibit B-21: Comparison of 2009 PMPM's to National Benchmarks**
***National from NAIC Statistical Compilation of Annual Statement Information for Health Insurance Companies in 2009***

| | NH | National | Difference $ | Difference % |
|---|---|---|---|---|
| Revenue | $385.11 | $276.86 | $108.24 | 39.1% |
| Medical Expense | $340.03 | $239.44 | $100.59 | 42.0% |
| Claim Adjustment Expenses | $9.92 | $10.00 | ($0.08) | -0.8% |
| General Administrative Expenses | $39.43 | $25.58 | $13.85 | 54.1% |
| Increase in Reserves | $0.96 | $0.18 | $0.78 | 435.7% |
| Underwriting Gain (Loss) | ($5.23) | $1.67 | ($6.90) | -413.3% |
| | | | | |
| Medical Loss Ratio | 88.3% | 86.5% | | |
| Total Expense Ratio | 12.8% | 12.9% | | |
| UW Gain as % of Revenue | -1.4% | 0.6% | | |

## Appendix C: Transcript from Carrier Hearing

**TRANSCRIPT**
**Public Hearing on Premium Rates**
**in the Health Insurance Market**
**Pursuant to RSA 420-G:14-a V.**

October 28, 2011, 9:00 a.m.
at NH Fire Standards & Training Academy, Concord, NH

New Hampshire Insurance Department:
- Roger A. Sevigny, Commissioner, Hearing Officer
- Alex K. Feldvebel, Deputy Commissioner
- Tyler Brannen, Health Policy Analyst
- Jennifer Patterson, LAH Legal Counsel
- David Sky, LAH Actuary

Compass Health Analytics, Inc.:
- James Highland, President
- Lisa Kennedy

Health Carrier Participants:
- Lisa Guertin, President, Anthem Health Plans of NH, Inc.
- Peter Lopatka, VP of Actuarial Services & Chief Actuary, MVP Health Care
- Beth Roberts, VP Emerging Markets, Harvard Pilgrim Health Care
- Tray Swaker & Patrick Gilespie, Cigna
- Michael Degnan, NH Health Plan

Others:
- Vanessa Santorelli, Director NH Public Policy, Bi-State Primary Care
- Scott Colby, Executive Director, NH Medical Society
- Paula Minnehan, VP Finance & Rural Hospitals, NH Hospital Association
- Tom Bunnell, Director Institute for Health Law, NH Voices for Health
- Jill Shafer Hammond (former state representative)
- Zandra Rice Hawkins, Executive Director, Granite State Progress Education Fund

**Roger Sevigny:** Good morning everybody. As I have said at some gatherings that I speak before, I kind of feel like I am in church again, everybody is sitting at the back of the room. I promise I am not going to preach or do anything of that nature. If anybody wishes to sit closer, feel free to move. Deb, if you could get me the list of.....

I'm Roger Sevigny, the Insurance Commissioner in New Hampshire. I want to welcome you to the first of what is to be an annual event, according to law public, a hearing concerning premium rates in the health insurance market. We have this facility until approximately noontime. I am going to, Tyler is pretty much going to layout the order of march, so to speak, with regard to who is coming to testify,

beginning, I think Tyler, with the carriers.

**Tyler Brannen:** Correct.

**Roger Sevigny:** And ultimately, we will get to the general public for those of you that want to provide testimony as well. I would ask that if you have testimony you either provide it orally or in writing or both. Anyone who doesn't get a chance to speak for whatever reason and wishes to provide testimony, I will take written testimony.

Let me introduce the Insurance Department participants. First is Alex Feldvebel our Deputy Commissioner, David Sky, Life Accident and Health Actuary, Jen Patterson, Life and Health Legal Counsel, and Tyler Brannen who is our Health Policy Analyst. And, of course, Deb who has helped set this thing up. The consultants Jim Highland who is the president of Compass Analytics, and Lisa Kennedy, Compass Health Analytics.

The carrier participants this morning are Anthem, Harvard Pilgrim, MVP, Cigna, and the NH Health Plan. I will also, like I said, invite others, we have provider reps from Bi-State Care that is going to provide testimony, we have the Medical Society that is going to provide testimony, the NH Hospital Association, and as I mentioned anyone else from the general public that wishes to do so, I invite you to do so.

In 2010, Chapter 240, which was Senate Bill 392 requires that I hold a public hearing concerning premium rates in the health insurance market and the factors, including health care costs and cost trends, that have contributed to rate increases during the prior year. Further, it requires that I prepare an annual report to provide information which identifies and quantifies health care spending trends and the underlying factors that contributed to increases in health insurance premiums.

Assisting the Department with this task is Mr. Jim Highland and Lisa Kennedy of Compass Health Analytics. And we are going to begin testimony this morning with New Hampshire's major health carriers, followed by provider reps and then members of the general public.

We do have a sign-up sheet if anyone has come in and wishes to provide testimony and hasn't signed up yet, come and get the sign-up sheet. And, with that, I will turn it over to Tyler and ask him to have the carriers begin.

**Tyler Brannen:** We have the major carriers in New Hampshire here to testify and we also have the NH Health Plan which is a little bit different than the carriers and will go last. We will start with New Hampshire's largest carrier **Anthem Health Plan**.

**Lisa Guertin:** Good morning everyone, my name is Lisa Guertin, and I'm President of Anthem Blue Cross and Blue Shield of New Hampshire. We are pleased to have the opportunity to share information with you today. In keeping with the specific language of the law that created this hearing, we will be presenting information on the factors that contributed to cost growth in health care services, increased utilization of health care and health insurance premiums in 2009 and 2010. As that language recognizes to understand what has been driving the increase in health premium costs it is necessary to address what's driving increases in underlying health care costs. And the reason this is true becomes clear when you deconstruct the health insurance premium.

Premium is comprised of two major components the expense associated with health care services received by our members, or claims costs, and expense associated with the health insurers administrative services and margins. Administrative services include things like care management, processing claims, enrollment, customer service, building and maintaining networks, as well as taxes and assessments, those things comprise administrative costs.

During the period of analysis, when we filed our premium rates they were intended to support 82% of that premium going toward paying claims, 6% as margin, which as you will see is important because based on that perceptively using a forecast of excepted claims which can and does vary. So this margin is used on claim expense when claims come in higher than we expected and is retained as profit if they don't. 9% is intended to support direct administrative cost, and 3% is also administrative cost, it's a pass-thru of known assessments and taxes.

In both years that we analyzed, for this first go with this hearing, claims took more than we anticipated in our filing. In fact, in 2009 claims took almost 88% of the premium we charged for a small group business, and so the difference came out of that margin. One of the reasons for that is that from 08 going into 09, claims costs went up 8.9% or just about 9%. So an important question to answer is why was that the case and what caused claim costs to go up year over year.

Generally speaking three things cause claims to go up year over year. The first thing is to answer the question what is driving costs. The first is unit cost increase. In very simple terms this means that a service from a hospital or physician costs more this year than it did last. Unit cost increases are impacted exclusively by our negotiations with hospitals and physicians. So if we break down that claim increase that I just spoke about going into 09, about half was explained by unit cost increases. The second thing that causes claim costs to go up is utilization increase. That is very simply people getting more care than they did in the past. This is impacted by a wide variety of factors including changes in demographics, economic conditions, severity of flu season, consumerism, just to name a few. Of that total increase that I spoke of, about 20% or 1/5 of it was driven by utilization increase. The third thing that impacts claim costs is service-mix changes. This one is probably the most volatile and complex. Many things contribute to it, but very simplistically stated, it means the mix of services people are getting is made up of more costly, complex, complicated things this year than in the past.

So I will try to touch briefly on how this is different than a unit cost increase. Let's say in a period of time we agree to pay X% more for a given service than the year before based on our negotiations with the hospitals and physicians in their network. We might also see an increase in cost beyond that because we would begin receiving claims for a service that didn't even exist in the prior year. It may surprise you to hear that 5 services that weren't offered at all, they weren't in existence in 2004 where they were in their infancy, were together responsible for $60M in billed charges to Anthem in 2010. Those things are PET Scans, Gastric Bypass Surgery, Remicade, IV-IG, and stereocathic radiation. That is a great example of a cost increase associated with service mix.

Another example would be if people are getting a more costly service like an MRI this year, where last year they were getting more xrays. So while it is possible that service mix could cause a lower cost service to replace a higher cost one, most often service mix changes as treatment and technology advances actually result in cost increases that show up in the premium. Of that increase I cited earlier, service mix changes drove about 1/3 of it so it is significant. So that is one way to look at the drivers of increased cost during that period of time.

**James Highland:** Lisa, ... I didn't hear what percent of the total increase was service mix vs. unit cost increase.

**Lisa Guertin:** It was about half the total, so it was half for unit cost, it was 20% for utilization and 30% for service mix in that period of time. And that varies, obviously, year to year. So that is one way to look at the drivers of increased cost during that period of time.

The Department also asked us to talk specifically about which categories of care drove cost the most. For our members the fastest growing category of cost during the period of analysis was outpatient hospital services. We took a longitudinal view of that and we saw that costs have increased for outpatient hospital services since 07 by 33.6%, which is noteworthy because it compares with a 17.7% increase for all other care, so that would be inpatient, professional and pharmacy. And with that growth, outpatient care now accounts for just over a third, or 34%, of our total spend.

Specific types of outpatient care that have been growing the fastest are outpatient surgery which has grown 28% since 07, outpatient radiology about 20.9% since 07, outpatient lab which has grown 63.6% since 2007, and IV infusion therapy which has grown 42.1% since 2007. That last one, IV infusion therapy is a great example of the type of emerging treatments and technology that contributes to cost increases and show up as service mix. Remicade which is one of those services I mentioned earlier is an infused therapy drug.

Because outpatient services have been the number one area of cost growth, and because the cost of these services vary widely, we did launch a site of service plan option at the end of 2009 to try to address this and provide premium relief of between 5 and 15% depending on the deductible level an employer pay. This uses transparency and consumerism to allow members to reduce or eliminate their out of pocket expense when they choose to seek lab work or outpatient surgery at a lower cost location. It does appear that this has started to mitigate those trends that I spoke of earlier in those categories.

The Department also asked that we provide information on which type of specific illness and injury are contributing most to cost increase. New Hampshire like the rest of the U.S. has an aging population, and, in fact, New Hampshire is aging faster than the national average. The incidence of obesity is also on the rise. These demographics impact utilization which in turn impacts costs. So we know that chronic disease like diabetes and heart disease are contributing disproportionately to the overall increase in costs. As people live longer, we also see an increase in frequency of both cancer and orthopedic conditions. Those are our top 2 categories of spend if you look at illness and injury, and we also see increased intensity of treatments required as the population ages.

The last area carved out by the Department specifically was to identify any other factors that contribute to increase costs, and I would like to highlight 3. The first is compliance with state and federal law, including of course health care reform, and ICD-10 which as you may know is a coding overhaul required by CMS whose costs affect not only the insurers but also the billers as well. We now estimate that it will cost our company overall at least $180M to make the system changes that are required for ICD-10. Also of course state mandates play a part. Within the last 5 years, New Hampshire has enacted 6 new mandated benefits. They are autism, hearing aids, bone marrow registry, certified midwives, bariatric surgery and early intervention. And finally a direct category – assessments. We pay about $7M per year for vaccine assessments and the high risk pool.

The second factor is government cost-shifting, which is certainly a component of rising costs here in New Hampshire. We know that in 2008 according to the Center for Public Policy Studies, the total amount shifted to private payers in New Hampshire to offset Medicare and Medicaid underfunding was $580M. By 2009 that number had grown to $683M. It's an 18% increase in one year, and this is obviously getting a great deal of attention now as a new wave of potential cost shifts affect the market.

And the third one is supply-side economics which also play a part. We are very fortunate in New Hampshire to have many fine hospitals, and historically consumers have wanted their local hospitals to have the newest and the best. So, since 2004, there have been 51 hospital construction and renovation projects in New Hampshire totaling $996M. Now while the hospitals certainly do their fundraising and capital campaigns to pay for some of this work, as we've just said with government payers paying less than their fair share to cover the expenses of the people that the hospitals serve on government programs it stands to reason that the extension of service costs is also borne to some degree by purchasers of commercial insurance.

Another thing that is a little bit unique to New Hampshire is that about 75% of PCP's and about 60% of specialty care providers are actually employed by the hospital system. This creates integrated systems that do tend to be used for referrals and retain much of the patient's care. We believe partially for this reason, but also because our population is small and rural, New Hampshire has had less supply-side competition in the form of some of the independent entities such as free-standing AFC's, imaging radiology centers, retail health clinics, commercial labs than we see in most states. This has started to change somewhat, but it is still a factor of what is a reality here in New Hampshire.

So overall the approaches that we've taken over the past several years to help control costs especially those that begin to really engage the patient as a true consumer of medical care appear to be mitigating these cost trends somewhat and in fact our small group rate increases for January 2012 will be the most moderate we've been able to offer in 4 years. Nonetheless, we recognize that the cost of health care and health insurance remains a challenge for all of our customers and New Hampshire citizens and this will continue to be our primary focus in collaboration with other stakeholders in the state.

Thank you.

**Commissioner Sevigny:** Thank you very much Lisa. I've got a couple of questions for you, but let me start with one of the factors that will contribute to increase cost. ICD-10 has the start date been moved on that, I know the NAIC worked hard to get that start-date moved and I haven't kept up with when that start date is.

**Lisa Guertin:** I don't know, I am not sure.

**Jim Highland:** 2013

**Commissioner Sevigny:** Okay, we were trying to get the feds to slow that down; it obviously has an impact. Now second, do you have any idea at all what the cost-shifting impact is on premium?

**Lisa Guertin:** I think we talked historically about a 17% hidden tax if you will, now that is an old number, I think it has gotten larger than that, but I would say the latest round of cost-shifting or

potential cost-shifting is not reflected in rates yet. What we've tried to say is that we don't believe the commercial customers can afford to take any more than they already have, and I know the hospitals are understandably very concerned about the latest round of cuts. I do not have that quantified to say if that did flow through the rates what would it be worth. But I think we can safely say that there is at least a 20% portion of the premium rate that can be attributed to that cost-shift.

**Commissioner Sevigny:** You mentioned earlier what you planned for is 82% of the premium goes to claims, 6% to margin, 9% to expenses and 3% to assessments and taxes, and in 2009 your claims in fact were 88%. Where did that come from? Where did the additional 6% to pay those claims come from?

**Lisa Guertin:** That particular year we really did see some effects of the economy if you recall that was the big H-1/N-1 year which I think all of the carriers subsidized there were some very particular factors that we hadn't forecast when we made our rates, I think there might have been one more, Jason do you remember what the 3rd one was – Cobra. That was the year the Cobra subsidy began and what that meant people that tend to pay for and keep Cobra typically have the highest claims. There is a loss ratio over 100% typically on people that choose to keep Cobra, because obviously they need it that is why they are keeping it. That year we saw a disproportionate infusion of Cobra members and that loss ratio also went up significantly. So those 3 things weren't anticipated when we filed the rates and accounted primarily for that 6% delta.

**James Highland:** Two requests and a question. Would you be able to provide your testimony in writing to the Department?

**Commissioner Sevigny:** If not, we can have it transcribed.

**Lisa Guertin:** The problem with going first is we don't know what everyone else is going to say to that question!

**James Highland:** And, secondly, the law requires the Department to study costs between 2009 and 2010, so any stats if those could be updated to 09-10 and provided supplementally that would be very helpful.

**Lisa Guertin:** That is in our data submission and what we understood this to be was really in those years and we just sort of picked one, but we do have that quantified for you in the submission.

**James Highland:** Some of the questions we are asking that you addressed in your testimony subdividing into specialty area, etc. is not a part of the submission. You had some facts that that were not presented for the 09-10 period.

**Commissioner Sevigny:** Thank you.

**Lisa Guertin**: Thank you.

**Tyler Brannen:** Next if we could hear from **MVP** which is the smallest of the commercial carriers we have presenting.

**Peter Lopatka:** (Written testimony – Exhibit A) Thank you everyone for the opportunity to present this testimony. My name is Pete Lopatka, I'm vice president and chief actuary at MVP Health Care, I'm

a fellow of the Society of Actuaries and have been in the health care industry for 18 years. Joining me today is Chris Henchey, executive vice president and chief operating officer who oversees MVP's business in New Hampshire.
MVP is a not-for-profit health care plan with a current enrollment of more than 700,000 members, and 18,000 roughly of those in New Hampshire.

MVP was formed in upstate New York in 1983 by doctors and community leaders. In 2004, MVP entered New Hampshire and created two New Hampshire domiciled companies: MVP Health Insurance Company of New Hampshire and MVP Health Plan of New Hampshire. In 2007, MVP assumed the policies and operations of Patriot Health Insurance Company under the supervision of the New Hampshire Department of Insurance.

By letter dated October 7th, the Department of Insurance directed MVP Health Care to answer specific questions in a separate submission which we have filed with the Department, and we appear here today to answer specific questions outlined in that letter.

In the letter we were requested to provide information about our cost growth subdivided by clinical area, with focus on those contributing most to cost growth.

From 2009 to 2010, MVP's cost growth, as defined by the change in allowed per member per month costs, increased by a total of 11.3% in New Hampshire. Make a note that allowed costs represent costs prior to the application of member cost sharing provisions, in other words, they are independent of plan design and reflect our underlying medical and prescription drug cost increases. And so that year to year increase was 11.3%. Subdivided by service category for inpatient services it matched that 11.3%, outpatient services 12.1%, physician services 10.9%, and prescription drugs 9.5%. So it is relatively consistent across the major service categories.

Another question asks for the cost growth subdivided by incidence, changes in severity and provider rate increases. The 11.3% increase, subdivided by the major components of trend by usage rates, unit cost and intensity mix was the usage rates went up 4.6%, the unit cost went up 5.5% and the intensity mix was 0.8% that contributed to that 11.3% over that time period. So roughly half the increase was due to increased usage of services and the other half was due to increased prices and intensity of services. That was relatively consistent among the service categories with a slightly higher increase in the outpatient services utilization rate, and relatively a lower increase in prescription drug utilization rates.

The final question that we address what are the significant cost contributors to premium cost growth. So we are switching now from talking about underlying cost drivers of allowed costs to our premium rates. MVP's premium increases from 2009 to 2010 exceeded our underlying cost trend rates and the primary contributing factor here premium cost growth from 2009 to 2010 and again from 2010 to 2011 was our actual experience for our medical and prescription drug claims matched up against our expected experience. So, in general, if the actual experience matches expected experience than you can reasonably expect the premium increases to match the underlying costs increases of the allowed cost trends. But MVP's actual claims experience materially exceeded expected claims experience for that base period for both actually 2010 and 2011 premium rate setting. So in order to set a premium reasonably expected to cover underlying medical and prescription drug costs, the premium needs to increase with underlying allowed cost trend plus the value of the difference between actual and expected claims in the base period. If that second component is not considered in premium setting,

premiums will perpetually be insufficient to cover costs.

MVP's New Hampshire Health Insurance Company operating income results for 2009 and 2010 illustrate the dynamic of actual costs exceeding expected costs. In 2009 our operating loss exceeded $19M in New Hampshire, and in 2010 our operating loss exceeded $17M.

As a relatively new health insurer in the state, MVP has encountered challenges in entering the New Hampshire market including a unique economic dynamic comprised of limited health insurer competition, wide variations in provider charges within regions of the state and across the state. Some of these charges varied by as much as 80%. As is almost always the case when a new insurer enters a new market, MVP was challenged to obtain provider contracts with competitive reimbursement without a large enrollment and found it difficult to achieve enrollment growth without competitive provider rates.

Even with these challenges, MVP continues to stay focused on serving the health insurance needs of New Hampshire with a range of choices.

We thank you for your time and invite you to pose any questions you may have for us at this time.

**Roger Sevigny:** Couple of questions. The first one, you talk about your operating losses in 09 and 10 and ultimately your effort to address those. Essentially, if I understand you, that was your effort to stop the bleeding, not to continue it, to experience losses, but as a matter of fact to try to operate, continue to operate.

**Peter Lopatka:** That's correct.

**Roger Sevigny:** And you talk about 11.3% overall increase in claim costs from 09 to 10 and then you break that down into the various components, you talked about increased utilization, where are you seeing that increased utilization?

**Peter Lopatka:** All of those service categories. Slightly more, I can follow up with the exact numbers, but in outpatient facilities, so outpatient hospital is a high utilization trend than the average. Compared to past years in the market slightly better in prescription drugs with the continued brand going off-patent and the increase in generic utilization rates we are hoping that is actual trend and the usage too, not just the unit costs go down when that happens for generic, you don't have the manufacturer's machine to direct consumer advertising and utilization rates also subsides when you have more generic drugs.

**Tyler Brannen:** How do your losses in New Hampshire compare to other markets?

**Peter Lopatka:** It varies by market, so as a percentage in this time period it was greater in New Hampshire than it was in other markets. And it depends on what line of business we are talking about. In New Hampshire we have a commercial line of business, in New York there is commercial and government programs, and we have a larger HMO line of business. Right now we it is basically nonexistent in New Hampshire now it is like 20 members or something. The HMO line runs better than our insurance company line. If we are just comparing commercial insurance company lines, commercial insurance company lines over this period as a percentage of total premium there were greater losses in New Hampshire than there was in New York.

**Alex Feldvebel:** I would like to ask you to talk a little bit more about the challenge that you mentioned, that MVP faced as a new carrier coming into the New Hampshire market. You mentioned the difficulty, without having a large member base to get favorable contracts with the providers and physician groups that would allow you to compete. We are interested in how open New Hampshire's health insurance market is, and I am wondering if you say anything about how New Hampshire might compare to other states. I know that as MVP grew they came through Vermont. Can you say anything or give us an idea how, how much of a market barrier this challenge of getting competitive provider contracts is to an insurance company trying to come into New Hampshire?

**Peter Lopatka:** Can I understand the question? For my clarification and feedback, there's going to be challenges entering any market. In terms of just that dynamic of negotiating rates if you don't have any volume it is going to be very difficult. And I will add to that too, going into any market inherently it is the actuarial client is based on historical experience and you take that historical experience and you trend it forward going into a new market. So you are making adjustments off of other data sets, so those are challenges in any market you enter into. Relative to other states, I am going to defer to Chris (Chris Henchey) on that. Sorry.

**Chris Henchey:** The nature of your question suggests that the dynamic in New Hampshire, that it is very difficult to come into New Hampshire and I don't think there is any necessary cause and effect. Since the early 80's there has only been 3 or 4 competitors in New Hampshire despite a lot of public policy activity there has always been 3 or 4 with very few new entrants. And the new entrants problem is one that we decided to make the investment to come to New Hampshire and for this year we are at least at a break even dynamic right now so we believe that the investment has been worthwhile. It is still very difficult to stay competitive given the provider dynamic in New Hampshire. On behalf of my provider colleagues, I would suggest that the shift that Lisa (Lisa Guertin) just talked about is a huge dynamic for us still, and I think is growing, and not only exaggerating the effect in the marketplace. Very difficult.

**Roger Sevigny:** I've got one other question for either one of you. Being the newest entrant into our market you've got some recent experience. Could you have entered our market and been able to survive if you had tried to enter it without a network? In other words in sort of an unregulated fashion.

**Chris Henchey:** I probably would except for the Commissioner of Insurance to have the ability to do that, assuming it was lawful, the fundamental guiding proposition of any health plan is its underlying network, but New Hampshire has very unique dynamics both geographically and well as socioeconomically, so I think you need the network in place. This is not a complex business, the building blocks, the foundational aspect of any health plan has got to be that.

**Tyler Brannen:** Next we will hear from **Harvard Pilgrim.**

**Beth Roberts:** (Written testimony – Exhibit B) Good morning. For the record, my name is Beth Roberts and I am the Vice President for Emerging Markets at Harvard Pilgrim Health Care. And I have with me today Peter Horman, Peter is our Director for Medical Trend Forecast and Analysis. So, if the questions get really challenging I'm deflecting, so that's my role, so Peter get ready. My lifeline, to phone a friend!

Harvard Pilgrim Health Care is a not-for-profit organization providing health benefits to approximately 140,000 people buying insurance here in New Hampshire. That equates to approximately 20% market share for Harvard Pilgrim in New Hampshire if you add together both our fully-insured and self-insured business.

I would like to say right away that my testimony is very similar to Lisa Guertin's testimony. So, I asked Lisa if it was appropriate to just get up and say "ditto" and she said sure, fine, so it is constructed a little differently but very similarly, so we started our testimony by really reflecting on the fact that a report came out that was issued by the New Hampshire Center for Public Policy Studies in September 2011 noting that health care spending in New Hampshire has been increasing more rapidly than economic growth. I don't think that's a surprise to any of us in the room. The report ascribes the growth not only to more people seeking care and the price of this care, but also the New Hampshire's aging population. By 2030, nearly 1/3 of New Hampshire residents will be over the age of 65. I think we all understand that that will have a tremendous impact and have implications for the state of New Hampshire and the health care system here. Older individuals not only require more care, but as we know, Medicare is the payer, predominant payer for those services. We also know that between Medicare and Medicaid the cost shift to the private sector is enormous and that cost shift costs a lot of money. Like Lisa, I don't know the exact amount of money that that costs, but I think a lot of us have seen Steve Norton's report on that and it ranges anywhere, hospital by hospital, from a 20%, we pay more on the commercial side by 20% up to 40% in some cases to cover that cost shift. So it is quite dramatic. That vicious cycle will not change unless the federal government does something. And I would say, I do agree, we do know that our hospitals cost a lot of money in the state of New Hampshire, but I think just to tie that together it is important to understand that this cost shift is a big reason for that. So, it is not just because hospitals want to make enormous profits in the state, but a lot of it is there is a legitimate issue here and the issue is when Medicare and Medicaid pay less than their fair share there is a cost shift to the commercial carriers, and that is factually accurate.

For small business in particular premium rate increases have been a problem. On average, small businesses tend to have older employees, their use of health care services is higher and, often, are less able financially to afford coverage than large firms. Combine this with high medical cost trends and state mandated benefits that small business are required to provide, unlike some large, self-insured businesses, and it's understandable why small businesses are feeling particularly vulnerable regarding premium increases.

Historically, we have seen very high cost trends in New Hampshire, with an average medical cost trend of 10.1% through 2010 and another 2% due to the aging of the population. Another 1% is due to the decreased impact of fixed deductibles and copayments, in contrast to coinsurance, as medical costs increase since these are not indexed to inflation. As a result of these different trends, rate increases have been on average 14%. That is the historical view for Harvard Pilgrim on average 14%.

Looking more deeply at the 10%, so we said 10% was the medical cost trend. Of that 10%, what providers are charging us is about 70% of that 10%. So the unit cost component of that trend is largely swallowed up by unit cost increases. Another 3 – 4% is due to high utilization, particularly in the hospital inpatient or outpatient setting, and the severity of the conditions being treated. Certain outpatient services, such as radiology, day surgery and prescription drugs, demonstrate high trends.

So the trends actually have been on the high side here in New Hampshire. Just a point of note New Hampshire trends have been going up higher than the other two states that we do business in – higher

than Maine and higher than Massachusetts. We have a higher rate of rise on the unit cost side, and we actually have a higher rate of rise on utilization than the other two states that we do business in. Bringing this forward now to 2010, 11 and 12, although not asked for in this particular testimony, I wanted to make sure I left everybody in the room with a good feeling that we actually see some of these trends mitigating. So I think that is good news for the state of New Hampshire. More specifically if we look at some of the categories within outpatient radiology, just to put a little bit flavor into this, in 2011 we are expecting a trend in radiology of about 6.2%. It will go back up in 2012 to 8.5, but that is still much lower than what it has historically been. Day surgery is going to go up by around 10% and prescription drugs around 7%.

While increases in the single digits may seem relatively modest, they are still several times greater than the general rate of inflation and, without serious efforts to address them, could increase even further when the general economy improves and pent-up demand due to delayed medical care occurs.

So what are we saying about what's coming ahead of us. We've just talked about 10 – 14% premium increases with a 10% medical cost trend. We are now saying that we are expecting a medical cost trend with those numbers that I gave you to equate to around 8%. So what was 10, we are looking at more like 8% in 2012. And we are actually anticipating that it may drop, it is tied to the economy, but we are anticipating it may drop a little further in 2013. While part of this decrease is due to the effects of the current prolonged recession, Harvard Pilgrim has also implemented a number of payment and care delivery strategies focused on decreasing the cost curve on a more permanent basis while maintaining and increasing the quality of care received. For the remainder of my testimony I am just going to highlight for you some of the things Harvard Pilgrim has been doing and will continue to do to make sure we take very seriously this mitigating trend and actually use it so that we can have prolonged lower trend.

So first aggressive provider contracting, that comes as no secret to my hospital friends and provider friends in the room, I think all health plans are taking very seriously the role of provider contracting. And really trying to work with you collectively and collaboratively to figure out how to spend that premium dollar, that health care dollar. So we believe that partnerships and working with the provider community is fundamental to the success of keeping that trend on the lower side.

We also think that moving from a fee-for-service system where we pay based on volume is paramount in order to make that transition as well. We need to work with you again rather than just spending our dollars we need to work with you on trying to figure out how to improve the cost in the state. In this room I think folks know that Harvard Pilgrim has been up front in its leadership of supporting the patient's centered medical home and the ACO initiatives both of which are state-based initiatives here in the state of New Hampshire. And that is not to suggest that we are not also doing that individually, so on top of the state initiatives, Harvard Pilgrim is working collaboratively throughout the state using various models to engage the provider community.

We've adopted some new medical management policies, not always popular, because some of those mean a little more rigor by the delivery system in order to make certain that the right care is being delivered at the right time and at the right place. Some examples of that is high-end radiology programs where we work with the clinician to make certain that it is the right radiology for the patient at that time. Sleep management programs, including sleep studies and CPAP. So what we do, and what Peter's job really is focused on is looking at what are the medical trends, we look at what do we see the dollars climbing at a really quick pace and then do a deep dive state by state and then say what

does that mean we need to do in the way of care management programs in order to get that trend to moderate a bit. And, so that is a lot of work that Peter's team does. And we are quite proud of that work. One of the more recent ones that we are going to be taking on in 2012 is about lower back pain. That is something that we see quite a significant trend on. Another is very aggressive formulary management. Harvard Pilgrim is very proud of the fact that we have an open formulary. But we work very hard to make certain that our members get access to inexpensive drugs. So more recently we have adopted a four-tier pharmacy program where we actually were able to roll out within our product portfolio members actually getting less co-pay on generic drugs rather than more co-pay. So we brought that first tier down a step and actually have $5 co-pay come back alive. So I think that is good news for a lot of people.

Through our care and disease management programs we have a full range of services that work with you when you are well, work with you when you are chronically ill, and work with you on every end of that spectrum in order to keep you as healthy as you can be no matter at what point within your care you are.

Products – we are introducing tiered network products. Within the market today we feel it is a very efficient way to have consumers get engaged in helping to select the care that they would like delivered by whom, but understanding the cost of that care, and having that as an element of the decision-making.

Tandem – we have a new partnership with Tandem which is a redirection service. So if a member chooses, they work with a nurse in order to find a less expensive, high quality care provider and if they choose to get redirected to that lost cost, high quality provider they will receive an incentive. So it is a provider engagement and consumer engagement tool.

Finally, Harvard Pilgrim has kept its administrative costs nearly flat. I think this is an important note to make for the audience today. And that is that we actually see that we need to keep our medical cost ratio in the state of New Hampshire at 87%. I think Lisa said 88%. And the reason why we need to be at 87% is because you have a 3% tax plus assessments for about for about 3% of the premium right off the bat, 87% loss ratio and then 10% admin costs. We are slightly higher than Anthem on admin, we run at 10 rather than 9. So you add that together, that is a break even situation. So Harvard as a not-for-profit, we are comfortable with break even. We would like to see a 1 to 2% margin to reinvest into our business. That said, 87% loss ratio in the state of New Hampshire is what we need to accomplish just to be a break even health plan. That is tremendously difficult. It is not an easy state to make that happen.

In summary, Harvard Pilgrim is committed to the state of New Hampshire with all of the work that we are doing and the provider transformation states where we are partnering with that provider community in order to try to figure out how to make sure we spend that health care dollar very effectively. We have those things looming that Lisa referred to which the affordable care act, we have that that we have to comply with, ICD 10 even if the date gets delayed we all have to start working on it. The work is real and true and it is multi-millions of dollars for each and every single health plan in order to build a capacity to migrate to ICD 10.

We have the mandates, as Lisa mentioned, and certainly, I have already mentioned the assessments. So through all of these challenges we remain committed. We expect to grow in the state of New Hampshire. It is the core focus of Harvard Pilgrim. With that I will take any questions, and thank you

for your time.

**Roger Sevigny:** Thank you very much Beth. I've got a couple.

**Beth Roberts**: Ok, Peter, get ready!

**Roger Sevigny:** These are going to be easy. Actually more of a comment than a question. It is the comment you made regarding Harvard Pilgrim looking very closely at method of reimbursement, and I know that is what other carriers are doing that as well, but I certainly think personally, and with all of the exposure I have had nationally with the NAIC that the current method of reimbursement is really a perverse method of reimbursement. And you are looking actively into doing something about that, working in collaboration and partnerships with the medical partners that you have out there is the way to go. Whether it's the ACO or the medical home, I don't know what the answer is, if I did I would probably be elsewhere with lots of money, but I do commend you, as well as others, for working actively at doing that.

And, secondly, let me ask you a question somewhat similar to what I asked MVP, and it has got to do with the current New Hampshire health insurance market and new entrants. We hear a lot about "you've got to bring more carriers in, you've got to bring more carriers in", can you just give what some of the barriers are to new entrants or to somebody coming or doing business in New Hampshire.

**Beth Roberts:** Happy to, but I would like to start with an opinion on that statement if you don't mind. We have to remember that we have 1.3 million people who live in the state of New Hampshire. And then we have to take out Medicare and Medicaid. So let's say that our total risk pool is 650,000 in the entire state of New Hampshire. Than you take that 650,000 and you take 50% of it away for the self-insured population. You are talking about a risk pool of, if we are lucky, 300,000 – 400,000 if we are lucky, in order to make a risk pool that is statistically valid. You then take that and you share that amongst numerous health plans, and I would suggest to you that competition or more carriers coming into the state isn't going to help lower costs. Because what happens is if your risk pool is too small you have to build in factors of protection to make sure that you can afford that level of risk. So the more that gets carved out by multiple players, and this is Beth Roberts opinion, so let me be on the record as being clear because I might deflect this to Peter and he may have a wholly different answer, but looking at the state of New Hampshire, we are not afraid of competition, we welcome anybody to come into the state, but at the same time I think it is somewhat of a false notion that if we add more and more carriers it will have a favorable impact on the bottom line. I would suggest to you that if we make the risk pool too small that you are going to have to include a lot more "fudge factors" if you will, to protect the volatility of risk to make sure that you don't lose your shirt. So I just think that being a small state, having four carriers is not that bad.

Barriers to entry, I think Chris (Henchey) you know hit on a big one, is it difficult to build a network? It is difficult and hard work. Can it be done – yes it can. It is a barrier to entry, but I don't think it is an impossibility. We did it, it is something you have to spend time doing, you have to invest the right resources to get it done, and it can be done. I would say a barrier to entry, even more noteworthy, cause an insurer expects to build a network, so I think that is just part of what your assessment is. I think what the distraction for New Hampshire is the high tax and assessments. We don't pay a 2% tax on our HMO business in the other two states that we do business in. We just don't pay that. We don't have assessments at the level that we have them today. So you add that together and you realize that upwards of 3% plus of premium is dedicated to that. I would say that that would be something that

people trying to come into New Hampshire would a hard look at and the combination of small risk pool and small potential and high cost of entry in the way of assessments and taxes that that dynamic might not make it the most attractive state to come into and do business. I don't know, Peter would you like to offer anything different than that?

**Peter Horman:** I completely agree. Provider networks are a substantial obstacle. New carriers entering the market, they're looking at starting with five or ten percent of the market share. It is hard to estimate costs, hard to build and network and it is hard to spread administrative costs and on top of that there is a 3% tax they have to deal with, so you know, we went through that. Trying to get experience, understanding the market, is very difficult.

**Lisa Kennedy:** You mentioned the 2% impact trend for rating, is that just a morbidity impact or would that include shifting from Medicaid or Medicare?

**Beth Roberts:** Peter?

**Peter Horman:** The 2% is just morbidity, our average age has gone up by a year say about 1 or 2% per year. So really if you're tracking inflation in the commercial population, the other dynamic, I think people are working a little longer, so we pick up many older people.

**Tyler Brannen:** Can we talk a little bit about buy-downs, what you have seen, what you anticipate?

**Beth Roberts:** I'll start and then I will see if Peter wants to add to that. We are seeing our most commonly sold plan in New Hampshire today around a $2,000 deductible. If you had asked me that question last year I would have told you it was a $1,500 deductible. So I would say that is about the clip that we are realizing. We do see a lot more product variation in the market today and so it is hard sometimes to do apples to apples comparisons, but I think a lot of us are playing with new product designs in order to see what sticks and what works and so you might start seeing more co-insurance as an example and maybe some limitations on office visits or things that are unique within product features that make that a little harder to say from my view. Peter you might have a more numerical response to Tyler's question.

**Peter Harmon:** One of the things we always see is that buy-down is used to offset rate increases due to trends. Agents maybe working with a budgeted trend of 5%... Harvard Pilgrim has a portfolio that gives a wide range maybe from where you could get up to 50% decrease in premium at some levels....as a nonprofit we don't want that to be the only lever for people to be able to lower their cost we are trying to have less traditional buy down options. Like we talked about $5 copay, tiered network products, where people have a consumers choice in order to save some money by making a choice, but if they are willing to want a higher cost provider they can make that choice and it will result in expending more money. So buy down over the aging has been 3 or 4% in response to the high trend. As trends mitigate you will see that buy down number go lower, but it is significant.

**Jim Highland:** You were mentioning programs related to high-end radiology, sleep disorders, lower back, etc. does that mean that those are also where you are seeing the highest quote in medical spending.

**Beth Roberts:** I think that we have seen a trend that we feel like we can match a program to a trend so, we adopted or introduced a high-end radiology program years ago that was based on soft steerage,

if you will, simply if a provider called and said I want to do an MRI on Beth Roberts, we would recommend no Beth Roberts should have a CAT scan let's say, that is the most appropriate test. If the provider disagreed and still chose to do the MRI we paid for it. So it was more a consultation approach and that program, the reason why we brought it in as high-end radiology was rising at a really fast clip. But that soft steerage program moderated that for a period of time, but then we saw it start to climb again. So we actually made a more recent change to that that now is hard denial. So instead of the consultation and the provider could still go forward with the MRI, now the person has to do the test that the agreement was based upon or that actually gets denied. So it is not a quantitative answer to your question, but it really is, when we see the trends that are jumping off the page and then we see that there is a program that we could implement that could help mitigate that trend, and then frankly iterate that program as we see the trends cause it will have an immediate impact, but then slowly somehow it figures out a way to climb up again. Peter is that a fair assessment that it is based on the trends that are running up.

**Peter Harmon:** (Mr. Harmon was standing too far from microphone, so this response is incomplete) That's exactly what we do...Massachusetts....long list of things they were going to help the health plan do to lower cost.....we do almost everyone of those. So as thing change as costs increase we try to respond to it. One of the things we are responding to now is there is a lot of high end care that is very expensive so as an example, not that we are going to have a policy on this one. An injectible drug is a procedure which may cost $50,000 per person. We might have 200 people at Harvard Pilgrim using this drug but that actually impacts more than $2,000 premiums which is significant for a small population just because the cost is so high. So, that is what we are looking more and more into managing some of those really high cost drugs, injectibles. Things like that which are creeping up in cost. Even to the point where it is taking more than common services that we used to think about, like physical therapy.

**Roger Sevigny:** Thank you.

**Beth Roberts:** Thank you.

**Tyler Brannen:** Next if we could hear from **CIGNA**-Connecticut General Life.

**Pat Gilespie:** Good morning everybody, good morning commissioner. My name is Pat Gilespie, I am a state government affairs director for CIGNA covering New Hampshire in addition to 8 other states, and I am located in the Jersey City office. With me today is Tray Swaker who is an actuarial director in our pricing unit out of Bloomfield our corporate headquarters. For all of the really hard questions Commissioner, I am going to relay on Tray. I was told early on that there would be no math involved when I became a lobbyist, so one of the reasons I was attracted to this profession.

But, thank you for providing us with the opportunity to participate in today's hearing. Thinking about today's hearing and thinking about the increase in health care costs in general, not only here in New Hampshire, but across the country, I am often reminded of the old Nike commercials with Spike Lee and Michael Jordan where Spike would try to figure out what Jordan's secret was and he would always say it's the shoes, it's the shoes, it's gotta be the shoes. Well, I think when it comes to health care costs in general, it's the claims, it's the claims, it's gotta be the claims. While the number of claims may fluctuate year after year, as we've talked about, and some of the other people have testified to in terms of utilization, the unit cost for medical services has, and will continue to outpace general inflation, by large margins, and that's also driving the claim costs.

The cost of care is often driven by innovation and specialty drugs, again one of the other carriers mentioned that in their testimony, particularly over the past 20 years science and patient expectations have all evolved. For example, some 20 years ago if you were 70 years old and you had a problem with your hip you would literally limp along. You would take some aspirin and you would live with the condition. The same way if you had a bad problem with indigestion or acid reflux you would simply avoid spicy food. And even just a few years ago for someone with prostate cancer an IV chemotherapy treatment was likely their only option. Today, however, we have titanium hip replacements which will outlive all of us, we have complex antacid relief medications that allow us to eat those spicy buffalo wings, and we have oral chemotherapy drugs that do not require a visit to the doctor's office and may cause less side effects to the patient. These developments in medicine, and many others, are wonderful innovations, not only do they help in terms of saving people's lives they also improve a patient's quality of life.

But with these innovations there is a price tag and it is often quite high. For example a total hip replacement costs about $22,000, a year's supply of those antacid medications costs about $2,800, and one round of oral chemotherapy medication for prostate cancer costs $93,000. Now if you multiply those costs over the 1.3 million people here in New Hampshire in terms of meeting their health care needs we see how these innovations can drive upward cost trends.

We have all heard and read about some of the national estimates, some of the national figures, but the national estimate that was cited in the New Hampshire public policy report that was issued recently is that in terms of 40 to 60% of growth in claims cost and in real health care spending is associated with changes in technology and medical practice. So, in addition to that we all know that the national health care spend exceeded $2 trillion dollars in 2006 and has risen an additional 20% in 2010 to $2.5 trillion dollars. Health care spending has increased as a share of GDP from 15.8% in 2006 to 17.5% in 2010. And, the amount spent per person for health care has increases 61% between 2001 and 2010 from $5,153 per person to $8,316.

Commissioner I would like to call upon Tray now to talk about some specific New Hampshire trends that we've seen and then I will come back.

**Tray Swaker:** Good morning. So to talk for a minute about the trends we've observed in New Hampshire in the past couple of years I will start with 2010 over 2009 and then talk about today, 2011, as well.

We expected a trend of just under 10% in New Hampshire for 2010 year end. That excludes some of the leveraging components that some of the other carriers have mentioned, but does include provisions for an aging demographic. And in 2010 we actually observed a lower trend than we expected. The expected trend was about a half percent related to increases with providers and physicians, and about half was utilization and mix of service expectations. And that is where we saw lower than expected trends. In our outpatient and professional services category we observed low single digit trends in terms of the utilization and mix of services. And, for inpatient trends it was negative, our bed days were down year over year. And when you look at the types of services where we saw the negative trend, it was lower maternity claims, lower routine surgeries. We didn't see much of a change in the catastrophic or even more unpredictable preterm babies and accidents, things like that. So it was lower than we expected and did take rates down accordingly.

In 2011 we expect on a go-forward basis a slightly lower trend, so around 8.5%, and again, excluding the fixed-cost leveraging because some of the economic factors that drove the lower utilization haven't gone away so we don't expect quite the rebound in trend. And, to date we have observed inpatient trends bounce back so they were positive again in 2011 and roughly to the absolute level of utilization is about where it was in 2009. Outpatient professional trends continue to trend upward but at a higher rate, more in the high single digits is what we have observed year to date in 2011 versus what were single digits in 2010.

In both years for our provider contracts we weren't necessarily surprised by the rate of change there. We have a fairly good management process so that the 4 to 5% increase in cost related to recontracting with providers and hospitals that came in very close to our expectations in both years and expected similarly to change going forward.

**Pat Gillespie:** Thanks Tray. So I think again to talk about we got all these increases going on and what is really CIGNA doing to try and bend this cost curve which is what everyone is after, the big $64,000 question. CIGNA, our mission is to improve the health, wellbeing and overall sense of security of the people we serve. And keeping that mission in mind in terms of serving peoples' health and their financial security, we are particularly proud of the work that we have done here in New Hampshire with Dartmouth-Hitchcock Hospital. We've worked together with Dartmouth-Hitchcock on a collaborative, accountable care organization. We started this relationship with them in 2008. This arrangement that we have combines the attributes of a patient setting medical home model where you have coordination of care, and an accountable care organization where you talk about payment reform in addition to that coordination of care. Our goal, and what we have been able to work with Dartmouth-Hitchcock and achieve is to meet a triple aim of improving quality, lowering medical costs and improving patient satisfaction. A key element of the program is sharing gap and care data with an embedded care coordinator at the physicians practice using that embedded care coordinator to help patients access CIGNA's other wellness programs that we provide. This care coordinator contacts that patient directly and makes sure that their prescriptions are filled, they keep up with their follow-up appointments, and they maintain any other tests that they may need given their condition.

We've been able, along with Dartmouth-Hitchcock, to demonstrate a 10% closure of gaps in care overall when measured against patients that are operating outside of this model. When it comes to hypertension it is a 16% improvement in gaps and care, and for diabetes patients its 8% improvement.

As I've said we have had this relationship here in New Hampshire as one of our first and one of our leading relationships since June of 2008. We are using the lessons learned here to broaden this program nationally and to expand it to other marketplaces. We hope to roll-out additional agreements over the next 12 to 18 months. We now have 8 collaborative, accountable care models going now, and again we are considering many others.

Commissioner, thanks for the opportunity to present today. I would ask your indulgence that if there is a questions that neither Tray nor I could answer we could supplement the record, understanding that that would be a public document, whatever we submit in writing.

**Roger Sevigny:** I've got a couple of questions to start. Tray you mentioned your trends were lower than expected, you anticipated a 10% trend but they were lower. Let me ask if you have any sense what factors came into play to cause that lower trend? In other words, did you have a mix of business that changed significantly, did your market share change significantly, are there things that might have

impacted those trend numbers unusually?

**Tray Swaker:** I would say nationally we observed the same phenomenon, but not as significantly as we observed in New Hampshire, so the negative inpatient trend was not true nationally, but closer to zero. But still most single digit trends for professional outpatient services. The mix of business hasn't changed dramatically, covered lives have increased a little bit in 2010 over 2009, but we do try to strip that out when analyzing total medical costs by state. I don't think that that is significant. But I think that there is a little statistical fluctuation because of the number of lives we cover in New Hampshire versus our national average experience.

**Tyler Brannen:** What impact on premiums have your efforts with the ACO and the medical home had?

**Tray Swaker:** It's been modest to date so the ACO started in 2008. I think for the first time this year we've actually changed our reimbursement methodology to a risk-sharing arrangement so it is at one facility, but up until then we hadn't changed our form of reimbursement methodology it was really just a health coordinator and the coordinated information sharing both CIGNA and Dartmouth for those results. So it hasn't materially impacted the trend to date, but the risk-sharing arrangement is factored into our forward looking outlook for unit cost trend. Overall it is not materially different when you consider all health care charges in 2012 versus 2011. We are still expecting a 4 to 5% rate change in unit cost on a going forward basis.

**Pat Gillespie:** Presumably as we move forward and we close these gaps in care particularly for diabetes, hypertension and these other diseases you are avoiding costs which will hopefully show up further on down as the agreements mature, as we continue to hold the providers accountable, I mean that's part of the model in addition to improving care is to hold the providers accountable for that improved quality.

**James Highland:** Two questions, one follow-up. Have you studied at all what your continuity of membership is? You've been doing it since 2008 improving gap and care for people with diabetes none of those people staying in the product and are you able to follow that up?

**Tray Swaker:** I think that the stat you mentioned on the reductions are based on a control match of a year to year membership. I don't have offhand how many members there were in that continued...08, 09.

**Pat Gillespie:** If you would like us to supplement that we can ask and see if we can "t" up that data but as Tray said we are measuring it over a period of time.

**James Highland:** Do you have any observations about looking at the 09-10 period what specific clinical areas or services areas in detail that would go beyond anything that was in the information requested that you could offer that was driving costs and utilization. Which things were higher, which things were lower.

**Pat Gillespie:** I think across the board we could see within outpatient higher I think dialysis trends, sort of higher than average trends. Within inpatient it was majority routine core admits that were down significantly. So what you might consider catastrophic or even more unpredictable those trended flat with modest increases but don't make up the majority of inpatient admit. So in terms of

the unit cost increases if you break it down by category we do see the higher rates of change with some of the high tech radiology and some of the categories other carriers have mentioned, but nothing different from prior testimony.

**David Sky:** You talked about important gaps in care and gave some numbers like with hypertension that there was a 60% improvement. What does that mean, how is that calculated. Tell me more about that.

**Tray Swaker:** Sure. Again, we have measured that against people who are in a controlled group who did not have the benefit of the accountable care coordinator and we set up a group of criteria making sure that prescriptions are filled, making sure that they have follow-up visits, making sure that for these chronic conditions they keep up with their treatment and identify gaps where people who are not a part of this project they would not get their prescription filled, they would not have follow-up visits and so on and so forth. If you would like I can try to give you some more detail about how it is calculated, but there are gaps in care particularly for these chronic conditions you are talking about worse results over time with people not keeping up with their treatment that results in either hospitalization or other more serious medical problems associated with their condition.

**David Sky:** So there is extra cost in implementing the program but there is a savings and what is the net effect on premium.

**Tray Swaker:** Correct. Today's been modest because we haven't until just recently changed our reimbursement methodology with the system. So closing the gap in care doesn't mean immediate decrease in cost but it serves as a future expectation that there could be fewer episodes so to date it hasn't factored materially into our pricing. And again the majority of the business that we have here is self-funded so it is customers paying claims out of their own bank account we are just providing the administrative service and coordinating on their behalf. So we continue to watch both the trend for premium and what is withdrawn from our customers bank accounts within future years.

**Pat Gillespie:** Again, just to get the company message we are trying to sell better health as well in addition to trying to control costs.

**Roger Sevigny:** Thank you.

Next, what I would like to do is ask Vanessa, cause I know she has got to leave, so if you have time Vanessa to you want to come up and speak now? Knowing that you have to leave soon.

**Vanessa Santarelli (Bi-State Primary Care Association):** Good morning. Good morning Commissioner Sevigny and members of the panel. My name is Vanessa Santarelli and I serve as Director of New Hampshire public policy for Bi-State Primary Care Association. Let me just preface my remarks by saying I didn't exactly stick to the topic for today, I added a little bit to it so hopefully you will indulge me.

Bi-State is a 501c3 non-profit organization whose members include: Federally Qualified Health Centers (FQHCs); FQHC Look Alikes (LALs); Rural Health Centers; a few hospital-based primary care practices; and free standing Community Health Centers. I want to thank you for the opportunity to provide testimony on this very important issue of rising health insurance costs. I am here to offer comments about how the rising cost of health insurance is adversely impacting our Community Health Centers

(CHCs), their employees, their patients, and New Hampshire's health care system overall.

As I talk about this topic I think it will actually tie into some of the things that some of the carriers talked about in terms of cost-shifting onto the private insurance market.

In 2010, Bi-State's members provided comprehensive and integrated primary and preventive care services in 32 New Hampshire communities to approximately 125,000 individuals (or approximately 1 in 10 New Hampshire residents). While recent state budget cuts of over 43% in the Community Health Center's general fund appropriations to provide direct medical services for the uninsured and underserved are having severe consequences on patient access to care and the primary care professional shortage; there is another factor that is exacerbating this problem – and that's the rising cost to provide health insurance for our Community Health Center's employees.

New Hampshire's CHCs provide access to care to anyone, regardless of their insurance status, including the uninsured. And providing equal access to the medically underserved is at the core of the mission of the Community Health Centers, but it also puts them in a fragile financial position. Due to the fact that New Hampshire's CHCs already operate on razor thin margins (*In 2010, the average number of days cash on hand at the Community Health Centers was 27 days, and that was actually before the state budget cuts this recent budget session),* they simply cannot afford to pay the rate increases to maintain health benefits for their employees and have resources left over to support the critical programs and services that they provide to their patients.

We asked our members to tell us what they are facing in terms of health insurance rate increases for the coming year, and from those who responded, the percentage increases ranged from a low of 22% to a high of 40%. And these costs are simply unsustainable numbers. The effects of this are serious and significant, and we request that the department work immediately to identify solutions to these problems by helping to reduce the cost of health insurance to providers of essential state services, like the Community Health Centers. And, we are willing and stand ready to work with the department and with the carriers and with others in this effort, including the legislature.

Below you will see, I have copies of testimony for you all, we've outlined some of the most significant consequences that we believe will come as a result of this crisis situation.

The first is the high insurance cost affecting recruitment and retention of primary care providers. Several of Bi-State's members have said that they will no longer be able to offer health insurance to their employees moving forward if they have to absorb these high insurance rate costs. This is problematic on a number of fronts: The inability to offer a competitive benefits package, especially to those with an advanced medical, dental, or nursing degree, will result in significant losses of staff, both medical and administrative. New Hampshire, like the rest of the country is in the middle of a primary care professional shortage. If New Hampshire's CHCs, many of which are located in rural areas, can't offer health insurance to their clinicians and professional staff, they will leave and, perhaps out of the community altogether. This has a direct impact on patient access to care, the fewer physicians and nurse practitioners you have, the fewer patients that can be enrolled in a medical home model of care. The fact that many hospitals have also been forced to lay off staff as a result of the state budget cuts, makes it less likely that our former clinicians would be able to find gainful employment in their region or anywhere in the state.

And, I would just say that we are actually, on a quarterly basis, checking in with our members about

the recent budget cuts and the impact that they are having on their providers. And, already so many of them have already had to lay-off some providers and we have asked if those providers remained in the community of if they have left. And, in a lot of cases they have left not just the community, but they have left the state. So that is going to create, I think, some other challenges moving forward in terms of providing access.
The second potential consequence that we can see is that fewer providers equals a loss of access to primary care and higher emergency department utilization. If the CHCs are unable to attract and retain primary care providers, it will worsen an already costly situation. Inappropriate emergency department utilization, that is to say individuals using emergency departments for non-emergency needs is incredibly costly and can be reduced if patients go to their primary care providers first for primary and acute care. For example, the average cost of a primary preventive health care visit at an FQHC is $150.00 according to national HRSA UDS data for 2010; but the average cost of an emergency department visit is between $1,500 and $2,500 according to the Medical Expenditure Panel Survey of 2008. However, if New Hampshire loses primary care capacity because of the reasons listed above, it will likely lead to higher frequency of inappropriate emergency department usage, costing the overall health care system more. Because patients don't like to wait for appointments when they are experiencing an acute care situation, such as an ear infection, if they lose their primary care provider and wait times grow at the health centers, they will go to the emergency department to address their situations with higher frequency.

I would just say actually some of our health centers have engaged in some really innovative pilot programs including ones having to do with high – there was a pharmacy pilot that was funded by HRSA for chronic diseases and diabetic patients. We actually showed at that health center significant drops both in inpatient stays at the hospital and ED utilization so these high frequency chronic disease patients.

And the final consequence that we can see sort of coming and continue to escalate is that paying more for health insurance takes resources away from patient health services. As I mentioned above, the Community Health Centers operate on tight margins. They work to consolidate back office functions, participate in a purchasing pool for goods and services, and strive for other efficiencies, so that they can put the dollars saved back into direct patient medical care. However, the recent rise in health insurance rates will not only make it impossible to do this, but it also may result in their having to scale back or eliminate the kinds of programs and services that improve patient health and save the overall health care system in avoidable inpatient hospitalizations. It is the goal of the CHCs to serve more patients, not fewer, but, attaining such a goal is becoming increasingly out of reach as the cumulative effects of cuts at the federal, state, and local level are realized on top of these health insurance rate increases. And, I would just mention that 6 of our health center members have achieved NCQA level 3 designation, and so that's obviously a designation that is very difficult to achieve, it's the highest quality care, and 6 of our members have achieved it, several others are going through the process right now, but that basically means that there patient center medical home level 3 highest quality.

I just want, in closing, to thank the commissioner and the department for holding this annual premium rate review hearing. We are committed to working together on finding ways to improve the health of the people of New Hampshire, and we hope that the issues raised in our testimony to compel actions to be taken to ensure the sustainability and availability of access to comprehensive and integrated primary care services for all. I'd be pleased to answer any questions. Thank you so much.

**Roger Sevigny:** Thank you Vanessa.

**David Sky:** I was wondering approximately what portion of the budget represents these, do health insurance benefits or employee welfare programs represent to the total budget of the average health center?

**Vanessa Santorelli:** Of their budget, I'd have to actually get back to you on that. They receive a patchwork of funding whether it's federal, state, foundation support, municipal support, the hospitals give them community benefit support, so that in terms of their, plus the reimbursement rates that they get so that is where their revenue comes from in terms of their total budget I am not totally sure, I assume that it may depend center to center, but I can get back to you on that.

**David Sky:** What about the population you serve, do you serve any of the insured population, and then maybe you could talk a little bit about, from the other side, the negotiation process, the pressures that you have been feeling in the negotiation process with carriers on reimbursement rates.

**Vanessa Santorelli:** I can definitely speak to the insured population that we serve, again, it varies from center to center. We serve all patients. So, we serve the uninsured, we serve privately insured, Medicaid, Medicare, you name it. Our doors are open anybody can come and get, actually I have private insurance and I am a patient of the Manchester Community Health Center. I think if you look at all of our Community Health Centers, I want to say that the privately insured population makes up between 17 to 22%, but again, depending on which health center you are talking about, if you are talking about White Mountain Community Health Center in Conway, they really don't have a lot of privately insured patients, mostly Medicaid and uninsured. But if you are talking about Mid-State Health Center in Plymouth, they have a larger percentage of privately insured patients, and in fact, in a lot of communities, the community health center is the only primary care provider. In Berlin and Gorham there isn't another primary care provider within 25 to 30 miles. So it varies from site to site, and in a lot of communities it is actually a provider of choice because of the high quality care that they deliver.

In terms of the negotiations between our health centers and the carriers, I'd have to talk to them about that, I'm not sure. And I know as we move forward with Medicaid care management initiatives we want to make sure that the health centers are included in the provider panel that the insurance companies are mandated to work with in that situation. I can get back to you on that as well.

**Roger Sevigny:** Thank you Vanessa.

I am going to break this for a very short maybe 5 minutes or so for the transition. Tyler and I have to leave to go before the Legislature. Alex will take over conducting the hearing. So if you could take about 5 minutes and come back in and we will resume the hearing.

**Alex Feldvebel:** Scott Colby has a pressing engagement so he will start us off.

**Scott Colby:** Thank you very much I appreciate that. And thank you for giving us the opportunity to speak today. I don't have written testimony this morning, but I have a few words that I would like to say addressing not only the cost shift but also some of the new benefit designs and steerage mechanisms that are being employed in the market.

My name is Scott Colby. I am the Executive Vice President of the **New Hampshire Medical Society**.

The Medical Society was formed in 1791. We are the state's largest physician organization and we represent over 2,100 physicians in New Hampshire.

The Medical Society offers general support to physicians in the practice of medicine in promoting health for their patients and public health as well. In the pursuit of our mission one of the things that we offer to our physician members is a Medical Society association health plan. And, so while we represent providers of service we too are a significant carrier, if you will, of insurance, not an insurance carrier, but certainly a plan sponsor. The Medical Society association health plan has approximately 1,100 subscribers. Of those subscribers approximately 600 are physicians in the state of New Hampshire. We have 2,300 members, and like many of the comments made earlier today by the carriers, we too see an aging population which is having a direct impact on the rate of increase in our premiums. We are fortunate, however, this year that as a large cooperative able to under the association plan smooth our risk, if you will, so that we can take small employers of one and two individuals and pool them together in the size I just mentioned, we are able to realize significant savings for our physician members this year. I think that is one of the exceptions perhaps to what we hear in the market, but I am told by our carrier that the savings this year to our groups has been in excess of $2 million dollars in premium. So we are very pleased by that.

The reason I mention that is because, as we heard from Vanessa a few minutes ago, our physicians are under great pressure in running their own businesses. Lisa Guertin mentioned that 75% of primary care physicians are employed by health systems in this state and that approximately 50% of specialists are. And the Medical Society would subscribe that the reasons behind that have less to do with desire the health systems have to employ physicians and more to do with the economic necessity that physicians aren't able any longer to effectively maintain and manage a viable practice due to in large part to significant cuts on the part of the federal and state governments relative to reimbursement.

Which leads me to my next issue and that is I wanted to address the issue of cost-shifting. We hear a tremendous amount about cost-shifting and at least from my vantage point, I've been with the Medical Society 15 months, that's typically been associated with hospital costs and the underfunding of the hospitals by the federal and state governments. However, for those in the room who work for the health systems and hospitals and are providers, maybe for everybody, physicians themselves face significant cuts January 1st. The federal government is poised to reduce physician reimbursement under the Medicare system across the board by 29.5%. Unfortunately, with the deficit reduction talks now taking place in the super-committee behind closed doors, and recommendations that have come out of Medpac that would have a devastating consequence on all providers, we believe that there is a decent chance that this 29.5% decrease is going to occur. What this means for the average physician practice with well over 30% of its revenue coming from Medicare is that it will see a top line reduction in revenue of at least 9% and for some of the more vulnerable specialties 25% of overall revenues as a result of these cuts. This is going to impact not only the independent physician but our colleagues that are employed by health systems as well. So while we saw our health systems take a $150 million dollar cut in reimbursement under the Medicaid program I can't imagine what the additional 30% under Medicare is going to do to compound that problem. Surely that is going to have access implications, and as Vanessa pointed out, our Community Health Centers are already struggling to keep their doors open and provide access in our most vulnerable communities.

So let me back that up with an anecdotal example. I was at a workers' comp advisory council meeting the other day a physician mentioned how in 2004 the reimbursement from Medicare for a knee replacement was $2,200 face value of the check, unadjusted for inflation Medicare today pays that

physician $1,200. And come January 1st that will be $800. You cannot sustain a business with the trend and 30% of your revenue going in that direction. It has been shifted to the carriers. Lisa, I believe, indicated that there's really no more room to shift, not really to the carriers but to the employers. So where does it come from?

I was at a meeting Wednesday with a large primary care group who was looking to expand and open a second office, independent practice, not hospital affiliated, and has had to put their expansion on hold. So they were looking to actually bring in new providers, open another office, and improve access to the citizens of New Hampshire, but the reason they have put that on hold because when a 30% reduction in Medicare is looming over their head that cannot possibly, responsibly invest the kind of capital that needs to be invested to increase access for residents.

These are large issues they are not going away. From our perspective a lot of focus has been on the cuts that the hospitals have endured, but again we face a very, very large threat on January 1st.

So with that I would like to just switch my gears a little bit to the tiered networks and steerage programs that we are seeing in the State. We have seen different programs to incentivize individuals to choose certain providers based on the price, if you will, and while we understand these are borne out of economic necessity, and that they are market driven, the Medical Society does just wish to ask the Department and also the carriers to consider one thing when working at these programs. We believe that pure economic credentialing can be detrimental to the patient. And that if we are simply steering patients to the lowest cost provider without consideration for quality then there will be some concerns and there could be some negative consequences. I believe the health plans are well intended when they institute these kinds of programs and I do know that the health plans do offer their own credentialing, and the patients are in fact steered to credentialed providers within the network. However, I would simply ask that as the popularity of these programs grows and that the access in these programs expands that the carriers be mindful of the importance of quality metrics around steering patients to care.

And with that I would like to conclude my remarks. I'd like to thank the Department again for these hearings I think they are very important and the Medical Society is very grateful for the opportunity to speak. And with that if you have any questions I would be happy to entertain them and if I can't provide the specific information I'd be happy to follow-up in writing.

**Alex Feldvebel:** Just one point, I think it is interesting when the Department invited representatives from the provider community to attend the hearing we didn't anticipate that much of the testimony would be health providers as employers, purchasers of health insurance. So I think that is a significant fact in itself.

**Scott Colby:** Right. Thank you very much.

**Alex Feldvebel:** Now could we hear from Mike Degnan on behalf of the **New Hampshire Health Plan, New Hampshire High Risk Pool for the Individual Health Insurance Market.**

**Michael Degnan:** Thank you very much. I am here by myself so any tough questions I will have David Sky answer for me. Anyway thanks very much. My name is Mike Degnan and I am the Executive Director of the New Hampshire Individual Health Plan Benefit Association commonly known was the New Hampshire Health Plan. We operate 2 insurance programs that offer coverage in the individual

market here in New Hampshire to citizens who are unable to obtain comprehensive coverage. The first is what you probably mostly know about is the State high risk pool, and the second is the federal pre-existing condition insurance plan which was one of the first initiatives of the Accountable Care Act.

The New Hampshire Health Plan is a not for profit voluntary organization established by the State of New Hampshire under RSA chapter 404-G. NHHP is a virtual company with no employees. The State program began operation in 2002 and currently serves 2,400 New Hampshire residents. We have three sources of funding in the State program, the first is carrier assessments, both Lisa and Beth talked about the carrier assessments and assessments levels, 2011 will be $6.2 million dollars to fund our program; we collect premiums from our enrollees and we have a small amount of federal grants. Our total budgeted revenue for 2011 is $20.7 million dollars. The carrier assessment is on a per member per month basis and the assessment rate for 2011 was $1.25/pmpm. And as both Beth and Lisa said the assessment fees are built into the costs that the carriers charge their customers.

The State program is a market mechanism envisioned as a safety net for accessibility to the individual market. We offer coverage to individuals who have been denied coverage due to a preexisting conditions of specific illnesses, and it is more and more becoming a safety net for affordability for micro groups in the small group market as well. As I mentioned previously, we have 2,400 enrollees today, that's a 51 percent increase since the start of the year. And interestingly enough our loss ratio for the State plan is 144 percent. We are doing better than the federal programs are.

The State high risk pool we have 7 coverage plans that we offer. These plans reflect offerings that exist in the individual market. We use leased networks for both our pharmacy services and clinical services. Our provider network is First Health Coventry and our pharmacy network is Restat. We also have developed our own inpatient provider network it offers deeper discounts than Coventry is now currently offering.

Our rate setting process for the State program is set by statute RSA 404-G:5-d. We analyze the carrier policy offerings in the individual market and calculate the standard risk rate. Once the standard risk rate is developed we set our rate at between 125 percent and 150 percent of that standard risk rate. We have been at the 125 percent rate since about 2006. And our rates are set on a semi-annual basis. The State program does offer a low income premium subsidy program that is funded by a grant from CMS. The current subsidy program offers discounts up to 20 percent of premium depending on the resources of the individual.

Talk a minute about the PCIP program. New Hampshire was the first state in the nation to contract with HHS for the PCIP program. We had the first enrollee in the nation, a woman who enrolled July 1, 2010. We offer coverage to individuals who have not had creditable coverage for the last 6 months, citizens and nationals of the United States and have a preexisting condition or have been denied coverage in the individual market. The PCIP program is totally funded by the federal government.

There are no State funds used to operate the program in any way whatsoever. We offer 3 coverage plans in the PCIP program and the rates are set at 100 percent of the standard risk rate. All rates and coverage plans require HHS approval prior to implementation. We currently have 258 individuals in the PCIP program here in New Hampshire. The key issue about the PCIP program is we were allocated $20 million dollars for this program here in New Hampshire to operate through 2013. And the way our calculations have gone we will run out of money in the second quarter of 2012. Our current loss ratio is about 1900 percent. Incredible program, it's going really well! So, we are currently in negotiations

with HHS about additional funding for 2012 and 2013. Yesterday, I was notified that they allocated us an additional $3 million dollars for 2011. So we are totally funded through 2011. I am pretty sure that we will be able to get through 2012 with this program. I am concerned about the viability of the program after that. On the national level the program was allocated $5 billion dollars for this. The national association of high risk pools estimated that they probably needed $25 billion to fund this program to the period of time they were trying to get it done.

So, I have asked in writing, with the approval of the Department, for an additional $106 million dollars for this program to fund us through until the exchanges come into place. I really believe we will get plenty for 2012 and potentially there could be a stopping of enrollment in 2013 cause I just don't see how we are going to get the level of funding we need to keep going.

But I think in summary NHHP offers two programs for the individual market – the State program which is actually funded by carrier assessments, and the federal program which is entirely funded by the federal government. The rest are set by using standard risk rates. And the bottom line is for our coverage the 2 programs, if this wasn't available we are serving over 2,700 people in New Hampshire today, I think individuals would be receiving charity care from the providers or not receiving care at all.

Thank you very much for the opportunity.

**Alex Feldvebel:** Thank you.

**Michael Degnan:** Thanks Alex.

**Alex Feldvebel:** Now could we hear from Paula Minnehan on behalf of the **New Hampshire Hospital Association**. Are you going to talk about the cost of health insurance for your employees?

**Paula Minnehan:** No, do you want me to?

**Alex Feldvebel:** No, that's alright.

**Paula Minnehan:** Good morning Alex and everyone from the Department of Insurance. My name is Paula Minnehan and I am the Vice President, Finance and Rural Hospitals at the New Hampshire Hospital Association, representing the state's 32 acute care and specialty hospitals. Thank you for the opportunity to appear before you today.

The Association and its member hospitals are committed to keeping health care affordable, and we believe this should involve every segment of the health care system – hospitals, insurers, other health care providers, businesses, government and individuals.

As stated earlier, I think by Beth, the status quo is not an option moving forward. We believe having a more transparent, public process to begin the dialogue of what factors drive premium rate increases is a positive step towards reform of the health care system. We see payment reform as moving away from fee-for-service medicine towards a more integrated form of health care delivery and reimbursement that will align incentives for providers and payors so that better, higher quality and more cost effective care is rewarded over simply doing more. We believe that fundamental reform must include changes that align payments and incentives across the health care system in a manner that improves access to care, and that achieves the most efficient, affordable, high quality health care.

And the solutions that must address all of the drivers of health care costs are challenging and facing our health care system are much broader and deeper than one segment alone. While hospitals certainly have a role to play there are many factors that contribute to the rising cost of health care and health insurance premiums, such as: the cost shift from the underpayment from Medicaid and Medicare which you will learn more about in a minute, and those who have no insurance, pharmaceutical costs and profits; health insurance company profits; the administrative costs for hospitals, doctors and other health care providers of billing for services from private insurers; technology costs, benefit plan designs that do not provide the right incentives for people to lead healthier lives and that shield them from the cost of their care; and individual choices such as smoking and misuse of alcohol. We believe, if we are going to truly create meaningful, lasting change, we must examine all elements of the system to more effectively manage escalating health care costs.

And one big challenge, of course, that is facing our hospitals is government underfunding. Which does contribute to higher health care premiums, no question about it. One of the most significant contributing factors to the high rate of health insurance premiums in New Hampshire is the fact that public programs, such as Medicaid and Medicare, do not pay the cost of services for the people who rely on those programs for their care. In New Hampshire, hospitals are being paid on average, it was over 50 percent, it is now well below 50 percent, of allowable cost for providing care to Medicaid beneficiaries, and 82 percent of the allowable cost to Medicare beneficiaries. That was 2009 data. In total, this cost shift amounts to $500 million dollars that gets added to the bills of those with private insurance to make up for the losses from Medicaid, Medicare, the uninsured and those who are unable to pay their bills.

And this problem was only made worse in June when the State budget was passed which included additional spending cuts, including Medicaid payments to hospitals by an additional $250 million through the end of the current biennium. That is on top of cuts enacted over the past couple of years, bringing the total spending cuts to hospitals to over $300 million dollars.

As the economy worsens, more granite state residents have lost their jobs and with it the health insurance they and their families depend on. That has pushed the number of people eligible to receive state-sponsored health care coverage through the Medicaid program up.

Hospitals are seeing more people come to their doors for care who have no insurance and who are having difficulty paying for their care. Charity care and bad debt are up across New Hampshire. And more people, unfortunately, are delaying care as uncertainty over their employment and economic situations continue.

All of this has had a significant impact on the financial condition of New Hampshire's hospital systems, which includes not only the care provided to patients on an inpatient basis, but also components under the hospital which include physician practices, nursing homes, home health care, ambulance and many others. In 2010, 7 New Hampshire hospital systems showed negative operating margins, meaning that those providers lost money on their operations. Another 5 are just at break even between 0 and 1 percent. Based on a recent survey of our members, almost all hospitals have seen a decline in their overall financial health. In addition, the stress on physician practices continues to grow as more seek the financial support of hospitals, including selling their practices or seeking hospital employment.

Alternative payment and delivery systems are certainly innovations that are taking place in the health care system and we're eager to learn more about accountable care organizations where providers, payors and patients have aligned incentives to provide the right care, at the right time, in the right place, every time. The ACO model is an important part of health care reform and by health care organizations around the country as they seek to develop these systems.
Many hospital systems in New Hampshire are currently working to develop an ACO model and this is because they fundamentally believe that the current method of fee-for-service payments must change so that incentives are properly aligned for providers, payors, businesses and patients. For the past couple of years, hospitals have been working through the Citizens Health Initiative payment reform pillar project to develop a pilot project to test a new payment and delivery model where providers would be responsible for the health of the population, including costs and outcomes. Providers would form an ACO that would be responsible for serving those patients in the most efficient and effective manner.

While implementing health reform in New Hampshire has been stalled it does not meant that the parties can't continue to work collaboratively to implement payment reform models, including the ACO pilots. And, in addition, we are interested in seeing the parties work together to reduce administrative costs through administrative simplification. Legislation is not needed to move forward on some of these innovative approaches that could prove to be effective tools in reducing health care costs.

Thank you, and I would be happy to answer any questions.

**James Highland:** Looking at the period 2009 to 2010 what were the change in Medicaid funding for hospitals?

**Paula Minnehan:** 2009 to 2010 it was about 54 percent of cost for hospitals and now it is below 50 percent. And in fact,

**James Highland:** That happened over that one year period?

**Paula Minnehan:** "Yes", and in fact now because of, and I don't know how much you've read on what is going on with the budget, but because of the change in the way disproportionate share payments are paid to hospitals and in the case of PPS hospitals, larger hospitals will not receive this payment, they actually are net payors to the system, they are paying the State of New Hampshire to be Medicaid patients because what they get paid in Medicaid is lower than what they are paying in a tax, the Medicaid enhancement tax. And the critical access hospitals, it is contemplated they will receive some DSH payments this year but we have not seen any data to indicate what that will be yet.

**James Highland:** What do you see as the biggest barriers or challenges to implementing an ACO model?

**Paula Minnehan:** Good question. The problem for us is that we what we want to do and what we have to deal with right now are so fundamentally different stratospheres it is hard to focus on moving forward with an ACO model which is an integration of care. I would have to say that one barrier is some of the strategies that some of the health plans have employed that have been discussed like the site of service plan is really making it difficult for an integration model to be successful. Because, as far as the services that the hospitals made money on, the services they are directing away from the

hospitals are what the hospitals are left with are trauma, inpatient, OB, cardiac, all of the very expensive services that need to be cross-subsidized, and there is nothing to cross-subsidize with unfortunately. ED is very expensive, so that is one of the biggest challenges, I would say right now, is that their reality and what they want to work towards is very difficult. It is not aligned at all.

**Alex Feldvebel:** I have a similar question. In terms of, you placed an emphasis on payment reform and particularly how the accountable care organization are opposed to the other model of tiered networks and site of service differentials. What do you see as the best avenue for promoting that kind of payment reform. We've heard about the coordinated effort through the Citizens Health Initiative, we have also heard several carriers mention their own individual efforts to set up accountable care organization models, what do you see as the most productive way of promoting that kind of payment reform?

**Paula Minnehan:** Very good question. I don't know. I understand why the carriers are doing what they are doing. It's a short term solution, it is not a long term solution. I guess I would say we just, it sounds like Pollyanna, but people that know me I sort of am Pollyanna, I believe that we stick together and start working on these things, having an adversarial relationship and everything that hits the press, all these battles between providers and carriers, we are not making progress, we are just battling and they both end up bloodied and in two different corners and no one is happy and the patients are caught in the middle. I don't think anyone here would agree that's a good model so we should sit down and start trying to work some of this stuff out. It is not easy, as we all know, we have all been in this business a long time, it is very complicated, but I think the parties present that work in New Hampshire are willing to do it, I know they are, so we just need to kinda roll up our sleeves and start plugging away. But there are a lot of barriers, not having federal funding to be planning for the exchange, all of these things make it very difficult for agencies like yours to make progress, and then it falls to the private sector, but then again we are all dealing with our economic realities, so it makes it very difficult. So a very good question but I think everyone is willing to sit down and start working on this, and I think we should.

**Alex Feldvebel:** Thank you.

**Paula Minnehan:** You are welcome.

**Alex Feldvebel:** We have two more people signed up to speak. I would like to ask Tom Bunnell of **New Hampshire Voices for Health** to come up.

**Tom Bunnell:** Deputy Commissioner Feldvebel and Department staff: Good morning, it is still morning. Thank you for this opportunity to provide testimony on premium rates in the health insurance market.

My name is Tom Bunnell. I am Director of the Institute for Health Law in New Hampshire, and I am offering brief testimony today on behalf of NH Voices for Health, also known as "Voices." Voices is a network of consumer and advocacy organizations and individuals allied in their commitment to securing quality, affordable health care and coverage for the residents of New Hampshire. The network represents over 200,000 members, consumers and constituents statewide.

It is no secret that New Hampshire families and businesses are struggling to afford premiums that have been rising faster than inflation, faster than wages, and faster than average business profits.

According to surveys by the federal Agency for Healthcare Research and Quality (AHRQ), health insurance premiums increased by 119 percent in New Hampshire between 1999 and 2009. That's the equivalent of a double-digit rate of premium increase for each of those 10 years, and it was 4.3 times faster than average employee earnings rose over that same period. These unsustainable increases in the cost of health coverage destabilize budgets for families, employers, and government at all levels in our state, and threaten all of our financial sustainability and stability.

For those reasons, and since New Hampshire has some of the highest health insurance premium costs in the nation, health care and coverage costs are a non-partisan issue – they are an issue that transcends partisanship in our state. And they are a matter of compelling concern to families, to the business community, and to the public at large.

So we are grateful to the Insurance Department for a process that will provide transparency, that will give all of us better and clearer information about the varied components of premium costs, including underlying health care costs, and the reasons for rate increases.

There is an age-old adage, applicable here, that sunlight is the best disinfectant. We are confident that health insurers and health care providers want to be good citizens. And so for them, this kind of transparency is merely a sensible, pragmatic, and meaningful building block to public understanding. But it is also the kind of transparency that allows and enables health insurers and health care providers to be accountable to their payors and customers. And isn't that what a healthy and functioning free market is all about?

We thank you for this rate review process, and for your attention to and consideration of these matters. Voices is happy to be a resource to you as you engage in this effort moving forward.

Thank you.

**Alex Feldvebel:** Okay, now there are two more people. Deb pointed out that I had missed one person that had signed up. Can we have **Jill Shafer Hammond**.

**Jill Shafer Hammond:** Thank you Assistant Commissioner for letting me speak this morning. Good morning, my name is Jill Shafer Hammond. In my professional life I am a freelance graphic designer. I live in Peterborough. You would think that this position would involve little discussion of health care costs, but I assure you that between my work and my daily interaction with a lot of other small businesses in the Peterborough area that health care costs are a really important part of our lives and our concerns. And also, I am on good speaking terms with our local hospital administrator and I know a lot of the problems that they are facing which were just outlined. I am also a former state representative and I served on the commerce committee and I heard a lot about the struggles that small businesses trying to provide health insurance for their employees, and I am also aware what our local school districts, and our municipalities go through in trying to buy health insurance for their employees.

Increased premiums have forced many of these employers to shift increased costs to their employees who may or may not be able to pick them up, may drop their own insurance and ultimately the employers drop the insurance altogether. And as I have seen over the last decade or so it is a slow motion death spiral going on for small businesses who are increasingly getting out of the market and people are just left to cope as best they can which in a lot of cases is not at all.

You guys are talking about the people who can afford to buy insurance. A lot of people can't. They work part-time. I'll give you an example, I share my house with 3 other women who earn minimum wage. We are all divorced, we all have grown children, we are all just coping, making ends meet. The various jobs we work at are part-time, I am a freelance graphic design, another woman does illustration work, another one is, has an advanced music degree; she would love to be teaching music to people, but she makes a living most of the time as a substitute teacher. Another woman also likes to do artwork but most of the time she is doing child work, gardening work, seasonal work at ski places or if EMS is hiring for the season she works during Christmas time. These three other women cannot afford health insurance. One would qualify for the high risk pool, she can't afford the premiums on a part-time income. These are a lot of people who are just left out of the system. Some of them have assets from their divorce so they don't qualify for Medicaid. We are in a trap. But they could possibly afford something if there was a mechanism so that they could contribute to the system in some way. For myself, as a former state rep, I have been able to buy in to the state employees' plan. It is very expensive from my standpoint, although I know it is a very competitive price if I were out in the private market. And because I did have one year where I went without insurance altogether I am not sure that I could afford to get back into the private market certainly not with a deductible that would be possible. I would like to have a deductible that was maybe $1,500. I probably would be lucky if I could get one with $5,000. On the state employees' plan my maximum out of pocket is $500.

Another part of the state employees' plan, now understand this is a self-insured plan so I am in a different kind of category, is that once a year, there is usually an adjustment in the premium. The annual premium goes up. It start out at $480 something when I started, it is now at $616 for an individual, but there is usually one month in April or May where we get a rebate. This past year the monthly premium was $350 at one point a drop of $250 because the previous year the cost hadn't been as great as they had anticipated so we got a rebate on our premium. I had a public option. Be interesting to see if that could happen anywhere else.

The rate review process facilitated by the New Hampshire Insurance Department could help us chip away at the underlying reasons for some of these increasing costs and provide the public with the transparency and accountability we should already receive in the health insurance services we purchase. For example, one of the questions I would like to have answered is how much of our premium dollars go for insurance company profits? The medical loss ratio establishes guidelines for the upper threshold, but as consumers of a product we all need we have a right to know how much is going to care versus profit. Another state with medical loss ratios showed that the insurance companies did have to give a rebate or a lower premium back to enrollees. And, if health care cost savings strategies like medical homes and ACO's do produce savings will those savings go into insurance profits or will they go back to the premium payers?

Another question concerns how much of a premium charge is cost that is shifted to us by health care providers to cover the uncompensated care costs of the insured or to cover the costs of what hospitals and doctors claim is underpayment by public insurance programs like Medicare and Medicaid. Something I see as a problem that we have always had here in New Hampshire and became really apparent to me while I was on the commerce committee is that there is absolutely no state support to help people pay insurance premiums if they cannot afford them. And so they then become part of the people who access and get uncompensated care which puts an incredible burden on our health care providers. And I see in our system people like my housemates who can't afford to buy insurance but could pay something and health care providers who are desperate to have some other sources of

revenue. What can we do to connect these two?

I for one believe the personal responsibility provision in the new personal responsibility provision in the new health law which ensures that everyone would have access and afford health care coverage to do so will create cost savings for the rest of us. In a time when the political rhetoric is to undermine this key provision of the new health law I would like solid data that points to what those cost savings will be. I encourage the committee to consider these questions and seek the answers as part of the rate review process and to make the report widely available to the public. Let's start paying for health care not health insurance and let's start by knowing what we are paying for right now.

Thank you for your time and I will take any questions.

**Alex Feldvebel:** Thank you Jill. I do want to announce that the Department will be producing a report under the statute that creates this yearly hearing. We also produce a yearly report providing our analysis which will be based in part on the information that we received today, in part on data that we have requested from the carriers and on our independent research.
So our final speaker is Zandra Rice Hawkins.

**Zandra Rice Hawkins:** Good morning. My name is Zandra Rice Hawkins. I am the Executive Director of **Granite State Progress Education Fund**, and we are a multi-issue advocacy organization working on issues of immediate state and local concern.

Each year we poll our membership on their top issue concerns. And I can tell you that transparency and accountability is one of the top rated every year. Transparency in the public sector to ensure that people's voice is being heard and followed; and in the private sector, to ensure the "bill of goods" we're sold is accurate.

As such, rate review is of great interest to a good many people, and we are delighted to see New Hampshire born and raised state legislation is dovetailing so nicely with rate review guidelines established under the Affordable Care Act. Between the annual public hearing, the routine public comment sessions, and the anticipated website for rate filings, families and small business in our state will have revolutionary ways to access information about the cost of their rates and comment on whether the bill of goods they are receiving fit what they have been told.

This system of transparency and public accountability is a vital piece of making the U.S. health care system more realistic and more reflective of the needs of the American people.

Accountability is also an area where the NH Insurance Department's role really takes shape. New Hampshire needs you to be as thoughtful and thorough as possible in the questions you ask of insurance companies to make sure we receive the answers we need regarding health care costs and trends in our state. I have been pleased with some of the questions that have been asked so far today. In a time of record profits for the insurance industry, responsible hardworking granite staters have found themselves under water and struggling to get by, let alone to pay their increasing insurance premiums. By requiring insurance companies to public justify reasonable and unreasonable premium increases and to identify the specific cost drivers they see in those premium hikes, the NH Insurance Department can bring greater transparency and lower costs to the state.

One cost driver already identified this morning is increased radiology. Radiology of course is used to

treat and diagnose, used in several ways, to treat and diagnose the top two causes of death in the United States today which are heart disease and cancer, followed by respiratory disease. Why do I bring this up? New Hampshire recently reduced the tax on cigarettes with the justification that doing so would increase sales. If the state is successful it follows that the state will also increase the need for radiology use and therefore costs to increase health care which then will be translated to all of us. Identifying and then addressing these cost drivers is important and I encourage the NH Insurance Department to not shy away from addressing those.

We can look in the broader context at rate review and great examples in other states where strong accountability measures have produced tremendous savings in health care premiums and put money back in the pockets of local families. In Arkansas, effective rate review helped the Arkansas Insurance Commissioner negotiate a lower rate affecting approximately 90,000 policyholders. In North Carolina, expanding the Commissioner of Insurance's authority over health insurance rates contributed to savings of $14.5 million when the Commissioner denied a rate increase request from the State's largest insurance company.

We encourage to follow examples set by these other states and use the full extent of your mandate to collect information and provide accountability for the benefit of New Hampshire families and small businesses.

On another note, our organization would also encourage you to consider how you will share rate review information with the general public and to take the outreach steps necessary to ensure that families know how to access the fruits of your labor.

Of the report, is great, I see a great many reports on websites and I can tell you that families are not accessing those, so public education and awareness is certainly an important piece of this.

Similarly, and I am going to get darts from my professional colleagues here, we'd recommend the Department consider hosting the next public hearing in the evening or in other hours outside of the typical workday. Certainly for advocates, lobbyists and a small collection of consumers and small business we have the flexibility to determine our own schedule but many cannot take the time from the workday to attend. And while they can submit written comments opportunity to participate in person will be extremely important and I think particularly important going forward after this first or second round of premium increases have been proposed.

I thank you for your time this morning and I will take any questions you may have.

I will give you a copy of my written comments which will differ from my oral.

**Alex Feldvebel:** Thank you Zandra. Anyone else who wants to speak. Okay thank you very much. That closes the hearing. And the next step will be for the Department to produce its report. Which you will see later this year. If anyone wants to submit written comment we will be able to accept those through the next 10 days. Thanks.